P63 – Long-term insurance business

Diploma in Insurance

October 2017 Examination Guide

SPECIAL NOTICE

Candidates entered for the April 2018 examination should study this Examination Guide carefully in order to prepare themselves for the examination.

Practise in answering the questions is highly desirable and should be considered a critical part of a properly planned programme of examination preparation.

P63 – Long-term insurance business

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Published February 2018

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IMPORTANT GUIDANCE FOR CANDIDATES

Introduction

The purpose of this Examination Guide is to help you understand how examiners seek to assess the knowledge and skill of candidates. You can then use this understanding to help you demonstrate to the examiners that you meet the required levels of knowledge and skill to merit a pass in this unit.

Before the examination

Study the syllabus carefully

This is available online at www.cii.co.uk or from Customer Service. All the questions in the examination are based directly on the syllabus. *You will be tested on the syllabus alone*, so it is vital that you are familiar with it.

There are books specifically produced to support your studies that provide coverage of all the syllabus areas; however you should be prepared to read around the subject. This is important, particularly if you feel that further information is required to fully understand a topic or an alternative viewpoint is sought. The reading list which can be found with the syllabus provides valuable suggestions.

Read widely

It is vital that your knowledge is widened beyond the scope of one book. *It is quite unrealistic to expect that the study of a single study text will be sufficient to meet all your requirements.* While books specifically produced to support your studies will provide coverage of all the syllabus areas, you should be prepared to read around the subject. This is important, particularly if you feel that further information is required to fully understand a topic or an alternative viewpoint is sought. The reading list which can be found with the syllabus provides valuable suggestions.

Make full use of the Examination Guide

This Examination Guide contains a full examination paper and model answers. The model answers show the types of responses the examiners are looking for and which would achieve maximum marks. However, you should note that there are alternative answers to some question parts which would also gain high marks. For the sake of clarity and brevity not all of these alternative answers are shown.

This guide and previous Examination Guides can be treated as 'mock' examination papers. Attempting them under examination conditions as far as possible, and then comparing your answers to the model ones, should be seen as an essential part of your exam preparation. The examiner's comments on candidates' actual performance in each question provide further valuable guidance. You can purchase copies of the most recent Examination Guides online at www.cii.co.uk. CII members can download free copies of older Examination Guides online at www.cii.co.uk/knowledge.

Know the structure of the examination
Assessment is by means of a three hour paper.

Part 1 consists of 14 compulsory questions, worth a total of 140 marks.

Part 2 consists of 2 questions selected from 3, worth a total of 60 marks.

Each question part will clearly show the maximum marks which can be earned.

Read the current Diploma in Insurance Information for Candidates
Details of administrative arrangements and the regulations which form the basis of your examination entry are to be found in the current Diploma in Insurance Information for Candidates brochure, which is *essential reading* for all candidates. It is available online at www.cii.co.uk or from Customer Service.

In the examination

The following will help:

Spend your time in accordance with the allocation of marks

- The marks allocated to each question part are shown on the paper.
- If a question has just two marks allocated, there are likely to be only one or two points for which the examiner is looking, so a long answer is a waste of time.
- Conversely, if a question has 12 marks allocated, a couple of lines will not be an adequate answer.
- Do not spend excessive time on any one question; if the time allocation for that question has been used up, leave some space, go on to the next question and return to the incomplete question after you have completed the rest of the paper, if you have time.

Take great care to answer the question that has been set

- Many candidates leave the examination room confident that they have written a 'good' paper, only to be surprised when they receive a disappointing result. Often, the explanation for this lies in a failure to fully understand the question that has been asked before putting pen to paper.
- Highlighting key words and phrases is a technique many candidates find useful.
- The model answers provided in this Examination Guide would gain full marks. Alternative answers that cover the same points and therefore answer the question that has been asked would also gain full marks.

Tackling questions

Tackle the questions in whatever order feels most comfortable. Generally, it is better to leave any questions which you find challenging until you have attempted the questions you are confident about. Candidates' should avoid mixing question parts, (for example, 1(a)(i) and (ii) followed by 2(b)(ii) followed by 1(e)(i)) as this often leads to candidates unintentionally failing to fully complete the examination paper. This can make the difference between achieving a pass or a narrow fail.

It is vital to label all parts of your answer correctly as many questions have multiple parts to them (for example, question 1(a) may have parts (i), (ii) and (iii)). Failure to fully distinguish between the separate question parts may mean that full credit cannot be given. It is also important to note that a full answer must be given to each question part and candidates should not include notes such as 'refer to answer given in 1(b)(i)'.

Answer format

Unless the question requires you to produce an answer in a particular format, such as a letter or a report, you should use 'bullet points' or short paragraphs. The model answers indicate what is acceptable for the different types of question.

Where you are asked to perform a calculation it is important to show **all** the steps in your answer. The majority of the marks will be allocated for demonstrating the correct method of calculation.

Provided handwriting is legible, candidates will **not** lose marks if it is 'untidy'. Similarly, marks are not lost due to poor spelling or grammar.

