Submission on discussion document: Insurance contract law review

Your name and organisation

Name	Naomi Ballantyne
Organisation	Partners Life

Responses to discussion document questions

Regarding the objectives of the review

1	Are these the right objectives to have in mind?
	We agree with the objectives of the review.
2	Do you have alternative or additional suggestions?
	We submit that the additional purposes of the Financial Markets Conduct Act s4 should also be considered. Specifically: 1. *To provide timely and understandable information to help people make good financial decisions.* 2. *To ensure appropriate governance arrangements apply in financial services companies.* 3. *To avoid unnecessary compliance costs.* 4. *To promote and control innovation and flexibility in financial markets.* *All of these additional purposes are equally relevant to insurance markets in New Zealand.*

Regarding disclosure obligations and remedies for non-disclosure

3	Are consumers aware of their duty of disclosure?
	No, we believe consumers are not aware of their duty of disclosure. We believe they do *understand the need to answer specific questions they are asked truthfully and completely, but that they* do not *understand that they have an obligation to disclose even if the insurer has not asked a specific question or has relied on broad, non-specific questions to elicit detailed information from the consumer.* *For this reason, Partners Life has a Claims Review Committee consisting of our Senior Executives and other specialists who consider all claims where material non-disclosure has been identified, before a claims decision can be finalised. This Committee will apply a fair and reasonable test to non-disclosures by questioning whether a reasonable person would have understood the need to disclose. We check the question(s) that we believe should have*

	been answered differently to be sure that the client would reasonably be expected to understand the correct answer, and we debate whether a reasonable person might have interpreted the question in a different way than we intended. We have paid numerous claims where material non-disclosure was identified by the claims team, but where the Claims Review Committee had identified a plausible reason for the client non-disclosing. Where that has arisen because a question in our application form was not clear, we then change the application form for new clients going forward, but we do not make the claimant pay for our mistake.
4	Do consumers understand that their duty of disclosure goes beyond the questions that an insurer may ask?
	No, we believe consumers do not understand this duty. *We also believe that the current duty is unfair to consumers.* *We believe consumers should be expected to truthfully and fully answer any specific questions they are asked by an insurer, provided the questions asked are specific rather than broad, are relevant and material to the insurer's assessment of risk, and are easily understood by consumers.* *We do not believe a consumer should be expected to know everything that they should disclose even when the insurer has not asked a specific question or where the insurer relies on broad, all-encompassing questions which are not specific.* *We distribute our products through non-aligned advisers who understand our products. A good advice process includes explaining the current duty of disclosure to clients. Advisers also generally guide clients through the application completion process ensuring they understand each question. Advisers will frequently notify us that they do not feel a client has been completely truthful when answering application questions, and encourage us to obtain further information, which we will do either from the client directly or from their medical providers.* *Further, our standard application form includes a prominent box on the client declaration and consent page entitled "Duty of disclosure". The first two paragraphs of this box state:* > *Before you enter this contract of insurance you have a duty to disclose to Partners Life Limited every matter that you know (or could reasonably be expected to know) is relevant to Partners Life Limited's decision whether to accept the risk of insurance and, if so, on what terms. You have the same duty to disclose those matters to Partners Life Limited when you apply to vary or reinstate the insurance.* > *If you fail to comply with your duty of disclosure to Partners Life Limited, Partners Life Limited will enact the remedies available to it under the terms and conditions contained within the policy document.* *Therefore, we submit that clients should be required to truthfully and completely answer all specific questions asked by the insurer, and to disclose any additional information that they are aware of about their health which they could reasonably assume would be important to an insurer.*
5	Can consumers accurately assess what a prudent underwriter considers to be a material risk?
	No, we do not believe that consumers know what a prudent underwriter considers to be a material risk.

	Moreover, we submit that consumers should not be expected to know or understand what a prudent underwriter considers to be a material risk. They should simply be expected to answer specific application questions truthfully and completely, without having to, or trying to, judge whether the information is important to the insurer or not. *The corollary of this is that insurers should ask specific questions about all of the risks that would be material and relevant to their assessment of the risk, and not rely on very broad, generalised questions which consumers could easily misunderstand or misinterpret. Of course, more plain English, specific questions tend to result in long application forms, however clients only need to answer the questions that are relevant to their health.* *For this reason, we write our application forms in plain English. We also structure our forms with numerous high level questions, and ask the client to complete additional questions for each high level question they answer affirmatively. For example, our standard application form states:* *Please indicate below by ticking the box if you are currently suffering from, experiencing symptoms of or being treated for, or if you have ever suffered from, had symptoms of or had treatment for any of the following. (If you tick a box, please also complete the indicated questionnaire(s) in section 6.0).* *1. High blood pressure. Questionnaire 1* *2. Abnormal or high cholesterol. Questionnaire 2* *3. …* *We distribute our products through non-aligned advisers, who can help their clients complete the application form and answer their questions.* *We also proactively call new customers to welcome them to Partners Life to ensure they understand the coverage that has been issued, and to answer questions they may have about their policies.*
6	Do consumers understand the potential consequences of breaching their duty of disclosure?
	We do not believe that consumers are fully aware of the consequences of breaching this duty. Our experience is that consumers do *understand that if they have non-disclosed or misstated a condition, that a claim for that condition is likely to be declined. They* do not *understand that by non-disclosing they may not be covered for claims that are not related to the non-disclosed condition and they* do not *understand that they could lose all of their covers because of it.* *Partners Life chooses to write our policy contracts so that the consequences of non-disclosure and misstatement are clearly written in plain English and we have included contractual ''fair and reasonable'' treatment into our policy wordings which ensure customers will be treated fairly in the event of non-disclosure or misstatement.*
7	Does the consumer always know more about their own risks than the insurer? In what circumstances might they not? How might advances in technology affect this?
	The knowledge of consumers and insurers differs, and the information asymmetry is two-way. The extent to which each party's knowledge outweighs the others depends upon the type of insurance. • *Insurers have a better understanding of the nature of risks, the effect of possible client facts on those risks, and the types of facts in which they are interested.*

- *Consumers have a better understanding of their own facts. For business insurance, businesses may also have a better understanding of their particular business risks and the financial positions of their companies.*
- *In some cases, third parties know relevant facts about consumers better than the consumers themselves. For example, medical professionals often know more about consumers' medical facts, and accountants may know more about consumers' financial positions.*

Partners Life believes that we should only ask questions in our application form that a reasonable person could be expected to know about their health and that are material to our underwriting. This removes the need for a consumer to have the same knowledge as their doctor, or the same understanding of risk as the insurer. They just need to answer the questions they are asked. The answers they give should then prompt the insurer to decide whether they can assess the risk from the client's answers alone, or whether they need to seek further third party information.

