From: Insurance Review
To: no-reply@mbie.govt.nz
Subject: RE: Response to Review of insurance contract law comprehensive form

From: no-reply@mbie.govt.nz [mailto:no-reply@mbie.govt.nz]
Sent: Monday, 8 July 2019 3:24 p.m.
To: Insurance Review
Subject: Response to Review of insurance contract law comprehensive form

Preamble question 1
Do you have any feedback regarding the objectives for the review?

In reaching its decisions MBIE should bear in mind the pooling function of insurance contracts, which is of particular importance to the life insurance market. Life insurance contracts are generally long-term contracts and dealings with one policyholder can affect other policyholders. For example, if an insurer pays a claim that is not covered by the terms of the insurance contract, the cost of that claim will be reflected in the future premiums paid by the other policyholders in the pool. Similarly, costs of complying with legislative or regulatory requirements are shared between policyholders.
We would like to submit on two further points as part of this review:
1. The law around ownership and beneficiaries should be reviewed; and
2. The interest rate provision in s41A of the Life Insurance Act 1908 should be reviewed.
The law around ownership and beneficiaries should be reviewed
The Life Insurance Act 1908 is ambiguous regarding to whom life insurance proceeds can be paid. We request that this is clarified.
• One interpretation suggests that when a policyholder dies, all memoranda of wishes and nominated beneficiary forms are revoked, and the proceeds must be paid to the policyholder's estate;
• Another interpretation suggests that when a policyholder dies, the insurance company should treat the policyholder as existing until proceeds are paid according to his/her wishes, ending the insurance contract.
We submit that the law should be clarified to state that memoranda of wishes and nominated beneficiary forms should continue to function until proceeds are paid and the contract ends.
In many cases, policyholders structure their policies poorly (particularly when they are sold without advice), and life insurance proceeds are tied up unnecessarily with the insured's estate. The insurance proceeds may be held in probate or administration for many months before they can be paid.
In some cases, a couple who jointly hold their insurance policies may separate and agree to split their life insurance policies. Under one interpretation, if one policyholder dies, the agreement ends, and the surviving former spouse could receive all of the proceeds.
The interest rate provision in s41A of the Life Insurance Act 1908 should be reviewed
There are now common law rules for late payment, based on the cause of the late payment. It is arguable that this section should be repealed and the matter be governed by general common law principles.
If (for any reason) a death claim is not paid within 90 days after the date of death, the insurer is liable to pay interest at a prescribed rate from the 91st day until the death claim is paid.
Insurers want to pay valid death claims promptly, and usually do so. However, there are sometimes circumstances an insurer cannot control, that delay settlement beyond 90 days. For example:
• When the Police refer a sudden unexpected death to the Coroner. There may delays between 3 months and 2 years before the Coroner releases the findings, and these findings can affect whether the claim can be paid.
• Delays obtaining probate or letters of administration, especially when a policyholder dies intestate.
• Delays receiving medical information, which must be reviewed before a claim can be paid.

• Delays caused by notifications of interests of other parties in the proceeds of the life insurance policy (including family disputes).
• Late notification of a death claim; in some circumstances the insurer may not become aware of the death until many years after it occurs.
• Difficulty contacting the policy owner or personal representatives to obtain the claim requirements, or delays receiving those requirements.

We note that compared to current deposit interests rates, rates defined in a policy or in section 12(3) of the Interest on Money Claims Act 2016 offer higher rates of return.

We submit that insurers should not be penalised by paying high interest rates on unpaid death claims when the insurer cannot control the delay. The prescribed interest rate should be linked to the Official Cash Rate (OCR) applicable through to the date proceeds are able to be paid.

Preamble question 2

Do you have feedback in relation to the options for disclosure by consumers?

We understand that option 1 (Duty to take reasonable care not to make a misrepresentation) is based on UK law, and option 2 (Duty to disclose what a reasonable person would know to be relevant) is based on Australian law.

We note that the Final Report of the Australian Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry recommendations include:

"Recommendation 4.5 – Duty to take reasonable care not to make a misrepresentation to an insurer Part IV of the Insurance Contracts Act should be amended, for consumer insurance contracts, to replace the duty of disclosure with a duty to take reasonable care not to make a misrepresentation to an insurer (and to make any necessary consequential amendments to the remedial provisions contained in Division 3)."

