

# Medical information and insurance

Joint guidelines from the British Medical Association  
and the Association of British Insurers

July 2008



Association of British Insurers



# Table of contents

1	Introduction	3
2	Medical factors in insurance	4
2.1	Why do insurance companies need medical information?	4
2.2	How is medical information collected?	4
2.3	Information required for different insurance products	5
3	Medical reports	6
4	General practitioner reports	7
4.1	Consent for disclosure	7
4.1.1	Proof of consent	7
4.1.2	Validity of consent	7
4.2	Access to GPRs	8
5	Independent medical reports	9
5.1	Consent	9
5.2	Access to independent medical reports	9
6	Content of reports	10
6.1	Sexually transmitted infections	10
6.2	HIV, Hepatitis B and C	10
6.3	Lifestyle questions	11
6.4	Genetic information	11
6.5	Family history	12
7	Explanations	13
8	Release of information to verify claims	14
8.1	Information about the insured person	14
8.2	Information about third parties	14
9	Adults who lack capacity	15
10	Deceased people	16
11	Fees	17
12	Return and quality of reports	18
13	Further information	19
	Appendix 1 Medical information in the assessment of risk	20
	Appendix 2 Confidentiality of medical reports	23
	Notes and references	24



# 1. Introduction

This joint guidance has been drawn up by the British Medical Association (BMA) and the Association of British Insurers (ABI) to set out best practice and practical advice on the use of medical information in insurance. It is primarily designed for providers of primary medical services who have a registered list of patients and hold their long-term records, and other doctors who are asked to provide medical information to, or who work with, insurance companies.

Some of the issues covered in the guidance are the subject of more detailed advice from the BMA and the ABI. Any such sources of advice are referenced and are available on the relevant website. Information about changes affecting this guidance will be made available on the BMA and ABI websites. Contact details are given at the end of this booklet. This guidance will be reviewed every three years. The next revision of this guidance is planned for 2011.

## 2. Medical factors in insurance

### 2.1 Why do insurance companies need medical information?

The insurance industry bases the premiums it charges for life and health-related products on the mortality and morbidity rates of the insured population. The basic rates for an insurance product are set by a company's actuarial department. These rates are calculated using mortality and morbidity tables and claims experience, and take into account the company's target market. This is why the same type of cover on the same life may cost differing amounts depending on the insurance company.

Individuals' lives are underwritten at the company's standard rate if their potential mortality or morbidity is not significantly greater than average for their age. Insured people who represent a risk that is worse than that of a standard life pay an extra premium or have restrictions imposed on their policies. The terms that the underwriter quotes need to be as far as possible commensurate with the extra risk and information about the applicant's health may be helpful in evaluating this risk.

The insurance industry also sometimes needs medical information when assessing insurance claims. Typically this happens when the payout on a claim is triggered by an insured person having a particular medical condition.

### 2.2 How is medical information collected?

If an insurance company wants information about a person's health before deciding whether, or at what premium, to offer insurance, the company can obtain this information in several ways:

- direct from the applicant him or herself
- from the applicant's general practitioner or other doctor, through a general practitioner's report (GPR)
- from an independent medical practitioner who examines the applicant specifically for the purpose of assessing medical risk factors
- from a medical examination by their general practitioner; and/or
- through the results of a health screening or blood test.

Often more than one source of information is used. A GPR is often commissioned where the company wants more information about, or investigation of, conditions identified by the applicant. Independent examinations are used for particular products, amounts of benefit or if the applicant is over a certain age. Such examinations are helpful in identifying conditions or illnesses, for example hypertension, which have not previously been diagnosed.

Although an insurance company may rely on factual information about an applicant's health in its underwriting decisions, it must not discriminate unfairly against any applicant, including people with disabilities. Guidance on the circumstances in which insurers may offer less favourable terms to people with disabilities is given in the ABI's An insurer's guide to the Disability Discrimination Act 1995.<sup>1</sup>

The insurance contract is between the policyholder and the insurance company. Applicants must provide answers to questions asked by the insurer carefully, accurately and to the best of their knowledge and belief. Failure to do so could invalidate a policy. Provided the applicant has given valid consent, the doctor's duty is to respond to the questions he or she is asked based on information acquired or held in a professional capacity as the applicant's doctor.

## 2.3 Information required for different insurance products

There are various types of insurance products providing life, health and disability cover, and different underwriting considerations for each of these types of cover. Insurance companies only need information that is relevant to the type of insurance, and should make unambiguously clear to doctors what information they require. It is worth noting that some applicants apply for more than one type of cover at a time.

