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**Term Insurance in Australia
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1. Abstract

This paper summarises the features of term insurance products on sale in the Australian market at 31 August 2003. The wide variations between the available products ensures that almost every attempted generalisation will have exceptions, sometimes including some extreme outliers.

2. Historical Background

One of the first products encountered by students of contingent payments is the “traditional” term insurance. The product has a level sum insured, a level premium and a fixed term. If the insured life dies during the term of the policy the sum insured is paid. If the insured life survives the term of the policy, the policy ceases with no benefit being paid. If the policy owner decides to discontinue the policy before the end of the term, it lapses without any benefit being paid.

While the above product is still useful as a simple introductory problem in the valuation of contingent payments, it is no longer sold in the Australia market.

In the early 1980s, insurers began selling term insurance in a new form, then usually referred to as Yearly Renewable Term Insurance (YRT), though the name Annual Renewable Term Insurance (ART) was also used.

Some insurers may still have some traditional term insurance policies amongst their in-force business. Statistics published by APRA do not separate traditional term insurance from YRT, so the mix cannot be easily quantified. However, informal comments from practitioners suggest that the traditional term insurance is no longer a significant component of the in-force business.

The traditional term insurance is now seldom mentioned, other than in introductory courses in contingent payments. As a result of this the modern YRT product is now usually just referred to as “term insurance” and the label “YRT” is falling into disuse. This paper will conform with this change in terminology and simply refer to the product currently being sold as term insurance. However, in any situations where there is a need to distinguish between the old “traditional” form of term insurance and the current “YRT” form, the latter will be called “modern” term insurance.

When a product with significantly new features is introduced to the Australian life insurance market, it is common for papers to appear in the Australian actuarial literature summarising the features of the product, perhaps listing any unusual risks inherent in selling the product and discussing methods of valuing the risks.

Curiously, modern term insurance business slipped into the Australian market without a mention in the actuarial literature.

This is unfortunate. Several product features have been added, removed and amended since the early 1980s. While this paper is principally concerned with summarising the product as it is sold in Australia today, where possible it also attempts to document significant design changes which have occurred to the product in the last two decades. Unfortunately, since there was no paper summarising the state of the product in the early 1980s, the discussion of design changes tends to be based more on memory than on documentary evidence. In particular, while discussions with colleagues usually resulted in agreement as to whether particular product features were in use in the 1980s, we had difficulty determining whether they should be described as the common or uncommon practice at that time. Hence the reader is warned in advance that the discussion of design changes will be somewhat vague in places.

3. A note on referencing

The major source documents for this paper are term insurance Customer Information Brochures (CIBs) on issue at 31 August 2003. The standard academic referencing technique (author and year of publication) is not very useful here, since the CIBs do not identify an author and they all have years of publication of 2002 or 2003. Instead, these documents will be identified by the insurer's name followed by the initials CIB, with the document's title also being included if the insurer had more than one term insurance CIB. The full list of CIBs used appears in the bibliography.

It is common to find that CIBs from competing insurers will contain identical or almost identical content on some issues. This may occur for several reasons. Where legal challenges expose ambiguities or loopholes in policy wording, these are adjusted and the adjustments flow back to the CIBs. Since all insurers monitor and adjust for the same body of legal cases, convergent evolution may occur, and CIB wordings from different insurers can become very similar. In some cases insurers may cooperate through industry bodies and deliberately adopt a common wording to assist customer understanding and hopefully provide a consistent treatment to customers. Some wordings are mandated or suggested by ASIC or its predecessors. Also, writing a CIB from scratch is a lengthy process, so there may be cases where insurers have speed up the process by copying sections from their Australian competitors' CIBs or from comparable overseas documents.

Where I quote a wording that appears in identical or virtually identical form in several different insurers' CIBs I will usually not identify the sources. To list all the companies involved would be tiresome. To list only one might incorrectly be taken as implying that I regarded that particular insurer as the inventor of the wording, where I have definitely not carried out the lengthy historical research that would be required to determine the original author. Where unusual or original wordings are quoted, the source will be cited.

4. The insurers

In late July 2003 the APRA web site contained a list of the 40 registered life insurance companies as at 10 July 2003.

Of these 40 insurers, 6 are reinsurers. The remaining 34 companies include several cases where, due to mergers or restructures, two or more life insurance companies are now effectively in the same group and only one of those companies involved is still writing new business. There are also two companies closed to new business for other reasons. This leaves 25 distinct direct life insurance groups selling new business.

Of these 25 groups, 5 do not sell term insurance. These 5 concentrate their effort on investment only products, and most do not sell any risk products, other than perhaps life annuities.

Attempts were made to obtain CIBs for term insurance from the remaining 20 insurers. In six of these cases the attempts were unsuccessful. The six cases tended to be smaller insurers. Perhaps the difficulties encountered when attempting to obtain CIBs contribute to their smallness.

This paper is based on CIBs obtained for the other 14 registered life insurance companies. They are listed in section 6.

The APRA web site also contains a list of 35 friendly societies as at 22 July 2003. On average, friendly societies are considerably smaller than life insurance companies. Hence, given the task of summarising the common features of term insurance, it is not immediately clear whether it is worth the effort required to obtain CIBs for term insurance from friendly societies.

As a quick and admittedly unscientific investigation, I carried out web searches for the friendly societies whose names were most familiar to me, hopefully the most significant friendly societies. This provided a probably biased sample of seven friendly societies. According to their web sites, only one of these friendly societies sold term insurance. An attempt to obtain the CIB from the relevant friendly society was not successful. At this point I decided to not expend further effort on friendly societies, so this paper is based solely on data from life insurance companies.

5. Contents of CIBs

The required content of Customer Information Brochures was specified by ISC Circular G.I.1 issued in February 1996. Responsibility for the content of CIBs subsequently passed to ASIC and this circular can now be obtained from the ASIC web site.

The Financial Services Reform Act 2001 implemented new requirements for disclosure which require life insurers to issue Product Disclosure Statements rather than CIBs. The Act allowed insurers time to implement the new requirements. In this investigation the term insurance disclosure documents collected from insurers were all CIBs. In many cases these CIBs will be the last the insurer issues before switching to the new Product Disclosure Statement structure.

Most CIBs collected contained errors. These included typographical errors which should have been detected by a spell-checker, defective or ambiguous grammar and contradictions between various parts of the document.

Some attempts were made to clarify the ambiguities and contradictions in CIBs by phoning the inquiry numbers listed in CIBs and/or on the insurers' web sites. Such attempts typically involve waiting in a queue to speak to customer inquiry staff, followed by a considerably longer wait while that person attempted to find the answer from a more senior staff member. Often the result was that the representative could only advise that they would ring back later when they found the answer, and usually they were never heard from again. Due to time constraints, the large number of ambiguities and contradictions found and the low success rate in resolving them, I had to take the decision to abandon attempts to clarify ambiguities and contradictions in CIBs.

6. The products and varieties

Term insurance products may allow the customer to add different options to the basic death cover, an extra premium being charged for each option. Two such options are TPD cover, which pays a benefit if the insured become Totally and Permanently Disabled, and trauma cover which provides a benefit on the occurrence of specified serious unpleasant medical events such as stroke or kidney failure. Products may also contain extra benefits which are included automatically "at no extra cost", meaning the cost has been included in the basic premium. Options and automatic extra benefits will be discussed in far more detail later; TPD and trauma cover have been briefly introduced now to assist in explaining other concepts in this section.

The label "product" is subjective. The product design team may build what they regard as a single coherent product containing a few different options, only to find that the marketing team writing the CIBs splits the product into two or three different products for ease of explanation or for purposes of market segmentation. The product design team may think of these as varieties with the product rather than distinct products. The computing team trying to make the product fit into the constraints of the existing administration system may find that the marketing team's products need to split into an even finer subdivision of products, perhaps regarding every optional extra that has its own premium scale as a product. Then the actuary responsible for assessing adequacy of premium rates may consider every different combination of the basic term insurance and optional extras that a customer can possibly buy as a product.

Rather than wrestle with problem of precisely defining what a product is, it is probably more productive (sorry) to indicate that my general approach matches that of the product design team mentioned above, and to allow the reader to develop a clearer understanding of my intended meanings of the words "product" and "variety" from their usage in the next few paragraphs.

Term insurance products clearly fall into two broad categories: no-frills and full-featured.

Full-featured products usually have a large range of options and automatic extra benefits. CIBs typically exceed 20 pages. Application forms include detailed health questionnaires. They are often available in both ordinary and superannuation forms.

No-frills products are designed to be simple to understand. The large range of options and automatic extra benefits does not occur. Some have no options at all, but where options do occur they are usually limited to TPD cover and Trauma cover. CIBs are quite short, perhaps less than 5 pages. The application form is also short with very few health questions, meaning that underwriting may be less precise. All the no-frills products encountered were only available in ordinary form, not as superannuation.

While the above descriptions may appear a little vague, in practice the gap between no-frills products and full-featured products is large and there was never any doubt as to which category a particular product should be assigned.

Of the 14 insurers involved in this investigation, 2 offered only no-frills products, 3 offered both a no-frills product and a full-featured product and 9 offered only a full-featured product, giving a total of 17 products.

For ease of explanation, some insurers subdivide their full-featured product into 2 or 3 varieties. Each variety has its own marketing name. The CIB will contain a completely separate description of each variety. The varieties may even be presented in completely separate CIBs.

The most common dividing lines for varieties are whether the policy is ordinary or superannuation and whether trauma insurance can be added. Due to restrictions in the Superannuation Industry (Supervision) Act 1993, trauma insurance cannot be written in superannuation form.

Most full-featured products adopt one of the following four structures.

- A single variety available in both ordinary and superannuation form, with a trauma cover option for ordinary policies. (e.g. AMP's "Firstcare Insurance.")
- An ordinary variety which can contain trauma cover as an option and a superannuation variety which cannot. (e.g. Colonial's "Total Care Plan" and "Total Care Plan Super.")
- A variety without trauma cover, available in both ordinary and superannuation form, and an ordinary variety where trauma cover is compulsory. (e.g. Asteron's "Term Life Insurance" and "Recovery Insurance.")
- An ordinary variety without trauma cover, an ordinary version with compulsory trauma cover, and a superannuation variety without trauma cover. (e.g. Citicorp's "Term Life Insurance", "Life Care Trauma Insurance" and "Term Life under Super.")

(The only exceptions were three full featured products which were not available in superannuation form at all. All these products had only a single variety with trauma cover available as an option.)

As can be seen from the next table, there is no clear consensus amongst insurers as to which of the above structures is best. Arguments can be made for each approach.

For example the first approach tends to result in a CIB which continually says things like "If you are purchasing the ordinary form then ... while if you are purchasing the superannuation form then ..." The reader who knows which option they want is continually having to skip over irrelevant sections, giving a disjointed effect. Similarly the reader not wanting trauma cover may be distracted by many scattered sections describing how that benefit interacts with other benefits.

Under the last approach the customers who know which variety they want can simply read the description for that variety, giving a much more coherent description. However, the customers who doesn't know which variety they want may find themselves flipping back and forth between the two descriptions trying to find where they differ. Also, some sections will be repeated in the descriptions of several of the varieties, so the total length of the document(s) is increased, adding to printing costs.

If the different varieties are presented in separate CIBs, each has its own application form tailored specifically to that variety. This makes the application simpler to complete. If the insurer's data

entry system correctly matches the format of each separate application form, data entry errors should be reduced. By contrast, if there is a single CIB and application form covering several varieties, many parts of the application become irrelevant to different varieties. As soon as customers have to make choices about which sections to complete, error rates tend to increase, no matter how well the instructions are written.

In this researcher's opinion, it is definitely worth splitting ordinary and superannuation into separate varieties and it is probably best to present the two varieties in two completely separate CIBs with application forms designed solely for that variety. CIBs which tried to present ordinary and superannuation forms within a single variety with a single application form tended to not cope well with the different terminology that can apply to the two forms. In particular, at times it was unclear which party was being addressed. By contrast, where two separate CIBs were used it was clear that the ordinary CIB was principally addressing the policy owner, who might also but need not be an insured life, while the superannuation version was addressing the insured life, who was definitely not the policy owner. (These roles are discussed in more detail later under the heading "The cast".)

That is, I would favour the 2nd or 4th of the approaches listed above, and have no preference between these two approaches.

Insurers offering term insurance usually also offer a "stand alone" trauma insurance policy. That is, the policy provides a benefit on satisfying the trauma conditions but not on death. The insurer is not suggesting that it is sensible to purchase trauma cover with no death cover. The most common purpose of the stand alone trauma cover is to allow a customer to purchase a superannuation term insurance covering death and a matching ordinary stand alone trauma cover. That is, they obtain the same benefits as they would from purchasing an ordinary term insurance with trauma cover, but purchasing the death cover in superannuation form may have more favourable tax treatment.

This investigation has not collected CIBs for stand alone Trauma cover. However, due to the way some companies have structured their products, it does include some varieties which are effectively trauma cover with optional death cover. While such varieties can be purchased as stand alone trauma cover, for comparability with the other products in this investigation such varieties will always be described assuming that they have been purchased with the optional death cover.

This investigation was intended to cover individual contracts rather than group products, but an exception was made for "MemberCare Life Insurance", a no-frills product from Cuna Mutual. Under this product a credit union purchases a group policy from Cuna and then markets it to its customers. This is a group policy. However, the distribution method more closely resembles the "badged" individual contracts which some insurers sell through building societies rather than the typical group policy sold to the trustee of a superannuation plan to cover its members. Also, given the difficulties encountered in obtaining CIBs from several insurers, I was disinclined to ignore a product from any insurer which did supply a CIB promptly.

Some insurers, particularly those associated with banks, also sell term insurance products specifically tailored to cover the outstanding loan under a home mortgage. These products have not been included in this investigation.

The following table summarises the products and varieties included in this investigation. Variety names are preceded by a dot and separated by dashed lines. Where the insurer has split a full-featured product into varieties, there usually isn't a collective marketing name for the product. Only the varieties are named. The bibliography includes a listing of the related CIBs.

There are 17 distinct products, 5 no-frills and 12 full-featured. Some of the full-featured products exist in only 1 variety, but some are split into 2 or 3 varieties, giving a total of 27 distinct varieties to consider. Much of the discussion in this paper will concentrate on the 17 products rather than the 27 varieties, since in most respects other than the major feature distinguishing between the varieties – such as one variety being ordinary and another superannuation – the varieties of a particular product are essentially identical.

Where the commonly used name of the financial group which owns the insurer is not obvious from the insurer's name, the former is shown in brackets. In some cases, the name of the holding company and the commonly used marketing name of the group were changed following a takeover or merger, yet strangely the registered name of the life insurance subsidiary has never been adjusted.

