



Association of British Insurers

ABI Statement of Best Practice

for

HIV and Insurance

July 2008

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1. Introduction

What is the purpose of this Statement?

- 1.1 The issue of how HIV, and HIV testing, is dealt with by insurers has long been a subject of public interest. This document makes it clear that insurers do not ask questions about an applicant's sexual orientation or request an HIV test be taken solely because of perceived sexual orientation, and will not take into account sexual orientation in assessing an application if it is inadvertently revealed by an applicant. Insurers are allowed to ask questions about HIV risk, including about risky sexual behaviour, and about travel to or origin from areas of the world with high levels of HIV.
- 1.2 This Statement is intended to help insurers selling long-term insurance products¹ to adopt best practice. It sets out requirements on, and guidance for, insurance industry professionals, for use when dealing with applications for insurance where HIV may be an issue. HIV is an issue of major concern to public policymakers, the insurance industry and the general public.
- 1.3 The Health Protection Agency's 2007 Report on HIV and Other Sexually Transmitted Infections in the UK² stated the number of new diagnoses reported to end June 2007 had increased 157% since 1997. Among all newly diagnosed individuals 3,727 (59%) were heterosexual and 2,301 (36%) were men who had sex with men (MSM). Most of the heterosexual infections were acquired abroad. The Report estimated there were 73,000 people living with HIV in the UK in 2006 (both diagnosed and undiagnosed). Of these an estimated 69,400 people were aged 15-59 years with 43% being MSM, 31% heterosexual women, 21% heterosexual men and 4% injecting drug users (IDU). African-born men and women accounted for 35% of the total number of adults and 31% of all those unaware of their infection. When only heterosexually acquired infections were considered, African born men and women accounted for 68% of the total and 61% of those unaware of their infection.

Who should read the Statement?

- 1.5 This Statement is intended primarily for insurance underwriters. Some aspects of it will also be relevant to others working in insurance companies, and staff should be made aware of it, including Chief Medical Officers, sales personnel and those working in customer services or complaints departments.
- 1.6 The Statement is also intended to explain to external stakeholders the way that the insurance industry deals with issues surrounding HIV. It will therefore be of interest to doctors, patient support groups, policymakers and interested individuals.
- 1.7 A consumer guide to HIV and Insurance is available at: www.abi.org.uk.

¹ The insurance products covered by this guide are income protection, critical illness, term life, long term care and the life insurance element of whole life and endowments.

² http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1203084355941

What status does the Statement have?

1.8 The Statement is an ABI arrangement with members.

How was the Statement developed?

1.9 The Medical Underwriting Committee developed the Statement. The ABI HIV Expert Working Party, the Terence Higgins Trust and Pinkfinance.com made significant contributions to the Statement. There was a wide response from insurers, reinsurers, insurance brokers and external interest groups to the consultation exercises that resulted in the Statement.

1.10 This Statement replaces all previous versions of the ABI Statement of Best Practice on HIV and Insurance, first published in 1994 and revised in 1997 and 2004. The 2008 Statement will be reviewed in 2011.

1.11 The Statement draws on ABI publications in related areas available at www.abi.org.uk. These are:

- An Insurer's Guide to the Disability Discrimination Act
- Statement of Best Practice for Critical Illness Cover
- Statement of Best Practice for Income Protection Insurance

Implementation

1.12 The content of the Statement was revised to incorporate the implementation of the Civil Partnership legislation in April 2008. There are no other changes to the content of the Statement and on this basis the 2008 Statement of Best Practice will take immediate effect.

2. Key principles

2.1 The key principles that underpin this Statement of Best Practice are:

- **Principle 1 – Underwriting approach** - take decisions on a case-by-case basis and assess premiums fairly
- **Principle 2 – Collection of information** - don't ask for excessive, speculative or irrelevant information
- **Principle 3 – Use of information** - take account of all relevant factors
- **Principle 4 – Accuracy of information** - stay up to date with developments and statistics
- **Principle 5 – Company policy on HIV and underwriting** - have an agreed policy on dealing with HIV which is updated at least every three years

2.2 The following paragraphs explain briefly what each principle is intended to cover. The other sections of the Statement expand upon the principles in greater detail.

