PERSONAL GENERAL INSURANCE

CIP-03

V2

Technical updaters

Since it was first published, a number of technical contributors have updated, reviewed and verified specific and specialised sections of this textbook. Their work has been invaluable in producing such a comprehensive textbook and is much appreciated.

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Version

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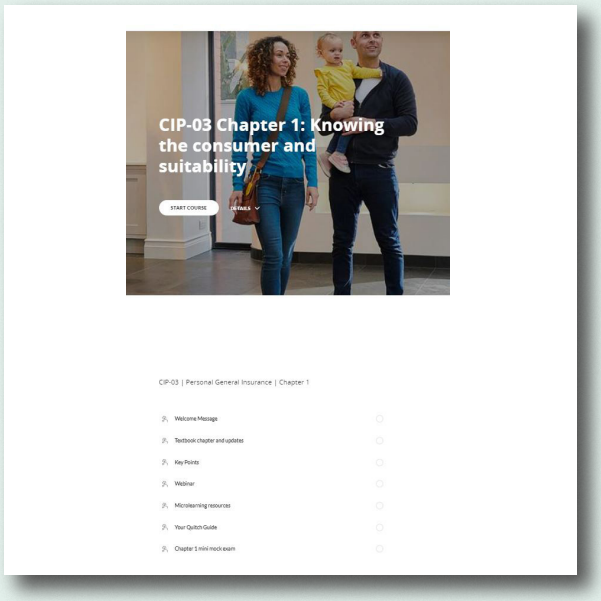

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Examples: These indicate how theories operate in simple day-to-day situations.

Just thinks: These offer you an opportunity to interact with the material by applying your learning.

Key terms: These appear in the margins and at the end of the textbook, and explain the meaning and context of insurance terms you may not have come across before.

Quick questions: These appear throughout the textbook and are designed to test your knowledge as you go. You can check your answers at the end of each chapter.

End of chapter questions: These are a great opportunity to test your learning and understanding of the chapter's topics. You can check your answers at the end of each chapter.

Sample multiple-choice questions: These can be found at the end of each chapter and are examples of the type of questions that may appear on your exam paper. These questions and solutions are provided to help you to focus your study and prepare for your exam.

Insurance policy extracts: Throughout this textbook you will see references to various insurance policies. The textbook summarises and abbreviates key information concerning policy wordings. They are not necessarily actual wordings nor should they be taken as applying universally across the market. There tend to be many variations of wording and ranges of exclusions. For this reason you are strongly advised to acquire a number of policy wordings yourself to see what is available in the market.

Consumer profiles: These are provided to assist you in your study of the various types of personal general insurances (Chapters 2-6). The consumer profiles are designed to help you reflect on how and why each different class of insurance may (or may not) be suitable for a particular consumer. This allows you to relate the material in the chapter to situations which you, as an adviser, may face on a daily basis.

Websites: Throughout the textbook we refer to websites that can be used to provide additional context to the material you're studying and keep you up to date with current trends and developments. It is important to note, however, that you will only be examined on the information contained within this textbook.

Index: At the end of the textbook, there is an index of websites, legal cases, legislation, acronyms, and key terms that provides a quick and easy reference to material featured in the textbook.

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Chapter

1

Knowing the consumer and suitability

What to expect in this chapter

In recent years, much of the regulation in the financial services sector has focused strongly on protecting and serving the interests of the insurance consumer. The Central Bank Consumer Protection Code (CPC), the Minimum Competency Code (MCC) and the **Minimum Competency Regulations (MCR)** play a significant role in ensuring that these objectives are met.

Those involved at every stage of the insurance process have a responsibility to ensure that the consumer is aware of what they are buying and agreeing to.

Advisers have an obligation to identify the most appropriate products and provide the best recommendations to their clients. They do this by using effective information gathering techniques. In this chapter, we'll see how insurance advisers take the consumer's information and match it with the insurers and insurance products in the market in order to recommend the best insurance solutions.

Learning outcomes for this chapter

Section	Title	At the end of each section you should be able to:
A	**Gathering information**	Describe the main items of information about a consumer that should be sought before providing advice about a general insurance policy.
B	**Considering insurers and insurance products**	Explain the criteria used to make recommendations to consumers with regard to both insurance products and insurers.
C	**Presenting the recommendation to the consumer**	Outline the scope of a statement of suitability used to detail the reasons underlying any advice or information given to the consumer regarding a general insurance policy.

A Gathering information

In the Compliance and Advice module, we explored Chapter 5 of the **Consumer Protection Code (CPC)** 'Knowing the Consumer', which blends regulatory principles with some very prescriptive timescales. To recap briefly, a **regulated entity** must gather and record sufficient information from the **consumer** prior to offering, recommending, arranging or providing an insurance product or service. While the level of information required may vary, depending on the nature and complexity of the product or service being sought, it must include details of the consumer's needs and objectives. The key objective is that the amount of information gathered must be sufficient to allow the regulated entity to provide a professional service.

The updated Guidance on the CPC issued by the Central Bank in May 2021 does not amend the CPC. It is a supplementary document that is for information purposes only.

In this section, we will consider the different stages and elements involved in the information gathering process.

Gathering information enables the insurance adviser to:

- identify and understand the risks faced by the consumer
- provide product choices that meet the consumer's wants and needs
- meet the wants and needs of that consumer on an ongoing basis
- act in the best interest of the consumer.

In carrying out this information gathering process, the adviser must:

- comply with the CPC
- comply with anti-money laundering requirements
- comply with data protection requirements
- obtain the consumer's address for communications
- obtain specific information about the consumer and their risks (e.g. sums insured, vehicles owned)
- confirm the consumer's insurance and claims history.

A1 Considering the consumer's wants and needs

The consumer will bring certain 'wants' to the adviser. The ideals put forward by the consumer may include a hope to extend or change cover (e.g. to provide comprehensive motor cover for the consumer's 19-year-old son), a desire to reduce the overall cost of insurance or simply to make a change to their insurance policy. However, a consumer's wants will not necessarily reflect their needs. The consumer's needs, which relate to their potential exposures (risks) and insurance requirements, exist whether or not they are aware of them (e.g. to meet Road Traffic Act requirements in relation to all users of the motor vehicle). The adviser's role is to identify the consumer's needs and blend these with their wants in order to recommend the most suitable solution.

Consumer Protection Code (CPC)

code issued by the Central Bank of Ireland setting out requirements that regulated firms must comply with in order to ensure a minimum level of protection for consumers

regulated entity

a financial services provider authorised, registered or licensed by the Central Bank of Ireland or another EU or EEA member state, that is providing regulated activities in the State

consumer

any of the following:

a. a person or group of persons, but not an incorporated body with an annual turnover in excess of €3 million in the previous financial year (a group of persons includes partnerships and other unincorporated bodies such as clubs, charities and trusts), or

b. incorporated bodies having an annual turnover of €3 million or less in the previous financial year (provided the incorporated body is not a member of a group of companies having a combined turnover greater than €3 million).

…and includes a potential consumer

risk appetite

measure of an individual or company's willingness to accept risk

risk-averse

a desire on the part of an individual or company to minimise the risks to which they are exposed, either through risk management or insurance

risk-seeking

a willingness on the part of an individual or company to accept risk

Quick question 1

A household insurance policy offers a choice of excess levels. The standard policy excess is €150, but an attractive premium discount is offered if the consumer opts for a €4,500 excess.

As an adviser, would you recommend the higher excess option to a consumer you identified as:

a) risk-averse?

b) risk-seeking?

The answer is at the end of this chapter.

excess (deductible)

first part of each and every claim that must be paid by the insured

A2 Considering the consumer's attitude to risk

It is also important for the adviser to understand each consumer's attitude to risk. The consumer's **risk appetite** will influence the extent to which they seek protection from the risks they are exposed to, and how they identify and prioritise their insurance needs. Extract 1.1 outlines the Central Bank requirement on assessing risk appetite.

1.1 Extract Regulatory imperative, CPC 5.16d (abbreviated)

When assessing the suitability of a product or service the adviser must, at a minimum, consider and document whether the product or service is consistent with the consumer's attitude to risk.

The adviser needs to identify each consumer's position on the scale that runs from the two extremes of **risk-averse** to **risk-seeking**. One of the most effective means of doing this is to discuss options or scenarios with the consumer to get some insight into their attitude towards risk. For example, if the consumer would prefer to retain their own damage risk for their car insurance, the adviser may exclude comprehensive quotations from the list of options.

Just think

Why can we not simply ask the consumer whether they consider themselves to be risk-averse or risk-seeking?

The main reason is that different people may have different understandings of the terms 'risk-averse' and 'risk-seeking'. Therefore, a specific question (e.g. how large an **excess** the consumer is willing to bear) is easier for the consumer to understand and can help establish a more accurate assessment of the consumer's risk appetite and will, therefore, be a better basis for arranging the insurance.

A3 What information do we need from the consumer?

In each of the product-related chapters (Chapters 2–6), we identify the key questions that an adviser should ask their clients in relation to the specific insurance product they are interested in, so the adviser can determine the most appropriate product.

At this stage, however, we are primarily considering the generic information required for all personal general insurance consumers. It is essential that advisers and other staff collecting or processing this information (personal data) are aware of and compliant with the **Data Protection Acts 1988-2018**. The requirements placed on organisations by data protection legislation were covered in the Compliance and Advice module.

Just think

What are the initial questions an adviser would need to ask to compile general information about the consumer?

Table 1.1 shows the type of information that needs to be gathered from all personal general insurance consumers/**clients**. Many **advisers** refer to this as developing a **client fact find**.

Table 1.1 General information

Required information	Main reason(s) for inclusion
Consumer	The full name of the individual seeking insurance, and that of the spouse/partner (if the insurance is to be in joint names). The full name of any relevant dependants (e.g. to be insured under a travel, healthcare or PMI policy or those living in the property to be insured). The full name of any other person who may use the item to be insured (e.g. vehicle or sports equipment).
Address	The full postal address for communication (including Eircode) and for pricing and underwriting purposes (e.g. assisting with flood and **subsidence** risk checks). This address and the addresses of any other properties owned (e.g. holiday homes) assist in checking on previous claims.
Occupation	In many classes of insurance (e.g. personal accident), this is an important pricing factor.
Age	This information will be used for pricing in personal accident, travel and motor insurance. Note that, in order to comply with equality legislation, pricing decisions related to age must be based solely on the insurer's actuarial or statistical data and/or other relevant underwriting or commercial factors.
Any business(es) carried on at the property	It is important that any business activities are described accurately and fully, as **insurers**' attitudes vary regarding their acceptability, e.g. a business extension to a household policy.
Forward plans	A proposed change of address, change in occupation, change of car or new driver (e.g. a son or daughter learning to drive), or plans to marry, will prompt different considerations. For example, does cover under an insurer's policy automatically provide for temporary increases in the contents sum insured around the date of the wedding?

client

a person, firm or organisation that has appointed a regulated entity to act on their behalf for insurance purposes

adviser

individual involved in the advising process; this may be an employee of an insurer or an intermediary

client fact find

a list of questions designed to elicit all necessary information as a starting point for analysing consumer needs

subsidence

gradual movement or sinking of land on which premises stand

insurer

a risk-carrying, regulated entity (product producer)

community rating

private health insurance principle that cross-subsidises the cost of private medical insurance from young to old and, to some degree, male to female

claims experience (history)

a detailed breakdown of past losses, including details of paid and outstanding claims; ideally confirmed by the holding insurer

firm

a regulated entity (as used throughout this textbook to refer to insurers and/or intermediaries)

proposer

a person, firm or organisation applying for insurance

Quick question 2

Consumers may wonder why all of this information is needed. What is the adviser trying to achieve by asking all these questions?

Table 1.1 General information (contd)

Required information	Main reason(s) for inclusion
Consumer experience/ history, including claims and insurance history	The adviser should obtain full details of previous losses and claims (settled and open) as this will impact on pricing for most products with the exception of private health insurance where previous claims do not affect the premium being quoted as a result of **community rating**. They should also check if the consumer's circumstances have changed in recent years. For example, if losses (such as flood) occurred at a different address, the **claims experience** can be presented to the market in a better light. Responses to questions about whether the consumer has previously been refused insurance, has had special terms applied or had their premium loaded will help the adviser ask more specific questions to ensure that all relevant information is disclosed.
Date of visit/ contact	Recording the time and date for receipt of all information/ instructions will demonstrate that the **firm** adheres to both its own internal requirements for consumer servicing and any regulatory requirements that may apply.
Reason for visit	If the visit is the result of a referral, this should be stated, including how regulatory requirements have been met. If the consumer has previously had a bad experience with an existing insurer or adviser, this should also be noted.
Introduction/ verification of consumer identity/contact information	The adviser must record the consumer's contact information and note the steps taken to verify the consumer's identity, in accordance with anti-money-laundering and regulatory requirements.
Inception/renewal date	This will provide the basis for timing of future action.
Current insurer and premium details	Insurers and intermediaries commonly request this, although the **proposer** may be reluctant to provide it. Nevertheless, this information provides a basis for discussing why the consumer requires the adviser's services.
Identification of adviser	Including the identity of the adviser ensures that the person carrying out the visit/contact is an accredited individual.

The information gathered in this process assists the adviser in providing full and accurate information to insurers. Compiling this information will also prompt discussions in relation to specific classes of insurance. Specific information regarding exposures and requirements for different classes will be added in later product-related chapters (Chapters 2-6).

B Considering insurers and insurance products

Having gathered the necessary information from a consumer, the adviser must then consider which insurer(s) and insurance product(s) will best meet their client's needs.

One of the key requirements of the CPC is that the adviser must recommend the most suitable product to meet the consumer's needs. To comply with this requirement, the adviser must:

- fully understand the consumer's wants and needs (see Section A1)
- understand the consumer's attitude to risk (see Section A2)
- have an up-to-date knowledge of the products available in the market (see Chapters 2–6).

In relation to this last point, if the adviser is a **tied insurance intermediary**, this is a fairly straightforward exercise (see Example 1.1). However, for advisers working in intermediary firms, the process is more complex, as they must give advice based on either a **fair and personal analysis of the market** or a **limited analysis of the market**.

Example 1.1

Deirdre is auctioneer with TopSales Ltd and is also a tied insurance intermediary of BeSafe Insurance DAC for household insurance business. Her client, James, asks whether the quotation she has just provided for him is the best available in the market. She is confident that it will compare favourably with other quotations. However, she cannot offer James an opinion on this as it would be the same as advising him on products from insurers with whom TopSales does not hold an agency appointment. Instead, she must explain that she is a tied insurance intermediary, only dealing with one insurer and, therefore, only able to provide advice on this insurer's products.

Unlike Deirdre (a tied insurance intermediary), an independent **intermediary** would be able to carry out a fair and personal analysis of the market which might result in a number of suitable products being offered to James to choose from.

tied insurance intermediary

any person who

a. undertakes insurance or reinsurance distribution for and on behalf of one or more insurance or reinsurance undertakings or other intermediaries, in the case of insurance products that are not in competition

b. acts under the responsibility of those insurance or reinsurance undertakings or other intermediaries, and

c. is subject to oversight of compliance with conditions for registration by the insurance or reinsurance undertaking or other intermediary on whose behalf it is acting.

Insurance Distribution Regulations 2018

fair and personal analysis of the market

advice based on an analysis of a sufficiently large number of contracts available on the market to enable the intermediary to make a recommendation, in accordance with professional criteria, as to which insurance contract adequately meets the customer's needs

Insurance Distribution Regulations 2018

limited analysis of the market

analysis of a limited number of contracts and product producers available on the market

intermediary

generic term for firms of all types that give advice on insurance products (see also 'insurance intermediary')

B1 Basis for insurer and insurance product recommendations

In this section, we will consider the insurers and insurance products available to meet the consumer's needs.

B1a Price

The most obvious factor for deciding between, and recommending, personal general insurance products is price. This is especially so in relation to motor insurance. Price may also be the client's primary concern, particularly if they have asked the adviser to find them the 'best deal'.

Just think

When it is obvious that most consumers' choices will be price-driven, why bother with the other criteria for insurer selection?

While price is a very important factor, it is only one factor in the decision-making process. The adviser must ensure that the consumer considers all the relevant factors before making a decision about an insurer or a product. These are outlined in Sections B1b-e.

B1b Levels of service and support

The adviser will look for desirable aspects of service such as:

- fast and comprehensive quotations
- an efficient system of accurate documentation
- efficient claims handling and prompt payment of claims
- a fair approach to complaint resolution
- the availability of credit facilities or flexible payment options
- quick and thorough response to requests for changes or information (e.g. claims experience)
- a dedicated relationship manager/executive to build a strong partnership with
- easy access to underwriters/decision-makers.

B1c Breadth of cover

The adviser will normally seek the widest possible cover (unless the consumer cannot afford or does not require this). However, the adviser must ensure that the consumer understands the variations between different insurers' policy wordings so they can make accurate comparisons. For example, saving €25 in price, if accompanied by an increase of €500 in the level of excess, may make little sense.

Variations in insurance policy wordings can impact significantly on a consumer's insurance cover. This reinforces the need for advisers to become familiar with the ways in which policies have been constructed. It cannot be emphasised enough that a simple comparison of apparently similarly headed sections in different policies is an inadequate and potentially misleading basis for comparisons.

The **Minimum Competency Code (MCC)** requires advisers to know the main features, benefits and limitations of generic types of general insurance policies. The adviser must then evaluate these in the context of achieving the best outcome for the consumer.

The Competition and Consumer Protection Commission (CCPC) provides information on financial queries (e.g. insurance) on its website.[1] It outlines the different types of insurance (e.g. car, house, travel, gadget and pet insurance) and provides information on getting insurance quotes and making claims. The Insurance Ireland website also provides information on general (non-life) insurance such as household, motor and travel for consumers to use as a general guide to insurance (www.insuranceireland.eu). In relation to health insurance products, the Health Insurance Authority (HIA) has an independent health insurance product comparison tool for use by consumers and advisers (www.hia.ie).

The use of **cover comparison charts** enables the adviser to highlight variations in policy cover and identify the most appropriate product for the consumer's circumstances and needs. These charts are particularly recommended for evaluating key elements of insurance policy cover. Insurers may also produce comparison charts relating to their own product range.

Example 1.2 lists some of the factors it may be appropriate to consider when comparing comprehensive private motor insurance policies. This is by no means the only way of comparing wordings but it provides a useful framework. Although it takes time to create these comparison charts, the ease of use they provide makes it worth the effort. Most quotation systems also highlight some of the main features and benefits of insurers' products.

Minimum Competency Code

code issued by the Central Bank of Ireland setting minimum professional standards to be met by those falling within the MCC's scope when undertaking certain controlled functions. The MCC has a particular emphasis on dealing with consumers

cover comparison chart

a means of visually displaying the key differences between the characteristics of different insurers' policies

[1] Competition and Consumer Protection Commission website, www.ccpc.ie

Example 1.2 Private motor insurance cover comparison

Own damage (accidental or malicious damage to the insured car)	Insurer A	Insurer B
Approved repairer scheme		
Courtesy car	Yes	Yes, but €200 limit
Work guaranteed	Yes	Assumed yes
Standard cover		
Replacement lock	• Yes, provided proof of knowledge of car location • No excess • **No claims discount** (NCD) unaffected	• Yes, if keys stolen from house by force • €1,000 limit • Normal excess • Affects NCD
Fire brigade charges	€1,000 extinguishing fire or cutting for access	No
NCD scale	1 year 10% 2 years 20% 3 years 30% 4 years 40% 5 years 50%	Not published, but 'insurer's scale' referred to in document
Mid-term alterations minimum charges	<€20, not collected or charged	<€25 not collected or charged
New car replacement	12 months of registration; repair cost 50% or greater of the current list price	12 months of registration; insurer decides whether write-off
Towing charges	To nearest repairer plus storage	To nearest repairer
Windscreen cover	Yes, affects NCD	Yes, does not affect NCD
Personal accident	Not included as standard	Yes, hospitalisation €150 per week
Personal effects	Yes, up to €200	Yes, up to €100
Driving other cars	No	Yes

no claims discount

a reduction of premium for successive claim-free years, which increases to a maximum over a period of (usually) 5 years, held in comsumer's own name

Quick question 3

What is the advantage of creating a cover comparison chart to compare different insurers' policy terms?

There would also be sections relating to other aspects of cover such as third-party cover, limitations for fire and theft, extra benefits, roadside assistance, personal effects, personal accident benefits, and use (e.g. commuting to work). All of these sections are explained in more detail in Chapter 2.

Just think

What is the main danger in compiling a cover comparison chart?

When using this kind of comparison chart, it is essential to have a system in place to monitor changes to insurers' wordings so the information is kept up to date. Otherwise, the advice given to the consumer will be neither accurate nor appropriate, and the adviser will have failed to meet the MCC requirement to have an up-to-date knowledge of the products available in the market.

B1d Experience

Certain insurers will gain a reputation in the market for covering particular types of risk, e.g. young drivers, unoccupied risks, holiday homes. This may be an important factor in the scope of the cover and the quality of the service.

B2 Adviser's experience and judgement

An adviser's ability to exercise sound judgement relies on a number of factors: their knowledge of the market and the products available; their familiarity with different insurers' approaches to types of risk; and an assessment of insurers' reputation in the market. These factors must be weighed alongside the obvious key areas of price and scope of cover in order to make appropriate recommendations. In different situations, individual factors may be of greater or lesser importance.

It is essential that advisers take a disciplined and proactive approach to updating their market knowledge, rather than relying on media reports. The adviser should, at all times, be up to date with any new developments or industry trends, many of which do not make the national media. The best and most reliable sources of information are the Insurance Ireland website and the trade press. In addition, Continuing Professional Development (CPD) activities are vital for maintaining existing qualifications, updating knowledge, and networking with colleagues.

Quick question 4

Petrina works for a tied insurance intermediary. Can she give advice or recommend a product or service from a wide range of insurers in the market?

C Presenting the recommendation to the consumer

statement of suitability

written statement setting out the reasons why a product or service (or options if listed) offered to a consumer is considered to be (most) suitable for that consumer (also known as a 'reason why' letter)

C1 Statement of suitability

As you will recall from the Compliance and Advice module, the CPC requires that, before providing a product or service to a consumer, a regulated entity must prepare a written **statement of suitability** setting out the reasons why:

- a product or service offered to a consumer is considered to be suitable for that consumer
- each of a selection of product options offered to a consumer is considered to be suitable to that consumer
- a recommended product is considered to be the most suitable product for that consumer.[2]

The principles governing this statement of suitability, and which an adviser must follow when recommending a product to a consumer, are as follows:

insurance intermediary

any person or firm, other than an insurer/reinsurer or their employees but including an ancillary insurance intermediary, which for remuneration takes up or pursues the activity of insurance distribution and is subject to the **Insurance Distribution Regulations 2018**

- The adviser must offer the most suitable option from those available. For **insurance intermediaries**, this will be based on either a fair and personal analysis of the market or a limited analysis of the market. Advisers who are tied insurance intermediaries or are employed by insurers must offer the most suitable option from their own range (where more than one policy is available).
- The adviser must offer a product meeting more of the consumer's needs than any other product. The adviser can offer their professional opinion to the consumer regarding the product and, if relevant, why it would not be the adviser's preference. This will allow the consumer to make an informed decision.
- If there are genuine reasons for offering options rather than recommending a single product, the adviser must highlight all relevant differences in cover levels, terms and conditions to enable the consumer to make an informed decision. There will be occasions when the adviser simply does not know which would be the consumer's favoured option. The adviser must then provide a full comparison of the competing available options as illustrated in Example 1.3.

[2] Provision 5.19, CPC.

Example 1.3

Jane is employed by Stronghold Insurance Brokers. She has obtained quotations for a consumer's household insurance. There are two suitable options available with a difference of €100 in the premium price. The policy with the lower premium has an excess of €350, as opposed to a €150 excess for the policy with the higher premium.

Both policies offer similar cover and meet the consumer's needs. Jane does not know which option her consumer will prefer. She must therefore present both options and explain their differences.

Just think

As it takes a long time to explain things, why not simply provide advice to a consumer without feeling the need to justify it?

The adviser is a professional and it is their job to ensure that the consumer can make a properly informed decision. The consumer can only do this if they understand how the recommendation meets their needs and objectives, personal circumstances and financial situation. Therefore, the adviser's recommendation must include a justification as to why it is the best policy for that particular consumer.

Quick question 5

Developing fact sheets and frequently asked questions (FAQs) provides consistency of advice, but what is the downside of over-reliance on these as a primary means of communicating advice?

C2 The form of the statement of suitability

A statement of suitability, which is sometimes referred to as a 'Reason Why' letter, can be structured in a number of ways. However, in all cases the following notice must appear at the beginning of the statement of suitability.[3]

Important notice – statement of suitability

This is an important document that sets out the reasons why the product(s) or service(s) offered or recommended is/are considered suitable, or the most suitable, for your particular needs, objectives and circumstances.

The adviser/regulated entity must sign the statement and provide a copy (on paper or on another **durable medium**) to the consumer, and retain a copy, at the time the quotation is being offered. Where immediate cover is required, a statement of suitability may be issued to the consumer immediately after the policy has been incepted.

One of the most straightforward ways of presenting information is to list both the consumer's wants and needs and show how the recommended product(s) meet these. If the recommended product(s) does not fully achieve this, the statement should outline to what extent the consumer's wants and needs have been met.

Appendix 1 (at the end of this chapter) shows an example of a statement of suitability based on wordings in use in the market. This example relates to a consumer seeking household insurance. The adviser has considered the consumer's wants and needs and is now in a position to recommend an insurance product (having followed the principles in Section C1). For a **personal consumer**, the statement of suitability for travel, motor and home insurance may be in a standard format, which we have used for illustration purposes.[4]

durable medium

any instrument that allows information to be stored and accessible for future reference, for a required period of time, and prevents the stored information from being changed or reproduced

personal consumer

a natural person acting outside their business, trade or profession

[3] Provision 5.20, CPC.

[4] Provision 5.22, CPC.

When presenting their recommendation(s) in the statement of suitability, the adviser should do so in a manner appropriate to the consumer's familiarity with insurance.

A statement such as, 'Your contents cover will be subject to average if you are underinsured', will probably confuse a person with limited knowledge of insurance terminology. The adviser needs to simplify this, possibly as follows:

> If your contents are damaged by an insured event, the insurer will pay the full repair or replacement cost provided that the sum you have declared is an accurate figure representing the full replacement cost of your contents. They automatically provide an index-linked inflationary increase each month to cater for future inflation, if necessary. However, if the sum insured represents less than the full value figure, the settlement figure will be reduced in direct proportion to the understated value. This means if you insure for only 75% of the total value, you will only receive 75% of the repair or replacement cost in the event of a loss. If you are responsible for the first part of any loss (an excess) this is deducted last.

For this reason, although it is helpful to create templates for statements of suitability (and other documents used in the insurance process), there must be scope for adapting them to take account of the consumer's level of understanding, vulnerability and their familiarity with insurance.

Just think

Why is it necessary to sign the statement of suitability?

The statement of suitability must be signed in order to comply with the CPC requirement that a signed copy must be given to the consumer.[5] It is also helpful for the consumer, the insurer and the adviser to know who the consumer was dealing with in the event that any queries may arise at a later date. The person signing the document must be suitably qualified to provide the advice.

[5] Provision 5.19, CPC.

C3 Insurance product information

The **Insurance Distribution Directive 2016** requires advisers to provide customers with an insurance product information document (IPID) prior to the conclusion of a contract (new business, renewal or online sale).

The IPID aims to enable customers to compare the product to similar products and to make an informed decision. This information must be provided by way of a standardised IPID, irrespective of whether any advice is given and whether the product forms part of a package.

IDD requires that the IPID shall contain the following information (see Appendix 2 for an example):

- information about the type of insurance
- a summary of the insurance cover, including the main risks insured, the insured sum and, where applicable, the geographical scope and a summary of the excluded risks
- the means, frequency, duration and number of premium payments
- main exclusions where claims cannot be made
- obligations at the start of the contract, during the term of the contract and in the event that a claim is made
- the term of the contract including the start and end dates of the contract;
- details of the cancellation conditions of the policy.

Under the **Consumer Insurance Contracts Act 2019**:

- before a contract of insurance is entered into or renewed, an insurer must inform the consumer on paper or on another durable medium of the general nature and effect of the pre-contractual duty of disclosure.
- the cancellation clause should explain that when an insurer is cancelling a contract of insurance, the balance of the premium for the unexpired term of the contract will be refunded to the consumer and the consumer will be informed of the reason(s) for the cancellation.
- unless an insurer asks specific questions at renewal, it is taken that the information previously provided still applies.
- an insurer must provide the consumer with a schedule of all premiums and claims paid for the preceding 5 years at renewal.

D Summary

In this chapter, we considered the initial stages of the relationship between the adviser and their client (the consumer), and the CPC regulatory requirements the adviser must satisfy. As outlined in Figure 1.1, we learned about the importance of information gathering, distinguishing between the consumer's wants and needs, exploring risk appetite, and comparing insurance products and insurers. We also looked at how advisers recommend the most suitable product for the consumer by preparing a statement of suitability.

Figure 1.1 Getting to know the consumer and suitability

D1 What's next?

In Chapters 2-6, we'll look at specific classes of personal general insurance. We'll see the cover provided by each type of policy and discuss the important issues that advisers must consider when recommending and arranging these policies.

D2 Study tips

It's important to remember that this textbook is the primary information source for this module. All the questions in your exam will relate directly to information featured in the textbook. Use the 'End of chapter questions', 'Quick questions' and the 'Sample multiple-choice questions' to quickly test what you've learned so far. Make a note of any topics/areas you need to improve in and keep it to hand so you can refer to it when you revise this chapter again before your exam.

In addition to the textbook, your Member Area has many online study supports that can help you as you study this module.

D3 Online learning supports

Your Member Area includes a learning plan, an automated study planner, an exam countdown timer and study tips guide. These study supports are invaluable in reinforcing what you have learned from the textbook so far. The webinars, chapter-by-chapter key points and other supports will help you to break down the chapter content when revising.

Completing online mock exams and reviewing the personalised feedback that follows is a great way of testing your knowledge and preparing for exam day.

To access these online study supports, just log into your Member Area on www.iii.ie and click on the **Connect** logo.

Appendix 1 Statement of suitability

Important notice – Household insurance statement of suitability

This is an important document that sets out the reasons why the product(s) or service(s) offered or recommended is/are considered suitable, or the most suitable, for your particular needs, objectives and circumstances.

Please ask us any questions you may have about the information in this document.

Dear Client

Based on our understanding of your insurance requirements, we recommend the insurance product(s) listed here as being suitable and in your best interests at this time.

In making this recommendation we have considered a number of factors. They include:

- the price of the product recommended
- the extent and nature of the cover provided
- your own attitude to risk
- the insurer's experience in this market
- the service (including claims service) provided by the insurer.

Information from you

Our advice is based on the information provided by you and the products and insurers available at a given time during our research. It may vary in the light of market changes or changes in your own circumstances.

There is an obligation to answer all questions on the proposal form honestly. The consequences of failing to do this are potentially very serious, and could invalidate the insurance policy. So, if in doubt please contact us to advise us of any changes.

Our recommendation

In selecting this product(s)/service(s) we have done so on the basis of a fair and personal analysis of the market. This means we considered a sufficiently large number of insurers and their products to enable us to recommend the most appropriate product to meet your needs.

Recommended policy

Household contents policy from XYZ Insurance DAC - cover for fire and a wide range of other perils (but not 'accidental loss or damage'). A summary of the main risks covered is attached. It is supplied for ease of reference. A full policy wording is available on request. The basis of insurance for contents is outlined here.

Replacement, except for the following if more than 4 years old:

- clothing, furs, household linen and fabrics
- TV, audio, video, computer, recording equipment and ancillary material including CDs, tapes, records and software
- floor coverings.

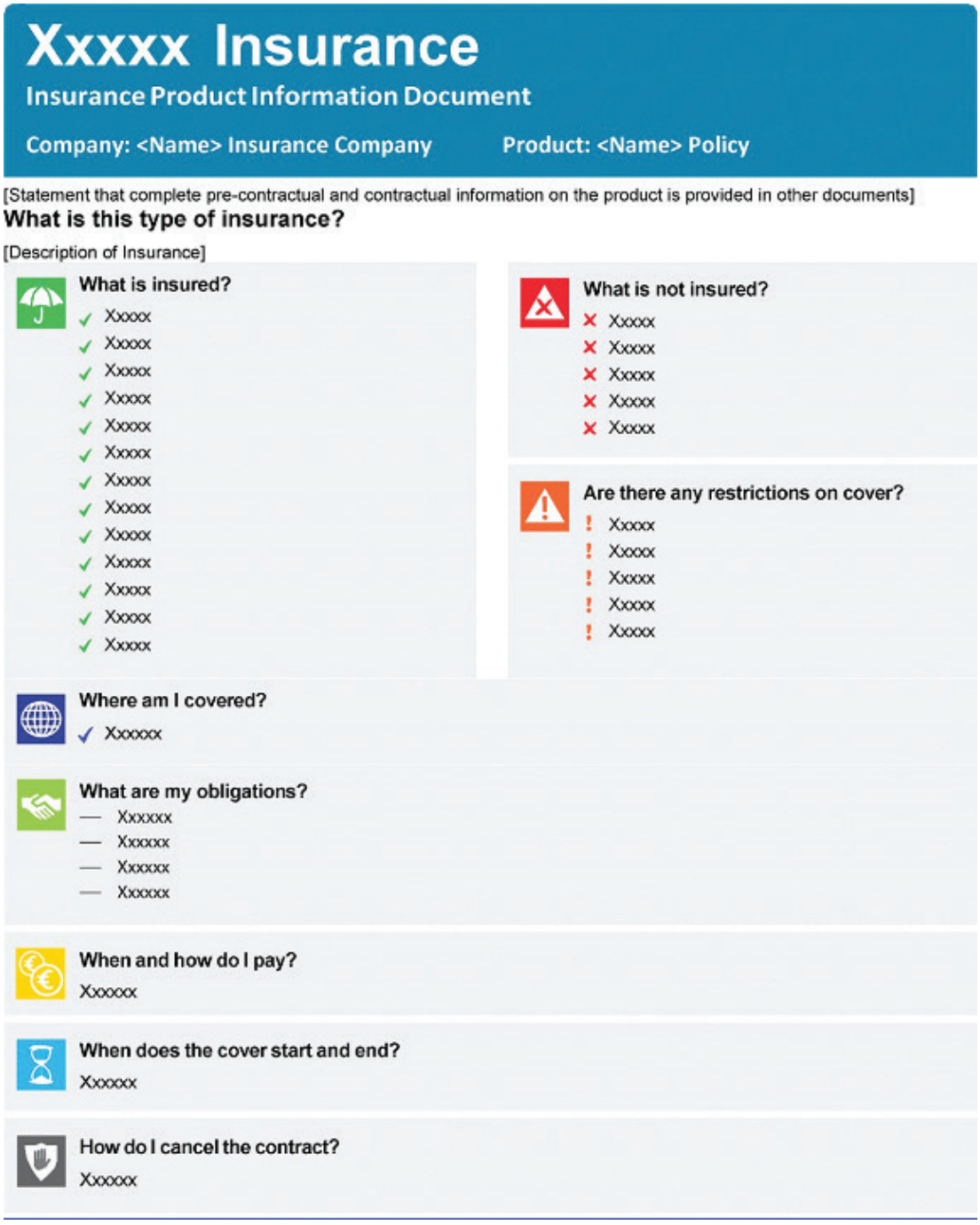
The sum insured on contents is €30,000 (subject to limitations for valuables individually of 5% of the contents sum insured, or 50% in total). The excess for most elements is €350. For many extensions to cover, lower levels of excess apply. The limit of liability for personal, homeowner and occupier liabilities is €3 million. The premium is €_____.

Signed _____for and on behalf of _____.

I accept the above and confirm my instructions to _____ to arrange the cover with the relevant insurers.

Signed _____ Date _____

Appendix 2 Insurance product information document



Xxxxx Insurance

Insurance Product Information Document

Company: <Name> Insurance Company **Product: <Name> Policy**

[Statement that complete pre-contractual and contractual information on the product is provided in other documents]

What is this type of insurance?

[Description of Insurance]

What is insured?

- ✓ Xxxxx
- ✓ Xxxxx
- ✓ Xxxxx
- ✓ Xxxxx
- ✓ Xxxxx
- ✓ Xxxxx
- ✓ Xxxxx
- ✓ Xxxxx
- ✓ Xxxxx
- ✓ Xxxxx
- ✓ Xxxxx
- ✓ Xxxxx

What is not insured?

- ✗ Xxxxx
- ✗ Xxxxx
- ✗ Xxxxx
- ✗ Xxxxx
- ✗ Xxxxx

Are there any restrictions on cover?

- ! Xxxxx
- ! Xxxxx
- ! Xxxxx
- ! Xxxxx
- ! Xxxxx

Where am I covered?

✓ Xxxxxx

What are my obligations?

- — Xxxxxx
- — Xxxxxx
- — Xxxxxx
- — Xxxxxx

When and how do I pay?

Xxxxxx

When does the cover start and end?

Xxxxxx

How do I cancel the contract?

Xxxxxx

End of chapter questions

Use these questions to test your understanding of what we've covered in Chapter 1.

1. List four things that information gathering enables an insurance adviser to do.

2. Distinguish between a consumer's 'wants' and a consumer's 'needs'.

3. State the primary aspect of the consumer's attitude the adviser will wish to establish when a consumer profile is being developed.

4. Explain why an adviser needs to obtain information regarding any business use of the home.

5. List four particular aspects that will be of significance to an adviser when considering the levels and quality of service offered by an insurer.

6. State the key purpose of 'cover comparison charts'.

7. List three principles an adviser must follow when determining which products to recommend to a consumer.

8. List the classes of insurance business for which the Central Bank permits a statement of suitability in a standard format.

9. Describe the dangers, if any, in attempting to provide every consumer with identical information in relation to products and their suitability.

10. Outline what must be taken into account by an adviser when setting out the suitability of a product.

11. Outline the important notice a statement of suitability must contain.

Answers to end of chapter questions

Check your answers against those below and make a note of any points you left out. This will highlight the sections you may need to look at more closely during your revision.

1. The gathering of information allows the insurance adviser to:
   - act in the best interest of the consumer
   - identify and understand the risks faced by the consumer
   - provide product choices that match the consumer's wants and needs
   - meet the wants and identify the needs of the consumer on an ongoing basis.

2. 'Wants' are what the consumer puts forward as a request or an ideal (e.g. a desire for their motor policy to be on an 'open driving' basis), while 'needs' are the consumer's exposures/requirements for insurance cover (e.g. motor cover to meet RTA requirements). The consumer may not be fully aware of their needs so the adviser may have to bring them to their attention.

3. An adviser will want to establish the consumer's risk appetite, i.e. whether the consumer is risk-averse or risk-seeking.

4. The adviser needs to obtain information regarding any business use of the home because insurers' attitudes vary widely in terms of their willingness to cover business equipment, legal liability and even to accept the activity at all.

5. Any four of the following factors are relevant when considering service levels:
   - fast and comprehensive quotations
   - efficient system of accurate documentation
   - efficient claims handling and prompt payment of claims
   - a fair approach to complaint resolution
   - the availability of credit facilities or flexible payment options
   - a quick and thorough response to requests for changes or information (e.g. claims experience)
   - a dedicated relationship manager/executive to build a strong partnership with
   - the availability of credit facilities or flexible payment options.

6. Cover comparison charts are designed to highlight relevant differences in insurers' terms and conditions so that cover can be measured against consumer needs.

7. The three principles an adviser must follow when determining which products to recommend to a consumer are:
   a. The adviser must offer the most suitable option from those available.
   b. The adviser must offer a product meeting more of the consumer's needs than any other product, even if it is not the adviser's preference.
   c. If there are genuine reasons for offering options rather than recommending a single product, all relevant differences in cover levels, terms and conditions should be highlighted to inform the consumer's decision.

8. Travel, home and motor insurance, when advising personal consumers only.

9. The danger is that the information provided will not take account of the consumer's familiarity with insurance. This could lead either to overly simplified information (not recognising the competence level of the consumer) or too little detail and the tendency to use jargon that some may not understand.

10. Suitability must reflect the consumer's needs and objectives, personal circumstances and financial situation.

11. A statement of suitability must contain the following important notice: 'This is an important document that sets out the reasons why the product(s) or service(s) offered or recommended is/are considered suitable, or the most suitable, for your particular needs, objectives and circumstances'.

Answers to quick questions

1. The higher excess is unlikely to be suitable for a risk-averse consumer. This person is more likely to prefer a policy with a lower excess, i.e. a higher level of cover. The higher excess may be suitable for a risk-seeking consumer, who will be more likely to accept higher levels of risk retention.

2. In asking all of these questions, the adviser is trying to get to know their client and establish their insurance requirements and is also trying to ensure that they are complying with their obligations under the CPC and data protection legislation.

3. A cover comparison chart enables the adviser to highlight variations in policy cover and identify the most appropriate product for the consumer's circumstances and needs.

4. No. As a tied insurance intermediary, Petrina is tied to one insurer and can only recommend products or services provided by that insurer.

5. Advice must often be tailored to a consumer's needs. Although there is real value in resources such as fact sheets and FAQs, they are not adequate to respond to the specific needs of a particular consumer or cater for their level of understanding of insurance.

Sample multiple-choice questions

Note: In your exam you will be awarded +3 marks for every question answered correctly, -1 mark for every question answered incorrectly, and 0 marks for every question you choose not to attempt. On the answer form you complete in the exam, you will be required to choose from Options A, B, C, D or E. Options A-D correspond with a possible answer to the question, while selecting Option E confirms that you are choosing not to attempt the question. When you attempt the mini-mock and full mock exam papers available on **Connect**, this marking system is applied to allow you to prepare for your exam.

1. The most obvious criterion for deciding between, and recommending, personal general insurance products is:

   A. levels of service
   B. financial stability
   C. breadth of cover
   D. price

   Your answer:

   ☐

2. Which of the following is an alternative name used for a 'statement of suitability'?

   A. Fact find.
   B. Proposal form.
   C. Reason why letter.
   D. Questionnaire.

   Your answer:

   ☐

3. DMB Brokers is meeting with a new client, Jennifer, who wishes to take out a motor policy. Which of the following questions would DMB ask Jennifer to help establish her risk appetite?

   A. How large a policy excess is Jennifer willing to bear?
   B. What is Jennifer's current address?
   C. How many years 'no claims discount' does Jennifer have?
   D. Does Jennifer intend to use her car for business purposes?

   Your answer:

   ☐

Answers to sample multiple-choice questions

Question 1

Chapter reference: Chapter 1B1

Question type: K

Correct response: D

Learning outcome: Explain the criteria used to make recommendations to consumers with regard to both insurance products and providers.

Question 2

Chapter reference: Chapter 1C2

Question type: K

Correct response: C

Learning outcome: Outline the scope of a statement of suitability used to detail the reasons underlying any advice or information given to the consumer regarding a general insurance policy.

Question 3

Chapter reference: Chapter 1A2

Question type: U

Correct response: A

Learning outcome: Describe the main items of information about a consumer that should be sought before providing advice about a general insurance policy.

The Insurance Institute

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Quitch

Chapter

2

Motor insurances

What to expect in this chapter

In this chapter we'll focus on motor insurance – the only class of personal general insurance that is compulsory by law in Ireland.

After studying this chapter, you'll be familiar with the cover provided by different motor insurance products (including motor, motorcycle and light commercial vehicle (LCV) insurance). You'll know what questions to ask a consumer looking for motor insurance, in order to establish their insurance wants and needs, thereby recommending the most suitable motor insurance product for them.

Essentially, what we're going to do is apply the advising process outlined in Chapter 1 to a motor insurance consumer. While it is not possible to cover every possible risk or event that may be relevant to every consumer, the methodology used and the key information requirements are common to all consumers.

Note that in this chapter (and in Chapters 3-6), the monetary values referred to (e.g. in relation to sums insured, policy limits or excesses) are for guidance only. Likewise, the policy guides are only summaries and abbreviations of key information from sample policies in the market. They are not necessarily actual wordings, nor should they be taken as applying universally across the market. There tends to be many variations of wording and ranges of exclusions. For this reason, you are strongly advised to get a number of policy wordings and see what is available in the market. You should also try to source examples of the documents which you learned about in the Compliance and Advice module and which are relevant to the provision of advice on motor insurance e.g. statement of fact, proposal form, 'gap in cover' declaration, no claims discount/named driver experience, driving licence, certificate of insurance and the schedule of cover.

To help you relate the material in this chapter to a real-life situation, we have included a sample consumer profile. This highlights some of the issues that an adviser may encounter when arranging motor insurance cover. It will help you reflect on how and why each element of the motor insurance cover may (or may not) be suitable for a particular consumer. The question to keep in mind as you work your way through Chapter 2 is: 'What are the key factors to be considered when advising Peter on the most appropriate motor insurance cover?'

Learning outcomes for this chapter

Section	Title	At the end of each section you should be able to:
A	**The compulsory nature of motor insurances**	Demonstrate the legal basis for motor insurance practice, the scope and limitations of different private motor insurance covers and standard options available.
B	**The scope of motor insurance policy cover**	
C	**The class of use**	
D	**Policy exclusions and conditions**	
E	**No claims discounts**	
F	**Questions to ask the consumer and why**	Outline the questions that encourage the consumer to disclose the necessary material information to enable advisers to provide them with the most appropriate motor insurance product.
G	**Motorcycle insurance**	Demonstrate the scope and limitations of motorcycle, guaranteed asset protection (GAP) and light commercial vehicle cover.
H	**Guaranteed asset protection insurance**	
I	**Light commercial vehicle insurance**	

Private motor insurance sample consumer profile

Peter is a 28-year-old biomedical engineer. He lives in Galway and works for a large multinational medical device manufacturer, also located in Galway.

Peter has had a full licence since he was 19. He has three penalty points for using his mobile phone while driving the car last year.

He owns a 6-year-old Volkswagen Golf 1.6D, valued at €10,000. He has a comprehensive motor policy with Wisebuy Insurance Company, a company that specialises in selling insurance directly to consumers over the telephone and internet. His policy is subject to a €350 own damage excess. Peter has a 50% no claims discount (NCD) on his policy, which he has earned by way of claims-free driving. He is the only person covered to drive on his policy.

Other than for driving to and from his place of work in Galway, Peter only uses his car for private purposes. He is asked by his employer to travel to the company's other premises in Athlone to assist on a research project and when doing so he is often required to carry samples. He uses his own car for the 170-kilometre round trip but is paid a mileage allowance.