Insurer [Group]	No-frills or full-featured	Product, or • Variety	Ordinary or Super-annuation	Trauma cover availability
American International Assurance Co. (Australia) Ltd	Full	Term Life Plan	Ordinary	Option
AMP Life Limited	No-frills	Firstcare Term Life Insurance	Ordinary	Not available
	Full	Firstcare Insurance	Either	Option (if ordinary)
Asteron Life Limited	Full	• Term Life Insurance	Either	Not available
		• Recovery Insurance	Ordinary	Automatic
Citicorp Life Insurance Limited	No-frills	LifeTime Insurance	Ordinary	Option
	Full	• Term Life Insurance	Ordinary	Not available
		• LifeCare Trauma Insurance	Ordinary	Automatic
		• Term Life (under super)	Super	Not available
The Colonial Mutual Life Assurance Society Limited [Commonwealth/Colonial]	Full	• Total Care Plan	Ordinary	Option
		• Total Care Plan Super	Super	Not available
Cuna Mutual Life Australia Limited	No-frills	MemberCare Life Insurance	Ordinary	Not available
HCF Life Insurance Company Pty Limited	No-frills	HCF Life	Ordinary	Option
ING Life Limited	Full	• Leading Life	Either	Option (if ordinary)
		• Recovery Cash	Ordinary	Automatic.
Lumley Life Limited	Full	• Life Insurance Cover	Either	Not available
		• Medical Catastrophe Insurance Cover	Ordinary	Option
		• Critical Illness Insurance	Ordinary	Option
MLC Limited [National]	Full	• Life Cover	Ordinary	Option
		• Life Cover Super	Super	Not available
The National Mutual Life Association of Australasia Limited [AXA]	Full	• Life Protection Plan	Ordinary	Not available
		• Superannuation Life Protection Plan	Super	Not available
		• Trauma Deluxe Plan	Ordinary	Automatic
NRMA Life Limited	No-frills	EasyLife Insurance	Ordinary	Not available
	Full	Term Life Insurance	Ordinary	Option
St George Life Limited	Full	Protection Choices	Ordinary	Option
Westpac Life Insurance Services Limited	Full	Westpac Term Life	Either	Option (if ordinary)

7. The basics of term insurance

7.1 Cash flows

The policy owner pays regular premiums throughout the life of the policy. On the death of the insured life, the insurer pays a death benefit equal to the sum insured and the policy ceases. Both the premium and sum insured may vary in complex ways described in section 11, but for the moment it will be safe to think about the simplest scenario where the sum insured is constant, and the premium changes each year to reflect the risk of the insured life dying in that year.

7.2 Yearly renewable

The policy was originally called “yearly renewable” because, shortly before each policy anniversary, the insurer advises the policy owner of the premium and sum insured for the next policy year and the policy owner decides whether she wishes to renew the policy for that year. This will occur each year until either:

- (a) the insured life has died and a death benefit has been paid;
- (b) the policy owner elects not to renew, in which case the policy ceases with no benefit being paid; or
- (c) the insured life reaches the “expiry age” or “expiry date”, in which case the insurer does not offer to renew the policy, and it ceases without any benefit being paid.

Most insurers offer expiry ages sufficiently high that (c) is unlikely to happen.

If premiums are paid monthly, the policy owner may also discontinue the policy during the policy year simply by not paying the monthly premium. Hence the label “yearly renewable” is somewhat misleading and it is probably a good thing that term is now seldom used.

7.3 Guaranteed renewable

Term insurance is written as a “guaranteed renewable” contract. This means:

- The policy owner is under no obligation to renew the contract.
- The insurer only underwrites the policy once, at the outset. If the insurer accepts the policy at the standard premium, it must continue to offer to renew the policy each year for as long as the customer wants it (subject to a maximum of the expiry age) at the then standard premium rate.
- The premium rates are not guaranteed. The insurer retains the right to alter the premium rates, though if it does so, the new rates will apply to all policies. That is, the insurer cannot alter the premium scale for one particular policy.

8. The Cast

We have already referred to the insured life and the policy owner. We now take a closer look at the cast of an insurance policy.

8.1 Ordinary Business

“Policy owner” is the term used in the Life Insurance Act 1995 and is the title most often used by insurers for that role. Other titles include “proposer” (American International Insurance), “plan owner” (AMP and National Mutual) and the single word “policyowner” (Lumley Life). The once popular title “policyholder” was not encountered in any CIBs.

While CIBs used many different titles for the insured life, they were merely minor variations: “insured”, “life insured”, “insured person”.

One term that did seem a possible cause of confusion was the use of the term “you”. It was sometimes unclear whether this was meant to refer to the policy owner or the insured life. There were also some cases where the “you” referred to in most of the application form could be different to the “you” in the direct debits agreement.

Most full-featured products allow nomination of one or more beneficiaries, though about half the products only allow beneficiaries when there is a single insured life who is also the sole policy owner. Where one or more beneficiaries are nominated, death benefits are paid to the beneficiaries while any other benefits (such as TPD or Trauma benefits) are paid to the policy owner. Where there is more than one beneficiary, the proportion of the death benefit to be paid to each must also be specified in the application. The policy owner may at any time change the beneficiaries or the proportions of the death benefit each is to receive.

“Beneficiary” was the most commonly encountered term in CIBs, with the minor variations of “preferred beneficiary” (AMP) and “nominated beneficiary” (ING and Westpac) also appearing. Cuna’s product makes an admirable effort to avoid jargon and simply asks the customer to nominate the “Person to receive the Sum Insured on your death”.

Most full-featured products allowed two policy owners with a small number allowing more than two. Six products allowed only a single insured life, three allowed two and three allowed more, the highest being ING’s product which allowed 10. Application forms tended to leave space for from 3 to 5 beneficiaries, though a few allowed further beneficiaries to be listed on a separate page, apparently with no maximum number.

By contrast no-frills products were more restrictive allowing only a single policy owner, and often only allowing a single insured life. One product allowed two insured lives to be listed on the application, but kept things simple by indicating that listing two insured lives resulted in two separate single life policies being issued. Some required that the insured life and policy owner be the same person. Most no-frills policies did not allow nomination of a beneficiary. When there can only be one life insured who must also be the sole policy owner and there are no beneficiaries, the task of explaining the policy is enormously simplified, which is why this structure is very popular with no-frills products.

8.2 Superannuation Business

Nine of the products surveyed are available as superannuation.

In all nine cases the insurer sells the product under a mastertrust superannuation fund with a company in the insurer’s group acting as the policy owner. In five cases this is the only way the product can be purchased, while in four cases the insurer also allows the customer to nominate some other superannuation fund to be the policy owner.

Only two of the nine superannuation products allowed more than one insured life. There is considerable variety in respect of the number of beneficiaries which could be allowed, including some products which did not allow any.

Technically the trustees of a superannuation plan have the responsibility for determining who receives death benefits paid from the plan. Members may nominate desired beneficiaries, but theoretically trustees may choose to ignore those nominations. However, since 31 May 1999, trustees may elect to make provision for members to make a “binding nomination of beneficiaries” which removes the trustees’ discretion. Two products allowed the customer to make a binding nomination of beneficiaries.

9. Premium Frequency and payment method

The following table shows the number of products offering various premium frequency choices.

Premium Frequency	No. of products
Monthly only	1
Annual or monthly	5
Annual, half-yearly or monthly	7
Annual, half-yearly, quarterly or monthly	2
Annual, half-yearly, quarterly, monthly or fortnightly	1
Annual, half-yearly, quarterly, monthly, fortnightly or weekly	1

No clear patterns emerge with respect to no-frills products. The product with no choice and the product with the most choices were both no-frills products.

Historically, premium frequencies have been a point of contention between sales staff and the financial controllers of life insurance companies. Sales staff press for a very large range of choices in the belief that this increases their chances of making sales. Financial controllers point out that

almost all business sold has either annual or monthly premiums, and that removing the other options will simplify administration and reduce costs. The above table indicates that recently the financial controllers have been winning, but historically more companies tended to provide a greater choice of frequencies.

Some CIBs were unclear on the issue of payment method. Where they were clear, there is a quite high level of agreement between insurers as to how premiums may be paid.

In general, if premiums are paid quarterly or more frequently, only two options available. The customer may enter into a direct debit agreement which authorises the insurer to automatically debit premiums from an account with a financial institution, typically a bank, building society or credit union. Alternatively the customer may sign a credit card authorisation which authorises the insurer to automatically charge the premiums to a Bankcard, Mastercard or Visa Card.

If premiums are paid annually or half-yearly, the above options are still available, as are the additional options of cash or cheque. Though few CIBs mention it, “cash” usually includes cash equivalents such as credit card (meaning a one-off charge rather than an automatic periodic charge arrangement as described above) and BPAY.

The product from HCF had two unique features. It was the only product allowing the weekly payment frequency and the only product to allow “group payroll” as a payment method. Both these features are more common for health insurance products. HCF is giving its customers the option to pay their term insurance premiums (and their disability income insurance premiums) at the same time and by the same method as their health insurance premiums, and offers a discount if they do so.

10. Minimum and maximum premiums and sums insured

Minimum acceptable policy sizes are usually specified in terms of premiums rather than sums insured. The products surveyed had minimum annual premiums ranging from \$100 to \$250, with \$200 being common. These minima were usually inclusive of extra premiums for optional benefits.

Only five products (2 no-frills and 3 full-featured) specified minimum sum insured for death cover, one being \$25,000 and the others all being \$100,000.

None of the CIBs for full-featured products specify a maximum acceptable sum insured for death cover. Large cases would be subject to financial underwriting, meaning the underwriter will attempt to ascertain whether the applicant has a real need for the proposed level of cover. Also, particularly large cases may be reinsured on a case-by-case basis, so the maximum policy that can be accepted may also depend on the reinsurer’s assessment of the application. Since the level of sum insured the insurer is willing to offer may vary significantly by applicant, it is simpler not to list any maximum in the CIB. Perhaps insurers have also decided that it is preferable to not indicate a maximum sum insured, since doing so may limit the applicant’s aspirations.

Four of the five no-frills products specified maximum sums insured, being \$250,000, \$300,000 and two at \$500,000. In the \$300,000 case, the CIB indicated the customer could make a case for a larger sum insured.

Two of the no frills products were “tick the box” style with only a limited range of possible sums insured. For NRMA Easylife the possible sums insured ranged from \$100,000 to \$250,000 in steps of \$50,000. For AMP’s Firstcare Term Life insurance they ranged from \$100,000 to \$500,000 in \$50,000 steps, except that \$450,000 was not available.

The issue of maximum sums insured on options will be discussed later when the options are examined more closely.

11 The common patterns of premiums and sums insured

11.1 Level sum insured, stepped premium

This is the simplest form of term insurance. The sum insured is selected at the outset and remains constant throughout the life of the policy. The premium is recalculated at the start of each policy year and reflects the risk of claim during that policy year. Thus premiums vary with age in the same manner as do mortality rates. Generally they increase with age, but they decline slightly over roughly the 20 to 30 age range due to the “accident hump”.

While this may be the simplest form of term insurance, it is not the most common.

Two of the 17 products in this study, both no-frills products, are only available in level sum insured form. Three more products give the option to select this form at the outset on the application form, while one more indicates in its CIB that this form could be selected at the outset but did not have a location on the application form to select it, presumably an oversight.

Also, some products written in the CPI-linked form will revert to the level sum insured form in some circumstances.

11.2 CPI-linked sum insured, stepped premium

On each policy anniversary the sum insured is increased in line with the Consumer Price Index (CPI). The premium for the policy year is then calculated based on the new sum insured.

While the premium rate (per dollar insured) still declines over roughly the 20 to 30 age range, the sum insured is increasing. Whether the premium declines depends on whether the premium rate falls faster than the sum insured increases.

15 of the 17 products were available in this form, the other 2 being the no-frills products mentioned above. This is by far the most common form of term insurance, at least in terms of availability.

Of the 15 products with CPI indexation, eight impose a minimum indexation rate on the CPI, seven using 3% p.a. and one using 5% p.a. Two products impose a maximum, one using 10% p.a. and one 15% p.a.

Of the 15 products with CPI indexation, five products also put a dollar limit on the sum insured which may result from indexation. The limits for the five products are \$300,000, \$1.5M, \$2M, \$3M and \$10M, so there is significant disparity here. The first product listed is a no-frills product, the \$300,000 also being the maximum allowed initial sum insured. That particular product also imposed a maximum of twice the initial chosen sum insured.

One product did not impose a dollar limit, but took the unusual step of specifying that where the sum insured exceeded \$1M, the annual increase would be the indexation rate multiplied by \$1M rather than by the sum insured.

Six products impose an age limit on indexation, effectively reverting to the level sum insured form from that age. Five use age 65 and one uses age 60.

One variety of the product from Asteron also reverts to the level sum insured version on payment of a terminal illness benefit or some TPD payments.

While most products don't allow the customer to select the level sum insured form at the outset, most do allow the policy owner to refuse the CPI increase at each policy anniversary. Three products impose the condition that if the CPI increase is refused at two consecutive policy anniversaries then no further CPI increases will be offered, so the policy effectively becomes the level sum insured form.

The above descriptions of the level sum insured and CPI-linked sum insured forms demonstrate several changes in approach since the 1980s.

It used to be more common for the refusal of two consecutive CPI increases to cause the product to revert to the level sum insured form. It was felt that if a customer who had refused increases for several years suddenly wanted them again, then they were probably in poor health and were selecting against the office. Now this condition only appears in three products, so most insurers seem to have decided the selection effect is not significant. Perhaps lower inflation rates have also reduced the size of the selection risk.

Another effect of reduced inflation is that several insurers impose minimum indexation rates. In the 1980s more insurers were only concerned with imposing maximum indexation rates.

It used to be common to allow the customer to select the level sum insured form from the outset. This is now rare, which should probably not be surprising. If the product is profitable, why would the insurer encourage the customer to buy the same cover every year rather than buying more each year?

However, in the light of the above question, it is natural to ask why some insurers choose to stop indexation at age 60 or 65. Mortality rates and hence premium rates are increasing rapidly by this age and this tends to produce high discontinuance rates. Indexing the sum insured causes the total premium to increase more, probably boosting the discontinuance rate further. Perhaps these insurers feel that at high ages the gains from CPI-linking the sum insured are more than offset by the losses from the resulting higher discontinuance rates.

11.3 “Premium Freeze”: Level premium, varying benefit

This is in some ways the inverse of the first form. Rather than fixing the sum insured and using the premium rate tables to work out the premium each year, the premium is fixed and the premium rates tables are used in reverse to work out what sum insured that premium can purchase each year.

This option is available on seven of the full-featured products studied, though curiously for one such product it is not available on the superannuation variety. Six call it “premium freeze” while the other calls it “decreasing benefit”. (In the 1980s some insurers called this form “level premium”, but that name is now used for the form described in the next section.) It is not available on no-frills products.

One of the products only allows the premium freeze form to be selected when the insured life is over 30. That is, a new policy may be written in this form if the insured is over 30, and an existing policy in one of the previous two forms may be changed to this form if the insured is over 30. Two other products have a similar requirement but with age 35. These ages have presumably been chosen so that the policy is beyond the troublesome downslope of the “accident hump” where premium rates decrease with increasing age. That is, they want to avoid the situation where say a 25 year old selects the premium freeze option and the sum insured increases for a few years before declining again. However, the other four products offering premium freeze have no such restriction.

