CHAPTER 8

GENERAL OVERVIEW AND PRINCIPLES OF CLAIMS

Learning Outcomes

When you have completed this chapter you will be able to

- explain the general aims of an insurer's claims department;
- list and briefly describe the information needed to verify the policy details at the claim stage;
- explain why the claims department needs to verify the policy details at the claim stage;
- discuss the impact on a claim of the discovery that information had been concealed from the life insurer's underwriter at the inception of the policy;
- explain how the validity of a claim can be established;
- describe how the average life insurer deals with early claims;
- explain the general policy amongst life insurers when dealing with a claim where death was as a result of the suicide of the life insured.

The aims and objectives of any claims department in a life insurance office is the payment of claims as efficiently and speedily as possible. Allied to this is, however, the need to make sure that every claim is valid, and that the right amount is being paid to the correct person.

An insurance contract is essentially an agreement between the life insurer and the proposer, arising after:

- the proposer has provided the insurer with all the required information;
- declared that the information is complete and correct; and
- on the basis of this information, the insurer has accepted the proposal and sent a policy document to the policyowner.

When any policy claim is considered, the insurer deems it as being in the interests of all its policyholders to ensure that the information that was provided in the proposal, was indeed complete and correct, and that any payment is made within the provisions of the policy.

The general aims of an insurer's claims policy, including ex-gratia payments, is to:

- empower claims staff to deviate from certain provisions of the policy contract where necessary, in order to benefit the policyowner and his dependants;
- lay down guidelines regarding the extent to which information provided by the claimant must be checked;
- provide claims staff with the necessary assistance needed in the interpretation of policy provisions;
- limit or prevent inconsistency in decision making; and
- strive towards the principle of fairness at all times.

8.1 VERIFICATION OF INFORMATION ("RETROSPECTIVE UNDERWRITING")

One of the first procedures to be followed by the claims staff, upon receiving a claim against a policy, is to verify all information relevant to the policy contract. This includes calling for the file and checking the information provided at the inception of the contract, on the proposal form with the information provided with the claims documentation.

This must at no time be considered as underwriting at claims stage. The aim and objective is merely to verify information, and check that no non-disclosure of a material fact that could have affected the risk was withheld.

8.1.1 INSURABLE INTEREST

Insurable interest can be defined as **the legal right to insure,** and means that the proposer must have an actual, recognised relationship with the person to be insured, as a result of which **he would suffer a financial loss** if the event being insured against occurs.

It is the responsibility of the underwriter to check that insurable interest exists at the **inception** of the contract.

Should it, however, appear to the claims clerk when a claim arises, that insurable interest was accepted during the proposal stage based on false information, the claim must be very carefully assessed. If it is found that the false information provided would have had a material influence on the decision to accept the proposal, or not to accept the proposal, by the underwriter, the claims clerk should recommend to the claims committee that rejection of the claim be considered.

8.1.2 PERSONAL PARTICULARS

Verification of personal particulars is only necessary in those areas where incorrect information provided at inception would have had a bearing on the underwriting of the proposal. Information such as name, postal address and nominated beneficiary, whilst important, would probably not have led to the underwriter imposing a loading or rejecting the proposal. The personal particulars dealt with below could well have led to such a decision.

Age and gender

Where these have not been confirmed they need to be at claims stage.

Smoking habits

There is a significant difference in rates for smokers and non-smokers. It is therefore essential to check that anti-selection did not take place. Unfortunately it is very difficult to obtain proof that the information provided during proposal was incorrect, and only in cases where irrefutable evidence can be found, is it possible that the values be adjusted.

Occupation

Only in cases where conclusive proof is found that incorrect information was provided intentionally in order to obtain better benefits or rates, must a recalculation be done or, in extreme cases, repudiation of the claim be recommended.

Part-time activities

The claims clerk should check to see whether incorrect information was provided intentionally at the proposal stage in order to obtain better benefits or rates. Where this is the case it is likely that repudiation of the claim should be recommended.

Health aspects

Where a policy has been re-instated within the last 12 months it is imperative that all aspects of the insured's health be checked and verified. The reason for this is the possible non-disclosure of a deterioration of the health of the insured in the declaration of continued good health that was required at the time of reinstatement.