Peter has just received his renewal notice from Wisebuy Insurance Company. He notes with some concern that the premium has increased by 10% since last year, even though he has not made any claims on his policy. His renewal notice also highlights some additional policy covers that he is being charged for, which he is unsure he really needs.

A The compulsory nature of motor insurances

Motor insurance is the only complete class of insurance business that is compulsory by law in Ireland.

Quick question 1

Why do you think that motor insurance is a compulsory legal requirement in Ireland?

The answer is at the end of this chapter.

The six **Motor Insurance Directives (1972-2009)** provide a legal framework to harmonise European Union (EU) law in relation to motor insurance across member states. The current Irish motor insurance legislation is derived from these Directives and is contained in a series of Acts and Regulations beginning with the **Road Traffic Act 1961**. This Act introduced the requirement for insurance protection for the interests of innocent victims of road accidents for death, injury and damage to their property.

'public place'

under the Road Traffic Acts this is 'any place where the public have access with vehicles'

It is illegal to drive, or be in charge of a mechanically propelled vehicle, in a '**public place**' unless there is an insurance policy in place that covers either the minimum required under Irish law (Road Traffic Act cover - see Section B1) or the law of the member state being visited, whichever is greater. Under the **Road Traffic (Compulsory Insurance) (Amendments) Regulations 1992**, a 'mechanically propelled vehicle' now includes trailers. This means that trailers (both attached and detached) are subject to all compulsory insurance requirements.

Insurance Ireland

an industry body that represents Irish life and non-life insurers

Declined Cases Agreement

an agreement among motor insurers, whereby motorists who experience difficulty obtaining motor insurance (after a minimum of three attempts) can apply for cover under the DCA programme as operated by Insurance Ireland

Due to the compulsory nature of motor insurance, **Insurance Ireland** operates the **Declined Cases Agreement (DCA)**. The Agreement's purpose is to ensure that the insurance market will not refuse to provide motor insurance to any individual seeking cover. The individual must attempt to obtain a quotation from at least three insurers and, in general, the insurer first approached will be required to offer a quotation. Where an individual has held a policy within the previous three years, the insurer of that previous policy is obliged to provide a quotation. The insurer can only refuse to provide cover where to do so would be contrary to public interest. In 2019, Insurance Ireland, which administers the scheme, dealt with 1,066 cases.[6]

[6] Department of Finance, 2020. 'Eleventh and Final Progress Update Cost of Insurance Working Group Report on the Cost of Motor Insurance Report on the Cost of Employer and Public Liability Insurance', October 2020. Available on www.gov.ie

B The scope of motor insurance policy cover

Motor policies contain two main areas of cover. The first element relates to injury, loss or damage caused to third parties or their property. The second (non-compulsory) element deals with loss or damage to the insured vehicle and additional policy benefits.

Motor insurances tend to be subject to **limits of indemnity** for third party aspects (but not in relation to injuries, where the **liability** cover must be unlimited). These are usually standard market limits of indemnity, set at high levels.

Cover for the insured vehicle is generally based on **market value** rather than a sum insured. Most claims are for partial loss, which is normally repaired. However, when considering claims for the total loss of a vehicle, insurers limit their payment to market value and will not normally pay more than the consumer's estimate of value stated in the proposal form. There is no question of '**average**' being applied to claims settlements when the vehicle is insured on a market value basis.

Premiums are based on several exposure measures including:

- vehicle (make, model, year of manufacture, carrying capacity and value)
- driver details (age, occupation, licence type and details of any accidents/claims/convictions)
- location of use
- cover required
- use of the vehicle
- past claims experience
- accidents /previous convictions/penalty points/health issues that may affect driving.

Each of these separate aspects will be integrated into a flat premium.

The consumer is obliged to purchase motor insurance, so their focus may well be price driven. However, the adviser's role is to make professional comparisons of insurers' quotations taking account of cover variations, and flexibility where it is needed, to provide for the consumer's needs.

The different types of motor insurance policy cover available are:

- **Road Traffic Act** cover – the minimum level of cover required by law (only used in exceptional circumstances)
- third party only
- third party, fire and theft
- comprehensive.

As there is no universally accepted market wording, we have used representative wordings in the following sections.

limit of indemnity

insurer's maximum liability for any one incident/claim (usually under the terms of a liability policy or section of a policy)

liability

being legally responsible for something, for example an accident or an injury to a third party

market value

the value achievable for an item on the open market at the time in question

average

principle that if a sum insured is less than the full insured value, the insured should be their own insurer for that proportion and share the losses accordingly

In the following sections, we will outline the covers and specific exclusions that apply to each type of cover. However, you should note that the following list of exclusions typically apply across all types of motor cover:

- bodily injury to the driver
- loss of use
- racing, pacemaking and/or speed testing
- employers liability risk – except to meet RTA requirements
- liability more appropriately covered by any other insurance policy
- general policy exclusions (see Section D2).

B1 Road Traffic Act cover

As the name implies, **Road Traffic Act** (RTA) cover is the minimum level of cover required by law. It applies in Ireland and throughout the EU and must provide indemnity for:

- bodily injury or death caused to third parties, including passengers (unlimited in amount)
- loss of, or damage to, property belonging to third parties, subject to a minimum of €1.22 million per claim
- third-party claimants' costs and other expenses of handling a claim
- emergency treatment for third-party injuries caused by, or arising out of, RTA liability
- liability arising from trailers attached to, or becoming detached from, the vehicle insured under the policy.

RTA cover is restricted to the use of the vehicle 'in a public place'. A public place would include a road, a public car park or a private field (if there was a special event to which people had vehicular access, such as a garden fete etc.). No indemnity is given if a third party is injured away from a 'public place' e.g. in a private driveway.

An important case to consider in relation to RTA cover in a 'public place' is the European Court of Justice (ECJ) ruling in the case of Damjian Vnuk v Zavarovalnica Triglav (the 'Vnuk' case) - see Case study 2.1.

2.1 Case study - Vnuk Ruling

Damjian Vnuk was injured after being knocked off a ladder by a reversing tractor in a farm yard in Slovenia. He brought a personal injury case against the insurer of the tractor. They did not deal with the claim on the basis that the tractor was not being used in a public place or on a public road and was, therefore, excluded under the motor insurance policy. That decision was appealed in Slovenia and was brought before the ECJ in September 2014.

The ECJ ruled that given that the incident occurred whilst the vehicle was in use and that use was consistent with the normal function of the vehicle, then it must be dealt with as a motor claim. The judgment made no specific reference to the duty to insure extending to private property (e.g. the farm yard Mr Vnuk was working in) but the court's view was that it did. This ruling is a precedent which must be considered by all lesser courts. This expansion of the understanding of a 'public place' and the definition of 'vehicle' may have a significant impact on how motor claims are dealt with and may necessitate fundamental changes to motor insurance policies and Road Traffic Acts.

At the time of writing, the relevant legislation is being finalised at European level.

RTA cover serves the purpose of ensuring that even those considered to be high risk drivers have the most basic motor insurance cover. It is only recommended and issued in exceptional circumstances. Examples are a driver who has been in breach of policy conditions or convicted of motoring offences, or a situation where an insurer feels bound to quote (or is bound to quote) under the terms of the DCA.

In such situations, the adviser's role would be to monitor the risk and keep track of developments that would make it more attractive to insurers. Examples would include a young driver reaching a certain age with a satisfactory driving record, a driver passing a driving test to have their licence reinstated after losing it, or a period of time elapsing in which a driver has not breached any policy terms or in which a conviction has become spent. Such developments would improve the possibility of acquiring realistic pricing and cover (normally at a subsequent renewal date) and the adviser would then present the available options to the consumer.

B2 Third party only cover

In addition to the cover provided under an RTA only policy, Third Party Only (TPO) policies also provide indemnity to the following:

- anyone driving the vehicle with permission, if allowed on the certificate
- anyone 'using' the vehicle (i.e. a passenger)
- an employer or partner (e.g. the **policyholder/insured** is driving their own car on the business of their employer or partner and is at fault for an accident) if that use is covered under the policy
- the owner of the vehicle or their personal representatives (i.e. if any indemnified person (e.g. insured, named driver or passenger) dies having incurred a legal liability, the cover will still apply and the insurer will handle the claim on their behalf)
- the hirer of the vehicle (for the negligent acts of the policyholder).

TPO policies also cover:

- third-party emergency treatment where required by law
- liability arising from loading and unloading the vehicle (for the driver and attendant)
- higher third-party property damage limit per claim (€30 million is a standard limit provided by insurers)
- legal representation at any inquest or fatal injury enquiry, or to defend a charge, e.g. of manslaughter
- unlicensed drivers (where a licence is not required by law and the person is old enough to drive the vehicle).

The **'driving of other cars'** extension may be offered. This only applies to the policyholder, who must have the permission of the owner of the other car, and is restricted to third-party cover regardless of the insurance cover held. However, some comprehensive policies offer comprehensive cover for driving of other cars, usually for an additional premium. This extension will only provide cover where none exists under another insurance policy, and it applies to private cars only. The extension will not provide cover for vehicles owned by, hired or leased to the policyholder – this is to avoid the extension being used to 'insure' multiple vehicles or uninsured vehicles. Some insurers may not offer this extension to younger drivers (e.g. under the age of 25 depending on the insurer), provisional licence holders or to drivers of certain occupations (e.g. taxi drivers or mechanics).

policyholder/insured

a person/firm that is insured under an insurance policy

driving of other cars

extension of cover whereby a policyholder may drive a third-party's vehicle. In certain situations this extension is referred to as 'driving of other vans' or 'driving of other commercial vehicles'

In addition to the typical exclusions applying to all covers (see Sections B and D2), TPO cover also excludes:

- any loss or damage to the insured vehicle or the insured's property
- use other than for the social, domestic, pleasure or business activities of the policyholder
- anyone insured under another policy.

Quick question 2

What is the extent of the 'driving of other cars' cover and what are its limitations?

B3 Third party, fire and theft cover

In addition to the TPO cover described in Section B2, third party, fire and theft (TPF&T) policies provide cover for damage or loss to the insured vehicle:

- by fire (including self-ignition, lightning or explosion)
- during an attempted theft or while it is stolen (Example 2.1 illustrates this)
- if stolen but not recovered.

Cover is normally subject to an excess and includes damage to or loss of (as a result of theft) spare parts and accessories kept in, or on, the car, or kept in the policyholder's private garage.

Aside from the typical exclusions applying to all covers (see Section B), TPF&T cover also excludes:

- theft or attempted theft if keys are left unsecured or in/on an unattended car
- depreciation, wear and tear
- mechanical/electrical fault or derangement
- malicious damage or vandalism
- breakage of glass in windscreens and windows (although these are sometimes available as an optional extra cover for an additional charge).

approved repairer

repairer that an insurer includes within a scheme to guarantee workmanship, labour rates and discounts on parts, and to reserve the right to reduce a policyholder's claim payment if they do not use the approved repairer

The addition of own damage cover (caused by fire or theft) introduces certain market practices (e.g. the use of **approved repairers**). The way in which the value of the claim is measured will depend on the cause of the loss (i.e. theft, liability or property damage claim).

proximate cause

main or dominant cause of the loss or the cause that is most powerful in its effect

Example 2.1

A 6-year-old car is stolen from outside the policyholder's house. The claim is accepted by the insurer. The car is recovered after a week. It is badly damaged but is not a write-off. Under the principle of **proximate cause**, all damage that occurs while a vehicle is stolen is treated by insurers as arising from theft, and the insurer is therefore liable for the repairs.

B4 Comprehensive cover

It is important for the adviser to ensure that their client fully understands the meaning of the term 'comprehensive', as applied to motor insurance. While this policy provides a considerable level of protection, it does not provide cover against every conceivable risk or event.

In addition to the cover provided under TPF&T, COMP cover also includes accidental loss of, or damage to, the vehicle, other than as a result of fire or theft, subject to an excess. This cover may include:

- replacement/'new for old' cover. If the vehicle is less than 1-year-old, hasn't exceeded a certain mileage (e.g. 24,000 kilometres) and repair costs exceed 50-60% (wordings vary) of current list price, a replacement of the same make, model and specification is provided
- spare parts and accessories kept in, or on, the vehicle or in the policyholder's private garage – limited to market value or policyholder's estimate, whichever is less
- breakage of glass in windscreens or windows (not sunroofs or panoramic roof glass), which may be subject to a limit and (possibly) an excess but does not affect the no claims discount (NCD). The cost of windscreen replacement, especially for newer, high value cars has significantly increased in recent years as a result of improvements in technology. Insurers closely monitor these costs and some have introduced a limit on windscreen replacement to control claim costs.

In addition to the typical exclusions applying to all covers, COMP cover typically excludes:

- depreciation, wear and tear
- mechanical/electrical fault or breakdown/derangement
- isolated damage to tyres, e.g. from punctures or blow-outs
- the cost of hiring a replacement vehicle (although this is often included as an additional benefit)
- loss/damage from using the vehicle in a rally, competition or on any racetrack or circuit loss/damage resulting from putting the wrong fuel in a vehicle
- loss of/damage to ancillary parts (e.g. sat nav, audio-visual equipment)
- import costs of parts from outside the EU.

Quick question 3

Suppose a car is stolen and then recovered but, while stolen, the paintwork has been covered in graffiti. Is this damage covered under a TPF&T policy?

B4a Additional benefits

These are additions to cover that may be included in comprehensive motor insurance policies or available for an additional premium. Specific exclusions apply to each extension.

- Driving of other cars (DOC) – insurers' DOC offerings vary between third-party only cover and comprehensive cover.
- Roadside/driveway assistance which can provide the following cover:
  - Repairs plus up to 1 hour's roadside assistance. (Note that some insurers provide this cover at the consumer's home/driveway, others stipulate that cover only operates when more than a minimum distance from the home, e.g. 2 kilometres).
  - Completing the journey – If repairs cannot be completed on the same day (or at the scene) insurers reserve options, as follows:
    - transport to intended destination
    - accommodation expenses, with a limit
    - hiring a vehicle for up to 48 hours
    - any other option for repair/transportation.
  - Towing – This will be to the nearest repairer or (i) home if nearer or (ii) anywhere the insured wishes if nearer.
- Courtesy car – Wide variations apply, including replacement car for up to 7 days (Ireland only) or completion-of-journey option. Some insurers provide a replacement car for up to 10 days in the event of the insured vehicle being 'written off'.
- Personal accident – If any person insured under the policy is seriously injured as the result of a car accident, policy benefits (usually capital sums) apply to specific injuries such as the loss of a limb or loss of sight. Limits in the market vary widely from €2,600 to €30,000.
- Medical expenses – These typically range between €100-€200 per occupant of vehicle.
- Replacement of locks and keys – Cover up to €1,500 towards the cost of replacing door locks, keys and key fobs and for locksmith charges following theft of the car keys from insured's home.
- Personal effects – This is usually up to €750 (not affecting NCD).

- Legal protection – This cover provides that if a person is involved in a motor accident that is not their fault, they have a legal right to claim their uninsured losses from the person who caused the accident. (This can also be purchased as a stand-alone policy.) This extension fulfils the following aims:
  a. It facilitates the recovery of uninsured losses and costs (€100,000 limit) following an event that:
     - causes damage to the insured's vehicle or to their personal property in it
     - injures or kills an insured person while they are in/on the insured vehicle
     - injures or kills an insured person while they are driving another vehicle
     - injures or kills an insured person while they are a passenger, cyclist or pedestrian.
  b. It defends the insured's legal rights if an event leads to the prosecution of an insured person for an offence connected with the use or driving of an insured vehicle (€25,000 limit).

When comparing different insurers' quotations, an adviser will consider these extensions carefully. When presenting options to the consumer, the adviser must clearly explain the exclusions to, and major limitations of, the cover they provide. If other aspects of cover are reasonably consistent, the cover provided by these extensions may play an important role in insurer selection.

Just think

Consider the automatic extensions under the comprehensive motor policy that would be of particular interest to Peter.

All of these extensions would be of interest to Peter, but the roadside/driveway assistance, towing and completion of journey would be particularly useful to him, to avoid being stranded on the roadside during travel.

C The class of use

It is essential for an adviser to establish the use to which the vehicle will be put so as to ensure that the correct use is shown on the motor insurance certificate and the correct premium is quoted.

There are four categories of use. However, wordings vary between insurers and it is essential to check the precise wording and relate this to the actual use required by the consumer. The following classes and their wordings are indicative of market practice:

- Class 1(a), social, domestic and pleasure use only. This covers the policyholder or spouse commuting to and from their usual place of work. However, if either has a job which, by its nature, requires travel to different customer locations from home at the start of the day, this is not covered and a wider class of use is needed. No business use is permitted whatsoever.
- Class 1(b), including use for business by the policyholder only with limited business mileage (usually between 1,000 and 5,000 kilometres per year). This permits use by the policyholder, in person, for their own business or profession, or that of their employer. Use would include travel to different locations throughout the country. Specifically excluded is use in connection with commercial travelling, the carriage of goods or samples and business use by other drivers named on the certificate of insurance. These appear as exclusions on the certificate of insurance. This type of cover would suit an employee who drives a limited amount of business-related mileage annually.
- Class 2. This permits the carriage of goods or samples belonging to the policyholder or their employer, and for other drivers named on the certificate of insurance to use the vehicle for the business of the policyholder. However, the goods or samples themselves are not covered. This type of cover would suit an employee requiring business use without limitations on mileage or a small business, owned by the policyholder. In some cases, an insurer may apply an annual mileage limit for Class 2 e.g. 10,000 kilometres. Use in connection with commercial travelling is excluded.
- Class 3. This permits Class 2 use, but also permits **commercial travelling** or soliciting orders. This is the highest-rated use, and would typically suit a company representative, salesperson, or delivery of items such as food or flowers.

Class 1(b), Class 2 and Class 3 also allow use for social, domestic and pleasure purposes. Every class of use excludes use for motor trade purposes, racing, rallying and carriage of passengers for hire and reward. Generally, insurers do not consider car sharing to and from work to be 'hire and reward'.

commercial travelling

where driving is a permanent aspect of the policyholder's job and they are selling goods or services while on the road

Example 2.2

Vincent is a veterinary surgeon and must provide indemnity to the Department of Agriculture. For this reason, his insurer insists on Class 2 cover, with an indemnity to the Department of Agriculture noted on his motor policy. The Department will pay any increase in premium required for the additional Class 2 cover.

Just think

Refer back to our sample consumer Peter from the start of the chapter. Which class of use would be relevant in his situation?

Peter drives his own car to his employer's other premises in Athlone, for which he is paid mileage. Payment for mileage does not dictate the class of use; this is determined by how often the vehicle is used for work purposes. As Peter uses his car for work purposes and carries samples, he would fall into Class 2. As stated, insurers differ in the practice in relation to Class 1(b) and Class 2 uses. Some accept risks such as Vincent (see Example 2.2) as Class 1(b) provided the annual business mileage does not exceed 5,000km.

D Policy exclusions and conditions

This section outlines the main policy conditions and exclusions found in a motor insurance policy.

D1 General policy conditions

The main general conditions are as follows:

- There is a duty on the part of the policyholder to tell the insurer of any changes to the risk during the period of insurance, e.g. change of vehicle, address or occupation.
- The vehicle must be maintained and roadworthy and have a valid NCT certificate where applicable.
- An insurer is entitled to cancel a motor insurance policy by giving notice in writing to the policyholder. While the **Road Traffic Act** specifies that the insurer must give the policyholder a minimum of 7 days' notice, general insurance market practice is that the insurer gives the policyholder 10 days' notice by registered (recorded) post.
- Any dispute over policy cover must be referred to **arbitration**.
- Fraud or deception. Most insurers will include a condition of fraud or deception that outlines that they may void or cancel a policy in the event of underwriting fraud (misrepresentation or non-disclosure) or claims fraud. This applies to consumers, only if the insurer establishes that the non-disclosure was the cause of the insurer entering into the contract of insurance and on the terms on which it did.

arbitration

a legally binding alternative dispute resolution process, whereby cases are heard by an arbitrator rather than a judge in court

Just think

Considering the policy conditions outlined, what do you think the implications of not having a current **national car test** (NCT) certificate on a private car would be?

national car test (NCT)

a roadworthiness test for cars introduced into the Republic of Ireland in 2000

In the event of a claim, insurers require proof of roadworthiness. A current NCT certificate would meet this requirement. Not all insurers ask for it, but some insurers may consider a vehicle unroadworthy if there is no current NCT Certificate. Inability to prove roadworthiness would mean that the insurer would only be required to cover the third-party element of the claim.

D2 General policy exclusions

Policy exclusions apply to all motor insurance policies regardless of the scope of cover. They include:

- use of the insured vehicle outside of the uses that the policy permits (see Section C)
- contractual liability
- radioactive contamination
- war and kindred risks
- racing, pacemaking
- terrorism
- earthquake
- riot or civil commotion
- sonic bangs.

customer

a person, firm or organisation, to whom a regulated entity provides or offers to provide an insurance product or service (for an intermediary the terms 'client' and 'customer' are interchangeable), and any person, firm or organisation who requests such a product or service

Consumer Protection Code (Definitions)

E No claims discounts

Insurers originally introduced no claims discounts (NCDs) or no claims bonuses (NCBs) in an effort to create **customer** loyalty. The aim was to encourage policyholders to stay with the same insurer, by giving a premium discount based on their years of claim-free driving.

Nowadays, many insurers allow NCDs in the driver's own name in the following circumstances:

- for successive years of claim-free driving (see Table 2.1 for sample NCD scale) – earned NCD
- as an incentive for drivers who have not yet earned an NCD in their own name (but have a good driving record under someone else's policy). This introductory NCD is also known as 'named driver experience' and is allowed by many insurers when a policy is effected by the named driver (in their own name).
- to allow an NCD earned on one vehicle to also be used on another vehicle e.g. an NCD earned on a private motor policy can also be used on a commercial motor policy – **mirrored NCD**.

mirrored NCD

no claims discount whereby individuals who have earned an NCD for one vehicle and who arrange cover on a second vehicle may be granted an equivalent number of years' NCD on the second vehicle. Limitations apply, e.g. normally insured only driving on the second vehicle and no cover provided where a young driver is a user on the second vehicle

Table 2.1

Number of claim-free years	NCD
1	10%
2	20%
3	30%
4	40%
5+	50%

The types of NCDs and the methods by which the discounts are given are outlined next.

Quick question 4

Using the NCD scale in Table 2.1 and referring back to our sample consumer, how many years' claim-free driving does Peter have?

E1 Types of NCDs

Insurers structure their NCD schemes in a number of different ways.

E1a Step back arrangements

Step-back NCD was originally introduced by insurers in order to retain business. It should be noted that competing insurers are not always willing to recognise this arrangement. Step-back NCD provides a cushion against the effects of a claim on the NCD entitlement for the year in which the claim occurs. Instead of losing the full NCD entitlement, the policyholder will only lose part of it. It is usually included free of charge in an insurer's standard policy, although some insurers charge extra for it. Some insurers apply a 2-year step-back NCD arrangement (e.g. 5 years NCD is 'stepped back' to 3 years, 4 years NCD is 'stepped back' to 2 years, etc.), while others apply a 3-year step-back NCD arrangement. Table 2.2 and Example 2.3 illustrate how a 3-year step-back NCD arrangement might work.

step-back NCD

a cushion against the effects of claims where the NCD is only partially reduced for every claim made

Table 2.2	
NCD	**Reduced to**
1 year – 10%	0 years
2 years – 20%	0 years
3 years – 30%	0 years
4 years – 40%	1 year – 10%
5 years or more – 50%	2 years – 20%

Example 2.3

Mary has private motor insurance and has just settled a large accidental damage claim under her policy with Crashcare Insurers. She has a 3 year step-back NCD protection and her NCD currently stands at 5 years (50%), which is the maximum bonus on Crashcare Insurers' scale. What effect do you think this claim will have on Mary's NCD at renewal?

The fact that she has a 3 year step-back NCD protection means that instead of her discount reverting to nil or 0%, it will be reduced by 3 years to 2 years, which represents an NCD of 20%.

E1b Protected NCD

protected NCD

NCD generally available once policyholders have reached their maximum entitlement on the insurer's NCD scale – usually 2 claims in a 3-year period

Protected NCD is also available, usually as an optional extra for an additional premium. A policyholder earning the maximum NCD available can opt to protect their NCD. Insurers allow, for example, up to 2 claims in a 3-year period without the NCD being affected. Some insurers apply a monetary limit to the claims. Should a further claim occur within the specified timeframe, the policyholder may revert to the step-back NCD scale, depending on the insurer's wording. When this happens the policyholder would only be eligible to re-join the protected NCD scheme once the NCD had been rebuilt to maximum by successive claim-free years. The premium for this cover varies between insurers depending on the policy type and vehicle insured. Example 2.4 shows how the protected NCD works in practice.

Example 2.4

Referring to Example 2.3, if Mary had a protected NCD with no monetary limit, her NCD would have remained at 50% after her claim. If she had another claim a year later, her NCD would still remain at 50% as the 2 claims are within a 3-year period. However, if Mary then had another claim 6 months later, her NCD would be reduced to 20%. Mary could not avail of protected NCD until her NCD had returned to 50%; that is after another 3-years claims-free.

guaranteed NCD

no claims discount that cannot be taken away no matter how many claims are made

E1c Guaranteed NCD

Guaranteed NCDs (lifetime NCDs) are quite rare in practice and are primarily used by a small number of direct insurers as a loyalty benefit. This protection is usually only given to the policyholder and their spouse (if named on the policy). Any other named drivers would enjoy the standard NCD protection applicable on the policy. As this is generally a benefit not paid for by the policyholder, the insurer can withdraw a guaranteed/lifetime NCD if it deems that it is being abused. The insurer can penalise a particularly bad claims record by imposing an increased basic rate, onerous terms, or may even decline to renew the policy.

If the policyholder is transferring to a different insurer, the existing insurer will usually show all claims in its confirmation of claims experience. It may not be in the best interest of a consumer with a guaranteed NCD to switch insurers as, in most cases, the consumer will not get this benefit from another insurer in the market. Example 2.5 shows how a guaranteed NCD might work in practice.

Example 2.5

Hughie is involved in an accident which results in a settlement to a third party. He has a guaranteed NCD so his NCD will not be affected at next renewal. Even if Hughie has two more accidents the following year, his NCD will still not be affected. He can continue to have claims without his NCD being affected. However, if his bad claims record continues, it is very likely that his insurer would apply a premium loading to reflect his claims history.

F Questions to ask the consumer and why

The list of questions in this section serves as a checklist to ensure that the adviser does not overlook anything significant when establishing the best product for a motor insurance consumer.

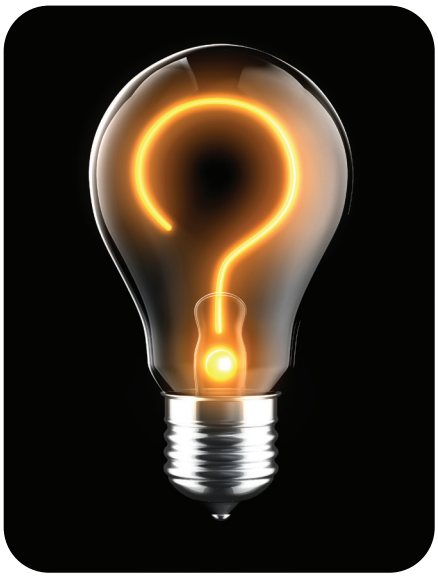
As noted in Chapter 1B1c, where insurers offer more than one motor insurance policy, they may have created a comparison chart that compares their different levels of cover. They will also have a proposal form (or equivalent) to obtain relevant information. This will look very similar to the template shown in this section.

An intermediary will wish to gain a complete and accurate picture of the risk so they can carry out an appropriate assessment of the cover, price and flexibility offered by different insurers' products. They will review the proposer's answers to the questions on the insurer's proposal form and, if necessary, will 'drill down' in certain areas to get more specific answers. An example would be where the adviser wishes to obtain a better understanding of the proposer's 'use' of the vehicle in order to make an accurate comparison of different insurers' definitions of 'use'.

As noted earlier, a number of key factors are taken into account in the pricing and **underwriting** of private motor insurance. These include the:

- vehicle (make, model, year of manufacture, carrying capacity and value)
- driver details (age, occupation, licence type and details of any accidents/claims/convictions)
- location of use
- cover required
- use of the vehicle
- past claims experience
- accidents/previous convictions/penalty points/health issues that may affect driving.

Table 2.3 outlines the questions that need to be asked in relation to each of these factors.



underwriting

process of risk pooling, risk selection (choosing who and what to insure) and assessment of individual risks that meet the insurer's risk criteria

Table 2.3

Questions to ask the consumer	Reason for question/effect on advice given
Questions relating to the consumer	
Proposer Name Address	For communication and pricing (e.g. area with high numbers of car theft).
Questions relating to the driver(s)	
Who will drive? Proposer only Proposer and spouse Any driver Named drivers Relationship to driver	Number of drivers will impact on pricing.
Who will be the principal driver?	Identifying the principal driver is very important as if it is someone other than the proposer (e.g. son or daughter), it may present a different risk profile.
Proposer and drivers Date of birth/age	These factors impact on pricing as they indicate the risk posed by each driver's age, job, licence status, driving and claims experience. Note that, in order to comply with equality legislation, pricing decisions related to age must be based solely on the insurer's actuarial or statistical data and/or other relevant underwriting or commercial factors.
Occupation	Occupation may impact on the class of use required or the need to provide 'Indemnity to principals'.
Full Irish licence/other Previous driving experience Convictions Number of penalty points held Claims or accidents (in the last 5 years)	Certain factors in this category may attract discounts (e.g. NCDs) or loadings (e.g. penalty points). Insurers must observe the requirements of the **Spent Convictions and Certain Disclosures Act 2016**.
Use of the vehicle	See Section C.
Have any drivers: • been refused insurance (or had special terms imposed)? • been disqualified from driving for any reason? • suffered from any medical condition that would impair their ability to drive? **If yes, provide details**	If the answer to any of these questions is yes, the driver concerned poses an additional risk.

Table 2.3 (contd)

Questions to ask the consumer	Reason for question/effect on advice given
Questions relating to the vehicle(s)	
Registration number Year Make Model Version Engine size Petrol/diesel/electric/hybrid Value Purchase date Has the vehicle been modified or adapted in any way? Is it left-hand drive?	Many insurers use risk intelligence software to verify the registration number and the exact vehicle model and type. This assists in correctly pricing the vehicle risk (e.g. a GTI model rather than a standard model). The answers to all of these questions are relevant to the assessment and pricing of the motor risk. The information also indicates to insurers the costs that may be incurred in relation to claims (own damage and third-party property damage).
Is the vehicle sourced from Ireland?	This is required to establish the position regarding parts. Also, if the vehicle is sourced from abroad, it may be left-hand drive and a premium loading may apply.
Is the vehicle kept in a locked garage?	If not, what security precautions are taken?
Is the vehicle registered to the proposer?	If not, why is the owner not insuring?
Has proof of NCD been provided for each vehicle?	This is normally required unless some introductory or mirrored discount is agreed. It is important to check the authenticity of a NCD with the issuing insurer as original documents may be altered.
Does the proposer own any other vehicles, not subject to this insurance? **If no, provide details**	This may give a picture of likely usage if a 'second' car.
Questions relating to cover	
Cover	**Requirement**
COMP/TPF&T/TPO	This will give the insurer an indication of the risk to which they would be exposed.
Excess level required	
Cover consistency	Has cover been the same throughout the period to which the claims experience refers and have the drivers been the same? (Could any claims be shown separately if outside the cover? Do any claims refer to drivers for whom cover is not now required?)
Third party property damage limit	This only needs to be considered if more than the standard limit is requested/required.
Trailer cover: type of trailer and use	Cover provided by insurers varies.
Foreign use – extent	Insurers provide different periods for automatic extensions.
Optional extensions required?	Impact on pricing.

Quick question 5

Why does an adviser ask whether cover has been the same throughout the period that the claims experience covers?

The adviser gathers all of this information in order to assess the risk, present it accurately to the insurer and recommend appropriate cover to the consumer. However, this information is equally important to the insurer. For example, if a large previous claim was caused by a driver who no longer drives the car, the insurer needs to know this in order to rate the risk correctly.

Just think

Referring back to our sample consumer, would Peter's responses to any of the questions in Table 2.3 require further investigation on your part as an adviser?

All of the information that Peter provides is relevant. However, the adviser should pay particular attention to Peter's penalty points, the power of his car and the travel that he does for work.

F1 Presentation of risk information

In most situations, there is no need to formally present a motor risk to an insurer, as the adviser will normally obtain a quotation through an automated system. However, where there have been past claims or other adverse features and an intermediary is considering alternative insurers, it may be necessary to make a formal presentation.

In these circumstances, the insurers considering the risk will require the confirmed claims experience and a fully completed proposal form from the intermediary before providing a quotation.

There is no regulatory pressure on a prospective insurer to provide a quotation if another insurer already holds the business. The decision as to whether to offer terms is a matter of commercial judgement.

differential pricing

where a customer with a similar risk and cost of service is charged a different premium for reasons other than risk and cost of service

dual pricing

treating the price of new businesses and renewal customers differently for reasons other than risk and cost of service

price walking

where a consumer is charged a higher premium relative to the expected cost, the longer they remain with an insurer

F2 Differential pricing

Following a Central Bank review including data gathered from almost 11 million policies, it was identified that some pricing practices were leading to unfair outcomes for motor and home insurance consumers. Following this review, insurers must avoid **differential pricing** for motor and home insurance policies.

The primary proposal is to ban **dual pricing** and **price walking**; thereby removing the loyalty penalty on such consumers. It would mean that insurers could not charge consumers who are on their second or subsequent renewal a premium higher than they would charge a new or year one renewal consumer with a similar risk and cost of service. Other proposals include an annual review of pricing and more transparent renewal processes. At the time of writing a consultation period is in place to review this practice.[7]

[7] Central Bank of Ireland, 2021. *Review of Differential Pricing in the Private Car and Home Insurance Markets (Final Report and Public Consultation)*, p.27, July 2021, www.centralbank.ie

G Motorcycle insurance

Motorcycles are also subject to the terms of the various **Road Traffic Acts**. The considerations relating to the compulsory nature of third-party cover and the issue of certificates are identical to those for cars. In broad terms the cover options are similar, and third-party cover has the same limits of indemnity as for private car insurance.

G1 The motorcycle insurance market

The motorcycle insurance market has some unique features that impact on the adviser's role. This market is limited in size, with a small number of insurance intermediaries (including **wholesale brokers**) offering exclusive schemes. These schemes are not available to all insurance advisors. As a consequence, some insurance intermediaries do not offer motorcycle insurance. In addition, as many of the major insurers do not write this business at all, the choices available may be very limited.

The underwriting and pricing of cover is strongly influenced by the age profile of the motorcycle riders and the significant risk of injury to which they and their passengers are exposed. Under the **Road Traffic Acts** (which follow EU directives in this respect), passengers cannot be excluded from cover.

wholesale broker

person/firm that acts on behalf of another intermediary in arranging and assisting in the performance of insurance contracts. Products distributed by the wholesale broker are usually not available to all advisers.

G2 The motorcycle insurance policy

The format of the motorcycle policy is much the same as, although simpler than, the private motor policy. Third party only cover, which covers the insured's legal responsibilities to third parties only, is the minimum level of cover provided. Table 2.4 outlines the typical key elements of comprehensive, fire and theft cover, compared with private motor insurance.

agreed value

sum insured as agreed at the beginning of the period of insurance and paid in respect of a total or partial loss claim as usually defined in the policy

Table 2.4 Typical policy cover (motorcycle)

Key elements – comprehensive, fire and theft

- Loss of, or damage to, the vehicle is covered, subject to an excess (which may be at a lower level for fire and theft claims).
- Cover for damage to, or theft of, spare parts and accessories (e.g. safety clothing) only applies while they are on or in the motorcycle, or kept in a locked private garage, and only if the motorcycle is stolen at the same time. Wordings in this regard vary, with some insurers insisting that accessories and spare parts are permanently fitted to the motorcycle for a claim to be valid. Regardless, the motorcycle itself must also be stolen.
- Cover is limited to market value or policyholder's estimate, whichever is lower.
- Some insurers offer cover on an **agreed value** basis.

Policies also cover removal to the nearest repairer if the policyholder cannot drive it following an accident (and delivery afterwards).

Insurers retain the option to pay cash, repair, or replace (where uneconomic to repair).

Some explicitly state that they may use parts not produced by the original manufacturer.

Comprehensive extensions

There may be extensions available or automatically provided for:

- side cars
- trailers
- indemnity to employer
- driving other cycles (third party only)
- breakdown and recovery
- legal protection cover.

Examples of excluded benefits

Unlike the private motor comprehensive policy, there is no cover for:

- personal accident benefits
- medical expenses
- personal effects.

An NCD earned under a motorcycle policy is not normally transferable to a private car insurance policy. Often the scale used is at a lower level. For example, for motorcycle insurance, the top of the NCD scale could be 50% while the top of the private motor insurance NCD scale could be up to 75% (typically the top end of the scale for a private motor insurance policy is between 50%-55%, but some insurers do provide a greater % NCD, which can be up to 75%). As with private motor policies, step-back protection is offered on most motorcycle policies. Some insurers offer full bonus protection at an extra charge, limited to either one claim per year or two claims in a 3-year period.

Quick question 6

Under a comprehensive motorcycle policy, which of the following is covered as standard:

a. damage to clothing and personal effects
b. emergency treatment fees
c. medical expenses
d. personal accident benefits.

Quick question 7

Paddy has had motorcycle insurance cover for the last 20 years. However, after a recent near miss that shocked him, he feels his biking days are over. He has never had any accidents, claims or convictions and has a full NCD with his insurer. Can he use this NCD to obtain private motor insurance?

H Guaranteed asset protection insurance

Guaranteed asset protection (GAP) insurance is designed to complement a consumer's private motor insurance cover. A claim under a GAP policy is always triggered by a claim under a private motor policy, in which the policyholder's car has been stolen and not recovered or **'written off'**.

Motor insurers settle total-loss claims on the basis of the market value of the car at the time of the accident or theft. This may not be sufficient to cover other financial liabilities the policyholder may have in relation to the car (e.g. car loan or hire purchase agreement) or to enable the policyholder to purchase a 'like for like' replacement car. GAP policies provide cover for such shortfalls. There are two different types of GAP insurance cover currently available in the market. These policies provide cover (normally for a 3-year period) for the difference between the motor insurance policy claim and either the:

- value of the car at the time the GAP insurance was purchased – known as Return to Value (RTV); or
- invoice price paid for the car originally – known as Return to Invoice (RTI).

GAP insurance allows the policyholder to replace their vehicle quickly or avoid a situation of 'negative equity'.

GAP insurance is purchased as stand-alone cover with a once-off premium. Usually this is sold by a motor trader in conjunction with a car sale. Premium levels vary depending on the value of the car.

Cover is subject to monetary limits, which vary between insurers. Some policies also include cover for the motor insurance policy excess.

Cover will not apply where the:

- theft or 'writing off' of a vehicle is not covered under the insured's motor insurance policy
- motor insurer offers to provide a replacement vehicle as settlement of the claim.

Typical underwriting criteria include the following:

- the car must normally be less than 7 or 8 years old
- the car must normally have been purchased from a dealer no more than 3 months before the GAP policy is arranged
- the car must be of an Irish specification, and must not have any non-standard modifications
- the recorded mileage on the car must be no more than a specified amount e.g. 80,000 or 120,000 kilometres.

guaranteed asset protection (GAP) insurance

covers the difference between the motor policy claim and either:

- the value of the car at the time the GAP insurance was purchased (return to value), or
- the invoice price originally paid for the car (return to invoice)

'written off'

term used to describe a vehicle that has been too badly damaged to be repaired or where the cost of repairs would exceed the pre-accident value of the vehicle

1 Light commercial vehicle insurance

This section looks briefly at the methods insurers use to underwrite and provide cover for vans commonly referred to as light commercial vehicles (LCVs) (which are mainly used for the carriage of own goods).

In considering the scope of cover for LCVs, we will make comparisons between larger trucks (commonly known as heavy goods vehicles (HGVs)) and private motor vehicles. Extract 2.1 differentiates between the various types of vehicles.

2.1

Extract (Abbreviated summary)

What is a private motor vehicle?

A private motor vehicle is a vehicle designed and constructed for the carriage of passengers and consists of no more than eight seats in addition to the driver.

What is a light commercial motor vehicle?

A light commercial vehicle (LCV) is a vehicle designed and constructed for the carriage of goods and having a gross vehicle weight (GVW) not exceeding 3,500 kgs.

What is a heavy goods vehicle?

A heavy goods vehicle (HGV) is a vehicle designed and constructed for the carriage of goods and having a Gross Vehicle Weight (GVW) in excess of 3,500 kgs.

The GVW includes the vehicle's chassis, body, engine, engine fluids, fuel, accessories, driver, passengers and cargo but does not include any trailers.

Just think

Michael is a self-employed electrician who uses a small van for personal use but also in connection with his business (including carrying his work tools). Michael's 20 year old son Ciarán works for him as a trainee electrician. Ciarán has a provisional driving licence, limited driving experience and also drives the van. Identify the category into which his small van would fit.

Michael would require LCV cover for his small van.

The rise in recent years of the manufacture of 'car vans' (i.e. commercial vehicles but very similar in looks and other respects to private cars, typically 2-door vans with storage area in the back, no rear passenger seats and no rear side windows) has influenced insurers to underwrite such vehicles in their personal lines departments. Insurers calculate premiums and provide policy cover for these LCVs in a similar way to private motor vehicles. This also explains why most insurers underwrite LCVs in their personal lines department rather than in the commercial lines department.

It is vital to note that the knowledge you acquire in this section is not sufficient to make you (the student) compliant with the MCC in respect of providing advice on commercial motor insurance. The intention is to make you aware of how insurers provide cover for LCVs for commercial use (carriage of own goods or carriage for hire & reward). This information is especially relevant for advisers, who need to understand the broader considerations, including the issue of liability and commercial cover versus private motor policy cover. The underwriting of commercial motor vehicles is covered in depth in the Commercial General Insurance module.

Just think

Going back to Michael's small van, list the insurer's main underwriting considerations when deciding how to rate that risk.

I1 Underwriting considerations

Insurers will vary in their acceptance criteria and this should be checked on a case-by-case basis.

In underwriting LCVs, the key considerations, similar to a private motor policy, will include the make, model, engine size, carrying capacity, year and value of the vehicle together with driver details, areas of use and no claims discount history.

In addition to these underwriting considerations, one of the most important factors in deciding how a commercial vehicle is rated is the use that the vehicle will be put to. For example, in the case of a proposal from a butcher with a standard LCV, it is most likely that the LCV has been modified to include a refrigerated insulated unit.

As you know from Section C, private motor insurance has Classes 1(a), 1(b), 2 and 3. Commercial vehicles (HGV and LCV) have 2 different main classes of use:

- use to carry the insured's own goods or
- use including the carrying of goods for hire and reward (known as haulage).

Carriage of own goods would include cover for social, domestic and pleasure purposes. Most tradesmen (e.g. plumbers, electricians, welders) also use their vehicles to drive to and from a place of work and to carry their tools or supplies. This motorist fits easily into the personal lines department. In many cases, they are one-person operations and, as we will see in Section I2, the policy cover provided is broadly similar to that for private motor vehicles.

On the other hand, 'carrying goods for hire' is a greater risk for insurers (these motorists are being paid to transport goods and this impacts on the liability exposure and mileage). Many insurers prefer to see this type of risk (e.g. couriers) handled in their commercial department, even when it involves an LCV. Given the increased risk, they do not view this risk as falling into the normal category of LCV.

It must be noted that the goods themselves are not covered under the motor policy, only the vehicle. For example, if an LCV is stolen and recovered, the policy will pay for the repairs to the vehicle but any damage to or loss of the goods in the LCV will not be covered by the motor policy. The goods can be separately insured under a 'goods-in-transit' insurance policy.

The policyholders/risks that insurers tend to cater for in their personal lines departments have a number of common elements. They are broadly similar in nature, are sufficiently numerous to make rating reasonably accurate, and do not have specific underwriting requirements (e.g. the cover provided can, in most cases, be the standard cover). LCVs fall into this category, which is often referred to as commodity type business.

If the underwriting requirements/rating are non-standard, the insurance business is usually handled in the commercial lines department. The reason for this is that the underwriting of non-standard risks would require an awareness and knowledge of non-standard features that **underwriters** in the commercial lines department would be more familiar with.

underwriter

person/firm who assesses a risk proposed for insurance, decides whether to accept it and, if so, sets the level of premium required and the terms and conditions applicable

Non-standard features of an LCV risk may arise from the use, occupation, nature of goods carried or increased potential exposure from the following sources:

- pollution risks due to types of goods carried and nature of work e.g. waste removal contractor
- access requirements to high-risk/hazardous locations, e.g. airports (where 'airside' cover may be required)
- indemnity to principal
- third-party property damage limits
- loading/unloading, e.g. for a carpet-fitting company or a glazier
- use of trailers – increased frequency of use, the size of the trailer, its actual use (potential increased risk depending on loads) and liability to third parties cover relating to trailers (subject to compliance with RTAs)
- different risks relating to the liability to passengers.

I2 Policy cover comparison

We will now look at how policy cover (including policy exclusions) provided for LCVs differs from that provided for private motor vehicles. The main differences are as follows:

- Third party property damage limit – The limit for commercial vehicles, including LCVs, is usually €1.3-€2.6 million for any one claim (with higher options available) compared with €30 million for a private motor vehicle. Historically, it made sense to provide a lower third-party property damage limit to LCVs, as a commercial vehicle could inflict significantly more expensive property damage than a private motor vehicle. While this lower limit has remained in place, insurers have revised it upwards over the years as they have moved to issue specific LCV type policy documents.
- Driving of other cars – A private motor policy usually provides third-party cover for 'driving of other cars' as standard. Insurers do not tend to offer this on an LCV policy.
- Personal benefits – Certain private motor policies provide additional benefits such as personal accident benefit, medical expenses, and cover for personal effects within the vehicle. These are not automatically included within an LCV policy. However, in some instances, death benefit may be provided for the driver or it may be possible to purchase other additional benefits, such as cover for effects (e.g. tools).
- Provision of a new replacement vehicle – This is an additional option on a private motor policy. It provides the policyholder with a new replacement vehicle if the vehicle is damaged beyond economical repair within the first year of registration. This is not available on an LCV policy.
- Foreign travel – Private motor insurers usually provide full policy cover for driving within the European Economic Area (EEA) at no additional charge. For LCVs, insurer practice varies, for example, some limit cover to a maximum of 30 days in any one period of insurance, others provide only minimum cover to comply with EU motor insurance requirements while others provide full cover for a specified period on payment of an additional premium. Significantly, this cover is not provided automatically (beyond the UK, Northern Ireland, Channel Islands and Isle of Man) for LCVs or, indeed, any commercial vehicle. Insurers take the view that it is quite acceptable to use a private motor vehicle to travel to the EU for holiday or business purposes, but that the use of a commercial vehicle in the EU needs special underwriting consideration, and this type of cover must be arranged separately. This view (especially in respect of LCVs) may change in future years.