Partners Life favours option 1 over option 2 because:
• Partners Life already uses detailed questions to elicit appropriate disclosure from its customers.
• Option 1 would enable New Zealand Courts to continue to rely on precedents from common law jurisdictions, particularly the UK and (if Recommendation 4.5 is adopted) Australia.
• Reinsurance and retrocession arrangements may be written through the UK, so there could be advantages in consistent treatment of disclosure.
• Option 2 would introduce an unacceptable level of uncertainty in establishing what a "reasonable insured" should disclose.

Partners Life strongly disagrees with option 3.

Requiring life and health insurers to use medical records to underwrite insurance applications will increase both the cost and time required to issue insurance policies. This may lead consumers to decide not to take out insurance, and therefore this option would reduce consumer access to the benefits of life and health insurance.

CONFIDENTIAL

END OF CONFIDENTIAL INFORMATION

Explanatory text for qn2

Preamble qn 3 and 4

Should insurers be required to warn consumers of the duty to disclose? Should insurers be required to warn all insureds of the duty to disclose, including businesses?

If the duty of disclosure is not abolished, Partners Life supports this option. The Partners Life application form already highlights the duty of disclosure to consumers.

We submit that this provision should be sufficiently flexible to allow electronic applications and electronic disclosure. In certain circumstances it would be reasonable to permit initial verbal disclosure followed by written disclosure.

Should insurers have to tell consumers what third party information they will access, when they will access it and if they will use it to underwrite the policy?

No. We do not agree that it is appropriate for insurance contract law to include such a specific legislative requirement. Such requirements are more appropriately dealt with by principles-based conduct regulation. Partners Life complies with the Financial Services Council Code of Conduct and recently submitted in favour of introducing a legislative duty to treat customers fairly.

When a consumer completes an insurance application form, the insurer does not know whether or when it will access or use third party information.

Requiring insurers to contact applicants before accessing third party information:

• Would increase the cost of processing applications and servicing policies. The increased cost would be the cost of staff to contact applicants or policyholders. These costs would be passed on to all policy holders in higher premiums.

• Would increase the time it takes to process applications or service policies. In situations where the applicant is difficult to contact, the delays could be considerable.

If it is decided that it is appropriate to include such a prescriptive provision in insurance contract law, or in conduct regulation, Partners Life proposes the following alternative: insurers could be required to make it clear in application documentation that (1) they require the consumer's permission to access information from third parties, but (2) they will only contact third parties if it is necessary to process the application or service the policy effectively.

Preamble q 5

What is your feedback on the options in relation to disclosure by businesses?

Partners Life generally agrees with the costs and benefits identified in the table. Partners Life notes that Option 2 (duty to make fair presentation of the risk) is equivalent to the duty introduced by the UK Insurance Act 2015. We note the significant work carried out in the UK to develop this standard. There could be advantages in New Zealand adopting equivalent laws to the UK, including:

• This would enable New Zealand Courts to continue to rely on precedents from common law jurisdictions, particularly the UK.

• Reinsurance and retrocession arrangements may be written through the UK, so there could be advantages in consistent treatment of disclosure.

We note that there has been some discussion amongst submitters as to whether different duties should apply to life and general insurance. We caution against introducing a distinction between general and life insurance as such a distinction could have unintended consequences.

Explanatory text for question 5

Preamble q 6

If we have a separate duty of disclosure for businesses, should small businesses have the same duty as consumers? If so, how should small businesses be defined?

Where a business does not have specialised knowledge about complex and uncommon risk, there may be grounds to argue that it should be treated the same way as consumers. Small businesses generally have fewer resources, less complex structures and less access to insurance expertise than larger businesses. If there is a separate duty for businesses, we support small businesses having the same duty as consumers, unless their business is unusually complex or uncommon.

We note the proposal that small businesses could be defined by turnover or assets. Different industries and business types have very different numbers of staff, so staff numbers could be a poor indicator of size (e.g. a fund manager can turn over $50m with 6-7 staff, and a manufacturing firm might require 100 staff to achieve similar turnover.)

If a duty of fair presentation is adopted, should businesses be allowed to contract out of the duty? What are the pros and cons? If businesses are allowed to contract out the duty of fair presentation, should the duty apply to all businesses?

Partners Life generally supports the right of commercial parties to contract freely, but can see the need for some limitations based on transparency and clarity of any exclusion to avoid the statutory regime from being undermined.

