

**Association of British Insurers**

**Statement of Best Practice  
for Sales of  
Individual and Group Private Medical Insurance**

**November 2017**

## Introduction

This Statement of Best Practice ('the Statement') applies to ABI members selling private medical insurance (PMI) to UK residents. Compliance with this Statement is voluntary for ABI members and any references to the requirements of insurers in this Statement apply only to those insurers who choose to comply with it (save for any references to compliance with legislation or regulations, which applies to all UK insurers). Any ABI member choosing to comply with the Statement should comply with it in full (save where it conflicts with any legal or regulatory requirements).

The Statement applies only to PMI that covers private treatment in the UK. The Statement is designed to facilitate consistency in the way ABI members provide information on PMI, in order to help anyone considering taking out a PMI policy understand the different underwriting methods and options for insurance cover, regardless of whether or not they are seeking independent advice. The Statement is a guide for members to help individuals:

- Get clear, consistent information about policies they are considering
- Understand the extent and limitations of cover under the policies they are considering
- Compare key aspects of the cover offered by different insurers
- Choose the most appropriate cover for their needs

This Statement covers individual, and group (including corporate) private medical insurance schemes. It requires Insurers to:

- Use common definitions for specific terms.
- Use standard examples to explain the scope of cover. The examples about cancer were originally developed with Cancerbackup – who are now part of Macmillan Cancer Support - and we gratefully acknowledge their contribution.
- Make information available to individual and group applicants, or the intermediary, if there is one.

Private medical insurers are required to comply with all relevant legislation and regulation. Insurers, in the UK, are regulated by the Financial Conduct Authority (FCA) and the Prudential Regulation Authority (PRA). All information insurers provide should be clear, fair and not misleading. This Statement builds on (and, in the event of a conflict, is overruled by) existing legislation and regulations to help give people considering purchasing private medical insurance the information they need.

This Statement supersedes and replaces all previous editions, which were compulsory for ABI members. Those ABI members who choose to comply with it should do so as soon as possible, but in any event within eighteen months of publication. This period allows the accommodation of IT updates and publication cycles. Any industry codes of best practice may be taken into account by relevant regulators and the Financial Ombudsman Service, as these types of codes outline good industry practice.

ABI members who choose to comply with the Statement should make their compliance with the Statement clear on their website and in any literature to which the Statement applies.

The Association of British Insurers is the voice of the UK's world leading insurance and long-term savings industry.

A productive, inclusive and thriving sector, we are an industry that provides peace of mind to households and businesses across the UK and powers the growth of local and regional economies by enabling trade, risk taking, investment and innovation.

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## 1 About Private Medical Insurance

- 1.1 Private medical insurance (PMI) aims to cover the costs of private medical treatment for 'acute conditions' that start after the policy begins.

The ABI defines an acute condition as follows:

*A disease, illness or injury that is likely to respond quickly to treatment which:*

- *aims to return the claimant to the state of health they were in immediately before suffering the disease, illness or injury, or*
- *which leads to a full recovery.*

Please note:

PMI is designed to work alongside, not to replace, all the services offered by the NHS and in all cases customers retain their right to use the NHS. Some policies may cover certain types of treatment for, or elements of, chronic conditions, but this is not usually the main purpose of PMI.

### Types of PMI

- 1.2 The type of PMI depends on who the policyholder is. The policyholder is the person with whom the contract for the policy is made, who takes out the policy and pays the premiums.

- **Individual PMI** – where the policyholder is an individual. The policy covers the policyholder and may also cover their family.
- **Group (including Corporate) PMI** – where the policyholder is a legal entity, usually an employer. The policy covers the scheme members (usually employees and sometimes their families). It is the person representing the employer (not the insurer) who chooses the scope of the cover and how any information about the policy is made available to their employees.

