Mental illness and life insurance

What you need to know – a detailed guide

This information sheet was produced in association with

beyondblue
the national depression initiative
www.beyondblue.org.au

Lifewise

FPA

Mental illness and life insurance

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Since 2001, the life insurance industry and mental health sector have been working together to improve life insurance outcomes for people with mental illness. This information guide has been developed as part of this partnership.

Since this work commenced, industry-wide guidelines relating to mental health conditions have been developed, and there has been a decline in the rate of refusal of insurance for those with a mental illness.

Further information on this project can be found on the Mental Health Council of Australia website at **www.mhca.org.au**

What is life insurance?

Life insurance is designed to provide the financial means to protect you and/or preserve your way of life, or that of your family, in the event of an accident (injury), serious illness or even death.

There are several types of life insurance, including:

- Term life insurance – pays a lump sum upon your death or diagnosis of a terminal illness
- Total and permanent disability insurance – pays a lump sum if you become disabled and are unable to ever work again
- Income protection insurance – provides a replacement income if you are unable to work due to illness or injury
- Trauma insurance – pays a lump sum upon the diagnosis of one of a list of specific illnesses such as heart attack, cancer or stroke.

Almost all working Australians will have some level of life insurance cover as part of their superannuation, so it is worth checking with your fund/s to see what cover you have in place.

What are the implications of mental illness on the insurance industry?

One in five Australians will experience a mental health or substance-use disorder in any 12 month period, and 45 per cent will experience a mental health or substance-use disorder in their lifetime.[1] Not all of these people will have a condition severe enough to require them to take time away from work. However, many will and the cost of this will be shared between employers, the government and the insurance industry.

One of the major causes of disability claims in Australia is mental illness. In recent years, there has been an increase in the incidence of these claims for both males and females.[2] Because of this, insurance companies are selective when assessing life insurance applications, especially with applications for disability insurance.

How does having a history of a mental illness affect your insurance application?

If you have experienced a mental illness, whether or not that condition was disabling in the past, insurance companies will consider you to be statistically more likely to make a claim in the future. This can affect the terms under which an insurer is prepared to offer you life insurance.

Life insurers are permitted by the *Disability Discrimination Act 1992* to offer applicants for insurance different terms based on the risk that they present, provided they are basing this discrimination on actuarial data, statistics or other evidence on which it is reasonable to rely.

Each insurance company offers a range of different products, with different benefits and features. In addition, each company has its own underwriting and claims philosophies, which are based on a range of factors, including the different pricing structures of their products.

You should make sure you understand the application process and different application options (e.g. online, by telephone, or in person). For example, online applications may have different underwriting guidelines to other products regarding past and present physical and mental illnesses. It is strongly recommended that before making any decision, you speak first to a representative from the insurance company. When considering a life insurance product it is important that you read and understand the Product Disclosure Statement (PDS) as it fully describes the product, its benefits and any limitations.

We recommend that you speak to an authorised financial planner or insurance broker who is qualified to provide advice on which company's products are best for your individual situation.

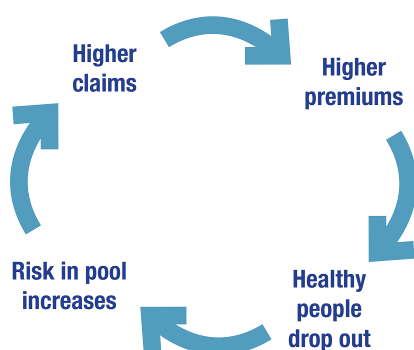
How is risk assessed?

'Underwriting' is a term used by life insurers to describe the process of assessing risk, ensuring that the cost of the insurance for an individual is proportional to the risk involved. This means that people with the same or similar risk pay the same rates.

To assess a person's risk, life insurers rely on information from a range of sources. When applying, you will be asked to complete an application form and a medical questionnaire. You may also be asked to undergo a medical examination or blood test, or the company may request doctors' reports (based on patient file records), financial evidence, or questionnaires about your health or any risky activities in which you participate.

[1] Australian Bureau of Statistics 2008 National Survey of Mental Health and Wellbeing: Summary of Results 2007, ABS, Canberra.
[2] IFSA Mental Health Working Group Claims Survey, 2006

After this information is received, the insurance company will assess the risk and decide whether or not to accept the application, and if they can accept it, whether the premium needs to be increased or some medical conditions excluded. For example, to insure someone who is already *severely* ill or knows they have a serious illness is considered by life insurance companies to be an unacceptable risk. The cost of paying the person's claim would fall on the rest of the people in the life insurance pool. If poor risks were accepted without appropriate underwriting or appropriate premiums being charged, it is likely the fund would run out of money.