Some insurance policies require the insured person who has been diagnosed with a condition that may be subject to dispute, such as mental illness or back pain, to have been diagnosed by and be under the care of a consultant or GP, who is a specialist in the insured person's condition. Neither the BMA nor the ABI wish to see NHS resources used inappropriately, and would not want to encourage an NHS GP to make a referral solely to satisfy the conditions of an insurance policy. If the insured person's NHS GP does not consider that a referral for specialist care is necessary, and an insurance company requires a specialist opinion, the payment of a private specialist opinion would need to be agreed between the insured person and the company concerned.

Appendix 1 provides an overview of the types of cover provided and the types of medical information that a company's chief medical officer (CMO) and underwriter will find useful in the medical assessment of an application or a claim. Insurance companies may find it helpful to provide information of this nature to doctors they are asking to write reports.

### 3. Medical reports

Insurance companies generally prefer to ask the applicant's GP to write a report rather than arrange an independent examination. A GP is likely to be able to provide an overall picture of the applicant's health instead of just the snapshot seen by an independent examiner. A GPR can, for example, validate the information that the applicant has provided or clarify whether an applicant's condition is being controlled. Some applicants also prefer this option as it may be more convenient than having an independent examination.

Some general practitioners have expressed concerns about this process, however, as they believe that it endangers the open, trusting nature of the doctor-patient relationship. There is anecdotal evidence to show that some patients do not share information with their GP or avoid going to their GP for advice or treatment because they think the information will not be kept confidential. They may believe that it will jeopardise their employment prospects, their chances of getting insurance at standard rates or of obtaining insurance cover at all. The BMA is concerned about the effects on the health of the individual and the public of information being withheld from doctors providing care. The scale of this problem is not known, but the ABI and the BMA suggest that, should such fears arise, insurers should explain to their clients the reasons why the information is needed, their confidentiality safeguards, and applicants' rights under the Data Protection and Access to Medical Reports Acts. Insurers should not submit GPRs to general practitioners without the applicant's consent obtained in accordance with the principles set out in this document.

It may, however, be the case in the future that, for example, with the introduction of polyclinics and expansion of private general practice, patients will not be registered with a traditional GP practice. Furthermore, how patient health information is stored and accessed looks set to change with the introduction of national care record systems. The ABI and BMA will monitor these developments and revise this guidance accordingly as the situation changes.

## 4. General practitioner reports

The ABI and BMA have developed a standard GPR form, which is available on the ABI and BMA websites ([www.abi.org.uk](http://www.abi.org.uk) and [www.bma.org.uk](http://www.bma.org.uk)) and is widely used.

Only relevant information should be provided and it is ethically unacceptable to provide extraneous information. Doctors must not send originals, photocopies or printouts of full medical records in lieu of medical reports and ABI members should not accept them. The full records are not necessary and will very probably include information that is not relevant to the insurance being applied for. Insurance companies only need information that is relevant to the policy. Disclosure or other processing of information that is released without the consent of the applicant or insured person is likely to breach the Data Protection Act 1998, and may compromise a doctor's registration.

### 4.1 Consent for disclosure

Doctors' professional, ethical and legal duties require them not to disclose information about their patients without consent. This is true in all but the most exceptional of circumstances.<sup>2</sup>

#### 4.1.1 Proof of consent

Doctors must not release information about patients simply because another person requests it. They must be able to justify any decision to disclose information to an insurance company. Except where the disclosure is about a deceased person (see section 10), that justification is evidence of their patients' valid consent. The GMC requires doctors to:

"Obtain, or have seen, written consent to the disclosure from the patient or a person properly authorised to act on the patient's behalf."<sup>3</sup>

Similarly, BMA policy states that doctors should refuse to complete insurance reports unless a copy of the applicant's written consent has been provided for the doctor's retention. The consent form should make clear what the applicant is agreeing to. Doctors should not rely on an electronic copy of the applicant's signed consent form unless satisfied that the company has in place robust mechanisms for verifying that the document has not been altered in any way.

#### 4.1.2 Validity of consent

Consent for disclosure of information is valid only where applicants understand the nature and extent of the information that is being requested, and the use to which it will be put. If doctors are in any doubt about whether valid consent has been given, they should check with the applicant. The GMC requires doctors to:

"Be satisfied that the patient has been told at the earliest opportunity about the purpose of the examination and/or disclosure, the extent of the information to be disclosed and the fact that relevant information cannot be concealed or withheld. You might wish to show the form to the patient before you complete it to ensure the patient understands the scope of the information requested."<sup>4</sup>

The insurance company or agent is responsible for ensuring that the consent is competently given and is based on a full understanding of the request. There is anecdotal evidence that, in the past, the subjects of GPRs have not always been aware of the extent of the information that is requested. To minimise the potential for misunderstanding, insurance companies, or their agents, could give applicants a copy of the questions their doctor will be asked, with time for the information to be read and understood, as part of the application process or the process of seeking consent.