Please note:

- Any policyholder is free to decide to be represented by a third party acting as an intermediary – for example, a firm of independent financial advisers, a specialist health insurance intermediary, or employee benefit consultants.
- Individuals and members of a group scheme can have an unresolved complaint referred to the Financial Ombudsman Service.
- Insurers who sell products online must comply with the information requirements about the online dispute resolution (ODR) platform, as prescribed in the Alternative Dispute Resolution for Consumer Disputes (Competent Authorities and Information) Regulations 2015

## **2 What insurers are required to do**

### **Legislation**

2.1 Private medical insurers are already required to comply with all relevant legislation, including on the following:

- Marketing and promotional material
- Unfair contract terms
- Anti-discrimination on age, disability, gender, race, ethnic origin, faith, sexual orientation and political beliefs
- Client confidentiality and data protection
- Contract structures
- Allowing customers to change their mind
- Competition

### **Regulation**

2.2 All insurers offering private medical insurance in the UK are required to comply with all relevant UK regulation. Insurers are regulated by the Financial Conduct Authority (FCA) and the Prudential Regulation Authority (PRA).

### **This Statement of Best Practice**

2.3 This Statement builds on existing legislation and regulations to cover the specific information needs of individual or group/corporate customers who are deciding whether or not to purchase PMI, are choosing between PMI policies, or having recently taken out cover are in their cooling-off period.

2.4 Insurers that opt to comply with this Statement will do all of the following':

1. Comply with the principles set out in this Statement in section 3 below including:
  - Make the required information available to individual and group scheme policyholders as set out in Principle 4.
  - Use the common definitions set out in the Annex A wherever they apply to help customers understand their cover and compare policies. This means that, these terms have the same meaning in all PMI policies.
  - Make the information as set out in the Annex B available to potential customers so they can make an informed buying decision:
    - Give customers a clear explanation of the underwriting choices available and how each option works as set out in the Annex B.1.
    - Explain the cover, if any, for long-term treatment or chronic conditions as set out in the Annex B.2.
    - Have a separate section to explain the cover, if any, for cancer as set out in the Annex B.3.
    - Explain the cover, if any, for drugs as set out in the Annex B.4.

2. Use the templates as set out in the Annex B to set out information so that customers can compare policies they are considering and make an informed buying decision.
  3. Use the relevant standard examples as set out in the Annex B to explain the scope of cover provided.
  4. Inform people what information they need to disclose and their rights to ensure that the contract is set up on a fair basis as set out in the Annex C.
- 2.5 Insurers will make all the mandated documents described in this Statement available to individual and group applicants, either directly or through the intermediary, if there is one. The information prepared by Insurers for the policyholder (and in the case of group PMI, for employees) will comply with this Statement.

### **3 Principles**

Insurers will ensure that their PMI business adheres to the following ABI principles:

**Principle 1** The ABI PMI common definitions must be used in all policy documents, where those words apply.

**Principle 2** **For individual customers** it is the Insurer's responsibility to work with any intermediary to ensure that each customer receives all of the mandated documentation described in this Statement.

**For group business** it is in the interest of the insurer for individual members of group/corporate schemes to know what cover they have. Insurers will make information available to the employer (the group customer) or the intermediary, if there is one. It is usually the employer's responsibility to give the information to scheme members. All information provided by the insurer, for the employer to give to their employees, will comply with the requirements of this Statement. This will not affect the right of any individual member of a group/corporate scheme to take any complaint they might have to the Financial Ombudsman Service.

**Principle 3** Insurers must provide explanations of core terms and conditions that are appropriate to the customer's circumstances and that are clear and in plain and intelligible language, to explain the details of cover.

In particular:

- a) What treatment is and is not covered by the policy including significant exclusions, exclusions for pre-existing conditions and conditions related to pre-existing conditions, cancer, exacerbations of an ongoing condition, information around limits to cover, withdrawal of cover (including when the policy holder cancels, or stops paying the premium for, all or part of the policy) and the terms that may need to be applied for the customer to transition to the NHS.
- b) Benefits and features including healthcare provider networks.
- c) Potential for there to be changes to the premium and/or policy terms at renewal.