It is also advisable that the insured's health be checked and verified if the period before maturity of the policy is greater than the periods indicated here:

- for death claims - 5 years;
- for disability claims - 10 years;
- for trauma claims - 10 years;
- for accident benefit claims - not required unless there is a suspicion that the insured may have suffered from some ailment that may have resulted in the accident, such as epilepsy.

The reason for this is that the claim has resulted in the insured falling outside the averages used by the actuaries in determining the premiums to be charged. As the norm is no longer applicable to the insured the reason for this should be established, where possible. This is not to say that the claim is invalid. The claims assessor does, however, owe it to the insurer and the other policyholders to investigate all situations that do not conform to expected standards.

The claims assessor should request a medical report from the insured's personal medical attendant (PMA) or any other doctor or institution that may possibly be in possession of information.

Where any claim results from unnatural causes, the medical report will not be necessary. It is however important to still check for false claims.

Should there be a suspicion that information has been concealed cases must be checked in the usual way.

Where a client's portfolio contains policies for which a medical report is not required, the finalisation of these claims must not be delayed.

If it comes to light that concealment was an issue under policies that have already been paid out, the benefits paid are very seldom reclaimed unless everything points to fraud being the sole intention. The decision to litigate on the repayment of the claim is a decision usually made by the executive committee of the life insurer. The investigation of the information provided at inception must be carefully checked to ensure that claims are fairly dealt with.

AIDS exclusion clauses

The negative impact that AIDS is having on South African communities and the South African economy, as represented by the life insurance industry, has resulted in the need for a clear and unambiguous policy toward this pandemic. Note the earlier mention of the fact that no member office may use HIV/AIDS exclusion clauses for new business, nor may they enforce any exclusion that may have been imposed for basic life and disability benefits. The claims assessor must always check for an HIV-positive status if the rider benefits were subject to AIDS exclusion clauses.

There are a few specially designed policies in the market which can be sold to HIV positive people, the rates being suitably loaded to cope with the reduced lifespan expectations. AIDS is also sometimes listed as a dread disease for policies with this kind of cover.

Where a policy has been in force for longer than 10 years and information regarding AIDS cannot be obtained from the available medical documentation, the PMA report is usually waived if this is the only way of obtaining this information. The benefit of the doubt is then granted to the insured, and the claim is paid on the assumption that the deceased was HIV-negative at claims stage.

8.2 THE IMPACT OF THE CONCEALMENT OF INFORMATION

An insurer has the right to repudiate a claim under a policy contract if the proposer misrepresented or failed to mention a material fact. It is assumed that the proposer is in possession of all the facts on which the insurer's liability will be based. In general, failure to provide all relevant information and applying the principle of the utmost good faith enables the prejudiced party to repudiate the validity of the contract.

On the other hand, the insurer also has a responsibility of disclosure in that it must disclose the precise conditions of the contract that will come into operation, and may not abuse the ignorance of the proposer.

The duty of disclosure puts the emphasis on material facts and reasonableness. According to legal principles, a fact is of material importance if, in the opinion of the reasonable man, it would have influenced the reasonable insurer's initial decision.

The test is not what the reasonable man would regard as a reasonable fact, but whether the reasonable man would believe that the information should have been disclosed.

In the light of the above, all information that was not disclosed must be tested by the claims assessor against the following questions:

- Would the information have materially influenced the terms on which the policy was accepted?

  It is particularly important that when a claim arises, the underwriter should be asked to think back to the circumstances during proposal. This recollection of information should be unbiased with neither the underwriter nor the claims assessor allowing themselves to be influenced by the present circumstances being death or disability.

Information can be classified as material if the risk would have been accepted with a 50% additional mortality or if exclusions would probably have been imposed.

- Did the proposer have the information at his disposal and is it reasonable to have expected that the information be disclosed when answering the questions on the proposal form?

It is not for the proposer to decide whether the information is material - the test is objective. The interpretation of the information rests with the insurer and not with the insured. Where the answers to the two questions above is "YES", the claim should be rejected, irrespective of whether the cause of the claim relates to the concealment.