Insurers seem far more concerned about selection with this form. In most products the insurer’s approval is required to convert the policy from premium freeze form to one of the previous two forms, a process some insurers call “unfreezing” the premium. Though it is not explicitly stated, gaining the insurer’s approval probably requires an inspection of the insured’s health. However, one insurer does allow the premium freeze to be removed at any time without evidence of health, though it is unclear from the CIB whether the policy reverts to the level sum insured form or the CPI-linked form.

One danger with this form is that, since the premium is fixed, moderately small policies may over time become unprofitably small policies, particularly in times of high inflation. The small sums insured that can result at high ages can also cause some discontent amongst the benefit recipients. It doesn’t matter that the benefit paid is the actuarially fair sum insured. There will still be someone who can say “My parents paid premiums for 50 years and all we got was this miserly \$1000.” One insurer takes some steps to remedy this, requiring that the sum insured stay above \$10,000, though curiously only for one variety of the product.

11.4 “Level premium”

This form is not available on no-frills products. It is available on six of the full-featured products.

While all the insurers selling this form call it “level premium” this is a misleading name.

In the typical form, the customer chooses a sum insured and the insurer sets a level premium to apply to the policy anniversary before age 65, assuming the sum insured is fixed. This sounds a lot like a traditional term insurance to the policy anniversary before age 65, but there are four important differences, the first three being the three reasons that “level premium” is not a good name.

- The insurer still has the right to adjust the premium scale. It’s only “level premium” if the insurer never has to adjust the premium scale.
- By default CPI indexation still applies and unless the policy owner refuses all CPI increases the premium will be adjusted to allow for the sum insured increase. The CIBs do not elaborate on the calculation method. The obvious approach would be that at each policy anniversary an extra premium is determined to cover the cost of the extra sum insured, assuming that extra premium and extra sum insured stay constant until the policy anniversary before age 65.
- In some products the insurer retains the right to index the policy fee component of the premium to CPI. (The premium is found by multiplying the sum insured by a premium rate and then adding a policy fee, which is specified as a dollar amount but which is indexed annually.) If this occurs, then even if the premium scale is not changed and the CPI indexation is refused, the premium is still not level.
- If the policy survives to the policy anniversary before age 65, the policy owner has the option to continue it on a stepped premium basis thereafter until the expiry age. By contrast, the traditional term insurance would cease with no option to continue beyond age 65.

In the above explanation we assumed the relevant upper limit for the process was the policy anniversary before age 65. In fact five of the six products offering this form of premium do use 65, though some use policy anniversary before 65 while others use policy anniversary after 65. The sixth product allows the customer to choose the upper limit and the policy expires if that limit is reached, rather than converting to stepped premium.

11.5 Unusual guarantees

Two products have features which couldn’t easily be explained under the above headings. Both relate to guarantees.

On the varieties of Citicorp’s full-featured product that don’t include trauma cover, customers electing to use a higher death cover premium scale have that premium scale partially guaranteed not to change for the life of the contract. The guarantee applies only to cost of the death cover, not the cost of any TPD options, it does not apply to the policy fee and the insurer still retains the right to adjust the scale to allow for such unexpected features as changes in tax or other government charges. This variety is available in CPI-linked and Premium Freeze forms.

The “Life Insurance Cover” variety from Lumley Life offers a level premium form (type 4 above) under which the underlying table of premium rates for death cover is guaranteed not to change for the life of the contract, (other than due to changes in government charges and taxes.) This variety seems to be the nearest thing to the traditional term insurance still being sold in Australia.

11.6 Premium bands

This issue is unrelated to the forms described above but still fits under the broad heading of patterns of premiums.

The issue here is not whether premium might just happen to be unchanged for a few years due to some pattern inherent in the underlying mortality, such as a plateau at the top of the “accident

hump”, but rather whether the insurer has deliberately chosen to consistently make premium rates level over some broader period than the year.

Only one case of banding was found, the no-frills product from NRMA, where the CIB shows premiums being constant to age 35 and then incrementing in 5 year age bands to age 50, the highest entry age. Premiums were not shown above that age, so it is unclear whether banding continues to the expiry age.

While no other cases of banding were found, the sample size is small since attempts to obtain tables of premium rates for several products were unsuccessful.

12. One-off Increases

Most of the products allow the customer to request a one-off increase in the sum insured at any time, the request being subject to the normal underwriting process. That is, the insured life would have to complete the normal health questionnaire and based on that information the insurer would decide whether to accept the policy at standard rates.

However, only three products clearly advertised in their CIB that such one-off increases are possible. Perhaps most insurers have decided that there is little point in advertising this possibility in the CIB, since customers will have forgotten about it by the time they need the extra cover. Perhaps they instead advertise this more strongly when they send out the annual advice which indicates the next year’s sum insured and premium.

A further four products did have some tangential reference to one-off increases in the body of the CIB. For example, when some CIBs defined their “level premium” form, they listed the circumstances that could cause the premium to change and this list might include “you choose to increase your sum insured”. That is, these four products were merely mentioning one-off increases where such increases impacted on another feature of the product; they were not actively encouraging them.

In several more products the only indication that one-off increases were possible was that the application form had a series of tick boxes where the customer had to indicate whether the application was a new policy or an increase to an existing policy. Some applications also had other options like replacing an existing policy or reinstating a lapsed policy. These tick boxes sometime had very brief titles like “increase” and “reinstatement” which seemed to be aimed at an intermediary and would mean little to the customer.

Four products had no mention of one-off increases in the CIB or application. Three of the these were no-frills products so perhaps they do not allow one-off increases, or perhaps in their efforts to keep the CIB extremely simple they have consciously decided to not mention them.

13. Death Cover Parameters

13.1 General comments on ages

Before discussing expiry ages and entry ages for death cover, I will summarise a few general problems concerning the explanation of ages. These comments also apply to the age parameters of many of the options discussed later, such as TPD cover and trauma cover.

Ages, such as entry ages and expiry ages, are a frequent source of ambiguity in CIBs.

Insurers usually prefer the expiry date to be a policy anniversary, since this avoids having to carry out premium adjustments to allow for the last policy year not being a whole year.

Most CIBs indicate, usually clearly, that the expiry date is a policy anniversary, but some merely specify an age, which many customers would read as meaning the policy expires exactly at a birthday rather than on a policy anniversary. For example, in respect of death cover, the CIBs for four of the 17 products seemed to imply the expiry date was a birthday. This is possibly faulty wording, but attempts to clarify this point with customer inquiry staff were not enlightening.

Many insurers specified entry ages as say “age 16 to 59”, sometimes with the word “inclusive” appended. Customers might interpret the upper limit as 59 exact or as 59 last birthday, interpretations which differ by a whole year in their effect. A few attempts were made to clarify which was intended, but as a general rule it seems that if the CIB does not clearly identify what is intended, customer inquiry staff won’t know either.

Maximum entry ages and expiry ages usually involve a multiple of 5 or one less than a multiple of 5. In some cases the difference is just due to age classifications. For example one insurer may state its maximum entry age is 69 last birthday and another may state 70 next birthday. In effect, they have both chosen the round number of 70 and are implementing the same rule – except perhaps for the rare case of someone who tries to buy a policy on their 70th birthday. To give some coherence to the discussion, I’ll report all maximum entry ages and expiry ages rounded to the nearest multiple of 5.

As stated above, some CIBs list ages as “age next birthday.” I suspect many consumers find this to be yet another point of confusion when they are trying to understand an already complex product. Premium rates are almost always listed by age next birthday and those working in the life insurance industry are used to this age classification. But in almost every other age-based scenario that humans have to cope with ages tend to refer to age last birthday. Even children’s sporting competitions which may adopt some arbitrary census date partway through or near the end of the relevant sporting season usually still classify by age last birthday at that census date.

To improve consumer understanding, I wonder whether it is time for the life insurance industry to consistently replace all “age next birthday” references by the corresponding “age last birthday” in public documents. After all, if actuaries have managed to pass torturous exposed-to-risk exams where they might have had to deal with deaths data classified by “age next birthday on the 1 January in the policy year of death,” surely they can cope with the mathematical feat of adjusting public documents to use age last birthday instead of age next birthday!

Incidentally, the practice of listing premium rates by age next birthday seems to date back to the early days of life insurance. The often quoted reason for the practice is that treating everyone aged x next birthday as if they were x exact builds an extra safety margin into the premiums. However, for term insurance this argument fails on the downslope of the accident hump, which is the age range where much of the new business is written. (The argument also fails for life annuities where to get a safety margin we should treat everyone x last birthday as x exact.)

13.2 Expiry dates – ordinary business

Almost all full-featured ordinary products had an expiry age in the region of 100. That is, typically the expiry dates were the policy anniversary either before or after either 99 or 100. There were only two exceptions, using ages 80 and 85.

Of the five no-frills products, one used 65, two 70 and two used 100.

Perhaps the most important thing to note about expiry dates is that, for most products, they are high enough to be irrelevant. It would be extremely rare for any customer to renew their policy beyond age 90. If they reach that age they are unlikely to have a need for death cover, since they are unlikely to have either family members financially dependent on them or business associates relying on their continued involvement in a business. Also, the premium rates become sufficiently high by this age that the product does not appear to be a sensible use of money.

Indeed, if tables of standard premium rates are obtained from insurers, it is found that several insurers do not show premium rates beyond age 80 or so. Those insurers that do show rates beyond that age show increasing diversity as age increases. For example, the basic premium rates from 2 insurers for death cover for a male non-smoker at age 95 are 25.9% and 42.6% of the sum insured. When premium rates vary that much it probably indicates that the insurers have little idea of what the correct premium rate should be since they have negligible claims experience at such advanced ages.

13.3 Expiry dates – superannuation business

The pattern for the nine products available as superannuation was less clear cut.

The government requirements for superannuation contributions become more stringent at age 65 and become tougher again at 70 and 75, by which age it's safe to assume that most customers will not legally be able to make superannuation contributions. Yet some superannuation term policies still have an expiry age in the region of 100.

The catch is that if the insured life's situation changes and she can no longer make superannuation contributions when the term insurance premium falls due, most insurers allows her to convert the policy to an identical ordinary policy without supplying evidence of health. Since there is no surrender value, it is a relatively straightforward process to convert a term insurance from superannuation to ordinary business at a premium due date.

Two superannuation products use an expiry age of 70 and three use 75, these being two significant trigger ages at which the superannuation contribution requirements become more stringent. One used 80, an age which does not seem to match any particular trigger in superannuation law. The remaining three simply used the same age as for ordinary business, all in the region of 100, in the knowledge that customers would fail the eligibility requirements for superannuation contribution at some time prior to this and in the hope that they would convert the policy to ordinary business when this occurred.

13.4 Entry ages – ordinary business

Most products had minimum entry ages in the range 15 to 18. The only exceptions were 2 ordinary products using age 10 and one no-frills product using 24. It is hard to imagine scenarios where a 10 year-old would require death cover.

The main reason for imposing a maximum entry age is to avoid selling policies which are likely to lapse at short duration. Thus the maximum entry age is usually at least 10 years before the expiry age, though there were a couple of outliers where the gap was only 5 years.

For full-featured ordinary products, the maximum entry ages are usually 65 or 70. The few products outside this range were two occurrences of 60, one of 75 and one of 80.

Four of the no-frills products had much lower entry ages, being two occurrences of 50 and one of 55 and 60.

Maximum entry ages have increased considerably since the 1980s. At that time the conventional wisdom was that beyond age 65 few insured lives would have a need for death cover. Also premium rates were sufficiently high by that age that they provided a strong incentive to not renew the policy. Thus, it was assumed that lapse rates would be so high from age 65 that it was not worth having a maximum entry age above about 55. Now, the prevalence of maximum entry ages of 65 and 70 appears to imply that lapse rates at high ages are lower than originally feared. Alternatively, perhaps the lapse rates are high but insurers have built this cost into the premium rates and found that the few customers willing to renew term insurance beyond age 65 can afford those premiums. This may be because the customers buying term insurance beyond age 65 require it for business rather than personal needs and are predominantly wealthy.

Another factor which may have influenced this change is the reduction in commission levels since the 1980s. If all other factors are unchanged, reducing the acquisition expenses will reduce the number of years a policy must run before the insurer recoups the new business strain. The gaps between maximum entry age and expiry age indicate that some insurers believe that a term insurance lasting only 5 years is now profitable

13.5 Entry ages – superannuation business

No product specified different entry ages for superannuation policies than for ordinary business. In some cases these ages are as low as 10, though the insurer wouldn't be expecting to write

superannuation policies at that low an age. Effectively these insurers are saying that they'll write a superannuation policy as soon as the customer can satisfy the eligibility requirements for superannuation contributions.

The maximum entry ages for most superannuation products are 65 or 70. These are the same ages as stated above for ordinary business, though the generalisation hides a few cases where an insurer used 70 for ordinary and 65 for superannuation.

Insurers writing superannuation term insurances at age 70 are probably not expecting them to last long as a superannuation policy. They *will* be hoping that these policies are converted to ordinary business rather than lapsing when the insured life can no longer satisfy the government requirements for superannuation contributions.

13.6 Entry ages and premium scale adjustments for the “level premium” form

Students of contingent payments will be familiar with a problem which can arise with the traditional term insurance. If premium rates are declining with age, as they may do around the 20 to 30 age range, it is possible to find that for a traditional term insurance to age 65, the premium for say a 21 year old is less than that for a 20 year old. So a customer taking out the insurance at age 20 has a strong incentive to lapse the policy a year later and take out a new policy at the lower premium, assuming they are still healthy enough to satisfy underwriting requirements. If a traditional term insurance lapses after one year it usually has a negative policy value at the point of lapse, so the insurer makes a loss. This is known as the lapse and re-entry problem.

The extent of the problem depends on the size of the accident hump. It is far less significant for females and varies slightly by smoking status. Some actuaries take the view that it need not be a serious problem if few customers are aware that they can exploit the situation, while others take the view that some brokers will be only too happy to inform customers of such an opportunity.

The lapse and re-entry problem can also occur for the modern term insurance if it is offered in the level premium form – the 4th form described in the section 11. (It is not a problem for any of the other forms described in section 11.)

There are two easy ways to fix this problem. One is to impose a higher minimum entry age for the level premium form. The other is to arbitrarily increase the offending premium rates so that premium rates never decrease with increasing age for the level premium form.

Both solutions are in use. Two insurers imposed a much higher entry age for the level premium form than the other forms, the ages being 24 and 25. Where premium rate tables were obtained for the level premium product, it was common to find that premium rates were all equal for entry ages up to some point in the late 20s, indicating that the insurer had probably just increased the premium rates at lower entry ages until the dip was eliminated. One insurer used a bit of both techniques, lifting the entry age from 10 to 15 and lifting the premium rates to eliminate the dip.

At least one insurer has taken the view that the lapse and re-entry problem is not a serious problem and has retained premium rates for the level premium form which decline with age, dropping about 30% in total for the most extreme rating group: male non-smokers.

Since I was unable to obtain premium rate tables for all the products involved, I cannot state how common the above solutions are. Indeed, one insurer who adopted the higher entry age solution did not disclose the higher entry age in the CIB and it only became apparent when the premium rate tables were obtained. Thus it is possible that this solution is more common than it first appears when examining CIBs.