- d) Implications for cover when switching from one policy or insurer to another including from a group scheme to an individual scheme.
- e) Any requirement for pre-authorisation before getting treatment.
- f) Processes including how to claim on, complain about and cancel the policy.
- g) Where applicable, an explanation of moratorium underwriting, including that underwriting is undertaken at point of claim, how regular check-ups affect the moratorium, and how symptoms affect cover where there is no diagnosis.
- h) Where applicable, an explanation of full medical underwriting – including that underwriting is undertaken at point of application, how symptoms affect cover where there is no diagnosis.
- i) Requirement to make full disclosure in response to insurer's question, in particular on pre-existing conditions.
- j) Set out the amount of excess and how the excess will be applied.

**Principle 4** Insurers must provide the following information to individual customers and group scheme customers, if applicable to the scheme, at the same time as the policy wording is required to be provided to the customer (this may be at the point of sale or as soon as possible thereafter):

- a) 'Are you buying PMI?' – the ABI consumer guide.
- b) 'Your underwriting options' - a clear explanation of the underwriting options and what each option means. The explanation should meet the requirements set out in the Annex B.1.
- c) 'Your PMI Cover for treatment for long-term/chronic condition(s)' - the format is prescribed so customers can compare different companies cover and exclusions as set out in the Annex B.2.
- d) Cover for cancer in a distinct section, using the prescribed headings and content of the Explanation of Cover for Cancer, separately from other conditions. The explanation should meet the requirements set out in the Annex B.3.
- e) An explanation of the cover for drug treatment. The explanation should meet the requirements set out in the Annex B.4.

In addition, insurers must make this information available to customers by drawing it to their attention and telling them where it is, for example on the website, on the following occasions:

- When there is a change to the terms and conditions
- When a new person is added to the policy, such as a spouse
- As part of the renewal process

## A Common Definitions

Insurers must use the common definitions set out in this section where that word is used in policy documents (with the exception of those relating to international products). The common definitions are not designed to describe the scope of cover provided by a product. Their purpose is to ensure that in whatever context the defined word or phrases are used they will have the same meaning.

Insurers may use additional information or support material to describe the extent, or otherwise, of cover provided.

### **Acute condition**

A disease, illness or injury that is likely to respond quickly to treatment which aims to return you to the state of health you were in immediately before suffering the disease, illness or injury, or which leads to your full recovery.

### **Cancer**

A malignant tumour, tissues or cells, characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.

### **Chronic condition**

A disease, illness, or injury that has one or more of the following characteristics:

- it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
- it needs ongoing or long-term control or relief of symptoms
- it requires your rehabilitation or for you to be specially trained to cope with it
- it continues indefinitely
- it has no known cure
- it comes back or is likely to come back

### **Day patient**

A patient who is admitted to a hospital or day patient unit because they need a period of medically supervised recovery but does not occupy a bed overnight.

### **Diagnostic tests**

Investigations, such as X-rays or blood tests, to find or to help to find the cause of your symptoms.

### **Inpatient**

A patient who is admitted to hospital and who occupies a bed overnight or longer, for medical reasons.

### **Nurse**

A qualified nurse who is on the register of the Nursing and Midwifery Council (NMC) and holds a valid NMC personal identification number.



**Out patient**

A patient who attends a hospital, consulting room, or outpatient clinic and is not admitted as a day patient or an inpatient.

**Pre-existing condition**

Any disease, illness or injury for which:

- you have received medication, advice or treatment, whether the condition has been diagnosed or not ; or
- you have experienced symptoms, whether the condition has been diagnosed or not; or
- you have received a diagnosis

in the xxx years before the start of your cover. (The same period is not common to all insurers)

**Treatment**

Surgical or medical services (including diagnostic tests) that are needed to diagnose, relieve or cure a disease, illness or injury.

It is recognised that some firms use the term 'active treatment'. This has the potential to confuse customers given the current agreed definition of treatment. If firms do use the term it must be accompanied by a specific definition.

## B Templates for setting out key information about PMI

### B.1 Explaining the choice of underwriting

Insurers must provide customers who are taking out individual policies with the following information, before the contract is concluded. This applies to employers of group/corporate schemes if the members are medically underwritten.

Insurers need to be explicit and present the choice of underwriting in an easy to understand way. One way may be to use a simple table format, such as the example below.