8.2.1 PROOF OF CONCEALMENT

Where concealment can be proved, the claim must be dealt with according to one of the following options:

- further medical information would have been requested during the proposal stage, for example, ECG, blood-pressure readings. If this information is not available, the claim is rejected and all premiums paid are forfeited. Where the policy's waiting period has expired, the cash value can be paid. Every reasonable effort must be made to determine terms rather than simply rejecting the claim. The terms must be assumed to be the heaviest that can be offered for the case in question;

- where the requirements can be provided and terms can be determined, the claim can be considered for the adjusted benefits in the usual way, if a premium loading would have been applicable, the premium must be kept constant and the benefits reduced pro rata; or

- where proof is submitted that a marketer or doctor was responsible for the concealment, the greater of the cash value and the premiums paid can be paid out. Where a marketer is involved, the commission must be reversed. Where a doctor is involved, the information must be passed on to a higher authority within the company, as it may be necessary to report the conduct of the doctor to ASISA or even the Medical and Dental Council of South Africa.

8.3 ESTABLISHING THE VALIDITY OF A CLAIM

In an insurance contract it is necessary to state the perils against which cover is given, so that the intention of the parties is clearly defined. Where the peril against which cover is given is the death of the insured, the validity of the claim is fairly simple to establish.

There are very few exclusions applicable to a death claim and, once these have been eliminated, the validity of the claim is beyond dispute. Where the claims assessor is, however, faced with a claim for one of the many other benefits available from a life insurer, the validity of the claim needs to be seen against a number of different factors such as:

- whether the condition for which the claim has been submitted is covered by the benefit under which the claim has been instituted;

- whether the cause of the condition for which the claim has been submitted does, or does not, fall within the benefit. A careful investigation of the cause of the disablement, injury or condition for which the claim has been submitted must be undertaken, to ensure that the cause does not fall into one of the exclusions linked to the benefit claimed against; and

- whether the cause of the condition stated in the claimant's declaration is the proximate cause of the condition, or whether some other factor, that is not covered by the definition of the benefit, is the cause thereof.

All contracts of insurance that include benefits such as:

- the supplementary benefits available;
- Permanent Health Insurance; or
- Health and Hospital Insurance (as a few examples),

are subject to conditions, which in insurance frequently state that certain causes of loss, or certain results of an otherwise insured peril, are excluded.

The reasons for this are:

- the extended cover may warrant an additional loading which was not included in the original determination of the premium, or
- the peril may be one which insurers regard as a fundamental risk which is more properly dealt with by the State, such as war risks or nuclear explosive devices.

It is necessary, therefore, that the claims assessor examines the cause of the condition claimed against in some detail.

It is also a fundamental law of insurance that the insurer is only liable for losses proximately caused by an insured peril.

The same principles, apply to life insurance as they do to the short term industry. It is perhaps relevant to consider that as the short term industry deals more with **loss of tangible items** than is the case in the life industry. The tangible evidence needed to institute litigation is a lot more prevalent in the short term industry, and it is often easier to make a short term claim than in a life insurance claim. Nonetheless, the principles are common.

The application of the doctrine of **proximate cause** is often a complex matter, as evidenced by the volume of legal cases dwelling upon it. There is usually a chain of events leading up to a claim, and one way to look at the proximate cause is to consider the first event in the chain, and to ask oneself what is likely to happen next.

By repeating the process at each link in the chain, one will arrive at the loss if there is an unbroken chain, showing that the original cause was the proximate cause. If in that chain there is an excluded peril, then there is no insurance cover for the loss, unless the policy wording moderates the rule.

Should another peril start to operate from another source, the same procedure must be followed and, on the facts of the individual case, it must be decided which is the dominant effective cause of the claim.

8.4 OTHER UNLAWFUL ACTS

The general rule of public policy that prevents a person from benefiting from his own criminal acts, also operates to prevent a claim being paid to a person who has murdered another, on whose life he holds a policy (*Prince of Wales Insurance Association Co. vs Palmer, 1858*). This does not apply where the murderer was insane (Re. Batten's Will Trusts, 1961).