Calculators

If you bring a calculator into the examination room, it must be a silent, battery or solar-powered, non-programmable calculator. The use of electronic equipment capable of being programmed to hold alphabetical or numerical data and/or formulae is prohibited. You may use a financial or scientific calculator, provided it meets these requirements. The majority of the marks will be allocated for demonstrating the correct method of calculation.

EXAMINER COMMENTS

Question 1
The majority of candidates did not answer this question.

Question 2
Few candidates gained high marks on this question, with many not mentioning the Trustee Act 1925, section 36.

Question 3
This question was reasonably well answered by most candidates. A number did, however, repeat or combine some of the options and as a result gained lower marks.

Question 4
Candidates who answered this question achieved high marks although a number of candidates did not attempt the question at all.

Question 5
Some candidates mixed their responses to parts (a) and (b) with a large proportion providing very brief answers to part (b), preventing them from achieving full marks.

Question 6
Many candidates did not achieve high marks on this question. A large number focused on general exclusions, rather than specific exclusions in relation to a change in occupation or in residency.

Question 7
This question was either very well answered or not. Some candidates chose not to attempt it at all.

Question 8
Overall, this question was answered well, with the stronger candidates able to go beyond describing briefly the advantage of a rules-based software system.

Question 9
This question was not very well answered as candidates focused on the claims assessment process, rather than the specifics relating to the self-employed.

Question 10
This question produced mixed answers, however it was reasonably well answered by many candidates.

Question 11
Candidates answers to parts (a) and (b) of this question were stronger than parts (c) and (d). Some candidates did confuse the different types of trusts.

Question 12
This question was reasonably well answered by most candidates. A fair proportion focused unnecessarily on the types of non-disclosure (innocent, deliberate and reckless).

Question 13
This question was reasonably well answered, although some candidates did not understand the use of the word 'amendment'.

Question 14
This question was well answered with candidates providing enough detail to achieve high marks.

Question 15
This question was the least popular of the Part II questions and produced mixed answers. Some candidates would have benefitted from more detailed answers to part (c) relating to the levels of group life cover which prevented them from achieving higher marks.

Question 16
This question was the most popular of the Part II questions with many candidates answering both parts very well. In general, candidates gained higher marks in part (a). In part (b), a few candidates incorrectly discussed considerations of the insurer and not the reinsurer as stated in the question.

Question 17
The majority of candidates who chose to answer this question provided enough detail in both parts to achieve high marks. Part (a) was reasonably well answered with most candidates identifying at least three out of the four claims definitions. In part (b), several candidates outlined the generic claims process and not the specifics around a total and permanent disability claim.

THE CHARTERED INSURANCE INSTITUTE

P63

Diploma in Insurance

Unit P63 – Long-term insurance business

October 2017 examination

Instructions

- Three hours are allowed for this paper.
- **Do not begin writing until the invigilator instructs you to.**
- **Read the instructions on page 3 carefully before answering any questions.**
- Provide the information requested on the answer book and form B.
- You are allowed to write on the inside pages of this question paper, but you must **NOT** write your name, candidate number, PIN or any other identification anywhere on this question paper.
- The answer book and this question paper must **both be handed in personally by you** to the invigilator before you leave the examination room. **Failure to comply with this regulation will result in your paper not being marked and you may be prevented from entering this examination in the future.**

Unit P63 – Long-term insurance business

Instructions to candidates

Read the instructions below before answering any questions

- **Three hours** are allowed for this paper which carries a total of 200 marks, as follows:

Part I	14 compulsory questions	140 marks
Part II	2 questions selected from 3	60 marks

- You should answer **all** questions in Part I and two out of the three questions in Part II.
- You are advised to spend no more than two hours on Part I.
- Read carefully all questions and information provided before starting to answer. Your answer will be marked strictly in accordance with the question set.
- The number of marks allocated to each question part is given next to the question and you should spend your time in accordance with that allocation.
- You may find it helpful in some places to make rough notes in the answer booklet. If you do this, you should cross through these notes before you hand in the booklet.
- It is important to show each step in any calculation, even if you have used a calculator.
- If you bring a calculator into the examination room, it must be a silent, battery or solar-powered non-programmable calculator. The use of electronic equipment capable of being programmed to hold alphabetic or numerical data and/or formulae is prohibited. You may use a financial or scientific calculator, provided it meets these requirements.
- Answer each question on a new page. If a question has more than one part, leave six lines blank after each part.