I3 No claims discounts

Insurers also offer no claims discounts (NCDs) on light commercial vehicle policies. The system works in the same way as in private motor insurance. The number of claims free years and the corresponding NCDs allowable vary between insurers. The maximum discount allowable would be 50-60%. The numbers and values of claims allowable would also vary between insurers. Most insurers will operate a step-back protection similar to that offered for private car insurance.

In relation to the different types of NCDs (e.g. step-back, protected etc.), it should be noted that competing insurers will not always recognise these arrangements. Whilst the current insurer may implement the NCD arrangement, a different insurer may not recognise the policyholder's NCD but will instead look to the number of years claims' free driving.

J Summary

In this chapter, we considered the scope of motor insurance and the range of vehicles it covers. We looked at the different types of policies available for cars, motorcycles, and vans/LCVs and learned about the policy conditions and exclusions that apply.

Now that we've completed Chapter 2, take another look at Peter's consumer profile at the start of the chapter, and think about what advice you would have given him.

J1 What's next?

In the next two chapters we're going to look at household insurance, and focus on developing solutions for consumers.

J2 Study tips

It's important to remember that this textbook is the primary information source for this module. All the questions in your exam will relate directly to information featured in the textbook. Use the 'End of chapter questions', 'Quick questions' and the 'Sample multiple-choice questions' to quickly test what you've learned so far. Make a note of any topics/areas you need to improve in and keep it to hand so you can refer to it when you revise this chapter again before your exam.

In addition to the textbook, your Member Area has many online study supports that can help you as you study this module.

J3 Online learning supports

Your Member Area includes a learning plan, an automated study planner, an exam countdown timer and study tips guide. These study supports are invaluable in reinforcing what you have learned from the textbook so far. The webinars, chapter-by-chapter key points and other supports will help you to break down the chapter content when revising.

Completing online mock exams and reviewing the personalised feedback that follows is a great way of testing your knowledge and preparing for exam day.

To access these online study supports, just log into your Member Area on www.iii.ie and click on the **Connect** logo.

End of chapter questions

Use these questions to test your understanding of what we've covered in Chapter 2.

1. State the categories of people that are usually given an indemnity under a third party only (TPO) motor insurance policy, apart from the policyholder.

2. List the key features of the 'driving of other cars' extension offered under comprehensive motor insurance policies.

3. State what extra cover is typically provided by the addition of 'fire and theft' to a TPO motor policy.

4. State the standard cover provided by roadside assistance.

5. List the two sets of circumstances normally provided for under motor legal protection cover.

6. A policyholder uses their car to commute to work and, occasionally, for business. List the questions that need to be asked to establish the appropriate class of use.

7. Explain what is meant by a 'step-back NCD'.

8. State the key benefits provided under a comprehensive private motor insurance policy, but not under a comprehensive motorcycle insurance policy.

9. State the cover provided by guaranteed asset protection (GAP) insurance.

10. List three differences in the cover provided for carriage of own goods/LCVs and the cover for private cars.

11. List three sources of potential exposure under a non-standard LCV policy.

Answers to end of chapter questions

Check your answers against those below and make a note of any points you left out. This will highlight the sections you may need to look at more closely during your revision.

1. The standard categories of people usually given an indemnity under a third party only (TPO) motor insurance policy are:
   - anyone driving or 'using' with permission, if allowed on the certificate
   - anyone 'using' the vehicle (i.e. a passenger)
   - the employer or partner (provided it is in compliance with the policy use)
   - the owner of the vehicle or their personal representatives (if the person is deceased)
   - the hirer of the vehicle (for the negligent acts of the policyholder).

2. The key features of the 'driving of other cars' extension offered under comprehensive motor insurance policies are as follows:
   - It only applies to the policyholder.
   - It is restricted to third-party cover regardless of the insurance cover held (unless the insurer offers comprehensive 'driving of other cars').
   - It is restricted to vehicles not owned by, hired or leased to the policyholder.
   - The policyholder must have the permission of the owner of the other car.
   - Cover cannot be available under any other insurance policy.
   - It only applies to private cars.
   - It may not be offered to younger drivers, provisional licence holders or to drivers of certain occupations (e.g. taxi drivers or mechanics).

3. The extra cover provided by the addition of 'fire and theft' to a TPO motor policy is damage to or loss of the insured vehicle:
   - by fire (including self-ignition, lightning or explosion)
   - during an attempted theft or while it is stolen
   - if stolen but not recovered.

   It may be subject to an excess (which may apply to theft cover for high value vehicles) but includes damage to or loss (as a result of theft) of spare parts and accessories kept in, or on, the car, or kept in the policyholder's private garage.

4. The standard cover provided by roadside assistance includes:
   - Repairs plus up to 1 hour's roadside assistance. (Note that some insurers provide this cover at the consumer's home/driveway, while others stipulate that cover only operates when more than a minimum distance from the home (e.g. 2 kilometres)
   - Completing the journey- if the repairs cannot be completed on the same day (or at the scene) insurers reserve options as follows: transport to the intended destination, accommodation expenses with a limit, hiring a vehicle for up to 48 hours, any other option for repair/transportation.
   - Towing of the vehicle to the nearest repairer or home if nearer, or anywhere the insured wishes if nearer.

5. The cover normally provided under motor legal protection cover is to:

   a. facilitate the recovery of uninsured losses and costs following an event that:

      - causes damage to the insured's vehicle or to their personal property in it
      - injures or kills an insured person while they are in/on the insured vehicle
      - injures or kills an insured person while they are driving another vehicle
      - injures or kills an insured person while they are a passenger, cyclist or pedestrian.

   b. defend the insured's legal rights if an event leads to the prosecution of an insured person for an offence connected with the use or driving of an insured vehicle.

6. If a policyholder uses their car to commute to work and, occasionally, for business, the questions needed to establish the appropriate class of use are:

   - Does the policyholder carry goods or samples (Class 2)?
   - Does the policyholder carry on commercial travelling (Class 3)?

   If the answer to both of these questions is no, Class 1(b) will be suitable.

7. A 'step-back NCD' is a cushion against the effects of claims where the NCD is only partially reduced for every claim made.

8. Under a comprehensive motorcycle policy, there are no personal accident benefits, medical expenses or personal effects cover. However, these benefits are covered under a comprehensive motor insurance policy.

9. GAP insurance complements private motor insurance cover in that it covers the difference between the motor policy claim and either:

   - the value of the car at the time the GAP insurance was purchased (return to value), or
   - the invoice price originally paid for the car (return to invoice) cover.

   Some policies also include cover for the motor insurance policy excess.

10. The differences in cover provided to carriage of own goods/LCVs and private cars are:

    - There is a lower third-party property damage limit, usually €1.3–€2.6 million compared to €30 million.
    - Foreign travel (beyond the UK, Northern Ireland, Channel Islands and Isle of Man) is not automatically covered; insurers must be consulted in advance of foreign travel.
    - Driving of other vehicles is not usually offered by insurers on an LCV policy whereas a private motor policy usually provides this benefit, at third-party cover, as standard.
    - Personal benefits are not automatically included, death benefit may be provided in some instances or it may be possible to purchase additional benefits.
    - Provision of a new replacement vehicle is not provided on a van/LCV policy but is an optional addition on a private motor policy.

11. The sources of potential exposure under a non-standard LCV policy are:

    - potential pollution risks
    - access requirements
    - indemnity to principal
    - third-party property damage limits
    - loading/unloading of vehicle
    - use of trailers
    - different risks relating to the liability to passengers.

Answers to quick questions

1. Motor insurance is a compulsory legal requirement in Ireland so that there is protection for the interests of the innocent victims of road accidents for death, injury and damage to their property.

2. 'Driving of other cars' usually provides TPO cover to the named policyholder(s) only, although some comprehensive policies also offer comprehensive cover for an additional premium. The policyholder must have the permission of the owner of the other car. This extension applies only to private cars, and it will only provide cover where none exists under another policy. Some insurers may not offer this extension to younger drivers, provisional licence holders or to drivers of certain occupations (e.g. taxi drivers or mechanics).

3. Yes – the graffiti damage is covered. The policy covers all damage during attempted theft or while the car is stolen, as well as paying a claim when the car is stolen but not recovered.

4. Using the NCD scale in Table 2.1, Peter has 5+ years' claims-free driving.

5. The reason an adviser may ask whether cover has been the same throughout the period that the claims experience covers is that if a different level of cover applied, or if a particular driver caused one or more accidents, claims could be separated out when presenting the risk.

6. Emergency treatment fees would be covered on a comprehensive motorcycle policy. Charges for emergency medical treatment arising out of use of a vehicle are compulsory under the RTAs.

7. No, Paddy cannot use his motorcycle insurance NCD to obtain private motor insurance. However, some insurers may offer an introductory bonus.

Sample multiple-choice questions

1. When underwriting guaranteed asset protection (GAP) insurance, the insurer will usually insist that the car must have been purchased from a dealer no more than how many months before the policy is arranged?

   A. 1
   B. 2
   C. 3
   D. 6

   Your answer:

   ☐

2. Which of the following questions on a motor insurance proposal form, indicates to insurers the costs that may be incurred in relation to own damage claims?

   A. What is the year, make and model of the vehicle?
   B. Is the vehicle kept in a locked garage?
   C. What is the proposer's occupation?
   D. Does the proposer have a full Irish driving licence?

   Your answer:

   ☐

3. Kevin is a business analyst and is proposing for motor insurance. When asked about 'class of use' he notes that he uses the car every day to commute to work and occasionally drives to customers' offices for meetings. His business mileage is estimated at approximately 2,000 km per annum. Which class of use is applicable to Kevin?

   A. Class 1(a).
   B. Class 1(b).
   C. Class 2.
   D. Class 3.

   Your answer:

   ☐

Answers to sample multiple-choice questions

Question 1

Chapter reference: Chapter 2H

Question type: K

Correct response: C

Learning outcome: Demonstrate the scope and limitations of motorcycle, guaranteed asset protection (GAP) and vans/light commercial vehicle cover.

Question 2

Chapter reference: Chapter 2F

Question type: U

Correct response: A

Learning outcome: Outline the questions that encourage the consumer to disclose the necessary material information to enable advisers to provide them with the most appropriate private motor insurance product.

Question 3

Chapter reference: Chapter 2C

Question type: A

Correct response: B

Learning outcome: Demonstrate the legal basis for private motor insurance practice, the scope and limitations of different private motor insurance covers and standard options available.

Chapter

3

Household insurances – definitions, insurable values and information gathering

What to expect in this chapter

This is the first of two chapters that focus on household insurances. The household insurance risk could be an owner-occupied premises or a non-standard household risk such as a holiday home, a thatched house or a B&B.

After studying this chapter, you'll understand the different policy definitions (e.g. buildings and contents) and the many variations in the market. The word definition is used throughout this chapter to refer to the meanings or interpretations given to particular terms or terminology. These are not legal definitions, rather custom and practice in the insurance industry has conferred certain meanings on such terms. However, the exact interpretation varies from insurer to insurer and you should acquire a number of policy wordings to see how such 'definitions' vary in the industry.

You'll be familiar with the factors involved in identifying what value a consumer should place on their buildings and contents for insurance purposes. You'll also know what questions to ask of a consumer looking for household insurance, in order to establish their insurance needs and recommend the best product for them.

Essentially, what we're going to do is apply the advising process outlined in Chapter 1 to a household insurance consumer. While it is not possible to cover every possible risk or event that may be relevant to every consumer, the methodology used, and the key information requirements are common to all consumers.

> Note that in this chapter, the monetary values referred to (e.g. in relation to sums insured, policy limits or excesses) are for guidance only. Likewise, the policy guides are only summaries and abbreviations of key information from sample policies in the market. They are not necessarily actual wordings, nor should they be taken as applying universally across the market. There tend to be many variations of wording and ranges of exclusions. For this reason, you are strongly advised to acquire a number of policy wordings to see what is available in the market.

To help you relate the material in this chapter to a real-life situation, we have included a sample consumer profile. This highlights some of the issues that an adviser may encounter when arranging household insurance cover. It will help you reflect on how and why each element of the household insurance cover may (or may not) be suitable for a particular consumer. The question to keep in mind as you work your way through Chapters 3 and 4 is: 'What are the key factors to consider when advising Frank and Susan on the most appropriate household insurance cover?'

Learning outcomes for this chapter

Section	Title	At the end of each section you should be able to:
A	**Defining 'buildings' and establishing an insurable value**	Explain the scope of, and variations in, definitions used in household insurance and demonstrate the means of establishing accurate sums insured under household policies.
B	**Defining 'contents' and establishing an insurable value**	
C	**Questions to ask the consumer and why**	Explain the questions that will encourage consumers to disclose the necessary material information to enable advisers to provide them with the most appropriate household insurance product.

Household insurances sample consumer profile

Frank is a 38-year-old accountant, and is a partner in a large accounting practice in Dublin. He is married to Susan and they have three children aged 6, 8 and 11. They live in a modern 4-bedroom detached house situated in a South Dublin housing estate. His wife Susan is a stay-at-home mother who looks after a neighbour's two young children as a source of extra income. The children are left at Susan's home each morning at 8am and are collected at 2.30pm.

Frank and Susan's home was recently valued at €750,000. The house is a modern structure built of concrete block walls, a decorative brick façade and a tiled roof. They have a greenhouse in the garden that Susan uses for growing tomatoes. They recently had a den built in the back garden at a cost of €12,000 for their children to use as a TV and games room. It is a Swiss chalet-type structure, constructed of timber and roofed with torch-on felt. They also have a large detached garage for housing Frank's Audi A7 and Susan's Toyota RAV4. At the side of the house is an extensive decking area where Frank and Susan like to host summer barbecues for their friends and family.

They have completed an inventory of all their household contents and estimated the replacement cost for everything at €150,000. Susan has jewellery worth €30,000, which includes a number of valuable pieces left to her by her late mother (a pearl necklace valued at €6,000, a diamond engagement ring valued at €9,000 and a Rolex watch valued at €7,500). Frank is a keen golfer and is a member of the local club. He reckons his golf clubs, cart and golf accessories would cost €5,000 to replace. He and Susan are also keen windsurfers and their surfboards, masts and trailers would cost €4,000 to replace. Frank likes to cycle and availed of the 'cycle to work' tax scheme to purchase a high-spec racing bike, which cost €1,500. Frank and Susan each have a smartphone. Susan also has an iPad and Frank has a high-spec laptop. These gadgets would cost €2,800 to replace.

A few years ago, Frank and Susan bought a holiday home in Lahinch, Co. Clare. The holiday home is valued at €200,000 and the contents are valued at €40,000. Susan and the kids spend two months there during the summer. They also spend a week there at Easter and a week there at Halloween. For most of the remainder of the year it is locked up and alarmed to a 24-hour monitoring station.

A Defining 'buildings' and establishing an insurable value

The vast majority of household insurances fall within the broad category of 'owner-occupied domestic dwellings'.

homogeneous risk (exposure)

the existence of a number of risks with similar profiles or characteristics, e.g. in terms of frequency and severity patterns

In practice, the **homogeneous** nature of household risks means that very few require any information to be provided beyond the completion of a proposal form.

However, if a risk contains any unusual features the adviser may require additional information in order to assist the consumer in obtaining the best cover and price. Table 3.1 lists some unusual or non-standard risks.

Table 3.1 Examples of unusual or non-standard risks

- Non-standard construction, e.g. homes with thatched or flat roofs or those that fall outside an insurer's definition of acceptable 'normal' construction
- High-hazard areas, e.g. homes built on reclaimed land or known flood plains
- Purpose-built blocks of flats
- Let property/property owners
- Overseas property
- Accommodation linked to commercial premises
- Holiday homes
- Unoccupied properties
- Mobile homes
- **Listed buildings**
- Affluent homeowners, i.e. with domestic staff, very high-value contents (e.g. artwork, jewellery, antiques) or single-article limits
- Unusually high frequency of claims
- Remote locations
- Guesthouse/B&B where additional cover will be required for guests' possessions, business interruption, money and liability.

listed building

a protected named structure; each planning authority must compile and maintain a record/list of these, outlining the protection extended to the structure's external and sometimes internal features

Just think

Does the issue of non-standard risks arise for Frank and Susan? If so, what additional information will be required from them?

There are evidently a number of non-standard risk features. The den is a wooden construction with torch-on felt roof, and the construction of the greenhouse (i.e. glass/metal frame) and the holiday home will have to be clarified. The valuation of jewellery may also be of concern to some insurers due to its total value and the high value of some individual items.

Aside from policies designed to cater for these unusual or non-standard risks, most household insurance products are reasonably standardised, with few variations in market practice for this class of insurance. However, there is no such thing as a standard policy document. Different insurers offer a different range of covers, wordings and excesses, and the definitions and limits they use also vary.

Having said that, the majority of insurers offer broadly similar terms and conditions in their policy documents. Try to obtain a number of sample policy documents from different insurers and then compare and contrast their cover, wordings and definitions.

Quick question 1

Consider how an insurer would view Susan's childminding activity.

The answer is at the end of this chapter.

A1 Defining 'buildings'

Individual insurers define the term 'buildings' differently, and it is important for the adviser to be aware of this.

Insurers usually define two terms in their policy document: 'the home' and 'buildings'. Again, there is no standard practice but these definitions normally include the following elements:

- The Home – the private house, bungalow, flat, maisonette or self-contained purpose-built apartment at the address shown in the schedule.
- Buildings – the home, domestic outbuildings, fixtures and fittings, swimming pools, greenhouses, terraces, footpaths, patios, drives, walls, fences and gates within the boundary of the home.

There are differences of approach in relation to items such as interior decorations, tennis courts, decking, hedges and septic tanks.

Service piping and cables (where these are the policyholder's responsibility) are generally not defined as part of the building, but are listed separately as being covered for accidental damage (cause not restricted to perils named in the policy).

Although the differences may appear slight, they are of significance to some consumers. Consider the 'buildings' definitions noted in Insurance policy extract 3.1, which are to be found in two different household policies currently available in the Irish market.

Insurance policy extract 3.1

Insurer A: 'The private home shown in the schedule and the following if they form part of the property:

a. domestic greenhouses, tennis hard courts, swimming pools, terraces, patios, drives, footpaths, walls, gates, fences, hedges, decking and septic tanks, all within the boundaries of the land belonging to the private home.

b. landlord's fixtures and fittings and decorations inside the home.'

Insurer B: 'The home and its domestic outbuildings, garages, greenhouses, sanitary fixtures, swimming pools, tennis courts, patios, terraces, drives, footpaths, walls, gates, fences; hedges under 2 metres high; aerials, satellites and their fittings and masts; solar panels and heat exchange units securely attached to the roof of the building, including landlord's fixtures and fittings to the building; fitted wooden or laminated flooring; kitchen, bathroom or bedroom units and their integrated appliances all on the same site.'

Both definitions appear to be broadly similar, with references to the home (or private home). However, there are some subtle differences. For example, in the second definition solar panels and heat exchange units are included, whereas in the first they are not. In the first definition septic tanks are included, but not in the second.

Advisers need to be aware of the differences between insurers' definitions. For this reason, when developing a client fact find, it is important to include questions that will identify these key areas. As noted in Chapter 1B1c, it is recommended that the adviser create a comparison chart that captures the details of variations in policy cover, in order to match the consumer's needs with the most appropriate product.

Just think

Consider the impact of the two insurance policy definitions of 'buildings' in Insurance extract 3.1 on our sample consumers (Frank and Susan) and their household insurance cover.

There are a number of items to be considered – the house, the garage, the greenhouse, the den, the decking. Although both definitions include the home and greenhouse, one includes the garage and patios but not the decking, while the other includes the decking and patios but not the garage. The den could be considered a domestic outbuilding for one policy but the other does not include domestic outbuildings at all. It is vitally important that the adviser is aware of the differences and informs Frank and Susan (and their insurers where necessary).

A2 Defining 'standard construction'

Insurers pay close attention to the construction of buildings and create a range of rates for 'normal' or 'standard' risks. In the case of household buildings (and usually also for contents), the fabric of the building is assumed to be fire-resistant and reasonably substantial. Flimsy construction (timber walls) or corrugated or plastic roofing, for example, will impact not only on the fire peril but also on theft, storm and flood. The theft risk is increased where access is made easier by virtue of the construction. Flimsy roof construction, in particular, increases the likelihood of storm damage.

Policy definitions of 'standard construction' may vary, but they are all designed to clarify and/or limit the insurer's exposure. In other words, if a building is constructed with elements that fall short of the standard, underwriters will factor the additional risk into the pricing of the risk. Example 3.1 illustrates the types of construction-related questions found on the proposal forms of three insurers.

Example 3.1

Insurer A – Is the property described constructed of brick, stone or concrete (including timber framed with concrete brick internal cladding) and roofed substantially (at least 70%) with slates, tiles, metal, concrete or asphalt?

Insurer B – Is the property built solely of brick, stone or concrete and roofed with slates, tiles, concrete, metal, asphalt or a flexible weathering membrane, provided that the membrane portion of the roof does not exceed 50% of the total roof area? (Exceptions must be detailed by the proposer.)

Insurer C – Is the home constructed solely of brick, stone or concrete and roofed solely with slates, tiles, metal, concrete or asphalt? If 'no' please specify.

As you can see, there are slight variations in the wordings. Timber-framed houses are referenced by Insurer A while 'flexible weathering membranes' are referenced by Insurer B. From an intermediary's perspective these differences may be significant, depending on the construction of a consumer's property.

Construction information should note any adverse features such as non-standard or combustible elements, linings, perspex and glass, as well as any unusual materials used in the building design. Other key factors are communication with adjoining buildings/multi-occupancy.

A3 Other definitions found in household buildings insurance policies

Other definitions relevant to household buildings insurance include:

- Family – relatives permanently residing with you
- Household – family and domestic staff
- Premises – buildings and land, within the boundaries belonging to them[8]
- Unfurnished – not adequately furnished or equipped for normal living purposes
- Unoccupied – not lived in by a member of your household or any other person authorised by you
- You – the person or people shown in the schedule.

As a general rule, when differentiating between what is classed as 'buildings' and 'contents', anything that the insured would normally leave behind when moving from a house can be regarded as part of the building, e.g. fitted kitchens, sanitary ware, integrated appliances and double-glazing. An exception is carpets, which are often sold with a property, but for insurance purposes are regarded as contents.

Quick question 2

An insurer is offered a household risk where the roof construction is of thatch. How do you think the insurer might respond to this?

Quick question 3

A policyholder contacts their insurer wishing to clarify the difference between the terms 'buildings' and 'premises' in their household insurance policy. Explain how you, as an adviser, would answer their query.

[8] Students should note that household policies only cover the immediate site used for personal and private occupation, as opposed to acres of land on which the house may be situated. This definition is not found in all household policies.

A4 Establishing insurable values for buildings

The basis for setting sums insured is normally the full cost of reinstating (rebuilding) the property. When an insurer accepts a claim on this basis, it will settle it without making a reduction for wear, tear, loss in value or deterioration, provided the building is in good repair and the sum insured is not less than the full cost of reinstatement.

The Society of Chartered Surveyors Ireland (SCSI) provides a house rebuilding calculator and publishes a reference guide on house rebuilding costs, which outlines minimum values for which the structure of a house should be insured. These are both very helpful for consumers valuing their properties.[9] The guide emphasises that the rebuilding costs indicated are intended to cover typical, speculatively built estate-type houses in Dublin, Cork, Galway, Waterford and Limerick, which were built since the 1960s, and it gives different rates for each geographical area. The application of these rates to the area of the house (square metre based on the floor area of all storeys totalled) provides a basis for determining the buildings sum insured. However, there are other costs that need to be added, including:

- boundary walls
- garages
- fitted kitchens
- outbuildings
- swimming pools
- drives (allowing for concrete pathways)
- surveyor/architect/quantity surveyor fees
- value added tax (VAT).

Specifically excluded from the guide are:

- properties with more than two storeys or with basements or habitable attics
- 'one-off' houses with special design features or period houses
- apartments/residential flats, because of split responsibilities for shared areas.

Just think

What kinds of changes commonly made by owners to their homes are likely to increase the building reinstatement costs? Are any of these relevant in the case of Frank and Susan (our sample consumers)?

Renovations such as new extensions, expensive flooring or fitted kitchens are all likely to increase rebuilding costs, particularly if any specialised materials are used. Frank and Susan should include the den, greenhouse and decking when revising the insurable value of their property. If the decorative brick façade is of specialised materials, they should also take this into consideration.

[9] SCSI, 'Are you fully insured? – Guide to House Rebuilding Costs for insurance purposes', online pdf, www.scsi.ie.

The current trend is to fit out properties to high specifications. Some commonly encountered elements that affect rebuilding costs are:

- solid timber or marble flooring
- under-floor heating
- solar panels
- fittings such as chandeliers or marble-top islands
- built-in wardrobes/kitchens/bathrooms
- timber decking and patio areas.

The SCSI guide does not take account of future inflation, either during the policy period or between the time of any loss occurring and reinstatement. As inflation will clearly impact on the sum insured (see Section A4b), it must be allowed for when calculating the figure.

As we have seen, there are many factors that need to be allowed for in establishing the buildings sum insured. It is important for the adviser to make it clear that the onus is on the consumer to determine the correct sum insured (possibly using the SCSI guide as a starting point).

A4a Relevance of market value

For a number of reasons, the market value of a property is not a good basis for valuation of the building for insurance purposes. The market value includes the cost of the land (which is irrelevant for the purposes of rebuilding), and it is also partly determined by a range of external factors (e.g. style, area, inflation, the state of the economy, housing availability).

A4b Index linking

The sum insured on buildings is normally adjusted monthly in line with the House Construction Cost Index prepared by the Department of the Environment, Community and Local Government - see Example 3.2. This is to avoid any shortfall that might occur either for a total loss or through the application of average. If the annual increase is less than 5%, then the higher figure of 5% is generally used. No additional premium is charged mid-term, but the renewal premium will be based on the increased figure produced by this formula, if appropriate.

Example 3.2

Valerie's house has a buildings sum insured of €200,000. Her household insurance policy is subject to index linking of 5% per annum. At next renewal the building sum insured will increase to €210,000 (i.e. sum insured of €200,000 plus 5%). The following year it will increase by 5% again to €220,500 (i.e. sum insured of €210,000 plus 5%).

A4c Building regulations

Under 'new for old' (reinstatement) policies, if the structure of the building insured does not conform to current building regulations, the policyholder must attempt to make provision in the sum insured to cover the cost of compliance with these regulations. They will be able to obtain cover but it will be limited overall by the adequacy of the sum insured.

Quick question 4

Our sample consumer's Frank and Susan's home was recently valued at €750,000. What advice would you give them regarding setting the building sum insured? Consider the holiday home also.

index-linking

method of calculating the sum insured on buildings and contents that is adjusted monthly in line with appropriate indices, but in times of very low inflation may be set at 'nil'

Quick question 5

Why is it not advisable to use the market value as the basis for setting the buildings sum insured?

B Defining 'contents' and establishing an insurable value

As with buildings, there is no standard market definition of the term 'contents'.

Variations in insurers' definitions affect the setting of sums insured and the covers and limits that apply, and it is very important for advisers to be familiar with these.

B1 Defining 'contents'

This section outlines the typical definitions that appear in contents insurance policies:

- Contents – household goods, personal belongings and valuables (including personal money up to the limit shown in the schedule) within your home that you or any member of your household own or for which you are responsible
- Credit and debit cards – credit, charge, cheque, debit, bankers' or cash-dispenser cards
- Home office equipment – personal computers, printers, facsimile, telephones, answering machines and the like, included for a specified amount in any one period of insurance (an optional extension on many policies, rather than an automatically provided policy cover)
- Money – cash, cheques, postal orders, bank drafts, travel tickets, savings stamps and certificates, premium bonds, current postage stamps, gift tokens, luncheon vouchers, trading stamps and telephone call cards (within the home), all held for social or domestic purposes.
- Valuables (also termed 'valuable property') – jewellery, items of gold, silver, or other precious metals, watches, photographic equipment, binoculars, paintings, works of art, curios, antiques, furs, collections of stamps, coins or medals, musical instruments, radios, televisions, other audio or video equipment (amount usually subject to a limit on what an insurer will pay under a valuable property claim).

Insurance policy extract 3.2

In relation to the definition of 'valuables' in the preceding list, consider this sample policy wording:

> … any one high-value item is covered, for no more than 10% of the contents sum insured (single article limit), and the total of these items are covered for no more than 33% of the contents sum insured (total limit for high-value items), unless a list of the valuable items has been furnished to the insurer and the items are noted on the schedule.

Just think

Consider the inventory of contents made by Frank and Susan (sample consumers) against the cover limits for 'valuables' outlined in Insurance policy extract 3.2. Are their valuables covered or do certain items need to be noted in the schedule?

Valuables are covered in the home. However, there are single article limits and total limits for high-value items. To answer the question, we need to look again at the details provided by Frank and Susan:

- Contents sum insured – €150,000
- Jewellery – €30,000, which includes items valued at €6,000, €9,000 and €7,500
- Golf clubs, surf equipment, bike and gadgets totalling €13,300.

The single article limit is 10% of the contents sum insured (€15,000) with a total high-value limit of €49,500 (€150,000 @ 33%), for valuables within the home. The total value of all the valuable items is within the policy limit, and no single high-value item exceeds the single article limit of 10%. However, they would need to monitor these valuables and the sums insured. Additional cover could be required in the future. The jewellery, golf clubs and surf equipment could be specified under the optional extensions on the policy, separate specialised policies could be arranged (e.g. surf board), or they may want to consider **'all risks'** cover for items outside the home (see Chapter 4C1 for an outline of 'all risks' cover).

We recommend that you review a selection of household policies to familiarise yourself with the range of covers and limits that may apply across different insurers' policies. As noted in Chapter 1B1c, it is advisable to create a comparison chart that captures the details of variations in policy cover, in order to match the consumer's needs with the most appropriate product.

'all risks'

general term used to describe the widest form of insurance cover, subject to a number of exclusions

Just think

Take a minute to remember how the following are defined in your sample household insurance policy:

- money
- contents
- valuables.

Quick question 6

Conor, whose dad is a household insurance underwriter, made the mistake of asking his dad for some 'money' when he was heading out last Saturday. Dad, being a comedian in his own mind, gave Conor an unusual assortment of things. Bearing in mind the definition of money within the contents section of a household policy, what might Conor have found in his wallet?

Although some insurers will extend their policies to cover some of these, the following items are not usually regarded as property for household contents insurance purposes:

- documents or securities (stocks and shares) valued at more than a specified amount – typically €400 in total
- caravans, watercraft, motor vehicles (including ride-on lawnmowers) or trailers, or parts/accessories for any of them
- any living creature or plants, trees or shrubs
- property used or kept for business, trade or professional purposes
- property more specifically insured.

B2 Establishing insurable values for contents

The basis for setting the sum insured on contents should be the full cost of replacing the contents, as new, after allowing for deterioration on items not covered on a 'new for old' basis (usually clothing, household linen and furs). Some insurers also make a deduction for wear/tear or deterioration on entertainment equipment (e.g. tv, laptop, dvds) once they are over a year old. Insurers can also apply a deduction for carpets over 5 years old.

For owner-occupiers, there are variations in the method of arriving at a sum insured. Insurers tend to offer two different approaches:

1. The sum insured is selected by the consumer.
2. The insurer offers a choice of contents sums insured amounts that represent a percentage of the buildings sum insured.

underinsurance

policy that has been effected, requiring full value as the basis for cover but where a lower figure has been declared

insurable values

basis of the policy claims settlement reflected in the values insured under the policy

All insurers reduce claim payments if there is **underinsurance**. For example, applying the pro-rata average condition reduces any claim payment in proportion to the amount of underinsurance, e.g. if the declared value of an insured item is 20% less than the actual full value at risk, the insurers will reduce the claim payment by that same percentage. Also, insurers will make a deduction for wear and tear of items when settling the claim.

Whichever method is used to arrive at the **insurable values** for contents, it is imperative that the sum insured is adequate. In this context, 'adequate' means calculated on the total values that would be paid out for a claims settlement. 'New for old' values are needed for all items covered in this way and an allowance should be made for wear and tear for those categories where the policy cover is limited.

The ideal method is a room-by-room approach and insurers often provide a template to assist with this process. The replacement costs can surprise consumers when they carry out this exercise for the first time. When a template guide is used as a prompt, the allowance for items such as frozen food or the contents of outbuildings boosts the overall figures.

If the policy is not index-linked, an allowance should be made for the anticipated level of inflation during the policy period, if appropriate. This depends very much on the economic climate. Otherwise, unless purchases are planned, the figures produced in the inventory should be used. In the event of a claim, these are the values insurers will use.

Index-linking of the contents sum insured operates in a similar way to buildings (see Section A4b). The contents figure is normally adjusted monthly in line with the 'Durable Household Goods' section of the Consumer Price Index issued by the Central Statistics Office.

This adjustment continues after any insured loss or damage, if the repairs or reinstatement are carried out without delay.

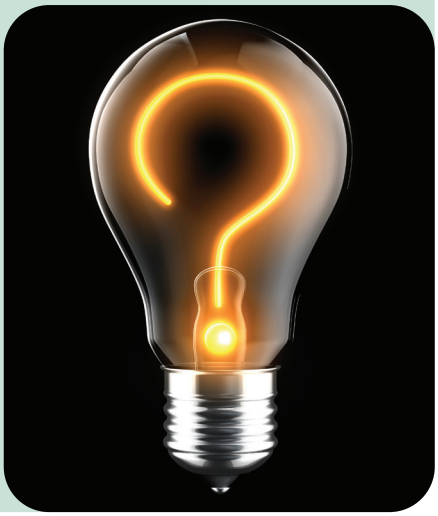
No extra premium will be charged during the period of insurance, but at the end of the period the insurer will calculate the renewal premium on the revised sum insured. If insurers do not intend this provision to apply, they must advise consumers and note this on the policy as part of the renewal process or at inception.

Quick question 7

If a consumer is confident they know the value of their contents and do not need to carry out an inventory, how would you, as an adviser, respond?

C Questions to ask the consumer and why

In order to establish which product(s) might be suitable for a particular household insurance consumer, the adviser must ask a range of questions. These questions must prioritise areas where distinctions between products are likely to be meaningful for the consumer.



Tables 3.2–3.4 outline the basic information required, suggest prompts for follow-on questions and highlight why certain responses to these questions may impact on the advice and recommendations that should be given. Certain information will be obtained from the generic fact find previously noted in Table 1.1. The further specific information has been divided into three categories:

1. the home, its ownership, structure and location
2. the cover, sums insured, values and limits required
3. specific questions prompted by different insurers' approaches to cover (particularly the wording of their exclusions).

These questions are likely to be asked, or confirmed by means of a Statement of Fact, when the policy comes due for renewal. This is as a result of the **Consumer Insurance Contracts Act 2019** which limits the information that needs to be disclosed by consumers.

For affluent (high-net-worth) individuals a more detailed approach will be needed, more akin to the formalised risk management approach that characterises many commercial insurance risks.

Table 3.2 Questions to ask a consumer relating to the home

Key information	Reason for question/effect on advice given
Ownership	
Age of proposer	If over 50, may be eligible for discount.
Does the consumer own the home?	If not owned, consider tenant's liability.
Is the property mortgaged?	Interest of mortgagee is to be noted on the policy. Advise insurers.
Structure	
Is the property a house? ▪ **If yes – detached/semi-detached/terraced/end-of-terrace?** ▪ **If no – detached bungalow/ semi-detached bungalow/ maisonette or ground floor/ basement flat/first floor or above (purpose built)?**	Insurers will require this information. If not purpose built, find out the position with regard to others being able to access the building.
Communication with adjoining property	Full details of communication are required, especially if business premises.
Age and construction	Establish if main buildings are all **standard construction**. Establish if any extensions are of non-standard construction (particularly roofs).
Is it a listed building?	Find out the reinstatement requirements.
When was it last re-wired and re-plumbed?	Information is needed if an old building.
Are two or more smoke detectors fitted?	Older buildings may not comply, but it may be an insurer requirement.
Is there a professionally installed and maintained intruder alarm? **Is the intruder alarm linked to an approved monitoring station/Gardaí?**	If it is not an insurer requirement, a discount may be allowable. If a **condition** is to be applied does the consumer comply with the terms?
Location	
Address/Eircode (remoteness)	Provides information about an area e.g. flood zones, flood protections, flood mapping, crime rates, distance from fire brigade, proximity to other risks (i.e. petrochemical plants or plant handling combustible materials).
Is the area subject to: flooding? subsidence/ground heave?	If known, should be disclosed along with previous losses.
Neighbourhood watch area?	Advise insurers.

standard construction

normally refers to building construction that is substantially of non-combustible components, e.g. block, brick and concrete walls with slate, tile or other non-combustible roofs (but market wordings vary)

condition

provision in a policy that must be complied with

Just think

Would our sample consumer Frank and Susan's responses to any of the questions in Table 3.2 require further investigation on your part as an adviser?

As noted earlier, the construction of the den (wooden with torch-on felt roof) and greenhouse (glass/metal frame) would require further investigation; as would the construction of the garage and holiday home.

This is the first level of information we need. Many consumers will present straightforward risks with no special features. However, this part of the information gathering process may reveal important features that will need to be disclosed, and may point towards a particular insurer's product if its underwriting approach is known to be more favourable towards particular non-standard features. For example, an intermediary may be aware of unusual risk features, such as adjoining commercial premises or non-standard construction. In these circumstances, special consideration and risk presentation will be needed.

For tied insurance intermediaries (i.e. advisers who can only recommend products from a single insurer), the information gathering process may be less onerous, even where there are different eligibility rules for alternative products from that one insurer. However, the requirement to act in the consumer's best interest still applies.

Table 3.3 considers the cover, sums insured and limits required.

Table 3.3 Questions to ask a consumer relating to the cover/sums insured/values/limits

Key information	Reason for question/effect on advice given
Cover	
Is a 'standard range of perils' required?	This will suit most consumers, unless they are risk-averse.
Is 'accidental damage' cover required?	If not required for all contents are there specific items to consider?
Sums insured	
Buildings **Reinstatement value (basis of assessment)** **(Can SCSI guide be used?)**	If guide cannot be used does the sum insured include an allowance for debris removal, architects' and surveyors' fees and local authority requirements?
If the sum insured is produced from index-linking (or index-linking has been suspended), has anything been done to the property to increase figures?	If so, on what basis is any additional sum insured to be assessed?
Contents – sum insured or percentage of buildings sum insured?	Basis of assessment – is it an estimate or has a full inventory been taken?
Values and limits	
Actual total of valuables?	Insurers' limits vary but are normally expressed as a percentage of contents sum insured.
Actual total value of television, personal computer, audio and video equipment, photographic equipment, works of art, curios and collections?	Insurers' limits vary but are normally expressed as a percentage of contents sum insured.
Maximum value of a single item of valuables?	Limits vary widely.
Contents in the open – likely maximum	Some insurers restrict amount covered while others have no specific restriction.
Contents in outbuildings – single building	Some insurers restrict to a percentage of contents sum insured – others have no specific restriction.
Money limit	Insurers' limits vary and the adviser should check the limit required by the consumer. If a consumer seeks an unusually high limit, this will prompt the adviser to ask if business money is kept in the home. Household policies exclude money that is held for business purposes.

We have not considered every possible limit, as it is highly unlikely that other policy limitations would be significant in decision-making. However, those in Table 3.3 are suggested as a basis for establishing the best fit with insurers' standard policies and the limits they offer.

Just think

Would our sample consumers Frank and Susan's responses to any of the questions in Table 3.3 require further investigation on your part as an adviser?

This part of the information gathering process may also reveal important features that may point towards a particular insurer's product. For example, if the homeowner is affluent, they may require a tailored policy to meet their particular insurance needs. In Frank and Susan's case, their particular sums insured and valuations would need to be fully explored.

Finally, Table 3.4 has questions that reflect particular features of policy cover in an attempt to highlight significant divergences of approach.

Table 3.4 Questions to ask a consumer relating to specific features

Key information	Reason for question/effect on advice given
Cover eligibility	
How long could unoccupancy last?	Insurers' limits vary from 30 to 60 days for eligibility for a variety of perils.
Details of home working	Not all insurers are prepared to insure business equipment.
Is B&B offered?	Insurers' attitudes vary according to cover restrictions and whether this is permitted.
Details of any trampolines or inflatables	These carry limitations or exclusions under some insurers' policies for personal liability.
Details of spas, hot tubs and swimming pools	These carry limitations under some insurers' personal liability sections if manufacturer's recommendations are not followed.

Just think

Would our sample consumers Frank and Susan's responses to any of the questions in Table 3.4 require further investigation on your part as an adviser?

Once again, the answers to these questions may reveal important features that point towards a particular insurer's product. For example, if B&B is offered, the consumer may require a tailored policy to meet their particular insurance needs. In Frank and Susan's case, details of Susan's childminding activities and the unoccupancy of the holiday home would be relevant.

Insurers' questions must be in plain and clear language, on a durable medium and result in all relevant information being gathered. Under the **Consumer Insurance Contracts Act 2019**, there is no requirement on a consumer to disclose any information not specifically requested by the insurer. There is a duty on the consumer to answer questions honestly and with reasonable care. Any failure by an insurer/adviser to further investigate an incomplete answer could result in the insurer waiving its right to further disclosure from the consumer. The insurance principle of utmost good faith still applies for non-consumer proposers.

C1 No claims discount

Typically, insurers offer no claims discounts (NCD) for successive claim-free years on a household insurance policy. For example, 10% for 1 year, 20% for 2 years, 30% for 3 years, 40% for 4 years and a maximum of 50% for 5 years of claim free insurance. The scale that insurers use differs with some offering 20% for 1 year claim free.

Insurers offer these discounts to encourage the loyalty of their policyholders who represent the better-performing risks they insure. Up until recently, household insurance scales of discount would reduce to 'nil' if a claim was paid, regardless of the number of previous claim-free years and there was no option to purchase a protected NCD. However, due to competition in the household insurance market, some of the main insurers are now offering step-back or protected NCDs (see Chapter 2E).

When recommending a change of insurer to a consumer, an adviser needs to establish how the consumer's NCD may be affected, and compare true net premiums. There is no guarantee of any transfer of NCD as some insurers do not allow an NCD on their home insurance products.

D Summary

In this chapter we looked at household policy definitions and the methods used to establish accurate sums insured. We outlined the range of questions the adviser must consider when gathering information from a household insurance consumer. We also highlighted the difference between advising on standard risks (e.g. normal, owner-occupied dwellings) and non-standard risks (e.g. premises that are non-standard due to the type of construction, the nature of their use or occupancy) and how the advice required may vary.

D1 What's next?

In Chapter 4 we'll consider the scope of cover provided in a household insurance policy.

D2 Study tips

It's important to remember that this textbook is the primary information source for this module. All the questions in your exam will relate directly to information featured in the textbook. Use the 'End of chapter questions', 'Quick questions' and the 'Sample multiple-choice questions' to quickly test what you've learned so far. Make a note of any topics/areas you need to improve in and keep it to hand so you can refer to it when you revise this chapter again before your exam.

In addition to the textbook, your Member Area has many online study supports that can help you as you study this module.

D3 Online learning supports

Your Member Area includes a learning plan, an automated study planner, an exam countdown timer and study tips guide. These study supports are invaluable in reinforcing what you have learned from the textbook so far. The webinars, chapter-by-chapter key points and other supports will help you to break down the chapter content when revising.

Completing online mock exams and reviewing the personalised feedback that follows is a great way of testing your knowledge and preparing for exam day.

To access these online study supports, just log into your Member Area on www.iii.ie and click on the **Connect** logo.

End of chapter questions

Use these questions to test your understanding of what we've covered in Chapter 3.

1. Certain risk types, or aspects of risks, benefit from the adviser obtaining additional information before they search for a product in the insurance market. List four examples of situations that will prompt this fuller presentation.

2. State why a standard/off-the-shelf homeowner's policy may not fully meet the needs of an affluent homeowner.

3. Give a definition of 'buildings' that might be found in a typical household policy.

4. List the other items that are treated as 'buildings' under a household policy, apart from the main building of the home.

5. Explain the difficulty in defining the term 'standard construction'.

6. Explain why it is important for an insurer to identify risks that do not meet its 'standard construction' requirements.

7. Define 'unoccupied' in the context of a household policy.

8. Give a definition of 'contents' that might be found in a typical household policy.

9. Explain how a consumer can calculate the insurable values (sum insured) for their contents.

10. The specific information required from a consumer in relation to household insurance falls into three categories. Name these categories.

11. Outline how an NCD on a household policy differs to that on a motor policy.

Answers to end of chapter questions

Check your answers against those below and make a note of any points you left out. This will highlight the sections you may need to look at more closely during your revision.

1. Examples of the risk types that benefit from a 'fuller presentation' to the market are:
   - non-standard construction (bearing in mind different insurers' definitions)
   - high-hazard areas, e.g. homes built on reclaimed land or known flood plains
   - purpose-built blocks of flats
   - let property/property owners
   - overseas property
   - accommodation linked to commercial premises, e.g. a flat in an industrial outlet, with no fire separation
   - holiday homes
   - unoccupied properties
   - mobile homes
   - listed buildings
   - affluent homeowners'
   - unusually high frequency of claims
   - remote location
   - guesthouse/B&B.

2. Affluent homeowners frequently possess high-value personal possessions, e.g. artworks, china/silverware, extensive wine cellars, jewellery, antiques and possibly firearms (shotguns/sporting guns). They may also employ domestic staff such as chauffeurs, cooks, grounds staff, security or cleaners. Standard homeowners' products may not fully cater for these aspects.

3. Definition of buildings: 'The home and its domestic outbuildings, garages, greenhouses, sanitary fixtures, swimming pools, tennis courts, patios, terraces, drives, footpaths, walls, gates, fences; hedges under 2 metres high; aerials, satellites and their fittings and masts; solar panels and heat exchange units securely attached to the roof of the building, including landlord's fixtures and fittings to the building; fitted wooden or laminated flooring; kitchen, bathroom or bedroom units and their integrated appliances all on the same site'.

4. Apart from the main building of the home ,'Buildings' under a household policy include outbuildings, sheds, walls, gates, fences, swimming pools and pathways, and, in addition, landlord's fixtures and fittings.

5. The difficulty in defining the term 'standard construction' arises from the fact that each insurer defines it differently and requires different assurances from the consumer about its own defined non-standard elements.