It is important to note that when third parties have better knowledge of client facts, there are costs and benefits to obtaining those facts directly from those third parties, with the client's consent. For medical information:

- *Usually no single entity has all of a client's medical history. For example, if a client has seen a health provider without a referral from his/her General Practitioner (GP) the GP will not have complete medical records.*
- *The Privacy Commissioner has stated that insurers must not "fish" for medical conditions by requesting a client's entire medical file. Instead, insurers may only request medical information relevant to known or suspected health issues.*
- *There are significant costs to obtaining a client's medical records. These costs include an administration fee to the intermediary Konnect to obtain the medical file, the GP's time preparing the information, and an underwriter's time reviewing the information. These costs must be passed on to the consumer in the form of higher premiums and slower application processes.*

Technology exists to increase the efficiency and lower the costs of these processes. However, no entity is working presently to deliver this service with technology. To do so would require significant investment, industry cooperation (medical professionals, intermediaries, insurers), and time. Moreover, there are many impediments to such a service, including:

- *Client medical information is spread across multiple medical professionals.*
- *Not all medical records (or all of medical records) are stored digitally. This is particularly true for older GPs.*
- *There is no unique client identifier across medical professionals.*
- *Medical data are unstructured.*
- *Some medical records are difficult to obtain, particularly for immigrants and New Zealanders who have resided overseas, where part of their medical history does not exist in New Zealand.*

Similar challenges are likely to impede technological impacts in other areas of insurance.

Partners Life believes that as long as the questions asked of the consumer are specific, relevant, material and understandable by a reasonable consumer, then insurers should be able to rely on these answers to determine whether further third party information is required to provide more detailed insight into the risk posed. We do not believe third party

	information should be obtained for every client irrespective of their answers as this would pose significant time and cost burdens onto every client's application.
8	Are there examples where breach of the duty of disclosure has led to disproportionate consequences for the consumer? Please give specific examples if you are aware of them.
	The consequences of non-disclosure can be disproportionate to the consumer if an insurer applies the current law exactly, which Partners Life does not. *For example, an insurer can elect to void a contract (and walk away from a claim) where non-disclosure has been identified at claim time, even if the non-disclosure would not have prevented cover being put in place had the full disclosure been made at application date. The current law only requires that the non-disclosed information be "material" to their underwriting, i.e., that it would have been a factor considered when assessing the risk.* *Having a contract voided means the consumer has no cover and will have to disclose that they have had a previous contract voided due to non-disclosure. This can mean they have difficulty obtaining replacement cover. Obviously given that they have been declined a claim, their health is likely to have deteriorated since they took out the contract and again this may prevent them from being able to replace their voided covers.* *On the other hand, a consumer who acquires insurance benefits that they would not have otherwise been entitled to by non-disclosing, is not worse off if a contract is voided, given they receive their premiums back and given they would never have been covered had they told the truth (for example, an illegal drug abuser).* *Partners Life includes a "fair and reasonable" treatment of non-disclosure in our policy wordings for the benefit of our clients. Even so, unfortunately, there have still been a small percentage of cases where Partners Life discovered non-disclosure or misstatement, and when, upon re-underwriting, we discovered that we would never have offered the client cover had the client disclosed correctly. This has left the client without cover.* *It is important to note that there are significant commercial reasons for insurers to pay all valid claims. An insurer who does not pay claims would quickly develop a poor reputation among advisers, and among consumers. It would not attract new business, and it would lose existing business as its policyholders moved to competitors because of their concerns about how their claims might be treated.*
9	Should unintentional non-disclosure (i.e. a mistake or ignorance) be treated differently from intentional non-disclosure (i.e. fraud)? If so, how could this practically be done?
	Partners Life does not believe you can appropriately differentiate between accidental or intentional non-disclosure meaning we do not believe they should be treated differently. *A client who has non-disclosed known health information will often claim they "didn't realise", or they "forgot" even despite sometimes overwhelming evidence to the contrary in their medical records. We accept that a consumer might genuinely fail to recall a material medical issue, but this should not mean they obtain a better insurance outcome than a consumer who didn't "forget" to disclose an issue. It is important to remember that the client is not expected to and should not be expected to disclose information they genuinely did not know. Partners Life is very careful to ensure any information we rely on regarding non-disclosure or misstatement had been discussed with the client by their medical provider prior to the application date. If we can't be sure the client knew, then we don't consider the information to be non-disclosed.*

The implications of non-disclosure or misstatement on an insurer's ability to assess risk is the same regardless of whether the intent to defraud existed or not.

The ability to prove whether a client deliberately or accidentally withheld information (that they knew about their health) is very difficult. Potentially, it would initially position all clients as fraudsters in terms of the investigations that would be required to rule out fraud. In our opinion, treating all non-disclosures and misstatements of information, that we know the client was aware of, as if it were accidental, will deliver the kindest outcome to clients.

On the other hand, any client who deliberately non-disclosed or misstated known health information can easily claim it was ''accidental'' upon discovery.

For this reason, we believe the test required to determine whether non-disclosure or misstatement should be material to an insurer, is that:

- *the information should have been known by a reasonable client (based on their medical records supporting this);*
- *that a reasonable consumer would have understood that the information should have been provided as an answer to a specific and easily understood application question; and*
- *that the non-disclosed information would have changed the underwriting terms that would have applied had the client correctly disclosed.*

No consideration then needs to be given to whether the client was acting fraudulently or not.