Myth: Insurers will use a history of a mental health condition to deny applicants insurance.

Fact: In order to remain a sustainable business, it is in the interest of an insurance company to insure as many people as possible. It is unlawful under the *Disability Discrimination Act* for insurers to deny applications for insurance without having reasonable and relevant information and data to support their decision. Today, insurers have access to extensive medical information and very few applicants are turned down.

What terms will an insurance company offer?

Different life insurance companies may offer different terms, such as:

- increased rates by either a percentage or flat dollar amount (also known as 'premium loading')
- a shorter period for the insurance contract
- an exclusion for one or more medical conditions or risky activities
- an offer of an alternative product
- a combination of any of these options.

Exclusions are used to remove foreseeable events or causes of claim from the cover provided. However, it is important to remember that the policy will still cover all other events caused by unforeseeable illness or injury.

Premium loadings are applied to take into consideration the increased chance that a claim will be made on the policy.

If you are given an underwriting decision that is not standard, you are entitled under the *Insurance Contracts Act 1984* to be given an explanation of the decision.

After the decision has been made and if the policy is issued, any subsequent changes in health will not affect the premium paid, nor can the life insurance company cancel the policy, provided that you disclosed all relevant information when you applied.

Myth: A history of seeking treatment for a mental health condition (for example, under a Mental Health Treatment Plan) can be used by insurers to deny applicants insurance.

Fact: Insurers seek to assess accurately the degree of risk that an applicant presents. An individual who is managing his/her mental illness through treatment is likely to present less of an insurance risk than someone who is not receiving treatment for a mental illness. Many people who now access treatment from a mental health professional do so through a Mental Health Treatment Plan. This enables them to receive Medicare rebates for consultations with mental health professionals, and requires an initial diagnosis and referral from a GP.[3] When assessing an insurance application, insurers will consider a range of factors including the effectiveness of treatment and current management of the condition, and will not rely solely on the diagnosis the individual may have received through a Mental Health Treatment Plan.

In a small number of cases, however, the insurance company may decide it is unable to offer any cover and decline the application.

If you have a history of mild depression or mild anxiety (and have been fully recovered for at least one to two years), you should expect your death or trauma benefits to be assessed with standard rates and your disability benefits to have a mental illness exclusion. If your condition was more serious, or symptoms are continuing, a premium loading may apply to death or trauma benefits. In addition, disability benefits may not be available as it is considered to be more likely in these circumstances that time off work may be required at some stage.

If you are still experiencing severe symptoms, it can be difficult for life insurers to make an accurate assessment, as the course of your condition may not be clear. As a result, there is usually a period of time from when severe symptoms are last experienced to when insurance is made available.

[3] For more information see *beyondblue* Fact sheet 24 – Help for depression, anxiety and related disorders under Medicare, available to download or order from **www.beyondblue.org.au** (click Get Information) or by calling **1300 22 4636**.

What are my obligations when I apply for or renew my insurance?

The law requires you to provide the life insurer with all the relevant information that may affect your application for life insurance. This will allow the life insurance company to undertake an accurate risk assessment of your application. You have the same duty to disclose any relevant information to the insurer if you vary or renew your life insurance.

Under the *Insurance Contracts Act 1984*, if you fail to disclose, or are untruthful about any relevant information, it may affect any later claims you make on a life insurance policy or the insurance company can decline your application. If you failed to disclose something when the policy was taken out, or at renewal, your claim can be rejected and you may have to repay any money paid relating to the claim.

How is my privacy protected?

Your personal information is protected under Australian law by the *Privacy Act 1988*, which requires insurers to comply with the National Privacy Principles. Life insurance companies must protect your personal information in a number of ways, including through their collection, use, disclosure and security of information about you.

For example, a life insurance company must:

- only collect personal information which is relevant to your life insurance application and any subsequent life insurance contract, including the assessment and management of a claim
- tell you why it is collecting the information
- only collect information by fair and lawful means
- tell you the consequences of not providing the information requested
- state the type of organisations to which it usually discloses your personal information
- not use or disclose your personal information for an unrelated purpose, or in a way that you would not reasonably expect, unless you have consented to the proposed purpose (there are limited exceptions to this requirement)
- keep your personal information secure.

For a full listing of the National Privacy Principles or to find out more, visit the website of the Office of the Federal Privacy Commissioner at www.privacy.gov.au

What happens when I make a claim for life insurance?

If you have to make a claim on a life insurance or income protection policy, the insurer will ask you to complete various forms and provide information so the company can evaluate your claim. The insurance company will assess whether your claim is covered by the policy based on medical and other evidence available to them. You might be asked to provide additional information to the insurance company to allow your claim to be assessed fully.