## 4.2 Access to GPRs

All doctors who write medical reports should be prepared to discuss the content of reports with the patient. The GMC advises doctors to check with insurance applicants whether they wish to see their report, unless it has been clearly and specifically stated that they do not.<sup>5</sup>

In addition, the Access to Medical Reports Act 1988 gives insurance applicants rights in respect of reports written about them. It covers reports written by the applicant's GP, a specialist, or any other registered health care professional who has provided care. Reports written by an independent medical examiner are not covered (see section 5).

The administrative requirements of the Act fall mainly upon insurance companies. Companies must inform applicants of their rights under the Act:

- to withhold permission for the company to seek a medical report (that is, to refuse consent to the release of information)
- to have access to the medical report after completion by the doctor either before it is sent to the company or up to six months after it is sent
- if seeing the report before it is sent, to instruct the doctor not to send the report; and
- to request the amendment of inaccuracies in the report.

The applicant must be notified in writing of these rights.

If an applicant indicates a wish to see the report before it is sent, the insurance company must tell the doctor and explain the applicant's rights.

The applicant has 21 days from the time of notification to exercise the right to see the report. It is the applicant's responsibility to contact the doctor regarding arrangements for obtaining access. If the report is not seen within 21 days, the doctor may send the completed report to the insurance company. If the applicant sees the report and withdraws consent for it to be released, it must not be dispatched and the doctor should inform the company.

If the applicant believes that there are factual inaccuracies in the report, he or she may seek their correction. If the doctor agrees that a factual error has been made, the report must be amended accordingly. If the doctor does not agree that there is an error, he or she must append a note to the report regarding the disputed information.

Doctors cannot comply with applicants' or insured people's requests to leave out relevant information from reports. If an applicant or an insured person refuses to give permission for certain relevant information to be included, the doctor should indicate to the insurance company that he or she cannot write a report, taking care not to reveal any information the applicant or insured person did not want revealed.

Doctors and insurance companies should ensure that they are familiar with the provisions of the Access to Medical Reports Act. Detailed guidance for doctors is available from the BMA.<sup>6</sup>

# 5. Independent medical reports

This section covers reports that are written by a doctor who examines the applicant solely for the purpose of writing a medical report, and has had no other professional relationship with the applicant.

## 5.1 Consent

Insurance companies asking applicants to be examined by an independent doctor should explain the nature and purpose of the examination, together with the necessary practical details. As part of this, applicants could be provided with a copy of the questions the doctor will be asked to answer, and must be provided with a copy on request.

The examining doctor also has responsibilities to ensure that he or she has valid consent to undertake the examination and that the applicant understands the nature and implications of any tests involved. Consent is also needed before information about the applicant may be disclosed to the insurance company. The General Medical Council says that doctors must:

“Be satisfied that the patient has been told at the earliest opportunity about the purpose of the examination and/or disclosure, the extent of the information to be disclosed and the fact that relevant information cannot be concealed or withheld. You might wish to show the form to the patient before you complete it to ensure the patient understands the scope of the information requested.”<sup>7</sup>

If during the course of, or as part of, an examination the examining doctor detects some significant abnormality or other feature of the applicant’s health that requires investigation or treatment, and of which the applicant may not be aware, the doctor has an ethical responsibility to ensure that either the applicant or, with the applicant’s consent, his or her GP, is informed promptly. The examining doctor should usually undertake this task. If this is not possible, the company’s CMO might need to be involved. The purpose of informing the GP is to give people the opportunity to discuss with their own GP their health management if they have a medical condition that needs attention. The GP has an ethical obligation to discuss with his or her patient that patient’s management and care. Examining doctors may find it helpful to ascertain the applicant’s views on disclosure to his or her GP before the examination, and to obtain permission to liaise with the GP and CMO, if the need arises.

## 5.2 Access to independent medical reports

All doctors who write medical reports should be prepared to discuss the content of reports with the applicant. The GMC advises doctors to check with insurance applicants whether they wish to see their report.<sup>8</sup>

In addition, the Data Protection Act gives people rights to see and have copies of health records which:

- are about them and from which they can be identified (either directly or in conjunction with other information the person holding the record has or is likely to have)
- consist of information relating to their physical or mental health or condition; and
- have been made by or on behalf of a health professional in connection with their care.

The ABI and the BMA believe that this includes reports written by doctors who examine people for the sole purpose of writing a report and who have no other clinical relationship with the person. The Data Protection Act also gives certain rights for inaccurate information to be corrected. Detailed advice for doctors about the Act, and the fees that may be charged for providing access to and copies of records, is available from the BMA.<sup>9</sup>

## 6. Content of reports

This section gives general guidance on completing medical reports. Insurance companies must ensure that they only ask for information that is relevant to the insurance product. Similarly doctors must ensure that they disclose only information that is relevant to the request and should be aware of their obligations of confidentiality to other patients, particularly the applicant's family (see section 6.5).