We submit that there should be prescribed remedies available to an insurer which:

- *accurately reflect the impact on the insurer's assessment of risk based on the non-disclosure or misstatement; and*
- *act as a discouragement to deter clients from deliberately non-disclosing or misstating; and*
- *deliver an outcome equivalent to that which would have occurred for both parties had the client fully disclosed the correct information at application time (this latter point is the approach taken by Partners Life by contractually including a ''fair and reasonable'' treatment of non-disclosure and misstatement in our policy wordings); and*
- *protects the client from any deterioration in their underlying health which occurs after the application date but before the non-disclosure has been identified, except where that deterioration relates to the non-disclosed or misstated condition; and*
- *reflects the additional costs to the insurer of having to reassess the correct information at the date it is identified.*

To achieve these aims we suggest the following remedies should be made available to insurers:

1. *Re-underwrite the client's covers **as at the date of application** (meaning only health conditions experienced up to that date can be considered by the insurer), considering the information that had been non-disclosed or misstated on their application. If the acceptance terms that apply following this re-underwriting are the same as those that were applied at application date, then no further remedy should be available to the insurer meaning the covers continue without amendment.*
2. *Should the insurer determine, following reassessment with full medical information at application date, that the covers could have been offered but on different terms*

*from those originally offered to the client, then the client should be advised of the corrected terms and those terms should then apply to the covers **from the application date forward**. If the amended terms require extra premium to be paid by the client the insurer should be required to offer two options to the client:*

a. *to pay the additional premium due since application date before any claim can be considered, or*

b. *to accept the reduced amount of cover which could have been purchased for the premiums actually paid by the client.*

In other words, the client should be able to choose to keep their cover levels in place and pay the correct accumulated premium for it, or they can choose to not pay the additional accumulated premium and instead accept reduced cover. Partners Life does not believe the insurer should decide which of these options should be presented to the client in these circumstances.

4. *Should the insurer determine, following reassessment with full medical information at application date, that any particular type of cover(s) would not have been made available to the client at application date then the insurer should be entitled to cancel the cover from the application date, meaning no claim will be payable. The insurer should then be required to calculate all premiums paid by the client for the cancelled covers and to refund these premiums, subject to point 5 below.*

5. *In all cases where non-disclosure has resulted in a change of those terms that were incorrectly offered to the client at application date, then the insurer should be entitled to recover the additional costs of their reassessment work before cover can be continued and/or claims can be processed. These costs should be limited to the actual costs paid by the insurer for any information collected from external sources; and an allowance for internal underwriting resources. Partners Life would suggest this allowance might be calculated based on an hourly rate of $100 per hour and assuming an underwriting time of between 2 and 6 hours of per case, depending on its complexity.*

10	Should the remedy available to the insurer be more proportionate to the harm suffered by the insurer?
	As discussed in 9 above, we believe the remedies available should be prescribed.
11	Should non-disclosure be treated differently from misrepresentation?
	No. The present legal distinction is confusing and unnecessary. We submit that the focus should be on providing correct, relevant information to the insurer, not on an artificial distinction. *We submit that insurers should have the same alternative remedies available for all cases of non-disclosure or misrepresentation. See our answer to question 9, above.*
12	Should different classes of insureds (e.g. businesses, consumers, local government etc.) be treated differently? Why or why not?
	No, not for life and health insurance.

	In our experience, most commercial entities know as little about insurance as retail customers. Instead, all parties should have a duty to answer the specific questions they are asked accurately and fully.
13	In your experience, do insurers typically choose to avoid claims when they discover that an insured has not disclosed something? Or do they treat non-disclosure on a case-by-case basis?
	In our experience, each insurer will have their own procedures to handle non-disclosure. Some may use all of the remedies available to them under the current act while Partners Life does not – we take a much more fair and reasonable approach to the treatment of non-disclosure and misstatement. We have seen examples in the past where an insurer will change their approach based on a change of management and/or whenever their claims experience falls outside of assumptions. *In Partners Life's opinion, the claims experience and outcome for a client should be consistent not only across time with any one insurer, but also across the industry. In this way, clients are not disadvantaged through the selection of their insurer, and/or through the particular time when the issue arises for them depending on the fluctuating experience of their insurer.*
14	What factors does an insurer take into account when responding to instances of non-disclosure? Does this process vary to that taken in response to instances where the insurer discovers the insured has misrepresented information?
	We do not respond differently to non-disclosure and misrepresentation. *Factors Partners Life considers include:* • *Whether the non-disclosure or misrepresentation is material – would it have actually changed our acceptance terms?* • *Has the policyholder's health improved since the application was made to the extent that we would have subsequently improved the amended acceptance terms prior to the claim arising?* • *The length of time between commencement of the policy and the time of claim. If a policy has been in force for many years (5+) then we will apply a much higher threshold for materiality than we would for claims that arise early in the life of a policy. This is because the time that has passed since application date has essentially demonstrated that the imminent risk we might have been concerned about at application date had not actually arisen.* • *The circumstances, event or condition that gave rise to the claim.* • *The type of policy or benefit claimed.* • *The value of the claim.* • *Reinsurer experience, and the terms of our reinsurance treaty.*

Regarding conduct and supervision

15 What do you think fair treatment looks like from both an insurer's and consumer's perspective? What behaviours and obligations should each party have during the lifecycle of an insurance contract that would constitute fair treatment?

	Insurer	*Consumer*
Product design	*Products where the insurer can underwrite accurately for risk and to price accordingly.* *The ability for an insurer to adjust book prices for emerging experience.*	*Products which do what they say they will in the marketing material.* *Policy wordings that are written in Plain English and are understandable to lay people.* *Products which are upgraded as emerging product and health care trends occur so that clients who have had a deterioration in health since they bought the contract are not locked into product features and benefits that have been replaced for new clients as they are no longer competitive.*
Marketing	*The ability to market to consumers across the widest range of mediums possible, including through intermediaries.*	*Plain English marketing information which a reasonable layperson can understand.* *Access to more in depth information where required* *No high-pressure sales processes.* *A cooling off period.* *No comparative misrepresentations about products (including and especially those provided by competitors).*
Enquiries	*The ability to record enquiries (either electronically or by way of minutes which are provided back to the client to confirm the conversation). This is to avoid clients who might become motivated by the idea of a claim to misrepresent what they were told.*	*Insurers required to record all conversations with consumers to protect them against miscommunication and/or misrepresentation.*

Application	*To be able to rely on the consumer's answers to the specific application questions asked as long as they are clear and easily understood by a reasonable lay person.*	*Application questions are specific, relevant and easily understood by a reasonable layperson.* *No broad çatch-all questions.* *No reliance simply on the duty of disclosure.*
Underwriting	*To be able to accurately assess the risk of claim presented by each client and to price or exclude coverage according to that risk.* *To be able to rely on the client's answers to application questions without having to check whether they are telling the truth or not.*	*The price and/or terms offered by the insurer are based on the actual risk of claim presented by the client at the date they apply for the policy.* *If existing cover is being replaced, it should be legally required for the sales person and/or adviser to notify the new insurer and that insurer should be legally required to wear the non-disclosure risk for the replaced benefits once the cover is issued. This means the insurer must obtain medical records for replaced business or else accept the non-disclosure risk for those replaced benefits.*
Contract formed	*Policy wordings are the basis of the contract.*	*Policy wordings are in plain English and are understandable by a reasonable lay person and do not contain any unfair contract provisions.* *They should include an obligation on the insurer to apply fair and reasonable treatment to any non-disclosure or misstatement discovered after the policy has been issued.*
Policy servicing and renewal		