Preamble question 8

What is your feedback in relation to the disclosure remedy options?

Partners Life supports option 1.

Partners Life already applies a proportionate approach to dealing with non-disclosure or misstatement. When a material non-disclosure or misstatement is discovered, Partners Life will obtain any information it requires to enable it to reassess the policy holder's original application. If Partners Life's original assessment would have been impacted by the non-disclosure or misstatement, Partners Life will reassess the application(s) as if that information had been known to Partners Life at the application date. If the reassessment indicates that Partners Life would have declined the application (or any specific benefit applied for), then Partners Life will adopt a fair and reasonable approach in deciding which remedy to apply. These contractual remedies can include avoidance, cancellation or alteration of terms.

For example, in cases where we would have provided cover but at a higher premium, we will reduce the amount of the claim payment by the amount of the additional (unpaid) premium. If we would not have provided the cover had we known the undisclosed circumstances, we will void the policy, and, in some circumstances, we will return the premium paid to the insured. If we would not have provided the specific benefit being claimed against, we will cancel the benefit but allow remaining benefits to continue.

The intention of the policy holder is important when assessing the impact of a non-disclosure or misrepresentation. Our policy wordings provide that Partners Life will undertake to adopt what it considers to be a fair and reasonable approach to any non-disclosure provided neither the policy owner nor the life assured had attempted to intentionally mislead or defraud Partners Life.

The reason for this approach is two-fold. Firstly, the purpose of insurance is to pool risks between policy holders. The amount of premium to be paid by each customer is calculated on the basis that each customer provides appropriate disclosure. If one policy holder can claim under a policy when that claim should not be covered, that will drive up costs for all other policy holders. If a policy holder who has disclosed fully and has their cover restricted, or premiums increased as a result, they should not be made worse off than a policy holder who has not disclosed fully and is not therefore similarly restricted. Further, if consumers become aware that non-disclosure may still result in a proportionate payment of a claim, this creates a moral hazard – customers may feel incentivised to fail to disclose material facts. Therefore, we submit that Option 1 is the most appropriate option in relation to disclosure remedies.

Explanatory text for question 8

Preamble question 9

Is it fair to require insurers to pay claims that are unrelated to a non-disclosure or misrepresentation, even if the insurer would not have entered into the contract had they known the facts?

Partners Life do not consider it is fair to require insurers to pay claims that are unrelated to a non-disclosure or misrepresentation, if the insurer would not have entered into the contract had they known the facts. The law should not allow clients to ''gamble'' on whether a claim might be paid or not depending on whether the claim event is related to pre-existing risk or not. This would drive up costs for all other policy holders and impact the sustainability of the insurance industry.

Should insurers be able to offer reduced cover or ask the insured to cover the difference in order to recoup the amount they would have charged if they had the facts?

We acknowledge that this is a complex issue, with conflicting views in the industry. Our view is that it is probably appropriate for this to be dealt with by the policy wording, not legislation. If legislative intervention is demonstrated to be necessary, it is important that any legislation ensures, as far as is possible, that:

- Deliberate or reckless non-disclosure is discouraged.
- Insurers can claim additional premium (should the insurer chose not to avoid the policy) where there has been deliberate or reckless non-disclosure. For example, insurers should be able to increase future premiums and claim retrospective unpaid premiums from the insured.
- The insured will maintain adequate insurance cover and not be underinsured.

In the case of innocent non-disclosure, the insurer be able to increase future premiums to reflect the increased risk. However, our practice is that in the case of innocent non-disclosure, generally we do not charge retrospective premiums.

Should we clarify that where a contract has been avoided and all claims rejected, the insured is not required to refund claims money if it is not easily returnable and would hard and unfair to the insured? Why or why not?

The insured should not be allowed to benefit from a deliberate (and potentially fraudulent) or reckless material non-disclosure, because this would increase costs for other policy holders who provided appropriate information at inception. In those cases, the insurer should have the right to seek the return of historical claims paid to the policyholder under the policy.
In addition, a policy holder who has not disclosed fully cannot be made better off than a policy holder who has disclosed fully, meaning they should not retain claim payments in circumstances where other policy holders would not have received a claim in the first place.
The knowledge that incorrectly obtained claims proceeds can be recovered should act as a significant deterrent to policy holders considering claims fraud.

Do you agree that section 35 of Subpart 3 of the Contract and Commercial Law Act should not apply to insurance contracts? Are there any other sections of the Contract and Commercial Law Act that should not apply to insurance contracts?

