

THE *facts*

How Life Insurance Works

The Need for Life Insurance

Life insurance is critical to effective financial planning as it provides financial protection for ourselves, as well as our families. It's therefore important that we all have a good understanding of how life insurance operates. One of the key barriers to understanding life insurance is industry jargon. The key purpose of this fact sheet is to provide people with an overview in everyday language of how life insurance works, with an emphasis on the underwriting process.

As explained below, in order to maintain a financially sound life insurance industry in Australia that can provide a full range of voluntary insurance products, there needs to be an effective risk classification system.

The Basis of Insurance

Simply, the basis of life insurance is to provide people with protection against the financial consequences if an insured event occurs (eg death, disablement, serious illness or injury).

A group of people (Policyowners) contribute to a central fund or pool (ie pay a premium) and when an insured event occurs, payment is made from the pool (ie claim payment).

Life insurance must, wherever possible, be offered on reasonable and affordable terms in order to give people access to insurance; on the other hand, premiums must be sufficient to meet all future claims. In addition, the premium must provide a sustainable margin sufficient to ensure that owners/shareholders have an interest in continuing to invest in the business.

The Underwriting Process

Insurers have to be selective when providing cover because life insurance is voluntary, not compulsory. That is, individually everyone chooses whether to insure themselves or not, for what type of cover, how much and when.

Underwriting is the process whereby the premium that each person has to contribute to the pool is calculated. The chief source of information used in the underwriting process is the application for insurance.

Once the application is submitted to the life insurer, the underwriting process begins. The length of the underwriting process is dependent on the complexity of the application, type of insurance applied for and the level of cover requested. The insurer may require additional health, financial, occupation or other information. The underwriter then uses underwriting manuals and expert medical and other opinions to assist them in evaluating the risk profile as presented by the gathered information in order to offer the most appropriate terms to the individual applicant. Each applicant is then given similar terms to other lives insured with a similar risk profile.

Upon completion of the underwriting assessment, the insurance company will either:

- Issue a policy as applied for;
- Offer a reduced amount of cover or different policy terms;
- Offer cover with a higher premium and/or an exclusion; or
- Defer or decline the application.

Once a life insurance application is accepted and a policy issued, the insurance company agrees that, as long as premiums are kept up to date, it will pay the policyowner (or their beneficiary) a specific amount of money if an insured event occurs.

Risk Classification

The policyowner pays for the policy by making regular premium payments. The amount of premium paid depends not only on the type and level of cover provided, but also reflects on the level of risk that the applicant brings to the life insurance pool. The greater the likelihood of the policyowner making a claim, the higher their contribution to the pool.

Applicants with similar risk factors are grouped together in pools and charged an appropriate premium. An example of this is smokers and non-smokers. The premium rates for these two groups are different, due to their different risk profiles. The smoker group will generally pay higher premiums, as it has conclusively been proven that, as a group, they have an increased chance of suffering from heart disease, cancer and stroke etc.

If someone is in a group with higher risk factors, this does not necessarily mean that they personally will claim or claim early. However, it does mean that they share similar risk characteristics with a group of people that, as a whole, will have a higher number of people who will claim, or claim early.

The practice of underwriting is the process by which individuals are placed in an appropriate pool on the basis of the likely cost of providing them with insurance.

Insurers rely on the information that applicants provide in relation to their individual circumstances. These generally include details regarding their:

- Health and age
- Family health history
- Occupation
- Pastimes
- Residency
- Smoking status
- Income and financial position.

Unlike car or house insurance, once a life insurance policy has been issued, it generally cannot be cancelled or have the premium increased due to a deterioration in a person's health. Life insurers usually only get one chance to fully assess the risk, which is why so much emphasis is placed on underwriting at the beginning of the policy.

Risk Management and Profitability

One of the key factors determining a life insurer's overall performance, or more specifically, their profitability, is the underwriting process. For example, if poor risks are accepted without charging the appropriate premium or declining them, then the profitability of the insurer will be adversely affected.

As all claims are paid from the premium pool, the people with a lower chance of making a claim would subsidise those who are more likely to make a claim. In time, the level of premiums contributed to the pool wouldn't be enough to pay further claims; therefore everyone would be asked to pay higher premiums.

As a consequence, many of those who perceive that they are 'low risk' would not be prepared to pay higher premiums and may cancel their insurance. Invariably, this would mean that the risk profile of the entire insured group would worsen, more claims would be made and premiums would continue to spiral upwards. This could make the insurer less competitive in retaining existing business or obtaining new business. Eventually, the insurer would not be able to attract enough new business and there would be a real risk that premiums, paid by ageing insured lives who are increasingly likely to claim, would not be sufficient to pay claims for people already insured. This situation would obviously be unacceptable to all policyowners and could lead to the demise of the insurance industry.

Information Requested from Applicants by Life Insurers

To assist in the risk classification process, life insurers rely on information from a range of sources. Apart from the personal statement in the application for insurance, life insurers may seek information from other avenues, including medical examinations, doctors' reports (based on patient file records), blood tests, health and pastime questionnaires, and also financial evidence.

Undoubtedly, the most important consideration for the underwriter is to obtain sufficient information to assess the risk. Ultimately, the underwriter must consider a range of factors in order to decide whether or not additional information is required.

Duty of Disclosure

The duty of disclosure (covered under the Insurance Contracts Act of 1984) is concerned with the quality of information provided by customers in their applications for insurance.

When entering into a contract with a life insurer, applicants have a duty to disclose every matter that they know, or that a reasonable person could be expected to know, is relevant to the insurer's decision as to whether to provide cover, and if so, on what terms.