PART I

Answer ALL questions in Part I

Note form is acceptable where this conveys all the necessary information

1. **(a)** Outline the main features of individual savings accounts (ISAs). **(7)**

(b) State the main provisions of the Help to Buy ISA scheme. **(4)**

2. Describe how a new trustee is normally appointed under a trust created by deed. **(10)**

3. State **four** options available to a policyholder, where a policy has lapsed and the policy has a surrender value. **(8)**

4. Outline the **three** Pillars of the Solvency II regulatory regime. **(9)**

5. **(a)** Describe briefly the emergence of new types of long-term insurance distributors. **(6)**

(b) Outline **four** ways a customer could purchase a long-term insurance product without using an advisor. **(4)**

6. Outline the normal exclusions that apply under an individual income protection policy in the following examples:

(a) The life assured travels or resides outside of the UK. **(5)**

(b) The life assured changes their occupation. **(5)**

7. State **six** of the key points from the Association of British Insurers Guide of Good Practice for Unit-Linked Funds. **(6)**

8. Describe briefly the advantages of a rules-based software system in relation to underwriting. **(8)**

9. Describe the financial assessment and evidence required under an income protection claim where the life assured is self-employed. **(14)**

10. Explain briefly the differences between a qualifying and non-qualifying life assurance policy. **(8)**

11. Describe briefly the following:

(a) An interest in possession trust. **(4)**

(b) A bare trust. **(4)**

(c) A mixed trust. **(3)**

(d) A settlor-interested trust. **(3)**

12. Explain the principle of the duty of disclosure, quoting relevant case law and statute to support your answer. **(12)**

13. State **six** examples where a life assurance policy may need to be amended. **(6)**

14. Describe the main requirements of the Data Protection Act 1998 as it applies to long-term insurance business. **(14)**

PART II

Answer TWO of the following THREE questions
Each question is worth 30 marks

15. Describe how group life cover differs from individual protection in relation to the following:

(a) Underwriting. **(10)**

(b) Taxation of premiums and benefits. **(10)**

(c) Levels of cover. **(10)**

16. **(a)** Explain why reassurance may be necessary and how an insurer cedes life assurance risks to another office. **(15)**

(b) Describe the key considerations a reassurer would take into account before agreeing to deal with a ceding office for the first time. **(15)**

17. **(a)** Explain the various total and permanent disability (TPD) definitions in the UK market. **(10)**

(b) Discuss the process an insurer will go through and the issues that may arise when assessing a TPD claim. **(20)**

TEST SPECIFICATION

October 2017 Examination – P63 Long-term insurance business	
Question	Syllabus learning outcome(s) examined
1	2 – Understand long-term business contracts 7 – Understand taxation considerations
2	2 – Understand long-term business contracts
3	2 – Understand long-term business contracts
4	6 – Understand consumer protection
5	1 – Understand the structure of the long-term business market
6	2 – Understand long-term business contracts
7	2 – Understand long-term business contracts 6 – Understand consumer protection
8	3 – Understand risk assessment and control
9	4 – Understand claims administration
10	2 – Understand long-term business contracts 7 – Understand taxation considerations
11	2 – Understand long-term business contracts
12	2 – Understand long-term business contracts 3 – Understand risk assessment and control
13	2 – Understand long-term business contracts
14	6 – Understand consumer protection
15	2 – Understand long-term business contracts 3 – Understand risk assessment and control 7 – Understand taxation considerations
16	1 – Understand the structure of the long-term business market 5 – Understand reassurance
17	2 – Understand long-term business contracts 4 – Understand claims administration

NOTE ON MODEL ANSWERS

The model answers given are those which would achieve maximum marks. However, there are alternative answers to some question parts which would also gain high marks. For the sake of clarity and brevity not all of these alternative answers are shown. An oblique (/) indicates an equally acceptable alternative answer.

Model answer for Question 1

(a)

- The individual savings account (ISA) is basically a tax-free scheme for saving.
- For investors, returns from ISA savings are free of UK income tax and capital gains tax.
- Income and capital gains tax arising in an ISA do not have to be entered on a tax return and funds can be removed from it at any time without a tax penalty.
- The overall annual subscription limit for the 2017/18 tax year is £20,000.
- The full amount can be held in cash, stocks and shares, or any combination of the two. This limit will be applied whether or not funds were withdrawn.
- However, changes which came into force from April 2016 mean that savers will be allowed to withdraw from and reinvest in a Cash ISA within a tax year without impacting their annual allowance in that tax year. The only restriction is that the investor will need to make any further investments to the ISA in the same tax year as the withdrawal was made, otherwise it will form part of the next year's ISA allowance.

(b)

- In March 2015, the Chancellor of the Exchequer announced the introduction of the Help to Buy ISA, which is now available through banks and building societies.
- It is designed to reward people that are working to save up for their first home.
- First time buyers that choose to save through a Help to Buy ISA receive a government bonus of 25% to help them make the first step on the housing ladder.
- The maximum amount which can be saved for is £200 per month, although it will be possible to pay in up to £1,200 initially. The minimum government bonus is £400, and the maximum is £3,000.
- The Help to Buy ISA scheme was introduced in December 2015 and will be available for new savers until the end of November 2019.

Model answer for Question 2

Under a trust created by deed, the initial trustees will be appointed by the deed itself. Where a trust is created by a Will then this should name the trustees, who are usually the executors as well. Under a trust set up under the laws of intestate succession, the administrators will be the trustees.

Anyone aged over 18 and sane can be a trustee. It may be necessary to replace a trustee or trustees at some time in the future, and it is for this reason that a trust deed will often name the person or persons (the appointor(s)) entitled to appoint new trustees. If there is no such provision, the power to appoint new trustees rests with the surviving trustee(s) or the legal personal representatives of the last surviving trustee.