	Full medical underwriting	Moratorium – option A (if any)	Moratorium – option B (if any)
What happens when an application for PMI is made			
What happens when a claim for PMI is made			
Why some customers choose this form of underwriting			

Insurers should also clearly set out the differences between full medical underwriting and moratorium underwriting. An example of how this could be written is below:

*You will not normally be covered for any illnesses you are currently suffering from, or have already had. These are known as 'pre-existing conditions'. You must answer all questions as fully and as accurately as you can, to the best of your knowledge and belief.*

*There are two main methods that PMI companies use to deal with your application for cover. These are:*

- *full medical underwriting*
- *moratorium underwriting.*

## **FULL MEDICAL UNDERWRITING (MEDICAL HISTORY DECLARATION)**

*You are asked to give details of your medical history. The insurer may write to your doctor for more information, but they do not do so in every case. You must give all the information you are asked for. If you do not, your insurer may reduce your claim or refuse to pay and cancel your policy. In some cases, insurers may also decline offering any cover. If you are not sure whether to mention something, it is best to do so. If you have a medical condition that is likely to come back, the insurer will issue a policy, but that condition (and any related to it) might not be covered. Depending on a number of factors, the condition may never be covered, or not covered for a set period of time.*

## **MORATORIUM UNDERWRITING**

*You are not asked to give full details of your medical history. Instead, the insurer does not cover treatment for any pre-existing medical condition that you have received treatment for, diagnostic tests for, taken medication for, asked advice on or had symptoms of, in the years immediately before your policy started. In other words, you will not be covered for any condition that existed in the past few years. The period of time for this can vary across different insurers.*

*These conditions may automatically become eligible for cover. But this will only happen when you do not have symptoms of, or receive treatment, medication, tests and advice (from your GP, a healthcare professional or a specialist) for that condition, or a related condition, usually for a continuous period of time after your policy has started. This period of time can vary across different insurers.*

*You do not need to tell the insurer about your medical history when you take out the policy. If you claim, however, your insurer might ask for medical notes that are needed to decide if your claim can be covered.*

*There are some conditions, for example chronic conditions, that will probably never be covered. This is because you will always need treatment, medication, tests or advice for them. You should not delay getting medical advice or treatment, simply to get cover under the moratorium terms.*

*If you have general health check-ups simply in the interests of maintaining good health, and not for any particular condition, then your insurer will disregard these check-ups when applying the moratorium.*

*Your insurer will give you information explaining how their moratorium works. You may also want to ask the insurer or adviser, to explain this.*

## **B.2 Explaining the cover for long-term treatment / chronic conditions**

### **'YOUR PMI COVER FOR LONG-TERM TREATMENT / CHRONIC CONDITION(S)'**

The format is prescribed so customers can compare different companies' cover and exclusions.

This information is intended to explain to customers any cover for treatment that is provided for conditions that are likely to continue or keep recurring and are sometimes called chronic conditions.

Insurers must provide the explanation at the point of sale or as soon as possible thereafter, but in any event at the same point as the policy wording is required to be

provided to the customer. It is recommended that insurers also send it to existing retail customers.

Insurers may choose to produce this information in the form of a leaflet or to incorporate it within their other point of sale material.

Only those examples relevant to the product need be used.

The explanation of cover for cancer must be provided in a distinct section, separately from information on other conditions (see annex B.3).

**Insurers are free to provide information on specific conditions where they believe that their customers would find this helpful. Some insurers produce separate leaflets giving details of their coverage of particular conditions. The Statement of Best Practice is designed to permit this flexible approach.**

**Insurers must use the following prescribed format when giving details of their coverage:**

1. Explanation

Include:

- An introductory paragraph stating its purpose.
- The statement 'Exclusions that would normally apply to long-term/chronic conditions may not apply to cancer. Please refer to the section on cancer.'

2. First Heading:

**'What is a xxx condition?'**

Include:

- The agreed Common Definition followed by a general description of the insurer's own approach to covering these.

3. Second Heading:

**'What does this mean in practice?'**

Explain:

- The process undertaken by the insurer to establish whether or not a treatment for a condition is, or has become, long-term and the subsequent actions arising from this.
- The situation where a person may transition from PMI to NHS care or if cover will stop once the treatment is considered to have become long term for a condition, and the implications of this.