The duty of disclosure aims to ensure that people applying for cover provide insurers with all of the relevant information to enable an accurate assessment of the risk, so that the appropriate level of premium is charged. This provides protection for all the policyowners contributing premiums to the overall pool, ensuring that they do not have to pay extra premiums to cover the risk of people who have wrongly obtained cover at a low premium or standard coverage under false pretences, by withholding important information about their risk profile from the insurer's underwriters.

There are serious consequences if this duty is not complied with. Any future claim could be denied or the policy may even be cancelled, irrespective of whether all premiums have been paid.

Applicants are not expected to disclose matters they are not aware of, or matters that would diminish the risk or matters that the insurer should be aware.

Beneficiaries of Life Insurance

Every day, life insurers receive new claims as a result of sickness, injury, diagnosis of a life-threatening medical condition, and death. The life insurance industry has an enviable reputation in settling legitimate claims promptly.

The insurance industry pays out millions of dollars on a daily basis. Benefits range from monthly payments, meeting the cost of daily living expenses (in the case of income protection), to lump sum payments in the event of death or diagnosis of a critical or terminal illness.

The benefits paid by life insurers goes to meet the needs of daily living for those who have suffered a serious illness or injury and to fund changes necessary to maintain their lifestyle. For those left behind on the death of a loved one, these vital funds can be used to reduce the deceased's debts and to provide for the family.

The Claims Process

There are various circumstances in which a policyowner or beneficiary will be entitled to make a claim under a policy. The client will be asked to complete forms and provide information to enable the insurer to evaluate the claim. It is an insurer's business to pay genuine claims that satisfy the terms and conditions of the policy, based on medical and other evidence available.

The insurer will strive to deal with the claim compassionately, efficiently and promptly, and keep the client informed throughout the process. In respect of disability type policies, where possible, the insurer will work with the insured, their doctors and rehabilitation providers in order to help them in their recovery and return to work.

If a claim cannot be accepted immediately, the reasons will be explained to the claimant. The insurer will advise what further information is required - for example, further medical reports or financial information relating to the insured's income. The insurer will treat all such information with strict confidentiality.

If the claimant is not satisfied with the claim decision, a review of the decision may be requested. If they remain dissatisfied with the review decision, they are entitled to complain to the Financial Industry Complaints Service. Further details on this process are set out below.

Increasing Concerns for Privacy

Insurers have a moral and legal obligation to keep personal details of individuals' health, finances and activities confidential, and have done so for decades.

Confidentiality of personal and sensitive information is now even more protected, under the Privacy Amendment (Private Sector) Act 2001. This Act ensures that private information is kept confidential by strict guidelines that limit the way in which information may be collected, used, stored or accessed.

For more information please refer to IFSA's Fact Sheet on Life Insurance and Privacy in Australia.

Life Insurers Operate in a Highly Regulated Environment

In Australia, the operations of all life insurers are highly regulated by Federal legislation. There are two main regulatory bodies that administer the key legislation that governs the life insurance industry: the Australian Prudential Regulation Authority (APRA) and the Australian Securities and Investments Commission (ASIC).

APRA is responsible for the administration of the Life Insurance Act 1995, while ASIC administers the Insurance Contracts Act 1984 and the Insurance Act 1984.

Consumer Rights

The life industry has operated under a Code of Practice that deals with inquiries, complaints and disputes since September 1995. This Code has now been replaced by the amendments to the Corporation Law, which took effect from 11 March 2004.

Formal internal and external complaint-handling processes in the life insurance industry were effected in the early 1990s. The external organisation that currently facilitates on complaints is the Financial Industry Complaints Service (FICS).

FICS was established to assist in the resolution of policyowner complaints regarding insurance policies issued by insurers. This service is free of charge to the public and is available to any individual or business pertaining to any dealings (excluding those related specifically to underwriting assessments) with life insurers, or others aligned to the service.



October 2004

Investment and Financial Services Association

FICS resolves complaints in respect of a wide range of financial services, including life insurance, and has the authority to investigate, negotiate and conciliate complaints against any of its members in the life insurance or financial industry.

Further information about the Financial Industry Complaints Service (FICS) can be obtained from their website: www.fics.asn.au or by phone on 1300 78 08 08.

The Superannuation Complaints Tribunal (SCT) is an independent tribunal established by the Commonwealth Government to deal with complaints about superannuation funds, annuities and deferred annuities, and retirement saving accounts.

SCT considers complaints about decisions made by superannuation providers. Superannuation providers include the trustees of Regulated Superannuation Funds and Approved Deposit Funds, as well as life insurance companies providing annuities policies. The SCT will try to resolve a complaint by conciliation; however, if conciliation is unsuccessful, the matter is referred to a Tribunal review meeting for a determination.

Further information about the Superannuation Complaints Tribunal (SCT) can be obtained from their website: www.sct.gov.au or by phone on 1300 884 114.

Other Fact Sheets in the Series

- Life Insurance in Australia
- Life Insurance and Privacy in Australia
- Life Insurance and Hepatitis C in Australia
- Life Insurance and Genetic Testing in Australia

Investment and Financial Services Association Limited

ABN 82 080 744 163

Level 24

44 Market Street

Sydney NSW 2000

Telephone + 61 2 9299 3022

Facsimile + 61 2 9299 3198

Email Address ifsa@ifsa.com.au

Website: www.ifsa.com.au

The information contained in this brochure is general information only and does not take into account your individual objectives, financial situation or needs. You should assess whether the information is relevant to you and consider talking to a financial adviser before making an investment decision.