Medical reports are about clinical facts and the doctor's opinion about the applicant's medical condition. Doctors should not be asked to give an opinion about whether an applicant's condition merits the application of a 'normal' or 'increased' rate of insurance. In cases where doctors consider it inappropriate to answer a question they should indicate this on the form.

### 6.1 Sexually transmitted infections

The ABI and the BMA are aware that the possibility that information about sexually transmitted infections (STIs) will be revealed to another party, such as an insurance company, might discourage some people from approaching their GP about this area of their health. The problem of information being withheld from the GP is particularly pronounced in this area since genitourinary medicine (GUM) is an area of specialist medical care that patients can access without a referral from their GP. Anecdotal evidence suggests that patients sometimes seek services direct from GUM clinics because they prefer to retain anonymity in this area, or in order to conceal from their GP information that they believe may affect their chance of obtaining insurance at standard rate, or at all.

The BMA and the ABI are concerned about the health implications of patients not seeking advice and testing for HIV and other STIs, and of patients' refusal to allow their GP to be kept informed about certain aspects of their health care. There is evidence to suggest that the actuarial implications of withholding information about isolated or non-serious STIs from insurance reports would be negligible. Such negligible impact on insurance companies, coupled with the potential to overcome some patients' disincentive to seek advice and testing regarding STIs, makes a strong medical and public health argument for this information being excluded from insurance reports.

The BMA and the ABI therefore believe that insurers should not request, and doctors should not reveal, information about an isolated incident of an STI that has no long-term health implications, or even multiple episodes of non-serious STIs, again where there are no long-term health implications. Other incidents of STIs may have actuarial or underwriting significance and should be revealed in accordance with the consent guidelines in this document.

### 6.2 HIV, Hepatitis B and C

Insurance companies should not ask whether an applicant for insurance has taken an HIV or Hepatitis B or C test, had counselling in connection with such a test, or received a negative test result. Doctors should not reveal this information when writing reports and insurance companies will not expect this information to be provided. Insurers may ask only whether someone has had a positive test result, or is receiving treatment for HIV/AIDS, or Hepatitis B or C.

For large value policies or where there is a need to clarify the level of risk, insurers may send applicants a supplementary questionnaire and/or request that they are tested for HIV, or Hepatitis B or C. A test will only be administered after the applicant has: been notified of the test procedure; given valid consent in writing; nominated a doctor or clinic to receive the results if the test is positive; and received an appropriate pre-test discussion before the test is undertaken. In the rare cases of a positive result it is important that the nominee is told the result as quickly as possible so the applicant can be informed and arrangements made for future care.

Existing life insurance policies will not be affected in any way by taking an HIV test, even if the result is positive. Providing that the applicant did not withhold any material facts when the life policy was taken out, life insurers will meet all valid claims whatever the cause of death, including AIDS-related diseases. Material facts the applicant might need to reveal include information about activities that increase the risk of HIV infection.

The ABI has published a statement of best practice on HIV and insurance.<sup>10</sup>

### 6.3 Lifestyle questions

Doctors are expert in clinical matters and can only give professional advice about those issues upon which they are expert. Nevertheless doctors often do hold information about patients' lifestyle, such as smoking, alcohol intake, drug use or sexual behaviour. The applicant might want his/her GP to provide any information about his/her lifestyle held in the GP record or the applicant might want to be the source of this information him/herself. Only the applicant has accurate information about lifestyle. Medical conditions that have arisen as a result of a patient's lifestyle choice are legitimate areas for doctors to comment on with, of course, appropriate consent.

### 6.4 Genetic information

The use of the results of genetic tests by insurers is tightly controlled. A genetic test is defined as "a test that examines the structure of chromosomes (cytogenetic tests) or detects abnormal patterns in the DNA of specific genes (molecular tests). A genetic test can be predictive or diagnostic:

- a *predictive* genetic test is taken prior to the appearance of any symptoms of the condition in question
- a *diagnostic* genetic test is taken to confirm a diagnosis based on existing symptoms"

The details of the arrangements are set out in the ABI's code of practice on genetic testing.<sup>11</sup>

Key points include:

- Applicants must not be asked or put under any pressure to undergo a predictive genetic test in order to obtain insurance.
- Insurance companies may not ask for predictive genetic test results from applicants for insurance policies up to £500,000 for life insurance or £300,000 for critical illness or paying annual benefits of £30,000 for income protection. Doctors must not give insurers predictive genetic test results that fall outside these levels and have not been approved for use by the Genetics and Insurance Committee.
- Above these levels, insurers may only take into account the results of genetic tests which have been approved for this purpose by the government's Genetics and Insurance Committee (GAIC) which assesses whether the tests and their results are relevant for insurance purposes<sup>12</sup>
- Applicants may wish to volunteer favourable genetic test results that demonstrate that they have not inherited a condition in their family. Insurers may take these into account in underwriting. In this case an insurer may wish to seek confirmation from the GP, or geneticist, of the interpretation of the test result with the patient's consent.
- Insurance companies have been asked to publicise their policy on the use of favourable genetic test results on their websites

## 6.5 Family history

Many companies ask an applicant to provide details if parents or siblings have suffered from or died of conditions with an inherited component. These usually include heart disease, stroke, MS, diabetes and cancer. GPR forms also often ask doctors to provide any information from the applicant's own medical record which shows that the applicant is aware of a family history of inherited conditions.

Requesting information about family history from an applicant's doctor presents ethical and practical difficulties. Information on GP records about a genetic risk may have come from a number of sources, including direct from the patient or from the GP's knowledge of other family members, and it is not always apparent which. Clearly patients can only give valid consent for the disclosure of information when they are aware of the nature and extent of the information being disclosed.

In order to ensure that there is no breach of family members' confidentiality, doctors may choose not to complete this section of the GPR if they wish. Doctors should, however, report the results of any tests or investigations they have undertaken on applicants because of their family history, whilst bearing in mind the limited moratorium on the use of genetic information in insurance (see section 6.4). This information may be useful in confirming or counteracting information about family history provided by the patient. For example if the applicant had mentioned a family history of breast cancer, it may be helpful for the doctor to report that the applicant had undergone tests, such as BRCA testing, which revealed a reduced risk of developing cancer (subject to the restrictions under 6.4 regarding disclosure of genetic test results). Under no circumstances should doctors reveal information about an insurance applicant's family if the information did not come from the applicant him or herself.

## 7. Explanations

Insurance companies must provide written reasons for any higher than standard premium, rejection of an application, exclusion, rejection of a claim or cancellation of a policy to applicants or insured people, on request. They must not ask applicants' doctors to explain their actuarial and underwriting decisions. If the company is concerned that the applicant is not aware of a health condition that has influenced the underwriting, or if it believes that further care or treatment may be beneficial, a medical officer of the company should discuss the best way to proceed with the applicant's GP promptly. Any health concerns that the insurance company has brought to the attention of the GP should be discussed (if the GP felt necessary) in a normal NHS consultation.

## 8. Release of information to verify claims

### 8.1 Information about the insured person

Consent is needed before information is disclosed to insurance companies for the purpose of verifying claims, for example before a company organises repatriation of an insured person taken ill abroad. In such cases, the company must approach the insured person for permission to release sufficient information to verify the claim. Evidence of that consent must be provided to the insured person's doctors in the usual way (see section 4.1.1). If the insured person is not competent to give consent, doctors may release information necessary to satisfy the claim provided that doing so is in the person's best interests and not contrary to his or her previously stated wishes (see in addition section 9).

### 8.2 Information about third parties

Sometimes insurance companies need information about people other than the holder of the policy. This is most often the case with travel insurance, for example where a close relative of the insured person becomes ill and the insured person has to curtail a holiday and return home urgently. In such cases insurance companies will want to confirm that the illness of the relative was sudden and unexpected and occurred at the time the insured person claimed. Depending on the particular nature of the policy, the company may also want to confirm that the seriousness of the condition was such that the insured person was urgently required to attend the relative. If competent to give it, the sick relative's consent is needed before doctors can release information to verify the claim. If the relative is not competent, doctors may disclose relevant information to the company provided this is not contrary to their patient's wishes or interests (see in addition section 9). The insurance company will explain what information is required in each case.

## 9. Adults who lack capacity

Although ordinarily disclosures of health information require consent, where adults lack the capacity to consent on their own behalf to disclosures of their information, in certain circumstances, disclosure can still take place. Both the Adults With Incapacity (Scotland) Act (2000), and the Mental Capacity Act 2005 for England and Wales contain powers to nominate individuals to make health and welfare decisions on behalf of incapacitated adults. Where these proxy decision makers require access to health information that is necessary to carry out their functions, that information should ordinarily be provided. These individuals can also be asked to consent for disclosure to third parties. Where there are no nominated individuals, requests for access to information relating to incapacitated adults can usually be granted where there is both a legitimate need for the information, and releasing the information would be in the best interests of the incapacitated adult. In all cases, only such information as is necessary to achieve the purpose or purposes for which disclosure has been requested should be released.