Principle 1 – Underwriting approach

2.3 The primary duty of insurers is to assess insurance applications fairly according to the degree of risk that the applicant brings to the insurance pool. Insurers should consider each application for insurance on a case-by-case basis, based solely on the best available relevant evidence, in accordance with the guidelines in this Statement. An individual's occupation is no guide to HIV risk. Being, for example, a cabin crew member, ballet dancer or hairdresser cannot of itself justify an HIV rating.

Principle 2 – Collection of information

2.4 Insurers will not request information that is unnecessary or irrelevant to the risk being insured, such as speculative questions that rely on inference and assumption on the part of the underwriter, for example house co-purchasing arrangements. Insurers must not differentiate between customers in civil partnerships and married couples.

Principle 3 – Use of information

2.5 In reaching a decision on a particular application, the underwriter will take account of all relevant information and will be able to explain the reason for the underwriting decision

Principle 4 – Accuracy of information

2.6 Insurers should continually review HIV incidence rates and statistics, with a view to updating company policy on HIV/AIDS every three years (see [Annex A](#) for evidence sources). Reinsurers should update their manuals in respect of HIV every three years.

2.7 The development of policy is informed by a group of multidisciplinary HIV experts from the insurance and reinsurance industry and stakeholder groups who would consider issues such as:

- The evidence base for HIV risk
- Cultural attitudes and encouraging responsible behaviour
- Rational and respectful decision making
- Fair policy and procedures

Principle 5 – Company policy on HIV and underwriting

2.8 Each member company of ABI should have a clear policy on how it deals with applications where HIV status may be an issue, and their practice on exclusions, to ensure that it reflects current knowledge as in [Annex A](#). Insurers should review and if appropriate update this policy at least every three years.

3. Action at the application stage

- 3.1 Insurers are bound by the Civil Partnership Act 2004 and must not differentiate between customers in civil partnerships and married couples when setting HIV testing limits.

Communicating with the applicant's GP

- 3.2 Care should be exercised when communicating with an applicant's GP. Prior explicit written permission **must be obtained** from the applicant before writing to the doctor with any information or questions that could directly or indirectly reveal the sexuality of the applicant to the GP. It is highly unlikely that insurers would know such information given the wording of the questions on HIV risk in this Statement.
- 3.3 The ABI/British Medical Association (BMA) agreed General Practitioner Report form (GPR) and the Guidance on Medical Information and Insurance advises GPs that they should inform insurers if the applicant is HIV positive or is awaiting an HIV test result or if the applicant has had one or more episodes of a sexually transmitted infection that has long term health implications.
- 3.4 The GPR does not include questions on applicant sexuality and this information, even if known, must not be disclosed to insurers. If it is inadvertently disclosed it should be ignored by insurers.

Medical Examiner's Report or Health Screening Report

- 3.5 Some insurers ask applicants to have a medical examination (unrelated to HIV risk), or use tele-underwriting, and repeat some of the questions contained on the application form. Where this is done, the same principles about consent and not passing on information about sexuality apply.

Asking about the applicant's HIV status and risk

- 3.6 Since publication of the ABI Statement of Best Practice on Underwriting Life Insurance for HIV in July 1994, insurers have not asked whether an applicant had undergone counselling about HIV, or had taken an HIV test. Instead, insurers ask whether the applicant had tested positive for HIV, or was awaiting the results of an HIV test.
- 3.7 Insurers that use "short" application forms (which have a minimum of medical questions) may choose to incorporate these questions in a separate questionnaire. ABI members should use the following questions (in bold type):

(A) HIV, hepatitis B or hepatitis C status

"Have you ever tested positive for HIV, hepatitis B, or hepatitis C, or are you awaiting the results of such a test?"