6. In setting rates, insurers assume the fabric of the building to be incombustible and reasonably substantial in nature. Anything that falls short of this standard requires careful consideration. For example, flimsy construction (timber walls) or corrugated or plastic roofing will impact not only on the fire peril but also on theft, storm and flood.

7. ‘Unoccupied’ is defined in the household policy as ‘not lived in by a member of your household or any other person authorised by you’.

8. In a typical household policy, ‘contents’ could be defined as household goods, personal belongings and valuables (including personal money up to the limit shown in the schedule) within your home, which you or any member of your household own, or for which you are responsible.

9. The basis for setting the sum insured on contents should be the full cost of replacing the contents, as new, after allowing for deterioration on items not covered on a ‘new for old’ basis (usually clothing, household linen and furs). For owner-occupiers, there are variations in the method of arriving at a sum insured. Insurers tend to offer two different approaches:

   - The sum insured is selected by the consumer.
   - The insurer offers a choice of contents sums insured that represent a percentage of the buildings sum insured.

   Ideally, a consumer should use a room-by-room approach, valuing the replacement cost of the contents of each room.

10. The specific information required from a consumer in relation to household insurance falls into three categories:

    1. the home, its situation, location and construction
    2. the cover, sums insured and limits required
    3. specific questions prompted by different insurers’ approaches to cover (particularly the wording of their exclusions).

11. The differences between an NCD on a household policy and on a motor policy are as follows:

    - Not all insurance companies allow an NCD on their home insurance products; as a result, it may not be transferable when switching from one insurer to another.
    - Unlike with most motor insurers, not all household insurers offer ‘protected’ or ‘step-back’ NCDs and in these situations, following a claim on the policy, the NCD will revert to zero at the next policy renewal.

Answers to quick questions

1. Insurers may want further details of Susan's childminding activities. For example, are any renovations required to be compliant with the relevant regulations? Is it likely that the activity will increase and lead to a more 'commercial operation'? Insurers may or may not apply special terms to the policy as a result. Indeed, some may decline the risk as the 'business' falls outside the 'office business use' usually allowed.

2. A thatched roof clearly presents a greater risk than 'standard' construction. Most insurers will decline to quote for this risk. Insurers who will consider this risk will wish to satisfy themselves about maintenance of the roof, heating arrangements and the standard of upkeep generally (and how recently it was rethatched). It is usual to charge a substantially higher premium, and the insurer may require fire extinguishing appliances to be available for use.

3. Under a household insurance policy, the term 'home' usually refers to the 'buildings and the land, within the boundaries belonging to them', while the term 'buildings' refers to 'the home, landlord's fixtures and fittings on or in the home, walls, gates, fences, hedges, terraces, patios, drives, paths, tennis hard courts and swimming pools, all at the situation of the premises shown in the schedule'. In differentiating between what is and is not classed as 'buildings' under a household policy, as a rule of thumb, anything that the policyholder would normally leave behind when moving from a house can generally be regarded as part of the building, e.g. fitted kitchens, sanitary ware, integrated appliances and double-glazing.

4. As an adviser you can explain how to use the SCSI guide to calculate the buildings sum insured using the square footage of the Dublin property, the detached house and garage. The same principles will apply to calculating the buildings sum insured for the holiday home. However, note that the SCSI guide valuations differ depending on geographical location and the holiday home is in Co. Clare. The adviser can pose questions about costs in relation to items such as fitted kitchens, flooring, and wardrobes. They should also draw attention to allocating a cost for architects' and surveyors' fees and the removal of debris. However, it is important to note that the onus is on Frank and Susan to determine the buildings sum insured.

5. It is not advisable to use the market value as a basis for setting the buildings sum insured, as the market value includes the site/land, which is not relevant for calculating rebuilding costs. Other factors that affect market price are the economy, supply/demand and, of course, location. It is the rebuilding costs that should be used as a basis for setting the buildings sum insured.

6. Conor might have found cash, cheques, postal orders, bank drafts, travel tickets, savings stamps and certificates, premium bonds, current postage stamps, gift tokens, luncheon vouchers, trading stamps and telephone call cards in his wallet.

7. As an adviser, you can explain the benefit of using an inventory to the consumer firstly by pointing out that a different method of calculation must be used for general household items and those where 'wear and tear' is to be taken into account. Secondly, the adviser can remind the consumer of some of the areas easily overlooked when setting the sum insured (e.g. deep freezer contents and ornaments). Finally, it might be helpful to highlight the dramatic effect on a claims settlement if there is underinsurance at the time of a claim.

Sample multiple-choice questions

1. When a consumer is completing a household insurance proposal form they will typically be asked to confirm that they have a **minimum** of how many smoke detectors fitted?

   A. 1

   B. 2

   C. 3

   D. 4

   Your answer:

   ☐

2. A fitted kitchen is classed under the definition of a 'building' rather than 'contents' under a household buildings and contents policy because:

   A. the insured would normally leave it behind when moving house

   B. the insured actively uses this on a daily basis

   C. it is defined as a household good rather than a personal effect

   D. it is a permanent structure that cannot be moved

   Your answer:

   ☐

3. Conor has a household buildings and contents policy with XYZ Insurance. His contents sum insured is €100,000. Any one high-value item is covered, for no more than 10% of the contents sum insured, and the total value of these items combined is covered for no more than 33%. Following a theft at Conor's home, he submits a claim for a number of items of jewellery that were stolen. The total value of the items stolen is €24,000. This includes an engagement ring valued at €12,000. Assuming the claim is valid, how much will Conor receive from XYZ?

   A. €12,000

   B. €16,000

   C. €22,000

   D. €24,000

   Your answer:

   ☐

Answers to sample multiple-choice questions

Question 1

Chapter reference: Chapter 3C

Question type: K

Correct response: B

Learning outcome: Explain the questions that will encourage consumers to disclose the necessary material information to enable advisers to provide them with the most appropriate household insurance product.

Question 2

Chapter reference: Chapter 3A3

Question type: U

Correct response: A

Learning outcome: Explain the scope of, and variations in, definitions used in household insurance and demonstrate the means of establishing accurate sums insured under household policies.

Question 3

Chapter reference: Chapter 3B1

Question type: A

Correct response: C

Learning outcome: Explain the scope of, and variations in, definitions used in household insurance and demonstrate the means of establishing accurate sums insured under household policies.

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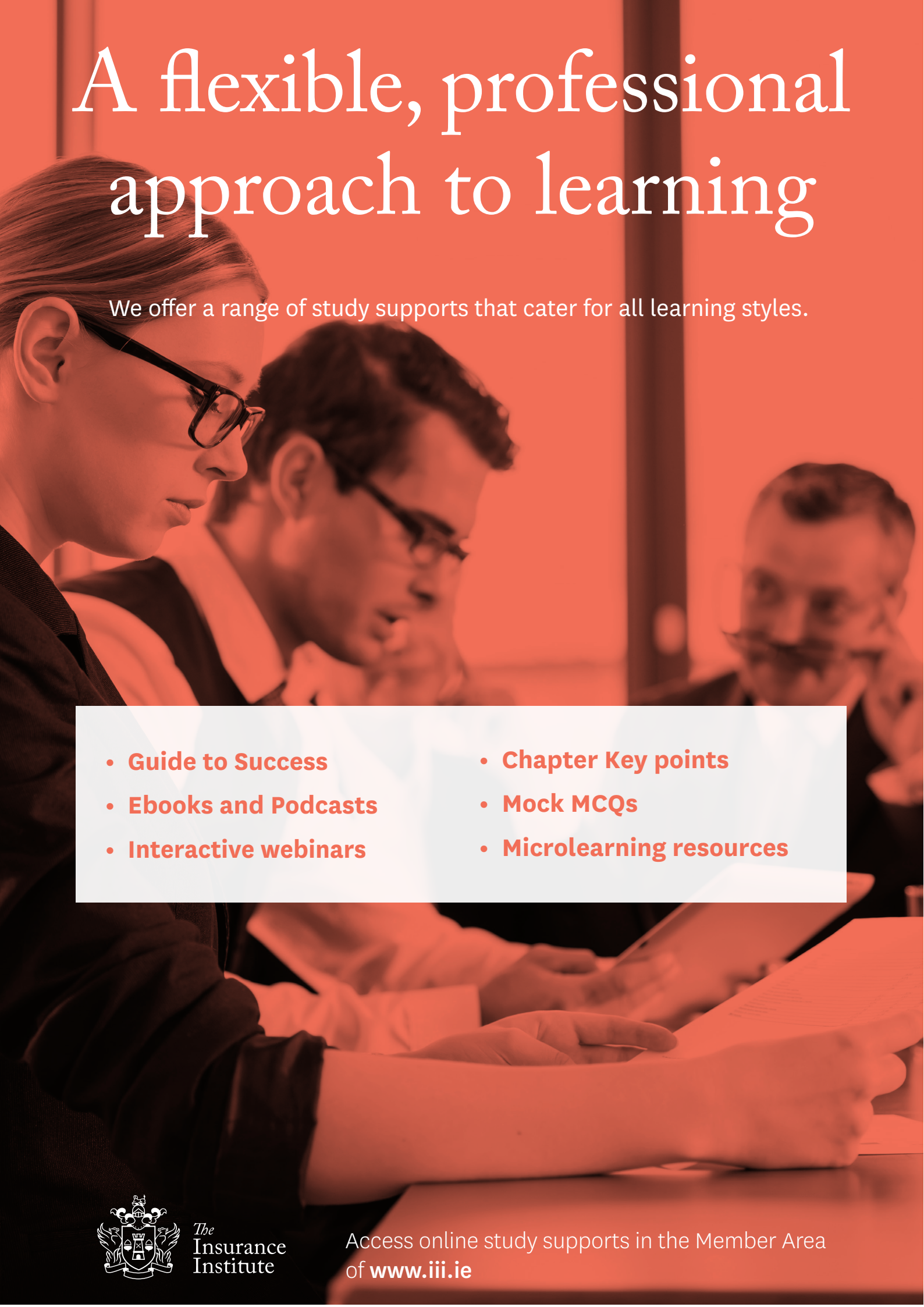

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Chapter

4

Household insurances

What to expect in this chapter

The aim of this chapter is to familiarise you with the household insurance product offerings available in the market. As noted in Chapter 3, there is no such thing as a 'standard' household policy. There are minor variations of cover under each insurer's policy and wordings vary. In this chapter we'll look at the basic cover most frequently provided by a household buildings and contents insurance policy. We'll also consider the optional extensions that may be available and explain the implications of the policy exclusions.

> Remember that the monetary values referred to (e.g. in relation to sums insured, policy limits or excesses) and policy wordings are for guidance only. They should not be taken as applying universally across the market.

As you work your way through this chapter, you should refer to other policy wordings to see how they compare and how they would affect the cover provided to the consumer. Remember also our sample consumers Frank and Susan and how these policies would meet their household insurance needs.

Learning outcomes for this chapter

Section	Title	At the end of each section you should be able to:
A	**Perils insured under a household buildings and contents insurance policy**	Describe and apply the scope and limitations of different household buildings and contents insurance covers and standard options available.
B	**Additional cover and benefits automatically included**	
C	**Optional extensions**	
D	**General household exclusions**	
E	**Specialist insurance policies**	Outline the scope and limitations of different specialist insurance policies.

A

Perils insured under a household buildings and contents insurance policy

Household buildings and contents are normally insured against damage caused by the 14 events or 'perils' listed in Table 4.1. The scope of cover and the exclusions applying to each of these perils are outlined in this section.

It is very important for students to memorise and understand all of these perils as they are an essential part of your study and exam preparation.

Insurers have sought to develop their own particular style and mix of perils, and even within a single insurance company different options will be available for different products. Nevertheless, as we compare market products we will find many common characteristics. There are some areas where practice differs significantly and advisers must be aware of these variations.

Table 4.1 Household building and contents cover

Perils and events normally included:

1. fire, smoke, lightning, explosion, (or thunderbolt) and earthquake
2. storm and flood
3. freezing/burst pipes
4. subsidence, landslip or ground heave
5. theft or attempted theft
6. riot, civil commotion, strikes, labour or political disturbance
7. vandalism and malicious damage
8. escape of water
9. leakage of oil
10. impact or collision
11. falling trees or branches
12. falling or breakage of aerials/aerial fittings/satellite dishes/masts
13. accidental damage
14. liability cover.

We will now look at each of these perils in turn. It should be noted that each peril may have exclusions that are specific to it alone. What is excluded under one peril may be covered under another. For example, frost damage is excluded under the peril of 'storm and flood' but some aspects of frost damage are insured under the peril of 'freezing/burst pipes'.

Cover under a household policy is normally subject to a standard excess of between €250 and €350 for each incident of loss or damage. However, some sections of the policy may have a higher excess. Where this is the case, we have noted the excess likely to apply for a claim under that particular section. It is important to note that only one excess applies per claim, regardless of the number of policy sections that contribute to the payment. The excess applicable will depend on the section of the policy the claim is being made under. Where multiple sections contributed to the payment, the proximate cause of the loss will usually dictate the excess to be applied. See Example 4.1.

Example 4.1

Audrey's household buildings and contents policy has an excess of €250 on theft claims and an excess of €350 on malicious damage claims. Intruders break into her home, steal some personal property and also vandalise the walls with graffiti. Audrey's insurer will apply the theft excess of €250 to the entire claim, as the proximate cause of the loss and damage was 'theft'.

Contents cover can be sold separately (from the main insurance policy on a property) to tenants as their contents are not usually insured under the owner/landlord's main household building and contents policy.

Most household policies will apply some restrictions to cover where a property remains unfurnished or unoccupied for more than a specified number of consecutive days. For example, if a house is left unoccupied for more than the specified number of consecutive days, cover will not be provided for damage caused by certain perils e.g.:

- theft or attempted theft
- vandalism
- escape of water from, or the bursting of, any fixed domestic water or heating installation
- escape of oil from any fixed domestic heating installation
- accidental breakage of fixed glass in windows, doors or roofs, or fixed sanitary ware in the home.

Other policies may restrict the policy to fire-only cover. The exact period varies from one policy to another and is typically between 30 and 90 days. Some insurers reduce the time limit to 14 days for let properties. However, despite this restriction, public liability cover is not affected and this cover is maintained subject to any conditions imposed, e.g. property properly maintained, regular checks on the property.

Quick question 1

Why do you think there are no standardised wordings for household policies in the market?

The answer is at the end of this chapter.

A1 Fire, smoke, lightning, explosion (or thunderbolt) and earthquake

All loss or damage resulting from fire, smoke, lightning, explosion, thunderbolt and earthquake is covered under this section.

Exclusions under this section include:

- smoke damage caused by fireplaces
- smoke damage from agricultural or industrial operations
- fires deliberately caused by or on behalf of the policyholder.

A2 Storm and flood

This section of the policy indemnifies the policyholder for loss or damage as a result of storm or flood.

The frequency and cost of weather-related events in recent years and improvements in flood mapping has resulted in several insurers being reluctant to cover flood risks for properties located in areas that are particularly prone to such damage. Insurers have also increased the flood damage excess to multiples of the standard excess; for example, if the standard excess is €250, then the flood excess could be €500 or even €1,000.

Insurers normally exclude loss or damage caused:

- by frost, subsidence, **ground heave** or **landslip** (each of these is covered under a separate policy section)
- to gates, fences or hedges
- by wear and tear or gradual deterioration.

A3 Freezing/burst pipes

Frost damage that causes a burst pipe is covered under a standard household policy. All resultant damage (i.e. water damage) is also covered under the policy, but damage to the apparatus itself (i.e. the pipe) is not covered.

Cover under this section often operates in tandem with cover under the **trace and access** section (see Section B1d).

Some insurers impose a higher excess of up to €1,000 to this peril.

Just think

After a pipe bursts, the water causes two worn exposed electrical wires to spark and a fire ensues. Is there cover and if so under what section?

Both the fire and water damage are covered by the policy and generally the insurer will settle the total loss under the fire section. However, account must also be taken of the exact cause of the damage and whether there are other policies in force.

A4 Subsidence, landslip or ground heave

Insurers normally exclude loss or damage:

- caused by **settlement**
- caused by building on made-up ground or filled-in land
- to walls, gates, fences, hedges, terraces, patios, drives, paths and tennis hard courts, unless the policy covers damage to the home from the same cause occurring at the same time
- to solid floors unless the foundations beneath the walls are damaged at the same time by the same cause
- to the contents, unless the policy covers damage to the home from the same cause, occurring at the same time
- caused by subsidence or ground heave, but arising prior to the period of insurance in which a claim may arise

ground heave

movement occurring when ground that has previously had a low moisture content suddenly absorbs moisture

landslip

'a rapid downward movement under the influence of gravity, of a mass of rock or earth on a slope' – *Oddy v Phoenix Assurance Co. Ltd* (1966)

trace and access

risk covered under a household policy that pays for tracing the source of water (and oil) leakage, payment for which may or may not be linked to perils otherwise insured under the policy (wordings vary)

Quick question 2

The decorative patio in your garden appears to have subsided over a number of months. A full inspection reveals that subsidence is indeed the cause. Is this covered under your household buildings policy?

settlement

common occurrence in new builds where the ground compacts beneath the foundations to accommodate the pressure of the new property

- or destruction, if any part of the buildings suffered previous damage by this peril, unless the previous damage has been disclosed to, and accepted by, the insurer
- arising from faulty workmanship, faulty design, faulty or poor drainage or using faulty materials.

Cover is subject to a large excess, which may be a fixed monetary amount (e.g. €2,500) or a percentage of the full rebuilding cost of all the buildings at the date the claim is notified (e.g. 3%).

A5 Theft or attempted theft (stealing or attempted stealing)

There is no requirement under the household policy for physical or forcible entry to, or exit from, the premises to have occurred. However, some household insurers are starting to apply this restriction, in an attempt to reduce their exposure and encourage home safety awareness.

Insurers normally exclude loss or damage caused:

- while part of the home is lent, let or sublet, unless entry to, or exit from, the home is made by violence and force
- by a member of the household (e.g. a child taking money from a parent's wallet), other than domestic staff.

Quick question 3

Lead flashing is stolen from your roof while you and your family are away for the weekend. Can you claim under the buildings section of the policy?

A6 Riot, civil commotion, strikes, labour or political disturbance

Loss or damage resulting from riot, civil commotion, strikes, labour or political disturbance is covered under this section.

Cover normally excludes loss or damage to:

- boundary walls and hedges
- tennis courts and pools
- gates and fences
- driveways
- lawns and trees, shrubs, plants.

A7 Vandalism and malicious damage

Damage caused by someone lawfully on the premises (e.g. tenants) is not normally insured.

A8 Escape of water

This covers damage resulting from the escape of water from:

- any fixed domestic water or heating installation (or the bursting of same)
- any washing machine, dishwasher, refrigerator, freezer or fixed fish tank.

Typically damage to the actual component or appliance is not covered. Neither is damage to walls, ceilings or tiles by gradual ingress or seepage of water from shower units, baths, tile grouting or seals.

Some insurers impose a higher excess to this peril ranging between €500 and €1,000.

A9 Leakage of oil

This covers the policyholder for all **material damage** or (property) losses as a result of the leakage of oil. This section is usually subject to a limit of approximately €750. Any legal liability arising as a result of escape of oil is covered under the liability section of the policy.

material damage

physical loss or damage to property

A10 Impact or collision

This covers collision or impact, by any aircraft, other aerial devices (or articles dropped from them), road or rail vehicles.

Policies normally exclude damage to buildings or contents caused by animals.

A11 Falling trees or branches

This section of the policy indemnifies the policyholder for loss or damage caused by falling trees or branches. The cost of removing any fallen trees or branches that have caused damage to the buildings is also insured.

Policies normally exclude:

- damage to gates, fences or hedges
- the cost of replacing the tree(s).

A12 Falling or breakage of aerials/aerial fittings/ satellite dishes/masts

This covers damage due to falling aerials, aerial fittings, satellite dishes, television/ radio aerials or masts. Damage to the equipment itself is usually limited to a specified amount (typically €700–€1,000).

A13 Accidental damage

This covers damage to buildings and contents at the insured premises, unless specifically excluded. The main exclusions relate to:

- damage caused by the policyholder's pets
- damage while the home or any part of the home is lent, let or sublet
- jewellery, watches, furs, contact lenses, hearing aids, items of a brittle nature (e.g. glass, china, porcelain, earthenware), mobile phones or computer equipment designed to be portable, while it is being transported, carried or moved (unless the loss or damage occurs within the property insured)
- any loss or damage or amount shown as not insured under the various perils listed in Sections A1-12.

Some insurers automatically provide accidental damage cover in the buildings section of a policy. However, most give the policyholder the option of choosing standard perils or accidental damage cover for both buildings and contents. If accidental damage cover is selected, then a higher premium will be charged.

Table 4.2 shows some situations in which a claim for accidental damage might arise.

Table 4.2 How an accidental damage claim could arise

- The policyholder is working in the attic and accidentally puts their foot through the attic floor/house ceiling (buildings).
- The policyholder knocks over a can of paint and damages the carpet (contents).
- The policyholder's son accidentally knocks over a television (contents).

A14 Liability cover

In addition to covering damage to the home and its contents, household policies also provide liability cover for the insured and members of their household.

Cover under a buildings policy (or the buildings section of a combined policy) relates to the insured's responsibilities as a property owner. It can typically provide 'owners liability to the public' for which the owner becomes legally liable to pay in respect of accident bodily injury, death, disease or illness of any person arising solely as **owner** (but not occupier) of the building. Typically cover excludes liability related to any members of the household.

Cover under a contents policy relates to their liability as an **occupier** (but not owner), employer of household staff and as a private individual.

limit of indemnity

insurer's maximum liability for any one incident/claim (usually under the terms of a liability policy or section of a policy)

Liability cover provides protection in situations where the policyholder (or a member of their household) may be legally responsible for an injury to a third party or damage to their property. Cover is restricted to liabilities connected with the insured's ownership or occupation of the home, and their activities as a private individual.

For all policy sections, the most that will be paid for any claim or claims arising from one event usually varies between €1.3 million and €3 million (depending on the insurer and the policy). This maximum amount is referred to as a **limit of indemnity**. A much lower limit applies to tenants' liability than to landlords.

Table 4.3 shows some of the situations in which a liability claim could arise and areas of the policy under which the claims will be considered.

Table 4.3 How a liability claim might arise

Circumstances	Policy section
An old tree in the policyholder's garden falls on a neighbour's garage.	Owner's liability (buildings)
The insured's childminder trips on a torn carpet and breaks her wrist, while looking after the insured's children.	Liability to household employees (contents)
The insured's dog bites the delivery driver.	Public liability/personal liability (contents)
The insured's daughter accidentally breaks a car windscreen while playing tennis in a local park.	Public liability/personal liability (contents)

Where a property is rented, the liability for the property remains the responsibility of the landlord/property owner. Tenants are responsible for their own liabilities and must arrange their own insurance policy. Where tenants have their own contents insured, the liability cover is included on the policy.

Using Table 4.3, if the property owner's dog bites a delivery driver, then the property owner's liability insurer will deal with any claim. However, if a tenant's dog bites a delivery driver, then the tenant's insurer will deal with the claim. The property owner's insurer is not responsible for the claim, as the property owner is not responsible for the behaviour of their tenant's animals.

B Additional cover and benefits automatically included

The following covers and benefits are normally included as standard under a typical household buildings and contents policy. We have significantly abbreviated the features and variations.

The adviser must be aware of the full scope of cover and the areas where there is significant market variation. Unless otherwise stated, the normal policy excess applies to each of these sections.

B1 Additional cover and benefits under the buildings section

Household buildings policies also contain a number of clauses that extend the protection provided by the main perils listed in the policy. We will consider the main additional covers and benefits next.

B1a Accidental breakage of fixed glass or sanitary fittings

Accidental breakage of sanitary ware and fixed glass in windows, doors and solar panels is insured under this benefit. It also includes accidental damage to plate-glass tops, fixed glass in furniture, glass shelves, ceramic hobs and mirrors, if such elements are in fixed items that normally form part of the buildings.

Typically, damage caused by vandals or malicious people lawfully on the premises (e.g. tenants or friends of tenants) is not insured under this policy section.

B1b Accidental damage to pipes and cables

Accidental damage to cables, underground pipes, or underground tanks servicing the home is insured under this benefit. This cover applies under both standard and accidental damage policies.

B1c Architect, surveyor, legal and other fees and associated costs

Costs necessarily incurred following damage by an insured event (provided adequate provision has been included in the buildings sum insured) include:

- architect, surveyor and legal fees
- the cost of shoring up, demolishing or dismantling any part of the buildings, and removing rubble/debris
- the cost of meeting current building regulations relating to the damaged portion of the building.

Fees incurred in the preparation of a claim are excluded under the policy.

B1d Trace and access

In the event of damage by water (or oil) leaking from any tank, apparatus or pipe, the policyholder may need to trace and access the source of the damage before repairs can commence. Some insurers will cover the policyholder for costs necessarily and reasonably incurred in locating the source of the damage. Depending on the cause of the loss, the cost of the actual repairs may be covered.

When this cover is provided, either an increased excess may apply or the insurer may limit its exposure to a maximum amount (usually €650–€2,000) under this section.

B1e Fire brigade charges

Fire brigade charges relating to the controlling or extinguishing of a fire that is affecting (or threatening to affect) the building are covered, provided that the circumstances that gave rise to the fire are covered under the policy. The maximum amount some insurers in the Irish market will pay for cover of this nature, for buildings and/or contents, typically ranges between €2,000 and €3,000.

Example 4.2 outlines a situation where the insurer would not reimburse the policyholder for these charges.

Example 4.2

Paul receives a bill from his local fire brigade charging him a fee of €750 relating to a call-out to Dun Laoghaire harbour to rescue the family labrador who fell into the sea and got into difficulties while chasing seagulls. Paul and his family were very grateful for the rescue operation and submitted a claim under their household insurance policy for the fire brigade charges.

The insurer rejected the claim as the policy only covers fire brigade charges relating to the controlling or putting out of a fire caused by an insured risk. Therefore, Paul has to pay the fire brigade charge himself.

B1f Rent/alternative accommodation

If the home is made uninhabitable due to damage, from any cause insured by the buildings and/or contents sections of a policy, the insurer will normally pay for:

- rent receivable by the policyholder
- rent payable by the policyholder
- the reasonable extra cost of comparable alternative accommodation
- the reasonable cost of temporary storage of furniture.

The most an insurer will typically pay under this policy section is approximately 15–20% of the buildings/contents sums insured.

Example 4.3 illustrates some of the additional covers provided under the buildings section of the household insurance policy in practice.

Example 4.3

Killian insures his home but it is totally destroyed by fire. Once the fire brigade has left the site, the first action he takes is to arrange alternative accommodation. He is aware that this is covered under his policy and that he must look for comparable accommodation.

After he has arranged his accommodation, Killian begins to consider reinstating his home. He visits the site and sees that there is a huge amount of debris and acknowledges that his only option is to hire a JCB and a driver. On top of these hiring charges, there is the cost of the disposal of the debris.

Some insurers restrict debris removal to 10% of the buildings sum insured but most advisers would not consider this significant, as any higher sum would be truly exceptional in practice. Cover provided for the cost of alternative accommodation can range from 15-20% of buildings and contents sum insured. Fire brigade charges are restricted to costs only where a valid claim exists.

B1g Selling your home

If the policyholder is selling their home, the insurer will provide indemnity to the buyer up to the date the contract is completed, unless they have arranged their own insurance. The buyer must keep to the terms and conditions of the policy.

Just think

Check a sample household insurance policy and see what cover is provided for:

- alternative accommodation following a fire
- storm damage to the roof after the house has been unoccupied for 60 days (may vary)
- trace and access.

B1h Title deeds

If the original title deeds to the property are lost or damaged by a cause insured under the perils 1-12 (listed in Section A), while in the home or while kept in the policyholder's bank for safe-keeping, the cost of preparing new title deeds is covered. The most an insurer will pay is approximately €1,300. Any loss, damage, or amount shown as not insured under perils 1-12 of Section A is not covered.

B1i Door lock replacement

The cost of replacing and fitting outside door locks to the home, if the keys of such locks are stolen, following a break-in or following an assault on the policyholder or a member of their household, is typically covered. The maximum amount some insurers in the Irish market will pay typically ranges between €650 and €1,200. The cost of replacing or fitting locks will not be covered if the keys were lost by the policyholder.

Just think

Consider the additional cover and benefits under the buildings section that would be of particular interest to Frank and Susan (sample consumers).

The additional cover and benefits under the buildings section that would be of particular interest to Frank and Susan are:

- trace and access in the event of burst pipes/leaks
- fire brigade charges in the event of a fire or call-out
- alternative accommodation
- door lock replacements
- architect, surveyor and legal fees and associated costs for rebuilding after a fire.

B2 Additional cover and benefits under the contents section

This section outlines the additional protection provided for contents under household policies.

B2a Accidental breakage of mirrors or glass

Accidental breakage (occurring in the home) of mirrors, plate-glass tops to furniture, fixed glass in furniture (e.g. coffee table) or ceramic hobs is covered.

B2b Accidental damage to audio/entertainment equipment

All household policies cover accidental damage (occurring in the home), to radios, televisions (including satellite decoding equipment), other audio or video equipment and computer equipment, up to a limit of €1,300-€2,000.

B2c Personal money

This covers accidental loss of, or damage to, money belonging to the policyholder or a member of their family, anywhere in the world, for an amount in the region of €400-€2,000.

A lower excess of €50–€100 usually applies to loss or damage under this section. Most insurers do not charge an extra premium for money and credit cards cover.

Example 4.4 outlines a situation where money kept in the home would not be covered under a household policy.

Example 4.4

When Dympna arrives at the bank with the office bank lodgement, it is already closed. She takes the money home, planning to lodge it first thing in the morning. The following morning, she discovers the money is missing, presumed stolen. She notifies the Gardaí immediately as per her household policy conditions and rings her insurer to report the loss. Unfortunately, Dympna is advised that the loss is not covered as this is not personal money and is therefore not covered by her household policy.

B2d Credit cards

Household policies usually cover financial loss following unauthorised use of credit cards belonging to the policyholder or a member of their family. The limit of indemnity is approximately €650-€1,500.

B2e Freezer or refrigerator contents

This usually covers deterioration of food or drink caused by:

- a change in temperature of the freezer or refrigerator in the home
- contamination by accidental escape of refrigerant or refrigerant fluids.

Cover tends to be on a strictly indemnity basis, with the insurer paying for the cost of replacing food and drink unfit for human consumption typically within a range between €500 and €1,000 (see Example 4.5).

Example 4.5

Mary makes a frozen food claim under her policy for €400. The policy limit for this cover is €600. The insurer issues a cheque and reinstates the sum insured. Three months later, Mary's frozen food is damaged by an insured peril and the loss is estimated at €450. As the sum insured has been reinstated, Mary can claim for the full amount of this latest loss (less the policy excess). If the sum insured had not been reinstated, the most Mary could have recovered would have been €200, as the original limit would have reduced by the amount of the earlier claim.

B2f Contents temporarily removed

The contents are insured within the geographic limits stated in the policy, while temporarily removed from the premises, against the loss or damage caused by:

- the perils numbered 1–3 and 5–12 in Section A
- theft or attempted theft.

There is usually a monetary limit on the insurer's liability under such a clause, e.g. 15% of the contents sum insured.

B2g Removal by professional furniture removers

Accidental loss or accidental damage to the contents is covered while a) they are being moved by professional furniture removers to the policyholder's new home (within the geographic limits) or b) while in temporary storage (up to 7 days in a furniture depository).

B2h Leakages

Following accidental damage to the domestic water or heating installation, the following losses are covered:

- oil from a domestic heating installation
- metered water.

Loss of central heating oil is usually insured up to a value of €650. The cost of trace and access is also provided under most policies and some insurers will provide an element of cover to repair or replace the damaged heating unit, usually up to a set limit (e.g. €750) or for units no older than a set age (e.g. 6 years). Loss or damage due to wear and tear, rust or gradual deterioration of any water/oil apparatus or installation is not covered. Furthermore, cover will not be provided where the property is unoccupied for more than the specified number of days.

B2i Title deeds

As outlined in Section B1h, this benefit is provided under both the buildings and contents sections of a household policy.

B2j Fatal injury/compensation for death

This covers fatal injury to the policyholder and/or their spouse or partner as a direct result of:

- fire, accident or assault in the premises
- an accident while travelling within the geographical limits as a fare-paying passenger in any road or rail vehicle
- assault in the street, within the geographical limits, provided death follows within 12 months of the injury.

The maximum amount payable by an insurer in respect of any one incident varies considerably. Some insurers provide benefits of €3,250 with others providing €30,000. It should be noted that not all insurers provide this extension.

B2k Extra contents cover at Christmas

Some insurers will typically increase the contents sum insured by 10% for the months of December and January to provide cover for gifts, food and drink purchased for the Christmas season.

B2l Wedding presents

The contents sum insured is automatically increased by 10% to insure wedding gifts during the period of 1 month before and 1 month after the wedding day of the policyholder or a member of their family.

B2m Contents in the open

The contents are insured while in the open, within the boundaries of the land belonging to the home, against loss or damage caused by peril 1 and perils 4-12 listed in Table 4.1. The most an insurer will pay under such a clause is approximately €650.

Generally, this extension is provided to offer a limited form of cover on garden/patio furniture. An extension may be available (for high-value households) that provides fire and malicious damage cover for trees, shrubs, plants and lawns, up to a limit of 5% of the buildings sum insured. Typically, there is a limit in the region of €1,250 for any one plant.

B2n Jury service expenses

In the event of the policyholder or their spouse serving on a jury in any law court in Ireland, some insurers will pay €25 per day to a maximum of €700 in any one period of insurance to cover expenses incurred. No excess applies to these expenses and a claim for such expenses will not affect the NCD.

B2o Visitors' and guests' property

Loss of, or damage to, the property of visitors and guests (other than paying guests) by an insured cause is included under this extension. A limit in the region of €1,000 per any one loss applies to all loss or damage to visitors' and guests' property.

Just think

Consider the additional cover and benefits under the contents section that would be of particular interest to Frank and Susan (sample consumers).

The additional cover and benefits under the contents section that would be of particular interest to Frank and Susan are:

- accidental damage to audio/electronic equipment, e.g. iPad
- leakages
- contents in the open
- contents temporarily removed
- extra contents cover at Christmas
- visitors' and guests' property
- freezer or refrigerator contents.

C Optional extensions

Some consumers may face additional risks that can be covered either by optional extensions to the household policy or as stand-alone niche or specialist policies.

Cover offered as an extension of a household insurance policy tends to provide less flexibility than would be available in a stand-alone policy. However, the household policy may still be the best option if it meets most or all of the consumer's insurance needs cost-effectively. If recommending the household policy, the adviser must inform the consumer that they will have to accept some limitations to these optional extensions, although wider cover may be available from other insurers.

Where optional extensions are included in the household policy to cover these risks, the general exclusions and conditions that apply to household policies will apply to these sections, along with their own specific exclusions.

The most common optional extensions (which can also be purchased as stand-alone policies) are outlined in this section. Section E outlines the cover provided by some of the less common and more niche specialist insurance policies.

C1 Personal possessions outside the home ('all risks')

The typical cover under a household contents policy protects the insured's possessions against loss or damage caused as a result of specific perils (or contingencies) occurring in the home. It provides very limited protection when items are temporarily moved elsewhere. Where consumers require extra cover for items they take outside the home, this is provided by 'all risks' cover.

C1a Summary of cover provided

Cover is provided for accidental loss, theft or damage to personal possessions (e.g. clothing, bags, jewellery, sports equipment) anywhere in the geographical limits, and worldwide for 30–60 days (wordings vary) in any one period of insurance. Items can be insured on a specified (the consumer must specify all items to be covered) or unspecified basis. Unspecified cover is typically limited to €1,000–€3,000 per item in value.

The scope of cover does not mean every risk is covered. It simply means that most risks are covered in most situations. The exclusions specific to this optional extension are vital in determining the exact scope of protection. However, this type of cover does not require an 'event', as such, to trigger a payment. Items that are lost and that cannot be found are covered.

C1b Main underwriting considerations

For specified items cover, a valuation certificate is usually required for items typically valued at €5,000 or more, although this amount may vary. Market practice is that valuations cannot be more than 2 years old. However, the cost of obtaining valuations can be high. A copy of the purchase receipt may be accepted as a valuation.

For unspecified items, insurers limit their exposure by applying standard limits to the value of individual possessions within the sum insured. Where the proposer wishes to insure high-value specified items, the underwriter may seek additional information regarding security precautions.

C2 Pedal cycles

Pedal cycle insurance is an 'all risks' type cover. Use is normally restricted to social/domestic/pleasure purposes, i.e. excludes use for professional purposes.

This cover is usually offered as an optional extension on a household policy but is also available as a stand-alone cover. Insuring the pedal cycle as an extension to a household policy (which is the usual practice) may not achieve the widest possible cover, therefore the insured may be advised to purchase a stand-alone policy.

C2a Summary of cover provided

Cover is provided for loss of (including theft) or damage to the pedal cycle(s), and is normally provided on a 'new for old' basis. Most insurers apply restrictions/conditions in relation to theft loss, and usually require the pedal cycle to be secured to an immovable object by a suitable/approved lock. Loss of, or damage to, pedal cycle tyres, lights or other accessories are not covered unless the pedal cycle is stolen or damaged at the same time.

Additional covers available on stand-alone products include personal accident, legal assistance, worldwide cover, competition (e.g. triathlons) or race cover and alternative bicycle rental (if the insured bicycle is damaged).

C2b Main underwriting considerations

Underwriting focuses on the storage/parking away from the home. Whether the pedal cycle will be used for extended periods abroad is also considered. Normal practice is for a pedal cycle valued over €350 to be specified on the policy on an 'all risks' basis. Some household policies have a maximum limit for pedal cycles, e.g. €1,500, while stand-alone policies may provide for more expensive models. Some insurers apply strict conditions in relation to approved locks, depending on the value of the pedal cycle i.e. the more expensive the pedal cycle, the higher quality of lock required. Proof of purchase/possession of such a lock may be a condition when making a claim.

Quick question 4

Gemma's front and rear lights were stolen from her bicycle while it was parked outside Trinity College Dublin, but her bicycle was not stolen. Under the 'pedal cycles' section of her household insurance policy, what can Gemma claim for?

C3 Caravans and mobile homes

Most insurers do not normally distinguish between caravans and mobile homes. There are two main categories of caravan/mobile home for which cover is available: touring caravans and those on fixed sites including mobile homes.

C3a Summary of cover provided

Policies cover:

- loss or damage to the structure, fixtures, fittings and equipment of the caravan/mobile home
- loss or damage to contents and personal effects while contained in or about the caravan/mobile home
- transport costs (to the nearest repairer or to the policyholder's home) following damage to the caravan/mobile home
- legal liability for third-party personal injury and damage to property in connection with the caravan/mobile home; normal limits vary between €1.3 million and €3 million.

As noted at the start of this chapter, most household policies restrict cover to fire-only if the property is unfurnished or unoccupied for more than a specified number of consecutive days – typically between 30–90 days. This unoccupancy exclusion does not apply to the caravan/mobile home section of the policy as these are normally vacant or out of use for long periods of time and the premium rate and policy wordings cater for this.

C3b Main underwriting considerations

The main considerations include the make, model, age, condition and value of the caravan or mobile home, and whether or not it is on a fixed site.

Just think

Consider the optional extensions that would be of particular interest to Frank and Susan (sample consumers).

The optional extensions that would be of particular interest to Frank and Susan would be 'all risks' cover for personal possessions outside the home, e.g. surf boards, golf clubs, jewellery (both unspecified and specified), and also pedal cycles.

D General household exclusions (applicable to all sections)

There are a number of risks/events that are not covered by household policies. These are known as general household exclusions.

Household policies do not cover:

- any event arising from war, invasion, act of foreign enemy, hostilities (whether declared or not), civil war, rebellion, revolution, insurrection, military force or coup
- loss or damage arising directly from pressure waves caused by aircraft and other aerial devices travelling at sonic or supersonic speeds
- any expense, **consequential loss**, legal liability, or loss of, or damage to, any property, directly or indirectly arising from:
  - ionising/radiation
  - contamination by radioactivity from any nuclear fuel, or from any nuclear waste, from the combustion of nuclear fuel
  - the radioactive, toxic, explosive or other hazardous properties of any nuclear assembly or nuclear component.

Other exclusions relate to:

- loss or damage as a result of confiscation (by government order)
- consequential loss (except loss of rent, as previously stated)
- fees (incurred in preparation of a claim)
- wear and tear, or similar (i.e. anything which happens gradually)
- business, trade or professional purposes (although some insurers now provide limited cover for home working)
- deliberate damage (caused by the insured, a member of the family, a tenant or anyone lawfully on the property)
- damage caused by pets, insects, vermin
- cyber losses (liability, loss, damage, cost or expense)
- faulty workmanship, design or materials.

consequential loss

indirect loss which accompanies an insured loss

E Specialist insurance policies

This section outlines the cover provided by some of the less common and more niche specialist insurance policies.

E1 Extended warranty insurance

Manufacturers (via retailers) normally give 12-month guarantees against product defects, e.g. the motor trade, retailers of domestic appliances, electrical goods, television, audio-visual and home computer equipment. Extended warranty insurance is, effectively, an extension of a manufacturer's guarantee, or warranty. Unlike many other insurances, the adviser simply needs to be aware of the scope of extended warranties as they cannot be amended. Electrical items, domestic appliances and computers are the items most typically covered by this type of insurance.

Purpose of cover	Summary of cover	Special features	Typical exclusions	Availability of cover
Extended warranty insurance is, effectively, an extension of a manufacturer's guarantee, or warranty.	• Repairs following electrical or mechanical defects • Typically for a period of 3–5 years – beyond the manufacturer's guarantee period.	• Some extended warranty covers provide an 'all-risks' type cover, as well as breakdown.	• Repairs must be carried out by the supplier of the goods as the insurer will not authorise payment to any other repairer.	Always sold as stand-alone and is only available via the retailer of the goods/ equipment. The policy is underwritten by an authorised insurer. The premium is paid as a single payment to the retailer, who in turn passes it on to the insurer.

E2 Pet insurance

Purpose of cover	Summary of cover	Special features	Typical exclusions	Main underwriting considerations	Availability of cover
Available for owners of dogs and cats; some exotic pets. Insurers insist on being involved at each stage of a process likely to give rise to a claim.	• Vets' fees (limit and excess apply) • Third party liability • Death by injury/ illness • Theft/straying • Kennelling fees • Cost of recovery/lost and found advert • Holiday cancellation.	• Death or theft/ straying claims based on price paid for the pet • Discount in first policy year for micro-chipped pets.	• Pre-existing conditions • Preventive treatments • Illness within 14 days of cover • Death from illness if animal is over certain age. • Any animal less than 8 weeks old • Dogs used for guarding, racing or coursing • Any amount if pet is confiscated or destroyed by government authorities in line with regulation.	• Age of the pet • Breed • Medical history.	A stand-alone cover; not normally offered as an extension on a household policy.

Example 4.6

David has two dogs and a cat and has a pet insurance policy with Paws Insurance DAC. One afternoon, the two dogs are hit by a car. The driver of the car does not stop, despite both dogs being injured. One dog dies on the way to the vet and the other undergoes a hip operation. David rings Paws Insurance DAC the following day and is advised that he will need to provide a claim form, a veterinary certificate stating the value of the dog that was killed and the vet's invoice for the costs associated with the injured dog. David completes the claim form and gets the necessary documentation from the vet. A week later, David receives his settlement cheque.

Just think

For pet insurances, why do you think that insurers insist on being involved in each stage of a process likely to give rise to a claim?

Insurers are concerned that the owner's motivation may be simply to have their pet restored to full health, possibly 'at any cost', but insurers wish to control claim costs and so insist on having control or influence over the process (and ultimately the sums paid out).

E3 Family legal expenses insurance

Purpose of cover	Summary of cover	Special features	Typical exclusions	Main underwriting considerations	Availability of cover
Pursuing legal rights and defending legal actions.	• Pursuit of legal rights of insured/ resident family member after death or bodily injury • Employment-related legal defence costs • Legal and accountant costs for Revenue investigation • Jury service • Contract disputes • Protection of legal property rights • Identity theft • Pursuit claim for single negligent clinical act.	• Telephone helplines manned by solicitors to explain legal matters in everyday language.	• Legal costs incurred without insurer consent • Civil claim without reasonable prospects of success • Claim intentionally brought by insured • Fines imposed by a court/ other authority • Alleged dishonesty or violent behaviour. • Costs more specifically insured by another policy e.g. a motor policy legal expenses cover.	• Declaration that insured is not aware of any circumstances that could result in a dispute that might be covered under the insurance • Such a situation would not form a valid claim.	As an optional cover on household insurance policy or as stand-alone cover.

Example 4.7

Julie works for a small architectural firm when she receives notice to serve on a jury. Her employer (Harry) is not happy and refuses to pay her wages for the days that she is away from the office. Julie serves on a 3-week murder trial and returns to find another woman sitting at her desk. Harry says that the woman is replacing Julie. Luckily for Julie, she had taken out a family legal protection policy 3 years earlier. She contacts her family legal protection insurer (KLM DAC) and explains the situation.

KLM DAC tell her that the wages she lost due to the jury service are covered under her family legal protection policy. They also advise that there are stringent legal procedures in place regarding the altering or termination of an employment contract and that, as Harry has not adhered to these, Julie has a right of redress against him. KLM DAC take note of all the details and confirm that they will pass the details to their employment disputes legal team and that one of their experts will be in contact with her. KLM DAC tell her not to worry, that the legal costs are covered under her policy.

Note that when legal expenses insurance is offered as part of a household insurance policy, it tends to provide less flexibility of cover. However, if the main household policy meets most or all of the consumer's needs cost-effectively, it may still be the best option.

E4 Small craft

Purpose of cover	Summary of cover	Special features	Typical exclusions	Main underwriting considerations	Availability of cover
Vessels not exceeding 17ft in length, with a maximum design speed not exceeding 17 knots, e.g. dinghies and outboard motor boats. Cover to the vessel and its contents, as well as legal liability arising from its use.	• Accidental loss or damage within the geographical limits • Loss of, or damage to, the craft, its accessories and trailer • Legal liability arising out of the use or ownership of the craft, including the cost of any attempted or actual raising, removal or destruction of the wreck of the craft, or any neglect or failure to do so.	• Items that can be covered include the craft, its trolley, life-jackets, buoyancy aids and water-skis, outboard motor and its trailer.	• Death, bodily injury or illness to any employee Theft: • of an outboard motor unless secured by anti-theft device • of gear and equipment unless using violent entry to, or exit from, the craft Loss or damage: • while craft is let • caused by wear/tear or deterioration Legal liability: • from accidents while craft is being towed • for injury to any person engaged in water sports while being towed.	• Certain mooring locations • Details of where the craft is kept when not in use.	As an optional cover on household insurance policy or as stand-alone cover.