Under the Trustee Act 1925 s.36, a new trustee can be appointed to replace a trustee who: is dead; remains out of the UK for more than a year; desires to be discharged; refuses to act; is unfit or incapable of acting (e.g. has become bankrupt or insane); or is an infant.

Model answer for Question 3

Any four of the following:

- The policy remains in force for as long as the surrender value exceeds the total of the outstanding premiums and late payment charges.
- The policy remains in force for 1 year and then the surrender value becomes payable and death cover ceases.
- The policy is converted on the expiry of the day's grace (or after 1 year) to a paid-up policy for the appropriate reduced sum assured.
- The policy continues in force until units are extinguished by mortality deductions and charges on a unit-linked policy.
- The policyholder can approach the life office to see whether the policy can be re-instated, possibly subject to a late payment charge.

Model answer for Question 4

- Pillar 1 covers quantitative requirements, including the amount of capital an insurer must hold.
- Pillar 2 includes requirements for the governance and supervision of insurers, including effective risk management, and a firm's requirement to carry out its own risk and solvency assessment.
- Pillar 3 includes requirements for disclosure and transparency, such as the requirement for a firm to publish details of the risks facing them, capital adequacy and risk management.

Model answer for Question 5

(a) The availability of financial services through businesses such as supermarkets and other high street presences, offering life assurance, savings accounts and credit cards. These organisations do not own insurance companies and the insurance provided is written by one of the types of long-term insurance company. Using their large customer base, brand loyalty and regular customer contact, these non-insurance businesses have already made some impact in the traditional insurance and investment marketplace. Other organisations which offer long-term insurance products to their members include The National Trust and Saga. From the characteristics of their customer database it is possible to target propositions which will be seen as attractive.

(b)
- Direct purchase following a postal marketing campaign.
- Direct purchase following a TV advertisement encouraging direct contact with the life office.
- Purchase through the workplace when some form of deal for staff has been arranged.
- Direct purchase following a targeted e-mail program.

Model answer for Question 6

(a) Benefit will only be payable while the insured is permanently resident within areas known as free limits. The free limits vary from office to office but will be at least the UK and the Republic of Ireland and will often extend to the EU or Western European countries or possibly even the USA, Canada, Australia and New Zealand.

It is common for offices to continue to provide cover if the insured travels or resides temporarily outside the free limits, but benefit will not then be payable for more than, say, three months. It is fairly common to provide for cancellation of the policy if the insured resides outside the free limits for more than a year.

(b) Most offices cease cover if the insured engages in an occupation additional to, or instead of, that shown in the policy unless the office agrees to continue it (possibly with an appropriate increase in premium). This is to allow for the possibility that the change in occupation carries a greater risk. A continuous disclosure clause means that the insured must disclose a change in occupation. Some companies have no such condition and have to underwrite the risk at outset. Most offices treat unemployment as a change of occupation.

Model answer for Question 7

Any six of the following:

- Policy conditions should explain how funds are managed.
- Where discretion is exercised, the primary requirement is treating customers fairly.
- Unit prices should be calculated in a fair and transparent manner.
- Transactions should be processed in a fair and transparent manner.
- The pricing basis of the fund must be kept under regular review to protect continuing policyholders.
- Rounding should be kept to a minimum, should not normally exceed 0.5% of the unit price, should be neutral and should be used as a way of levying a charge.
- All charges should be clearly defined and disclosed to policyholders.
- Errors should be quickly identified and rectified. Compensation should normally be paid where a unit pricing error is 0.5% or greater.
- Significant or persistent pricing errors should be reported to the Financial Conduct Authority.

Model answer for Question 8

It is possible to program the protocols required to assess life and health insurance proposals into a rules-based software system. Systems are available to buy from specialist providers and reinsurers while some companies have developed their own. The system can be deployed at the point of sale to provide immediate acceptance or may be used later in the underwriting process. It enables fast and consistent processing of disclosures and can be used to drive drill-down questioning within tele-interview and tele-underwriting processes.

Traditionally the answers to proposal questions are reviewed manually by an underwriter. A rules-based system allows the responses to be processed automatically once the rules have been set by the underwriters to enable standard proposals to be assessed with no human intervention or additional evidence. Systems can also be programmed to prompt for additional evidence and suggest ratings, referral to underwriters or even to postpone or decline proposals.

The rules will be regularly reviewed and updated considering any medical developments and ensuring increased accuracy of underwriting.

Model answer for Question 9

Self-employed people include both sole traders and partnerships. They will pay income tax through the self-assessment system, Class 2 and Class 4 National Insurance, and VAT if they reach the registration threshold.

The self-employed pay tax on business profits and other income. In order to consider an income protection claim, the assessor will need to establish the net profit of the business for the twelve-month period prior to incapacity. The usual evidence for this is: self-assessment tax return and calculation if provided by Her Majesty's Revenue and Customs (HMRC); any additional forms to go with the tax return which are known as schedules; profit and loss accounts.