Note: If the result is negative, the fact of having an HIV test will not, of itself, have any effect on your acceptance terms for insurance"

(B) HIV risk – potential sexual transmission

3.9 There are five main infection routes:

- People who have unprotected sex³
- People who have been resident or travelled in or to countries with high HIV prevalence who caught HIV there
- People who inject non-prescription drugs
- People who have had blood transfusions or blood products, or surgery, outside the EU
- Mother-to-baby-transmission

3.10 Being gay does not necessarily mean a person is at higher risk of HIV infection. The person concerned may be celibate, or always have protected sex. Insurers and the medical profession, who have dealt with this issue for some time (for example, for blood donors), ask specific questions about personal behaviour. Questions must be directed at personal behaviour. Whereas people might not be sure of what constitutes safe sexual behaviour, most people are aware of what constitutes **unsafe** sexual behaviour. We therefore recommend the following question –

“Within the last five years have you been exposed to the risk of HIV infection?”

3.11 Insurers can ask questions on injecting drug use, blood transfusions carried out outside the EU and travel or residence abroad separately. Insurers may also wish to include in the question above examples of increased risk of HIV. Asking if a person is gay would not be acceptable. However the following are:

“(this can be caught through unsafe sex, intravenous drug abuse, or blood transfusions or surgery undertaken outside the EU)”

3.12 If insurers wish to explain unsafe or safe sex they may do so but the explanation must be related to individual personal behaviour, for example, unprotected sex and not to a person’s sexuality.

3.13 It is **optional** for insurers to invite applicants to give information that they think may mean that they are less at risk of HIV infection. The question would need to be “open” to avoid asking leading or intrusive questions. We propose the following:

“Have you anything to add to your declaration, which in your view, means that you are (or are not) at risk of HIV?”

(C) Other sexually transmitted diseases / infections (STDs/STIs)

3.14 Insurers can ask applicants if they have had other sexually transmitted infections. This is to identify whether applicants have serious STIs (like syphilis) and because repeated infections may indicate an increased risk of HIV.

³ anal, oral or vaginal sex

- 3.15 GPs only disclose STDs with long-term health implications, in accordance with the joint BMA-ABI guidance on medical information and insurance. Whether an STD has a long-term health implication is, in many cases, more dependent on how it was acquired rather than the type of infection – for example if acquired through injecting drug use. Members of the public cannot be asked to make judgements as to what infection may or may not have long-term health implications. This is something that would almost certainly be outside their normal or expected knowledge range. From an underwriting standpoint the key issues would depend upon the stage to which it had progressed at the time of diagnosis and how it had been acquired.

Insurers continue to have the option of asking the following question:

“Within the last five years have you tested positive or been treated for any disease, which was transmitted sexually?”

(D) Intravenous drug use

- 3.16 Information on drug use is not always related to HIV or hepatitis C risk. Insurers can ask about the use of recreational drugs such as cocaine. A typical question to obtain information about injecting drug use is:

“Have you ever injected non-prescription drugs?”

(E) Blood transfusions or surgery

- 3.17 Insurers can ask for information about blood transfusions or surgery from outside the EU. There may be issues concerning some countries in the enlarged EU. An option would be to narrow the question to countries outside the UK (see residence in paragraph 3.18). There is no recommendation either way as this is a matter for continued policy development.

(F) Residence and travel outside the UK

- 3.18 Insurers should maintain a list of countries or areas of high HIV prevalence as part of their policy on when to ask for HIV tests and should make this available on request to applicants (see [Annex A](#) for evidence sources). Countries with high HIV prevalence are generally those where at least 1% of the population has HIV. This prevalence is considered as "high" because at this level insurers would usually need to take account of the increased risk for individuals from those countries when compared to the UK.

(G) Supplementary questions

- 3.19 Adoption of the questions in the previous paragraphs means that the practice of asking additional supplementary questions is obsolete. Insurers can choose to ask any of the above questions or not but they may not ask additional supplementary questions – for example about monogamy, number of sexual partners, and length of relationships.