Note that when **small craft** insurance is offered as part of a household insurance policy, it tends to provide less flexibility of cover. However, if the main household policy meets most or all of the consumer's needs cost-effectively, it may still be the best option.

E5 Gadget insurance

Purpose of cover	Summary of cover	Special features	Typical exclusions	Main underwriting considerations	Availability of cover
Cover for owners of small electronic or electric items, e.g. smartphones, tablets, e-readers, camcorders, laptops, netbooks, sat-nav devices, hand-held computer games, digital cameras or other small personal electric/electronic items.	• Accidental loss or damage • Theft • Water damage • Breakdown • Worldwide cover • Unauthorised calls.	• 24-hour replacement for lost/stolen phones • Monthly or annual payment options are usually available.	Damage: • within 14 days of the policy inception • due to wear and tear • to items that are more than 12 months old at policy inception Theft: • from a road vehicle • or loss if left unattended • Repairs that are covered by a warranty • More than 2 claims in a 12-month period.	• The type of equipment to be covered • The value of the item. • Proposer's claims experience (gadget insurance).	As a stand-alone cover.

Just think

Consider the specialist insurance policies that may be of particular interest to Frank and Susan (sample consumers).

The specialist insurance policies that may be of particular interest to Frank and Susan are:

- gadget insurance for the iPad, smartphones and laptop
- extended warranty on laptop and any new household items
- small craft for items such as the surf board, masts
- family legal expenses.

small craft

normally defined as those that comply with a speed restriction of 17 knots (32 kph) and not exceeding 17 ft in length

Quick question 5

List three typical exclusions in a small craft policy.

F Summary

Now that we've studied the two household chapters, you'll know that each insurer has its own style of wording and decides what covers to package together in its standard products. In reality, price is the most important issue for most consumers. However, where a reduced cost is accompanied by significant restrictions, the adviser must point out the important differences to the consumer.

At this point, you should revisit the case of Frank and Susan at the start of Chapter 3 and think about the advice you would have given them.

F1 What's next?

In Chapter 5, we'll consider the underwriting of travel and protection insurances. We'll look at the scope of these insurances with a focus on developing solutions for consumers.

F2 Study tips

It's important to remember that this textbook is the primary information source for this module. All the questions in your exam will relate directly to information featured in the textbook. Use the 'End of chapter questions', 'Quick questions' and the 'Sample multiple-choice questions' to quickly test what you've learned so far. Make a note of any topics/areas you need to improve in and keep it to hand so you can refer to it when you revise this chapter again before your exam.

In addition to the textbook, your Member Area has many online study supports that can help you as you study this module.

F3 Online learning supports

Your Member Area includes a learning plan, an automated study planner, an exam countdown timer and study tips guide. These study supports are invaluable in reinforcing what you have learned from the textbook so far. The webinars, chapter-by-chapter key points and other supports will help you to break down the chapter content when revising.

Completing online mock exams and reviewing the personalised feedback that follows is a great way of testing your knowledge and preparing for exam day.

To access these online study supports, just log into your Member Area on www.iii.ie and click on the **Connect** logo.

End of chapter questions

Use these questions to test your understanding of what we've covered in Chapter 4.

1. State the exclusions under the 'storm and flood' section of a typical household policy.

2. Briefly describe the cover provided under the 'leakage of oil' section of a typical household policy.

3. List at least three perils for which cover is not provided if a house is left unoccupied for more than a specified number of consecutive days, e.g. 30.

4. Explain the range of possible covers under the additional benefit known as 'trace and access'.

5. Briefly describe the cover provided under the 'rent and alternative accommodation' section of a typical household policy.

6. List six common additional covers under a household contents insurance policy.

7. List two particular questions that might be asked in relation to the use of pedal cycles.

8. Outline the cover normally provided under extended warranty insurance.

9. List three typical exclusions to the cover provided by a pet insurance policy.

10. Summarise the cover provided under a small craft policy.

11. List six items/devices that might be suitable to insure on a typical gadget policy.

Answers to end of chapter questions

Check your answers against those below and make a note of any points you left out. This will highlight the sections you may need to look at more closely during your revision.

1. Under the 'storm and flood' cover of a typical household insurance policy, insurers normally exclude loss or damage caused:
   - by frost, subsidence, ground heave or landslip (each of these is covered under a separate policy section)
   - to gates, fences or hedges
   - due to wear and tear or gradual deterioration.

2. The 'leakage of oil' section covers the policyholder for all material damage or (property) losses as a result of the leakage of oil. Any legal liability arising as a result of escape of oil is covered under the liability section of the policy.

3. If a house is left unoccupied for more than 30 consecutive days, examples of perils for which cover is not provided are damage caused by:
   - theft or attempted theft
   - vandalism
   - escape of water from, or the bursting of, any fixed domestic water or heating installation
   - escape of oil from any fixed domestic heating installation
   - accidental breakage of fixed glass in windows, doors or roofs, or fixed sanitary ware in the home.

4. In the event of damage by water (or oil) leaking from any tank, apparatus or pipe, the policyholder may need to 'trace and access' the source of the damage before repairs can commence. This cover only applies when the event leads to a valid claim under the policy. It may be limited to 'tracing' leaks only, although some insurers (depending on the cause of the loss) may cover the cost of the actual repairs. When this cover is provided, either an increased excess may apply or the insurer may limit its exposure to a maximum amount (usually €2,000) under this section.

5. If the home is made uninhabitable due to damage, from any cause insured by the buildings and/or contents sections of a policy, the insurer will normally pay for:
   - rent receivable by the policyholder
   - rent payable by the policyholder
   - the reasonable extra cost of comparable alternative accommodation
   - the reasonable cost of temporary storage of furniture.

   The most an insurer will typically pay under this policy section is approximately 15–20% of the buildings/contents sums insured.

6. Additional covers under a household contents policy are:
   - accidental breakage of mirrors or glass
   - accidental damage to audio equipment
   - personal money
   - credit cards
   - freezer or refrigerator contents
   - contents temporarily removed
   - removal by professional furniture removers
   - leakages
   - title deeds
   - fatal injury/compensation for death
   - extra contents cover at Christmas
   - wedding presents
   - contents in the open
   - jury service expenses
   - visitors' and guests' property.

7. Particular questions that need to be asked in relation to the use of pedal cycles include:
   - Where is the pedal cycle stored/parked away from home?
   - Will the pedal cycle be used for extended periods abroad?
   - What is the value of the bicycle?

8. Manufacturers (via retailers) normally give 12-month guarantees against product defects, e.g. the motor trade, retailers of domestic appliances, electrical goods, television, audio-visual and home computer equipment. Extended warranty gives purchasers the option of extending this period, e.g. to 5 years, for a single premium payment, which is collected by the trader and passed on to the insurer. The product is only available via the seller of the equipment. Essentially, this policy provides cover for free repairs following electrical or mechanical defects.

9. Exclusions to cover under a pet insurance policy are:
   - pre-existing conditions
   - preventive treatments
   - illness contracted within 14 days of cover
   - death from illness if animal is over a certain age.
   - any animal less than 8 weeks old
   - dogs used for guarding, racing or coursing
   - any amount if pet is confiscated or destroyed by government authorities in line with regulation

10. Small craft cover includes:
    - accidental loss or damage within the geographical limits
    - loss of, or damage to, the craft, its accessories , and trailer
    - legal liability arising out of the use or ownership of the craft, including the cost of any attempted or actual raising, removal or destruction of the wreck of the craft, or any neglect or failure to do so.

11. Devices insured on a gadget policy could include smartphones, tablets, laptops, netbooks, e-readers, sat-nav devices, hand-held computer games, digital cameras and camcorders (or other small personal electric/electronic items).

Answers to quick questions

1. The reasons why there are no standardised wordings for household policies are:
   - Insurers wish to retain a competitive edge and define cover themselves.
   - Each insurer's claims experience and claims data is based on its existing wordings; insurers would therefore be reluctant to change to a standardised wording.
   - The Central Bank may conclude that identical wordings unfairly restrict consumer choice.

2. Subsidence of the decorative patio is not covered, unless the insurer admits liability under the policy for damage to the home from the same cause, occurring at the same time. In the absence of information that the house is damaged, subsidence of the decorative patio is not covered.

3. Lead forming part of the roof would be covered against theft under the buildings section of the policy. Assuming none of the exclusions apply, the claim should be paid less the section excess (€250–€350).

4. In this case, Gemma would not be able to claim for her stolen lights, as her bicycle was not lost or damaged at the same time.

5. Typical exclusions in a small craft policy could include any three of the following:
   - death, bodily injury or illness to any employee
   - theft of an outboard motor unless it is secured by an anti-theft device
   - loss or damage while the craft is let for hire or reward
   - loss or damage caused by wear and tear, or gradual deterioration
   - theft of gear and equipment unless entry to, or exit from, the craft is made using violence and force
   - legal liability for accidents while the craft is being towed and for injury to any person engaged in water sports while being towed.

Sample multiple-choice questions

1. Which of the following covers usually operates in tandem with the cover available under the freezing/ burst pipes section of a household policy?

   A. Storm and flood.

   B. Vandalism and malicious damage.

   C. Leakage of oil.

   D. Trace and access.

   Your answer:

   ☐

2. A gadget insurance policy will typically exclude damage to any items that are more than how many months old at policy inception?

   A. 9

   B. 12

   C. 18

   D. 24

   Your answer:

   ☐

3. Fiona and Geoff have a household policy with ABC Insurance with a contents sum insured of €50,000. Their policy includes cover for wedding presents for the month before and after the wedding. In the month before their wedding therefore, ABC will automatically increase their contents sum insured to what **maximum** amount?

   A. €52,500

   B. €55,000

   C. €57,500

   D. €60,000

   Your answer:

   ☐

Answers to sample multiple-choice questions

Question 1

Chapter reference: Chapter 4A3

Question type: K

Correct response: D

Learning outcome: Describe and apply the scope and limitations of different household buildings and contents insurance covers and standard options available.

Question 2

Chapter reference: Chapter 4E5

Question type: K

Correct response: B

Learning outcome: Outline the scope and limitations of different specialist insurance policies.

Question 3

Chapter reference: Chapter 4B2l

Question type: A

Correct response: B

Learning outcome: Describe the main items of information about a consumer that should be sought before providing advice about a general insurance policy.

Chapter

5

Travel and protection insurances

What to expect in this chapter

In this chapter we'll look at travel, personal accident and sickness, health related, and payment protection insurances. As we know from Chapter 2, a limited form of personal accident cover is often available on comprehensive motor insurance policies. For those seeking wider personal accident cover, a stand-alone policy should be considered.

After studying this chapter, you'll be familiar with the scope and limitations of these types of insurances. This information, coupled with a knowledge of the cover provided by different insurance products in the market, will enable you to match individual consumers' needs with the most appropriate product(s) for them.

Although it is not possible to cover every possible risk or event that may be relevant to every consumer, the methodology and key areas of information are common to all consumers. What we're going to do is apply the stages of the advice process outlined in Chapter 1 to travel, personal accident and protection policies.

> Note that the monetary values referred to (e.g. in relation to sums insured, policy limits or excesses) are for guidance only. Likewise, the policy guides are only summaries and abbreviations of key information from sample policies in the market. They are not necessarily actual wordings, nor should they be taken as applying universally across the market. There tends to be many variations of wording and ranges of exclusions. For this reason, you are strongly advised to acquire a number of policy wordings to see what is available in the market.

To help you relate the material in this chapter to a real-life situation, we have included a sample consumer profile. This highlights some of the issues that an adviser may encounter when arranging these types of insurance cover. It will help you reflect on how and why each type of insurance cover may (or may not) be suitable for a particular consumer. The question to keep in mind as you work your way through Chapter 5 is: 'What are the key factors to be considered when advising John and Mary on the most appropriate insurance cover?'

Learning outcomes for this chapter

Section	Title	At the end of each section you should be able to:
A	**Travel insurance**	Demonstrate the scope and limitations of travel and personal accident and sickness insurance covers in order for consumers to be provided with the most appropriate products in these classes of insurance.
B	**Personal accident and sickness insurance**	
C	**Health related insurance products and services**	Outline and apply the range of insurer's risk-rated health products and services.
D	**Payment protection insurance**	Demonstrate the scope and limitations of payment protection insurance.

Travel and protection insurances sample consumer profile

John and Mary have both recently retired. John is 65 and Mary is 63. Now that they have time on their hands they would like to travel and see the world and visit their children who are now living abroad. Mike lives in Colorado, Emma lives in France and their youngest son, Dermot, lives in Australia.

John and Mary have drawn up their travel plans, which involve flying to Denver in September for three weeks to see Mike. They will spend a month in Sydney at Christmas with Dermot and his wife and a month with Emma in Cherbourg in June. They have booked their flights to Denver and Sydney but have decided to take their car on the ferry to France to see Emma.

John and Mary are anxious to ensure that all the travel details are attended to, and notes that they will need to have adequate insurance cover in place to cover all possible eventualities. They also want to make sure that arrangements are in place to cover any accident, sickness or unforeseen medical costs they might incur on their travels. John and Mary have made an appointment with their insurance adviser to discuss their insurance requirements for the forthcoming 'world tour'.

A Travel insurance

People travelling within Ireland or abroad, whether on holiday or on business, face a number of risks, both before and during the journey. These risks include cancellation charges, injury, death, medical costs, loss of personal possessions and third-party liability.

Travel insurance products are available directly from health and general insurers and also from insurance intermediaries. In recent years, travel insurance has become a commodity product, primarily purchased online through websites.

Key questions an adviser must ask to establish the need for this type of cover and the level of cover required relate to the:

- countries to be visited
- duration of the trip(s)
- if a separate health insurance policy is in place
- ages of the insureds, and
- excess required.

There are two types of travel insurance available to consumers and the cover they provide is similar. These are:

1. Single trip travel insurance – This covers a single trip up to a maximum duration of 30 days. This is suitable for individuals, couples and families going on short-term travel.
2. Annual multi-trip travel insurance – This covers all trips taken in a year, up to a certain duration. The limit on the duration of each trip can range from 17 to 60 days depending on the age of the insured person and the destination. The maximum number of days' travel in a year is normally set at 180. This type of product is suitable for individuals, couples and families who may travel a number of times during the year.

Regardless of their type, travel policies are very detailed. Wordings vary significantly in terms of scope of cover, exclusions limits and excesses. Because of this wide variety, advisers need to concentrate on the core elements of cover, and not the 'extras' which, although helpful, are not usually critical to the consumer's decision to buy the policy.

Insurers adopt very different approaches in the structure of their wordings. Some rely on exclusions that relate to the policy as a whole, others tailor their exclusions to apply to particular sections.

We will now consider the cover provided by the different policy sections and the implications of this for advisers.

Quick question 1

What is the difference between single-trip insurance and annual multi-trip insurance?

The answer is at the end of this chapter.

Just think

Lily has a multi-trip travel insurance policy. She is planning a surprise trip to Bruges for herself and her husband for their anniversary. Does Lily need to advise her insurer of her travel plans or will cover automatically operate?

Lily does not need to notify her insurer, as the cover will automatically operate. Travel insurance can be purchased without the insured having any holiday or travel plans. This is one of the main benefits of a multi-trip policy as it covers all trips abroad during the policy period subject to the terms and conditions. The exception to this rule would be if Lily was intending to partake in any activities not covered in a standard policy, e.g. winter sports. In a situation like this, Lily would have to inform her insurer to request the additional cover required and possibly pay an additional premium.

A1 Accident and medical

Table 5.1 outlines the typical cover provided by the accident and medical expenses section of a travel insurance policy.

Table 5.1 Typical benefits – travel insurance (accident/medical expenses)

Personal accident benefits	• Capital sums for death, loss of sight or limb(s), permanent total disablement • Benefit varies from €5,000 to €40,000 (children under 16 have a restricted death benefit) • A weekly benefit for temporary total disablement for employed claimants (some insurers only); benefit levels starting from €26 per week (104 weeks maximum up to the sum insured).
Medical expenses benefits	• Emergency medical, surgical, hospital, ambulance and nursing fees, and charges incurred outside of the country of residence • Accommodation costs plus air ambulance if necessary • Benefit limits – €1,000,000 to €10,000,000. **Cover generally includes:** • In the event of death, burial or return home of remains • If an in-patient for more than 10 days, costs for a friend or close relative to bring the policyholder home • **Repatriation** costs • Accommodation, food and nursing for 10 days after repatriation • Companion to bring home children under 16 if insured is unable to do so.

The accident and medical section is by far the most important section of the policy. The medical expenses cover, its effectiveness, scope and limits may well determine, for most consumers, the choice of product. Each benefit outlined in Table 5.1 is subject to general and specific exclusions.

Hazardous activities, such as winter sports, water-skiing, pot holing or mountaineering, are generally excluded, but some insurers will cover these on payment of an additional premium.

personal accident benefit

compensation in the event of injury, disability or death resulting from a sudden, accidental, violent and specific event

medical expenses benefit

covers medical and surgical expenses, hospital charges and other associated expenses resulting from an illness, injury or death

Just think

Given our sample consumers John and Mary's travel plans, what elements of the accident and medical expenses travel cover are particularly relevant to them?

The elements of the accident and medical expenses travel cover that are particularly relevant to John and Mary are:

- Personal accident benefits – The capital sums for death, loss of sight or limb(s), permanent total disablement would be relevant. However, as neither of them is working, the weekly benefits would not be paid.
- Medical expenses benefits – Emergency medical costs, repatriation costs, accommodation and nursing costs (important given their ages) would also be relevant.

A2 Cancellation and curtailment

Cancellation in this context means that a policyholder has to cancel their trip before the planned departure date. This may be for a variety of reasons. However, travel insurance typically covers the cancellation of a trip for only certain specified reasons. Following the Covid-19 pandemic, most insurers have clarified their policy wordings to exclude travel cancellation due to pandemics.

Curtailment refers to a situation where the policyholder cuts short a trip and returns home before the expected return date. Curtailment is also usually covered in the event of bodily injury, illness and death of the policyholder or anyone who may have travelled with them. Curtailment cover provides compensation for all the unused accommodation and additional travel expenses accrued as a result of the unexpected curtailment. Cover is usually provided up to €3,000.

Table 5.2 indicates the typical scope of cover for cancellation and curtailment section of a travel insurance policy.

Table 5.2 Typical policy cover guide – travel insurance (cancellation and curtailment)

Loss of deposits
• Irrecoverable unused travel and accommodation costs plus reasonable additional travel expenses for cancellation or curtailment through death, bodily injury or illness to the policyholder, travelling companion, close relative or business associate • Compulsory quarantine, witness or jury service, or unexpected redundancy – for the policyholder or travelling companion • Withdrawal of leave for members of the armed forces, emergency services or government departments – only for the policyholder • Burglary, fire, storm or flood at their home (perils vary) – only for the policyholder • Hijacking (some insurers only) • Overall limits of (typically) €3,000 to €6,000.

Lists of exclusions are fairly standard across the market, although some insurers impose more restrictions than others. Basically, whatever the description of the scope of cover, insurers will not cover areas where it is already known that problems exist, e.g. known redundancy or health issues. Therefore, although we would not treat this as a dominant area of cover, it is important to establish whether there are any issues that could lead to the cancellation of travel plans.

Just think

Why would the cancellation and curtailment travel cover be so important to John and Mary (sample consumers)?

John and Mary will already have incurred the costs of flights and ferry. In the event of cancellation, they can recover their outlay, subject to the policy terms and conditions. Also, if one of them falls ill while on holiday, they may have to curtail their current trip, and/or it may impact on their future travel plans resulting in cancellation of one of their other trips.

A3 Travel delay

The cover in respect of travel delay typically provides a fixed benefit following a delay of at least 12 hours as a result of industrial action, bad weather or mechanical breakdown of transport. Typical benefits are €20 after the first 12 hours, plus €20 for further 12-hour periods. An overall limit of around €200 to €400 will apply. Policies may also include a further payment in respect of accommodation and travel costs as a result of consequent missed connections or abandonment of the journey.

A4 Personal liability

The personal liability section covers the insured's legal liability for third-party personal injury and damage to property. The policy also includes indemnity to legal representatives (in the event of the policyholder's death). Cover is subject to a limit of indemnity, which is normally up to €3 million.

A5 Baggage and extensions

There are many different practices in this area. Although the main features are consistent in terms of the items covered, the overall **inner limits** and excesses vary, and at least one insurer provides no cover for money and credit cards. Advisers must be aware of these variations when recommending a product to a consumer.

Table 5.3 outlines the typical cover provided by the baggage section of a travel insurance policy.

Table 5.3 Typical policy cover guide – travel insurance (baggage and extensions)

Baggage and standard extensions cover
• **Theft or damage** – to personal baggage; single article €250 to €400; overall limit of €2,000 to €4,000 (valuables limit of €200 to €400 in total) (see Example 5.1)
• **Delay in arrival of baggage** – for at least 24 hours (although one insurer states 12 hours); €130 to €200 for emergency purchases
• **Personal money/credit cards** – limit approximately €650; €260 to €350 for cash, either separately or as an inner limit
• **Loss of passport** – limit €320 to €400.

inner limit

an indicator of the largest payment that will be made under a specific insurance policy heading (expressed either as a monetary amount or a percentage of another limit)

Example 5.1

John's travel policy has an overall limit of €3,000 for baggage and an inner limit of €400 for valuables. John's watch (valued at €350) and his wedding ring (valued at €800) were stolen during his holiday. The maximum amount that his travel insurer is liable for is €400.

Each insurer has its own unique exclusions for these covers, such as unattended valuables, money or credit cards.

Example 5.2 outlines a sample travel insurance claim.

Example 5.2

Tom travels to Spain for a 2-week holiday. When he arrives in the airport in Spain, his suitcase is missing. The airline investigates and discovers that it is still in Dublin airport. The suitcase is transported on another plane, which arrives in Spain 10 hours later. Tom knows that delayed baggage is covered under his travel policy, so he immediately buys clothing to the value of €100 and toiletries costing €25.

When his holiday is over, Tom's return flight is delayed due to snow at Dublin airport. Tom goes to the information desk and is told that there will be no flight until the following day as Dublin airport has just closed and will not re-open for 24 hours. Tom books a suite in a hotel in a nearby city at a cost of €220 and incurs an additional cost of €60 in travelling expenses and €150 for food and drinks.

Tom returns to Ireland the following day and rings his travel insurer. He states that his baggage was delayed for 10 hours and the replacement items cost him €125. His insurer advises that compensation for delayed baggage is only provided if the baggage is delayed for over 24 hours therefore no cover is provided under Tom's policy.

Tom explains that, when returning home, he was delayed for 24 hours. His insurer advises that this is covered up to a policy limit of €250 less a policy excess of €50. Tom states that he incurred an additional cost of €430 due to the delayed departure, but the insurer advises that a policy limit cannot be exceeded and that an excess is deducted from every claim settlement. Tom is told to complete a claim form and return it with confirmation from the airline regarding the delay and a receipt for the accommodation and travel expenses. The insurer states that once it receives these documents, it will forward a cheque for €200.

Quick question 2

Your best friend, Ed, has just returned from a trip to Barcelona where he had the misfortune to have his passport stolen. You are booking the family summer trip to Portugal and you are wondering if your policy provides cover for lost/stolen passports, so you ask your adviser.

What would the adviser's response be to this question?

A6 Extra sections of cover available

Extra covers that may be available under a travel policy include:

- Emergency service – typically operated by a specialist company such as First Assist, which provides a 24-hour multilingual helpline plus repatriation costs (including an air ambulance where necessary) and a wide range of other helpline-related benefits, e.g. drug replacement
- **Hospital cash benefit** – broadly the same exclusions as medical expenses
- Scheduled Airline Failure – a benefit of €500-€2,000 applies
- Missed departure – accommodation and travel expenses for missed departure following transport failure, breakdown or interruption (e.g. accident en route to airport), industrial action or adverse weather conditions (normal limit approximately €400-€600). Exclusions include less than two hours allowed between connecting flights, improperly serviced vehicle, refusal of reasonable alternative transport and industrial action announced pre-booking
- Hijack – a benefit of €50-€100 per day to a limit of 10 days
- Winter sports – optional extra, including skis damaged/lost by an airline, weekly benefit for inability to ski following accident, illness or theft of ski pass, daily benefit for lack of snow, avalanche causing delay and piste closure (benefits vary)
- Golf cover – optional extra, including golf liability, pre-paid green fees (illness or cancellation) and hole-in-one bar bill
- Legal costs and expenses – incurred in pursuing a claim arising out of death or injury to the policyholder
- Kidnap and ransom – reimbursement of associated costs
- Gadget insurance.

Just think

Which of the extra covers outlined in Section A6 might be of interest to John and Mary (sample consumers)?

John and Mary may decide to go skiing in Denver or golfing in Sydney. Travel policies do not automatically cover winter sports or golf so these would need to be purchased as extra covers when the policy is being arranged. An additional premium will be payable.

Hospital cash benefit

benefit under a travel insurance policy, payable in addition to other policy payments as a daily sum for each 24-hour stay, subject to an overall maximum

Quick question 3

Apart from health matters, what is the single most significant question that an adviser should ask the consumer regarding the cancellation and curtailment cover provided by a travel insurance policy?

B Personal accident and sickness insurance

Personal accident insurance and sickness insurance are relatively simple forms of cover. Basically, under either policy the sum insured is paid if the insured suffers an accident or is off work due to sickness. The main underwriting considerations for both policies are the age, occupation, and existing medical condition or disability of the insured.

benefit policy

a policy that provides stated pre-agreed amounts/benefits on the occurrence of certain defined events rather than exact financial compensation

Personal accident policies and sickness policies are **benefit policies**, rather than policies of indemnity. Although they provide cover at relatively low cost, and helpful financial assistance at a time of difficulty, they cover very limited circumstances. The trigger for these policies is an 'accident', normally defined as 'a sudden and unexpected event occurring at an identifiable time and place' (though exact wordings vary). For this reason, an adviser may wish to explore the consumer's needs more fully before recommending this particular policy. It is worth noting that the policy underwriting with these covers tends to be done at the point of claim and not at the point of joining.

Examples of consumer requirements that would prompt the adviser to consider **other** policies are:

- compensation for loss of income over a significant period of inability to work following injury or illness; a permanent health insurance contract should be considered (see Section C1)
- cover required for hospital costs while based in or outside of the Republic of Ireland (see Sections C2-C4)
- protection of monthly repayments for regular outgoings following redundancy or injury; a payment protection policy should be considered (see Section D)
- a lump sum is required upon death; some type of life protection policy, e.g. term assurance, may be more appropriate
- a lump sum in the event of suffering a serious illness such as cancer.

An important aspect of the adviser's role is to explain the choices available and give advice on the wider range of options that may be available.

Limited personal accident cover is often offered by motor insurers under their comprehensive motor policy (see Chapter 2B4a). However, as stand-alone policies offer a greater range of benefits and are not limited to motor-related incidents, we will consider personal accident and sickness cover as stand-alone covers.

B1 Personal accident

The trigger for these policies is an accident, normally defined as 'a sudden and unexpected event occurring at an identifiable time and place and causing bodily injury' (though exact wordings vary). It is worth noting that with this cover, underwriting takes place at the point of claim and not at proposal stage.

Table 5.4 outlines a typical range of circumstances covered by a personal accident policy.

Table 5.4 Typical policy cover guide – personal accident insurance

Chosen capital benefits (sums) for incidents occurring within 12 or 24 months of an accident:

- death
- loss of sight in at least one eye, or loss of one or more limbs
- permanent total disablement (assessed as continuing for life)
- disappearance (where an assumption of violence is reasonable) may be covered.

Chosen weekly benefit for:

- temporary total disablement (from attending own business)
- temporary partial disablement (from attending a substantial part of own business).

The terms 'total' and 'partial' disablement refer to the insured's inability to work; they are not medical definitions. Often, 'partial' is set at 40% of 'total' benefit (104 weeks maximum).

Conditions that apply generally

- Obligation to notify insurer of material change in occupation (continuing requirement).
- Pre-existing conditions may appear either as an exclusion or a condition; this relates to conditions for which treatment has been, or should have been, sought before inception of the policy.
- Obligation to notify insurer of any incident likely to give rise to a claim, and to arrange to see a medical practitioner as soon as possible – documentation requirement.
- An age limit, e.g. 60 or 65 applies.

Group personal accident policies can be purchased by companies to cover employees travelling or working on company business.

B2 Sickness cover

Sickness insurance provides a weekly benefit if the insured suffers **temporary total disablement** (**temporary total disability benefit**).

Cover is normally subject to a time **franchise** of 7 days, and excludes illness contracted within 21 days of policy inception. Blindness and paralysis may be offered as additional benefits under this cover.

Some insurers have longer lists of exclusions for areas such as working conditions (height restrictions, power-driven machinery or dangerous pastimes, and possibly stress or fatigue).

capital benefits (sums)

benefits payable as lump sums for death and certain permanent disabilities under personal accident policies

Quick question 4

Why is a personal accident policy often not a 'first choice' of recommendation by an adviser?

temporary total disablement

benefit under a personal accident (and sickness) policy payable for up to 104 weeks provided the policyholder is unable to carry out any part of their normal occupation

franchise

a minimum amount of loss that must be incurred before insurance coverage applies (similar to an excess except that once the amount of the franchise is exceeded, the whole of the claim is paid)

B3 Important considerations when advising the consumer

proximate cause

main or dominant cause of the loss or the cause that is most powerful in its effect

Advisers must exercise great care in relation to policy exclusions. Some insurers state that they apply even if the exclusion contributes to the event rather than causing it. This changes the way in which **proximate cause** operates.

In addition to the issues raised in Table 5.4, there is another issue the adviser must consider. If the consumer suffers a serious accident that renders them unable to carry out their usual occupation, the adviser must ascertain whether the consumer is willing to undertake whatever gainful employment is possible. The reason for this is that most policies that provide a permanent total disablement benefit state that the policyholder must be prevented from undertaking any occupation. Therefore, if the policyholder is able to undertake any form of work, the benefit is not payable. It may be possible to broaden the cover by referring specifically to the policyholder's usual occupation, and some schemes are written on this basis. A comparison of precise wordings is crucial.

Some insurers impose an age limit requirement or rely on a blanket exclusion for pre-existing illness or disability; others may consider the particular issues that arise with declared conditions.

There are many situations in which insurers will acknowledge existing conditions and provide full policy cover. An example might be diabetes mellitus (type 2) if controlled by diet.

Just think

Given our sample consumers John and Mary's ages, would they need to purchase personal accident insurance and/or sickness insurance?

Under personal accident insurance and sickness insurance, benefits are paid if the insured suffers an accident or is off work due to sickness. As both John and Mary are retired, they would not be entitled to any benefits under either policy. Instead, they should consider life insurance or possibly critical illness cover. However, even these policies might be very expensive given their age.

C Health related insurance products and services

Private health insurance is governed by a range of principles contained in the **Health Insurance Acts**, such as community rating. We will consider this in detail in Chapter 6.

In this section, we will focus on health insurance products and some general products that are offered by the international health insurance sector but are not governed by these Acts, and to which the principles set out in those Acts do not apply. These products are **risk-rated** and, for this reason, we will look at them separately here. Community-rated products are discussed in Chapter 6.

Some products that fall within the broad category of health insurance, such as permanent health insurance and **critical illness cover**, are offered by life assurance companies. This category also includes other similar products, such as major medical expenses insurance and long-term care insurance (not available in Ireland). These products do not provide compensation for healthcare costs but provide stated benefits when a specified event occurs.

There are a number of other risk-rated products available exclusively within the private health insurance market, and we will consider them briefly in the following sections. The information given here is just an outline, therefore advisers would need to familiarise themselves fully with these products before providing advice to a consumer.

C1 Permanent health insurance

Permanent health insurance, also called 'income protection' or 'income continuance', provides a regular income if the policyholder suffers a loss of earned income as a result of being unable to work due to sickness, accident or disability lasting longer than the 'deferred period' under the policy. The '**deferred period**' will typically be 13, 26 or 52 weeks. Example 5.4 illustrates how deferred periods are applied in practice.

When calculating the maximum benefit a policyholder can receive, insurers take into account social welfare entitlements, and other entitlements such as sick pay from an employer to ensure that the total amount received is capped in the region of 50-75% of pre-illness income. The maximum percentage is dependent on the insurer. This approach is undertaken to encourage those temporarily out of work to return to the workplace. However, having a permanent health insurance policy does not affect a person's social welfare or other entitlements. Example 5.3 demonstrates how this works.

risk-rated policy

a policy whose rating follows principles that include applying discrimination factors to proposers

critical illness cover

provides a capital sum in the event of the policyholder being diagnosed as suffering from, or contracting any of, the serious illnesses specified in the policy

permanent health insurance

policy providing a replacement income until normal retirement age in the event that the policyholder is unable to work due to accident, illness or injury

deferred period

a set period of time agreed by prior arrangement between the policyholder and insurer, where a waiting period applies from the first day of a person's claim to when the policy actually pays out the first benefit

Example 5.3

Laura is employed and earns €60,000 per annum. Her employer does not have a sick pay scheme in place. Laura wishes to purchase a permanent health insurance policy and wishes to know the maximum benefit that she can purchase. Assuming that the insurer in question will provide up to 75% of earnings, and that Laura is entitled to the State Illness benefit, the calculation is as follows:

€60,000 x 75% = €45,000

(this is the maximum Laura can earn from all sources)

€45,000 less State Illness benefit of €10,556 = €34,444

(this is the maximum Laura can receive from a permanent health insurance policy).

The term 'permanent' relates to the fact that, once the insurance company has issued the contract, it cannot cancel it regardless of the claims experience, provided the policyholder continues to pay the premiums due.

C1a Payment of benefit

The benefit is payable for as long as the policyholder suffers a loss of earned income and is deemed unfit to return to work. If the individual can never return to work, the benefit is paid until the expiry date of the policy. There are typically two ways in which the inability to work (disability) is defined. The policyholder will decide which definition to apply when purchasing the policy. These definitions are typical of those that insurers would use:

- Own Occupation - the policy will pay out if the policyholder is unable to do their own job
- Suited Occupation - the policy will pay out if the policyholder is unable to do a job of similar skills and experiences.

If a policyholder's permanent health insurance claim is successful, the insurer will pay the pre-determined percentage of the policyholder's gross salary (depending on the insurer), or a pre-agreed monetary amount, once this doesn't exceed the maximum allowed.

Permanent health insurance policies have a fixed age at which payment of the benefit ceases, typically 55, 60 or 65 ('benefit cessation age'). A claim payment can be reduced or terminated where the insurer feels that, on medical grounds, the policyholder is fit to return to work. During the term of a permanent health insurance claim, ongoing medical evidence is required to establish if the policyholder is still unfit on medical grounds to return to work. In some cases, a permanent health insurance provider may be prepared to pay a partial benefit where the policyholder goes back to work part-time, or at a much lower level of income than before.

Example 5.4

Vincent is employed as a Second Engineer on board a company vessel. On 2 January, Vincent had an accident in which he fell and hurt his back. Following the accident, he experienced back pain which was subsequently diagnosed as a bulge on his vertebrae. His doctor advised that he should undergo surgery to fix the issue and following this, should avoid prolonged standing, walking and lifting heavy objects. Vincent's recovery from the surgery means that he will be absent from work for a lengthy period. Fortunately, Vincent has a permanent health insurance policy with a deferred period of 13 weeks.

Vincent submitted his claim prior to undergoing surgery in February. His permanent health insurer assessed his claim in the context of the policy terms and conditions and his surgical report. Following this assessment approval was granted.

Due to the application of the deferred period of 13 weeks, no payment will be issued to Vincent until the month of April. The permanent health insurance benefit will be paid on a monthly basis until he recovers and returns to work or, if he cannot resume work, up to the age as specified in policy terms and conditions.

C1b Limitations and restrictions

Because of the long-term nature of a permanent health insurance policy and the resulting large potential claim payments (as illustrated in Example 5.5), underwriting of this type of policy is extremely stringent. Significantly more proposals for this type of policy have loadings or exclusions applied, or are even declined, than for other types of health or life insurances. Examples of exclusions include where the illness giving rise to the claim arises from self-inflicted injury, drug or alcohol abuse, a pre-existing condition, participation in certain dangerous pursuits or active participation in a riot, civil commotion or criminal act.

Example 5.5

Niamh is aged 35 and has a permanent health insurance policy which covers 75% of her gross income, which is €75,000 per year. Niamh suffers a serious accident and is permanently unable to work again. She is entitled to State Illness Benefit of €10,556 (€203 per week). As per the limitations of her permanent health insurance policy, Niamh is entitled to a percentage of her pre-illness earnings minus her State Illness Benefit. In this case, Niamh will receive €45,694 (€75,000 x 75% = €56,250 - €10,556). Niamh's retirement age is 65, and her policy expires at this age. Therefore, the total benefit she will receive from the policy is €45,694 x 30 years = €1,370,820.

C1c Premium

Permanent health insurance policies may be of two different types:

1. The premium is fixed and guaranteed for the term of the policy, usually to the chosen benefit termination age, e.g. 60th birthday.
2. The premium is fixed for a certain initial period, e.g. 5 or 10 years, after which the permanent health insurance provider may 'review' the premium, and could charge a higher premium for the same cover if the permanent health insurance claims experience was worse than expected and/or investment returns were lower than expected.

Permanent health insurance policies offer a 'waiver of premium' option. This means that if the individual becomes unable to work due to sickness, accident or disability lasting longer than a specified deferred period, the premium payable under the policy is not charged. It helps to continue the policy during a period of long-term illness, when the individual may be under financial pressure because of reduced income.

Premiums for permanent health insurance policies are eligible for tax relief at the policyholder's highest rate of tax, up to a yearly limit of 10% of total income.

C1d Group permanent health insurance

While individuals can take out permanent health insurance policies, most people who have this cover obtain it through a group scheme. For example:

- A large employer may arrange a group permanent health insurance scheme.
- Many public sector unions have voluntary group schemes designed to bridge the gap between their sick pay and ill health pension entitlement and a specified level of income, usually 75%.

Just think

Would a permanent health insurance policy be of interest to John and Mary (sample consumers)?

Permanent health insurance is an 'income protection' policy. As both John and Mary are retired and no longer in employment, this type of policy would not be of any benefit to them.

C2 Hospital cash

Hospital cash can be purchased as an additional benefit on a life insurance contract. It pays a sum of money if the life assured spends a certain minimum time in hospital.

Hospital cash pays out a daily amount, typically between €30 and €300 for each day spent in hospital as an inpatient. Cover is normally subject to a time franchise (i.e. if the life assured is hospitalised for more than a minimum number of consecutive days (e.g. more than 3 days), the claim is usually paid in full from day one). Some insurers may impose a **deferred period** rather than a time franchise.

Typically, there is a limit on the maximum number of days that can be claimed under the policy (e.g. 365 days) and the cover may end at a specific age (e.g. age 60), even if this is still within the term of the policy. This limit on the number of days that can be claimed is over the lifetime of the policy.

Quick question 5

What is the maximum level of permanent health insurance cover an individual can have?

hospital cash (hospital income)

plans that provide daily sums to a policyholder for being admitted to a hospital

deferred period

a set period of time agreed by prior arrangement between the policyholder and insurer, where a waiting period applies from the first day of a person's claim to when the policy actually pays out the first benefit

The benefits paid out under the policy are not linked to medical expenses and therefore, can be used by the policyholder for any purpose.

This cover benefits those who would struggle financially if they were in hospital for a long period of time. This should not be seen as a replacement cover for health insurance as there is a maximum benefit payable per day for a maximum length of time.

If hospital cash is added to a policy, the insurer may provide a portion of the benefit to the policyholder's children free of charge, but the children's daily benefit rate is lower (usually 50% of the daily adult rate). Typically, the child must be between the ages of 1 and 18 to qualify.

The following general exclusions may apply, depending on the insurer:

- hospitalisation due to psychiatric, mental or nervous illnesses
- self-inflicted injuries stemming from alcohol or drug abuse
- hospitalisation occurring due to pre-existing conditions
- hospitalisation due to pregnancy within 9 months of the start date of the policy.

Examples 5.6 and 5.7 highlight how a hospital cash benefit operates.

Example 5.6

Martha has a hospital cash that provides a benefit of €60 per day (subject to a 3-day time franchise). As a result of a 10-day stay in hospital, she will receive a total benefit of €600 (i.e. 10 days × €60). This is because the claim is paid from day one if Martha stays in hospital for at least 3 days. This is a tax-free benefit and Martha can spend this money as she wishes. The maximum days cover on the policy will reduce by 10 days (i.e. 365 days less 10 = 355 days).

Example 5.7

Alan has a hospital cash benefit that provides a benefit of €60 per day (subject to a 3-day 'deferred period'). As a result of a 10-day stay in hospital, he will receive a total benefit of €420 (i.e. 7 days × €60). The maximum days cover on the policy will reduce by 7 days as a result (i.e. 365 days less 7= 358 days).

The key differences between a hospital cash and a private health insurance product that is community-rated are as follows:

- Hospital cash is priced on the basis of age, i.e. risk-rated, whereas health insurance is community-rated (see Chapter 6).
- Hospital cash benefits pay a specific amount according to events (i.e. number of days spent in hospital), whereas private health insurance indemnifies for costs only (e.g. accommodation or treatment).
- Pre-existing conditions are excluded under hospital cash, but not under private health insurance (waiting periods do apply).
- Cover is only available for persons up to a certain age on hospital cash, whereas private health insurance does not have an upper age limit.

Just think

Given the often-publicised concerns about the cost of private health insurance, would a hospital cash be a viable alternative?

Quick question 6

State the exclusions that typically apply to a hospital cash benefit.

While hospital cash would be cheaper, it would not be a substitute for private health insurance cover as it would not provide any indemnity for the costs associated with in-patient hospital treatment. Depending on the level of the hospital cash, the benefit towards private hospital cover will likely result in a significant shortfall. However, for those accessing public hospital services only, the payment from the hospital cash may actually cover the cost of the public hospital charge.

C3 Dental insurance products

There are currently two providers of dental insurance to consumers in Ireland – DeCare Dental and Vhi Healthcare. In addition, private health insurers sometimes include dental benefits as part of a health insurance policy, such as cover for **emergency dental treatment** and some routine, major and orthodontic dental treatments. Benefits are either a fixed monetary amount or a percentage of the treatment costs, normally up to a specified monetary limit or an agreed price for specific treatments.

emergency dental treatment

treatment for the immediate relief of pain caused by a natural tooth being lost, damaged or infected, howsoever caused, or from any trauma to the mouth

The range of benefits in a typical dental insurance policy are set out in Table 5.5.

Table 5.5 Typical dental insurance policy benefits

Treatment	Benefit	Waiting period
Care and prevention		None
Dental examinations and x-rays	100%	
Scale and polish or cleaning	100%	
Emergency treatment worldwide (once per year)	100%	
Basic treatments		3 months
Fillings, extractions, gum disease	70%	
Major treatments		12 months
Root canals	50–60%	
Dentures, bridges and implant supported crowns	50–60%	
Crowns, inlays, onlays, veneers	50–60%	
Orthodontics		24 months
Orthodontics (lifetime allowance)	€500–€1,000	
Oral cancer		None
Oral cancer (lifetime allowance)	Up to €5,000	

Major treatments are subject to a policy excess which is only applied to the first treatment, once per policy year.

Dental insurance policies usually have maximum amounts that will be paid out in any 12-month period. These maximum amounts depend on the plan the policyholder has selected and ranges from €500 to €2,000. Some insurers allow the policyholder to select the policy maximum payment for a higher premium.

Some major treatments are also subject to an annual maximum.

In order to establish the need for this type of cover and the level of cover required, the adviser must ask some key questions. These include:

- the number and ages of the insureds
- whether dental treatment is currently underway or planned, and
- whether the consumer has private health insurance.

Factors that affect pricing of dental insurance include age, range, and level of benefits.

All dental insurance premiums are billed net of tax relief, which is deducted at source by the insurer. The tax relief available for dental expenses incurred is dealt with in Chapter 6F2d.

C4 International health insurance

International health insurance is designed for consumers who are working, travelling or studying abroad for 6 months or more. However, they are not emigrating permanently and they intend to return to Ireland in the short to medium term.

international health insurance

insurance that provides comprehensive health insurance for the insured while overseas for an extended duration

Whereas private health insurance contracts in Ireland generally require the policyholder to be resident in Ireland for more than 180 days in a calendar year in order to be eligible for inclusion, these products provide comprehensive cover for a consumer while overseas for an extended period. They differ from travel insurance (which, in terms of health, only covers emergency treatment) in that they cover elective treatment and provide a longer duration of cover with more comprehensive benefits. They are risk-rated products and factors such as age, existing medical history, countries being visited etc. potentially have an impact on the premium.

The typical features of an international health insurance product, depending on the level of cover and product, are as follows:

- medical and hospital expenses
- dental treatment expenses (often optional)
- maternity cover/plan (often optional)
- emergency medical transfer, evacuation and repatriation
- repatriation of mortal remains/local cremation/burial
- temporary return to home country
- additional transportation and accommodation benefits for accompanying child and one adult
- wellness benefits – optical and audiology.

A combination of increased competition and changing customer demands and expectations means that international health insurers are providing an ever-increasing range of additional products and services.

Traditionally, international health insurers only provided health cover with the main features outlined, as well as dental cover and hospital cash plans. Nowadays, they offer some non-health insurance products such as travel insurance (see Section A) and protection insurance (see Section D). These products are not exclusive to international health insurance and are offered by other insurers.

They have also extended their services to focus on chronic conditions, illness prevention and wellbeing.

There is a focus on digitalisation, offering these services remotely. For example, telehealth allows policyholders to video conference directly with a doctor and avoid the need to visit a GP.

Key questions an adviser must ask to establish the need for this type of cover and the level of cover required relate to:

- the countries to be visited
- the time to be spent abroad
- the age of the insured(s)
- existing health conditions
- whether the insured's employer already has a global travel policy in place and
- whether the insured has private health insurance.

As a result of the complexity, cost and low level of demand, there are very few advisers giving specific advice on international health insurance cover at present. However, there is evidence that this is a growth market with increasing number of employers seeking to deploy resources abroad temporarily with an associated requirement for quality medical cover.

There is no one standard approach in the market when moving from a domestic health insurance product to an international health insurance product when looking for continuity of cover.

Just think

Joe is 25 and takes a post overseas for two years so cancels his health insurance cover in Ireland when he leaves. He is covered by Health Co. (a global health insurance service company) whilst abroad and on his return to Ireland, he applies to his old health insurer to re-join. Even though he can prove that he had excellent cover with Health Co. whilst he was away, what will the likely reaction of the Irish health insurer be?