# 10. Deceased people

Doctors have an ethical obligation to keep personal information confidential after a person dies. In 2006 the Information Commissioner also ruled that, other than the limited rights of access under the Access to Health legislation, legally, a duty of confidence attaches to medical records of the deceased under section 41 of the Freedom of Information Act 2000.

Insurance companies request information about deceased people in order to assess claims. Such requests are known as 'duration certificates'. It is preferable that risks are properly assessed before a company agrees to offer cover. The contract between insurer and insured person is one of good faith and doctors should not be asked to provide guarantees against fraudulent claims. It is recognised, however, that the law does, in certain circumstances, give people with a claim arising from the death of an individual statutory rights of access to information necessary to satisfy the claim. Insurance companies should exercise those rights only where there are reasonable grounds to believe that relevant information may have been withheld at the time the policy was taken out. In the case of life insurance, this may be for example, where the insured person dies, apparently unexpectedly, say within six months of taking out the policy or where an insured person has died of heart disease although the application made no mention of the condition.

Requests for information after a person's death are made under the Access to Health Records Act 1990, that covers manual health records made since 1 November 1991, and in Northern Ireland the Access to Health Records (Northern Ireland) Order 1993, that covers manual records since 30 May 1994. Access to information recorded before these dates may only be given where this is necessary to make any later part of the records intelligible. Rights of access are limited to information necessary to satisfy the claim. Insurance companies must not ask for full records to be released, and doctors must not provide any information that is not relevant to the claim. There are three further categories of information that must not be released:

- information that the deceased made known they did not want released
- information that identifies a third party who is not a health professional
- information that, if disclosed, is likely to cause serious mental or physical harm to somebody's health.

Doctors may wish to counsel their patients about the possibility of disclosure after their death and solicit their views if it is apparent that there may be some sensitivity. People's views and wishes should be recorded in their health records. It also follows that insurance companies must explain to applicants if there is a chance that information will be sought following their death. Insurance application forms contain a clause asking applicants to agree to information about them being disclosed after their death in the event that a claim is made. Although this agreement may have been given a significant time before disclosure is actually sought, it does give doctors an indication of the applicant's wishes at the time the policy was taken out. Before disclosing any information, doctors should consider their obligations under the Access to Health Records Act.

# 11. Fees

Reports and medical examinations undertaken at the request of insurance companies are not part of the terms of service of either NHS GPs or hospital doctors. Doctors may therefore charge the company a fee for this work. Fees are covered in an agreement between the BMA and the ABI. The agreement covers GPRs, supplementary reports, medical examinations undertaken by an applicant's own GP, quality of work by GPs and the process for reviewing the agreement should this prove necessary in the future. Information about agreed fees is available on the BMA website.

NHS GPs are reminded that they cannot charge their NHS patients for consultations that arise from this process, such as the discussion of health concerns that have come to light during the course of applying for insurance.

There is no agreement, as yet, on fees for HIV testing for insurance purposes. Fees for this work should be fully reflective of the time and expertise needed for pre- and post-test discussions.

## 12. Return and quality of reports

Doctors are encouraged to return reports as quickly as possible. If proper professional fees are to be charged, high quality reports should be produced and processed quickly, normally within 20 working days of receipt of the request. If a delay is expected, doctors should make this clear to their patients and indicate when they expect to be able to complete the report. Reports must be legible and authorised by the doctor.

It should be noted, however, that some of these reports are covered by the Access to Medical Reports Act (see section 4.2). Under this Act, if an applicant indicates that he or she wishes to see the report before it is dispatched, the GP should refrain from sending it for 21 days from the receipt of the request for the report. It may be advisable to inform the insurance company if a request to see the report has been made. Once the applicant has seen the report he or she may decide to withdraw consent for it to be sent. In such circumstances the insurance company will still pay the appropriate fee.

# 13. Further information

**For further information about these guidelines BMA members may contact:**

askBMA on 0870 60 60 828 or  
British Medical Association  
Department of Medical Ethics, BMA House  
Tavistock Square, London WC1H 9JP  
Tel: 020 7383 6286  
Fax: 020 7383 6233  
Email: [ethics@bma.org.uk](mailto:ethics@bma.org.uk)

**Further information for BMA members about fees**

is available from the BMA's website and askBMA 0870 60 60 828.