4. Company policy on asking an applicant to take an HIV test

4.1 Insurers must have a clear policy on asking an applicant to take an HIV test, as set out in principle 5, and make this available on request to applicants. As with all requests for all other medical tests, requests for HIV tests should have a clear reason, which is evidence based and can be explained to the applicant for example:

- Answering “yes” to the question about exposure to risk of HIV, for example through unsafe sex
- Having being diagnosed with (a) sexually transmitted disease(s) with long-term health implications
- Being resident or visiting in a non-UK country with high HIV prevalence (see 3.18; a list of countries should be available for applicants)
- Applying for a relatively large amount of insurance
- Injecting drug use
- Blood transfusions or surgery

5. Arranging an HIV test

Detailed Guidance

5.1 The guidance note at [Annex B](#) explains the points that insurers should consider when arranging for an applicant to be tested for HIV. It gives guidance on:

- The choice of test method and provider
- Customer discussion and consent
- Recommended clinical procedures

Annex C and Annex D contain:

- Model pre-testing leaflet and consent letters to the applicant
- An example HIV protocol for health professionals

Before the test – pre-testing leaflet and consent issues

5.2 It is particularly important that applicants are made fully aware of the purpose of the HIV test before they are asked to consent to being tested. To this end, a HIV pre-testing leaflet letter and a consent form must be issued directly to every applicant who is asked to have an HIV test. These must not be sent via the sales intermediary.

5.3 Applicants should receive their pre-test information before the test takes place. The testing centres must ensure that the applicant has read the pre-testing leaflet before consent to a test is given. This is part of the protocol between the insurer and the centre (see [Annex D](#)). The consent form is part of the pre-test information and must be completed at the time of the test. The test cannot

happen unless consent has been given. Consent forms should be signed in accordance with the procedures in Annex B of the Statement.

- 5.4 The pre-testing leaflet explains that the applicant should take the unsigned consent form with them to the test centre where, if they are willing to take the test, they should sign it and have their signature witnessed. As part of the consent process they should nominate a professional contact that they wish to be notified by the insurer in the unlikely event of a positive HIV test result. Options include their own GP, or a named Genitourinary Medicine (GUM) clinic or professional HIV counselling service. If they are unable or unwilling to nominate one of these it should be explained that the test centre (if it offers appropriate services) or their own GP would be the point of contact. The insurer **must** satisfy itself that, should the applicant refuse to provide written consent, the health professional will not proceed with a test.

All test results

- 5.5 The insurer must ensure that the applicant (or nominee) is told the result as quickly as possible to relieve uncertainty. In the rare cases of positive results this is even more important so that arrangements can be made for counselling and future care.
- 5.6 Wherever possible, the salesperson should not be aware that an HIV test has been requested. Whether they are or not, however, the salesperson **must not** be told the result of the test.

Negative test results

- 5.7 Negative test results should be communicated as soon as possible to relieve applicant uncertainty. The insurer should also explain that the negative test had no effect on the applicant's insurance rating. This is particularly important where premiums are rated or exclusions applied as applicants may be under the misapprehension that negative tests have an impact on insurance.

Positive test results

- 5.8 In those rare cases where an HIV test returns a positive result, indicating that the individual has contracted HIV, the insurer **must** ensure that the applicant is told the result – by the person they have nominated on their consent form or the test centre or their own GP – as quickly as possible, so that arrangements for counselling and future care can be discussed.
- 5.9 If the Chief Underwriter or Underwriting Manager receives the test result, they should communicate it to their Chief Medical Officer (CMO) immediately. Once the CMO is aware of a positive test result, they **must** contact the person nominated on the applicant's consent form, or the test centre, as quickly as possible.
- 5.10 The applicant's nominee or test centre should be asked to advise the CMO when the counselling meeting has taken place. Only once this confirmation has been received should the insurer issue a letter, signed by the CMO or the Chief Underwriter, to the applicant giving the underwriting decision. Care must be taken to ensure that the decision letter is **not** issued until after the applicant has been counselled.

- 5.11 The applicant's HIV status must **not** be referred to in any oral or written communications with third parties, unless the applicant has given written consent. Insurers have no role in notifying partners of applicants with positive test results. Responsibility for partner notification lies with the infected person, or their nominee or the test centre or their own GP if there are grounds to believe that the partner will not be told. Under these circumstances, the General Medical Council (GMC) advises that the doctor *may* disclose information to a person who is at risk of HIV infection. Insurer CMOs should receive positive test results. If any ethical dilemmas arise they should be dealt with by CMOs in accordance with the GMC guidelines on Serious Communicable Diseases at www.gmc-uk.org/standards/serious.htm.