Even though Joe had continuous cover since leaving Ireland, the Irish health insurers are under no obligation to recognise the time spent with Health Co. whilst abroad. Strictly speaking, Joe will be considered a new policyholder and the standard waiting periods for new policyholders may apply depending on the stance taken by the domestic insurer.

Quick question 7

For someone taking an extended trip abroad for 6 months or more, why would a standard travel insurance policy not be sufficient to cover this risk?

D Payment protection insurance

Payment protection insurance (PPI) is also referred to as creditor insurance, credit protection insurance or repayment protection insurance. This cover enables the borrower to insure some or all of their loan repayment(s) if certain events should occur that may negatively impact their ability to pay these loans/debts. These events can include the following:

- death (typically for outstanding loan balance)
- accident and sickness
- critical illness (typically for outstanding loan balance)
- disablement
- redundancy/job loss.

PPI can be purchased to insure many types of loans including credit card debt, personal loans, store cards or mortgages. Although the policy is purchased by the borrower, the benefit paid in the event of a claim usually goes to the company that extended credit to the consumer.

For credit cards and store cards, PPI usually covers minimum monthly payments. For mortgages and personal loans, the cover will be for the full monthly repayment. An important aspect for the borrower/insured to note that the benefit is usually only paid for a specific period, typically no longer than 12 months. After this point the borrower must find other means to repay the debt, although the period covered by insurance is usually long enough for most people to get back to work and start earning enough to resume repayments.

Eligibility to claim on a PPI policy is subject to strict criteria, and payment will not normally be made if the claimant:

- is aged under 18 or over 65
- works less than 16–18 hours per week
- is aware that they may become unemployed
- takes voluntary redundancy
- is self-employed and goes out of business
- is a temporary/contract worker and loses their job
- is aware, or should be aware, of an existing medical condition
- is unable to work because of certain common conditions, such as stress or backache
- makes a claim during the first 3 or 6 months of taking out the policy.

PPI premiums may be:

- charged on a monthly basis for stand-alone policies
- added to a loan upfront (a single premium policy)
- paid monthly as part of a mortgage repayment.

Just think

Do John and Mary (sample consumers) fulfil the PPI claim criteria? Would PPI insurance be relevant to them?

John and Mary both fulfil the claim criteria from an age point of view. However, as neither is working, the policies would not be relevant to them.

Example 5.8

In 2011, the Central Bank raised concerns that credit institutions had not complied with the Consumer Protection Code (CPC) when selling PPI products. It instructed 11 credit institutions to review their sales of PPI for compliance with the CPC.

The review was completed in May 2014. It resulted in €67.4 million being refunded to around 77,000 policyholders who had been mis-sold PPI since July 2007. The review found that 22% of all PPI policies sold (by the institutions under review) were mis-sold. Refunds were paid in cases where credit institutions did not comply with, or could not demonstrate having complied with, the CPC when selling PPI.

Quick question 8

What are the differences between a permanent health insurance and a payment protection insurance policy?

E Summary

In this chapter, we looked at a range of insurances including travel, personal accident and sickness, and payment protection. We also considered the risk-rated health insurance products available in the market and the basis on which these are made available to consumers.

The range of cover available under many of these insurances is complex. The differences in limits and cover provided under different insurer's policies are significant. Comparison charts (see Chapter 1B1c) are helpful in ensuring that the adviser can make meaningful comparisons in a straightforward and efficient way when providing advice to a consumer.

You should now revisit the sample consumer profile at the start of the chapter and think about the advice you would have given to John and Mary.

E1 What's next?

In Chapter 6 we'll look at private health insurance, with a focus on developing solutions for consumers.

E2 Study tips

It's important to remember that this textbook is the primary information source for this module. All the questions in your exam will relate directly to information featured in the textbook. Use the 'End of chapter questions', 'Quick questions' and the 'Sample multiple-choice questions' to quickly test what you've learned so far. Make a note of any topics/areas you need to improve in and keep it to hand so you can refer to it when you revise this chapter again before your exam.

In addition to the textbook, your Member Area has many online study supports that can help you as you study this module.

E3 Online learning supports

Your Member Area includes a learning plan, an automated study planner, an exam countdown timer and study tips guide. These study supports are invaluable in reinforcing what you have learned from the textbook so far. The webinars, chapter-by-chapter key points and other supports will help you to break down the chapter content when revising.

Completing online mock exams and reviewing the personalised feedback that follows is a great way of testing your knowledge and preparing for exam day.

To access these online study supports, just log into your Member Area on www.iii.ie and click on the **Connect** logo.

End of chapter questions

Use these questions to test your understanding of what we've covered in Chapter 5.

1. Explain the type of benefit provided by the delay in arrival of baggage extension on a travel policy.

2. List three extra sections of cover available under a travel insurance policy.

3. List activities that are generally excluded from accident and medical cover on a travel insurance policy.

4. Outline the potential problem with relying on the cover provided for personal accident under a comprehensive motor insurance policy.

5. Explain why personal accident insurance policies and sickness insurance policies are not contracts of indemnity.

6. Sickness insurance policies are normally subject to a time franchise. State how this affects the way that claims are settled.

7. Name two healthcare products underwritten by life assurance companies.

8. Identify the key features of permanent health insurance.

9. List the limitations and restrictions on a permanent health insurance policy.

10. Personal accident and sickness benefit policies are basic benefit policies. List four examples of consumer requirements that might lead an advisor to consider more suitable products.

11. Define emergency dental treatment.

12. Outline the main categories of treatment covered under dental products.

13. Identify the type of consumer most likely to avail of an international health insurance plan.

14. Explain how the medical expenses cover on an international health insurance plan differs from that on a travel insurance policy.

15. List the risks that may be covered under a typical payment protection insurance policy.

16. Payment protection insurance customers must meet strict eligibility criteria if they are to make a successful claim. List any three of these criteria.

Answers to end of chapter questions

Check your answers against those below and make a note of any points you left out. This will highlight the sections you may need to look at more closely during your revision.

1. The delay in the arrival of baggage extension covers the purchase of essential items of clothing and toiletries, when baggage is delayed for a certain period (usually ranging from 12-24 hours) after the time at which it should have arrived on the outward journey.

2. Extra sections of cover available under a travel insurance policy include emergency service, missed departure, hospital benefit, winter sports, golf cover, kidnap and ransom, and legal costs and expenses in pursuing a claim arising from the death of, or injury to, the policyholder.

3. Hazardous activities such as winter sports, water-skiing, pot holing or mountaineering, are generally excluded from accident and medical cover under a travel insurance policy.

4. Relying on the cover provided for personal accident under a comprehensive motor insurance policy is problematic for two reasons: a) some insurers' cover is extremely limited and b) it only comes into effect if the claim is as a result of a car accident. Depending on the extent of the consumer's requirements, the adviser may recommend separate personal accident cover.

5. Personal accident insurance policies and sickness insurance policies are benefit policies. A benefit policy is one that pays a fixed amount on the occurrence of certain defined events. Unlike an indemnity policy, it does not try to put the insured back in the same financial position that they were in before the loss.

6. A time franchise is a period of time that must elapse before cover operates under the policy. The time franchise for a sickness insurance policy is generally 7 days. If the sickness lasts for a shorter period than the time franchise, then no benefit is payable.

7. Permanent health insurance and critical illness insurance are two healthcare products underwritten by life assurance companies.

8. A permanent health insurance policy is a protection policy which pays a regular income if the policyholder suffers a loss of earned income by being unable to work due to sickness, accident or disability lasting longer than the 'deferred period' (a set period of time agreed by prior arrangement between the policyholder and insurer, where a waiting period applies from the first day of a person's claim to when the policy actually pays out the first benefit). The benefit is payable as long as the individual suffers a loss of earned income; it is capped as a percentage of pre-disability earnings, less the single person's State Illness Benefit.

9. Permanent health insurance policies usually have exclusions and restrictions on the payment of benefit, e.g. where the illness giving rise to the claim arises from self-inflicted injury, drug or alcohol abuse, a pre-existing condition, from participation in certain dangerous pursuits or from active participation in a riot or civil commotion or criminal act.

10. Examples of consumer requirements that would prompt the adviser to consider more suitable policies are:

- Compensation for loss of income over a significant period following injury or illness – whereby a permanent health insurance contract should be considered
- Cover required for hospital costs while based in or outside of the Republic of Ireland
- Protection of monthly repayments for regular outgoings following redundancy or injury; whereby a payment protection policy should be considered
- A lump sum required upon death, whereby some type of life protection policy may be more appropriate.
- Making provision for life-changing events following a serious injury, a serious (critical) illness policy should be considered.

11. Emergency dental treatment is treatment for the immediate relief of pain caused by a natural tooth being lost, damaged or infected, howsoever caused, or from any trauma to the mouth.

12. The main categories of treatment covered under a dental insurance product are:

- basic treatments
- major treatments
- orthodontics
- oral cancer.

13. International health insurance is designed for consumers who are working, travelling or studying abroad for 6 months or more.

14. International health insurance provides cover for elective medical treatment while abroad. Travel insurance only covers emergency medical treatment.

15. Risks covered under a typical payment protection insurance policy can include:

- death (typically for outstanding loan balance)
- accident and sickness
- critical illness (typically for outstanding loan balance)
- disablement
- redundancy/job loss.

16. The strict eligibility criteria to make a successful claim on a payment protection insurance policy could include any of the following. The policyholder must not:

- be aged under 18 or over 65
- work less than 16–18 hours a week
- take voluntary redundancy
- be self-employed and go out of business
- be a temporary/contract worker and lose their job
- be aware, or should be aware, of an existing medical condition
- be unable to work because of certain common conditions, such as stress or backache
- make a claim during the first 3 or 6 months of taking out the policy.

Answers to quick questions

1. Single-trip travel insurance covers a single trip up to a maximum duration of 30 days. An annual multi-trip travel insurance policy covers all trips up to a certain duration in a year.

2. Yes. A lost passport is covered under the baggage and extensions section of a travel insurance policy. Amounts of up to €400 are payable for the cost of obtaining an emergency passport while abroad, subject to the policy terms and conditions.

3. Apart from health matters, the single most significant question an adviser should ask the consumer regarding the cancellation and curtailment cover provided by a travel insurance policy is: 'What is the likely highest advance payment/contractual liability for any one holiday (or outstanding at any one time)?' The reason for this is that the standard limit for 'loss of deposits' cover varies between insurers.

4. A personal accident insurance policy is often not an adviser's 'first choice' of recommendation, because the trigger for these policies is an 'accident'. Other, more focused products may be more appropriate: loss of income (permanent health); a lump sum required upon death (life assurance); protection of monthly repayments (payment protection insurance).

5. The maximum level of permanent health insurance cover an individual can have is 75% of their earnings, less any income from other sources, including social welfare and sick pay entitlements.

6. The exclusions that may apply to a hospital cash benefit are:

   a. hospitalisation due to psychiatric, mental or nervous illnesses

   b. self-inflicted injuries stemming from alcohol or drug abuse

   c. hospitalisation occurring due to pre-existing conditions

   d. hospitalisation due to pregnancy within 9 months of the start date of the policy.

7. Standard travel insurance policies are designed for short trips abroad up to 60 days. For trips lasting 6 months or more, a specialist travel policy covering the entire duration of the trip will be required.

8. Permanent health insurance provides income protection, replacing earnings lost due to sickness or disability. Benefits are paid directly to the policyholder. In contrast, payment protection insurance will pay loan repayments for a finite period, with the payments going to the creditor, not the policyholder. It provides cover for redundancy/job loss, critical illness, as well as sickness and disability.

Sample multiple-choice questions

1. An insurer will normally decline a claim on a payment protection insurance (PPI) policy if the claimant works **less** than how many hours per week?

   A. 10

   B. 12

   C. 16

   D. 24

   Your answer:

   ☐

2. Malcolm cancels his holiday and will lose his deposit of €750. His travel insurer will **not** reimburse the deposit because the cancellation was due to:

   A. Malcolm being called for jury service after booking the holiday

   B. the unexpected serious illness of Malcolm's father

   C. a fire at Malcolm's home

   D. a pre-existing medical condition re-occurring before Malcolm's holiday.

   Your answer:

   ☐

3. Andy holds a hospital cash benefit that provides a benefit of €100 per day (subject to a 2-day deferred period). Andy has been in a public hospital for 11 days and has incurred a bill of €750. What is the **maximum** benefit that Andy will receive?

   A. €550

   B. €700

   C. €900

   D. €1,100

   Your answer:

   ☐

Answers to sample multiple-choice questions

Question 1

Chapter reference: Chapter 5D

Question type: K

Correct response: C

Learning outcome: Demonstrate the scope and limitations of payment protection insurance.

Question 2

Chapter reference: Chapter 5A2

Question type: U

Correct response: D

Learning outcome: Demonstrate the scope and limitations of travel and personal accident and sickness insurance covers in order for consumers to be provided with the most appropriate products in these classes of insurance.

Question 3

Chapter reference: Chapter 5C2

Question type: A

Correct response: C

Learning outcome: Outline and apply the range of insurers' risk-rated health products and services.

Chapter

6

Private health insurance

What to expect in this chapter

In this chapter, we'll look at private health insurance and highlight the issues that are of particular importance to consumers when taking out this type of insurance.

After studying this chapter, you'll be familiar with the cover provided by the range of products available. You'll also know what questions to ask of a consumer seeking private health insurance, in order to establish their insurance needs and thereby recommend the most suitable product for them.

Once again, we're going to apply the stages of the advising process outlined in Chapter 1, this time with the private health insurance consumer in mind.

Note that in this chapter, the monetary values referred to (e.g. in relation to benefit levels, policy limits or excesses) are for guidance only. Likewise, the policy guides are only summaries and abbreviations of key information from sample policies in the market. They are not necessarily actual wordings, nor should they be taken as applying universally across the market. There tend to be many variations of wording and ranges of exclusions. For this reason, you are strongly advised to acquire a number of policy wordings to see what is available in the market.

To help you relate the material in this chapter to a real-life situation, we have included a sample consumer profile. This highlights some of the issues that an adviser may be presented with when arranging private health insurance. It will help you reflect on how and why each element of the private health insurance cover may (or may not) be suitable for a particular consumer. The questions to keep in mind as you work your way through Chapter 6 are: 'What are the key factors to be considered when advising James and Orla on the most appropriate private health insurance cover?' and 'Why is it important that James and Orla should urgently make a decision on their health cover?'

Learning outcomes for this chapter

Section	Title	At the end of each section you should be able to:
A	**Private health insurance**	Illustrate the private health insurance principles and minimum benefit regulations that impact on the scope of cover these products provide.
B	**Principles of private health insurance**	
C	**Minimum benefits**	
D	**Private health insurance products**	Describe the scope and limitations of different private health insurances covers and the standard options available. Identify questions that encourage the consumer to disclose the necessary material information to enable advisers to provide them with the most appropriate private health insurance product.
E	**Tax relief**	Identify and apply the tax treatment of medical expenses and private health insurance premiums and benefits and outline the rules for transferring between private health insurers.
F	**Policy continuity and transfer**	

Private health insurance sample consumer profile

James and Orla are both aged 56. They have three children who are well on the way towards 'leaving the nest'. Peter, aged 22, is a 4th-year engineering student in University College Dublin. Emma, 20, is a 1st year-physiotherapy student in Edinburgh University, and Bill, aged 15, is studying for his Junior Cert at a nearby secondary school.

James and Orla have had private health insurance all their working lives, and each child was added to their policy at birth. They have been with the same health insurance company (BeSafe Healthcare) all their lives. Their premium costs have been steadily rising in recent years, to the point of becoming unaffordable. When Orla recently lost her job, some bills went unpaid, including the renewal of the health insurance.

James and Orla are aware that their health insurance was due to be paid last month. They are worried that they have not yet made a decision about renewing their health cover, and immediately make an appointment to see their insurance adviser.

At this meeting, they also want to review the suitability of their existing health insurance cover considering that their financial circumstances have recently changed. The family have been on the same health insurance plan for many years. Although they have been loyal customers of BeSafe Healthcare, they simply cannot afford this year's renewal premium.

A Private health insurance

There are currently 11 organisations that offer private health insurance in Ireland. In order to offer private health insurance, a company (undertaking) must register with the Health Insurance Authority (HIA) on the Register of Health Benefit Undertakings and be authorised by the Central Bank.

The Register contains two categories of undertakings:

1. Open membership undertakings – These companies are obliged to provide health insurance cover to anyone who seeks it. Irish Life Health, Laya Healthcare, HSF Health Plan and Vhi Healthcare fall into this category. They all offer comprehensive in-patient products, with the exception of HSF Health Plan (which provides health insurance cash plans only). It should also be noted that Laya Healthcare is a registered intermediary for its underwriter.
2. Restricted membership undertakings – These schemes are restricted to a particular class of membership and are not open to the general public, e.g. St Paul's Garda Medical Aid Society, the Prison Officers' Medical Aid Society and the ESB Staff Medical Provident Fund; all of which are only open to current and retired employees and their dependants.

The specific principles that apply to private health insurance, coupled with the limited number of insurers, give the market some unique characteristics that impact on the way advice is provided to consumers.

As only Irish Life Health appoints intermediaries, an adviser, who is required to give a 'fair analysis of the market', may provide this advice on a fee basis rather than relying on commission. Alternatively, the adviser may state that for health insurance, they give advice on a 'limited analysis' basis as they only deal with a certain number of health insurers.

B Principles of private health insurance

In the Compliance and Advice module we considered the principles on which the private health insurance market operates in the Republic of Ireland. We include a brief summary of these principles here in order to provide a background to the sections that follow.

It is worth noting that private health insurance operates in a completely different way to other insurances. The health-related insurances covered in Chapter 5 were risk rated (i.e. price and acceptance terms are based on factors such as age, health status, claims experience) but private health insurance does not operate in this way, as you will see in this chapter.

The **Health Insurance Acts** are the primary source of regulation for the private health insurance market and represent the legal basis of the principles on which the market operates. The Acts also established an independent statutory regulator of the private health insurance market – the Health Insurance Authority (HIA).

The principles on which the market operates are as follows:

- Community rating
- Open enrolment
- Lifetime cover
- Minimum benefits

Each principle will now be discussed in turn.

B1 Community rating

Community rating refers to the principle that an insurer offering private health insurance cover for a specific level of benefit must charge the same premium to all policyholders regardless of the insured's health-risk status, age, gender or claims experience.

Variations and modifications to the principle of community rating include:

- Children, where the premium must be no more than 50% of the adult rate.
- Young adults (aged 18-25) may be offered reduced premiums.
- Members of group schemes, where the premium may be reduced by up to 10%.

community rating

private health insurance principle that cross-subsidises the cost of private medical insurance from young to old and, to some degree, male to female

lifetime community rating

the older a person is when they take out private health insurance, the higher the premium they will pay; however, the premium may not subsequently be increased to reflect the person's advancing age

B1a Lifetime community rating

Since May 2015, the principle of community rating has also been modified by a system of **lifetime community rating** (LCR). Its aim is to encourage people to join the private health insurance market at a younger age. Community-rated markets depend on a continuing influx of younger people as they claim less on average and, accordingly, keep premiums down for everybody. LCR means that where a person aged over 34 enters the market for the first time, or after a break in cover of more than 13 weeks, they will have to pay a loading on the premium charged. This loading will depend on their age at entry and is payable for a period of 10 years. The loading begins at 2% on gross premiums, for each year that the insured person's age exceeds 34 years, up to a maximum loading of 70%. So, for example, a 35 year old buying a policy for the first time will pay a loading of 2%, a 37 year old would pay a loading of 6% and so on. Breaks in cover of up to 13 weeks are allowed without affecting the loading.

B1a1 Credited periods

Credited periods are provided in certain circumstances, and once certain criteria have been satisfied as outlined in this section.

For previous periods of cover

Where a person had previously held private health insurance but gave up their cover, a 'credited period' (reduction in loading) will apply. If a person takes out inpatient private health insurance after 01 May2015, their previous periods of cover will be taken into account in calculating the loading that applies to them. If a person had continuous cover for the period 1 May 2009 to 30 April 2015, the insurer will consider them to have had continuous cover since the age of 23. Credit does not apply to periods of cover as a child. Loadings will not be applied to cash benefit plans and equally credit periods are not provided for periods of cover under such plans.

For the unemployed

Where a person who previously had health insurance cover prior to the introduction of the loadings ceased to have cover on or after January 2008, because they became unemployed, a further credited period of up to 3 years will apply. The person must have been in receipt of a Social Welfare benefit during the period directly after being made redundant and giving up their health insurance, and they must have been unemployed for a period of not less than 6 months. Effectively, when calculating any premium loading, such periods will be treated as if the person held insurance cover up to a maximum credit of 3 years.

For persons who cancel their health insurance

Persons who have cancelled their insurance for 6 months or more, having previously been insured for at least 3 years, will be credited for any periods of non-cover that began on, or after, 1 February 2019. The period of 3 years cover does not need to be consecutive. The credited period is limited to 3 years and is available regardless of why the insured person cancelled their insurance.

For persons who emigrated and are returning to Ireland, or persons newly resident in Ireland

A person who lived outside the State on 1 May 2015 and subsequently moved to Ireland has 9 months from the date of moving to Ireland to purchase inpatient private health insurance avoiding an LCR loading.

For a person that lived within the State on 1 May 2015 and subsequently moved to live outside the State, a credited period is given for any periods of cover of not less than 6 months commencing on or after 1 November 2018 in respect of which a person resides outside the State, provided he or she becomes an insured person within 9 months of ceasing to reside outside the State.

For those people who immigrate to Ireland, if private health insurance is purchased within 9 months of becoming resident in Ireland, they will not have to pay a Lifetime Community Rating loading.

For former members of the Permanent Defence Forces and the EU Joint Sickness Insurance Scheme

Credit is being given for such persons provided they became an insured person on, or after, 1 September 2018 and within 9 months of ending their membership.

B2 Open enrolment

Open enrolment refers to the principle that an insurer must accept all individuals regardless of the risk they pose, their age or gender.

B3 Lifetime cover

Lifetime cover refers to the principle that once an individual has a health insurance policy, an insurer may not cancel or refuse to renew such cover irrespective of that insured's claims experience, age or risk status (other than for non-payment of premium or fraud, or where the insurer ceases to write health insurance business in the State).

B4 Minimum benefits

Minimum benefits refer to the principle that all private health insurers must provide cover for a statutory minimum schedule of benefits as laid down in the **Health Insurance Act 1994 (Minimum Benefit) Regulations 1996 (as amended)**.

Just think

Eamon is 50 years old and had private health insurance for 5 years in his late 20s but let it lapse. What factors will be considered when calculating Eamon's premium under lifetime community rating?

Eamon's age of entry under lifetime community rating is his age when purchasing insurance less any previous periods of cover. For Eamon this is 50-5 = 45. So he will pay the same loading as a 45-year-old who is purchasing private health insurance for the first time.

Just think

Given these constraints, how do private health insurers manage the pooling of risk and policy pricing in the way that other insurers do?

Clearly, the application process for private health insurance is very different from the process used for other insurance products. Due to the principle of community rating, private health insurers cannot vary the premium they charge different individuals purchasing the same product to reflect the risk they present. It is therefore critical that the premium they set for each product ensures that all of the contributions received will be enough to successfully operate the insurance pool.

open enrolment

the principle that a private health insurer must accept all individuals regardless of the risk they pose

lifetime cover

the requirement that, once an individual has been put on cover, the insurer may not cancel or refuse to renew such cover, irrespective of that individual's claims experience

minimum benefits

the principle that all private health insurers must provide cover for a statutory minimum schedule of benefits as laid down in the **Health Insurance Act 1994 (Minimum Benefit) Regulations 1996 (as amended)**

Quick question 1

What are the implications for James and Orla (from the sample consumer profile) under lifetime community rating if they decide to let their cover lapse?

The answer is at the end of this chapter.

Quick question 2

John is 40 years old. He returned to Ireland two months ago; having emigrated in January 2015. How many months does John have to purchase an inpatient health insurance plan without incurring the LCR loading?

B5 Waiting periods

waiting period

legally permitted specified periods of time following the start of a private health insurance policy during which particular policy benefits are not available to the insured

In recognition of the constraints imposed by these principles, private health insurers are permitted to impose certain **waiting periods**. The circumstances in which the waiting periods may be applied, along with the maximum waiting periods, are all set out in Regulations made under the **Health Insurance Acts.**

These waiting periods essentially mean that a person cannot selectively choose to take out cover or change their level of cover in the knowledge that they will require specific treatment, and expect the costs to be paid immediately. In May 2015, new open enrolment regulations came into force which set the maximum waiting periods that can be applied irrespective of age.

Private health insurers can decide how they will apply these waiting periods, once the maximum stated durations are not exceeded. Market practice varies and each insurers' approach is summarised on the HIA website.

There is no waiting period for treatment arising as a result of an accident or injury after the person is included on the policy. Waiting periods apply primarily in respect of in-patient treatment (although they may also be applied to out-patient benefits).

There are four different types of waiting periods. The first three in the following list apply to new policyholders whereas the fourth applies to those changing or upgrading their cover:

1. **Initial waiting period** – This starts from the date on which the individual first enrols and applies for 26 weeks irrespective of the person's age at enrolment. During this period, the insurer is only required to pay benefits in respect of treatment resulting from an accident or injury. There is no waiting period for a newborn infant or adopted child who is included on a contract within 13 weeks of their birth/adoption.
2. **Maternity waiting period** – There is a specific maximum waiting period of 52 weeks for maternity benefits. This means that there must be 52 weeks insurance between the date of joining and the newborn's date of birth to qualify for maternity cover under the policy.
3. **Pre-existing waiting period** – This starts from the date on which the individual first enrols. It applies to claims for **pre-existing conditions**. The maximum waiting period is 5 years from the date of enrolment on the contract.
4. **Upgrade waiting period** – This applies where a person upgrades their level of hospital cover, i.e. subscribes for additional benefits. The maximum waiting period is 2 years. Insurers usually apply this waiting period in respect of pre-existing conditions only, but may also impose a reduced waiting period of 26 weeks on the new benefits coming into effect. During this waiting period, cover is normally provided at the previous level. Some insurers exclude 'day-to-day' benefits from the rule while most insurers apply a 26-week waiting period for additional 'day-to-day' cover for policyholders over a certain age.

pre-existing condition

an ailment, illness or condition, the signs or symptoms of which existed in the period of 6 months prior to the person becoming insured under an insurance contract

Example 6.1 illustrates the application of one such waiting period.

Example 6.1

Karl, a 36-year-old male, takes out health insurance for the first time. His policy will be subject to a 26-week waiting period on joining. If, after 2 months, he develops tonsillitis and a tonsillectomy is recommended, he will not be insured for this operation unless he defers his hospital treatment until the waiting period has expired. If he is admitted after the expiry date of his waiting period, then the claim will be paid according to the policy held, assuming that the condition was not present before Karl joined the scheme. If the condition was present during the 6 months before Karl joined the scheme he would be subject to a 5-year waiting period for that condition. If Karl was admitted to hospital for this procedure during the waiting period, then his claim would be rejected by the insurer.

Quick question 3

What waiting periods would our sample consumers James and Orla be subject to if they decided to upgrade their cover?

Quick question 4

Mary is 36 and is purchasing an inpatient health insurance plan. Her only period of previous cover was for five years during her childhood under her parents' policy. What, LCR loading, if any, applies to Mary?

B6 Risk equalisation

B6a Objective of risk equalisation

Health insurance claims costs increase with age. Figure 6.1 illustrates this trend.[10]

Figure 6.1 Claim variation by age.

The **risk equalisation** process aims to equitably equalise differences in insurers' claims costs arising from variations in the age profile of the people they insure. It is a common mechanism in countries with community-rated health insurance systems. The **Health Insurance (Amendment) Act 2012** introduced the Risk Equalisation Scheme (RES), which became effective in January 2013.

The RES helps to spread some of the claims cost of the high-risk, older and less healthy policyholders among all the private health insurers in the market, in proportion to their market share.

risk equalisation

a process that aims to equitably neutralise differences in insurers' costs that arise from variations in the age profile of the individuals they insure

[10] Health Insurance Authority, *HIA Annual Report 2019*, pdf, Appendix B, www.hia.ie.

advanced cover

a health insurance contract that provides cover for 66% or more of the full cost for hospital charges in a private hospital

non-advanced cover

a contract that provides no more than 66% cover for the full cost of hospital charges in a private hospital, or cover that is equivalent to that prescribed in the Minimum Benefit Regulations

B6b Funding of risk equalisation

The risk equalisation process works through a system of levies (money collected from insurers) and credits (money paid back to insurers).

The health credits vary by policyholders' age, gender and level of cover, and the levy varies by adult, child and level of cover. The differentiation in level of cover is determined by whether the contract is deemed to be either **advanced cover** or **non-advanced cover**.

The rate of credits applicable for policies entered into or renewed from 1 April 2021-31 March 2022 under the **Health Insurance (Amendment) Act 2020** is set out in Table 6.1 while the community rating levies are set out in Table 6.2.

Table 6.1 Health credits

Age band	Non-advanced		Advanced	
	Men	Women	Men	Women
64 and under	€0	€0	€0	€0
65–69	€350	€200	€1,025	€550
70–74	€550	€400	€1,675	€1,150
75–79	€825	€625	€2,500	€1,800
80–84	€1,025	€700	€3,150	€2,250
85+	€1,250	€825	€3,750	€2,550

Table 6.2 Community rating levies

	Non-advanced	Advanced
Adult (18 and over)	€157	€449
Child (17 and under)	€52	€150

Note that depending on the claims experience of insurers, these credits and levies are reviewed on a regular basis and can and do change.

Quick question 5

What age-related health credits would our sample consumers James and Orla's private health insurance policy attract (presuming it is an advanced contract)?

Just think

On the basis of figures provided in Tables 6.1 and 6.2, how much might an insurer receive and be charged for insuring a 72-year-old male on an advanced plan (covering public and private hospitals)? Assume the net premium payable for the plan is €800 (gross premium is €1,000).

Quick question 6

What community rating levy would apply to our sample consumers James and Orla's private health insurance policy (presuming it is an advanced contract)?

Included in the gross premium is a community rating levy of €449 which is paid by the insurer to the Revenue Commissioners (Revenue) who pass this money to the risk equalisation fund. As per Table 6.1, this insurer will receive a health credit from this fund of €1,675 for insuring this 72-year-old policyholder. In this case, the insurer will be a net beneficiary from the fund in that they will receive €1,675 versus the €449 that they paid in. This shows the purpose of the fund which is to compensate those insurers deemed to be carrying a disproportionate level of claims risk relative to the market.

In addition to the health credits, there is a hospital bed utilisation credit designed to compensate insurers for claims costs associated with those who are less healthy. This credit is also funded by the levy and is paid from the fund to insurers in respect of each night an insured person spends in private or semi-private accommodation. Under current legislation the hospital bed utilisation credit is €125 per night and €75 per day-case.

C Minimum benefits

We will now consider the minimum benefits that must be covered by law under a private health insurance contract.

The **Health Insurance Act 1994 (Minimum Benefit) Regulations 1996 (as amended)** require that insurers provide a minimum level of cover in respect of a broad range of investigative and medical interventions. These must be appropriate and necessary, and provided on an in-patient or day-patient basis, with some very limited cover required in respect of out-patient benefits. The rationale underpinning the minimum benefits is to ensure that the rules of community rating are not undermined, that consumers do not underinsure and that the lowest level of cover is equivalent to cover for private services in a public hospital.

The minimum benefits schedule in force corresponds broadly with the basic elements of the entry level products available from each insurer (see Section D), although many of these products tend to exceed the minimum benefit requirements. Table 6.3 sets out the minimum benefit requirements for hospital in-patient services.

Table 6.3 Private health insurance – minimum benefits

Prescribed service	Prescribed minimum payment
Public accommodation in a public hospital[11]	In-patient levy payment[12]
Semi-private (or **multi-occupancy room**) room in a public hospital	The daily rate for a multi-occupancy room plus the in-patient levy
Private day care services in a public hospital	The daily rate for day care services plus the in-patient levy
Semi-private room in a private hospital	A percentage of the private hospital charge or defined fixed sum
Private room in a private hospital	
Private day care services in a private hospital	
In-patient services in a registered nursing home (convalescence care)	€25 per day up to 14 days
Hospital charges associated with a normal maternity delivery	€381
Other prescribed minimums	
• 35% payment of hospital charges in relation to certain special (fixed-price) procedures • 180 days' cover for in-patient treatment in any year • 100 days' cover for in-patient psychiatric treatment in any year • 91 days' cover for substance abuse in any continuous 5-year period	
Medical consultants	
• Prescribed minimum payments set out for the payment of medical consultants for a wide range of in-patient medical treatments and investigations.	

multiple-occupancy room

category of private hospital accommodation under the **Health (Amendment) Act 2013**, which removes the distinction between private and public beds in public hospitals and charges on the basis of single-or multi-occupancy rooms and day care

Quick question 7

Why are health insurers obliged to provide cover for a minimum level of benefits?

[11] Note: Private health insurers are not required to cover all public hospitals.

[12] This is a statutory charge for overnight and day inpatient services of €80 per day, up to a maximum of €800 in any 12 consecutive months.

Certain minimums are set for out-patient benefits, i.e. consultants' fees, radiology and pathology services. There is no requirement for the inclusion of GP services.

Where an excess applies, the net amount paid by the insurer must be greater than the prescribed minimum payment set out in the Minimum Benefit Regulations.

The Regulations also specify a number of services/treatments that private health insurers are not required to cover. These exclusions are set out in Table 6.4.

Table 6.4 Permitted exclusions from minimum benefits

- Treatment for male and female birth control, infertility and any form of assisted reproduction
- Dental, orosurgical or orthodontic treatment or consultation (except for prescribed services)
- Cosmetic services or treatment except for accidental disfigurement or significant congenital disfigurement
- Health services relating to eating disorders or weight reduction
- Check-ups or screenings (as these are mainly covered by preventive health services)
- Health services provided by a nursing home other than a registered nursing home
- Nursing care to dependants other than in-patient, day-patient or out-patient services
- Health services received overseas
- Health services provided other than:
  - those resulting from a referral to a health service provider by a registered medical practitioner
  - in an emergency
  - in connection with an obstetric condition
- Health services necessitated directly or indirectly by war or civil disturbance.

Although insurers are not legally obliged to cover any of the items listed in Table 6.4, most insurers provide limited cover for some of these exclusions, such as A&E abroad, screening or more recently infertility treatment.

Quick question 8

When considering the permitted exclusions outlined in Table 6.4, how would you group these together as categories of exclusions? An example of a category would be 'services that are not medically necessary'. (Think of common threads that link some exclusions together).

Quick question 9

Why do you think private health insurers are given the right to challenge whether the type of care or treatment is appropriate?

C1 Treatment in an appropriate setting

Under the Minimum Benefit Regulations, private health insurers may adjust the rate they pay to reflect the **appropriate setting** for the treatment provided. For example, if an insurer considers that treatment provided on an in-patient basis could have been provided on a day-patient basis, the insurer is only obliged to pay the day-patient rate. This is to discourage the policyholder from 'overspending' on unnecessary facilities or accommodation.

appropriate setting

the right of a private health insurer to determine whether it is medically appropriate to pay benefits on an in-patient, day-patient or out-patient basis and to adjust the rate it pays to reflect the type of treatment considered necessary

D Private health insurance products

Although the number of products available in the Irish private health insurance market continues to grow, there are essentially 3 main types of community-rated products.[13]

D1 Hospital-only products

These products offer hospital cover only, with a limited range of outpatient benefits that are subject to a high excess. These products are favoured by those who choose not to insure the cost of outpatient benefits. This may be because, historically, they have not incurred many outpatient expenses, or they are willing to risk not having cover for such expenses. Table 6.5 describes the cover typically provided and outlines available variations.

Table 6.5 Hospital-only cover

Hospital cover	Description	Variations available
Public hospital	Full cover for day care, semi-private (multi-occupancy) and private accommodation (single-occupancy) in a public hospital	• Cover for private room • No cover for private room in a public hospital • Varying maternity cover • List of hospitals covered
Private hospital (standard)	Up to 100% cover for day care, semi-private and private accommodation in a standard private hospital	• Cover for private room • List of private hospitals covered, e.g. St Vincent's Private, Beacon Hospital, Hermitage Clinic (Dublin) and Bons Secours (Cork) • Varying percentage cover according to setting, e.g. day care 100% and semi-private 50% • Varying excess according to setting, e.g. day care
Private hospital (hi-tech)	Ranging from no cover up to 100% cover for day care, semi-private and private accommodation	• Cover for private room • List of hi-tech hospitals covered, e.g. Blackrock Clinic and Mater Private • Varying percentage cover according to setting, e.g. percentage for private, if only covered for semi-private • Varying excess according to setting, e.g. day care • Capped or deferred excesses, e.g. limit on number of excesses that may apply

[13] For full details of all insurers' products, it is helpful to refer to the individual websites of private health insurers or view the independent product comparison tool on the HIA website, www.hia.ie.

Table 6.5 Hospital-only cover (contd)

Hospital cover	Description	Variations available
Specified cardiac procedures (high-tech special)	Ranging from no cover up to 100% cover	• List of hospitals covered • List of procedures covered
Specified other procedures	Ranging from no cover up to 100% cover	• List of hospitals covered • List of procedures covered
Restricted procedures	Reduced cover for certain hospital procedures, e.g. certain orthopaedic and ophthalmic procedures	• 50–80% cover per procedure • €500–€2,000 co-payment per procedure
Private hospital excess	A fixed amount payable (e.g. €50-€150) by the consumer on private hospital claims, which may be tiered depending on type of private hospital, accommodation level in that hospital and/or procedure type, or per policy Potential shortfall or co-payment on certain procedures	

There are different levels of hospital-only products, ranging from cover only in public hospitals to cover in both public and private hospitals. Table 3.6 illustrates typical product benefits at various levels of cover.

The pricing reflects the level of cover, i.e. the higher the level of cover, the more a policy costs.

D1a Examples of differences in levels

Although the level of cover varies depending on the product and the insurer, hospital-only products generally have certain standard components. Table 6.6 details the typical product benefits offered in the Irish market at each of these levels and, in doing so, illustrates the entry, mid and high-end products available. It should be noted that, in recent years, insurers have begun to introduce products that limit the number of public and/or private hospitals covered.

Table 6.6 Typical product benefits at various levels of cover

Entry level
• Full cover, either for all or for a limited number of public hospitals (multi- or single-occupancy room) • Limited cover (e.g. up to 66%) for a limited number of standard private hospitals or no cover at all for private hospitals • Limited or no cover for private hospitals (high-tech) • Full cover for consultants' fees for hospital treatment (usually in public hospitals only) • 100 days' cover for psychiatric treatment (in public hospitals only) • 91 days' cover for alcohol and substance abuse within a 5-year period (in public hospitals only) • 3 days' full cover for maternity in a public hospital or the minimum benefit as set out in the Health Insurance Regulations.

Table 6.6 Typical product benefits at various levels of cover (contd)

Mid-level

- Full cover for public hospitals (multi- or single-occupancy room)
- Full cover for semi-private accommodation in a private hospital (standard), which may include products with **restricted illness cover** and also private hospital excesses
- Limited cover for private hospitals (high-tech)
- Full cover for specified cardiac procedures in high-tech facilities
- Partial cover (e.g. 90%) or full cover for specified other procedures in the same facilities
- Full cover for consultants' fees for hospital treatment
- 100–180 days' cover for psychiatric treatment
- 91 days' cover for alcohol and substance abuse within a 5-year period
- 3 days' full cover for maternity in a public hospital.

Mid-level products are the most popular in the market. Many **corporate products** that offer 'hospital and day-to-day cover' combined would also fall into this level. As a result, there are many variants between and within each of the health insurers' product portfolios.

High-end level

- Full cover for public hospitals (single-occupancy room)
- Full cover for private accommodation in a standard private hospital
- Full cover for private accommodation in a private hospital (high-tech)
- Full cover for specified cardiac and other procedures
- Full cover for consultants' fees for hospital treatment
- Up to 180 days' cover for psychiatric treatment
- 91 days' cover for alcohol and substance abuse within a 5-year period
- 3 days' full cover for maternity in a public hospital.

High-end products offer the most extensive hospital cover.

restricted illness cover

a health insurance policy that specifies certain illnesses as 'restricted' for which the insurer will pay only a certain percentage of the hospital charges, usually 80%, with the insured paying the balance

corporate products

a product specifically designed for company-paid groups that provide tailored private health insurance for their employees

D2 Hospital with 'day-to-day' products

These products add comprehensive 'day-to-day' benefits to the 'hospital-only' products.

Day-to-day benefits include those associated with the out-patient component of a hospital stay (e.g. consultants' fees, radiology and pathology services). These are sometimes referred to as 'out-patient benefits'. Day-to-day benefits include a range of benefits associated with more frequent expenses, such as visits to GPs, dentists, physiotherapists, complementary and alternative therapists. These 'day-to-day' benefits also typically have a very low excess, e.g. €1. Hospital only products offer limited cover for these expenses, with a high annual excess.

The combination of these elements makes this product type the ideal choice for the consumer who experiences regular 'day-to-day' medical expenses but who also wants cover in the event that they need hospital treatment. Many corporate plans are available across all providers at this level.

D3 'Day-to-day' only products and health insurance cash plans

health insurance cash plan

policy that pays 'day-to-day' out-patient benefits and may include a daily cash contribution towards in-patient hospital stays

hospital cash (hospital income)

plans that provide daily sums to a policyholder for being admitted to a hospital

These products do not provide hospital cover and tend to fall into two categories.

The first category comprises 'day-to -day'-only products that offer benefits in respect of a wide range of everyday medical expenses (see Table 6.7).

The second category is referred to as a **health insurance cash plan** that provide cover on a fixed amount or fixed percentage basis (see Table 6.8) and are subject to community rating, open enrolment and lifetime cover. Laya Healthcare and Vhi Healthcare offer these types of product. However, the only specialist provider of these products in the market is HSF Health Plan.

Students should note that the health insurance cash plans are different from **hospital cash** which is covered in Chapter 5C2.

Table 6.7 'Day-to-day' products

Benefits available		
Acupuncture	GP visits	Physical and massage therapy
Child counselling	Health screening	Physiotherapy
Child speech and language therapy	Hearing testing	Pre- and post-natal consultations
Chiropody/podiatry	Home nursing	Prescription costs
Chiropractic	Homeopathy	Psycho-oncology counselling
Clinical psychology	Manual lymph drainage	Public A&E
Consultants' visits	Occupational therapy	Radiology
Dentistry	Eye-testing	Pathology
Dietary	Orthopody	Reflexology
Emergency dentistry	Osteopathy	Speech and language therapy

Quick question 10

What are the two key differences between the levels of cover when comparing 'hospital-only' and 'hospital with 'day-to-day' benefits'?

Approximately 5% of private health insurance consumers have a 'day-to-day' only product. If a consumer has both a 'day-to-day' only product and a hospital-only product, there may be an overlap of cover between the products. In such circumstances, if the consumer makes a claim, the insurer only pays the total cost of the claim. This is to prevent the insured from profiting from the claim.

Table 6.8 Examples of health insurance cash plan cover

Dental and optical	50% up to €290
GP and A&E	€13 per visit, max. 10 visits
Prescription	€7 per prescription, max. 4 prescriptions
Physiotherapy, osteopathy, chiropractic, acupuncture, homoeopathy, chiropody/podiatry	50% up to €430
Specialist and investigations	50% up to €840
Birth grant/adoption grant	€440

Table 6.8 Examples of health insurance cash plan cover (Contd)	
– Inpatient hospital admissions	General and hospital: €71 per night, max. 40 nights Accident: €71 per night, max. 40 nights Elderly and mental health: €71 per night, max. 50 nights from first registration
Recuperation	€140 after 7 nights
Day case surgery and treatment	€71 per occasion, max. 8 occasions
Surgical appliances and hearing aids	50% up to €330
Personal accident:	€14,000
– permanent disability	€7,000
– accidental death	€7,000
– temporary disability	€30 per week
Fracture:	
– leg fracture	€140
– arm fracture	€70
Max per accident	€380

Just think

Having reviewed the private health insurance products, what are our sample consumers James and Orla's key requirements?

Based on the information provided in the sample consumer profile, James and Orla's key requirement is to reduce their premium cost. It would be important to establish what cover they currently hold, their desired premium cost and the trade-offs they are willing to make in order to achieve this. These could include settling for less hospitals covered, accepting a higher excess or restricted procedures on their policy, and reviewing the option of day-to-day cover. The adviser would need to conduct a detailed fact-finding exercise to determine their exact requirement in this regard. James and Orla can split their cover if they wish, i.e. they can put each person on different plans based on their specific needs but still keep everyone insured on the one policy. If necessary, they could even split their cover across insurers if this achieves the right balance between cost and benefits.

D4 Premium variations

Premium rates vary for an adult, a young adult and a child. The young adult rate varies based on age from 18 up to and including 25. Each insurer can decide whether to offer a young adult rate on a particular product so this may vary from insurer to insurer and even from product to product within an insurer's product range.

D5 Guidance for advisers

Firstly, in order to be able to provide appropriate advice to consumers, the adviser must be fully familiar with all of the health insurance products available. The HIA comparison tool is a good starting point, however, as is clearly stated on the website, it is merely a guide. It will only be beneficial in circumstances where the adviser knows which products to compare. As noted in Chapter 1B1c, cover comparison charts are a valuable tool for isolating the key features and effectively comparing variations between products.

Secondly, the adviser must have a thorough understanding of the consumer's needs and wants in order to recommend the most suitable product(s) for them. The best way is to develop a client fact find. Table 6.9 outlines the types of generic questions the adviser should ask all consumers prior to giving advice or making recommendations.

Table 6.9 Client fact find generic questions

Required information	Main reason(s) for inclusion
Consumer details	• The full name and address of the individual is needed for communication purposes, together with information regarding the spouse/partner and dependants. • Consumer address details are also used when considering the plan to be chosen in relation to the options available in local hospitals, e.g. semi-private or private. • Full contact details, including phone numbers and email addresses, will be captured here. • Date of birth is required for all new member applicants as lifetime community rating loadings may be relevant depending on age at the date of joining. It is also relevant to apply different rates for child/young adults etc. • Is the prospective policyholder a member of a group scheme? This will enable the insurer to apply a group discount, if available, and determine if the premium is subsidised or can be paid through salary deduction.
Previous insurance history	Has the consumer held a private health insurance policy in the past with any Irish health insurer? If yes, establish which insurer, which policy and how long they were insured. Check this for each person on the policy. You need to check for any breaks in cover or whether there have been any upgrades to the cover at any time. This information is required to apply/amend waiting periods for time served and ensure the consumer understands exactly what this means. This information will also be relevant in determining whether or not there is any credited period relevant if a lifetime community rating loading is to be applied.