Claims	*The insurer should have remedies available to them where the client has non-disclosed or misstated at application time and the correct information would have been material enough to have changed the underwriting terms that were actually offered at application time.*	*The insurer will communicate in a timely and empathetic manner when dealing with a claim.* *The client should expect to be kept informed of the process and the expected time frames.* *If non-disclosure or misstatement is discovered, then that will be treated in a fair and reasonable manner.* *Once accepted, claims proceeds will be paid promptly.*
Complaints	*Complaints conversations can be recorded.*	*Complaints conversations are recorded.* *Complaints are addressed at an appropriate level within the insurer.* *There is a complaints escalation process if a resolution does not occur.* *The insurer is obligated to record and report escalated complaints and/or systemic complaint trends.*

16 To what extent is the gap between ICP 19 and the status quo in New Zealand (as identified by the IMF) a concern?

Partners Life welcomes conduct regulation in life insurance. Presently, the financial markets regulator lacks resource and comprehensive knowledge about insurance.

There are presently gaps in New Zealand's insurance regulation that are concerning.

Sales without advice are unregulated in New Zealand, and these are a particular area of concern. Consumers are at risk from:

- *Mis-selling, when they are sold an insurance product they don't need.*
- *Misunderstanding, when they buy an insurance product thinking it covers a circumstance that it doesn't.*
- *Replacement business, when they are sold an insurance product and they cancel a product they already have with better cover.*

The FMA's mandate in insurance, other than for financial advice, only extends to fair dealing (Financial Markets Conduct Act, Part 2), and (where relevant) anti-money laundering.

This means that most parts of the insurance life cycle are not regulated for conduct, including product design, policy wordings, underwriting, policy servicing and claims.

- *Product design (ICP 19.5). An effective regulator could act in the place of a ''reasonable lay person'' to determine whether marketing material and policy*

wordings are easily understandable, and if not, to request changes. They can also ensure policy wordings for existing policies, which are no longer marketed, do not fall significantly behind new policies being sold by an insurer in terms of features and benefits – effectively to avoid clients who cannot move insurers because of changes to their health after the policy commencement date.

- *Underwriting. An effective regulator can ensure that underwriting practices are sustainable and robust and are not predatory, simply to gain market share in the short-term. For example, offering transfer terms can benefit new applicants who do not have to complete an underwriting process, but is always to the detriment of existing policyholders who ultimately pay for the increased risk the insurer has agreed to take for the transferred (non-underwritten) clients at no extra cost to the transferring clients.*
- *Policy servicing (ICP 19.9). Some insurance products (more often medical benefits) include the right to detrimentally change cover or other terms during the life of the product – how are these insurer rights communicated effectively to clients? Do they understand that the features and benefits they are buying might be removed or altered before they need to claim against them and entirely at the determination of the insurer? Do these clients understand that they may not be able to move to another insurer once they realise the cover they bought was not guaranteed?*
- *Claims (ICP 19.10). Low loss ratios can indicate products were mis-sold (i.e. sold to clients who were unlikely to be able to claim against those products or were unlikely to understand their entitlement to claim and/or the process to do so), or do not meet the needs of clients effectively meaning the price being charged is too high for the likelihood of claims occurring. Periodic reporting of key metrics to the regulator can enable effective monitoring of claims processes.*

The UK's PPI scandal illustrated the impact of poor conduct regulation in insurance. We submit that effective conduct regulation in insurance would benefit consumers in New Zealand. We strongly believe the most effective regulation of conduct is to require insurers to demonstrate how they manage the competence, qualifications, training, ethics and values of their employees.

17 Does the lack of oversight over the full insurance policy 'lifecycle' pose a significant risk to purchasers of insurance?

Yes. See question 16, above.

18 What has your experience been of the claims handling process? Please comment particularly on:

- timeliness the information from the claims handler about:
  - timeframes and updates on timeframes
  - reasons for declining the claim (if relevant)
  - how you can complain if declined
- The handling of complaints (if relevant)

There are important commercial reasons for insurers to pay valid claims. An insurer who does not pay claims would quickly develop a poor reputation among advisers, and among

	consumers. It would not attract new business, and it would lose existing business as its policyholders moved to competitors. *Efficient claims processes reduce overall costs, and increase the profitability of insurers. Therefore, insurers aim to make their claims processes as efficient as possible.* *The claims process is required to ensure that insurers pay valid claims and decline invalid claims. Insurance is a pooling of risk – many people pay premiums to indemnify them if an insured event occurs. If an insurer pays invalid claims, the costs are borne by other policyholders in the form of higher premiums.* *Consumers have access to an Insurance Ombudsman whose service is available free of charge to claimants who feel aggrieved. Insurers have to pay the costs of any ombudsman investigation. The Ombudsman ruling is binding on the insurer, but not on the consumer (who can pursue other avenues if they don't like the ombudsman's decision).* *Partners Life's view is that the majority of life and health insurers are very good at managing claims for their clients and take great pride in the value of claims proceeds we have contributed to New Zealanders in need.* *There are only two reasons to deny a claim:* • *The event claimed is not covered by the policy, or* • *The policyholder failed to disclose material information to the insurer when applying for the policy, which would have changed the insurer's offer of terms.* *As a QFE, Partners Life has a robust complaints process, which is described in our Adviser Business Statement. Clients can also complain to our Disputes Resolution Scheme, the Insurance and Financial Services Ombudsman.*
19	Have you ever felt pressured to accept an offer of settlement from an insurance company? If so, please provide specific examples.
	N/A
20	When purchasing (or considering the purchase of) insurance, have you been subject to 'pressure sales' tactics?
	N/A
21	What evidence is there of insurers or insurance intermediaries mis-selling unsuitable insurance products in New Zealand?
	We have no comment.
22	Are sales incentives causing poor outcomes for purchasers of insurance? Please provide examples if possible.
	Sales incentives have the potential to cause poor outcomes for consumers regarding conflicted advice or pressured sales which are driven by the needs of the sales person (or their employer) or the adviser rather than the client. *Without sales incentives there would be very poor outcomes for consumers as they do not tend to seek out life risk products on their own (hence the under-insurance gap in New Zealand) so they need to be educated about their needs and then offered a solution to those*