Partners Life submits that as far as possible the regime to govern insurance contract law should be included in one piece of legislation. For that reason, we support the proposal that the remedies in insurance contract law override the remedies provide by the Contract and Commercial Law Act 2017.
Whether it is necessary to maintain rights in relation to misrepresentation by the insurer is a proposal that requires further investigation because it could cause unintended consequences. We note that any misrepresentation made by the insurer would be subject to the prohibitions in part 2 of the Financial Markets Conduct Act 2013 (and equivalent provisions in the Fair Trading Act).

Preamble qn 13
Do you agree with the proposed change to the misrepresentation provisions in the Insurance Law Reform Act 1977? Why/why not?

Partners Life supports the proposal to bring the remedies for misrepresentation into line with any new remedies for an insured's failure to disclose.

Preamble qn 14
Which of the terms in Table 4 are unfair? In your opinion, are they exempt from the unfair contract terms prohibition?

Our comments on the contract terms examples in Table 4 (that are applicable to the Life and Health insurance industry) are provided below.
Insurer may make unilateral changes to a contract
Under current Life Insurance regulations, insurers can't make unilateral, detrimental changes to contract terms and conditions after the contract has been issued.
Unlike fire and general products, where the insurer has control of the type, amount, terms and condition, and price of cover they offer at each renewal (and can therefore amend any of these each year based on emerging claims experience of the book, as well as of claims experience of each individual client), life and health Insurance policies are by their very nature, designed to be long-term. They are designed to capture a client's health status at application and then to provide guaranteed protection to that client for the term of the policy, irrespective of any deterioration in the client's health in the interim.
Once a client has been underwritten, the insurer is unable to then individually price or adjust the client's cover going forward. Pricing can only be adjusted across all clients in a pool, and benefit terms and conditions cannot ever be unilaterally changed by the insurer, to the detriment of the client. Clients have the option to request detrimental changes to their terms and conditions (if they

wish to reduce premiums, for example) but the insurer cannot impose such changes on the client.
All life and some health benefits provide coverage for as long as the client continues to pay premiums (i.e. for life). The key exception are products which are designed to protect income/expenses during the working life of the client, for which coverage expires at a nominal ''retirement age''. These protections are referred to within the industry as ''guaranteed wordings".
There are some health benefits which are designed more similarly to fire and general benefits, in that terms and conditions can be changed unilaterally by the insurer, but again only if these terms and conditions apply across the pool of clients, rather than to any specific client. These products are referred to within the industry as "non-guaranteed" wordings.
The long-standing ''fairness'' principles behind these guarantees in life insurance are that:
1. The client has very little control of their evolving health (following their insurance being issued); and
2. Any deterioration in health over time can render an insurable client uninsurable; and
3. Clients are not likely to put their health at risk, simply in order to make a claim.
Because of these twin guarantees of both health risk and terms and conditions, life insurers are effectively guaranteeing to administer existing policies under the agreed terms and conditions long into the future, irrespective of what happens in that future in respect to technology, medical advances, diagnostic procedures, immigration and emigration statistics, government benefits (such as sickness benefits and ACC) and claims experience.

This is the reason many insurers have legacy systems and products where their current offerings are very different to their historical offerings, but they cannot simply migrate those old policies into new products.
The health, and terms and conditions, guarantees in life insurance, mean that the insurer has only one chance at the date of application, to determine their risk of claims arising over the life-time of the policy.