The financial circumstances of a sole trader or partnership are private and not publicly disclosable except to HMRC. Most keep annual accounts to help with their HMRC self-assessment return. All businesses are required to keep relevant records and documents to support the financial information they submit to HMRC, but it is not essential for a formal set of accounts to be kept for taxation purposes. From the self-assessment return, the tax is calculated on the profits arising in the tax year itself. If the accounting period is different from the tax year, then the tax will be calculated on the profit arising in the twelve-month accounting period ending in the tax year

A profit and loss account is a summary of business transactions for a given period – normally twelve months. The profit and loss accounts form part of what is referred to as the company accounts, which also contain the balance sheet, the auditor's report, the director's report and notes to the accounts.

If the business is a limited company or a partnership whose members are limited companies, they are legally required to produce profit and loss accounts. Self-employed sole traders or partnerships that are not limited do not have to produce these, but they do have to keep accounting records and there are key benefits to keeping formal accounts.

In the case of a self-employed person, drawings are withdrawals and are represented by capital invested and profit accumulated from previous years. There is no restriction on the amount that can be withdrawn other than the limit placed by available resources and the requirements of the business and some capital accounts do become 'overdrawn'. If there is a partnership agreement, the division of profits will be documented in this.

Drawings should never appear in a profit and loss account as they are not expenditure incurred in carrying out the trade. They should in no circumstances be used to establish the pre-incapacity earnings for a self-employed person for IP.

A letter from the accountant may be submitted as evidence when making an IP claim, usually when the accounts and/or self-assessment form have not yet been completed. It is not generally acceptable as evidence as it is usually based on information the claimant has given the accountant rather than because of a thorough review of the accounts.

A claimant may advise that the net profit has been affected as a result of their medical condition. If this can be supported by medical evidence then a reasonable approach should be taken, for example to use the average net profit figure over a maximum of three years.

Model answer for Question 10

Qualifying life assurance policies

Under qualifying policies, the beneficiary pays no income tax on the proceeds when the policy matures. The insurance fund into which the policy is invested has paid tax, but this tax cannot be reclaimed by the beneficiary.

Qualifying policies must fulfil the following main criteria: the policy term is at least ten years; premiums are paid annually or more frequently, and paid for ten years or until death; life assurance must be included in the policy equivalent to 75% of the total premiums paid; and where the policy includes critical illness, payments on this part of the cover must bring the policy to an end and there cannot be a payment on a subsequent death or maturity.

Non-qualifying life assurance policies

Non-qualifying policies also apply to surrenders within ten years, or three-quarters of the term if earlier, and if the policy is made paid-up within that time.

The proceeds on non-qualifying policies are subject to basic rate income tax, which the insurer pays to Her Majesty's Revenue and Customs and then pays the net proceeds to the beneficiary. If the beneficiary is a higher rate taxpayer, further income tax must be paid by them by declaring this on their self-assessment form.

However, policyholders can withdraw up to 5% of the amount invested in a non-qualifying policy in each year before the policy matures, without immediately attracting higher rate tax. These withdrawals can take place for a maximum of 20 years. Then any tax due is deferred until the year the policy is cashed in or matures.

Model answer for Question 11

(a) Under an interest in possession trust, the trustee must pass all of the income received from the trust assets, less any expenses, to the beneficiary. The beneficiary may not have any rights over the capital held in the trust. The capital may eventually pass to a different beneficiary or beneficiaries in the future. The trust deed will specify the beneficiaries' entitlement. This arrangement often arises from a will where an individual leaves shares in a trust from which the share dividends can be paid to their surviving spouse. Then on the death of the spouse, the trust will transfer ownership of the shares themselves to the surviving children.

(b) Bare trusts or simple trusts are where the beneficiary has an immediate and absolute right to both the capital and income held in the trust. So, the assets and any interest earned will go directly to the beneficiaries named in the trust deed. Once the trust has been set up, the beneficiaries cannot be changed. Bare trusts are commonly used to transfer assets to children. Trustees hold the assets on trust until the beneficiary is aged 18 in England and Wales, or aged 16 in Scotland.

(c) A mixed trust is one where the income is taxable on more than one basis. This may be because there are distinct different parts to the trust fund from the start so that the income is always held in different trusts.

(d) A settlor-interested trust is the term used when the settlor or their spouse or civil partner benefit from income from assets held in a trust. This can occur under interest in possession trusts, accumulation trusts, or discretionary trusts.

Model answer for Question 12

A general principle of insurance is that the proposer must disclose all material facts known by them to the insurer.

The Marine Insurance Act 1906 states that 'every circumstance is material which would influence the judgement of a prudent insurer in fixing the premium or determining whether he will take the risk.'

The duty of 'utmost good faith' has applied since the 1906 Act. The duty is to disclose voluntarily, and the proposer cannot withhold a material fact because no specific question was asked on that point in the proposal or medical examination.