*Sample wording*

'Payment for treatment may stop at some point – this could be because of a policy limit, or because the condition is no longer short term and therefore the treatment is not something that your policy covers. There are many different conditions that can be acute or chronic. By the time you need to claim on your policy the treatment

that is available may well have developed and improved from the time you first bought the policy. We consider your individual circumstances and examples are set out below to explain this. If you are receiving treatment which is covered by your policy at the time your cover ends, we may contact you so that you can discuss this and make arrangements with your specialist such as, a transfer to NHS care or for you to continue funding private treatment yourself.'

4. Third Heading:

**'What if your condition gets worse?'**

Explain:

- What happens when treatment for a condition has been deemed long-term and then the condition has an acute flare-up.
- PMI is intended to complement the NHS not replace it and patients may need to return to the NHS at a point where treatment for their condition is no longer covered under their policy. Different insurers manage this transition in different ways.

*Sample wording*

'It is not usually possible to predict accurately the cost of a course of treatment at the time of diagnosis. It is also difficult to estimate whether the amount of treatment available within a set time or financial limit will be sufficient to complete your treatment. If the costs of your treatment exceeded this limit, you may need to move to the NHS or choose to self-pay for your own treatment. This might require you to change hospitals, change doctors and change drug therapies or other treatments, part way through a cycle of treatment, potentially limiting the scope of your overall treatment.'

5. Fourth Heading:

**'Examples'**

The following examples should be worded exactly as they are shown below, with each insurer explaining how they would respond in the circumstances described. Where the example relates to a benefit which is not included in the product it need not be used, for example *Example 4* relates to treatment by an osteopath, if osteopathy is not covered under the policy this example should not be used.

***Example 1 – Angina and Heart Disease***

Alan has been with *insurer's name* for many years. He develops chest pains and is referred by his GP to a specialist. He has a number of investigations and is diagnosed as suffering from a heart condition called angina. Alan is placed on medication to control his symptoms.

**Will Alan be covered?**

Insurer's response (to be included here)

Two years later, Alan's chest pain recurs more severely and his specialist recommends that he have a heart by-pass operation.

<b>Will Alan be covered?</b>
Insurer's response (to be included here)

### **Example 2 – Asthma**

<p>Eve has been with <i>insurer's name</i> for five years when she develops breathing difficulties. Her GP refers her to a specialist who arranges for a number of tests. These reveal that Eve has asthma. Her specialist puts her on medication and recommends a follow-up consultation in three months, to see if her condition has improved. At that consultation Eve states that her breathing has been much better, so the specialist suggests she have check-ups every four months.</p>
<b>Will Eve be covered?</b>
Insurer's response (to be included here)
Eighteen months later, Eve has a bad asthma attack.
<b>Will Eve be covered?</b>
Insurer's response (to be included here)

### **Example 3 – Diabetes**

<p>Deidre has been with <i>insurer's name</i> for two years when she develops symptoms that indicate she may have diabetes. Her GP refers her to a specialist who organises a series of investigations to confirm the diagnosis, and she then starts on oral medication to control the diabetes. After several months of regular consultations and some adjustments made to her medication regime, the specialist confirms the condition is now well controlled and explains he would like to see her every four months to review the condition.</p>
<b>Will Deidre be covered?</b>
Insurer's response (to be included here)
One year later, Deidre's diabetes becomes unstable and her GP arranges for her to go into hospital for treatment.
<b>Will Deidre be covered?</b>
Insurer's response (to be included here)

### **Example 4 – Hip Pain**

<p>Bob has been with <i>insurer's name</i> for three years when he develops hip pain. His GP refers him to an osteopath who treats him every other day for two weeks and then recommends that he return once a month for additional treatment to prevent a recurrence of his original symptoms.</p>
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<b>Will Bob be covered?</b>
Insurer's response (to be included here)

### B.3 Explaining the cover for cancer

This information is intended to explain to customers how insurers cover cancer. The explanation of the cover for cancer must be available before the conclusion of the contract.

Insurers must have a distinct section in their policy documents to explain the cover for cancer. To allow for flexibility in approach, firms may consider having a separate leaflet, or a separate section in a leaflet, to explain the cover for cancer.