Invalid test results

- 5.12 Occasionally, the test laboratory may not be able to obtain a clear result from the applicant's sample. This may be due to the sample being insufficient, contaminated, or being mislaid. In these circumstances the applicant should be told that the test was inconclusive and the reasons for this (if known). In these cases we recommend that another test be arranged. Some insurers in these circumstances waive the requirement for a further test. This raises serious ethical issues – particularly if the applicant were to assume that this meant the test was negative.

6. Confidentiality

Insurance company confidentiality – ABI guidelines

- 6.1 Insurers recognise the importance of ensuring the confidentiality and privacy of sensitive personal information of the kind disclosed on insurance application forms. They are also fully aware of their responsibilities under data protection and other legislation. To assist member companies in fulfilling their obligations, the ABI has produced a set of confidentiality guidelines published in the ABI Code of Practice on Genetic Testing.

Group/corporate insurance policies

- 6.2 This Statement refers in general to the “applicant” for insurance. However, the contract is between the policyholder and the insurer and, in some circumstances, for example, group insurance policies, the insured person and the policyholder is not the same person. For group insurance policies, for example, the policyholder is the employer, not the employee.
- 6.3 When dealing with such cases, insurers **must** ensure that they communicate directly with the “insured person”, rather than the policyholder (where they are different), on all personal, sensitive and medical issues. The policyholder must not be informed of any enquiries the insurer makes about the insured person's risk of HIV infection. Should the insured person be HIV positive it is not for the insurer to give this information to the policyholder. As in paragraph 5.11, the GMC Guidelines apply and any ethical issues should be dealt with by the insurer's CMO.

Confidentiality and joint life applications

- 6.4 Where an applicant is asked to complete a supplementary questionnaire, it is important to recognise that the information disclosed is confidential to that person. In particular, when underwriting applications for joint life insurance, insurers **must** protect the confidentiality of such information. They must ensure that the “ignorant” party to a joint life application cannot infer any confidential information from the underwriting result (but see also paragraph 5.11).

Security of electronic communications

- 6.5 Insurers should ensure, in their dealings with doctors and laboratories that positive test results are only sent by post. Negative test results should normally be sent by post but secure fax is acceptable for negative results from medical test centres. All test results must be sent promptly.

7. Complaints

- 7.1 Insurers should ensure that their complaints procedure takes account of this Statement. Where a complaint is received that falls within the area covered by this Statement, the complaint handler should consult the insurer's Chief Underwriter or Underwriting Manager and, if necessary, the Chief Medical Officer.

8. Further information

References:

ABI Code of Practice on genetic testing

Civil Partnership Act 2004

ABI/BMA joint guidelines: “Medical information and insurance”

ABI “An Insurer’s Guide to the Disability Discrimination Act, January 2003”

ABI “Consumer guide for gay men on HIV and insurance”

ABI “Consumer guide – countries with high HIV prevalence”

ABI/BMA agreed wording to request a General Practitioner’s Report

Health Protection Agency Annual Report on HIV and other Sexually Transmitted Infections in the United Kingdom (see) www.hpa.org.uk

Contact:

Association of British Insurers, 51 Gresham Street, London EC2V 7HQ
020 7600 3333 www.abi.org.uk

Annex A

Guidance: underwriting – evidence and exclusions

Evidence

A1 Insurers should review their underwriting practice and approach regularly to ensure that it is up to date. Annual reviews are recommended for evidence. Insurer policies should be reviewed at least every three years in the light of this evidence. Data sources are:

- Statistics in the UK – insurers should monitor regularly the data collected by the Health Protection Agency (www.hpa.org.uk/infections) and their own death claims, and consider whether these suggest the need for changes in policy or practice;
- Higher risk countries – underwriters should have up to date information on the situation in those countries where the incidence of HIV infection is high. The World Health Organisation collates HIV data from specific countries:
 - WHO web address www.who.int
 - statistics and maps www.who.int/globalatlas/default.asp
 - global atlas of infectious diseases www.who.int/emc-hiv/fact_sheets/All_countries.html
 - World maps showing HIV prevalence www.gamapserver.who.int/mapLibrary/app/searchResults.aspx
 - Other useful sources of information are the EU Commission’s epidemiological surveillance site www.eurosurveillance.org the Joint United Nations Programme on HIV/AIDS www.unaids.org www.ceses.org