A recent case (Re. K. Deceased, S/J/Col 129, p 132), emphasises that this rule also applies to manslaughter, where death was an unintended consequence of a deliberate act.

Example

In this case a wife threatened her husband with a shotgun, which then went off and killed him. Another interesting case recently, also arose on this subject (*Hewitson vs The Prudential Insurance Co. Ltd*.). Here Mrs Hewitson was the owner of a policy on the life of Mr Hewitson. Together they took part in an armed robbery, although their guns were actually imitations.

The robbery failed and Mr Hewitson was shot and killed in the course of trying to escape. Mrs Hewitson claimed under the policy. The court decided that Mr Hewitson's death was caused by his own criminal act, the attempted armed robbery. It was also held that, as Mrs Hewitson was an active participant in that crime, it would be contrary to public policy to allow her to benefit as a result of that crime, and the insurers were not held to be liable to pay the proceeds to her.

8.5 EARLY CLAIMS

Life insurance premium rates are calculated by actuaries using mortality tables that give an indication of the expectancy of life of the proposer. Unfortunately, as is often said, the only certainties in life are death and taxes, and both can be extremely unpleasant. Death catches most people unawares, and it can be assumed with some certainty that only a person contemplating suicide will know the exact time of death.

It is for this reason that people buy life insurance. Not knowing when they may die means that they cannot fully tie up all their affairs. Therefore, life insurance is bought with the intention of providing sufficient funds to cater for any unforeseen eventualities, and settle any unpaid debts.

Premium rates are determined by actuaries using assessments and assumptions that are based on the law of averages. Where a person, therefore, dies suddenly, and very shortly after having taken out a life policy, the death will fall outside the norm used in the actuarial assessments and assumptions. These assessments and assumptions have been determined using statistics based on an extremely comprehensive base over an extensive period of time, and are therefore unlikely to be incorrect.

The claims assessor should, therefore, identify the claim as falling outside the average, and perhaps even consider that the time and cause of death are suspect.

This is not to say that the claim should be repudiated. It does, however, mean that the claim should be investigated very thoroughly, and any discrepancies on information received dealt with.

8.5.1 CLAIMS BEFORE COVER COMMENCES

Death before date of cover

Most companies work on the basis that the date of commencement of the cover on a new life insurance policy is the last occurring of:

- the inception date requested in the proposal by the proposer;
- the date on which the first premium is paid; or
- the date of notice of acceptance.

If the life insured dies before the date on which cover commences, the claim will usually be considered if:

- all documents were already in the life insurer's possession. For this purpose documentation in the hands of a marketer or broker will also be considered as being in the hands of the life insurer; and
- the risk would have been accepted based on the information in the proposal documentation; or
- the proposer or insured accepted the terms expressly or by implication, for example, by paying an extra amount for an increased premium, or by giving permission for a loading before terms were known, if the risk was acceptable on terms other than ordinary rates;
- a cash premium was submitted with the proposal, and there was no request for the inception date to be later than the first of the following month;
- death occurred during the month preceding the inception date; or
- premiums were to be paid by debit order or stop-order, and the ability to pay can be established beyond reasonable doubt.

Immediate cover

Life insurers are aware of the fact that life insurance is bought as a result of the establishment of a need by a marketer, broker or insured. The client, being made aware of the need, wishes to ensure that, should anything happen to him, his family will be adequately catered for.

Unfortunately, the process of underwriting and issuing a policy can take some time and, therefore, some life offices have decided to grant all applicants a measure of protection while the process of issuing a policy is being undertaken.