**Non-members may contact:**

British Medical Association  
Public Affairs Department, BMA House  
Tavistock Square, London WC1H 9JP  
Tel: 020 7387 4499  
Fax: 020 7383 6400  
Email: [info.public@bma.org.uk](mailto:info.public@bma.org.uk)

Health and Protection  
Association of British Insurers  
51 Gresham Street  
London EC2V 7HQ  
Tel: 020 7600 3333  
Fax: 020 7696 8999  
Email: [info@abi.org.uk](mailto:info@abi.org.uk)  
Web: [www.abi.org.uk](http://www.abi.org.uk)

# Appendix 1

## Medical information in the assessment of risk

This appendix provides an overview of some of the types of insurance cover that are provided and the medical information that a company's chief medical officer (CMO) and underwriter will find useful in the medical assessment of an application.

### Life insurance

Many products fall within the general description of life insurance. The most common types are:

- **Term insurance:** the simplest form of life insurance. The policy is limited to a definite term with the sum insured payable only on death within that term.
- **Whole of life insurance:** pays the sum insured upon the death of the insured person whenever that should occur.
- **Endowments:** combine life cover and an investment element. The sum insured is paid at the end of a fixed term or on the prior death of the insured person.

Other products include:

- **Impaired Life Annuity** – pays a guaranteed income in return for a capital sum to someone with a significant impairment that reduces his/her life expectancy. An impaired annuity pays out a higher regular amount than a normal annuity.
- **Discounted Gift Scheme** – enables a person to donate a gift to a trust while keeping the right to get an income from the gift. Under these arrangements, the value deemed to be transferred for tax purposes depends, among other things, on the life expectancy of the person making the gift.

Terminal illness benefit is frequently included in life insurance policies. This benefit means that the policy pays out in full if the insured person is diagnosed as having an illness or injury from which he or she is expected to die within a time specified in the policy.

### Information required

A life insurance underwriter must calculate the actuarial risk of the applicant dying before the end of the term. Thus the underwriter is interested in the diagnosis, treatment, severity and prognosis of a medical condition that will predictably result in premature death, not the applicant's quality of life. Non-life threatening conditions/illnesses are not relevant in the assessment of life insurance. Examples are colds, flu, routine vaccinations, wisdom teeth, uncomplicated pregnancies, contraception, minor breaks and sprains, common childhood complaints where there have been no sequelae, or a single episode of a sexually transmitted infection.

## Critical illness insurance

Critical illness policies typically pay out a lump sum if the insured person either dies or is diagnosed with a critical illness that meets the insurer's policy. Policies usually cover cancer, coronary artery bypass surgery, heart attack, kidney failure, major organ transplant, multiple sclerosis and stroke, and may specify other conditions. There are model wordings for the most common conditions. While insurers are free to decide on the conditions or exclusions applicable to their products, where a model wording is available, it should be used.<sup>13</sup>

Critical illness insurance can be marketed as additional cover on a life insurance product or as a stand-alone policy. In addition to the specified critical illnesses, policies can also include cover for total and permanent incapacity.

### Information required

The underwriter is concerned with the possibility of one of the covered critical illnesses occurring. Information is therefore needed about the existence of any of the conditions covered, and other health factors that affect the likelihood of the conditions covered developing. The ABI Statement of Best Practice for Critical Illness defines the conditions that are covered.

Total incapacity can be covered in critical illness cover, and in such cases the underwriter is also interested in medical conditions that, whilst not on the list of conditions, mean that the insured person is permanently unable to carry out any part of his or her occupation.

## Income protection plans/permanent health insurance

Income protection cover protects the insured person against the loss of earned income resulting from illness or accident. The income continues to be paid until the insured person is fit to return to work, or the policy ends. Benefits are paid after the insured person has been unable to work because of an illness or injury for an agreed period – typically three or six months but other periods are available. With health and disability cover it is the morbidity of an applicant that is relevant in the medical assessment. Therefore whilst life-threatening conditions are of importance, conditions which could possibly lead to chronic health and disability problems are of equal concern when assessing the medical information. The nature of the applicant's occupation may affect the significance of certain conditions.

### Information required

The underwriter needs the insured person's diagnosis, the date the problem was first noted, dates of subsequent problems, details about the care being received (including treatment and investigations), severity of the condition, prognosis and the amount of time the insured person has had off work due to the condition. If a part of the body is affected, it is important to specify whether it is the right or left side.

## Waiver of contribution

This optional benefit means that the insured person does not have to pay the premiums on the policy while the insured person is too ill to work. For example waiver of contribution taken out with a pension plan covers the payment of the premium if the insured person is unable to carry on working due to ill-health or disability beyond a pre-defined period, usually six months.

### Information required

The risk being assessed is similar to that of income protection/permanent health insurance therefore the same medical information and considerations are relevant.

## Long-term care

Long-term care benefit is payable if the insured person becomes physically or mentally disabled as a result of illness, accident or old age, and requires routine care for an extended period of time. It is payable to insured people who are unable to carry out specific activities of daily living, as set out in the policy. Activities of daily living (ADLs) include bathing, dressing and feeding.