Fire and general insurers, on the other hand, get to underwrite each year at the renewal date, meaning there are no underwriting protections for the client to lose.
The fundamental difference in life insurance is that emerging claims experience cannot be resolved by changing the nature of the covers in force for existing clients. It can only be addressed by premium increases (as they are allowed for under the terms and conditions of the policies, and only as the apply to the whole pool), and in adjusting terms and conditions for new policies.
This means there is no immediate ability to restore profitability by changing the nature of the claims coverage following poor claims experience, as exists within fire and general contracts.
With fire and general a problematic benefit can be removed from all existing covers within a 12-month period. With life insurance those problematic benefits are guaranteed for as long as the client keeps paying for them, meaning the ''fix'' for such claim issues can take many years to achieve.
Conversely beneficial enhancements can be made unilaterally to life insurance contracts, provided doing so does not directly increase premiums. Partners Life automatically upgrades all existing contracts in this way whenever beneficial product changes are made, but this is not a regulated requirement, and is not universally practiced by life insurers.
There has been some discussion by regulators of perceived customer harm that can come from automatic retrospective product upgrades in respect of the premiums customers ultimately pay for increasing claimability. It is important to understand that the premiums clients pay are made up of claims, commissions, expenses and insurer profit margins. The administration of legacy products is a huge and increasingly expensive exercise for insurers and has been a significant driver of poor customer outcomes in Australia where clients and insurer staff struggle to deal with old products based on old policy wordings and often administered on old systems. There are significant efficiency advantages to insurers having only one version of each product (the latest) to administer across its entire book. This efficiency results in better customer service and lower expenses as a counter to their increased claimability. Ensuring the client has the best version of their product at any given time also limits the opportunities for adviser driven ''churn''. Given the client has the sole ability to amend their covers to meet affordability requirements, Partners Life believes its automatic upgrade

process is of significant value to the client and should be considered as such by regulators.
Health insurance contracts which contain non-guaranteed wordings are not subject to life insurance regulations and can therefore, legally, be able to be contracted on a unilaterally changeable basis as per Fire and General Contracts, and a number of Health Insurers provide their contracts on this basis.
Partners Life includes its medical insurance benefits under its Life Insurance contracts and therefore apply the life insurance protections (guaranteed for life) to its medical benefits. It is very important, given the differences in the way Health Insurance contracts can be structured (i.e. guaranteed as per life or changeable as per fire and general), that consumers are made fully aware of whether their terms and conditions are guaranteed or not when making any purchase decision.
Unilateral premium changes can be made to life insurance contracts, for example when medical advances or new disease treatments render existing actuarial claims assumptions under-costed. In these circumstances, premium changes can only be applied to a pool of clients, not to specific clients based on their individual claims profile.
Partners Life believes these existing life insurance protections for policy holders should be maintained under regulations and in addition, given the potential confusion for consumers around whether medical benefits from different providers will be guaranteed or changeable, clear disclosure of the applicable contractual structure should be required.

Income protection policies: insurer has discretion to decide whether the insured is unable to work
The decision about whether an insured meets the requirements of an income protection policy requires three types of expertise: medical expertise; occupational expertise; and insurance product expertise.
It should be a medical expert who provides an opinion about whether the insured is medically unable to work, using the product definitions provided by the insurer.
It should be an occupational expert who provides an opinion about the key tasks required to adequately perform a role, in the instance that a medical expert might not have sufficient understanding of the requirements of a job in order to determine the degree to which a health condition might impact on a life assured's ability to perform their key tasks.
The insurer should be required to consider expert medical and occupational opinions when making its decision (for example, own occupation definitions are more favourable to the insured than any occupation definitions).
In matters of disagreement, legal experts and the courts would determine whether the inability to work meets the definition of the income protection policy.
Life insurance: Exclusions for any "unlawful act"
We agree that loss caused to the insured by the unlawful acts of third parties, if excluded from a life insurance policy, would be an unfair contract term.
Usually in Life and Health insurance contracts, the only unlawful act exclusion is caused by the unlawful act of the insured, not the unlawful acts of third parties. We are not aware of life insurance policies that exclude cover if the insured suffers loss as the result of the unlawful acts of third parties.
We do not believe this should be an allowable exclusion for Life and health insurance contracts.
Broad exclusions for pre-existing conditions (insurers can decline claims for any symptom, regardless of whether insured knew it was a symptom)

We agree that insured's cannot be required to disclose things they simply do not know. For example where an abnormal blood test has been received by their doctor but not communicated to the client. However we do believe that the client should be obliged to tell the insurer everything that they do know, even if they don't yet have a diagnosis.
As a result, we submit that these are not unfair contract terms. At the time of claim, the decision about whether a condition is pre-existing is a question of fact that is determined by medical evidence. It is not a subjective decision made by the insurer.
If these terms are made unlawful, they will eliminate the availability of non-underwritten insurance policies. These policies are well suited to a large segment of consumers who are unwilling to obtain insurance if they must complete long application forms required for underwritten policies. This will