Excluding HIV/AIDS as a cause of claim

A2 Life insurance policies do not normally exclude AIDS. However, HIV/AIDS exclusions are more common with other long-term health products such as critical illness (CI) and income protection (IP) insurance. The ABI’s Statements of Best Practice for CI and for IP insurance require that any general exclusions (for example, “drug abuse”) and any specific conditions, such as HIV/AIDS, that are not covered by the policy are shown prominently in the Key Features Document given to the customer as part of the sales process, so that the scope of the cover is clear.

A3 Where an exclusion for HIV/AIDS is applied, the model wording which is recommended is:

‘We will not pay a claim if it is caused directly or indirectly by infection with Human Immunodeficiency Virus (HIV) or by conditions due to any Acquired Immune Deficiency Syndrome (AIDS).’

A4 Exclusions worded in this way ensure that, while HIV and AIDS are not included in the scope of cover, someone who has been diagnosed with HIV or AIDS is not prevented from claiming on their policy if they suffer an unrelated condition such as a heart attack.

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A5 The ABI document “An Insurer’s Guide to the Disability Discrimination Act 1995” makes clear (section 2.8.2) that insurers “must not use general exclusions that have the effect of preventing a person from claiming for a condition that is not related to the excluded condition. General exclusions that have this effect are not lawful as they would be regarded as both unfair contract terms ... and discriminatory”. The Guide then gives, as an example of an unlawful HIV/AIDS exclusion, the following: “we will not pay a claim if the insured person has HIV or AIDS”.

A6 When imposing exclusions on policies, insurers should pay particular attention to the following points:

- If the exclusion means that the questions (Paragraphs 3.12 - 3.14) about a person’s **risk** of HIV infection are irrelevant the questions should NOT be asked. This is particularly likely to be the case for stand-alone income protection and critical illness policies because it should usually be relatively simple to establish whether or not HIV/AIDS is the cause of the claim. In the case of menu/multi benefit products (for example CI and term life), if any part of the policy does **not** include an HIV exclusion, the HIV risk questions may be asked. Insurers may still ask for details of positive HIV tests as to do otherwise would be to offer an unfair contract to those already infected.
- Problems arising from, for example, the limitations of old computer systems should be solved, through manual administration if necessary. Individuals should not be declined a policy simply because the system cannot impose a particular exclusion;
- The policy should state clearly whether the exclusion relates to the whole contract, to some part of it, or to one or more of the benefits;
- Where HIV/AIDS is excluded, name the occupations (if any) where the exclusion will be waived – for example, medical or emergency workers where HIV/AIDS is contracted through normal occupational duties;
- Documents should include the full names for HIV and AIDS:
 - HIV = Human Immunodeficiency Virus;
 - AIDS = Acquired Immune Deficiency Syndrome;
- Where definitions are required, suggested forms are:
 - HIV – a viral infection, caused by the human immunodeficiency virus, that gradually destroys the immune system;
 - AIDS – the most serious stage of HIV infection characterised by symptoms of severe immune deficiency.

Annex B

Guidance: arranging an HIV test

B.1 This guidance note details the points that insurers should consider when arranging for an applicant to be tested for HIV.

Choice of test method and provider

B.2 When deciding whether to employ blood or saliva or OMT (oral mucosal transudate) tests, and when deciding which testing centres and laboratories to use, insurers may wish to consider:

- The quality of pre-test discussion and care given to applicants
- The robustness of individual laboratories' protocols
- The testing kits used – in particular their reliability and whether they are customer-friendly. If saliva tests are used, whether this is sufficiently accurate to give a positive result
- The service standards of each laboratory
- The cost of the testing procedure
- Any customer requirements

B.3 Insurers will want to undertake regular reviews to ensure that the chosen testing centres and laboratories continue to be reliable and effective providers of test services.

Customer pre-testing leaflet and consent

B.4 A pre-testing leaflet and a consent form **must** be issued directly to every applicant who is asked to have an HIV test. They should be sent by first class post, and the name and address should be carefully checked prior to posting.