### Information required

The vast majority of applicants for long-term care insurance are retired. The underwriter is looking for chronic and progressive mental and physical conditions/illnesses that could lead to the applicant being unable to perform the activities of daily living.

# Appendix 2

## Confidentiality of medical reports

The insurance company's chief executive is responsible for the confidentiality of medical information that the company holds. The chief executive must take advice from the chief medical officer (CMO) or other medical adviser in respect of medical information.<sup>14</sup>

The information companies hold about individuals may only be used for the purposes for which the information is supplied. If an applicant applies to the same company for a different product, consent is needed for the information already held to be used for this new purpose. Under no circumstances is it acceptable for insurance companies to use information gained about one person in actuarial assessment of his or her relatives.

Insurance companies requesting medical reports must supply doctors with envelopes, pre-addressed to the CMO or senior medical adviser. Reports should be returned in these envelopes and marked 'confidential – medical report'. Administrative duties in respect of these reports may be delegated to non-medical staff, but the CMO or senior medical adviser remains ultimately responsible for confidentiality. Similarly, the CMO or senior medical adviser is ultimately responsible for medical decision-making relevant to requests for medical information about applicants or insured people.

The Data Protection Act 1998 and the Financial Services Authority regulations apply to all those involved in the sales process, including the company's own salesforce, appointed representatives, telesales units, and all administrative staff within head offices, regional offices and branch offices. The Data Protection Guidance<sup>15</sup> sets out how medical reports and other information should be handled within the company. Only staff with a business need to handle medical evidence, as directed by the CMO, should have access to such evidence and efforts should be made to ensure that staff with no need to know do not come into contact with health information. All staff working in an environment where sensitive information is handled must have a thorough understanding of the company's confidentiality policy.

Special considerations apply to confidentiality and external bodies. Subject to the applicant's or insured person's explicit and informed consent, medical information may be shared with or shown to people outside the company if this is necessary for the conduct of business. This may be necessary to process the individual's application and policy; to handle a complaint; and to satisfy audit requirements, or to prevent fraudulent applications.

The Data Protection Guidance also covers methods of communication and the storage of confidential information.

# Notes and references

- 1 Association of British Insurers (2003) *An insurer's guide to the Disability Discrimination Act 1995*. London: ABI. Available on the ABI's website: [www.abi.org.uk](http://www.abi.org.uk).
- 2 Detailed advice about confidentiality and the situations in which it may be breached are given in: British Medical Association (2008) *Confidentiality and disclosure of health information tool kit*. London: BMA. Available on the BMA's website: [www.bma.org.uk](http://www.bma.org.uk).
- 3 General Medical Council (2004) *Confidentiality: protecting and providing information: frequently asked questions*, qu 13. London: GMC.
- 4 Ibid.
- 5 Ibid.
- 6 British Medical Association (2007) *Guidelines on the Access to Medical Reports Act 1988*. London: BMA. Available on the BMA's website: [www.bma.org.uk](http://www.bma.org.uk).
- 7 General Medical Council (2004) *Confidentiality: protecting and providing information: frequently asked questions*, qu 13. London: GMC.
- 8 Ibid.
- 9 British Medical Association (2007) *Access to health records by patients*. London: BMA. Available on the BMA's website: [www.bma.org.uk](http://www.bma.org.uk).
- 10 Association of British Insurers (2004) *Statement of best practice on HIV and insurance*. London: ABI. Available on the ABI's website at: [www.abi.org.uk](http://www.abi.org.uk).
- 11 The terms of the ABI's moratorium and *Genetic testing – ABI code of practice* are available on the ABI's genetics and insurance website at: [www.abi.org.uk](http://www.abi.org.uk).
- 12 A current list is available on the ABI website at: [www.abi.org.uk/consumer2/disclosure.htm](http://www.abi.org.uk/consumer2/disclosure.htm).
- 13 The full list of model wordings for assessing claims on critical illness policies can be found in the ABI's *Statement of best practice for critical illness insurance*, available on the ABI website at: [www.abi.org.uk](http://www.abi.org.uk).
- 14 The BMA issues general guidance on confidentiality for doctors: British Medical Association (2008) *Confidentiality and disclosure of health information tool kit*. London: BMA. Available on the BMA's website: [www.bma.org.uk](http://www.bma.org.uk).
- 15 The financial services area, Association of British Insurers, Association of Unit Trusts and Investment Funds, British Bankers Association, Consumer Credit Trade Association, Council of Mortgage Lenders, and Finance & Leasing Association joint guidance on the Data Protection Act, including confidentiality guidelines available at [www.bba.org.uk](http://www.bba.org.uk) reference ISBN 1-874185-16-6.