	needs before they will buy. Without motivated, incentivised sales people and/or advisers the underinsurance gap in New Zealand will worsen very quickly. *Regulation of any conflicts, and management of the competence and ethics of salespeople and advisers, will do far more to protect consumers than any regulation of incentives on their own, and will help avoid the unintended consequences of harming the financial education that consumers need in order to insure themselves adequately.*
23	Does the insurance industry appropriately manage the conflicts of interest and possible flow on consequences that can be associated with sales incentives?
	Insurance (particularly life and health insurance) must be sold to consumers, because it is not something consumers actively buy. Reasons for this include: • *the optimal experience is to pay a regular premium and never make a claim;* • *insurance conversations require consumers to think about things we prefer not to (bad things that might happen);* • *behavioural bias leads consumers to prioritise their present over their future selves; and* • *it is easy to delay these actions (until it is too late).* *New Zealanders also think they can rely on government benefits such as ACC and WINZ benefits in the event of a health crisis. They are not aware of the quantum of these benefits, or of the likelihood that it is illness not accident that will impact their ability to continue their normal existence.* *The need to "sell" insurance led to various models to incentivise sales. All of these models have inherent conflicts of interest. (Indeed, the IAIS state that conflicts of interest are inherent in insurance distribution.) Moreover, as advisers arose who were not aligned with any one insurer and could offer product choice, the costs that were borne by tied agency insurers fell onto the shoulders of the non-aligned advisers themselves, and to compensate commissions and incentives increased. Competition for non-aligned adviser business from insurers also led to increased incentives. Commissions are only paid by an insurer after the lead generation and advice process has been completed, and the adviser has made a product recommendation. Therefore, the cost is only borne by the insurer when they are the successful provider (i.e. it is a totally variable cost).* *Because of the Commerce Act, insurers cannot collaborate to redesign incentives. Moreover, any insurer who reduces incentives will reduce their competitiveness in the market – FMA research shows that intermediaries are influenced by these incentives. Therefore, there is a last mover advantage for insurers.* *Should incentives reduce to the extent that advisers can no longer afford to pay the costs of lead generation and consumer education, then insurers will need to increase their spend to identify potential customers (lead generation). If the insurer is paying directly for this lead generation activity (i.e. a fixed cost), then they will understandably expect those clients to be offered their products exclusively. This leads to less choice for the consumer and potentially increased consumer harm, because the product they are offered due to these expectations might not be the best fit for their needs.* *Access to high quality advice is a key objective of our regime, and international experience shows that banning commission reduces access to high quality advice. In the UK,*

	commissions were banned in the Retail Distribution Review, and insurance commissions were subsequently reintroduced after adviser numbers fell, the cost of advice increased, and advice became more limited. *Insurers acknowledge that conflicts of interest exist in all distribution channels. In responses to the FMA/RBNZ letter, all insurers had to explain how they manage these conflicts of interest, and ensure they provide good customer outcomes.* *The Financial Services Legislation Amendment Bill will introduce s431J into the Financial Markets Conduct Act, which requires anyone giving financial advice to give priority to the client's interests if there is a conflict of interest.* •

Regarding exceptions from the Fair Trading Act's unfair contract terms provisions

24	Are you aware of instances where the current exceptions for insurance contracts from the unfair contract terms provisions under the Fair Trading Act are causing problems for consumers? If so, please give examples.
	We are not aware of such instances.
25	More generally, are there terms in insurance contracts that you consider to be unfair? If so, why do you consider them to be unfair?
	The exclusions in s46L of the Fair Trading Act 1986 are fundamental to contracts of insurance. Therefore, we consider that these terms are not unfair.
26	Why are each of the specific exceptions outlined in the Fair Trading Act needed in order to protect the "legitimate interests of the insurer"?
	Certain terms are essential in contracts of insurance to ensure that insurance can function effectively. This is why the exclusions in s46L of the Fair Trading Act 1986 were enacted. *These exclusions enable insurers and their clients to transact with confidence at all points in the life cycle of an insurance policy, which is the first objective of this review.* *Section references in this answer refer to the Fair Trading Act 1986.* *Section 46L(4)(a) identifying an uncertain event or specifying the subject matter insured or risk insured against* *These are main terms of an insurance contract, and are likely to be excluded as unfair terms under s46K(1)(a). This exclusion should be retained for clarity and certainty for both consumers and insurers.* *Identifying the nature and scope of uncertain events is a critical feature of the insurance contract which is required to price risk and set premiums.* *Paying benefits to the policyholder relies on uncertain events occurring. Policyholders pool risk, and those who do not suffer the insured event contribute to the costs of those who do. Without this exclusion, it could be argued that it is unfair for a policyholder to pay premiums for the life of a contract but never be entitled to make a claim.*

Section 46L(4)(b) specifying the sum insured

It is more difficult to price risk if the value to be paid if an event occurs cannot be defined. Without this exclusion, insurers would have to increase premiums for all policyholders to cover the risk of higher payments. Higher premiums are not in the interests of policyholders – it will reduce access to insurance products and increase the underinsurance gap – so this exclusion should be retained.

Section 46L(4)(c) excludes or limits the liability of the insurer

To keep premiums down, insurers need certainty of the risks they accept under insurance contracts. Exclusions also allow insurers to offer consumers a limited insurance contract in circumstances where the risk would otherwise be too high and leave some consumers uninsurable. For example, a client who has suffered a prior heart attack can be offered insurance to cover conditions other than heart-related; without this exclusion, the client may be uninsurable for life and health insurance.

The ability of insurers to exclude or limit liability also enables insurers to develop innovative products covering limited risks that may be more affordable for consumers.

If insurers were uncertain whether liability in certain circumstances were excluded or limited, premiums would increase, and some consumers would be denied insurance contracts.

Section 46L(4)(d) basis on which claims are settled, or specify contributions by the insured

The basis on which claims may be settled is an essential factor in pricing risk. For example, income protection policies may pay benefits for two years, or to age 65.

