

Non-disclosure and what it means to advisers - Financial Adviser – (July 2006).

Every adviser selling and advising on protection products today should consider what non-disclosure may come to mean to them over the coming months and years.

There are now clear signs of a quite substantial storm building, the implications of which could lead to some significant claims against advisers for the business they have written since January 15th 2005 (the advent of protection regulation) and for every piece of business they plan to write over the remainder of their careers. In the light of current events all advisers should consider whether or not they should change their protection sales process.

The Background

- The number of critical illness claims are rising
- Declinature of claims for non-disclosure (not answering the application form questions properly) is significant at over 10% of all claims
- Customers whose claims are declined are complaining that any non-disclosure is the fault of their 'adviser'
- The sums in dispute are significant (sums insured)
- The FOS now regularly adjudicates disputes on the basis of "the balance of probabilities", so complainants can win their case if there is a greater than 50% chance that their complaint is true
- The number of no-win no-fee complaint firms focused on financial advisers is growing

The facts

Although initially difficult to disseminate, due to some creative presentation by insurers, from the first 8 or so insurance providers to release their critical illness claims statistics, we can see that the annual rate of critical illness claims is around £520 million a year. Of these approximately £101 million go unpaid with on average 54% of those being declined due to non-disclosure at application stage. The run rate for declined non-disclosure claims is therefore just over £1 million a week!

Insurers, re-insurers and now the FOS are seeing some of these declined claims turn into complaints from customers about their advisers. Consider the following comments:

"We sometimes find when a claim is rejected due to non-disclosure that the customer accuses their adviser of omitting important medical facts from the application form, facts the customer says were disclosed to the adviser".

Insurance Company's Claims Manager

"We often decline claims and the policyholder says that the adviser told them it was OK not to disclose information".

Re-Insurer

"Intermediaries should never advise a client about what should be disclosed".

and

"Many consumers tell us they gave the agent information but it was not recorded".

FOS Ombudsman

As with other types of complaints by customers some are justified and some are not. Can you be certain that un-justified complaints will be found in your favour?

The Effects of Regulation

Prior to the commencement of regulation of Pure Protection sales by the FSA, the insurers effectively accepted responsibility for the sale of their products under an agreement reached through the ABI.

Since regulation advisers now accept responsibility for the sales process including the collection of medical disclosures.

Most of today's CI claims relate to sales made pre-regulation, however it is only a matter of time before we see claims for sales made post-regulation. Insurers and re-insurers are aware of the impending problems, are you?

Application Process

As with all impending disasters the effect on the adviser of non-disclosure is not properly understood by most practitioners. And for a clear view of how events may unfold in your business it pays to take a step above the day-to-day business issues to consider the risks inherent within your current sales process. It is imperative that you review your current practice coldly and dispassionately to understand whether you are personally at risk, you must then consider appropriate changes.

Having worked on both sides of the fence (insurer and adviser) it is my view that if the protection industry were starting out today insurers would not ask **financial** advisers, brokers and salesmen to ask customers intimate questions about their past and current illnesses, diseases (sexually transmitted or otherwise), sexual partners, whether they practice unsafe sex or participate in recreational drug abuse. They would not ask advisers to discuss with their clients any problems with their bodily functions including gynaecological, the state of their mental health or whether they suffer the effects of stress including questioning around suicidal thoughts, it just isn't appropriate and it does not lead to good disclosure.

Many advisers have 'grown up' with the current process but they haven't registered the considerable changes that have taken place within the health questions, largely because these have been 'dripped' in over time. However, many of their customers are not expecting such questions during a financial interview/arrangement and as is clear from the published statistics they do not feel comfortable disclosing in this environment.

Those who do not fully disclose, but can imagine the effects of non-disclosure, will understand the policy is not worth buying or keeping it and will generally find ways of not proceeding with the cover, at best cancelling it soon after it is arranged. Others will forget about the non-disclosure until it is too late and in desperation later blame advisers, it happens. *It is amazing isn't it that customers who 'can't remember' their medical condition and complaints for the 5 years preceding their application can, up to 8 years later, recall verbatim your advice to answer a question in a particular way.* Thereafter it is all up to the handling of the complaint by the adviser, the FOS and, because of the sums involved, possibly the courts. Even if you avoid paying a claim consider the effects of the lost time and costs to your business.

The Alternatives

Currently these are few and far between and, in fact, the developments by most major insurers in recent years have been to make the advisers exposure worse through the greater number and complexity of their questioning. In particular consider the question about the practice of unsafe sex asked by all insurers today, this has no clear definition – how do you explain what it means to your clients?

The introduction of online submissions has clear benefits for the insurer, but the risk to the adviser grows out of all proportion to the additional 5% or 10% of LAUTRO commission paid, especially when you consider the additional 'drill down' questions posed.

Much is written in the trade press at present about tele-underwriting, in truth most insurers have deployed this innovation to avoid the delays and costs associated with GP reports and, in the main, still require advisers to have dealt with the original disclosures first.

Assuming you still want to advise on protection and earn the revenue from doing so then the only risk free solution to avoiding complaints about non-disclosure is for you to deal with the financial aspects of the advice which you have been trained to carry out and, leave it to other trained professionals to collect the medical facts and disclosures. This can be done at a time convenient to the customer (usually the evening), when they are in a place where they are comfortable with making such disclosure (usually at home) and in a way that makes it easier to disclose (over the phone). This tele-data capture process can and does have clear benefits to the adviser, saving time and risk, improves the disclosure so the insurer and re-insurers

can be more confident in the package of information they are underwriting and the customer can be more confident that their insurance is valid.

Express Underwriting, a tele-data capture service launched 3½ years ago now collects disclosures on behalf of hundreds of advisers, from typically 4,500 applicants a month and across a number of products (life, critical illness and income protection). The insurers supporting the service are Bright Grey, Friends Provident, Legal & General, Liverpool Victoria, Norwich Union, Scottish Widows, Scottish Provident, Scottish Equitable and Standard Life. There are also plans to launch with BUPA and one or two others in the near future.

The service has been a clear success from each of the stakeholders' perspective. Advisers are reporting greater numbers of sales, taking full advantage of the risk and time savings and all the feedback from customers is that they prefer this approach to traditional application processes, insurers and re-insurers who have audited the process are clear that they are securing a greater level of disclosure through the process.

More recently a few insurers have piloted the delivery of similar services for their own applications however to be really effective such a service needs to be aggregated across a broad range of providers through one or more competing sources. This is because most insurer's application volume fluctuates month to month due to the competitive nature of comparative quotation engines and the extensive re-pricing activity undertaken nowadays. The process of data-capture/tele-underwriting it is so humanly intensive it is simply inefficient for each insurer to provide themselves. When an insurer is busy then the service aspect reduces and complaints grow, frustrating advisers and customers alike. When business slows you have great service but it costs the insurer too much. Aggregation is the key to providing a consistent quality of service and a good 'experience' which is paramount when establishing adviser confidence in something new.

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