If you are making a claim for disability benefits, either under a disability policy or an income protection policy, you might be asked to undergo a medical examination by a doctor, psychiatrist or other medical practitioner of the insurance company's choice. If you and your treating doctor/s disagree with this person's assessment, you should consider making a complaint, particularly if the assessment results in the rejection of your claim or the termination of your benefits.

If the insurance company does not accept your claim, it should provide you with an explanation of why your claim was rejected.

What can I do if I am not happy with the company's decision relating to my application or claim?

If you believe an insurance company has not treated you fairly due to mental illness, there are several ways you can seek a review of the decision. In the first instance, you (or your financial adviser) should contact the insurer to request a review by the underwriter who made the decision. If a suitable outcome is not achieved, the matter can be pursued by the following avenues.

APPEAL THE DECISION

Step 1 – Appeal: Submit a complaint to the insurance company.

As the first step, we suggest you write to the Chief Underwriter or Complaints and Disputes Resolution Manager of the insurance company. Set out your complaint in full and ask him/her to address each issue. The company's address will be shown in the Product Disclosure Statement that is contained in your application form.

If you feel the company's decision is unfair, you should discuss your situation with your doctor. It might be possible to get the company to change its decision if your doctor provides a more comprehensive report – particularly a report that addresses the concerns put forward by the company in its letter to your doctor regarding your insurance application. You might have to pay your doctor for such a report, which would not be rebated under Medicare.

Step 2 – Submit a complaint to the company's internal dispute resolution service.

If you don't receive a satisfactory response, write to the Complaints and Disputes Resolution Manager of the insurance company. Every company is required to have such a person and the company must observe standards set down by the Australian Securities and Investments Commission (ASIC) in the handling of complaints, including reporting to the Australian Prudential Regulation Authority (APRA) the number and types of complaint received and whether the complaint has been resolved to your satisfaction.

Step 3 – Submit a complaint to the Financial Ombudsman Service.

If you still don't receive a satisfactory response, write to the Financial Ombudsman Service (FOS). Note: You must go through the company's own complaints and disputes resolution process before the FOS will become involved.

The FOS is a national service and can be contacted by writing to:

Financial Ombudsman Service Limited
GPO Box 3
MELBOURNE VIC 3001
Telephone: 1300 780 808
Facsimile: (03) 9613 6399
Email: info@fos.org.au
Website: www.fos.org.au

The FOS is an independent body and its services are free to complainants. There are some circumstances in which the FOS cannot consider your complaint. The FOS can advise you of these circumstances.

SEEK INSURANCE WITH AN ALTERNATIVE COMPANY

In the interest of maintaining a competitive industry, some companies might be more willing to enter into a contract of insurance with you than others. Generally, a company is willing to give you an indication of the underwriting terms it might be prepared to offer you without you having to formally apply for a policy.

However, you should note that if you have been refused insurance by a company or offered cover under revised terms, you may be asked to tell other insurance companies about it, depending on the type of product.

Myth: Once I am denied insurance, I will never be able to get it.

Fact: Different insurance companies use different criteria when determining who to insure and what price to charge. Insurance is very competitive and consumers should always seek alternative insurers. Also, if a company declines your application as a result of a current health problem that improves or goes away, the company may reconsider your application.

CONTACT THE MENTAL HEALTH COUNCIL OF AUSTRALIA

The Mental Health Council of Australia (MHCA) is the peak, national non-government organisation committed to achieving better mental health for all Australians. The MHCA website provides detailed information to assist consumers and carers to understand their rights and responsibilities in relation to various forms of insurance.

If you continue to experience difficulty in purchasing or have experienced difficulties accessing life and income insurance, you can register your complaint with the MHCA. The MHCA have an online complaints form for this purpose, which can be accessed at www.mhca.org.au

Alternatively, the MHCA can be contacted at:

Mental Health Council of Australia
PO Box 174
DEAKIN WEST ACT 2600
Telephone: (02) 6285 3100
Facsimile: (02) 6285 2166
Email: admin@mhca.org.au

Please note that the MHCA is not able to act as an advocate for individuals in resolving specific insurance complaints. However, it will be able to advise you on what mental health advocacy groups are available in your area and will forward all complaints received to the Financial Services Council. The Financial Services Council, MHCA and *beyondblue* are working together to address issues identified through the complaints process.

SUBMIT A COMPLAINT UNDER THE DISABILITY DISCRIMINATION ACT 1992

At any time, you could submit a disability discrimination complaint to the Australian Human Rights Commission. The Disability Discrimination Act does allow insurers to make distinctions on the basis of disability, but only where this can be shown to be reasonable, including by reference to available actuarial data, statistics or other evidence.