The basis on which claims may be paid, or sums are contributed, also has a material impact on pricing risk. For example:

- *Each wait period is priced differently; an income protection policy with a 90-day wait period has a lower premium than one with a 30-day wait period.*
- *Some companies (including Partners Life) allow customers to lower their health insurance premiums by opting for a greater excess payable on claim.*
- *For income protection, 75% of income payable is most common. Increasing the claim amount payable would increase the premium.*

If this exclusion is removed, it will reduce certainty of insurance contracts, and increase costs and prices for consumers and insurers.

Section 46L(4)(e) payment of premiums

This is the price payable under the contract, and should be excluded as unfair contact term under s46K(1)(b). This exclusion should be retained for clarity and certainty for both consumers and insurers.

Section 46L(4)(f) duty of utmost good faith

In insurance, the duty of utmost good faith underpins the duty to disclose. Better disclosure means:

- *A better underwriting and risk process upfront produces more accurately priced premiums. This benefits all consumers (not just the insured).*
- *For policyholders, greater certainty that claims will be paid, and of the amount that will be paid on claim.*

- *A quicker claims process, which is better for both parties (particularly for the policyholder, given claims are made in times of need).*

If this exclusion is removed, insurers lose certainty about remedies for non-disclosure or misrepresentation. For consumers, this increases uncertainty that a claim will be paid (or that the amount paid will be reduced), and increases the length of time it takes to process a claim.

Section 46L(4)(g) disclosure requirements, and effects of non-disclosure or misrepresentation

As above, better disclosure means more accurate pricing of risk, better certainty for both policyholder and insurer, and a quicker claims process. Terms setting out the impact of non-disclosure or misrepresentation by the insured are main terms of insurance contracts. These are required to meet the first objective of the review, insurers and insureds can transact with confidence at all points in the lifecycle of an insurance policy.

27	What would the effect be if there were no exceptions? Please support your answer with evidence.

Refer to question 26, above.

Regarding difficulties comparing and changing providers and policies

28	Is it difficult for consumers to find, understand and compare information about insurance policies and premiums? If so, why?

It is extremely difficult for consumers to understand and accurately compare policies and premiums without assistance. It is also almost impossible for them to understand how their needs change over their life-times and therefore what they need to do to keep their insurance solutions relevant over time.

RFAs and AFAs 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.

The outcomes of the Christchurch earthquakes have unfortunately demonstrated that left to their own devices consumers will only make decisions based on price as they do not have any ability to understand the differences in products. As a result, many of those effected by the quakes ended up with completely inadequate cover (for example, inadequate temporary accommodation relief) because they did not understand the value of this seemingly small part of the contract. Those who bought product through advisers generally had much richer coverage for the premiums that they paid (and as an extra benefit had someone to help them understand their entitlements at claim time).

For consumers without access to advice, this question contains many components.

Find information about insurance policies

*General information about types of insurance is available online, on insurers websites, and other websites such as **Life-Info**, **Citizens Advice Bureau**, and the **Financial Services Council**. Consumers can use these sites to learn about insurance.*

Policy wordings can be more difficult to find. Some insurers make their most recent policy wordings available online. It is more common for insurers to have plain language guides available on their websites. Historical policy wordings can be difficult to obtain (sometimes even if you are a policyholder trying to obtain a copy of your own policy documents), and require contacting the insurer directly.

Find information about premiums, or compare premiums

Many insurers have online pricing calculators, so consumers can enter details and obtain a price estimate. Depending upon the consumer's individual circumstances and the detail available in the calculator, these estimates are likely to be based on standard rates. For underwritten products, consumers' individual health conditions can result in price loadings of +50% to +400% of standard rates.

*There are companies, such as **LifeDirect**, where consumers can compare insurance policy prices. Price comparisons are risky, because there can be significant variations in cover across policies, and buying the cheapest policy may not be best for the consumer. (For example, level premium policies may be more expensive than rate-for-age policies in the short term, but much cheaper if the policy is maintained for many years.) Therefore, Partners Life prefers to distribute our products through non-aligned advisers, who have the expertise necessary to compare products.*

Understand information about insurance policies; compare insurance policies

Insurance policies are usually long, complex documents that are difficult for consumers to understand. Even if they are written in plain English, policies are long and detailed.

When comparing policy wordings, it is difficult to identify and understand differences without expert knowledge.

Some product comparisons or product ratings are available to financial advisers or to consumers, such as Consumer Magazine, Canstar ratings, and LifeDirect comparisons (provided by Quality Product Research). Sometimes individual circumstances mean that generic comparisons can give the wrong results. Advisers can also access tools like IRESS and Quality Product Research which are not available directly to the public, and even if they were, would be very difficult for someone without insurance experience to understand the reasoning and methodology behind the comparative positioning.

29	Does the level of information about insurance policies and premiums that consumers are able to access and assess differ depending on the type of insurance? E.g. life, health, house and contents, car insurance etc.

Yes. Life and health insurance (including income protection and trauma insurance) operates as a separate industry from fire and general insurance (including house, car, and contents insurance). Therefore, providers, tools and services differ markedly between the industries.

Life insurance contracts are guaranteed and are not changeable by the insurer, whereas fire and general (F&G) insurance products are annually negotiated and can be cancelled by the insurer.

Life and health insurance contracts deal with the health of an individual and the oftentimes lengthy or permanent interruption to their normal lives. For example, F&G insurance often deals with "things" like cars which can be replaced if income continues to be earned. Life and health insurers are often dealing with the insured's income being interrupted altogether.

Unfortunately, many New Zealanders seem to have a belief that it is okay to defraud your insurer (as evidenced by the fraud statistics in F&G insurance). There is a mind-set that, "I've