Where a fully completed proposal form is submitted together with the first premium in cash or EFT, immediate life cover is automatically granted on receipt of the proposal. This benefit is, however, subject to the following limitations:

- the selected policy commencement date must be within 30 days of the receipt of the proposal form;
- the immediate cover will expire when a risk assessment is given, or any evidence required for risk assessment such as medical, financial, occupational and/or hobby evidence, is outstanding for longer than 21 days;
- the immediate cover is not applicable to proposals where the life to be insured is older than 60, or is a sub-standard risk in any form;
- the immediate cover is not applicable where a proposal for life insurance is being considered simultaneously by another life office;
- non-disclosure of any information that, in the opinion of the underwriter is material to the risk assessment, will render the immediate cover benefit void;
- death caused by any condition, illness, occupation or pursuit that, in the opinion of the underwriter of the life office was material to the risk assessment, will not be recognised as a valid claim;
- all normal policy conditions that will apply to the policy, when issued, will also apply to the immediate cover benefit;
- should a proposal not be proceeded with for any reason, any immediate cover which was in effect will be charged against the premium paid on the basis of a level term insurance contract;
- the amount of immediate cover available is usually the sum insured requested on the proposal, excluding any supplementary benefit amounts. It is, however, normally subject to the following further limitations:
    - on any term insurance policy, the immediate cover is usually restricted to 50% of the sum insured that has been applied for;
    - an overall maximum for the amount of immediate cover depending on the life insurer, is normally applicable.

Disability and other supplementary benefit claims before the date of cover

Immediate cover normally is only applicable to the basic life cover applied for on the proposal. Any payment of a supplementary benefit will be at the discretion of the life office's claims committee. The recommendations made by the claims assessor will have a bearing on the decision made by the committee.

Generally speaking, life insurers tend to treat these types of claims in a similar way to death claims that happen before the cover starts. The help of the underwriting department must, however, be called in by the claims assessor to determine whether the policy would have been issued with the supplementary benefit requested.

Should the underwriting decision have been to decline the supplementary benefit, then it stands to reason that an ex-gratia payment would place the claimant in a better position than he would have been if the policy had been issued under normal conditions. That is not the intention of this facility made available by most life insurers.

Deterioration in risk before date of cover

During the period of time between the submission of the proposal and the issuing of the contract, the proposer must inform the insurer of any changes to the information provided on the proposal form. The underwriting department bases its decision on the acceptability of the life insured on the information contained in the proposal form.

Should this information change, and the proposer not inform the underwriters, the omission can be construed as non-disclosure of a material fact, with the resultant repudiation of a claim.

Should the deterioration of the life insured be so severe that a decision to decline the policy is likely, the claims assessors may be approached to consider an **ex-gratia** payment of a claim. This would depend on the policy having a supplementary benefit covering the life insured for disability. It is important to realise that the risk must be reconsidered based on the latest information, and the policy amended if necessary.

8.5.2 REINSTATED POLICIES

When a debit order is in operation and a premium request is returned unpaid by the bank, the outstanding premium will usually be paid out of the investment account, and the policy will continue as if premiums had never been in arrears. Policy claims that arise during this period, will be considered as usual.

Should a policy, however, reach a stage where no further funds are available in the investment account to pay the premiums, the policy will enter a state of lapse and no claims will be considered. Most life offices will usually only allow a lapse to occur after the premiums have been in arrears for three months or more. The lapse will, however, be dated from the date on which the last premium was paid.

This will not apply to policies that have not yet built up sufficient funds in their investment accounts. Policyowners can determine whether their policies have funds in their investment account by establishing whether the policy has a surrender value or not. A surrender value is an indication that the policy's investment account has a positive balance.

8.5.3 DEATH BY SUICIDE

Most life insurers impose a suicide clause which states that a death claim as a result of suicide during the first 24 months of the contract will automatically be repudiated. More recently the period has tended to be limited to 12 months. Special consideration should be given to claims where it appears that the cause of death is suicide.

It is widely believed that it is a fundamental principle of insurance law that an insured cannot receive a benefit if, by his own deliberate act, he causes the event insured against. This is supported by the judgement of Lord Atkin and Lord MacMillan in the leading case of *Beresford vs Royal Insurance Co. Ltd (1938)*.

These judges considered that the rule preventing payment was not that of public policy, but a fundamental implied term of the contract that "a man cannot by his own act cause the event on which the insurance money is payable".

The above principle does not apply if the life insured commits suicide whilst insane, as it can be said that he does not have the mental capacity to appreciate what he is doing. It can therefore be argued that his estate would be able to recover the policy monies in such an instance.