For more information see the Commission's website at www.humanrights.gov.au/complaints_information or call 1300 656 419.

More information

Australian Human Rights Commission

1300 656 419 www.humanrights.gov.au/complaints_information

beyondblue: the national depression initiative

1300 22 4636 www.beyondblue.org.au

beyondblue provides information about depression, anxiety and related disorders, available treatments and where to get help.

Financial Ombudsman Service

1300 780 808 email: info@fos.org.au www.fos.org.au

Insurance Law Service

1300 663 464 www.insurancelaw.org.au

The Insurance Law Service is a free legal service available to anyone in Australia who would like advice on insurance law or advice on resolving a dispute with an insurer. It acts as a first point of contact for people to get advice about their rights and legal options when they are dealing with insurers or when they find themselves in an insurance dispute.

Lifewise

Email: lifewise@lifewise.org.au   www.lifewise.org.au

'Lifewise' is an education initiative managed by the Financial Services Council on behalf of the life insurance industry. It aims to provide Australians with information to make conscious, informed decisions about their life insurance needs.

The Mental Health Council of Australia (MHCA)

(02) 6285 3100   www.mhca.org.au

MHCA is the peak, national non-government organisation committed to achieving better mental health for all Australians. The MHCA website provides detailed information to assist people with mental health problems and carers to understand their rights and responsibilities in relation to various forms of insurance. It includes an online complaints form for people with mental health problems who have had negative experiences accessing insurance. The MHCA can also advise you of the mental health advocacy groups operating in your area.

Superannuation Complaints Tribunal

1300 780 808   Email: info@sct.gov.au   www.sct.gov.au

For complaints relating to insurance linked with superannuation funds, you can contact the Superannuation Complaints Tribunal.

Glossary of life insurance terms

Accidental death

Accidental death provides a lump sum benefit on the death of the life insured due to an accident caused solely by violent, visible and external means, which occurs within a specified period following the accident.

Disability income insurance/Income protection insurance

Disability income insurance or income protection cover provides for the payment of a monthly benefit, usually up to a maximum of 75 per cent of the insured person's income, while the insured person is prevented from working due to sickness or injury.

The benefit is usually payable after an initial waiting period which is selected by the policyholder and which can vary from two weeks to two years.

Benefits are payable whilst the insured person continues to be disabled for up to the policy term, which again is selected by the policyholder. Generally, benefit terms range from two years through to age 65.

Exclusions

Exclusions are used to remove the foreseeable events or causes of claim from the cover provided. However, it is important to remember that the policy will still cover all other events caused by unforeseeable illness or injury.

Life cover

Life cover provides an agreed amount for payment in the event of the death of the life insured. In today's market, the most common form for providing this cover is through guaranteed renewable term insurance. 'Guaranteed renewable' means that as long as the policyholder continues to pay the premium, the individual policy cannot be cancelled or modified by the insurer.

Premium loadings

A premium loading is an amount an insurance company adds to the basic premium to take into consideration the increased chance that a claim will be made on the policy.

Risky activity

An activity involving risk, danger or a hazard. Occupational examples include offshore driller, underground mine worker and explosives worker. Pastimes include bungee jumping, diving, abseiling and motor sports.

Total and Permanent Disablement

Total and Permanent Disablement (TPD) provides for the payment of a benefit if the life insured meets the definition of Total and Permanent Disability under the policy. The TPD benefit is normally only available as an extra option to a policy providing life cover and the standard version provides for prepayment of the life cover agreed amount in the event of becoming totally and permanently disabled.

Trauma insurance/crisis cover/critical illness

Trauma insurance provides for the payment of a lump sum benefit if the insured person is diagnosed with one condition from a list of specified trauma conditions, such as heart attack, stroke, cancer or a chronic disease like kidney failure. Most insurers do not provide cover for the major critical illnesses if they occur within three months of commencement of the policy.

Underwriting

Underwriting is a term used by life insurers to describe the process of assessing risk, ensuring that the cost of the insurance for an individual is proportional to the risk involved, and that people with the same or similar risk pay the same premium rates.

This guide was developed by:

- Australian General Practice Network (AGPN)
- Australian Medical Association (AMA)
- Australian Psychological Society (APS)
- *beyondblue: the national depression initiative*
- Financial Planning Association (FPA)
- Financial Services Council (FSC)
  - formerly Investment and Financial Services Association (IFSA)
- Mental Health Council of Australia (MHCA)
- Royal Australian and New Zealand College of Psychiatrists (RANZCP)
- Royal Australian College of General Practitioners (RACGP)

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