	paid for it, so I need to get something back". This mindset can also flow over to life and health insurance, and manifest itself through non-disclosure/misstatement at application (very often in relation to medical insurance where they have a current medical issue for which a long wait for public treatment is required, so they buy private medical cover without disclosing, thinking they can then claim for it), or even claims fraud (especially regarding income replacement type benefits where the extent of their disability is fictitious).
30	What barriers exist that make it difficult for consumers to switch between providers?
	There is a significant difference between life and health insurance, and fire and general insurance: • *Fire and general insurance are term contracts that both parties have the right, but not the obligation, to renew at the end of the term (usually annually).* • *Life and health insurance are term contracts where the policyholder has the right, but not the obligation to renew at each policy anniversary. In contrast, insurers are obliged to renew the contract if the policyholder chooses to do so. Life and health insurers, therefore, have one chance – on application – to assess and price the risk of a client.* *In life and health insurance, changes in health can be a significant barrier to switching providers. As a policyholder's health changes, the existing insurer is obliged to continue pricing on the original terms; if a consumer applies for a policy with a different insurer, that insurer can underwrite with the client's present health conditions. The new insurer may load the policy (offer a higher price) or decline cover for certain existing conditions (exclusions).* *This challenge can be exacerbated if the policyholder or their adviser has trouble obtaining existing policy wordings, without which, the existing policy cannot be compared to the proposed policy.* *A barrier that applies equally across insurance types is consumer apathy. Insurance is a decision that is easily delayed, so consumers may stay with the same policy because they do not actively consider changing insurer.*
31	Do these barriers to switching differ depending on the type of insurance? E.g. life, health, house and contents, car insurance etc.
	Yes. See question 30.
32	What, if anything, should the government do to make it easier for consumers to access information on insurance policies, compare policies, make informed decisions and switch between providers?
	<u>Something the government can do</u> *As stated above, it can be difficult for consumers (and financial advisers) to obtain policy wordings, especially for historical products.* *We submit that the government should create a public register of all policy wordings for which insurers are receiving premiums from consumers. (The register would contain standard policy wordings only, not individual offers of terms, which are private information.)* *Partners Life also believes insurers should be required by regulations to provide policyholders with copies of the exact policy wordings that they were issued with along with details of any*

	beneficial upgrades that have been made to the contracts since the policy was issued. Insurers should have to do so within 10 working days of the request being received. *Things the government should not do* *Some jurisdictions regulate wordings for certain conditions. These restrictions limit innovation in the insurance industry. For example, insurers are unable to offer new products for lower prices that offer cover less than the required wordings.* *One jurisdiction has a government run price comparison tool. This encourages consumers to compare products on price, but differences in cover can be significant. Additionally, government providers often fail to improve products over time, and private providers can be more innovative (e.g. it is very difficult to extract data from the **Disclose Register**).*

Regarding third party access to liability insurance monies

33	Do you agree that the operation of section 9 of the Law Reform Act 1936 (LRA) has caused problems in New Zealand?
	We have no comment.
34	What are the most significant problems with the operation of section 9 of the LRA that any reform should address?
	We have no comment.
35	What has been the consequence of the problems with section 9 of the LRA?
	We have no comment.
36	If you agree that there are problems with section 9 of the LRA, what options should be considered to address them?
	We have no comment.

Regarding failure to notify claims within time limits

37	Do you agree that the operation of section 9 of the Insurance Law Reform Act 1977 (ILRA) has caused problems for "claims made" policies in New Zealand?
	We have no comment.
38	What has been the consequence of the problems with section 9 of the ILRA?
	We have no comment.
39	If you agree that there are problems with section 9 of the ILRA, what options should be considered to address them?
	*We support the recommendation of the Law Commission in **NZLC R46**.*

	Section 9 of the Insurance Law Reform Act 1977 restricts the ability of insurers to contract time limits for claims. The Law Commission recommended that claims made policies should be excluded from these restrictions.

Regarding exclusions that have no causal link to loss

40	Do you consider the operation of section 11 of the Insurance Law Reform Act 1977 (ILRA) to be problematic? If so, why and what has been the consequence of this?
	Yes, section 11 of the Insurance Law Reform Act 1977 created problems for insurers and consumers. *We understand that this section intended to stop insurers from denying claims when:* • *There is an exclusion in the policy.* • *The exclusion applies at the time of the claim event.* • *The claim was caused by something other than the excluded circumstances.* *We agree with this intention. However, the current wording is too broad.* *Insurance policies are priced based on risk. Exclusions reduce the insurer's risk, and reduce premiums.* *Courts have applied section 11 to exclusions where actuarial or statistical data established an increased risk of loss in the circumstances covered by the exclusion, even if the exclusion has resulted in the insured paying lower premiums.* *We submit that section 11 should not apply when the exclusion is based on actuarial or statistical data, and the insured has benefitted from resulting lower premiums.*
41	The Law Commission proposed reform in relation to exclusions relating to the characteristics of the operator of a vehicle, aircraft or chattel; the geographic area in which the loss must occur; and whether a vehicle, aircraft or chattel was used for a commercial purpose. Do you agree that these are the areas where the operation of section 11 of the ILRA is problematic? Do you consider it to be problematic in any other areas?
	We have no comment.
42	If you agree that there are problems with section 11 of the ILRA, what options should be considered to address them?
	We submit that the reformed section 11 should not apply: • *if actuarial or statistical data establishes a generalised increased risk of loss in the circumstances covered by the exclusion, and* • *if the insured accepted the cover with that exclusion.*

Regarding registration of assignments of life insurance policies

43	Do you agree that the registration system for assignment of life insurance policies still requires reform?

	Yes. The current system is archaic. *The first thing to consider is whether the need that existed when this law was passed still exists in the same way today.* *When whole of life and endowment policies were the most common forms of life insurance, the surrender values of these policies made assignment relatively common. Now that most policies are term life with no surrender value, assignment of policies is less common.* *Technological advances also mean that insurers have much better records of policy owners. When a policy owner transfers ownership to another, insurers have processes to handle these transfers.*
44	If you agree that there are problems with the registration system for assignment of life insurance policies, what options should be considered to address them?
	We submit that there is no longer any need for a prescribed register of assigned life insurance policies. *Insurers should be required to maintain records of the owners of all policies. If a policy owner assigns ownership to another, the insurer should have a clear process to validate, facilitate and record it. Each life insurer should be able to determine what is the most appropriate form and process to be adopted for their entity.*

Regarding responsibility for intermediaries' actions

45	Do you consider there to be problems with the current position in relation to whether an insurer or consumer bears the responsibility for an intermediary's failures? If possible, please give examples of situations where this has caused problems.
	Section 10 of the Insurance Law Reform Act 1977 can produce unjust outcomes for insurers. This section deems that any person who receives valuable consideration from an insurer for arranging an insurance contract is an agent of the insurer. *This law was enacted when the structure of the life and health insurance industry differed significantly from its present state. Financial advisers were often separate entities from insurers, but aligned to them – most financial advisers sold insurance for only one insurer. Insurers would usually train advisers, which included the systems and processes for giving financial advice.* *From the 1990s, it became more common for financial advisers to have agency agreements with multiple insurers. Therefore, in 1977 insurers had closer control over financial advisers than they have presently, which included greater involvement in their training, systems and processes.* *The present structure is also influenced by the Financial Advisers Act 2008, by independent industry training (the New Zealand Certificate in Financial Services Level 5), and will be further influenced by the Financial Services Legislation Amendment Bill. All of these changes distance financial adviser businesses further from the insurer.* *In this environment, we submit that it is inequitable for the insurer to be liable for the actions of non-aligned intermediaries.*