If the policy contains a suicide clause then the position depends on the wording of the clause. Many offices include a clause such as:

> *"if the life insured commits suicide within twenty four months from the date of the policy all benefits which otherwise have become payable shall be forfeited and belong to the insurer".*

Suicide would, therefore, not be covered if it occurred during the specified period. If suicide occurs after that period then the office would be liable for the claim, even if the life insured was of sound mind at the time. This is because, by having a suicide clause expressly excluding cover for a limited period, the office is impliedly insuring that risk after that time.

Most suicide clauses protect the interests of a third party, preserving the value of the policy for cedents. A typical provision would be:

> *"this suicide condition shall not prejudice the interest in such monies of any third party who shall have bona fide acquired that interest for valuable consideration".*

If this is the case, the life office itself is not a third party, as was shown in *Royal London Mutual Insurance Society vs Barrett (1928)*. There, a life policy was ceded to the life office along with leasehold property. The life insured committed suicide and the court held that the life office was not a third party, therefore, the policy was void and they could recover their debt against the leasehold property.

Where a life insurer can repudiate a claim on the grounds of suicide then, not only can the legal personal representatives not claim, but all those claiming a share in the estate as beneficiaries or creditors are equally barred.

This would also extend to the trustees of an own life policy effected on trust for others.

The burden of proving that suicide was the cause of death, is on the life office. One concern is that the coroner's findings are not always conclusive proof.

Example

The case of *Walsh vs Legal & General Insurance Society Ltd. (1935)*, illustrates the difficulties which can arise. The life insured died when he fell from a train during the first year of a policy which excluded suicide within the first year.

There were no other passengers in the compartment and examination of the carriage door showed no effect that might have allowed it to open of its own accord. In view of these circumstances, the coroner's verdict was, "suicide while of unsound mind". Legal action was brought to claim the sum insured. It was held that the coroner's verdict was not conclusive proof of suicide and that, as the life office could not positively prove it was suicide, they were liable.

Suicide after reinstatement

The non-permanent suicide clause stipulates that no claim will be admitted, if suicide is committed within the set period of months from the date of the letter in which notice is given, that the policy has been accepted or reinstated.

Policies that are reinstated without proof of good health, with or without the exclusion of claims, will be subject to the suicide clause, only to the extent to which the original period still applies.

Policies that are reinstated with proof of good health, are again made subject to a suicide clause from the date of reinstatement.

In order to ensure uniformity, most life offices work with calendar months, where a calendar month begins on the date of the above mentioned letter, and ends on the same day of the following month. Weekends, public holidays and leap years, therefore, do not affect the period of months.

Additional information

It is perhaps interesting to note that, in the case of small policies, for example, assistance insurance business, the suicide clause has been done away with completely.

This is most likely as a result of the negative publicity that has been linked to the repudiation of death claims resulting from the suicide of the insured in markets where the exclusion is not understood, or where the suicide of the deceased is difficult to prove.

QUESTIONS ON CHAPTER 8

Mental revision questions

Work through these mental revision questions as a test of your understanding of this chapter. We suggest that you attempt these before tackling the written questions. Please note that suggested answers are not provided as the chapter's text contains the answers.

1. What do you understand by the term retrospective underwriting in the context of a death claim?

2. When must the insurable interest on a life insurance contract be verified?

3. At what level would information that was not disclosed at the inception of the policy come to be considered material to the assessment of the risk?

4. Briefly explain the insurer's dilemma regarding AIDS if the policy is more than 10 years old.

5. How can the materiality of an undisclosed fact effect the decision to meet a claim or not?

6. What is immediate cover?

7. Would a claim submitted 20 months after the reinstatement of a policy be considered if the cause of death was suicide?

Written questions

Attempt these questions after you have completed this chapter and its mental revision questions. Suggested answers to these questions are at the end of this book.

1. List and briefly explain what information the claims assessor must verify before the process of assessing the claim can be started.

2. Write an essay on the AIDS problem in South Africa and its implication on the life insurance industry.

3. Under what circumstances would a life insurer consider a claim if the life insured dies before the policy comes into force?

4. Explain the general policy applicable to claims where the cause of death is the suicide of the insured.