The following example(s) should be worded exactly as below, with each insurer explaining how they would respond in the circumstances described.

#### **Example 1 – Cancer**

<p>Beverley has been with <i>insurer's name</i> for five years when she is diagnosed with breast cancer. Following discussion with her specialists she decides:</p> <ul style="list-style-type: none"><li>• to have the tumour removed by surgery. As well as removing the tumour, Beverley's treatment will include a reconstruction operation</li><li>• to undergo a course of radiotherapy and chemotherapy</li><li>• to take hormone therapy tablets for several years after the chemotherapy has finished</li></ul> <p><b>Will her policy cover this treatment plan, and are there any limits to the cover?</b></p>
<p>Insurer's response (to be included here)</p>
<p>During the course of chemotherapy Beverley suffers from anaemia. Her resistance to infection is also greatly reduced. Her specialist:</p> <ul style="list-style-type: none"><li>• admits her to hospital for a blood transfusion to treat her anaemia</li><li>• prescribes a course of injections to boost her immune system</li></ul> <p><b>Will her policy cover this treatment plan, and are there any limits to the cover?</b></p>
<p>Insurer's response (to be included here)</p>
<p>Despite the injections to boost her immune system, Beverley develops an infection and is admitted to hospital for a course of antibiotics.</p> <p><b>Will her policy cover this treatment and are there any limits to the cover?</b></p>
<p>Insurer's response (to be included here)</p>
<p>Five years after Beverley's treatment finishes the cancer returns. Unfortunately, it has spread to other parts of her body. Her specialist has recommended a treatment plan:</p> <ul style="list-style-type: none"><li>• a course of six cycles of chemotherapy aimed at destroying cancer cells to be given over the next six months</li><li>• monthly infusions of a drug to help protect the bones against pain and fracture. This infusion is to be given for as long as it is working (hopefully years)</li></ul>



<ul style="list-style-type: none"> <li>• weekly infusions of a drug to suppress the growth of the cancer. These infusions are to be given for as long as they are working (hopefully years)</li> </ul> <p><b>Will her policy cover this treatment plan, and are there any limits to the cover?</b></p>
Insurer's response (to be included here)
<p>David has been with <i>insurer's name</i> for X years when he is diagnosed with cancer. Following discussion with his specialist he decides to undergo a course of high dose chemotherapy, followed by a stem cell (sometimes called a 'bone marrow') transplant.</p> <p><b>Will his policy cover this treatment plan, and are there any limits to the cover?</b></p>
Insurer's response (to be included here)
<p>When his treatment is finished, David's specialist tells him that his cancer is in remission. He would like him to have regular check-ups for the next five years to see whether the cancer has returned.</p> <p><b>Will his policy cover this treatment plan, and are there any limits to the cover?</b></p>
Insurer's response (to be included here)
<p>Jenny has been diagnosed with cancer. Her policy has a limit and she decides to commence private treatment.</p> <p><b>What help will be available if the policy limit is reached and she needs to transfer into the NHS?</b></p>
Insurer's response (to be included here)
<p>Eric would like to be admitted to a hospice for care aimed solely at relieving symptoms.</p> <p><b>Will his policy cover this, and are there any limits to the cover?</b></p>
Insurer's response (to be included here)

Where the policy provides cover for cancer, firms must explain clearly the cover for cancer using the mandated headings and content below, including:

- Limits on time periods
- Cycles of treatment
- Maximum payments
- Circumstances in which firms would not provide cover
- When cover might be withdrawn

**For individual business** – Insurers will use the table, format and detail (headings and content) of the template below.

**For group (including corporate) business** – Insurers will use the detail (headings and content) in a format that is appropriate to the other information provided to their customers.

Insurers may choose to provide additional separate information that is specific to a type of cancer.