Most of the “level premium” forms also used a lower maximum entry age than their corresponding stepped premium or “premium freeze” forms. This has nothing to do with the “lapse and re-entry problem.” Rather, it just seeks to ensure that the policy will be in level premium mode long enough to be worth the effort. Usually the maximum entry age adopted was 55 or 60, which is consistent with the “level premium” feature only lasting to age 65, where it converts back to stepped premium.

13.7 Exclusions

The most common exclusion is suicide during the first 13 months of the policy. That is, if the insured dies by suicide during the first 13 months of the policy, no death claim is paid and the policy ceases.

However, the precise wordings adopted by insurers vary. Many CIBs simply use the term “suicide”, while others refer to “an intentional self-inflicted act,” “by the life insured’s own act”, “as a result of your intentional or deliberate act or omission” or “dies by their own hand”. Legal opinion may differ, but to the layman, these definitions do not appear equivalent. Some exclusions seem to include (if that isn’t a contradiction) an *unintentional* self-inflicted act. One insurer explicitly mentions both “suicide” and “an intentional self-inflicted act” in its death claim exclusions, as if it is concerned that the former might not cover the case of a person who was only trying to intentionally inflict a minor injury, perhaps to receive a few weeks of Workers’ Compensation benefits, but made a fatal misjudgment in the process.

The period of 13 months, or for one product 1 year and 30 days, ensures that, if premiums are paid annually, at least 2 years’ premiums have been paid. Only one insurer uses a shorter period, Colonial using 1 year.

Approximately half the products also applied the exclusion to CPI increases. That is, assuming the relevant period was 13 months, then on death by suicide within 13 months of a CPI increase, the increase would not be paid. The other products only applied the exclusion during the first 13 months of the policy and beyond that the full sum insured would be paid, including recent CPI increases. Curiously, this was one area where faulty wordings were common. Three separate CIBs adopted wording which implied that if death by suicide occurred within 13 months of a CPI increase, this would void the whole sum insured, rather than just the increase. In two of these cases the faulty wording only appeared in one variety of the product with the other varieties only voiding the relevant CPI increases. Hence it is assumed these were drafting errors rather than an intention to void the whole sum insured.

Only 4 products made reference to sum insured increases other than CIB increases. These include one-off increases requested by the customer and increases arising from buybacks, which are discussed later in this paper. Where these were mentioned, it was always to imply that the exclusion also applied to these increases for 13 months after the increase. Rather than listing all the possible causes of increases, a common wording here was to say the exclusion applied either to all increases, or to all increases other than CPI increases.

The no frills product from NRMA excluded claims arising from AIDS. More specifically, it excluded claims arising from

“Acquired Immune Deficiency Syndrome (AIDS) or any AIDS related condition, or infection with the Human Immunodeficiency Virus (HIV)” (NRMA Easylife CIB p9)

Two other products, one no-frills and one full-featured, defaulted to excluding AIDS claims. However, if the insured voluntarily chose to answer a series of “lifestyle” questions, then based on the answers given the insurer might lift the exclusion. The lifestyle questions concern sexual history, intravenous drug use and blood transfusions. In practice, this procedure probably has much the same effect as the procedure adopted in the remaining products. They do not exclude AIDS by default, but their application forms do include the lifestyle questions, and based on the answers given the insurer could still apply AIDS exclusions to particular insured lives regarded as high risk.

14. Options and automatic extra benefits

The basic term insurance is a relatively simple product. In an attempt to differentiate their products from their competitors, and perhaps to make it harder for consumers to directly compare prices, insurers have invented a range of extra benefits.

The extra benefits may be divided into options and automatic extra benefits.

Options are, not surprisingly, optional. The customer can choose to add them to the policy and if they do an additional premium is charged. Options have also been called riders, though this term is falling into disuse, at least in material produced for the public.

Automatic extra benefits are included by default. CIBs may indicate that these have been included “at no extra charge”, meaning the charge has been included in the basic premium.

Where an extra benefit proves particularly popular with consumers all insurers tend to implement it, often with a fairly high degree of consistency between the insurers. We commence this discussion with the four most common extra benefits. Two are options: TPD cover and trauma cover, already mentioned briefly earlier. Two are automatic extra benefits: terminal illness cover and interim accident cover. We will then move onto the less common extra benefits, which tend to exhibit a much higher degree of diversity of form between insurers.

Some extra benefits can be very complex and a full discussion of their features could fill a whole paper. For example, there are several papers in the actuarial literature solely on trauma insurance. Thus this paper will of necessity deal with some of the extra benefits at a rather shallow level.

Another relevant warning is that the worst complications of term insurance arise not from a particular extra benefit but rather from the unexpected ways that extra benefits can interact. In some cases we will need to describe each benefit separately before discussing the nasty interactions.

15. Terminal illness benefits

Terminal illness benefits become payable if the life insured is likely to die in the near future. The precise definition is discussed more fully below.

15.1 Availability

Of the products surveyed, all but the two varieties described below include terminal illness cover as an automatic extra benefit.

One insurer does not provide terminal illness benefits on the variety of its product which must contain trauma insurance, though it does provide these benefits on the variety which cannot include trauma cover.

One insurer does not provide terminal illness benefits on the superannuation variety of its full-featured product, though it does on the ordinary varieties. The “sole purpose test” in the Superannuation Industry (Supervision) Act 1993 does cause some difficulty here since it does not mention terminal illness as one of the acceptable reasons for paying a benefit from a superannuation plan. As one CIB states in respect of its superannuation variety of term insurance:

“Where a Terminal Illness claim is admitted the proceeds will be paid to the trustee. The trustee will need to be satisfied that the payment meets the total and permanent incapacity test as defined under superannuation law prior to making any payment from the fund.

If you do not meet the definition, the terminal illness Benefit must be rolled over as a preserved benefit to the fund of your choice.” (National Mutual CIB, p8)

It is possible for a person to satisfy the insurer’s definition of terminal illness, not satisfy the insurer’s definition of Total and Permanent Disablement, yet satisfy the legislation’s definition of total and permanent incapacity. This means that they can take their terminal illness benefit as cash, though they would not be eligible to collect a TPD benefit from the insurer.

15.2 Definition

The definition of terminal illness usually involves an illness which is expected to cause death within a specified period. All except three products use a period of 12 months. Those three products, two no-frills and one full-featured, use six months.

There is significant variation between insurers in the precise definition of terminal illness, though where an insurer sells both a no-frills product and a full-featured product they have used the same

definition for both. The variations relate mainly to the level of certainty required and the acceptable medical staff. When comparing different insurer's definitions, no clear patterns emerge on either of these issues. Here are some examples.

"unequivocal medical evidence acceptable to AIA, the life insured is diagnosed with a terminal illness which in AIA's opinion will result in death within 12 months regardless of any treatment that may be undertaken ..."

(American International Assurance CIB, p12)

"...diagnosed as having less than 12 months to live ..."

(AMP Risk Protection CIB, p3)

"... diagnosed by a specialist medical practitioner as having a life expectancy of 12 months or less due to an illness, regardless of any treatment that may be undertaken. This diagnosis may need to be confirmed by a specialist medical practitioner of our choice."

(Asteron CIB, p2)

"... supply us with medical evidence satisfactory to us that the insured has a disease or condition which will lead to their death within 12 months."

(Colonial CIB, p23)

"... diagnosed with less than 12 months to live because of illness ..."

(Cuna CIB, p3)

"... life insured is diagnosed as being terminally ill and death is likely to occur within 12 months ... Two medical practitioners will be required to certify the extent of the illness (or injury), one being the doctor treating the condition and the other being a doctor nominated by Lumley Life who must confirm the diagnosis and prognosis."

(Lumley CIB, p22)

These examples demonstrate the variety of definition. Some definitions require that the insured life *will* die within 12 months, others only require that death within 12 months is *likely*, immediately prompting the question: "How likely?" and still others require the *life expectancy* to be less than 12 months.

Actuaries will be familiar with analysing disability income insurance claims rates subdivided into the two mutually exclusive groups of "sickness" and "accident". Plain English interpretation would regard "illness" as equivalent to "sickness". However, the definitions of terminal illness are less clear. Some definitions specifically require that the trigger be an "illness", some are vague on this point, and one explicitly indicates that "injuries" are also acceptable, so it appears that "terminal illness" benefits can also arise from accidents. Some CIBs don't clearly define "terminal illness".

As with any legal issue, a few disclaimers have to be placed on the above observations. The observations are based on plain English interpretations; legal interpretations can sometimes be surprising. The observations are based on the CIBs and the policy document might not necessarily be consistent. However, if the wording used in advertising, such as in a CIB, differs from wording in a subsequent contract, such as a policy document, there is further risk that a court's decision may be surprising!

15.3 Benefit size

The terminal illness benefit brings forward payment of part or all of the death benefit.

The most common terminal illness benefit is the death benefit, subject to a maximum of a fixed dollar amount. The common dollar amounts were \$1M and \$2M, with one occurrence of each of \$1.5M and \$2.5M. Four of the five no frills product had capped the death sum insured to levels well

below \$1M and so did not bother specifying a maximum dollar amount on the terminal illness benefit.

Note that the dollar limits on terminal illness benefits are quite high and are likely to effect very few customers. That is, in the majority of claims, a terminal illness benefit results in payment of the full death sum insured and the policy ceases.

If the death sum insured were \$1.2M and the terminal illness benefit was subject to a maximum of \$1M, a successful terminal illness claim would result in a terminal illness benefit of \$1M. The death cover would be reduced to \$200,000 and future premiums would be reduced to reflect this lower sum insured.

Only two products adopted terminal illness benefits in a different form to that described above. Both set the terminal illness benefit at 75% of the death sum insured. One also imposed a \$2M maximum but the other, being a no-frills product with a lower limit on the death benefit, did not. In both cases, if a terminal illness benefit is paid, the death cover is reduced by the amount of terminal illness benefit paid.

The terminal illness benefit is a relatively recent innovation. When Australian insurers first added it to the modern term insurance product the absence of claims experience naturally caused them to be cautious. Early versions limited the terminal illness benefit to a small proportion of the death sum insured, often 10%. As the claims experience grew insurers increased this limit and we have now reached the situation where the benefit is usually the whole sum insured, except for policies with large sums insured.

15.4 Expiry date

Almost all products adopt the same expiry date for terminal illness benefits and death benefits.

One insurer requires that the terminal illness be diagnosed at least 12 months prior to the expiry of the policy, effectively meaning that the expiry age for terminal illness benefits is one year earlier than that for death.

Two insurers adopt more significant gaps. One used an expiry date of the policy anniversary before 70 for terminal illness, while the corresponding ages for death were 99 for ordinary and 80 for superannuation. The other has its terminal illness benefits expiring at 64 while the death benefit expires at the policy anniversary before 99.

15.5 Exclusions

Eight products applied exclusions to their terminal illness benefit. In all eight cases the exclusions included some variation of the “self-inflicted” exclusion and this was usually the only exclusion.

Legal advice would be needed when designing exclusions. However, to the layman using plain English interpretation, there seems to be some variety in approach.

The exclusions showed similar variations to death benefit exclusions, the major issue being whether the exclusion relates to *all* self-inflicted events or only *intentional* self-inflicted events.

As discussed earlier, in some products a terminal illness benefit can arise from accidents as well as sickness. “Accident” was not usually defined in this context, but where it is defined in other contexts it usually requires the event be “external”, so intentional self-inflicted events would not appear to qualify as accidents.

If the terminal illness benefit does only relate to sickness, it could be argued that exclusions are unnecessary, since self-inflicted events are likely to involve injuries which wouldn’t be classified as sickness, or death. The insurers not applying exclusions to terminal illness may be taking this view.

Some products treated their terminal illness exclusion as akin to their TPD and trauma exclusions, applying it for the whole duration of the policy. However, it was more common to explain this exclusion alongside the death benefit exclusion and use consistent wording for both. Thus the

terminal illness benefit exclusion would usually only apply for the first 13 months of the policy, and may apply to some increases for 13 months after the increase.

Three products also excluded AIDS related claims, the nature of the exclusion being consistent with that for the death exclusions described previously.

If the insured life and policy owner are different people, AMP Firstcare Insurance also excludes claims arising from the policy owner injuring the insured life. This appears to be a sensible exclusion, leaving one wondering why no other insurers do likewise. Perhaps they rely on being able to refuse such claims on the grounds that the policy owner should not obtain financial gain from a criminal act.

Only one product, the no-frills product from HCF, contained additional exclusions, applying its full list of TPD and trauma exclusions to the terminal illness benefit.

Nine products did not apply any exclusions to their terminal illness cover. It is unclear whether this was an oversight or intentional. In the interests of simplicity, it is perhaps viable to have no exclusions if the terminal illness benefit only covers illnesses. However, some of these nine products also allow claims for terminal illnesses arising from injuries. In this scenario it appears very risky to fail to exclude self-inflicted acts.

16. Total and Permanent Disablement (TPD) Insurance

16.1 Availability

Three of the no-frills products have no options at all. The other 14 of the 17 products allow TPD cover to be selected as an option.

16.2 Typical definition

Warning: The next three sections are gory in places. Sensitive readers may wish to skip ahead to the discussion of benefit structure at section 16.5.

TPD definitions are curious beasts. While there are certainly many lengthy sections which appear word for word in several different insurer's definitions, there are many different ways to select from the pool of common wordings. On top of this several insurers have added unique oddities, the net effect being that it seems that no two insurers are using identical definitions of TPD. To give some coherence to the discussion I will ignore variations that appear in only one or two products, unless they are particularly interesting variations.

While there are considerable minor variations in the definitions, most definitions take the same structure, so before we launch into a discussion of those variations, here is a typical example of the structure, which is actually three different definitions for three different scenarios

1. The "any occupation" definition:

- (a) You are regarded as Totally and Permanently Disabled if:
 - (i) you have been absent from work due to illness or injury for six consecutive months; and
 - (ii) at the end of this six months, a suitable medical practitioner assesses that you will never again be able to obtain gainful employment in any occupation for which you are reasonably suited by your education, training or experience.
- (b) You will also be regarded as Totally and Permanently Disabled if you suffer the permanent loss of:
 - The use of two limbs,
 - the sight in both eyes, or
 - the use of one limb and the sight in one eye.

In the industry clause (b) usually goes by the cheerful name of "the Lord Nelson clause".

2. The “own occupation” definition:

Clause (a)(ii) is replaced by:

- (ii) at the end of this six months, a suitable medical practitioner assesses that you will never again be able to work in your own occupation.

The own occupation is usually only offered to insured lives in professional occupations and the premium scale will be higher than those in the same occupations who choose the “any occupation” definition.

3. The “homemaker” or “home duties” definition:

The subsections of clause (a) are replaced by:

- (i) you are unable to perform normal domestic duties, leave your home unaided, nor be engaged in any employment for a period of six consecutive months; and
- (ii) at the end of this six months, a suitable medical practitioner assesses that you will never again be able to perform normal domestic duties nor be able to obtain gainful employment in any occupation for which you are reasonably suited by your education training or experience.

Normal domestic duties are those normally performed by a person who is not working in regular employment. Typical examples given are cleaning the home, washing, shopping for food, cooking meals and looking after children.