therefore increase the number of consumers without insurance.
It may also result in much longer applications forms for underwritten insurance products, because insurers will be unable to rely on a question such as, "do you have any other medical condition that may be relevant to your application?"
Policy holders who become aware of signs or symptoms and are seeking, intending to seek, or have been advised to seek investigations in order to determine an underlying cause for those signs or symptoms, will legitimately be able to state that they were unaware that they had a sign or symptom of a specific disease or disorder, given a diagnosis has not yet been made. This is not appropriate.
Currently policyholders are required to disclose that they have signs or symptoms, and/or that they are undergoing or have been advised to undergo investigations, irrespective of whether they know what those signs or symptoms might be caused by. This is appropriate as it prevents people from seeking insurance benefits during the diagnosis process, and obtaining those benefits without the insurer being able to quantify the potential emerging risk, or being able to defer its assessment until investigations have been completed and the risk can be accurately quantified.

Preamble qn 15
What is your feedback on the UCT options?

Partners Life supports option 3 (Completely exempt insurance contract for UCT provisions and rely on conduct regulation). The changes to the Fair Trading Act 1986 were introduced relatively recently and should be given the opportunity to be tested by the Courts. Further, Partners Life submitted in response to the recent Options Paper on Conduct of Financial Institutions that there should be an overarching duty to treat customers fairly, in line with the Insurance Core Principle 19 of the International Association of Insurance Supervisors. Introduction of conduct regulation for financial institutions will support the fair treatment of customers.
Options 1 and 2 would increase uncertainty of the risk covered and so could increase the cost of insurance.
In considering option 1 and option 2, it is important to note that there are significant differences between (1) life and health insurance, (2) fire and general insurance, and (3) liability insurance. For fire and general policies and liability policies, the insurer can choose not to renew a policy at the end of the policy term. Conversely, once a life or health insurer has accepted risk from an insured and issued a policy, the insurer must continue with that policy if the insured continues to pay the premium. This means that a life or health insurer has only one chance to assess the insured's risk. Our answer to this question is particular to life and health insurance.
If option 3 is not adopted, we submit that the most suitable option is option 1 (tailor generic unfair contract terms provisions to insurance).

Explanatory text for question 15
Preamble question 16
What is your feedback on the options to help consumers understand and compare contracts?

Partners Life distributes its products through non-aligned advisers, who can help their clients understand and compare contracts. Partners Life contracts are written in plain English, although insurance policies that contain rich benefits will always be long, detailed and contain technical language. We comment on the proposed options below.
Option 1, Require plain language insurance policies
While we agree with the principle that insurance policies should be as easily understood as possible, the nature of life and health insurance policies necessitates the use of medical terminology.
Reading scales used to determine plain language include Gunning fog and Flesch Reading Ease. These indices reduce a readability score for passages using polysyllabic words, grammar and punctuation (including bullet points), and paragraph length.
We submit that it is reasonable to require good layout and structure, such as that proposed by the WriteMark.
Terms such as the "permanent loss of cognitive function" cannot be written in "plain language", so it is likely they would be removed from insurance contracts altogether. This would result in significant loss of benefits for policyholders, and therefore be to consumers' detriment.

We submit that it may be possible to write non-policyholder collateral (e.g. marketing brochures) in simplified plain English. It may also be possible to write the summary statements proposed in option 3 in plain English but it could be damaging to customers to rely on the plain English summaries and then discover at a later point that the policy wording had a more technical and/or layered approach to qualifying conditions.

Financial advisers who are not aligned with any one insurer are the most effective solution to this issue. Life risk insurances are complex because they involve significant sums of money based on complex health risks and claimable events. Access to information, education, advice, review and claims advocacy is essential for a consumer to have the best insurance outcome at claim time. These services are all provided by non-aligned financial advisers.

Option 2, Require core policy wording to be clearly defined

We support this option, with caveats.

It is in insurers' interests to define key terms where they are insurance jargon. This includes life and health insurance terms such as "signs and symptoms", "conditions", and "disorder".

We submit that life and health insurance policies should not be required to define technical medical terms. Insurers should be able to reference recognised medical definitions.

Option 3, Require a summary statement to be provided

We support this option, with caveats.

A summary statement would be useful to consumers. However, it should not take precedence over policy wording. The summary statement should not be misleading, but it would be impossible to ensure that the statement is complete.

It may be possible to write these summaries mostly in plain language, but it may be necessary to include non-plain language terms such as "non-Hodgkin lymphoma" or "cardiovascular disease".