The duty of utmost good faith still applies to commercial insurance contracts. However, on 6 April 2013 this duty ceased to apply to consumer insurance with the enablement of the Consumer Insurance (Disclosure and Representations) Act 2012. This new law applies to long-term insurance taken out by individual consumers as well as group policies taken out for the benefit of individual consumers.

Under the 2012 Act, it is the duty of the consumer to take reasonable care not to make a misrepresentation to the insurer before the contract is entered into or varied. However, the consumer will now only have to answer questions asked by the insurer rather than being obliged to disclose all material facts. Despite the provisions of the Marine Insurance Act 1906, the insurance industry had already largely adopted the principles of the Consumer Insurance (Disclosure and Representations) Act 2012 for a number of years. So, the new Act brought the law into line with existing life insurance practice.

The case of *Simmer v New India Assurance Co. Ltd* (1994) made it clear that the duty of disclosure is confined to matters within the proposer's actual or presumed knowledge and does not require the proposer to make enquiries as to matters outside this knowledge.

There is no duty to disclose:
facts which the insurer already knows; facts which the insurer ought to know; facts about which the insurer waives information; facts possible of discovery, where enough information has been given to provoke enquiry by the insurer; and facts which lessen the risk.

The duty of disclosure also applies in reverse, in that insurers must disclose all material facts about the insurance to the proposer. For life policies, this will be achieved by the Financial Conduct Authority disclosure rules.

Model answer for Question 13

Any six of the following:

- Increase in the sum assured.
- Decrease in the sum assured.
- Conversion of the policy.
- Increasing the period covered by the policy.
- Reducing the period covered by the policy.
- Addition of life assured.
- Removal of life assured from a joint policy.
- Fund switch on a unit-linked policy to improve investment prospects.
- Change due to guaranteed insurability options.
- Change of premium frequency.

Model answer for Question 14

The Data Protection Act 1998 (DPA) obliges organisations to protect the information they hold about individuals. The DPA applies to any organisation that processes personal information, e.g. businesses, hospitals and local authorities. It does of course significantly affect the operations of insurance businesses, which are subject to constraints in obtaining and holding data from or about their customers, including medical information.

Any organisation that holds data about individuals must register as a data controller with the UK's Information Commissioner's Office (ICO). The ICO keeps a register of all data controllers and this is available to the public.

Data controllers must make sure that security controls are in place and are followed. For example, firewalls and backup arrangements need to be in place and unique user names, passwords for employees will be used. The same applies where customers use a company's website to access information or services personal to them. Only employees who need to use personal data to carry out their work should have access to that data; e.g. employees working in an insurer's marketing department should not have access to a customer's claims data.

There are more strict conditions about how sensitive personal data is used (includes someone's racial or ethnic origin, political opinions, religious beliefs, health, sexuality, or criminal proceedings/convictions). It may go so far as the insurer restricting computer access to certain files or even making sure its employees lock paper files away to avoid any risk of personnel getting access to such data. Insurers may regularly refresh and test their employees' DPA knowledge.

Insurance businesses must notify their customers who the data controller is, why the data is being processed and what the data will be used for. So, for example, customer details used to underwrite a new application for insurance must not be used for marketing purposes without the data subject's permission. Insurance companies typically include wordings on their websites, application forms and claim forms to explain the customer's rights under the Act, what their data will be used for and to obtain a signature or other indication of the customer's agreement for how they want to use the data. For sensitive data, specific permission for its use must be obtained from the data subject.

The Act provides rules as to how long the data can be kept for. Insurers can retain records for the duration of their relationship with the customer, but they must destroy records within a specified period once that relationship has ended. Therefore, the duration will differ between a long-term insurance contract, which is in force over many years and a declined application for insurance where no policy is put into force.

Fines or even imprisonment may be imposed under the Act for giving out personal information without permission. The Financial Conduct Authority also has powers to penalise firms that breach data security. Over the last few years of firms have been fined where employees for example have accidentally left laptops holding customer data in accessible places.

Model answer for Question 15

(a) Group life cover

Group schemes offer a free cover limit. This is the amount of cover each individual in the scheme can have before medical evidence is required.

The free cover limit is usually calculated as a fixed amount of cover multiplied by the number of scheme members, therefore the larger the scheme the higher the free cover limit. For large group schemes very little underwriting is likely to be required as the free cover limit is quite high. Generally, the smaller the scheme the higher the likelihood of underwriting individual lives being required.

If an individual has cover which exceeds the free cover limit, medical information would be required and the office would determine whether the individual is accepted at standard rates, if an individual has a pre-existing condition, the office can increase the individual's premiums or add a policy exclusion. It is important to note that any extra premium charged only applies to amounts of cover which exceed the free cover limit.

Individual protection

Most proposers for life assurance in the UK are accepted at the standard rate of premiums and are usually underwritten based only on the information disclosed on the proposal form.

If the sum assured requested by the proposer exceeds the routine medical evidence limits, set by the office, additional medical and non-medical evidence will be obtained. Medical evidence will also be obtained when a disclosure requires further clarification.

A proposer who cannot be accepted at the standard premium rate may be charged an extra premium (loading). The loading adjusts the standard premium to reflect the increased risk that individual presents.