There is clearly considerable room for legal disputes when assessing TPD claims. For example, a common riddle some years ago (original source unknown) ran as follows. A person suffers serious injuries in a car accident. Under normal circumstances, with suitable rehabilitation treatment, she is likely to be disabled for 2 years but will then be able to work, so she wouldn’t be regarded as *permanently* disabled. However, she also has terminal cancer and will probably die within 1 year, before she recovers from disablement. Is she permanently disabled? While such problems may give barristers hours of entertainment (and employment), the actuary can usually ignore them. The actuary only has to be alert for significant changes in the legal interpretation of the TPD definition which may make past claims experience not a valid guide to future claim costs.

16.3 Prevalence and availability of definitions

12 of the 14 products offering TPD cover include the Lord Nelson clause.

The “any occupation” definition is regarded by most as the default definition for employed people and it appears in some form in all 14 products.

10 of the 14 products offer the “own occupation” definition. It is not offered in the 2 no-frills products that offer TPD cover. It is usually restricted to certain occupations, typical descriptions being “professionals”, “professionals and other white collar” and “white collar professional or profession requiring tertiary qualifications”. Curiously, one insurer makes the “own occupation” definition available on its ordinary variety but not on its superannuation variety.

11 of the 14 products offer the “home maker” definition. This definition seems to have first appeared in the last decade or so but has quickly become common.

16.4 The more common variations on definitions

With respect to the Lord Nelson clause, insurers have adopted the same numbers and combinations of items to be lost, but there was significant variation in precisely what the items were. While most refer to the loss of *the use of* a limb, others require the loss *of* the limb, some using the word “severance” to remove any doubt. Some that use the “use of” version also require that the loss be “unable to remedied”. Where some refer to “limb”, some refer to “hand” or “foot”. Some refer to “loss of limb” but then further define that phrase to accept either *severance* above the wrist or ankle or the permanent loss of *the use of* the hand or foot.

In respect of clause (a)(i), several insurers require the insured to have been under the supervision of and/or following the advise of a registered medical practitioner for the whole of the six months

In respect of clause (a)(ii), in all three definitions, the major source of variation is whether the insured *will be* unable to work or perform domestic duties again, or whether they are *unlikely to* be unable to do so.

The definitions can include several references to “gainful employment”. Some insurers use the perhaps clearer expression “income producing employment”, though one explicitly states that you must be unable to obtain “paid or unpaid employment.” One explicitly refers to work “on a full-time or part-time basis,” though this is probably regarded as implicit in the other definitions.

In three products the insured is also regarded as satisfying the TPD definition if they are unable to complete “two of the five activities of daily living”, while one insurer also accepts “significant cognitive impairment”. These categories of claim will be discussed in more detail later in the section on Loss of Independent Existence benefits.

16.5 Benefit Structure

The TPD benefit may be structured in two ways, which I shall name “early payment” and “separate payment”. One insurer refers to these as “linked cover” and “stand alone cover” respectively and a few other call them “single benefit” and “double benefit” respectively. There are also a few occurrences of unhelpful meaningless names presumably thought to have marketing appeal.

Under “early payment”, the TPD benefit is regarded as an early payment of part or all of the death benefit. That is, where the TPD sum insured was equal to the death sum insured, payment of a TPD benefit caused the policy to cease. If the TPD sum insured is less than the death sum insured, payment of the TPD benefit causes the death benefit to be reduced by the TPD benefit paid, and future premiums for death cover are based on the new reduced sum insured.

Under “separate payment” the death cover and TPD cover are regarded as quite separate. Payment of a TPD benefit does not reduce the death benefit.

Of the 14 products offering a TPD option, nine structure it as early payment. These nine products include the two no-frills products that offered TPD cover.

Two of the 14 products give the choice of early payment or separate payment.

The other three products offer the choice of early payment or separate payment in the varieties that did not allow trauma cover, but only offer early payment in the variety where trauma cover option is mandatory.

In some of the above cases the separate payment structure is only available to certain occupation groups, though precisely which groups these are is not clearly stated.

Historically, insurers tended to retain the right to pay the TPD benefit by instalments over a number of years rather than as a lump sum. This practice predates modern term insurance and was for example also common for TPD options attached to traditional term insurances, whole life policies and endowment insurances. The intention usually was that this option would only be exercised in situations where the insurer had some doubt as to whether the disablement was permanent. If the insured did recover from the disablement, the paid instalments were not reclaimed, but the remaining instalments would not be paid. If further evidence emerged which convinced the insurer that the disablement was permanent, the remaining instalments could be paid immediately as a lump sum.

This practice is now rare. Only two of the term insurance products included this right. In both cases the insurer retained the right to pay the benefit in 10 half-yearly instalments and the CIB gives no indication of when the insurer would choose that option. The death cover sum insured would be reduced by the amount of each instalment as it was paid, the premium being reduced appropriately. From a strictly financial point of view, the insurer is better off paying all TPD claims by

instalments, since there is a chance of recovery, delaying payment boosts investment earnings, and delaying the reduction to the death sum insured boosts the premium income for the death cover.

16.6 Benefit Size

The TPD sum insured is usually subject to a maximum of the death cover sum insured, though two products do not impose this restriction and one other limits the TPD sum insured to twice the death sum insured. For one product, the variety including trauma insurance required identical sums insured for death, terminal illness, TPD and trauma.

Most products, also subject the TPD sum insured to a maximum dollar amount. Maxima are typically in the range of \$1M to \$2.5M with no easy generalisations possible about patterns emerging within that range. One no-frills product imposes a maximum of \$500,000. A few products impose different maxima for the three different definitions, using a maximum of \$500,000 if the “homemaker” definition is being used.

When setting maximum sums insured, no product differentiated between the “separate payment” and “early payment” structures.

Minimum sums insured were rare, only two products specifying minima of \$50,000. That is, if TPD cover was included the minimum sum insured for TPD is \$50,000, but it is still possible to not include TPD, effectively giving a TPD sum insured of zero.

16.7 Expiry Date

Before discussing expiry dates, we need to briefly mention the Loss of Independent Existence (LIE) option which will be discussed in more detail later. LIE cover can be viewed as a replacement for TPD cover when the insured life reaches the normal retirement age, where the normal “unable to work” TPD style of definition would be inappropriate. However, some insurers view it instead as a replacement for trauma cover, used when the insured approaches the ages where trauma cover becomes prohibitively expensive and a cheaper option needs to be offered for marketing reasons.

One insurer might say that their TPD benefit expires at say 65 and the LIE benefit starts there and expires at say 100. However another insurer might say that they have a TPD benefit which expires at 100, but at age 65 the definition of TPD changes from the form of section 16.2 to the form that other insurers use for LIE. Clearly these two insurers are offering identical benefits – they have just presented them differently. For the purposes of this section we summarise the situation using the first form of presentation, treating the TPD benefit as expiring at 65.

Most products adopt an expiry date in the vicinity of 65, usually the policy anniversary before 65 or the policy anniversary after 65. One explicitly states expiry is the 65th birthday. Some CIBs imply the expiry date is 65 exact or 64 exact, but this may faulty wording with a nearby policy anniversary being the intended date.

Only one insurer adopted a different age, using 60.

In the 1980s it was reasonably common to find that TPD sums insured “tapered” over the last 5 or 10 years before expiry, meaning that they reduced in annual linear steps. Only 2 products still do this. One, a no-frills product, reduces the TPD sum insured by 10% on each policy anniversary after age 55, becoming zero on the policy anniversary after 64. The other, a full-featured product, reduced it by 20% each year from age 60.

16.8 Entry ages

The minimum entry age is usually the same as for death cover. However, in the few products where the minimum entry age for death cover is 10, that for TPD cover is 15. Also, one no-frills product with a minimum entry age of 18 for death cover uses 21 for TPD cover.

Almost all products use maximum entry ages of 55 or 60, the latter being slightly more common.

Exceptions are rare. One insurer uses 50 for blue collar staff and 60 for white collar. As for death cover, there are also a few cases where a lower maximum entry age is specified if the “level premium” form is selected, these maxima being consistent with those used for death cover.

Another way to summarise maximum entry ages is to consider the gap between them and the expiry age. Most products use 5 years. Two products allow entry up to the year before expiry, though in both cases “expiry” is really the age at which the TPD cover converts to a Loss of Independent Existence cover. There were two cases of gaps of about 10 years, and one insurer had a gap of about 5 years for white collar staff and 15 years for blue collar.

16.9 Exclusions

12 of the 14 products containing a TPD option contained an exclusion for self-inflicted events, the precise nature of the exclusion showing the variations already discussed under death and terminal illness cover.

The other two products were a no-frills product and a full-featured product from a single insurer. This insurer does exclude self-inflicted events for trauma cover, so perhaps the omission of a similar exclusion for TPD was a drafting error.

Three products also explicitly excluded attempted suicide. Presumably the other products are relying on the self-inflicted events exclusion covering this case.

A few products state in their list of exclusions that they won’t pay claims arising from a condition that existed at the commencement of the policy. While many insurers don’t explicitly state this exclusion, it is often implicit in the TPD definition, where the tenses used imply that the event giving rise to the disablement must be in the future, meaning at least after the date the application is signed and arguably after the commencement of the policy. This is a subtle point which the average reader may not notice, so the use of an explicit exclusion seems wise.

It is also relevant to note that any relevant pre-existing conditions should have been disclosed in the application, so the underwriter also has the opportunity to explicitly exclude particular conditions for particular applicants and the insurer has the opportunity to refuse the claim if the applicant fraudulently failed to disclose a pre-existing condition.

Eight products exclude TPD claims arising from acts of war.

Two exclude claims arising from AIDS if the insured chooses not to complete the AIDS questionnaire. Two products exclude claims arising from use of non-prescription drugs or alcohol, with two others excluding these for particular types of TPD claims, such as those due to “significant cognitive impairment.” One product excludes claims arising while engaging in any unlawful activity. As for terminal illness cover, AMP Firstcare insurance excludes claims arising from the policy owner injuring the insured life.

17. Trauma Cover

17.1 Label

At the discussion of Fabrizio (1994), several speakers expressed concern about the marketability of the then common label “dread disease insurance,” and there was much discussion of suitable alternatives. I will use the label “trauma” since it is now by far the most common label, with seven products using either “trauma cover”, “trauma benefit” or “trauma insurance”.

Other labels in use include “critical illness insurance” (twice), “crisis cover”, “recovery benefit”, “recovery insurance”, “crisis recovery benefit”, “medical catastrophe insurance cover” and “living benefit”.

17.2 Availability

Three of the no-frills products have no options at all. The other 14 of the 17 products allow trauma cover to be selected as an option. All the products that can include TPD cover can also include

Trauma cover and vice versa. Of course, as mentioned previously, where a full-featured product is subdivided into varieties, trauma cover is not necessarily available within all the varieties. For example, trauma cover is not available for superannuation policies.

17.3 Trauma events

This is a topic where even a not particularly thorough summary could fill a whole paper. Here I present only a very brief, very shallow summary.

Waiting periods apply to some trauma events, most insurers using 3 months, or less frequently the almost equivalent 90 days. There are only two exceptions, one insurer using 120 days and another 6 months. The 3 month waiting period means that the insurer will not pay a claim for that event if it occurs within 3 months of the commencement of the policy. Some insurers also apply the waiting period to CPI increases, meaning that if the event occurs within 3 months of the increase, the benefit will be the sum insured prior to that increase.

Trauma cover was first sold in the Australian market with a very limited range of events covered, but over time the number of events has increased. There is still considerable variety between insurers concerning the events insured. The following is a brief list of the more commonly encountered events.

Typical events covered which would be subject to the waiting period are:

- Aortic Surgery
- Cancer
- Coronary Artery Angioplasty
- Heart Attack
- Stroke

Typical events which would not be subject to the waiting period are:

- Alzheimer's Disease
- Aplastic Anaemia
- Blindness
- Cardiomyopathy
- Chronic Liver Disease
- Chronic Lung Disease
- Chronic Kidney Failure
- Coma
- Dementia
- Encephalitis
- HIV/AIDS, medically acquired and/or occupationally acquired
- Loss of Hearing
- Loss of Independent Existence
- Loss of Speech
- Major Head Trauma
- Major Organ Transplant

- Motor Neurone Disease
- Multiple Sclerosis
- Muscular Dystrophy
- Paralysis – Diplegia, Hemiplegia, Paraplegia, Quadriplegia, Tetraplegia
- Parkinson’s Disease
- Primary Pulmonary Hypertension
- Severe Burns

The definition of some of these conditions can also vary by insurer.

Though less common, some insurers also include the “Lord Nelson” clause from the TPD definition as a trauma event.

Many insurers also include specific benefit limits on a small number of benefits, the most common being Coronary Artery Angioplasty. The common limits are 10% or 25% of the trauma sum insured, with several also applying dollar limits falling in the range of \$10,000 to \$25,000.

Two insurers offered two different levels of trauma insurance on their full featured products, one of which used a smaller set of insurable events and which hence had a lower premium.

17.4 Benefit Structure

Almost all insurers only offer their trauma cover as “early payment” of the death benefit. Only one product, a full-featured product gives the customer the choice of “early payment” or “separate payment” forms. Curiously one product, a no-frills product, only offers the “separate payment” form.

17.5 Required Survival Period

Five products specify that the insured life is only eligible for a trauma benefit if they survive for a specified period after the trauma event. Three of these products use a survival period of 14 days, one uses 28 days, and the other provided contradictory information, the survival period being listed as 14 days and 56 days in different parts of the CIB. AMP is alone in requiring that the insured must satisfy its 14 day survival requirement without the assistance of a life support system.

The other 9 products do not impose this form of requirement.

For some events such as heart attack or aortic surgery, the event clearly happens at a particular point in time, and the required survival period is measured from that point. Other events such as Parkinson’s disease and Alzheimer’s Disease occur gradually and the survival period is measured from the date of diagnosis of the condition.

Some of the trauma events are life-threatening conditions, so the number of trauma claims excluded by this form of requirement is not negligible.

If the trauma benefit uses the “separate payment” structure the effect of imposing a required survival period is to completely eliminate some trauma claims, and the size of death claims is unaffected. That is, the total claim cost is reduced. Not surprisingly, both the products with a “separate payment” structure do impose a required survival period. Similar comments would apply to stand alone trauma products and such products also usually include a required survival period.

However, if the trauma benefit is an “early payment” the effect of imposing a required survival period of 14 days is to eliminate some trauma benefits and correspondingly increase some death benefits occurring no more than 14 days later. The insurer seems to gain little from this arrangement. The major reason for this arrangement is probably that these insurers sell stand alone trauma products with a survival period, and it is administratively simpler to keep the benefit conditions on the trauma option consistent with those on the stand alone product.

17.6 Benefit Size

Most products imposed a maximum of the death benefit and of a dollar amount. Most of the dollar maxima were \$1.5M, with two occurrences of \$1M and one of \$250,000 on a no-frills product.

Exceptions to the above structure were rare. One product, a no-frills product only imposed a maximum of the death benefit. Two products did not impose a maximum of the death benefit, one of these imposing a maximum of \$1.5M and the other not listing any maximum.

Dollar maxima applied to trauma benefits tend to be less than dollar maxima on TPD benefits on the same product. The only notable exceptions are the cases where insurers have imposed different TPD maxima for the different definitions. Then those using the “home duties” definition tend to encounter a \$500,000 maximum on TPD and \$1.5M on trauma.