**Format for a section to explain the cover for cancer**

<b>Headings</b>	<b>Content – including limits and what is not covered</b>
Place of treatment	<ul style="list-style-type: none"> <li>• Hospice</li> <li>• Hospital – inpatient</li> <li>• Hospital – out patient</li> <li>• At home</li> </ul>
Diagnostic	<ul style="list-style-type: none"> <li>• What types do you cover?</li> <li>• Consultation</li> <li>• Test e.g. screening, monitoring</li> <li>• Scan</li> <li>• Genetics</li> </ul>
Surgery	<ul style="list-style-type: none"> <li>• What types do you cover?</li> <li>• Preventative</li> <li>• Treatment e.g. of secondary cancer</li> <li>• Palliative</li> <li>• Reconstructive</li> </ul>
Preventative	<ul style="list-style-type: none"> <li>• Screening</li> <li>• Surgery</li> <li>• Vaccines</li> </ul>
Drug therapy	<ul style="list-style-type: none"> <li>• What types do you cover?</li> <li>• Chemotherapy</li> <li>• Biological therapy</li> <li>• Drug status eg pre-licence, not NICE approved</li> <li>• To maintain remission</li> <li>• Maintenance therapy</li> </ul>
Radiotherapy	<ul style="list-style-type: none"> <li>• Symptom relief eg for pain</li> <li>• Treatment</li> <li>• To maintain remission</li> <li>• Maintenance therapy</li> </ul>
Palliative	<ul style="list-style-type: none"> <li>• Maintenance therapy</li> </ul>
End of life care	<ul style="list-style-type: none"> <li>• Maintenance therapy</li> <li>• Nursing support</li> </ul>
Monitoring	<ul style="list-style-type: none"> <li>• Follow-up appointments</li> <li>• Tests</li> <li>• Time limits</li> </ul>
Limits	<ul style="list-style-type: none"> <li>• Time</li> <li>• Financial</li> <li>• Stage of illness</li> <li>• Clinical research trials</li> <li>• Other</li> </ul>
Other benefits	<p>Is there a level of cover that is specific to cancer?</p> <ul style="list-style-type: none"> <li>• Experimental treatment</li> <li>• Advanced therapy</li> <li>• Pre-licensed</li> <li>• NICE appraised</li> <li>• Clinical research trials</li> </ul> <p>Are any additional services available to cancer patients?</p> <ul style="list-style-type: none"> <li>• Psychiatric</li> </ul>

<b>Headings</b>	<b>Content – including limits and what is not covered</b>
	<ul style="list-style-type: none"><li>• Physiotherapy</li><li>• Nutritional support</li><li>• Stem cell/bone marrow transplant</li></ul>

## **B.4 Explaining the cover for drug treatment**

The explanation of the cover for drug treatment should include:

- Instances where the insurance cover might end before drug treatment is completed and that not all drug treatment may be available on the NHS.
- What options may be available to the customer in such a case. These could be:
  - Return to the NHS and receive the same treatment, if available
  - Return to the NHS and receive alternative treatment
  - Pay for the treatment privately on a self-pay basis

### *Sample wording*

'If you are receiving treatment which is covered by your policy at the time your cover ends, we may contact you so that you can discuss this and make arrangements with your specialist such as, a transfer to NHS care or for you to continue funding private treatment yourself.'

## **C Applicant requirements to disclose and their rights**

C.1 Applicants need to know about requirements to disclose in response to the insurer's questions.

### *Sample wording*

'You must give all the information you are asked for. If you do not, your insurer may reduce your claim or refuse to pay and cancel your policy'.

C.2 Applicants are under no obligation to:

- a) Find out medical information not known to him/her to complete the application form.
- b) Consent to disclosure of identifiable personal information to another party outside of the insurance company unless they are directly involved in assessing or managing the application or claim, or in reinsuring the risk.

C.3 Applicants have the right to Fair Treatment including to:

- a) Change their mind about proceeding with the application for insurance.
- b) Apply to another insurer.
- c) Expect the insurer to assess an insurance application fairly, based solely on relevant evidence.
- d) See a medical report prepared by their doctor before it is sent to the insurer, and to amend or add comments to it, under the Access to Medical Reports Act 1988 (or equivalent legislation in Northern Ireland).
- e) Find out what personal, including medical, information the insurer has on file about themselves other than in specific circumstances, under data protection legislation.

## D Group (including Corporate) Schemes – roles and responsibilities