There should be no specific format required for these summaries and again it could be damaging for customers to rely on the summaries and then discover at a later point that the policy wording had a more technical and/or layered approach to qualifying conditions.

Option 4, Require insurers to work with third party comparison platforms

We support this option, with caveats.

It is valuable for consumers to be able to compare insurance policies, particularly when they are sold directly to the public, without financial advice, or through vertically integrated organisations. This is particularly common with fire and general insurance. But where policies are sold through financial advisers, the financial adviser's role and skills includes comparing different policies and comparing policies to the client's personal circumstances.

This should be balanced with ensuring that comparator sites are high quality, complete, and not misleading. For example, comparing price without comparing major features is misleading – a trauma policy that covers seven conditions should be significantly cheaper than one that covers over 50 conditions; comparing them by price alone is misleading. Such sites must also be able to demonstrate that that they are operated independently. (These criteria may be achieved by requiring comparator websites to be licensed by the FMA.)

Moreover, if insurers are required to supply data to comparator sites, and they proliferate, insurers are likely to receive many data requests in different data formats. The cost of preparing these data exports and keeping them current as policies are upgraded is likely to be significant.

We submit that a workable solution is to have one centralised data request. The host of the data could be the Companies Office, as it does with the Disclosure Register. However, unlike the Disclosure Register, the aim of the data supplied should be to supply high quality data suitable for comparator link to the database via application programming interface (API) and publish comparative information in formats appropriate for consumers.

Option 5, Require insurers to disclose key information

We support this option.

We submit that the disclosure should follow the same approach as disclosure for regulated financial advice – defining when to disclose and what to disclose, but not the format for disclosure.

Although research shows that disclosure is of limited benefit to consumers, it is relatively low cost, and the benefits are likely to outweigh those costs.

Explanatory text for qn 16

Preamble qn 17

What is your feedback on the options?

We do not support options 1 (status quo) and below identify some issues with option 2 (provide for some intermediaries to be agents of the insured). Of the options presented Partners Life supports option 3 (impose a statutory obligation on intermediaries to pass on information to insurers). We further submit that licensed financial advice providers should be liable for the advice they provide and should be required to have enough financial resources (e.g. professional indemnity insurance) available to support this liability.

We comment on each option in turn.

Option 1 status quo

Partners Life does not support this option.

The current situation was suitable when financial advisers were agents tied to insurers and represented the insurers brands. Insurers provided systems, processes, administrative support, and training.

Since the 1990s, the trend has changed, and financial advisers often work for independent companies that represent multiple insurers. These companies are responsible for their own systems, processes, administration and training. Therefore, it is inappropriate that the insurer is deemed to have the knowledge of a non-aligned financial advisers.

Option 2 provide for some intermediaries to be agents of the insured

Although there may be advantages in this approach we are concerned that it could lead to confusion and uncertainty for the consumer. Further, this proposal must be considered in light of the new financial advice regime (Financial Services Legislation Amendment Act 2019).

When a financial advice provider represents one insurer and holds itself out as an agent of the insurer, then the insurer could be deemed to know what the salesperson or the person providing financial advice knows. In these cases, the consumer could reasonably assume that they are dealing with the insurer, and the person providing financial advice would pass all information on to the insurer.

In all other cases, the insurer should not be deemed to know what the salesperson or person providing financial advice knows, and the financial advice provider should be liable for their own errors. For example, when a financial advice provider represents multiple insurers, it is reasonable to suggest that the financial adviser is an agent of the consumer.

Option 3 obligation on intermediaries to pass on information to insurers

We support this option. We think it is reasonable to require intermediaries to pass all relevant information about policyholders and insured persons to the insurer.

Other options

We do not support the other options proposed (pages 35 and 36 of the options paper). We submit that this creates confusion for clients and complexity in the insurance market. We submit that these costs are greater than the benefits.

Explanatory text for qn 17

Can the issues with the status quo be overcome with insurers contractually requiring representatives to pass on all material relevant information? What are the benefits of a statutory obligation requiring representatives to pass on information?

Yes. Please see answer to question 17.

We submit that insurers should have contractual arrangements requiring intermediaries to pass all relevant information to the insurer. We submit that a statutory obligation will reinforce that requirement and provide an alternative avenue for enforcement. Increased penalties and increased likelihood of enforcement is more likely to influence intermediary behaviour, and this will benefit consumers.

Should consumer insureds be treated differently from commercial insureds in relation to these issues?