(b) Group life cover

Premiums paid by the employer to insure group life benefits for employees are allowable as a deduction against income for corporation tax purposes where they are 'wholly and exclusively' for the purposes of the trade or business concerned. Her Majesty's Revenue and Customs (HMRC) does not normally allow premiums paid for any employees with a proprietorial interest in the company to be treated as a business expense.

Premiums paid by the employer are not regarded as a benefit in kind for members.

Group life benefits, whether a lump sum or death-in-service pension, payable in accordance with the provisions of a discretionary trust do not form part of the deceased member's estate and are normally free of inheritance tax.

Under a registered scheme, lump sum benefits are usually tax free if, when combined with all other payments made from registered arrangements both past and current, the amount is within the member's lifetime allowance applicable at the date of death. Some employers may set a maximum amount of lump sum under their registered scheme. This may be related to the lifetime allowance for pensions – possibly 100% of the lifetime allowance or a lesser percentage.

The lifetime allowance is the limit on the value of retirement benefits that can be drawn from registered pension schemes before tax penalties apply. Some individuals may have elected for enhanced, primary or fixed protection in which case different limits can apply.

Beneficiaries of lump sum benefits are liable for any lifetime allowance charge – in proportion to their share of the overall benefits paid on the member's death. The personal representatives of the member are responsible for ascertaining whether there is a chargeable amount.

Individual protection

These days, the premiums individuals pay for long-term business do not attract any tax relief. However, many insurers will have customers with in-force policies that were taken out before March 1984. If they were qualifying life assurance policies, they attracted life assurance premium relief that allowed the premium-payer tax relief on the premiums.

The tax relief was abolished from 6 April 2015. Until then, the relief was 12.5% and capped to premiums up to £1,500 or $1/6^{th}$ of total income, whichever is the greater.

(c) Group life cover

Originally, group life cover was written through group pension schemes. The limits on the benefits that can be provided under registered pension schemes and receive beneficial tax treatment, including death-in-service benefits, have been set and amended over time by HMRC and its predecessors as far back as the 1920s. Nowadays, some lump sum death benefit policies are written on what is called an excepted basis outside the pensions rules.

Sometimes, there can be different benefit levels for different categories of members – such as directors, managers and members who are staff. The policy is held under a trust with discretionary powers for the trustees.

The trustees have a liability to provide the benefits set out in the scheme rules. They take out a policy to insure that liability. If a member dies, the insurer pays the benefit to the trustees who have absolute discretion to whom the lump sum benefits are paid but must consider the deceased member's wishes. These have usually been set out in an 'expression of wish form'.

The legislation governing the taxation of registered occupational pension schemes is contained in the Finance Act 2004. The definition of a registered occupational pension scheme includes arrangements set up to provide benefits on death in service only.

Individual protection

The level of cover under an individual life policy is determined by the proposer, however if the sum assured requested by the proposer exceeds the routine evidence limits set by the assurer, additional medical and non-medical evidence will be obtained.

Model answer for Question 16

(a) The basic principle of spreading the risk is common to all types of insurance. Reassurance is merely an extension of the concept whereby the individual risks underwritten by one insurer are further spread by having a small part of each transferred to another insurer, the reassurer. The main difference being that a reassurance contract between the two insurers does not directly involve the original policyholder, who will not normally be aware of the arrangement.

If the reassurer were for any reason fail to meet its obligations, the original insurer would still be liable for the whole of the risk to the policyholder. The rules made under the Financial Service and Markets Act (FSMA) 2000 relating to the selling and marketing of life policies do not apply to reassurance arrangements, although the prudential regulations do.

The need for reassurance on life policies arises, because calculations based upon the mortality risk may not, on their own be sufficient to guarantee a profit. Other factors which may have a bearing include, for example, the size of reserves held by the life office against the actual sums payable as death claims. Under the level premium system, the reserve is built up over many years and the real cost of a claim to the life office is the sum assured less this reserve. This may however be quite small in the early years of the policy and the difference between these two figures is known as the death strain on the life fund.

Each life office will have its own limits as to the maximum amount of cover it wishes to hold on any one life and this is known as its retention limit. To accept a sum assured above this limit the office will need reassurance because, although mortality tables allow a reasonably accurate forecast to be made as to the number of claims, they cannot tell the office which particular policies will be involved.

Since early claims might be in respect of policies with the highest sums assured this could adversely affect the results for that year.

Quota share reinsurance is a type of reinsurance whereby the principal office offers reinsurers a fixed percentage of every policy in a particular class of business. For every policy covered by this agreement the reinsurer will receive a fixed percentage of the premium and be liable for that percentage of the sum assured. The split is negotiated between the principal office and the reinsurer but could be as much as 90% reinsurer and 10% principal. This type of reinsurance is a highly effective way of reducing new business strain.

Under a reinsurance treaty the element of discretion is removed. With a fully automatic treaty all amounts over the retention limit of the principal office up to a specified maximum figure must be agreed by the reinsurer. Any excess over the treaty's maximum limit would have to be reinsured facultatively.