Minimum sums insured were rare, two products specifying minima of \$10,000 and two others specifying \$50,000.

When a dollar maximum is applied to a TPD benefit it usually relates to the maximum payable in respect of the policy. By contrast, when maximum amounts are specified for trauma benefits, they are often specified as a limit on all trauma style benefits payable from all policies with the insurer. For example, a limit of \$1M would mean that the insurer will pay a maximum of \$1M in trauma benefits in respect of all policies pertaining to the insured life.

17.7 Expiry dates

Some trauma covers convert to a Loss of Independent Existence benefit at advanced ages. As for the discussion of TPD expiry dates, to gain consistency in this discussion, I will treat that conversion age as the expiry date for trauma cover.

The common expiry ages were 65 and 70, six products using the former and five the latter. There was one occurrence each of 75 and 85.

One insurer offered different expiry ages on its two levels of trauma cover. The “standard” version with a limited range of trauma events used an expiry age of 65 while the “premier” version with more events used 70.

17.8 Entry ages

Almost all insurers use identical minimum entry ages for TPD and trauma, and we have previously noted that TPD minimum entry age is the same as that for death unless the latter was 10. This nice generalisation was breached by only one insurer using 10 for death, 15 for TPD and 18 for trauma.

The most common maximum entry age was 60 with three occurrences of 55 and two of 65. One product used 60 for white collar staff and 50 for blue collar. There are also a few cases where a lower maximum entry age is specified if the “level premium” form is selected, these maxima being consistent with those used for death cover.

For most products the gap between maximum entry and expiry age was 5 or 10 years, with outliers at 15 and 30 years.

Attempts to form generalisations about how the gap from maximum entry age to expiry varies between TPD and trauma cover for each product tend to be foiled by the Loss of Independent Existence (LIE) benefit. There is a tendency for insurers to adopt a smaller gap on the cover which converts to the LIE benefit, but for some insurers this is the TPD cover, for some it is the trauma cover, and for some it may convert from either.

Most products allow trauma cover to be added to the policy without TPD cover being present. Here are the few exceptions.

For two products, the varieties including death cover and trauma cover also require TPD cover to be present, with all those covers having the same sum insured. However, since both products allow

death cover to be purchased by itself and both insurers also offer stand alone trauma cover, it is possible to obtain death and trauma cover without TPD by using two policies.

Two products include TPD in the list of trauma events, so selecting trauma cover automatically includes TPD cover for the same sum insured.

17.9 Exclusions

All trauma products exclude self-inflicted events, with similar variations in the precise definition as discussed for TPD cover.

Most products use the same list of exclusions for trauma as for TPD, but there are a few odd exceptions. Two products which did not exclude TPD claims arising from pre-existing conditions do exclude trauma claims arising from pre-existing conditions. While eight insurers excluded TPD claims arising from war, only four carried this exclusion through to trauma claims.

The above discussion related to what we might call “generic trauma exclusions”. In addition to this, most trauma covers apply more specific exclusions to particular trauma events. For example, a chronic liver failure event may exclude liver disease caused by drug abuse, including alcohol abuse. These exclusions vary considerably by product, so here we merely note they exist and that a more detailed discussion belongs in a paper specifically about trauma events.

18. Interactions between death, terminal illness, TPD and trauma benefits

18.1 Single sum insured; early payments

Some products offer TPD and trauma benefits, but restrict the sum insured to the same level for all benefits. The sum insured is paid when the insured life either dies, or satisfies the definitions of terminal illness, TPD or trauma, and the policy ceases. If a trauma claim occurs for an event which limits benefits to a lower level, say 10% of the sum insured, then that benefit is paid, the sum insured reduces to 90% of the original level and the premium is recalculated for the reduced sum insured. Usually the policy will not allow another trauma claim for the particular event already claimed, but all the other trauma events are still available.

The only extra complication that can arise is if a maximum benefit limit is breached. For example, say the sum insured is \$1.1M, but the terminal illness benefit is capped at \$1M. A death, TPD or trauma claim still results in the \$1.1M sum insured being paid and the policy ceasing. However, a terminal illness claim results in a benefit of \$1M being paid and the policy would continue providing death, TPD and trauma cover with the reduced sum insured of \$100,000.

18.2 Different sums insured; early payments

The most common scenario is that the customer can choose different sums insured for death, TPD and trauma. Usually the TPD and trauma are each restricted to a maximum of the death benefit. The customer cannot choose the size of terminal illness benefit, which is automatically determined from the death sum insured. Often it will equal the death sum insured, but it may be less due to a maximum dollar limit being imposed on the terminal illness benefit, or less frequently due to the terminal illness benefit being defined as a proportion of the death benefit.

The general rule here is that the payment of any benefit results in all the sums insured being reduced by the benefit paid. If this would result in a negative sum insured, that benefit ceases. For example, consider a policy with the following sums insured.

Death	\$1,100,000
Terminal Illness	\$1,000,000
TPD	\$800,000
Trauma	\$500,000

The terminal illness sum insured was not *selected* as \$1,000,000 but rather results from the terminal illness benefit being defined to be the death sum insured, subject to a maximum of \$1,000,000.

On death the benefit would be \$1,100,000 and the policy would cease.

On terminal illness a benefit of \$1,000,000 would be paid, terminal illness, TPD and trauma cover would cease, and the policy would continue as a “death only” policy with a sum insured of \$100,000.

On TPD a benefit of \$800,000 would be paid, death cover would reduce to \$300,000 and TPD and trauma cover would cease. But should the new terminal illness benefit be the new death cover, subject to a maximum of \$1,000,000, giving \$300,000, or should it be the old terminal illness benefit reduced by \$800,000, giving \$200,000? The answer depends on whether the \$1,000,000 maximum was intended to cap the amount of benefit collected due to terminal illness or whether it was intended to cap the total benefits received by the terminally ill claimant at any time prior to death.

Most CIBs indicate that the death sum insured is reduced by TPD and trauma benefits paid, and define the terminal illness benefit from the death sum insured, giving the first of the two approaches discussed above. One insurer states that TPD and trauma benefits reduces both “Death and Terminal Illness cover,” which suggests the second approach above, but that CIB also contains contradictory statements concerning the application of the maximum terminal illness benefit, so the intended approach is unclear. Another insurer explicitly stated a more severe reduction to the terminal illness benefit than either of the two approaches mentioned above. The formula appeared somewhat arbitrary, but there is nothing wrong with such an approach when it is clearly stated in the CIB.

Returning to the example, on a trauma event a benefit of \$500,000 would usually be paid, the death sum insured would reduce to \$600,000 and the TPD sum insured to \$300,000. As in the previous example, there are two possible interpretations for terminal illness, giving \$600,000 or \$500,000, most CIBs indicating the former.

However a trauma claim relating to event which imposed a maximum claim of say 10% of the trauma sum insured would pay only a \$50,000 trauma benefit. The death sum insured would reduce to \$1,050,000, the TPD sum insured to \$750,000 and the trauma sum insured to \$450,000.

It is also possible for an insured to simultaneously satisfy two benefits. For example, some insurers include the Lord Nelson clause as a trauma event, so in the above example someone satisfying the Lord Nelson clause would satisfy both the TPD and trauma definitions. In general, CIBs do not clearly state what happens in this situation. Industry practice is not to pay both the \$800,000 TPD benefit and the \$500,000 trauma benefit. Rather, insurers take the view that the two benefits are processed one at a time. The order is irrelevant. If we process the TPD claim first, the TPD benefit is \$800,000 and this reduces the trauma sum insured to zero, so no trauma benefit is paid. If we process the trauma claim first the trauma benefit is \$500,000, which reduces TPD sum insured to \$300,000. Then we process the TPD claim, giving a \$300,000 TPD benefit, so the total benefit is still \$800,000. Either way, the residual death benefit is \$300,000. Clearly the first approach involves less paperwork, so in practice, when it is possible to claim two benefits at once, choose the larger benefit.

18.3 Different sums insured; mix of early and separate payments

Consider again a policy with the following sums insured.

Death	\$1,100,000
Terminal Illness	\$1,000,000
TPD	\$800,000
Trauma	\$500,000

However this time, while the trauma benefit is still an “early payment”, we’ll make the TPD benefit a “separate payment” style of benefit. Essentially this means that the TPD sum insured will not be effected by and will not effect other sums insured.

On death the benefit would be \$1,100,000 and the policy would cease.

On terminal illness a benefit of \$1,000,000 would be paid, terminal illness and trauma cover would cease, the death sum insured would reduce to \$100,000, but the TPD sum insured would stay at \$800,000. From this point, if the insured dies they receive \$100,000 and the policy ceases, but if they satisfy the TPD definition they receive \$800,000 and the policy continues with the \$100,000 death sum insured still intact.

On TPD a benefit of \$800,000 would be paid, and the policy would continue in force with the other sums insured unchanged.

On a trauma event (other than the special events involving reduced benefits) a benefit of \$500,000 would be paid, the death sum insured would reduce to \$600,000. The TPD sum insured would stay at \$800,000. As in the previous example, there are two possible interpretations for terminal illness, giving \$600,000 or \$500,000, most CIBs indicating the former.

This time if someone satisfied the TPD and trauma benefits simultaneously they would receive both benefits, totalling \$1.3M. The trauma benefit would reduce the death sum insured to \$600,000.

18.4 Different sums insured; separate payments

Now, if both the TPD and trauma cover were structured as “separate payments”, the situation would become simpler again.

A TPD or trauma claim would result in payment of the relevant sum insured and the other sums insured would be unchanged. Payment of a death benefit would still cause the policy to cease.

Essentially the only interactions remaining would be that payment of a terminal illness benefit would reduce the death benefit. That is, in spite of the heading on this section, industry practice is that terminal illness benefits are always regarded as an early payment, not a separate payment.

18.5 An unusual variation

St George’s term insurance product includes TPD as a trauma event. It calls its trauma cover the “Recovery Benefit”. Hence a customer selecting the Recovery Benefit is effectively also getting TPD cover at the same time for the same sum insured. However, the customer can also purchase TPD cover separately. (NRMA’s full featured product also includes TPD in its trauma events but does not allow the TPD option to be selected along with the trauma option.)

The CIB also states:

“The Total Permanent Disability sum insured will reduce by any amount paid under this policy for terminal illness and the Recovery Benefit (if selected).”

and

“The Recovery Benefit sum insured will reduce by any amount paid under this policy for terminal illness and the Total Permanent Disability Benefit (if selected).”

Consider a policy with the following sums insured.

Death	\$500,000
TPD	\$100,000
Recovery Benefit	\$200,000

On a normal trauma event (one not satisfying the TPD definition) a Recovery Benefit of \$200,000 would be paid and the TPD sum insured would be reduced to zero.

Recalling that TPD satisfies the requirements for a Recovery Benefit, what benefit is paid on TPD?

The natural approach initially is to try to analyse the problem in the way we analysed previous benefits, by claiming one benefit at a time. If we claim the \$100,000 TPD benefit first, the Recovery benefit reduces to \$100,000 and then we claim that. The total benefit is \$200,000. If we claim the Recovery Benefit first, we collect \$200,000, and the TPD sum insured is reduced to zero, so again we get \$200,000. The unsettling thing here is that using this logic, adding the \$100,000 TPD cover to the policy does not increase the benefits received in any circumstances. The TPD sum insured has no favourable effect for the customer unless it exceeds the Recovery Benefit sum insured. Since the CIB doesn't include any warning to this effect, we assume this interpretation is wrong.

The only sensible way out of this is to assume this policy behaves differently to what we're used to and that on TPD we are allowed to simultaneously claim the \$100,000 TPD benefit and the \$200,000 Recovery Benefit before the clauses about reducing sums insured take effect. Customer inquiry staff confirmed that this is indeed the case and that in this scenario TPD results in a total benefit of \$300,000.

But then why does the CIB specify that the Recovery Benefit sum insured is reduced by amounts paid under the TPD benefit? This seems superfluous. A TPD claim automatically also pays out the Recovery Benefit, so the Recovery Benefit sum insured is "used up" anyway even if we don't reduce it by the TPD benefit paid.

This question was also addressed to the customer inquiry phone line. The reply was that the reduction process is not superfluous since under this product the insurer has the right to pay TPD benefits by 10 half-yearly instalments rather than as a lump sum, so the Recovery Benefit sum insured is reduced by the TPD instalments as they are paid. Recovery Benefits arising from the insured satisfying the TPD event may also be paid by instalments and then the TPD sum insured is reduced by the Recovery Benefit instalments as they are paid.

If claims are being paid by instalment, it seems natural to reduce the TPD sum insured by the TPD instalments paid and to reduce the Recovery Benefit sum insured by the Recovery benefits instalments paid, but the CIB does not state that such reductions occur.

However, to reduce each sum insured by the instalments paid on the other benefit gives some unexpected behaviour. For example, in the above example if five Recovery Benefit instalments of \$20,000 are paid, this is enough to reduce the TPD sum insured to zero, which leaves one wondering whether the TPD instalments should cease even though only a total of \$50,000 in TPD benefits has been paid. Now if the insured were to satisfy one of the non-TPD Recovery benefit events after the five instalments had been paid, it would seem natural to pay out the original \$200,000 Recovery benefit sum insured less the \$100,000 of recovery benefit instalment paid, but according to the CIB the reduction applied would be the \$50,000 of TPD benefit paid.

Also, we've already established that under this policy the TPD claimant is able to simultaneously collect both the TPD and Recovery Benefit *before* any of the clauses about benefit reduction take effect. Hence it is natural to wonder if this right extends to other benefits. If a single event caused the insured to simultaneously satisfy a trauma event and the terminal illness definition, could she claim both the \$500,000 terminal illness benefit and the \$200,000 Recovery Benefit before either reduces the other? This would be consistent with how the TPD benefit is determined.

Perhaps one relevant suggestion that could be made is that if insurers adopt unusual benefit structures, it would be useful for the CIB to include some numerical examples like those above to indicate how the policy behaves. Where the CIB doesn't contain examples, customer inquiry staff appear to have difficulty inventing relevant numerical examples or coping with examples that researchers spring on them without warning.

18.6 Premium reduction issues

In any scenario where a benefit payment causes other sums insured to be reduced, a new premium is determined based on the reduced sum insured. Where a TPD claim has reduced the TPD cover to zero, the new premium won't charge for TPD cover. Similar comments apply to trauma claims. However, terminal illness claims are a little inconsistent since their cost is included in the basic death cover premium. If a terminal illness claim has reduced the death cover sum insured to say \$100,000, the reduced premium will be the normal premium for death and terminal illness cover of \$100,000, even though the insured now only has the death cover and can't lodge another terminal illness claim.

If premiums are to be recalculated, the obvious question is: When? Unfortunately, CIBs are unclear on this issue. In fact, when discussing how the sum insured is reduced, about half the CIBs don't even mention the premium being reduced. This is assumed to be an oversight. Basing the premium on the original sum insured rather than the reduced sum insured leads to unreasonable results. For example, if the sum insured reduction was large and the insured life was at an high age, then basing the premium on the original sum insured could give a premium exceeding the reduced sum insured that can actually be claimed.