No, we submit that commercial insureds and consumer insureds should be treated the same. The majority of New Zealand businesses are small and are not sophisticated in matters of insurance – they rely on the knowledge and expertise of financial advisers.

Preamble qn 20

What is your feedback on the options in relation to section 11 of the Insurance Law Reform Act 1977?

Option 1 was recommended by the Law Commission; option 2 is based on untested UK law. We submit that option 1 has been far more rigorously analysed for the New Zealand market than option 2, and we submit that option 1 is an appropriate solution. We are concerned that option 2 could have unintended consequences for life and health insurance.

Preamble qn 21

What is your feedback on the option to provide that Section 9 of the Insurance Law Reform Act 1977 does not apply to time limits under claims made policies?

Partners Life supports option 1 (provide that section 9 does not apply to time limits under claims made policies).

Explanatory text for qn 21

If section 9 were to no longer apply to claims-made policies, should there should be an extended period (e.g. 28 days) for notifying claims or potential claims after the end of a policy term?

Partners Life considers that such provisions should normally be dealt with by contract wording.

Preamble qn 23-24

What is your feedback in relation to the options for section 9 of the Law Reform Act?

Partners Life supports reform of section 9 of the Law Reform Act. We submit that the law in this area is presently suboptimal, and the proposed solution improves outcomes for consumers and insurers.

Explanatory text for qn 23

If the option is adopted, should it apply to insolvency only? Should third parties be required to get leave of the court? Should reinsurance contracts be excluded from the application of the option?

No comment.

Preamble qn 25

What is your feedback to the options in relation to the duty of utmost good faith?

Partners Life supports options 1, the status quo. We do not support option 2, to codify the duty of utmost good faith as such codification could cause confusing or contradictory obligations. We submit that the common law should be allowed to develop in tandem with any legislative duties introduced as a result of the recent Conduct of Financial Institutions Options Paper.

Explanatory text for qn 25

Preamble qn 26

Do you have any feedback on the proposal to consolidate non-marine insurance statutes into a single statute?

Partners Life supports the proposal to consolidate non-marine insurance law to a single piece of legislation. We note that it will be important to test the drafting thoroughly to ensure it will work as intended, and it does not introduce unintended consequences.

Preamble question 27

Do you have feedback on our proposed approach in relation to the Marine Insurance Act 1908?

Partners Life supports the proposal to maintain a specific piece of legislation for marine insurance.

Preamble qn 28

Are the above provisions redundant ? Why/why not? Are there other redundant provisions in the legislation covered by this review?

Partners Life supports the repeal of legislative provisions that are redundant.

Preamble qn 29

Do you agree with the proposed option in relation to registration of assignments of life insurance policies?

Partners Life supports the proposal to prescribe that notice of assignment must be sent by writing to the insurers and be registered by the insurer, without requiring any particular form. The existing law does not reflect the communication methods used today. The proposed solution is an improvement.

Preamble qn 30

Should the maximum payment amounts for life insurance policies for minors be increased? Why or why not?

Partners Life submits that the maximum payment amounts for life insurance policies for minors should be increased. We submit that the benefits of higher amounts of cover outweigh the risks of moral hazard.

The death of one's child is a terribly traumatic event. The role of life insurance is to alleviate financial hardship at a time when a loved one is dealing with grief.

At minimum, we submit that life insurance for a minor should be permitted at a level that would cover the costs of the minor's funeral. We further submit that the level should also enable the policyholder to take a period of extended leave from his/her workplace to deal with the grief and cover the costs of counselling for the same purpose.

Your name

Your organisation

Partners Life

Your email address

In what capacity are you making this submission?

business

Other capacity

Use of personal information - intro

Can we include your name or other personal information in any information about submissions that we may publish?

no

We intend to upload submissions to our website. Can we include your submission on the website?

yes

You may ask us to keep your submission, or parts of your submission, confidential. If so, you'll need to attach reasons and grounds under the Official Information Act 1982 for consideration.

yes

You've indicated that you would like us to keep your submission confidential. Please tell us your reasons and grounds under the OIA that we should consider.

Pursuant to section9(2)(b)(ii) and (ba) of the Official Information Act 1982 Partners Life requests that the information in response to question 2 (and the appendices) which is identified as confidential, be kept confidential. The release of any of that information (in whole or part only) is likely to unreasonably prejudice the commercial position of Partners Life.