Table 6.9 Client fact find generic questions (contd)

Required information	Main reason(s) for inclusion
Details of illnesses or injuries/pre-existing conditions	These details are not, strictly speaking, essential. However, to ensure you are aware of any treatment that is either pending or underway it is important to understand any current illnesses or conditions present that the consumer is receiving treatment for. This information is vital when developing appropriate consumer solutions and determining the most suitable type of product and level of cover required.
Key priorities	It is important to establish the key priorities for the consumer, e.g. cost savings, comprehensive cover for maternity. Open-ended questions are important in this regard. If cost is their primary concern, it would be useful to confirm their available budget for healthcare cover.
Date of contact	Timing of receipt of information/instructions will demonstrate adherence to internal requirements for customer servicing.
Authorisation to contact and full disclosure requirements	Under the CPC, all advisers must get written permission from consumers before they can contact them regarding any other products. This usually involves having the consumer sign a disclosure authorising the adviser to contact them in relation to other products and services. Some advisers will also ask consumers to sign their client fact find, confirming that the information provided is accurate.

As we have seen, there are multiple insurers in this market offering in-patient products and there is a vast array of products geared to meet particular needs or aimed at target groups. The adviser's task is to recognise key differences and unique aspects of cover. For those employed by an insurer, the challenge is to meet the CPC requirements of suitability and advise on the most appropriate product within the insurer's range to best suit the needs of the consumer.

E Tax relief

It is important to note that, in the context of private health insurance, tax relief arises in two ways:

1. Private health insurance premiums
2. Medical expenses.

E1 Tax relief on private health insurance premiums

Section 470 of the **Taxes Consolidation Act 1997** provides for tax relief in respect of premiums paid to an authorised private health insurer. It applies in respect of the individual taxpayer, their spouse and children or other dependants, at the standard rate of tax – this is known as **tax relief at source (TRS)**. The current rate of tax relief is 20% of gross premium up to a maximum relief of €200 for an adult and €100 for a child (any individual under 21 years of age). Example 6.3 shows how this is applied.

tax relief at source (TRS)

tax relief provided where an individual pays their own 'net' premium on a qualifying contract to the insurer, who then claims the balance from the Revenue Commissioners

Example 6.3

Where the gross premium for an adult is €900, the tax relief will be €180 (€900 × 20%).

However, where the gross premium is €1,200 for an adult, the tax relief will be capped at €200 as that is the maximum relief available for an adult.

E1a Qualifying contracts

Only **qualifying contracts** are eligible for tax relief. All of the open and restricted membership undertakings (with the exception of the New Ireland/Irish National Staff Benevolent Fund) are listed as authorised insurers.

The contract may provide a range of benefits, however, to be eligible for tax relief, it must be a contract entered into with an authorised insurer and provide cover for the full or partial reimbursement of actual health expenses, as tax relief is not available for other benefits. Therefore, even though health insurance cash plans have been included in the list of eligible contracts (from 1 April 2010), and Irish Life Health, HSF Health Plan, Laya Healthcare and Vhi Healthcare are listed as authorised insurers for the purposes of tax relief, the level of relief may vary depending on the level of health expenses actually covered by the policy. For example, as some of the benefits under the HSF Health Plan policies are not actual health expenses, the level of tax depends on the level of medical expenses cover under the policy.

qualifying contracts

private health insurances eligible for tax relief on premiums paid, i.e. those contracts entered into with an authorised insurer for the full or partial reimbursement of actual health expenses

Quick question 11

What is the monetary limit on the amount of tax relief a private health insurance consumer can receive on their total premiums in any one period of insurance?

Example 6.4 provides an illustration of how TRS operates.

Example 6.4

The insured person is aged 37 and has a qualifying insurance contract with a gross premium of €1,375. The TRS will be applied to a maximum of €1,000.

TRS = €200 (€1,000 × 20%)

Net premium payable to the insurer = €1,175 (€1,375 minus €200)

The Revenue Commissioners pay the amount of the TRS directly to the authorised insurer.[14]

The system applies differently to those whose health insurance premiums are paid (or part paid) by their employers. Tax relief is personal to the taxpayer, so even though an employer may be paying an employee's premium, the employer is not entitled to claim the employee's tax relief. The payment of premiums by employers results in certain tax liabilities for the employee. These tax implications are beyond the scope of this textbook, as its focus is on giving health insurance advice to individuals, rather than on employer-employee arrangements.

Quick question 12

Why do you think the State provides tax relief towards the cost of health insurance premiums?

E2 Tax relief on medical expenses

Section 469 of the **Taxes Consolidation Act 1997** provides that taxpayers are entitled to tax relief in respect of 'allowable expenses' incurred in the provision of health care. If some of the expenses are claimable under a private health insurance policy, the level of 'allowable expenses' will be reduced by this sum (see Example 6.5).

Example 6.5

Mary incurred the cost of €60 for a GP visit. Her private health insurer reimbursed her €20 under her policy for this cost. Therefore, Mary is only entitled to claim tax relief on €40 which means she will receive €8 from Revenue. (€40 × 20%)

E2a Rate of tax relief available

In relation to the rate of tax relief on health expenses, the standard rate (20%) of relief applies irrespective of whether an individual is taxed at the standard or higher rate (40%) of tax. Relief in respect of nursing home expenses will be provided at the highest rate of tax you pay. So, where a person pays the standard rate of tax, the relief will be 20%, but where a person pays the higher rate of tax, the relief will be 40% (see Example 6.6). Claims may be submitted for up to 4 years. These claims are not subject to an excess.[15]

[14] Revenue Commissioners, 'IT5 – Medical Insurance Relief', online report pdf, www.revenue.ie.

[15] Further information can be found on www.revenue.ie.

Example 6.6

John incurs a total of €500 for health expenses in the year. He is not entitled to any reimbursement under an insurance policy. He pays tax at the highest rate of 40% but is only entitled to 20% tax relief on his health expenses. Therefore, John is entitled to claim €100 from Revenue.

John, however, would be entitled to claim 40% back on the cost of nursing home expenses as tax relief for this expense is allowable at the highest rate of tax he pays.

E2b Dependants

Tax relief can be claimed for health expenses incurred by the claimant in respect of any individual. There does not need to be any relationship of dependency; the claimant simply needs to have actually paid for the health expenses claimed.

E2c Allowable expenses

Allowable expenses for healthcare relate to the 'prevention, diagnosis, alleviation or treatment of an ailment, injury, infirmity, defect or disability'. There are two categories of allowable expenses: automatically allowable expenses, and those that must be prescribed by a medical practitioner (i.e. a GP, consultant or dentist).

The complete list of allowable expenses is extensive and only part of it is provided here, as it is relevant for tax relief but not for product selection.

The listing includes:

- doctor and consultant fees
- diagnostic procedures
- drugs or medicines prescribed by a doctor, dentist or consultant
- physiotherapy or similar treatment prescribed by a practitioner
- speech and language therapy
- transport by ambulance
- provision of pregnancy and routine maternity care
- educational psychological assessments.

Cosmetic surgery (except where medically necessary) is excluded.

E2d Dental and optical treatment

Tax relief is not given for routine dental and ophthalmic care.

Legislation specifically excludes tax relief for the cost of routine dental treatment, which includes extractions, scaling and filling of teeth and the provision and repairing of artificial teeth and dentures. This exclusion applies even if there is an underlying medical condition giving rise to the dental treatment, or if the treatment in a particular case is considered to be of a non-routine nature. Crowns, extraction of impacted wisdom teeth (undertaken in hospital or in a dental surgery) and dental implants are examples of the types of dental treatments that qualify for tax relief.

Routine ophthalmic treatment covers sight testing, provision and maintenance of glasses and contact lenses.

E3 Making a claim

Tax relief is not available for any expenses that can be reimbursed from another source, e.g. under a private health insurance policy. If a taxpayer is able to claim some of the expenses under a private health insurance policy, the level of 'allowable expenses' would be the balance that was not covered under that policy.

Tax relief can be claimed after 31 December of the year in which expenses are incurred, for up to 4 years. A person can choose whether they want the relief given for the year in which the payments were made or the year in which the expenses were incurred. This might arise when a taxpayer gets a bill for medical services at the end of December and pays the bill in January of the following year. However, the norm is for the claim to be made for the year in which the expenses were incurred.

Expenses are claimed through an individual's income tax return. If the claimant is a PAYE taxpayer, they also have the option to claim relief in real time during the year.[16]

Just think

What supporting documentation is required when submitting a claim for tax relief on medical expenses to Revenue?

There is no requirement to submit receipts with a claim, however Revenue do reserve the right to ask for these receipts, for auditing purposes, for a period of up to 6 years post claim. As insurers require original receipts when dealing with out-patient and 'day-to-day' type claims, policyholders should make copies of any receipts in case they are asked to produce them at a later date. Normally, however, Revenue will accept an insurer's claims statement as proof of expenses incurred.

[16] Revenue Online Service, www.revenue.ie

F Policy continuity and transfer

Private health insurance contracts are for a period of 12 months.

All insurers must provide a 14 business day cooling-off period from the commencement of the contract or the date when the consumer is informed that the contract has been concluded. During this time the policy may be cancelled, and the premium fully refunded. No claims will be paid in respect of these 14 days if the policy is cancelled.

Each insurer has specific rules regarding mid-term adjustments. In some cases, the insurer will require a payment if the contract is cancelled mid-year, or will refuse a refund upon cancellation. However, current market practice is that the insurer will seek the pro-rata amount of the outstanding levy paid at inception by the policyholder as well as an administration fee for policy cancellation.

Some insurers will allow certain alterations to a policy mid-term. These include the addition of another person to the policy, movement to a group scheme, and changes of address.

If insurers enhance benefits on certain products, they may choose to do so from a current date rather than from the next renewal date – this differs between insurers. If an insurer increases the price or reduces the benefits on a plan, this only affects existing policyholders from their next renewal date. In the unlikely event that an insurer removes a hospital from their approved listing mid-term, they must write to all affected policyholders advising them of this change.

F1 Renewal process

The renewal process for private health insurance is straightforward.

The health insurers provide a renewal notice with the following information:

- name of policyholder
- level of existing cover
- new premium amount
- number of dependants (if applicable)
- any material changes to benefits since last renewal.

The renewal notice will also include an up-to-date policy document outlining any benefit or rule changes made since the last renewal. As noted in Chapter 2C3, an IPID must also be issued at renewal.

At renewal, policyholders have a number of choices. They can:

- renew the cover as proposed, by the continued payment of premiums
- contact the insurer to explore other product solutions
- contact alternative insurers with a view to switching
- cancel their cover.

F2 Transferring to another private health insurer

One of the key features of the private health insurance system in Ireland is that a policyholder can transfer from one private health insurer to another without having to re-serve waiting periods. The new insurer is obliged to treat the new applicant as having joined its scheme with the same effective date of the previous policy. The new insurer may impose a waiting period in respect of any additional benefits that fall within the 'upgrade of cover' rule, or in respect of any portion of the original waiting periods that have not been fully served. While the upgrade rule applies, the policyholder is still entitled to the benefit levels of their previous scheme during that period (assuming the new plan covers the same benefits).

Where a consumer has had a break in cover of more than 13 weeks, they are treated as a new applicant, and all relevant waiting periods will apply.

When a policyholder transfers from one insurer to another, the new insurer is entitled to information regarding the level of cover held and the length of time the person was insured with the previous insurer. Any benefits that contain overall maximums, such as 91 days' cover for substance abuse, will be reduced to take account of the number of days covered by a previous insurer.

Just think

Will James and Orla (sample consumers) have to serve a waiting period if they decide to transfer their private health insurance policy to a different insurer?

This will depend on whether:

- they transfer within 13 weeks from the date of lapse of their previous cover and
- they have upgraded to a higher level of cover.

If they fail to transfer within 13 weeks, they will have to serve all waiting periods as if they were taking out health insurance for the first time and may also be liable to age loadings, based on their age on re-joining, less any credit for time already insured on previous contracts.

G Summary

In this chapter we considered the unique legal principles that govern the operation of the private health insurance market in Ireland. We looked at the nature and scope of the products available and considered the minimum benefits that all private health insurance products must provide. We learned that private health insurance products are community rated, and we discussed the implications this has for the adviser's role.

At this point, you should take another look at the sample consumer profile at the start of the chapter and reflect on the advice you might give to James and Orla.

G1 What's next?

We've now completed the last of our product-specific chapters. In Chapter 7, we'll consider the claims process and the adviser's role in it.

G2 Study tips

It's important to remember that this textbook is the primary information source for this module. All the questions in your exam will relate directly to information featured in the textbook. Use the 'End of chapter questions', 'Quick questions' and the 'Sample multiple-choice questions' to quickly test what you've learned so far. Make a note of any topics/areas you need to improve in and keep it to hand so you can refer to it when you revise this chapter again before your exam.

In addition to the textbook, your Member Area has many online study supports that can help you as you study this module.

G3 Online learning supports

Your Member Area includes a learning plan, an automated study planner, an exam countdown timer and study tips guide. These study supports are invaluable in reinforcing what you have learned from the textbook so far. The webinars, chapter-by-chapter key points and other supports will help you to break down the chapter content when revising.

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End of chapter questions

Use these questions to test your understanding of what we've covered in Chapter 6.

1. Explain what is meant by 'community rating'.

2. Under the Minimum Benefit Regulations, identify what level of cover must be provided for in-patient services in a registered nursing home.

3. State why check-ups or screenings are typically excluded from the prescribed cover for minimum benefits.

4. Explain why the private health insurance market is characterised differently from the rest of general non-life insurance.

5. Briefly outline the cover provided under a health insurance cash plan and state the main exclusion that applies to this policy.

6. Explain what 'qualifying contracts' are, in the context of tax relief for private health insurance premiums.

7. Define 'allowable expenses' for medical expenses tax relief and give two examples.

8. List three types of waiting periods and outline when each is applied.

9. List three dental expenses that qualify for tax relief.

10. How long after health expenses are incurred can claims for tax relief be submitted to Revenue?

11. Outline what restriction could apply if an individual transfers from one private health insurer to another but upgrades their cover in the process.

Answers to end of chapter questions

Check your answers against those below and make a note of any points you left out. This will highlight the sections you may need to look at more closely during your revision.

1. Community rating means that an insurer offering health insurance cover for a specific level of benefit must charge the same premium to all policyholders regardless of their health-risk status, age, gender, or frequency of provision of health services to the insured (frequency of claims).

2. Under the Minimum Benefit Regulations, a fixed daily rate of €25 up to 14 days must be provided for in-patient services in a registered nursing home.

3. Check-ups or screenings are excluded from the prescribed cover for minimum benefits because they are preventive health services rather than treatment. However, with increased competition in the market, these benefits have been included on many corporate plans.

4. The specific principles (such as community rating and minimum benefits) that apply to private health insurance, coupled with the small number of insurers, give the market some unique characteristics.

5. A health insurance cash plan provides cover on a fixed amount or fixed percentage basis for specified medical expenses but does not provide indemnity for hospital cover.

6. A qualifying contract is one that is entered into with an authorised insurer for the full or partial reimbursement of actual health expenses, and is thereby eligible for tax relief.

7. Allowable expenses for medical expenses tax relief are those that relate to the 'prevention, diagnosis, alleviation or treatment of an ailment, injury, infirmity, defect or disability'. Examples of allowable expenses include:
   - doctor and consultant fees
   - diagnostic procedures
   - drugs or medicines prescribed by a doctor, dentist or consultant
   - physiotherapy or similar treatment prescribed by a practitioner
   - speech and language therapy
   - transport by ambulance
   - provision of pregnancy and routine maternity care
   - educational psychological assessments.

8. The different types of waiting period are:
   - Initial waiting period – starts from the date on which the individual first enrols and applies for 26 weeks irrespective of the individual's age at enrolment.
   - Maternity waiting period - a specific maximum waiting period of 52 weeks exists in relation to maternity benefits. This means that there must be 12 months insurance between the date of joining and the newborn's date of birth to qualify for maternity cover under this policy.
   - Pre-existing waiting period – starts from the date on which the individual first enrols and applies to claims for pre-existing conditions that existed at any time in the 6 months before the individual enrolled. The maximum waiting period is 5 years from the date of enrolment.
   - Upgrade waiting period – applies where an individual upgrades their level of hospital cover. The maximum waiting period is 2 years.

9. Crowns, extraction of impacted wisdom teeth (undertaken in hospital or in a dental surgery) and dental implants are examples of dental treatments that qualify for tax relief.

10. Claims for tax relief for health expenses can be submitted to Revenue up to 4 years after being incurred.

11. If an individual transfers from one private health insurer to another but upgrades their cover in the process, a 2-year waiting period may be applied to any increased benefits (upgrade rule). However, they will be able to avail of the benefits that applied under their previous scheme during that period.

Answers to quick questions

1. If James and Orla let their cover lapse, they may find themselves subject to a loading on their premium. They will be given credit for the duration of their previous policy so they will not be exposed to the maximum loading for their age group.
2. John has 7 months to purchase an inpatient health insurance plan.
3. If James and Orla decided to upgrade their cover, they would be subject to a 2-year waiting period for pre-existing conditions but may also be subject to an initial waiting period of 26 weeks on the new benefits.
4. Credited periods do not apply to periods of cover as a child. Therefore, Mary is subject to a 4% loading.
5. As they are both only 56, James and Orla's private health insurance policy would not attract any age-related health credits.
6. The community rating levy that would apply to James and Orla's private health insurance policy is €1,946 (4 Adults @ €449, plus 1 child @ €150).
7. Health insurers are obliged to provide cover for a minimum level of benefits to ensure that:
   - the rules of community rating are not undermined
   - consumers do not underinsure and
   - the lowest level of cover is equivalent to cover for private services in a public hospital.
8. These permitted exclusions can be grouped into services that are:
   - not medically necessary
   - not insurable risks
   - elective in nature
   - not designed to alleviate or treat a medical condition
   - long-term in their nature.
9. Private health insurers are permitted to challenge whether the type of care or treatment is appropriate, as otherwise there is nothing to deter the policyholder from 'overspending' on unnecessary facilities or accommodation.
10. The two key differences between the levels of cover provided by 'hospital-only' and hospital with 'day-to-day' benefits' are the level of excess applied to the 'day-to-day' benefits and the overall maximum allowed per person per year.
11. Tax relief is limited to the lesser of 20% of the gross amount of the premium or 20% of €1,000 gross for an adult (i.e. max €200 relief) and 20% of €500 gross for a child (maximum €100 relief).
12. The State provides tax relief on private health insurance premiums because the more people insured on private healthcare products the less pressure there is on the public system. Private healthcare also acts as a revenue generator for the State, in that health insurers effectively pay the private rates for all those who access private healthcare services in the public system.

Sample multiple-choice questions

1. What is the **maximum** level of hospital cover provided by a private health insurance policy offering mid-level cover?

   A. Full cover for private accommodation in private hospitals (standard).
   B. Limited cover (e.g. up to 66%) for a limited number of private hospitals (standard).
   C. Full cover for private accommodation in private hospitals (high-tech).
   D. Full cover for semi-private accommodation in private hospitals (standard).

   Your answer:

   ☐

2. How do private health insurers typically apply the 'upgrade' rule for hospital cover to meet the cost of a treatment not covered under the insured's original policy?

   A. They include a policy condition that allows them to send the insured for an independent medical, if they suspect a claim relates to a pre-existing condition.
   B. They apply a waiting period, so that for a stated period of time, they will only pay the insured benefits based on their original level of cover for any pre-existing condition.
   C. They get the insured to sign a declaration confirming they don't have any pre-existing medical conditions and are currently in good health, before upgrading cover.
   D. They include a policy condition that states that pre-existing conditions will not be covered under the upgraded plan in any circumstances.

   Your answer:

   ☐

3. Clara pays tax at the higher rate and her gross private health insurance premium is €1,200. What amount of tax relief will she be entitled to, in respect of this policy?

   A. €100
   B. €200
   C. €240
   D. €480

   Your answer:

   ☐

Answers to sample multiple-choice questions

Question 1

Chapter reference: Chapter 6D1a

Question type: K

Correct response: D

Learning outcome: Describe the scope and limitations of different private health insurance covers and the standard options available and identify questions that encourage the consumer to disclose the necessary material information to enable advisers to provide them with the most appropriate private health insurance product.

Question 2

Chapter reference: Chapter 6B5

Question type: U

Correct response: B

Learning outcome: Illustrate the private health insurance principles and minimum benefit regulations that impact on the scope of cover provided by this product.

Question 3

Chapter reference: Chapter 6F1

Question type: A

Correct response: B

Learning outcome: Identify and apply the tax treatment of medical expenses and private health insurance premiums and benefits and outline the rules for transferring between private health insurance providers.

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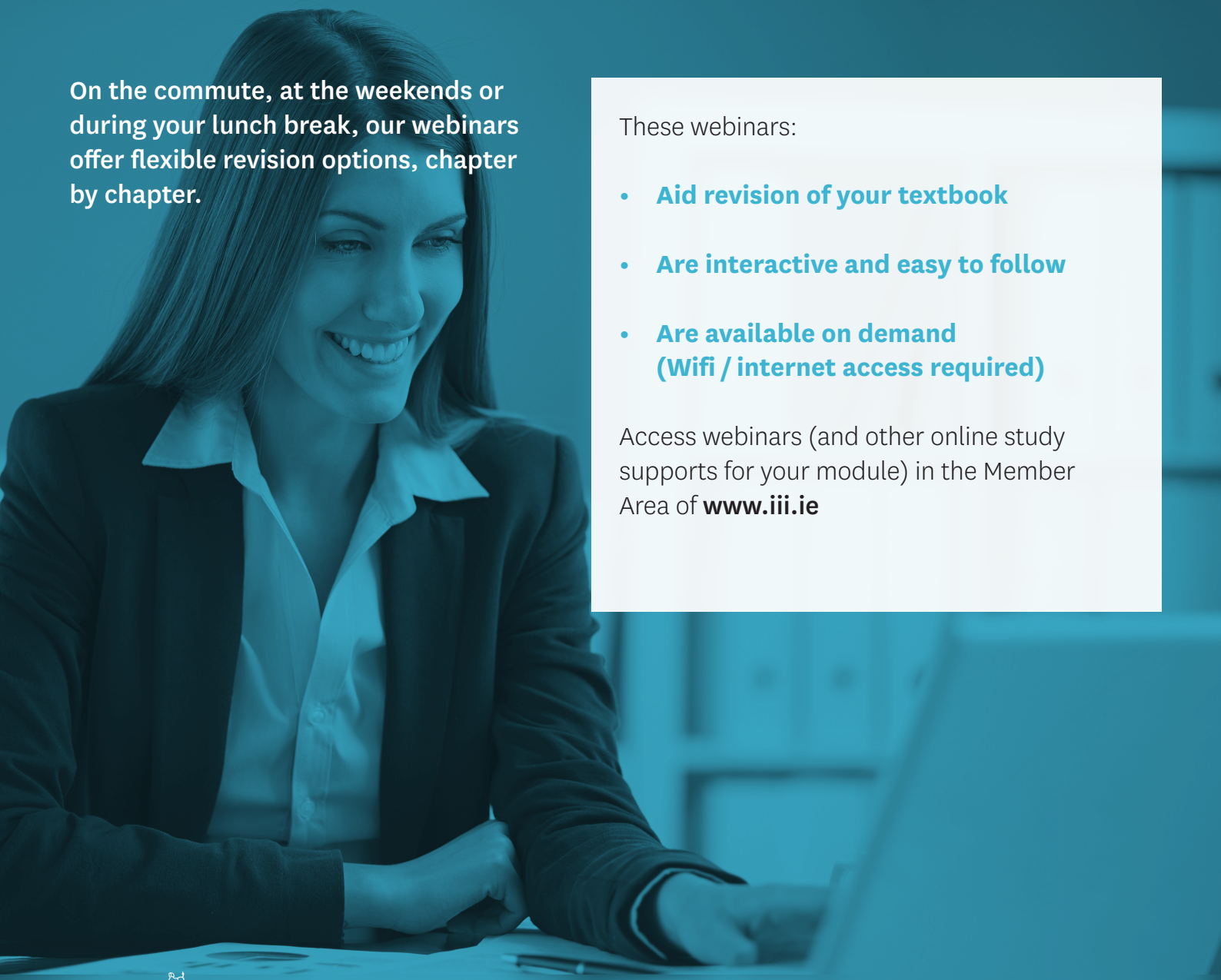

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Chapter

7

The claims process

What to expect in this chapter

From a policyholder's point of view, the process of making a claim is the real test of the insurance contract. It is the point at which they discover the true value of their insurance policy. This is why the claims department is often referred to as the 'shop window of the insurer'.

In this chapter, we'll look at the claims process for personal general insurances, the role of the adviser in this process, and the other people and organisations involved at the different stages. In doing so, we trace the journey of a typical claim from the moment of first notification by the policyholder, to the insurer's decision about the outcome of the claim.

Although the chapter will focus primarily on the claims process followed by insurers, intermediaries may also be involved, and we will consider their potential role in Section B. Advisers working for intermediary firms should, of course, be familiar with the wider claims process, so that they can provide professional and timely advice to their clients.

Learning outcomes for this chapter

Section	Title	At the end of each section you should be able to:
A	**The claims process**	Identify the stages of the claims process and demonstrate the role of the intermediary in this process.
B	**The role of the intermediary**	
C	**Claims notification**	Demonstrate the general insurance claims process and explain the roles and responsibilities of all parties throughout this process.
D	**Claims reserving**	
E	**Claims investigation**	
F	**Claims settlement**	

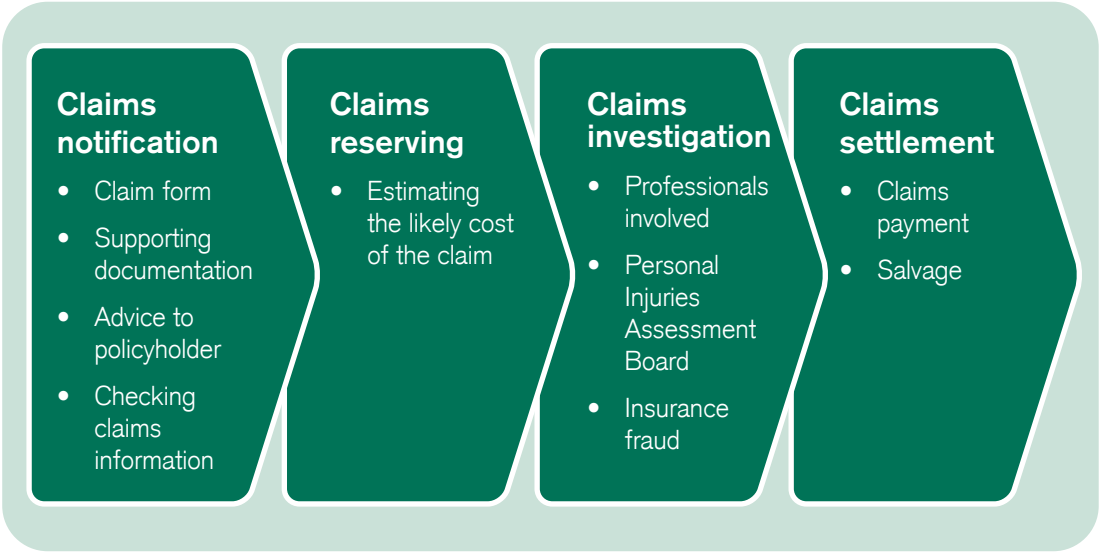
A The claims process

This chapter examines the different stages of the claims process. This begins with notification of a potential claim, followed by the investigation of the claim and ultimately the outcome (usually settlement of the claim).

Sometimes, these stages may be merged, or some might be omitted altogether. For example, an insurer may be willing to accept claim notification and information over the telephone rather than requiring the completion of a claim form.

Figure 7.1 outlines the different elements involved at each stage of the claims process.

Figure 7.1 The claims process



Although there are common elements, the handling and processing of claims will differ according to a number of factors:

- the type of insurance and cover
- the claimant
- whether the claim involves loss, injury, damage or liability
- the nature and potential size of the claim.

Many different accidents, incidents and scenarios may result in claims. Some of these may be simple and straightforward, e.g. a motor damage claim, while others can be significantly more complex, e.g. a multiple-car pile-up involving injuries or fatalities. As a result, there is almost limitless scope for different outcomes to emerge.

Claims departments often use templates or checklists when processing claims. The benefit of these is that they identify the key actions required by a claims handler or adjuster and ensure a structured approach to the different stages of the claims process. Figure 7.2 shows a claims handling checklist for household property claims.

Figure 7.2 Claims handling checklist

Claims handling checklist
– household buildings and contents insurance

POLICYHOLDER

- ☐ Act as if uninsured.
- ☐ Notify and supply information.

NOTIFICATION

- ☐ Give the policyholder proper instructions about what he must do.
- ☐ Advise re emergency repairs, notification to Gardai, if appropriate.
- ☐ What is the claimant's interest in the policy?
- ☐ Was the policy in force at the appropriate time?
- ☐ Has the premium been paid?
- ☐ Did the loss result from an insured cause/peril?
- ☐ Does an exception/exclusion apply?
- ☐ Is there a breach of a relevant Warranty or Condition?

If an exception/exclusion applies or there has been a breach of warranty or condition, advise the insured that the claim may not be admissible and reserve rights. Further investigation may be required.

- ☐ Is the claim below the amount of any excess? **If so, advise the policyholder.**
- ☐ Is any action necessary to avoid further damage?
- ☐ Request the completion of a claim form and any supporting information (for small straightforward claims only).
- ☐ Appoint Loss Adjuster (if a larger more complex claim) and advise the policyholder of the Loss Adjuster's contact details and also of their right to appoint their own Loss Assessor at their own expense.

CLAIM FORM

- ☐ Gather any further details needed from the policy-holder.
- ☐ Check the claim form/claim information in line with the policy cover – clarify any discrepancies.
- ☐ Check the adequacy of the sums insured on the policy – is there any underinsurance?
- ☐ Obtain a copy of the Garda Report, if applicable.
- ☐ Obtain written repair and/or replacement estimates and proof of purchase if appropriate.
- ☐ Does an excess apply?
- ☐ Is the policyholder registered for VAT? (if so, any claims payments will be exclusive of VAT)
- ☐ Issue all supporting documentation to Insurers.

INVESTIGATION/LOSS ADJUSTER ACTION

- ☐ Do experts need to be appointed/consulted?
- ☐ Establish that cover exists under the policy.
- ☐ Establish the amount of the loss.
- ☐ Are there any subrogation rights?
- ☐ Issue Final Report to Insurers.

SETTLEMENT

- ☐ What is the most appropriate means of settlement? (repair/replace/cash/reinstatement)?
- ☐ Obtain Acceptance Form
- ☐ Cheque to be issued within ten business days of the settlement amount being agreed.
- ☐ Refer to Arbitration/Conciliation/Mediation if any dispute regarding quantum or liability.

POST SETTLEMENT ACTION

- ☐ Advise the policyholder that claim payments may affect future contracts of this type.
- ☐ Is there an Automatic Reinstatement of Sum Insured Clause on the policy?
- ☐ If so, is an additional premium due?
- ☐ If not, appropriate cover should be arranged.
- ☐ Is there any salvage following settlement of the claim? If so, it should be requested or collected from the claimant.

B The role of the intermediary

Where a policy has been arranged through an **insurance intermediary**, the policyholder will typically make the first notification of a claim to the intermediary. In this situation, the intermediary's primary responsibility is to inform the insurer of the potential claim and pass the relevant documents to the insurer within 1 business day[17].

Following the initial notification of the claim, the nature of the intermediary's involvement will depend on a number of factors. We will now consider each of these in turn.

B1 Relationship with consumer

In some cases, the intermediary may wish to be involved in the claims process to a greater extent than strictly required. For example, they may wish to:

- support the client relationship and demonstrate the added value that they bring
- bring their expertise and experience to bear for both the policyholder's and insurer's benefit
- be fully appraised of any situation in which a claim will be declined or not fully met
- assist the insurer in complex situations where the intention of the parties may not be clear (although this is rare for personal insurances)
- assist in recovering claims for uninsured losses
- provide advice to the consumer if a complaint is made following the declinature of a claim, e.g. in relation to procedures involving the **Financial Services and Pensions Ombudsman** (FSPO).

Just think

How might the intermediary benefit from being involved in the claims process?

A claim can present an opportunity for an intermediary to strengthen the relationship with a policyholder and to show the added value that they bring to the process. This can have a positive effect on consumer loyalty and on retention rates.

intermediary
generic term for firms of all types that give advice on insurance products (see also 'insurance intermediary')

insurance intermediary
any person or firm, other than an insurer/reinsurer or their employees but including an ancillary insurance intermediary, which for remuneration takes up or pursues the activity of insurance distribution and is subject to the **Insurance Distribution Regulations 2018**

Financial Services and Pensions Ombudsman
an office that deals independently and impartially with unresolved complaints from consumers about the conduct of a pensions provider or a regulated financial service provider

[17] Provision 7.8, CPC.

B2 Type of claim

The extent of the intermediary's role will vary according to the type of claim. For example, it would be unusual for them to have a significant involvement in claims from third parties. In this instance, the intermediary's main role is to emphasise to the policyholder the need to forward correspondence received from third parties to the insurer, quickly and unanswered.

However, the intermediary's role in property or own damage motor claims (for example) may be more significant. They can add considerable value to the claims process through their specialist knowledge of an industry or niche market. However, for some classes, e.g. motor, the intermediary's role may even be restricted to one of assisting with any problems that emerge, rather than active involvement throughout the process.

delegated authority

authority granted to the agent of an insurer, usually in the context of a scheme arrangement, to issue policy documentation and/or possibly carry out limited underwriting and claims functions

B3 Delegated authority

Occasionally, an intermediary may have **delegated authority** to settle claims on behalf of the insurer. In this situation, all of the insurer's regulatory obligations will fall upon the intermediary. We considered the insurer's regulatory obligations with regard to claims in The Nature of Insurance module.

C Claims notification

Normally, the policyholder will contact their insurer or intermediary when they have a clear intention to make a claim under a personal general insurance policy. However, for some policies, notably motor, the policyholder is obliged to report any event that is likely to give rise to a claim as soon as possible.

Sometimes, an insurer will receive initial notification from a person other than the policyholder. This may be because the policyholder is unaware of the incident, e.g. a pedestrian is clipped by a wing mirror on a vehicle without the driver noticing. Alternatively, a third party to a motor accident might contact the insurer before the policyholder reports the incident. When this happens, the insurer will normally contact its policyholder and make further enquiries before proceeding with negotiation or settlement.

The policy will outline the process for notifying a claim to the insurer. Property insurance policies usually state that initial notification should be immediate and followed up with full particulars of a claim in writing within a specified time period, e.g. 7, 15, or 30 calendar days. Under the terms of the **Consumer Insurance Contracts Act 2019**, an insurer cannot refuse to pay a claim on the basis of late notification only. However, early notification will assist with a prompt claims service.

The claims notification conditions in a policy are designed to ensure:

- early investigation in order to minimise the cost
- early appointment of loss adjusters or solicitors where appropriate
- detailed evidence is not lost through delay
- the insurer's financial position is accurate and up to date (through early and accurate reserving)
- the insurer reports certain losses to reinsurers within the required timelines
- potential recoveries from third parties can be initiated.

If the policyholder fails to comply with the claims notification conditions, the insurer may have grounds to reject the claim. Insurers as already stated, cannot decline a claim made by a consumer because of late notification alone. However, the insured may be liable to pay damages to the insurer for the additional expense arising from the late notification. To decline a claim based on late notification, the insurer must be able to demonstrate that they have been prejudiced by the delay.

Just think

Can you think of any exception to this rule? Is there any other situation in which the policyholder's failure to comply with claims notification conditions would not give the insurer grounds to reject the claim?

The other exception to this general rule is that insurers cannot avoid **Road Traffic Act** (RTA) liability claims on these grounds (**Sixth Motor Insurance Directive 2009**). However, the insurer may be able to recover its outlay from the policyholder.

C1 Claim forms

Claim forms are an effective way of obtaining full details about a claim. The purpose of a claim form is to:

- Establish whether the policyholder is entitled to indemnity under the policy. The insurer must be satisfied that the loss, actual or potential, is covered under the terms of the policy, and that the information given on the form matches that given on the proposal form.
- Provide sufficient information to permit the insurer to begin processing any claim, if appropriate.
- Help the insurer decide the severity (potential cost) of the claim. This allows the insurer to place an accurate case reserve (estimate) on the loss, damage or liability and to review this as the claim progresses.
- Enable the insurer to take an early view on whether there is likely to be a claim from a third party (for motor and liability insurance).
- Enable the insurer to take an early view on the possibility of recovery rights, either by **subrogation** or **contribution**.

subrogation

the right of an insurer, following payment of a claim, to take over the rights of the insured to recover payment from a third party responsible for the loss

contribution

the right of an insurer to share the cost of an indemnity payment among similarly (but not necessarily equally) liable parties

accident report form

preferred term for a claim form used in motor and liability insurances

In motor and liability insurances, the claim form is known as an **accident report form**. It is a policy condition in these insurances that all accidents are reported to the insurer, irrespective of whether or not the policyholder intends to make a claim or expects a claim to come from another party, hence the term 'accident report form', rather than claim form.

Where a claim form is needed, the CPC requires the insurer to issue this document within 5 business days of the claim notification. We considered these claims related regulatory obligations in The Nature of Insurance module.

Quick question 1

List three key reasons for insurers to request a claim form.

The answer is at the end of this chapter.

C2 Other supporting documentation

In addition to the claim form, other supporting documentation may be needed. This will vary according to the type of policy and the nature of the claim and includes:

- Property claims - receipts, estimates, valuations, photographs.
- Motor claims - purchase receipt, vehicle service history, vehicle registration certificate, driver's licence, vehicle's national car test (NCT) certificate, witness statements, Garda report, other driver's insurance details.
- Personal accident and sickness claims - medical reports, death certificate.
- Private health insurance claims - receipts for medical expenses and medical reports.
- Travel claims – receipts, airline confirmation of lost baggage or flight delays, medical reports, hospital receipts.

C3 Insurer's advice to the policyholder

Following the initial notification, the insurer will advise the policyholder about what they should do, or what the insurer intends to do.

In order for insurers to provide an indemnity, the policyholder must adhere to the claims' conditions on the policy at the time of, and immediately following, a loss. The consequences of a breach of a **condition** or **warranty** were dealt with in The Nature of Insurance. Remember also from that module that under the **Consumer Insurance Contracts Act 2019**, a representation made by a consumer cannot be treated as a warranty.

Examples of common claims' conditions are that the policyholder must:

- take immediate action to minimise the loss
- keep any damaged items, as the insurer may need to inspect them
- notify the Gardaí immediately about loss or damage by theft, malicious act or riot, strikes, civil commotion or labour disturbances
- notify the fire brigade immediately of any fire or explosion
- send the insurer any letter, claim, writ, summons or other legal document, unanswered, as soon as received
- not admit liability, offer or negotiate any payment of a third-party claim unless the insurer approves.

Depending on the type of claim, the insurer will need to take specific action when notified of an incident. For example, the insurer may:

- arrange for towing of damaged vehicles to the nearest repairer
- advise of any requirement to approach the **Personal Injuries Assessment Board (PIAB)** (if sufficient information is available)
- advise the policyholder to take steps to prevent further damage or loss, e.g. arrange for boarding up of broken windows or other property protection measures
- advise that it will appoint a loss adjuster.

Quick question 2

While driving, Seán loses concentration and collides with another vehicle. As the driver of the other car is quite distressed, Seán tries to calm him by admitting that he was entirely to blame. He tells the driver not to worry because the insurer will sort things out. How might the insurer react to Sean accepting responsibility for the accident?

condition

provision in a policy that must be complied with

warranty

term (in an insurance contract) that, if broken, automatically voids the contract as a whole from the date of breach

Personal Injuries Assessment Board (PIAB)

independent statutory body set up to assess compensation due to an injured party when liability is not an issue

C4 Checking the claim information

Once the policyholder has provided the required information, the insurer will check that:

- the cover was in force at the time of the loss (or, under certain policies, when the claim was made)
- the premium was paid in full
- the person making the claim is a person entitled to indemnity or is named in the policy
- insurable interest existed at inception/renewal and at the time of the loss (for non-consumer insurance contracts)
- the peril (or event) is covered by the policy
- the policyholder has taken reasonable steps to minimise the loss
- all warranties (for non-consumer insurance contracts only) and conditions have been complied with
- the questions on the proposal form were answered honestly (i.e. there was no misrepresentation on the proposal form and, if there was, establish whether it was innocent, negligent or fraudulent)
- no policy exceptions or exclusions are relevant
- the value of the loss is accurate and is not in excess of the sum insured.

These checks will give an indication of the likely outcome of the claim. Claims may be:

- valid – payable under the policy when the insured person meets all of the requirements outlined.
- invalid – if the insured person does not meet all of the requirements, or if fraud can be proven.
- partially met – where the claim is valid, but subject to a reduction e.g. an excess or the application of average (because of underinsurance).

In a non-consumer insurance contract, if it appears that there may have been a breach of a warranty, the insurer will arrange for a detailed investigation of the claim. The adviser should alert the policyholder to the seriousness of the situation and liaise with the insurer to establish its attitude towards the breach and its proposed course of action. If the breach of warranty is not material to the loss, it is usual for insurers to continue to deal with the claim.

In the case of a consumer insurance contract, the **Consumer Insurance Contracts Act 2019** imposes post-contractual duties on the consumer and insurer. These replace the principle of utmost good faith. Under this Act, an insurer can refuse a claim where there is a subsequent change in the subject matter of the contract to such an extent that the insurer can properly say is a new risk that it did not agree to cover. For example, a thatched roof extension to a house.

The insurer may also request the Garda report of an incident. For many classes of insurance, e.g. motor, and money (where theft or riot is involved) there will be a policy condition that the policyholder must inform the Gardaí. This can be confirmed by providing insurers with the Garda reference number (also known as the 'Pulse' number[18]) or a copy of the Garda report form. This form shows the brief details of the loss and is stamped by the Gardaí to confirm that they have been advised of the loss. For some motor claims, a full Garda abstract report will be required. This will include measurements of the accident location and witness statements.

Quick question 3

What must you do if your car is broken into and your personal effects are stolen?

[18] Pulse is the Gardaí computer incident report system.

C4a Private health insurance

The objective of claims assessment or investigation for private health insurance is to establish whether:

- the patient is covered under the policy
- premiums have been paid for the dates of treatment
- the hospital (and scale of bed occupied) is covered by the policy
- costs are within the benefits specified and charges comply with the contract that exists between the insurer and the hospital
- the consultant is participating
- the condition is pre-existing
- relevant waiting periods have been served.

Other checks may include the insurer determining if:

- the treatment is covered under the policy (e.g. cosmetic surgery is not normally covered except in certain limited circumstances)
- the 5-year limit on substance abuse has been reached or exceeded (where applicable)
- annual or other benefit limits have been reached or exceeded (where applicable)
- any excess applies to the policy, and if the excess has been paid in an earlier qualifying claim
- the policyholder has upgraded their cover for an existing condition, and whether the upgrade rule should apply.

D Claims reserving

When an incident is notified to the insurer, the claims handler estimates the likely cost of the claim. This estimate is known as the case reserve.

When setting a case reserve, all relevant aspects must be considered. This may include damage to the policyholder's property, claims from third parties for damage to their property, personal injuries or other losses, professional fees, potential subrogation or contribution and VAT. The initial case reserve is normally based on limited information, so it will need to be updated when more information becomes available.

Insurers adopt a variety of practices at the early stages of notification. It is common for an insurer to assume, in liability situations, that the policyholder is 100% liable until it knows differently and is able to make an accurate assessment. Insurers may apply a standardised case reserve based on the information they have to hand and their previous claims experience of average claims costs.

Normally, for property and own damage claims, fairly accurate estimates can be made at an early stage. However, with larger losses, this may not be possible until some time after the event. When an insurer appoints a loss adjuster, it will ask them to provide a preliminary report as quickly as possible. This report will include an assessment of the likely extent of the loss.

A claims reserve is the money set aside by insurance companies to pay policyholders who have filed or are expected to file legitimate claims on their policies. Insurers use the fund to pay out incurred claims to be settled.

Just think

Can you list the reasons why it is important that insurers reserve accurately?

Accuracy in claims reserving is very important for a number of reasons:

- Insurers must make adequate provision for their present and future claims liabilities. This is a vital element in calculating an insurer's solvency margin and fulfilling its regulatory responsibilities as set out by the Central Bank.
- Underwriters rely on claims data when setting premium rates. They consider claims **reserves** and claims payments when assessing the profitability of each class of business. If the claims reserves are inadequate (too low or too high), these premium projections (estimates) will produce inappropriate rates.
- An insurer may be required at any time to provide a report on its underwriting results or profitability. Accurate claims reserves are vital to any assessment of an insurer's financial performance.

reserve

a stated amount that an insurer must have set aside to cover claims from current insurance policies and any other outstanding liabilities

E Claims investigation

The purpose of the investigation process is to establish whether or not a claim is valid. This involves considering all aspects of the loss and to what extent the policy should respond to the claim.

The steps involved in the investigation process will vary according to the type and size of the claim. Some claims may be settled quickly, with little need for investigation. Others require more detailed enquiries and the involvement of other professionals.

E1 The claims handler

The role of the claims handler is to:

- deal with claims quickly and fairly
- distinguish between genuine and fraudulent claims
- assess the likely cost of a claim in order to allocate an appropriate case reserve
- determine whether others (e.g. loss adjusters) should be involved
- determine whether recovery can be made from third parties, the insurance or another insurance policy
- settle claims efficiently and cost-effectively.

The claims handler may settle some claims immediately, provided the policyholder has submitted all the necessary documentation. For example, if the claim involves minor loss or damage to the policyholder's property, the claims handler may decide that no further investigation is needed. Call recording may be used for verification purposes.

A claims handler will normally oversee all aspects of the investigation and handling of a claim. Where a claim cannot be settled straightaway, the handler may decide to make further enquiries. This may be because:

- the claim is large or complex
- the circumstances or full extent of an injury are unclear
- the policyholder's claims history is of concern
- fraud is suspected.

In these circumstances, the claims handler may seek assistance from a **claims investigator** or a **loss adjuster**.

claims investigator (inspector)

an individual who is skilled, experienced and qualified to investigate the circumstances of individual claims on behalf of an insurer

loss adjuster

independent expert in processing claims from start to finish (appointed by the insurer)

Just think

Why do you think insurers have dispensed with claim forms for certain types of claim?