	Here is an example of that inequity: *A financial adviser helps a client to complete an application form. The applicant asks whether he/she should disclose a skin condition. The adviser wants the application to proceed quickly, and says, "no".* *Had the applicant disclosed the condition, the insurer would have excluded claims related to the skin condition.* *The application is processed without the insurer underwriting for the skin condition, and the policy is issued.* *A few years later, the policyholder claims on the policy for a health problem related to the skin condition.* *The insurer is deemed to know about the skin condition because the financial adviser knew. The insurer must pay the claim. All other policyholders cover the cost of that claim unfairly, because the financial adviser gave the policyholder poor advice.*
46	If you consider there to be problems, are they related to who the intermediary is deemed to be an agent of? Or the lack of a requirement for the intermediary to disclose their agency status to the consumer? Or both?
	We submit that this problem will not be solved if financial advisers are required to disclose that they are agents for the insurers. *These problems exist because non-aligned intermediaries, with operations and training that are completely independent of insurers, are deemed to be agents of the insurers.*
47	If you consider there to be problems, what options should be considered to address them?
	We submit that the Financial Services Legislation Amendment Bill creates an opportunity for financial advice businesses to take liability for the advice they give to consumers. *Presently financial advisers can (and do) enter and leave the industry effectively without barriers (over 6,000 financial advisers who are deregistered from the FSPR were registered for less than 2.5 years). In the forthcoming regime, financial advisers will have to be engaged by licensed financial advice providers.* *Requirements to obtain a licence are determined by the Financial Markets Conduct Act **section 316**, and Financial Markets Authority licensing requirements. These requirements are likely to ensure that entities responsible for financial advice exist as businesses that are going concerns, rather than potentially temporary occupations for some individuals.* *Requirements to obtain a licence can ensure that licensed financial advice providers have sufficient financial resources to cover this liability (for example, with their public liability insurance).*

Regarding insurance intermediaries – Deferral of payments / investment of money

48	Do you agree that the current position in relation to the deferral of payments of premiums by intermediaries has caused problems?
	No comment.

49	If you agree that there are problems, what options should be considered to address them?
	No comment.

Other miscellaneous questions

50	Are there any provisions in the six Acts under consideration that are redundant and should be repealed outright? If so, please explain why.
	No comment.
51	Are there elements of the common law that would be useful to codify? If so, what are these and what are the pros and cons of codifying them?
	No comment.
52	Are there other areas of law where the interface with insurance contract law needs to be considered? If so, please outline what these are and what the issues are.

Section 41A of the Life Insurance Act 1908

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 extreme circumstances the insurer may become aware of the death many years after it occurs.*
- *Difficulty contacting the policy owner or personal representatives to obtain the claim requirements, or delays receiving those requirements.*

*Sometimes the interest rate defined in the policy or in **section 12(3)** of the Interest on Money Claims Act 2016 can offer an attractive return at low risk, relative to alternative investment options.*

We submit that insurers should not be penalised by paying high interest rates on unpaid death claims when the insurer cannot control the delay. We agree that the insurer has had

	use of the proceeds in these circumstances. The prescribed interest rate should be linked to the OCR applicable through to the date proceeds are able to be paid.
53	Is there anything further the government should consider when seeking to consolidate the six Acts into one?
	No comment.

Other comments

We welcome any other comments that you may have.
Our comments explain key elements of insurance, and particularly life and health insurance. *<u>Pooled risk</u>* *Insurance exists because groups of people with similar risks are unable or unwilling to cover the cost of an unexpected event if it happens to them. Each person pays into a pool, a fair share (the premium) of the cost if the event occurs. Those to whom the event occurs claim from the pool.* *Therefore, if the event does not happen to a person in the pool, it is not possible to refund that person's share of the cost, because that premium was used to pay the costs of others to whom the event happened.* *Each person in the pool receives value in knowing that their costs will be covered if the unexpected event happens to them. If the event does not happen to them, they already received that value – the transfer of risk.* *<u>Actuaries</u>* *The groups of people in the pool rarely have identical risks. The actuary's job is to calculate the relative risk of each person in the pool. Actuaries set premiums based on these relative risks so that each person in the pool pays according to their own risk.* *Actuaries use statistical data to determine these relative risks.* *<u>Underwriting</u>* *When someone applies for insurance, they supply information about their risks. Underwriters compare the risks of individuals against underwriting rules, which enable us to put the applicant into the appropriate premium pool, and exclude items for which we are unwilling to take risk.* *For high value applications, or applications indicating particular health risks, underwriters may request more information from the applicant. This may be through a telephone call or email to the applicant, or it may entail requesting the applicant's medical records.* *Underwriters limit requests for medical records to situations where they are necessary, because these records are expensive to obtain, they take time to receive (often weeks), and they take time to review. This delays the consumer's experience, and increases the costs of insurance.*

<u>Reinsurance</u>

Insurers are often unable or unwilling to carry the risks of all of their policyholders alone. Insurers take insurance policies to cover these risks. The counterparties are reinsurers, and these policies are reinsurance treaties.

Reinsurers are large global entities with significant knowledge, experience and information about insurance risks. They will usually provide rules for underwriting and claims, and audit the insurers adherence to those rules.

<u>Life and health insurance differs from fire and general insurance</u>

The insurance industry actually comprises two different industries:

- *Fire and general insurance are term contracts that both parties have the right, but not the obligation, to renew at the end of the term (usually annually).*
- *Life and health insurance are term contracts where the policyholder has the right, but not the obligation to renew at each policy anniversary. In contrast, insurers are obliged to renew the contract if the policyholder chooses to do so. Life and health insurers, therefore, have one chance – on application – to assess and price the risk of a client.*

Few companies in New Zealand manufacture life and health, and fire and general insurance. Companies in each industry also have different industry bodies (fire and general, Insurance Council of New Zealand; life insurance, Financial Services Council; health insurance, Health Funds Association of New Zealand).