(b) When negotiating with the ceding office a reassurer will want to be satisfied with the office's experience and premium rates, if original term assurance is to be used, and be sure that its staff and underwriters have the appropriate skills to accept business on a sound basis. A reassurer will not normally be in a position to assess a risk for itself before acceptance, because the majority of business will be received under the terms of a treaty, binding it to accept in advance, all risks falling within its terms. Difficulties can sometimes be caused with original terms reassurance in the case of with-profits policies as the reassurer is effectively taking on a potential indeterminate liability over which it has no control.

In the case of a life office which has less experience of the market for a particular business, the reassurer may request to see all substandard risks itself before deciding on the acceptance terms that will bind them both. This approach can be useful in helping the new office gain experience through contact with the reassurer's own underwriters, who will have a considerable body of knowledge about substandard risks accumulated over many years. In addition, the reassurer's chief medical officer will usually be a senior practitioner, with wide experience of various medical disciplines and who can sometimes suggest better acceptance terms for a substandard life than the ceding office might be willing to offer on its own.

A reassurer will also want to be confident that the ceding office's administrative staff are properly trained to deal with any changes to existing polices, as well as in the handling of negotiating of claims, so that its interests are not prejudiced. There may be an agreement to refer certain alterations or claims to the reassurer before a decision about acceptance is made.

If there is a reassurance contract in place the ownership of the original contract remains with the ceding office who still need to meet the obligations to the policyholder even if the reassurer fails to meet its obligations.

Model answer for Question 17

(a) Own occupation

A claim is paid where the insured is totally and permanently unable due to illness or injury to perform their own occupation, which usually means the job role they were doing immediately before onset of disability. It normally relates to the job role, rather than the specific employer or organisation where they worked. For example, a clerical worker may have been a civil servant, but their role would apply equally well to an equivalent administrative role for a private sector company. If they could do no such role their claim would be paid.

Suited occupation

This is a more difficult test to meet than own occupation as it means that if the claimant is unable due to disability to do their own previous occupation, but they can still do another occupation by using existing transferrable skills, then they would not be entitled to receive a claim payment.

Any occupation

The insurer will only pay a claim if the claimant can perform no occupation whatsoever as a result of permanent illness or injury. However, insurers are expected to treat customers fairly. In other words, it would be unreasonable to expect a claimant who has limited qualifications and who has only ever performed manual labour to be able to adapt to certain office jobs.

Activities of daily living, activities of daily working or functional ability tests

For this definition the policy will specify typically six activities. If the claimant is permanently unable to perform three or more of the activities due to their disability their claim will be paid.

(b) The assessment of total and permanent disability (TPD) can be lengthy and contentious. TPD definitions do not specify what illness or injury you need to have in order to claim. Therefore, the claims assessor may be faced with claims from insured individuals with a wide range of symptoms and conditions.

Where injuries are clear or there is a clearly diagnosed disabling physical or mental illness an assessment is fairly straightforward, for example industrial injuries.

The assessor will obtain reports from the claimant's general practitioner and specialist, which should give clear details of the extent of the disability, the treatment received, and the extent of any predicted recovery. The assessor may also obtain a job description or other information from the claimant's employer, if they had one. Employers may be able to provide any reports that exist detailing occupational health assessments, or that justify retirement on health grounds. The assessor will often be able to accept a claim where this mix of evidence supports the policy definition.

However, many claims for TPD are more subjective as conditions, such as chronic fatigue syndrome, and fibromyalgia can be difficult to diagnose and measure objectively. Often patients are given such diagnoses by exclusion. In other words, they have undergone a range of medical tests to investigate possible causes, but results have not revealed anything conclusive, meaning other possible medical conditions have thereby been ruled out. Therefore, a diagnosis may be reached by taking account of the symptom reporting and demeanour of the patient, and after having ruled out other illnesses. While it is the claimant's duty to demonstrate that they have a valid claim, the difficulty for the assessor in these cases is to establish satisfactory objective evidence that the claimant's symptoms are totally disabling and will be so permanently for the rest of their life.

Often such patients complain of a range of concurrent symptoms, such as pain, fatigue, depression, headaches and irritable bowel syndrome. Patients tend to visit their doctor frequently and will have been recommended a range of medical assistance options, including mobility aids, home assistance and medical treatment options. These might include several types of medication to treat individual symptoms and therapies such as pain management and cognitive behavioural therapy (CBT). Often such patients have difficulty in undertaking treatment courses due to mobility problems, fatigue and, sometimes, mental ability to cope. Furthermore, there may be a limited availability of treatment locally for CBT or pain management on the National Health Service. Some patients can and do get better, but it can take months or years in some cases to do so.

The assessor will need to be satisfied that all reasonable treatment options have been exhausted and that there is no prospect of a recovery before they can accept a TPD claim. Such claims can therefore take some months or even years to be concluded if there are ongoing treatment options. This can be understandably frustrating for the claimant and so the assessor will need considerable judgment skills to identify the claims that can be identified as valid straightaway, and those that may take longer before a decision can be reached.