The few CIBs that do offer any sort of clarification refer to "future premiums" being reduced. This seems to imply they are adjusted from the next premium due date, which may be sooner than the next policy anniversary if premium are paid more frequently than annually.

Technically, a case could be made for providing a refund of part of the last premium paid prior to the claim, on the grounds that for the remaining period till the next premium date, the potential sizes of benefits have been reduced. This would be administratively cumbersome and no CIBs indicate any intention of doing this.

When benefits are reduced, and premiums consequently reduced, this may result in a premium less than the acceptable minimum premium. Most CIBs are silent on this issue, but here are some possible solutions.

The minimum premium could be waived where the breach results from a benefit reduction. The resulting policy may be unprofitable, but this may be a rare occurrence. The insurer could retain the right to cancel the remaining policy if the premium falls below the minimum. One insurer, when describing the way benefits are reduced, includes the condition that if a reduction causes any sum insured to fall below \$25,000, that benefit is cancelled. If the resulting sum insured is very small, it may be simpler and cause less ill-will to simply pay the sum insured. For example, if indexation had increased a death sum insured to \$1,000,100 and the insured lodged a terminal illness claim which the policy indicates should be capped at \$1,000,000, it would be simpler to ignore the cap and pay the full death sum insured rather than leave a residual \$100 sum insured or to appear petty by cancelling the \$100 policy.

18.7 Option premiums may not be additive

It is also worth noting that premiums for options are not necessarily additive. For example, premium rate tables obtained from some insurers show that the extra premium for adding TPD and trauma cover is less than the sum of the extra premium to add only TPD cover and the extra premium to add only trauma cover. Costing the interactions between options is another complex issue deserving of its own paper. This paper already has quite enough on its hands merely trying to explain how the benefit amounts are determined!

19. Interim Accident Cover

In its most common form, interim accident cover provides insurance against death due to an accident during the period while the application for term insurance is being considered. The CIB usually contains an interim accident cover certificate which will be signed and dated by the

insurer's agent when accepting the term insurance application form from the customer. This certificate constitutes the policy for the interim cover.

The financial needs of the surviving dependents are the same whether the insured died due to accident or sickness. Thus any cover which only pays benefits if death was due to an accident can be regarded primarily as a marketing ploy.

Several CIBs are remarkably vague on some key aspects of their accident cover. For example, many do not seem to indicate to whom the benefit would be paid. Also, while it is usually clear that the insured lives are the same as those in the application for term insurance, many interim covers do not identify the policy owner. Perhaps the unstated intention is that the interim cover has the same policy owner as the application for term insurance. But the application may be for superannuation term insurance with the trustees of a superannuation plan being the policy owners, and it does not seem appropriate for those trustees to be the policy owners of the interim cover which appears to always be an ordinary policy.

There is a tension here between simplicity and thoroughness. There are a large number of aspects of interim cover which could be specified in precise detail and if the legal department were given free rein they could probably fill 5 pages with the fine detail of interim cover. On the other hand, claims under interim cover are rare and it is primarily a marketing initiative, so there is a strong desire to keep the presentation brief and to the point. Most CIBs limit the description to a one page "Interim Accident Certificate" which also acts as the policy document. This length limit seems to have necessitated some vagueness in places.

19.1 Availability

Two of the no-frills products do not provide interim accident cover. One CIB for a full-featured product omits any reference to interim accident cover in just one variety of the product. There seems no obvious reason for doing this so perhaps it is an oversight.

All other products automatically include interim accident cover at no extra charge.

Two insurers do not make interim cover available to people over 60 and discontinue the interim cover if the proposed insured life turns 60 while the application is still under consideration.

A few CIBs state that interim cover is not available if the insured has had a previous application for cover declined. This stops a declined applicant from obtaining a lengthy period of free accident cover by reapplying for term insurance over and over again, with different insurers. The applicant would need to pay the first premium with each application, but could do so in the knowledge that the application would probably be declined and the premium returned.

A few CIBs state that interim cover is not available if the application is to replace an existing policy. In that scenario the usual practice is to choose a sensible date to discontinue to the existing policy, probably the next premium payment date if it is a term insurance, and start the new policy at that same date. Since there is no gap between the two policies, no interim cover would be needed.

A few CIBs give the insurer the right to cancel interim cover at any time by notifying the policy owner in writing.

The AMP Firstcare Insurance CIB states that interim cover is not available if the insured is currently applying to another insurer for insurance.

19.2 Period of cover

Cover commences on the date the term insurance application form is lodged, usually with the requirement that the first premium be lodged with the application. Cover expires when the insurer accepts that application and term cover commences, the insurer rejects the application, or the applicant withdraws the application.

A maximum period of cover is also specified, 90 days being most common, but 45 days and 60 days also being used. In all cases, this period is well beyond the time it would normally take to assess and accept or reject the majority of applications.

19.3 Definition

A few CIBs just refer to “death by accident” without further clarification. Most give further definition, many requiring that death result from “bodily injury caused directly and solely by violent, external and visible means and independent of all other causes” or minor variations of that wording.

Six products also required that the death occur within a set period from the accident, four using 90 days, one using 14 days and one using 12 months. The remaining products do not impose such a requirement.

19.4 More complex variations

Six products also provide interim accidental TPD cover and interim accidental trauma cover if the application for term insurance includes those options. Where interim trauma cover is provided, the interim cover usually only includes a very limited range of trauma events.

Asteron’s interim cover is unique in that the interim death cover and interim TPD cover pay benefits for all death and TPD claims (subject to the normal exclusions) rather than just those arising from accidents. Their interim trauma cover is still restricted to events caused by accidents.

19.5 Benefit Size

The interim accident cover sum insured is usually the amount of term insurance death covered applied for, subject to a maximum figure. The maxima on the interim cover are usually well below the maxima on the term insurance. The maxima vary from \$250,000 to \$1,000,000 with about half the products using \$500,000. Two no-frills products did not set a maximum on the interim cover, but both had both set low maxima on the amount of term insurance death cover.

For the six products where interim TPD cover and interim trauma cover are also provided, the interim cover sums insured are the term insurance TPD and trauma sums insured respectively, each subject to a maximum. There is little pattern to the maxima. Three products apply the same maxima to each benefit. Two other products use TPD and trauma maxima which are half the death maxima, and the last adopts the same maxima for death and TPD but uses half that amount for trauma.

19.6 Effect on the application of an interim cover claim

If the interim cover is still in effect, then by definition the term insurance application has not yet been accepted. So if the applicant for the role of insured life dies before the application is accepted, the term insurance application would lapse and the initial premium lodged with the application would be refunded, but an interim cover claim would be payable if the death was accidental.

Similarly if the product provides interim TPD or trauma cover, a claim for those benefits could be taken into account when deciding whether to accept the term insurance application. While this may appear harsh, it is merely a special case of the insurer’s right to use any relevant information in the underwriting process. For example, in the section labelled “Your duty of disclosure” most CIBs indicate:

“Your Duty of Disclosure continues until the contract of life insurance has been accepted by the insurer and confirmation in writing has been issued.”

Hence even if the interim cover did not include TPD or trauma cover, the applicant is still required to advise the insurer of any serious accidents or illnesses occurring during the interim cover period.

Underwriting decisions on the application may also flow back to the interim cover. Many CIBs indicate that if the information in the application is such that the application for term insurance is rejected, the interim cover is also void.

A smaller number of CIBs give greater detail on the other possibilities here. For example, if the underwriting process results in the insurer offering to provide the term insurance with extra exclusions or reduced sums insured applying, those adjustments would also retrospectively be applied to interim cover.

Some also indicate that if the insurer applies a premium loading, the interim cover sum insured reduces to the level that would have been purchased by the initial premium allowing for the premium loading. That arrangement sounds counterintuitive at first glance so perhaps a numerical example will.

For simplicity ignore policy fees. Ann lodges an application for \$100,000 death cover on her own life, enclosing a cheque for the first year's premium which happens to be \$140. The underwriter decides Ann is a substandard life and loads the premium 100%. The insurer writes to Ann offering \$100,000 cover at double the normal premium and if she accepts she must pay the extra \$140 premium promptly. The underwriting decision also retrospectively reduces the interim cover sum insured to \$50,000. This may appear harsh, but remember that if Ann died before the insurer finalised the decision to offer the policy with a loading, then the application for term insurance would lapse and the insurer would have returned the premium that Ann lodged. It's hard to label any particular interim cover sum insured as "the fair sum insured" when the insured has in effect paid nothing for it! The somewhat arbitrary arrangement of halving the sum insured for the applicant who was thought to have double the normal risk is probably the best we can do.

19.7 Exclusions

Three products do not apply any exclusions to their interim cover.

For the other products, exclusions for interim cover were sometimes equivalent to, but more often more severe than those for the term insurance. There was also considerable variety between insurers. Most products excluded claims arising from:

- suicide, (with no need to specify a 13 month maximum since interim cover is only short term)
- intentional self-inflicted injury
- participating in any sport, pastime or occupation which would not normally be insured at standard terms

Exclusions encountered less commonly, though still appearing in several products, were claims caused by:

- being under the influence of alcohol or non-prescription drugs;
- being engaged in any unlawful activity;
- war, declared or not;
- pre-existing conditions which the insured was aware of or for which the insured received advice or treatment;
- taking part in competitive sport or parachuting;
- flying other than as a fare paying passenger on a commercial airline;
- active participation in riot, strike, civil commotion or usurpation of power.

Several interim covers did not cover the insured outside Australia, and two discontinued the interim cover as soon as they left Australia, so that even a brief absence from Australia early in the application process would void the remainder of the potential interim cover period.

National Mutual had an interesting variation on the "flying" clause, excluding claims caused by:

"making or attempting to make a flight in an aircraft (other than as a passenger for whom a fare or fee has been paid, or as a passenger in an aircraft under charter)"

This “attempting to” phrasing presumably avoids confusion about accidents during take-offs where a litigant might argue that the plane was still in contact with the ground and so wasn’t “flying” yet.

19.8 Multiple insured lives

Where there are multiple insured lives on the application, most CIBs clearly indicated that they are all covered by the interim cover.

However, some of the interim accident certificates then confused the matter. In a few cases there could be multiple insured lives on the term insurance application, but there was only space on the interim cover certificate to enter the name of one insured life. Another certificate correctly left space for two insured lives, but also stated that the interim cover certificate should be retained by the “person” (singular) to be insured.

20. Loss of Independent Existence (LIE) cover

Loss of Independent Existence (LIE) cover may be viewed as a replacement for TPD or trauma cover at advanced ages, typically commencing around age 65 or 70.

20.1 Labels

There is very little consistency in names for this cover. Sometimes even different varieties of the same product adopt different names for it. The names in use include Loss of Independent Existence, Loss of Independent Living, Loss of Independence, Continuation Benefit, TPD Continuation Benefit, LifeCare Continuation Benefit and Long Term Care. Also two products that present that cover as a continuation of TPD cover with an altered definition do not give it a separate name - it is just part of the cover called “TPD cover”.

In this paper I have adopted the label Loss of Independent Existence since it is the only label used by two different insurers. If the industry does eventually adopt a single consistent label for this cover, it is still anyone’s guess what that label will be.

20.2 Availability

Nine products provide LIE cover. However, for one of those products it was not available on the superannuation variety.

LIE cover is a recent development, arising during the last decade or so. It is not currently what would be described as one of the standard available options, but given the relative speed with which several insurers have adopted it, it may soon become standard, at least for full-featured products.

There is still considerable variety in how different insurers have implemented the cover, so unfortunately it is difficult to give broad generalisations for this cover and much of the discussion is going to degrade into merely listing lots of variations, many only occurring in one product. Over time, as insurers refine their current design, we may see more standardisation of approach. This section will also contain some attempt to overwhelm the reader with confusing detail, in the hope that readers will strive for greater simplicity if they ever have the task of designing an LIE cover.

20.3 Benefit criteria

Given the variation amongst other features of this product, there is remarkable consistency between insurers on the benefit definition.

The basic criteria is that the insured will permanently be unable to perform at least two of five specified “activities of daily living”, namely

- bathing and showering
- dressing and undressing
- eating and drinking
- using the toilet

- mobility

Several slight variations in these definition occur, but most only occur for a single insurer each. The only more common variation is in the definition of mobility, which some define with phrases like “moving from place to place by walking, wheelchair or with assistance of walking aid” while others take an approach like “moving from place to place, in and out of a bed and in and out of a chair”, sometimes also adding “wheelchair” as an alternative to “chair”.

It is interesting to note that only one insurer adopts the additional retrospective requirement commonly used in TPD definitions, requiring that the insured must have also been unable to perform two of the five activities of daily living for a continuous period of 6 months. Given that the “activities of daily living” definition is viewed by many products as a replacement for the “unable to work” clause in a TPD definition, it is perhaps surprising that this is not more common.

In addition to the “activities of daily living” approach, five products give an alternative approach to satisfy the LIE requirements. Two use the Lord Nelson clause as the alternative. The other three use “significant cognitive impairment”. Precise definitions of this term vary, but typically include the requirement that the impairment lead to a need for continuous care and/or supervision.

20.4 Exclusions

The exclusions for the LIE cover are generally consistent with the cover it converted from, either TPD or trauma.

20.5 Benefit Structure and sums insured

A typical structure is as follows. A product may have a TPD option with an expiry age in the vicinity of (usually policy anniversary before or after) age 65. At that point TPD cover ceases and LIE cover starts, continuing to perhaps the vicinity of age 100. We’ll refer to the changeover point as the conversion date or conversion age.

In some products the above structure would be presented not as TPD cover to 65 followed by a LIE cover to 100, but rather as TPD cover to 100 with a change of definition of TPD at age 65. Indeed, the latter presentation is the more common approach. However, this is merely a matter of presentation and doesn’t alter the benefits paid. To obtain consistency of explanation here we’ll describe all products in the former “conversion” style rather than the latter “change of definition” style”.

Sometimes the LIE cover arises from conversion from trauma cover rather than TPD cover. It is never possible to obtain LIE cover by purchasing a policy after the conversion age. LIE can only be obtained by already having a policy with TPD or trauma cover as appropriate prior to the conversion age.

Three products subject the LIE sum insured to a maximum dollar amount lower than the maxima which applied to the TPD or trauma sums insured as appropriate. Two products used \$1M while one used \$500,000. These maxima would be applied after using the processes described below to determine the LIE sum insured.

In four of the products LIE cover arises from conversion of TPD cover only and the LIE sum insured would be TPD sum insured. In one product it arises from conversion of trauma cover only and the LIE sum insured would be the trauma sum insured. There was also one product where LIE cover arose from TPD cover in one variety and trauma cover in another.

In three products LIE can arise from either TPD or trauma cover. If a policy only has one of these two options the comments in the previous paragraph apply. If a policy has both options then it becomes more complex. In one of these products the CIB doesn’t clarify what happens. In the other two products the LIE sum insured is the maximum of the TPD or trauma sums insured. To complicate things further, in one of these products different conversion dates applied to the two covers. So, at the policy anniversary before age 65 the TPD cover would convert to LIE, the LIE

sum insured being the TPD sum insured. Then at the policy anniversary before age 70 the trauma cover would convert to LIE, the LIE sum insured increasing to the trauma sum insured if it is greater.