B.5 Recommended text for the pre-testing leaflet and the consent form are reproduced at the end of this annex.

Recommended procedures for the insurer

B.6 If an HIV test is to be requested, it will need to be carried out by a clinician. The insurer should inform the applicant that a test is being requested and at which testing centre it will be carried out. If the applicant wishes the test to be carried out by their own doctor or by another centre this should be treated on its merits. The applicant should also be told to take the leaflet and consent form with them to the testing centre.

B.7 If an insurer “approved” testing centre is **not** to be used, the surgery or centre that is used should be asked to provide the insurer with a copy of the protocol used by their health professionals. The insurer will want to be satisfied that the professional who will carry out the test has clear instructions covering:

- The content of the discussion to be given prior to obtaining consent for the test and confirmation that they will check that the applicant has read and understood the pre-testing leaflet;

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- The need to obtain the applicant's written consent to a tissue sample being taken, and to obtain the contact details of the applicant's nominee who the insurer will contact if the test result is positive;
- The need to refuse to proceed further if the applicant does not provide consent.

Annex C

HIV Pre-testing leaflet

As you are probably aware, the Acquired Immune Deficiency Syndrome (AIDS) is caused by infection with a virus known as Human Immunodeficiency Virus (HIV).

When insurers consider an application for life or health protection insurance, they sometimes require additional information about your risk of HIV. This assessment of HIV risk is designed to protect the funds held for both existing and future policyholders. Your insurance company has asked you to undergo an HIV antibody test. This could be because of answers you gave on your application form which revealed that you could be at risk of HIV, or it could be because you have applied for a relatively large amount of insurance.

The nurse/doctor will take a sample of blood/saliva (delete as appropriate). The test will form a routine part of your medical examination and the sample will be sent to a specialist laboratory. Your test will be protected by a strict code of confidentiality, and will only be disclosed if you give your written consent to the disclosure. Your insurer asks you to consent to your test result being released to your local GP, GUM clinic or HIV counselling service, as insurers are unable to provide adequate post-test support if your test proves to be positive.

A positive test would mean that you have been exposed to HIV and have developed antibodies. You should be aware of the possible consequences of testing positive. It would, however, enable you to access effective treatments earlier. If you decide not to have the test at this time, please sign the appropriate section of the enclosed declaration and ask the doctor/nurse to return it to the insurance company. You will, of course, understand that this will mean that we cannot proceed further with your application. Your decision not to test will not be held against you for any future applications.

If you have no objections to this test being performed, please sign the declaration and consent in the nurse's presence.

Your Full Name:

Details and address of person nominated to receive a test result if it is positive
Details and address of person nominated to receive a test result if it is positive

.....
.....
.....
.....

Signature:

Date:

Witnessed by (Nurse):

Insurance Company:

Reference Number:

Refusal to be tested form

REFUSAL TO BE TESTED
I am unwilling to undergo testing for HIV antibodies. I understand that, as a result, my application for life assurance will be cancelled.
Signature:
Date:
Witnessed by (Nurse):.....

Annex D

Example text for HIV protocol

To: The health professional providing HIV discussion and test services

We would be grateful if you could please follow the procedures below when dealing with individuals who have applied for insurance with us, and whom we have asked to take an HIV test. This will help to ensure that a consistent and thorough approach is maintained.

1. Ensure that the person to be tested has read and understood the HIV pre-testing leaflet that has been sent to them
2. Carry out the pre-test discussion
3. Ask the applicant if they are willing to take the HIV test
4. If they are, ensure they complete the written consent form for the HIV test, including nominating another individual apart from themselves (normally their GP or GUM clinic) who the insurer will contact if the test result is positive. In the event of the applicant being unwilling or unable to make a nomination confirm (and obtain their agreement to) yourselves being the contact point. (If the centre is not able to provide suitable support the default option would be the applicant's own GP)
5. Witness their signature on the consent form
6. Take a sample of blood or saliva, as directed by the insurer;
7. Send the sample to the analysing laboratory on the same day;
8. Return the completed consent form to the insurer with the medical examiner's report.

[Insurance company sign off.]