Insurers have dispensed with claim forms for claims that are straightforward and require no further investigation. This eliminates unnecessary paperwork, uses call recording for verification purposes, leads to early settlement, is less costly for insurers and leads to faster and more efficient claims settlement.

E2 The claims investigator

A claims investigator is often an employee of the insurer, although they may also work on a freelance basis or for a specialist claims investigation company. The claims handler may appoint a claims investigator to contact the policyholder and obtain more information about an incident. This may involve:

- inspecting and photographing damaged property or an accident location
- taking a statement from the claimant, policyholder or witnesses about an incident
- investigating the cause of an accident or incident
- assisting the claims handler in making an early assessment of whether or not the policyholder was at fault
- offering an opinion on the claims reserve
- negotiating settlement of the claim.

Claims investigators are often involved in motor or liability claims.

E3 Loss adjusters

A claims handler will typically appoint a loss adjuster for large property damage claims or those that involve complex policy wordings. The role of the loss adjuster is to investigate claims on behalf of the insurer.

Where an insurer appoints a loss adjuster (or expert appraiser) it must:

- notify the policyholder of the loss adjuster's contact details
- tell the policyholder that the adjuster acts in the interest of the insurer
- advise the policyholder that they have the option of appointing a loss assessor at their own expense
- maintain a record of this notification.

Loss adjusters also provide other services which include:

- ensuring that the interests of the policyholder are preserved
- ensuring that any emergency action is undertaken, e.g. to protect property
- checking that the insurance cover was in force and was adequate
- acting to minimise the extent of the loss (benefiting both the insurer and the policyholder)
- attempting to bring about a fair and swift settlement as defined within the terms of the policy.

A loss adjuster will supply the following documentation to the insurer:

- Preliminary report on the claim – This normally outlines the full circumstances surrounding the loss, e.g. date, how the loss occurred, and if a third party was involved or responsible. This report may include photographs of the damage and will include a full description of the risk, e.g. details of construction and occupancy. The preliminary report also comments on whether the cover is adequate, suggests the amount the insurer should reserve as the possible settlement figure and tells the insurer what steps are now being taken in the handling of the claim. The insurer will then review all the details provided, in conjunction with the policy cover.
- Final report on the claim – This provides full details of the claim and how settlement was calculated. It will also address the possibility of recovery from a third party. For complex losses, or where there is long waiting periods, the loss adjuster may provide an interim report. They may also recommend an interim payment to assist recovery.

E4 Loss assessors

loss assessor

expert in dealing with insurance claims, appointed by the insured to prepare and negotiate a claim on their behalf

Although not appointed by insurers, **loss assessors** may also become involved in the claims process. They are appointed by and act on behalf of the policyholder. The policyholder pays the assessor's fees, but they cannot recover these costs from the insurer, i.e. their fees cannot form part of the insured's claim.

The services and assistance that loss assessors provide include:

- ensuring that the interests of the policyholder are protected
- checking that the insurance cover was in force and was adequate
- attending at the loss scene to meet with the loss adjuster appointed by the insurance company
- assessing the damage and formulating the claim
- advising the policyholder on claim preparation and presentation of the claim, including documentation required
- advising the policyholder on options offered or available
- negotiating and ensuring that the proposed settlement is fair and reasonable under the terms of the policy
- attempting to bring about a swift settlement.

Just think

What is the main difference between a loss assessor and a loss adjuster?

Loss assessors and loss adjusters have similar skills and perform some similar functions. However, there are two very important differences:

- The policyholder appoints the loss assessor to act entirely on their behalf and for their benefit. This is in contrast to loss adjusters who, although appointed by insurers, have a duty to be independent and impartial.
- Loss assessors, who act on behalf of consumers, must be registered as insurance intermediaries under the **Insurance Distribution Regulations 2018**. As we have already noted (see Chapter 1A), insurance intermediaries are subject to the CPC. They are also subject to the Central Bank MCC and Fitness and Probity Standards. Loss adjusters do not require registration under the **Insurance Distribution Regulations 2018**. They are specifically exempt under these regulations as they are considered to be either independent or acting on behalf of the insurer if they have delegated authority.

E5 Solicitors

In complex liability or motor claims, the insurer may appoint a solicitor to investigate or defend the claim on behalf of the policyholder against a third-party claimant. The solicitor (who may be an in-house solicitor of the insurer) may also be involved in the defence of criminal proceedings covered by the policy (e.g. motoring or health and safety offences). Insurers may also seek the advice of a solicitor where there is a dispute in general about a policy wording, or the application of a principle of insurance.

Quick question 4

Who pays the fees of (a) a loss adjuster and (b) a loss assessor?

E6 Doctors/hospitals

For claims involving personal injury, insurers may require that the claimant undergoes a medical examination.

E7 Motor engineers

Whether an employee of the insurer, or contracted for a particular job, the motor engineer will:

- confirm that the damage has, in fact, occurred
- confirm the repairer's estimate on the extent of damage, cost and length of repair time
- confirm whether damaged parts should be repaired or replaced
- establish whether the vehicle can be economically repaired or whether it is a total loss
- oversee the disposal of the vehicle (if it is a total loss) and recommend a valuation
- issue a report to the insurer outlining the facts and providing photographs of the damaged vehicle.

In many cases, the engineer will also arrange for bidders to make offers for **salvage**. Motor engineers deal with the damaged subject matter of insurance (i.e. the vehicle) and the insurer; they do not deal with the policyholder (claimant).

salvage

what remains of the subject matter of insurance after an insured event, where the insurer treats the claim as a total loss

E8 Special considerations for third-party claims

Where a claim involves injury to a third party or damage to their property, the insurer will investigate the circumstances of the incident and the allegations of negligence against its policyholder. For personal injury claims (with the exception of medical malpractice claims), the Personal Injuries Assessment Board (PIAB) will play a significant role in the assessment of the claim.

E8a Personal Injuries Assessment Board

The Personal Injuries Assessment Board (PIAB) is the independent statutory body set up to assess compensation due to an injured party when liability is not an issue. Its aim is to reduce costs (especially legal costs) and administration fees for personal injury claims and to reduce the time frame for claim settlement.

Most claims involving personal injury must be submitted to PIAB for assessment. The parties to the claim follow a formal process that is subject to strict deadlines, and according to compensation levels set by the **Personal Injuries Guidelines**.[19] These guidelines came into effect on 24 April 2021 and replaced the Book of Quantum. It is anticipated that the overall level of personal injury awards and the associated legal costs will reduce significantly with the implementation of these Guidelines.

In addition to the new Personal Injury Guidelines, the remit of PIAB has been widened to include psychiatric damage.

PIAB will not make an assessment if

- there is insufficient precedent (i.e. similarity to previous cases) to quantify (assess) the injury or
- the claim arose from medical negligence.

When investigating personal injury claims, insurers must take account of PIAB procedures and timescales. Of particular importance is the 90-day (calendar days) deadline for the insurer to confirm whether or not it consents to an assessment by PIAB. In practical terms, this means that the insurer needs to investigate the incident without delay and make a decision as to whether its policyholder was at fault.

If the insurer disputes liability and refuses to agree to an assessment, PIAB will issue the claimant with an 'authorisation' which will allow them to pursue their action through the courts system.

Personal Injuries Guidelines

guideline principles governing the assessment and award of damages for personal injuries with a view to achieving greater consistency in awards

Quick question 5

Maria has suffered severe disfigurement following a botched medical procedure. Can Maria bring her case to PIAB for assessment of damages?

[19] The Personal Injuries Guidelines can be found at www.piab.ie

E9 Insurance fraud

Insurance Ireland estimates that insurance fraud costs the Irish insurers and policyholders €200 million annually. Fraud prevention has become a very high-profile issue in recent years. Examples of how fraud occurs in individual insurance claims include:

- the inflation of a genuine claim, e.g. a gross exaggeration of damage values
- creating an entirely fictitious event, e.g. a theft that never took place or medical treatment that was never received
- not disclosing, or misleading insurers about, the financial interest in an insured property, e.g. a motor claim where the policyholder does not disclose that the vehicle is the subject of a car loan
- causing deliberate, as opposed to accidental, damage to an insured property, e.g. arson
- taking out different policies on the same risk, e.g. multiple personal accident policies
- adding a false element to an otherwise valid claim, e.g. following a theft, claiming for items that did not exist or were not stolen.

Example 7.1 illustrates a fraudulent claim for flood damage to a vehicle.

Example 7.1

A policyholder alleged their BMW X5 jeep was written off as a result of flood damage. The claim was worth €45,000. The claimant had only third-party cover at the time of the flood damage. However, the following day they took out comprehensive cover and, with a tow-truck driver assisting the scam, alleged that the flood damage took place 3 days after the cover was increased. Both the claimant and the tow-truck driver were convicted of conspiracy to defraud and were sentenced.[20]

[20] 'Caught Out' (General Motor – Motor Fraud/Flood Damage), ©2013 Insurance Ireland, www.insuranceconfidential.ie.

All advisers need to be aware of fraud indicators. Once a defined number of indicators are present, insurers are prompted to undertake a fraud investigation. Examples of fraud indicators are:

- frequent change of insurer, perhaps to avoid a single insurer gathering too much information
- unusual changes to cover, e.g. adding accidental damage cover to a household policy mid-term
- unclear ownership of goods, as this may suggest that the property was either stolen or owned by someone other than the policyholder
- financial difficulties, though this can be difficult to establish
- excessive pressure to settle, or to settle quickly for a smaller sum
- an inconsistent story or possible false facts
- lack of cooperation
- suspicious timing of claim e.g. a delay in submitting the claim or a claim submitted shortly before renewal or shortly after policy inception
- an insistence on a cash settlement, where an insurer would prefer a different settlement method
- suspicious documentation, e.g. a total lack of receipts or paperwork, or conversely, documents that seem 'too good to be true' to an experienced claims handler.

E9a Fraud prevention and detection

A number of industry initiatives have been designed to deter would-be fraudsters as well as to detect fraud after the event. These include the following:

- Insurance Ireland, in cooperation with An Garda Síochána, has put in place 'Guidelines for the reporting of suspected insurance fraud'.
- Insurance Ireland set up the 'Insurance Confidential' hotline in 2003 to allow members of the public to report cases of suspected fraud.
- **InsuranceLink** allows insurers to cross-reference individual claims with other insurers.

The Insurance Fraud Coordination Office (IFCO), a new centralised Garda unit to combat fraudulent claims, was established in late 2021. It reports to the Garda National Economic Crime Bureau. This unit serves insurance policyholders who feel they have been the victim of a false claim. It allows policyholders to bypass their insurer and submit their suspicions directly to the IFCO. The establishment of this unit is expected to serve as a significant deterrent to anyone contemplating making a false or exaggerated claim. While insurers have always been able to report concerns about fraudulent claims to Gardaí, the difference is that there is now a dedicated unit devoted to the task.

InsuranceLink

database of past claimants, maintained by Insurance Ireland

The **Civil Liability and Courts Act 2004** states that if a plaintiff (claimant) gives false or misleading evidence in respect of any aspect of their claim, the court will dismiss the action unless it would result in an injustice. This legislation also provides for fines of up to €100,000 or a term of up to 10 years' imprisonment, or both, for those who knowingly give false or misleading evidence in a personal injuries action. On summary conviction (i.e. relatively minor offences), a fine of up to €3,000 and/or a term of imprisonment of up to 12 months are the maximum penalties. The combination of these penalties, together with the dismissal of the whole action – if any fraud is proved – have undoubtedly had an impact in reducing the level of fraudulent claims in Ireland, although it is difficult to measure their effectiveness.

Quick question 6

List four typical insurance fraud indicators.

F Claims settlement

The vast majority of claims are settled in a way that satisfies both the policyholder and the insurer. However, situations may arise where it proves impossible to reach agreement, or where the policyholder is dissatisfied with an insurer's decision.

The Compliance and Advice module addressed the topics of dispute resolution and complaints handling in the claims process, including the role of the FSPO and arbitration clauses in insurance contracts.

F1 Payment of the claim

The final stage in the claims process is the actual settlement. The claim has been notified, verified and investigated and all that remains is for settlement to be finalised.

Students will recall from The Nature of Insurance module that insurers have four options when settling claims: payment of money, repair, replacement or reinstatement. The repair, replacement and reinstatement options only apply if stated in the policy. If those options are not stated, the claimant has a legal right to financial compensation. It should also be noted that the reinstatement option does not usually apply to motor insurance.

F1a Payment of money

This is a very common method of settling claims. Some types of claim (e.g. business interruption, liability, money, personal accident and fidelity guarantee) are always settled in this way.

Unless an interim payment has been made, a cash payment is made in full and final settlement of a claim. This is typically confirmed by an 'acceptance form' which is signed by the policyholder. Where a third party to the claim also signs this agreement, it is known as 'a form of discharge'. These forms are used to ensure that the claim cannot be reopened at a later stage if, for example, the claimant feels that the settlement amount was too low.

Payment to the claimant must be made within 10 business days of their agreement to accept the settlement offer.[21] Where payment is made to a third party, the policyholder must be informed of the final outcome of the claim, including details of the settlement.[22]

[21] Provision 7.18, CPC.

[22] Provision 7.21, CPC.

F1b Paying for repairs

If an insurer decides to settle a claim by arranging and paying for repairs, it must notify the claimant in advance of the scope of the work and its cost. The onus is on the insurer to make sure that the work is carried out to a satisfactory standard. The insurer must certify in writing that the repairs restored the claimant's property to at least the same standard as before the damage.[23] This is the most common way motor claims are settled.

Most motor insurers have their own panel of approved repairers who will allow a price reduction on both parts and labour, in return for a guaranteed volume of work. Approved repairers also provide a guarantee of standards.

The benefits of approved repairer schemes for the motor insurance policyholder include the following:

- Collection and delivery of the damaged vehicle
- No requirement to obtain repair estimates
- Guarantee of quality for the repair work
- Provision of a loan car while repairs are carried out.

For the policyholder, there are often financial benefits (e.g. a reduced excess or provision of a courtesy car) if they use the insurer's approved repairers. Insurers will make these benefits and options known to proposers at the quotation stage.

Insurers may also use approved repairers for other types of property claims, e.g. damage to computers, mobile phones or photographic equipment and for glass breakage.

F1c Replacement

Where an item is lost, stolen or damaged beyond repair, insurers may arrange to replace the item in question, rather than make a cash settlement based on its value. In reality, this method of settlement is more common in personal than in commercial insurances. It is often used in situations where an insurer suspects that a fraudulent claim was made by the insured in the expectation of a cash settlement.

F1d Reinstatement

Property insurance policies normally also give an insurer the right to settle a claim by reinstating a property that has been destroyed or extensively damaged. However, as outlined in The Nature of Insurance module, insurers rarely exercise this option.

[23] Provision 7.13-7, 14, CPC.

F1e Private health insurance claims

Under private health insurance policies, claims generally arise in one of two ways:

- Direct settlement claims – These are claims settled directly by the insurers with the relevant medical providers. They would include in-patient related costs, and other treatments such as radiology, where the medical provider has an arrangement with the insurer to settle directly.

  When advising a policyholder in relation to direct settlement claims, it is important to note that these claims are not subject to the provisions of the CPC. This is because they are settled directly with the medical provider on behalf of the policyholder and the policyholder is not exposed to a financial loss during the period of the settlement. Nevertheless, a policyholder should be informed as to how the direct payment system operates, and assisted in establishing if they have the appropriate level of cover for the proposed treatment before admission to hospital, i.e. is the procedure covered?, is the hospital covered?, is the consultant fully or partially participating?, are there any waiting period restrictions?

- Direct to insured claims – These are out-patient and 'day-to-day' claims submitted directly by the policyholder to the insurer (e.g. consultants' fees, physiotherapy or pathology).

  These claims are subject to the rules set out in the CPC. For these claims, receipts are scanned to the insurer either via their website or an 'application' and the claim is paid directly into the policyholder's bank account. This can be done at any time during the policy year; not necessarily at policy-end). Various terms are used to describe this service (e.g. 'Snap and Send'). Each receipt must contain the following information:

  – the full name of the person receiving treatment
  – the practitioner's full details, including name, address and qualifications, which must appear on headed paper
  – the date of treatment
  – proof of payment.

  The insurer then processes the claim against the benefit entitlement, applying any applicable excesses, and reimbursement is made directly to the policyholder.

Example 7.2

Luke has incurred a number of out-patient/'day-to-day' expenses over the past year, as follows:

- 2 GP visits at €50 per visit
- 7 physiotherapist visits at €30 per visit
- 2 dental visits at €70 per visit.

Luke has a private health insurance policy that covers 50% of each of these expenses to a maximum of 5 visits per each practitioner type. He is also subject to an annual excess of €1.

Luke will need to submit receipts for each of these visits outlining his name as the patient, the date of treatment, the practitioners' full details and proof of payment. Once the claim is processed he will receive the following benefit:

- 2 × €25 for the GP visits
- 5 × €15 for the physiotherapist visits (two excluded because of the five-visit cap)
- 2 × €35 for the dental visits.

The total benefit payable to Luke is €194 (€195 less the €1 excess).

Quick question 7

An insurer has agreed a car destroyed by a fire is no longer usable and should be treated as a total loss. There are some parts that could be sold for scrap but the policyholder would rather leave all this to the insurer to sort out. Is the policyholder entitled to do this?

F2 Salvage

When a motor or a commercial property claim is settled on a total-loss basis, an insurer is entitled to the value of the salvage. Salvage simply means what remains of the subject matter of insurance after the insured event, e.g. an unrepaired car following a motor accident. The insurer will often choose to take charge of the salvage and obtain the best price for its disposal. However, the policyholder has no right to abandon the salvage to the insurer.

G Summary

In this chapter we learned about the claims handling process from initial notification through to settlement. We looked at the role an intermediary may play in advising the claimant, and we discussed the roles and responsibilities of other individuals and organisations involved at different stages of the process.

The claim, and its outcome, will be a key factor in determining whether the insurance product has 'worked well' for a consumer. The consumer's satisfaction or dissatisfaction with the claims process will undoubtedly influence their future decisions about insurance products and insurers.

Before you start your revision and exam preparation, think about how Chapter 7 relates to the material that you studied in the earlier chapters.

In Chapter 1, we identified that:

- A consumer's past experience (including their experience of making a claim) will influence the wants and needs that they present to an insurance adviser when considering their future options (see Chapter 1A1).
- When deciding which insurer or product to recommend to a commercial client, the adviser will consider the quality and efficiency of the insurer's claims service (see Chapter 1B1b). If an insurer consistently provides a poor claims service, the adviser will be reluctant to recommend that insurer to a client.
- Where an insurer provides an excellent claims service, both the client and the adviser are likely to have a preference for remaining with that insurer.

As you worked through Chapters 2, 3, 4, 5 and 6, you will have built up a detailed knowledge of personal general insurance products. This product knowledge is key to the adviser's ability to guide their client through the claims process. The extent of cover under a policy, the policyholder's awareness and understanding of this policy cover and their compliance with the policy conditions will directly determine the outcome of a claim. It is therefore essential that an adviser has a detailed knowledge of the personal general insurance products available in the market.

G1 Study tip

It's important to remember that this textbook is the primary information source for this module. All the questions in your exam will relate directly to information featured in the textbook. Use the 'End of chapter questions', 'Quick questions' and the 'Sample multiple-choice questions' to quickly test what you've learned so far. Make a note of any topics/areas you need to improve in and keep it to hand so you can refer to it when you revise this chapter again before your exam.

In addition to the textbook, **Connect** has many online study supports that can help you as you study this module.

G2 Online learning supports

Your Member Area includes a learning plan, an automated study planner, an exam countdown timer and study tips guide. These study supports are invaluable in reinforcing what you have learned from the textbook so far. The webinars, chapter-by-chapter key points and other supports will help you to break down the chapter content when revising.

Completing online mock exams and reviewing the personalised feedback that follows is a great way of testing your knowledge and preparing for exam day.

To access these online study supports, just log into your Member Area on www.iii.ie and click on the **Connect** logo.

End of chapter questions

Use these questions to test your understanding of what we've covered in Chapter 7.

1. Explain why an intermediary might wish to be involved in the claims process beyond what is strictly required by regulation.

2. State the main purpose of the claims notification conditions in a personal general insurance policy.

3. State the obligation the CPC places on an intermediary when forwarding a claim form to an insurer.

4. As an adviser, your client has just contacted you to report a potential liability claim. State the two main pieces of advice you should give them.

5. Outline the contents of a loss adjuster's preliminary report.

6. State the regulatory status of a loss assessor who acts on behalf of a consumer.

7. State the functions of a motor engineer in connection with an own damage motor claim.

8. State which type of personal injury claims PIAB does not make an assessment for.

9. State whether an insurer is obliged to agree to an assessment of injuries to a third party by PIAB.

10. List three ways in which fraud may occur in personal general insurance claims.

11. Identify which types of claim are always settled by the payment of money.

12. Outline the benefits of an insurer's approved repairer scheme for the motor policyholder.

13. List the two ways in which claims arise in private health insurance.

Answers to end of chapter questions

Check your answers against those below and make a note of any points you left out. This will highlight the sections you may need to look at more closely during your revision.

1. An intermediary may wish to be involved in the claims process so they can:
   - support the intermediary–consumer/client relationship, therefore providing added value
   - assist the insurer in complex situations where the original intention may be in doubt
   - bring their expertise and experience to bear for both the consumer's and insurer's benefit
   - be fully aware of any situation in which a claim will be declined or not fully met
   - assist in recovering claims for uninsured losses
   - provide advice if a complaint is made after an insurer declines a claim, e.g. in relation to Financial Services and Pensions Ombudsman (FSPO) procedures.

2. The claims notification condition in a policy is designed to ensure:
   - early investigation in order to minimise the cost
   - early appointment of loss adjusters or solicitors where appropriate
   - detailed evidence is not lost through delay
   - the insurer's financial position is accurate and kept up to date
   - the insurer may report certain losses to reinsurers within the required timelines
   - potential recoveries from third parties can be initiated.

3. Under the CPC an intermediary must, on receipt of the completed claims documentation transmit it to the insurer within 1 business day.

4. You should advise your client:
   - to forward you (the adviser) all correspondence they may have received relating to the incident 'unanswered' (for onward forwarding to the insurer)
   - not to admit liability or to enter into any discussions with the injured party, unless this has been approved by the insurer.

5. A loss adjuster's preliminary report will usually contain:
   - full circumstances surrounding the loss, e.g. date, how the loss occurred and if a third party was involved or responsible
   - photographs of the damage
   - a full description of the risk
   - a suggested case reserve as the possible settlement figure
   - comments on the adequacy of the cover
   - steps being taken in the handling of the claim.

6. Loss assessors, who act on behalf of consumers, must be registered as insurance intermediaries under the **Insurance Distribution Regulations 2018**.

7. The motor engineer will:
   - check that the damage has, in fact, occurred
   - confirm the repairer's estimate on the extent of damage, cost and duration of repair
   - confirm whether damaged parts should be repaired or replaced
   - establish whether the vehicle can be economically repaired or whether it is a total loss
   - if a total loss, oversee the disposal of the vehicle and recommend a valuation
   - issue a report to the insurer outlining the facts and providing photographs of the damaged vehicle.

   They may also arrange for bidders to make offers for salvage.

8. PIAB will not make an assessment if:
   - there is insufficient precedent (i.e. similarity to previous cases) to be able to quantify the injury or
   - the claim arose from medical negligence.

9. An insurer is not obliged to agree to an assessment by PIAB. If agreement is not given by the insurer, the claimant is issued with an authorisation to pursue their claim through the courts.

10. Fraud can manifest itself in any three of the following ways:
    - the inflation of a genuine claim, e.g. a gross exaggeration of damage values
    - creating an entirely fictitious event, e.g. a theft that never took place
    - not disclosing, or misleading insurers about, the financial interest in an insured property, e.g. a motor claim where the insured does not disclose that the vehicle is the subject of a car loan
    - causing deliberate, as opposed to accidental, damage to an insured property, e.g. arson
    - taking out different policies on the same risk, e.g. multiple personal accident policies
    - adding a false element to an otherwise valid claim, e.g. following a theft, claiming for items that did not exist or were not stolen.

11. Business interruption, money, liability and fidelity guarantee claims are always settled by the payment of money.

12. The benefits of an approved repairer scheme for the motor policyholder include the following:
    - Collection and delivery of the vehicle
    - No requirement to obtain repair estimates
    - Guarantee of quality for the repair work
    - Provision of a loan car while repairs are carried out.

13. Claims generally arise in one of two ways in private health insurance:
    - Direct settlement claims
    - Direct to insured claims.

Answers to quick questions

1. Claim forms enable insurers to:
   - establish whether the policyholder is entitled to indemnity under the policy. The insurer must satisfy itself that the loss, actual or potential, is covered under the terms of the policy, and that the information given on the form agrees with that given on the proposal form.
   - begin processing any claim, if appropriate.
   - take a view as to the severity (potential cost) of the claim. As a result, the insurer can place an accurate case reserve (estimate) on the loss, damage or liability and to review this as the claim progresses.
   - take a preliminary view on whether there is likely to be a claim from a third party (in respect of motor and liability insurance).
   - take a preliminary view on the possibility of recovery rights, either by subrogation or contribution.

2. Strictly speaking, the insurer could turn down the claim because Seán breached a claim's condition. In this situation, they would only deal with the Road Traffic Act element of any claim and then seek recovery of their outlay from Seán. In practice, insurers will only do this if they felt their position had been prejudiced. (In other words they are committed to pay out something they would otherwise not have had to pay).

3. If your car is broken into you must, without delay, do the following:
   - take immediate action to mitigate further loss
   - notify the Gardaí and obtain the 'Pulse' number
   - notify your adviser or insurer with details of items stolen and any damage to the vehicle.

4. The fees of (a) a loss adjuster are paid by the insurer and the fees of (b) a loss assessor are paid by the insured.

5. Maria cannot bring her case to PIAB for assessment of damages because medical negligence claims are beyond the remit of this body.

6. Any four of the following:
   - frequent change of insurer, perhaps to avoid a single insurer gathering too much information
   - unusual changes to cover, e.g. adding accidental damage cover to a household policy mid-term
   - unclear ownership of goods, as this may suggest that the property was either stolen or owned by someone other than the policyholder
   - financial difficulties, though this can be difficult to establish
   - excessive pressure to settle, or to settle quickly for a smaller sum
   - an inconsistent story or possible false facts
   - lack of cooperation
   - suspicious timing of claim e.g. a delay in submitting the claim or a claim submitted shortly before renewal or shortly after policy inception
   - an insistence on a cash settlement, where an insurer would prefer a different settlement method
   - suspicious documentation, e.g. a total lack of receipts or paperwork, or conversely, documents that seem 'too good to be true' to an experienced claims handler.

7. The insurer's agreement to pay a 'total loss' means the insurer is entitled to the value of the salvage. However, it is the insurer's choice whether to take charge of the salvage and obtain the best price for its disposal. The policyholder has no right to abandon the salvage to the insurer.

Sample multiple-choice questions

1. For larger or more complex property claims, supporting evidence of the loss will be externally investigated on the insurer's behalf by:

   A. a loss assessor
   B. an arbitrator
   C. a loss adjuster
   D. a claims handler

   Your answer:

   ☐

2. A claim on an insurance policy will only be **partially** met if:

   A. the questions on the proposal form were not answered honestly
   B. part of the claim is found to be fraudulent
   C. cover lapsed on the date that the loss occurred
   D. the principle of average has to be applied

   Your answer:

   ☐

3. Jack notifies his broker of his claim on Monday, 1 October. His broker must inform Jack's insurer and provide it with any relevant documents by **no later** than:

   A. 2 October.
   B. 3 October.
   C. 6 October.
   D. 8 October.

   Your answer:

   ☐

Answers to sample multiple-choice questions

Question 1

Chapter reference: Chapter 7E3

Question type: K

Correct response: C

Learning outcome: Outline and apply the general insurance claims procedure, describe the advice to be given to the consumer regarding the necessary procedures and documentation required to pursue a claim successfully and explain the roles and responsibilities of all parties throughout the claims settlement process.

Question 2

Chapter reference: Chapter 7C4

Question type: U

Correct response: D

Learning outcome: Outline and apply the general insurance claims procedure, describe the advice to be given to the consumer regarding the necessary procedures and documentation required to pursue a claim successfully and explain the roles and responsibilities of all parties throughout the claims settlement process.

Question 3

Chapter reference: Chapter 7B

Question type: A

Correct response: A

Learning outcome: Identify the stages of the claims process and demonstrate the role of the intermediary in this process.

Study Tip

Do you wish to find a specific website, legal case, acronym, key term or legislation within this textbook?

You can do a quick find in the module eBook, which is available on **Connect** via your Member Area Login at www.iii.ie.

Referenced websites, legal cases, acronym and legislation

Websites

Central Bank of Ireland
www.centralbank.ie

Competition and Consumer Protection Commission
www.ccpc.ie

Financial Services and Pensions Ombudsman
www.fspo.ie

Health Insurance Authority
www.hia.ie

Hospital and Medical Care Association
www.hmcaireland.ie

The Insurance Institute of Ireland
www.iii.ie

Insurance Ireland
www.insuranceireland.eu

Insurance Ireland Insurance Confidential
www.insuranceconfidential.ie

Insurance Link
www.inslink.ie

Personal Injuries Assessment Board (PIAB)
www.piab.ie

Revenue Commissioners
www.revenue.ie

Revenue On-Line Service (ROS)
www.ros.ie

Society of Chartered Surveyors Ireland (SCSI)
www.scsi.ie

Case law

Oddy v Phoenix Assurance Co. Ltd (1966)

Damjian Vnuk v Zavarovalnica Triglav

Legislation

Civil Liability and Courts Act 2004
Consumer Insurance Contracts Act 2019

Data Protection Acts 1988-2018

Health (Amendment) Act 2013
Health Insurance Acts 1994-2020
Health Insurance Act 1994 (Minimum Benefit) Regulations 1996 (as amended)
Health Insurance Act 1994 (Open Enrolment) Regulations 2015

Insurance Distribution Directive 2016
Insurance Distribution Regulations 2018

Minimum Competency Regulations 2017
Motor Insurance Directives (1972-2009)

Road Traffic Act 1961
Road Traffic (Compulsory Insurance) Regulations 1962
Road Traffic (Compulsory Insurance) (Amendments) Regulations 1992

Sixth Motor Insurance Directive 2009
Spent Convictions and Certain Disclosures Act 2016
Taxes Consolidation Act 1997

Acronyms

Organisations/bodies/regions	
Competition and Consumer Protection Commission	CCPC
Designated Activity Company	DAC
European Court of Justice	ECJ
European Economic Area	EEA
European Union	EU
Financial Services and Pensions Ombudsman	FSPO
Health Insurance Authority	HIA
Hospital and Medical Care Association	HMCA
Insurance Fraud Coordination Office	IFCO
Insurance Ireland	II
Personal Injuries Assessment Board	PIAB
Revenue On-Line Service	ROS
Road Safety Authority	RSA
Society of Chartered Surveyors Ireland	SCSI
Terminology and legislation	
comprehensive	COMP
Consumer Protection Code	CPC
Continuing Professional Development	CPD
Declined Cases Agreement	DCA
driving other cars	DOC
frequently asked questions	FAQs
gross vehicle weight	GWV
guaranteed asset protection	GAP
heavy goods vehicles	HGVs
light commercial vehicles	LCVs
Minimum Competency Code	MCC
Minimum Competency Regulations	MCR
national car test	NCT
no claims bonus	NCB
no claims discount	NCD
payment protection insurance	PPI
return to invoice	RTI
return to value	RTV
Risk Equalisation Scheme	RES
Road Traffic Act	RTA
tax relief at source	TRS
third party fire and theft	TPF&T
third party only	TPO

Glossary of Key Terms

accident report form	preferred term for a claim form used in motor and liability insurances
advanced cover	a health insurance contract that provides cover for 66% or more of the full cost for hospital charges in a private hospital
adviser	individual involved in the advising process; this may be an employee of an insurer or an intermediary
agreed value	sum insured as agreed at the beginning of the period of insurance and paid in respect of a total or partial loss claim as usually defined in the policy
'all risks'	general term used to describe the widest form of insurance cover, subject to a number of exclusions
appropriate setting	the right of a private health insurer to determine whether it is medically appropriate to pay benefits on an in-patient, day-patient or out-patient basis and to adjust the rate it pays to reflect the type of treatment considered necessary
approved repairer	repairer that an insurer includes within a scheme to guarantee workmanship, labour rates and discounts on parts, and to reserve the right to reduce a policyholder's claim payment if they do not use the approved repairer
arbitration	a legally binding alternative dispute resolution process, whereby cases are heard by an arbitrator rather than a judge in court
'average'	principle that if a sum insured is less than the full insured value, the insured should be their own insurer for that proportion and share the losses accordingly
benefit policy	a policy that provides stated pre-agreed amounts/benefits on the occurrence of certain defined events rather than exact financial compensation
broker	an insurance intermediary that provides their principal regulated activities on the basis of a fair analysis of the market Consumer Protection Code (Provision 4.18)
capital benefits (sums)	benefits payable as lump sums for death and certain permanent disabilities under personal accident policies
claims experience (history)	a detailed breakdown of past losses, including details of paid and outstanding claims; ideally confirmed by the holding insurer
claims investigator (inspector)	an individual who is skilled, experienced and qualified to investigate the circumstances of individual claims on behalf of an insurer
client	a person, firm or organisation that has appointed a regulated entity to act on their behalf for insurance purposes
client fact find	a list of questions designed to elicit all necessary information as a starting point for analysing consumer needs
commercial travelling	where driving is a permanent aspect of the policyholder's job and they are selling goods or services while on the road
community rating	private health insurance principle that cross-subsidises the cost of private medical insurance from young to old and, to some degree, male to female
condition	provision in a policy that must be complied with
consequential loss	indirect loss which accompanies an insured loss

consumer	any of the following: a. a person or group of persons, but not an incorporated body with an annual turnover in excess of €3 million in the previous financial year (a group of persons includes partnerships and other unincorporated bodies such as clubs, charities and trusts), or b. incorporated bodies having an annual turnover of €3 million or less in the previous financial year (provided the incorporated body is not a member of a group of companies having a combined turnover greater than €3 million). …and includes a potential consumer
Consumer Protection Code (CPC)	code issued by the Central Bank of Ireland setting out requirements that regulated firms must comply with in order to ensure a minimum level of protection for consumers
contribution	the right of an insurer to share the cost of an indemnity payment among similarly (but not necessarily equally) liable parties
corporate products	a product specifically designed for company-paid groups that provide tailored private health insurance for their employees
cover comparison chart	a means of visually displaying the key differences between the characteristics of different insurers' policies
critical illness cover	provides a capital sum in the event of the policyholder being diagnosed as suffering from, or contracting any of, the serious illnesses specified in the policy
customer	a person, firm or organisation to whom a regulated entity provides or offers to provide an insurance product or service (for an intermediary the terms 'client' and 'customer' are interchangeable), and any person, firm or organisation who requests such a product or service Consumer Protection Code (Definitions)
Declined Cases Agreement	an agreement among motor insurers, whereby motorists who experience difficulty obtaining motor insurance (after a minimum of three attempts) can apply for cover under the DCA programme as operated by Insurance Ireland
deferred period	a set period of time agreed by prior arrangement between the policyholder and insurer, where a waiting period applies from the first day of a person's claim to when the policy actually pays out the first benefit
delegated authority	authority granted to the agent of an insurer, usually in the context of a scheme arrangement, to issue policy documentation and/or possibly carry out limited underwriting and claims functions
designated activity company (DAC)	a new company type introduced by the **Companies Act 2014**; a limited company type applicable to companies that want to outline and define a specific type of business in their constitution (rather than have unlimited powers as per the LTD. company type)
differential pricing	where a customer with a similar risk and cost of service is charged a different premium for reasons other than risk and cost of service
'driving of other cars'	extension of cover whereby a policyholder may drive a third-party's vehicle. In certain situations this extension is referred to as 'driving of other vans' or 'driving of other commercial vehicles'
dual pricing	treating the price of new businesses and renewal customers differently for reasons other than risk and cost of service
durable medium	any instrument that allows information to be stored and accessible for future reference, for a required period of time, and prevents the stored information from being changed or reproduced

emergency dental treatment	treatment for the immediate relief of pain caused by a natural tooth being lost, damaged or infected, howsoever caused, or from any trauma to the mouth
excess (deductible)	first part of each and every claim that must be paid by the insured
extended warranty insurance	insurance which extends a manufacturer's guarantee or warranty
fair and personal analysis of the market	advice based on an analysis of a sufficiently large number of contracts available on the market to enable the intermediary to make a recommendation, in accordance with professional criteria, as to which insurance contract adequately meets the customer's needs **Insurance Distribution Regulations 2018**
Financial Services and Pensions Ombudsman	an office that deals independently and impartially with unresolved complaints from consumers about the conduct of a pensions provider or a regulated financial service provider
firm	a regulated entity (as used throughout this textbook to refer to insurers and/or intermediaries)
franchise	a minimum amount of loss that must be incurred before insurance coverage applies (similar to an excess except that once the amount of the franchise is exceeded, the whole of the claim is paid)
ground heave	movement occurring when ground that has previously had a low moisture content suddenly absorbs moisture
guaranteed asset protection (GAP) insurance	covers the difference between the motor policy claim and either: ▪ the value of the car at the time the GAP insurance was purchased (return to value), or ▪ the invoice price originally paid for the car (return to invoice)
guaranteed NCD	no claims discount that cannot be taken away no matter how many claims are made
health insurance cash plan	policy that pays 'day-to-day' out-patient benefits and may include a daily cash contribution towards in-patient hospital stays
homogeneous risk (exposure)	the existence of a number of risks with similar profiles or characteristics, e.g. in terms of frequency and severity patterns
hospital cash benefit	benefit under a travel insurance policy, payable in addition to other policy payments as a daily sum for each 24-hour stay, subject to an overall maximum
hospital cash (hospital income)	plans that provide daily sums to a policyholder for being admitted to a hospital
index-linking	method of calculating the sum insured on buildings and contents that is adjusted monthly in line with appropriate indices, but in times of very low inflation may be set at 'nil'
inner limit	an indicator of the largest payment that will be made under a specific insurance policy heading (expressed either as a monetary amount or a percentage of another limit)
insurable values	basis of the policy claims settlement reflected in the values insured under the policy
insurer	a risk-carrying, regulated entity (product producer)
insurance intermediary	any person or firm, other than an insurer/reinsurer or their employees but including an ancillary insurance intermediary, which for remuneration takes up or pursues the activity of insurance distribution and is subject to the **Insurance Distribution Regulations 2018**
Insurance Ireland	an industry body that represents Irish life and non-life insurers
InsuranceLink	database of past claimants, maintained by Insurance Ireland

intermediary	generic term for firms of all types that give advice on insurance products (see also 'insurance intermediary')
international health insurance	insurance that provides comprehensive health insurance for the insured while overseas for an extended duration
landslip	'a rapid downward movement under the influence of gravity, of a mass of rock or earth on a slope' – *Oddy v Phoenix Assurance Co. Ltd* (1966)
liability	being legally responsible for something, for example an accident or an injury to a third party
lifetime community rating	the older a person is when they take out private health insurance, the higher the premium they will pay; however, the premium may not subsequently be increased to reflect the person's advancing age
lifetime cover	the requirement that, once an individual has been put on cover, the insurer may not cancel or refuse to renew such cover, irrespective of that individual's claims experience
limited analysis of the market	analysis of a limited number of contracts and product producers available on the market
limit of indemnity	insurer's maximum liability for any one incident/claim (usually under the terms of a liability policy or section of a policy)
listed building	a protected named structure; each planning authority must compile and maintain a record/list of these, outlining the protection extended to the structure's external and sometimes internal features
loss adjuster	independent expert in processing claims from start to finish (appointed by the insurer)
loss assessor	expert in dealing with insurance claims, appointed by the insured to prepare and negotiate a claim on their behalf
market value	the value achievable for an item on the open market at the time in question
material damage	physical loss or damage to property
medical expenses benefit	covers medical and surgical expenses, hospital charges and other associated expenses resulting from an illness, injury or death
minimum benefits	the principle that all private health insurers must provide cover for a statutory minimum schedule of benefits as laid down in the **Health Insurance Act 1994 (Minimum Benefit) Regulations 1996 (as amended)**
Minimum Competency Code (MCC)	code issued by the Central Bank of Ireland setting minimum professional standards to be met by those falling within the MCC's scope when undertaking certain controlled functions. The MCC has a particular emphasis on dealing with consumers
Minimum Competency Regulations (MCR)	regulations outlining the obligations on regulated firms in respect of minimum competency
mirrored NCD	no claims discount whereby individuals who have earned an NCD for one vehicle and who arrange cover on a second vehicle may be granted an equivalent number of years' NCD on the second vehicle. Limitations apply, e.g. normally insured only driving on the second vehicle and no cover provided where a young driver is a user on the second vehicle
multi-occupancy room	category of private hospital accommodation under the **Health (Amendment) Act 2013**, which removes the distinction between private and public beds in public hospitals and charges on the basis of single-or multi-occupancy rooms and day care
national car test (NCT)	a roadworthiness test for cars introduced into the Republic of Ireland in 2000
no claims discount	a reduction of premium for successive claim-free years, which increases to a maximum over a period of (usually) 5 years, held in consumer's own name

non-advanced cover	a contract that provides no more than 66% cover for the full cost of hospital charges in a private hospital, or cover that is equivalent to that prescribed in the Minimum Benefit Regulations
open enrolment	the principle that a private health insurer must accept all individuals regardless of the risk they pose
permanent health insurance	policy providing a replacement income until normal retirement age in the event that the policyholder is unable to work due to accident, illness or injury
personal accident benefit	compensation in the event of injury, disability or death resulting from a sudden, accidental, violent and specific event
personal consumer	a natural person acting outside their business, trade or profession
Personal Injuries Assessment Board (PIAB)	independent statutory body set up to assess compensation due to an injured party when liability is not an issue
Personal Injuries Guidelines	guideline principles governing the assessment and award of damages for personal injuries with a view to achieving greater consistency in awards
policyholder/insured	a person/firm that is insured under an insurance policy
pre-existing condition	an ailment, illness or condition, the signs or symptoms of which existed in the period of 6 months prior to the person becoming insured under an insurance contract[24]
pre-existing condition exclusion	exclusion of benefit payable for any condition for which the insured has (or should have) sought/received advice, diagnosis, treatment or counselling at any time prior to inception of a policy (relevant to pet, personal accident, private health insurance)
price walking	where a consumer is charged a higher premium relative to the expected cost, the longer they remain with an insurer
proposer	a person, firm or organisation applying for insurance
protected NCD	NCD generally available once policyholders have reached their maximum entitlement on the insurer's NCD scale – usually 2 claims in a 3-year period
proximate cause	main or dominant cause of the loss or the cause that is most powerful in its effect
'public place'	under the Road Traffic Acts this is 'any place where the public have access with vehicles'
qualifying contracts	private health insurances eligible for tax relief on premiums paid, i.e. those contracts entered into with an authorised insurer for the full or partial reimbursement of actual health expenses
regulated entity	a financial services provider authorised, registered or licensed by the Central Bank of Ireland or another EU or EEA member state, that is providing regulated activities in the State
repatriation	to return somebody back to their country of citizenship or residence.
reserve	a stated amount that an insurer must have set aside to cover claims from current insurance policies and any other outstanding liabilities
restricted illness cover	a health insurance policy that specifies certain illnesses as 'restricted' for which the insurer will pay only a certain percentage of the hospital charges, usually 80%, with the insured paying the balance
risk appetite	measure of an individual or company's willingness to accept risk
risk-averse	a desire on the part of an individual or company to minimise the risks to which they are exposed, either through risk management or insurance
risk equalisation	a process that aims to equitably neutralise differences in insurers' costs that arise from variations in the age profile of the individuals they insure

[24] Health Insurance Authority, www.hia.ie

risk-rated policy	a policy whose rating follows principles that include applying discrimination factors to proposers
risk-seeking	a willingness on the part of an individual or company to accept risk
salvage	what remains of the subject matter of insurance after an insured event, where the insurer treats the claim as a total loss
settlement	common occurrence in new builds where the ground compacts beneath the foundations to accommodate the pressure of the new property
small craft	normally defined as those that comply with a speed restriction of 17 knots (32 kph) and not exceeding 17 ft in length
standard construction	normally refers to building construction that is substantially of non-combustible components, e.g. block, brick and concrete walls with slate, tile or other non-combustible roofs (but market wordings vary)
statement of suitability	written statement setting out the reasons why a product or service (or options if listed) offered to a consumer is considered to be (most) suitable for that consumer (also known as a 'reason why' letter)
step-back NCD	a cushion against the effects of claims where the NCD is only partially reduced for every claim made
subrogation	the right of an insurer, following payment of a claim, to take over the rights of the insured to recover payment from a third party responsible for the loss
subsidence	gradual movement or sinking of land on which premises stand
tax relief at source (TRS)	tax relief provided where an individual pays their own 'net' premium on a qualifying contract to the insurer, who then claims the balance from the Revenue Commissioners
temporary total disablement (temporary total disability benefit)	benefit under a personal accident (and sickness) policy payable for up to 104 weeks provided the policyholder is unable to carry out any part of their normal occupation
tied insurance intermediary	any person who a. undertakes insurance or reinsurance distribution for and on behalf of one or more insurance or reinsurance undertakings or other intermediaries, in the case of insurance products that are not in competition b. acts under the responsibility of those insurance or reinsurance undertakings or other intermediaries, and c. is subject to oversight of compliance with conditions for registration by the insurance or reinsurance undertaking or other intermediary on whose behalf it is acting. **Insurance Distribution Regulations 2018**
trace and access	risk covered under a household policy that pays for tracing the source of water (and oil) leakage, payment for which may or may not be linked to perils otherwise insured under the policy (wordings vary)
underinsurance	policy that has been effected, requiring full value as the basis for cover but where a lower figure has been declared
underwriter	person/firm who assesses a risk proposed for insurance, decides whether to accept it and, if so, sets the level of premium required and the terms and conditions applicable
underwriting	process of risk pooling, risk selection (choosing who and what to insure) and assessment of individual risks that meet the insurer's risk criteria

waiting period	legally permitted specified periods of time following the start of a private health insurance policy during which particular policy benefits are not available to the insured
warranty	term (in an insurance contract) that, if broken, automatically voids the contract as a whole from the date of breach
wholesale broker	person/firm that acts on behalf of another intermediary in arranging and assisting in the performance of insurance contracts. Products distributed by the wholesale broker are usually not available to all advisers.
'written off'	term used to describe a vehicle that has been too badly damaged to be repaired or where the cost of repairs would exceed the pre-accident value of the vehicle