Most products structured the LIE benefit as an early payment rather than a separate payment. In most cases this was the only logical choice, since the benefit resulted from a conversion from a TPD cover or trauma cover which was only available in the early payment form. However, there were also two varieties (from two different products) where the TPD cover was available in both early payment and separate payment form, but on conversion the LIE benefit was always structured as early payment.

There was one product where LIE cover was presented as a continuation of trauma cover with an altered definition, the trauma cover was available in both early payment and extra payment form and the form chosen flowed through to the LIE cover.

Finally there are two more confusing products where the CIB did not adequately explain the products behaviour.

In one product the LIE benefit may arise from the TPD or trauma benefit. While the trauma benefit is an early payment, the TPD can be early payment or separate payment. The complexity arises where a policy has both options but the TPD is a separate payment. It could be argued that the logical behaviour would be to have two separate LIE sums insured, each inheriting the properties of the benefit it converted from. Hence, an LIE claim would result in both the former TPD and trauma sums insured being paid, and the death cover would only be reduced by the amount of the trauma sum insured, not by the TPD sum insured. This does not happen. The CIB indicates that the LIE sum insured will be the maximum of the TPD and trauma sum insured. It also indicates that the LIE cover will be treated as a separate benefit when it arose from the TPD cover of that form, but it unclear which cover the LIE benefit is treated as arising from when the policy has both TPD cover and trauma cover.

The other product can be thought of as the reflection of the above. This time the TPD cover is an early payment and the trauma cover as an extra payment. This product clearly presents its LIE benefits as being TPD and trauma covers under which the definition changes. Hence, after the covers convert to LIE definitions (which happens at two different ages) we can make the same sort of logical argument as the previous case. On an LIE claim it would be logical to pay both sums insured, and the death cover would only be reduced by the amount of the TPD sum insured, not by the trauma sum insured. However the CIB does not adequately describe this scenario so it is unclear what the insurer intends to happen.

20.6 Effect of claims on availability of LIE cover

Consider a product where the LIE benefit arises from the TPD cover. Assume all the benefits are structured as “early payment” rather than “separate payment”. Clearly a TPD claim prior to the conversion age will “use up” the TPD benefit, so the LIE cover becomes unavailable. Also, if a trauma cover claim or terminal illness claim is paid, the TPD sum insured is reduced by the amount of the claim, and the potential LIE benefit is similarly reduced. In some cases the claim will exceed the TPD sum insured, TPD cover will cease and the LIE benefit becomes unavailable. Of course, a death claim causes the policy to cease.

Similar arrangements occur if the LIE cover arises from trauma cover rather than TPD. However, then there is the added complication that some trauma events pay less than the full trauma sum insured, in which case the trauma sum insured and hence the potential LIE sum insured are reduced rather than being totally eliminated.

There were also three products where the LIE benefit could arise from both TPD and trauma. One of these products had an unusual structure and will not be considered again. In the other two, the LIE sum insured would be the maximum of the TPD and trauma cover. If the TPD sum insured were less than the trauma sum insured, then a TPD claim would cause the trauma sum insured to

reduce but still be positive, so one could argue that at the conversion age the LIE cover should be available at the reduced sum insured. In fact, both these insurers have taken a more stringent line. The payment of any TPD or trauma claim, even a trauma claim paying less than the full trauma sum insured if we take the CIBs literally, causes the LIE benefit to become unavailable. One of these products also makes the LIE cover unavailable if any terminal illness benefit is paid.

20.7 Conversion dates

These are effectively the expiry ages of TPD and trauma covers. While these were discussed earlier, we are now dealing with a smaller subset of the products and simpler generalisations can be made for this subset.

When the LIE cover arises from TPD cover, the conversion date is almost always in the vicinity of (typically policy anniversary before or after) age 65, with age 60 being the only and very rare alternative. When the LIE cover arises from trauma cover, the conversion date is almost always in the vicinity of age 70, with age 65 being the only and very rare alternative.

20.8 Expiry dates

There were a few cases of expiry date varying by variety. The majority of products used an expiry age in the vicinity of 100. As mentioned earlier when discussing death cover expiry, an expiry date this high is effectively irrelevant given the low probabilities of renewal beyond age 90.

Expiry dates in the vicinity of 65, 70, 75 and 85 were also encountered, each only occurring for one product or one variety.

There was also one product which, while having an expiry age of 100, converted the LIE cover to the “Premium Freeze” (Level premium, varying benefit) form from the policy anniversary after age 75.

21. Death Cover Buybacks

21.1 The simplest form

There is no particular buyback which can be regarded as typical; there is just too much variety. Instead we’ll start by describing a relatively simple buyback. This will at least give the reader some sort of feel as to the general type of critter we’re dealing with and then we can go on to describe the multitude of species.

If a TPD or trauma benefit is structured as an “early payment”, then on payment of a TPD or trauma claim the death sum insured is reduced by the amount of the claim. If a buyback is in place, then if the insured survives 1 year from the date of the TPD or trauma claim, she has the right to increase the death sum insured by the amount of the TPD or trauma claim, without supplying evidence of health.

That last sentence looks messier than it needs to be – there is a tendency here to want to say “increase the sum insured back to the level it was at before the claim occurred”. However, since CPI increases may intervene, this is not the same thing.

Buybacks don’t apply to the TPD or trauma sums insured themselves. That is, if a TPD claim reduces the death and trauma sums insured, the buyback only allows the death sum insured to be subsequently increased, not the trauma sum insured. So, when people loosely refer to a “TPD buyback”, this is not intended to mean the TPD sum insured is increased, but rather it is a reference to the right to increase the death sum insured that has previously been reduced due to a TPD claim

Buybacks don’t apply if the TPD and trauma benefits are structured as “separate payments”. In that scenario the payment of a TPD or trauma benefit does not reduce the death benefit, so there is no reduction to restore.

The term “buyback” is perhaps misleading, implying that there is some special charge involved. There isn't. The sum insured increases, so the premium also increases to reflect that, but there is no extra fee for implementing the buyback.

Any special conditions such as premium loadings which were applied to the death sum insured also apply the buyback amount.

21.2 Availability

None of the no-frills products contain buybacks.

11 of the 12 full-featured product offer a buyback on at least one variety. However, the pattern of buybacks amongst the varieties seems haphazard and defies a neat summary. To help get this point across, the rest of this section will attempt to overwhelm you with descriptions of the variations encountered.

21.3 Covers with buybacks

Four products consistently offer buybacks in respect of TPD and trauma claims. Three products consistently offer them on trauma claims but not TPD. Another product only offers buybacks on the more comprehensive of two levels of trauma cover. Then three products do not offer any buybacks if death and TPD cover is selected, but if the customer chooses death, TPD and trauma cover, buybacks then become available for both TPD and trauma cover!

Seven of the products offer buybacks on a cover which converts to an LIE benefit. Three of the these consistently offer the same buyback on the LIE benefit after conversion, though in one case the buyback expires at age 75 rather than continuing all the way to the LIE's expiry age. The other four do not offer buybacks on the LIE cover. In two of these cases the buyback expires at the age at which the TPD or trauma cover as appropriate converts to LIE cover. In the other two cases the buyback may expire up to 5 years prior to the conversion date.

21.4 Option or automatic benefit

Five products treat buybacks as an option, involving an extra premium. Three products treat them as automatic benefits, included “at no extra cost” once TPD or trauma cover as appropriate is selected. For one product it isn't clear whether the buyback is a option or an automatic addition. One product includes a TPD buyback as an option, a basic trauma buyback automatically and a faster trauma buyback as an option. Another product uses different patterns for different varieties.

21.5 Timing and spread of options

The major risk with buybacks is that they are giving extra death cover to people who have just experienced TPD or trauma claims, many of whom are very substandard lives. This risk is lessened by requiring the life to survive a year after the claim before receiving the buyback.

All products position the first buyback 1 year after the date of the TPD or trauma claim as appropriate. In one product it was possible for a TPD claim to be paid by half-yearly instalments over 5 years, in which case the buyback is positioned one year after the last instalment. That is, given that the insured must be continuously disabled for 6 months before lodging the claim, the buyback can only be implemented 6 years after the disablement, which drastically reduces the risk inherent in the buyback. This is yet another incentive for the insurer to elect to pay TPD claims by instalment if they have the right to do so.

Seven of the products implement the buyback in one step. Two products spread the buyback over 2 and 5 years respectively. For example, in the latter case the death cover can be increased by 20% of the trauma benefit paid on each of the first 5 anniversaries of the trauma claim. The other two products involve mixtures of spreading over 3 years, with an accelerated buyback being available for an extra premium which causes the buyback to be offered in a single step, and with one of those products involving different treatments depending on whether a TPD or trauma claim was involved.

One product implements the buyback automatically. This may reduce the selection effect against the insurer.

The other products all “offer” to implement the buyback and the customer has to decide whether she does actually want to increase the sum insured by the amount of the claim. Six products indicate that the customer has a window of 30 days to accept the offer, otherwise it lapses, and one product gives 60 days. In some of these cases the window is clearly identified as starting at the anniversary of the claim. In other cases the timing is not clear, though the CIB seems to imply the increase would occur on the claim anniversary. Perhaps the insurer alerts the customer a little over 30 (or 60) days prior to the claim anniversary and the customer has to accept soon enough to allow the increase to be implemented on the anniversary. Three products do not identify any time limit on the offer.

21.6 Effect on terminal illness benefit

We have said that the buyback increase the death cover, so an obvious question is whether it also increases the potential terminal illness benefit.

In one variety of one product it is explicitly stated that the terminal illness benefit is also increased and in one product it is explicitly stated that it isn’t increased. In the other cases one has to read the CIB closely and try to infer the meaning. For example, in some products it is stated that the buyback increases the “death sum insured” and the terminal illness benefit is based on the “death sum insured”, so it also increases.

My best guess is that in six products the terminal illness benefit increases, in one product it doesn’t, and in three products it is unclear from the CIB.

21.7 Exclusions

Three products explicitly indicate that trauma claims resulting in partial payments of the trauma sum insured won’t trigger buybacks. Rather, buybacks only come into play when full trauma sum insured has been paid. However, there were a few more cases where this wasn’t stated explicitly, but various comments in the CIB suggested that the insurer had assumed this would be the case.

ING does not allow a buyback to occur if a terminal illness claim has been previously paid. It is of course unwise to let the customer increase the sum insured if they are expected to die within a year! It could be argued that this exclusion was not necessary, since the claimant would need to survive a year to activate the buyback and the fact that she is eligible for the terminal illness benefit implies she probably won’t survive the year, but given the difficulties of precisely estimating dates of death for terminally ill lives this exclusion appears wise.

National Mutual does not allow a buyback on trauma claims where the claim was in respect of a terminal illness. That is, an insured life may simultaneously satisfy the requirements for a trauma benefit and a terminal illness benefit. She may claim the trauma benefit rather than the terminal illness benefit in the hope that she will survive long enough to claim the buyback. National Mutual has ensured this action does not allow the buyback to be accessed.

There were also a few exclusions relating to particular trauma events, none occurring on more than one product.

22. Guaranteed Future Insurability

Guaranteed Future Insurability gives the customer the option of increasing the amount of death cover at standard premium rates without having to provide evidence of good health.

If this were an open-ended option to increase death cover by any amount at any time, then there would be a significant risk that those electing to take large increases would be of much poorer than average health and that the standard premium rate would be inadequate. Hence the policy document will restrict both the amount by which the death cover may be increased and the timing of those increases.

Usually the insurer restricts the increases to events which result in a genuine need for greater death cover. This makes it more likely that most of the options for potential increases will be exercised. That is, it alleviates the risk that only those in poor health will take up the increases.

Typically to exercise the option the customer will have to increase the sum insured within 30 days of the event occurring, with a few products using 60 or 90 days.

The events which trigger the right to increase the sum insured may be divided into personal events, such as marriage or birth of a child, and business events such as salary increases or increases in the value of a business owned by the insured.

22.1 Availability

None of the no-frills products contain guaranteed future insurability.

Nine of the 12 full-featured products offered guaranteed future insurability with personal events, four as an automatic benefit and five as an option with an extra premium. Six of the full-featured products offered guaranteed future insurability with business events, two as automatic benefits and four as an option with an extra premium.

The above discussion includes three products where guaranteed future insurability was not available on all varieties. One withheld it from the superannuation variety, one from the trauma variety, and one from both the trauma and superannuation varieties.

22.2 Personal events

There was a high level of consistency between products as to the personal events which would trigger the right to increase the sum insured and the size of the increase. All lists of personal events included:

- Marriage, with some products imposing a limit of one per insured life;
- Birth or adoption of a child; and
- Effecting or increasing a first mortgage,

For most products these were the only personal events. Less commonly encountered events included:

- The insured life completing their first undergraduate degree at a recognised Australian university.
- Some arbitrary time pattern, such as every 5th policy anniversary or every 5th birthday from 25 to 45.
- Divorce.

In most cases the event would give the right to increase the sum insured by the lesser of 25% of the original sum insured and \$100,000. The mortgage events triggered the right to increase the sum insured by the amount of the mortgage or the increase as appropriate, subject to a maximum. The maximum tended to be either the lesser of 25% of the original sum insured and \$100,000 or the lesser of 50% of the original sum insured and \$200,000.

Several products also imposed a minimum increase of \$25,000. In cases where the above formula implied an increase of less than \$25,000, it wasn't clear whether the increase would be disallowed or be rounded up to \$25,000.

From the insurer's point of view, one of the frustrating features of the standard personal events is that the insurer usually does not know when a relevant event occurs – though they might detect if an insured life applies for a mortgage from an associated bank – and so they cannot remind the customer of the option when the trigger event occurs. The fear is that most customers will have forgotten about the guaranteed insurability option by the time one of the relevant events occurs, and

the few who will remember are those in poor health who have deliberately researched their options to increase their death cover. This may explain why some insurers have adopted the 5th policy anniversary or 5th birthday event. This provides a regular series of events where the insurer can remind the customer prior to the option date and hopefully convince significant numbers of healthy lives to use the option, reducing the average level of selection against the insurer.

22.3 Business events

These show considerably more variety than the personal events and are difficult to summarise, but they tend to be of two broad types.

Some products used an event of a significant increase in annual remuneration, and expressed the allowed sum insured increase as some multiple of the increase.

Other products require the insured life to be a key person in a business, often a partner or director. The trigger event would be the insured experiencing a significant increase in the value of their financial interest in the business.

22.4 Limits

All products impose an overall limit to the increases, usually using the total of increases for both personal and business events where relevant. For most products the limit is the lesser of the original sum insured and \$1M.

Several products also placed a limit of 1 increase per year, though it is usually unclear whether this refers to calendar year, policy year or any 12 months period.

Most products also impose an age limit, the most common being that no increases are allowed after age 55, though sometimes a policy anniversary near 55 is specified.

22.5 Cover effected

In most products guaranteed future insurability increases the death cover, which effectively also increases the potential terminal illness benefit. The TPD, trauma and LIE sums insured were not usually increased.

There was one product where the business events option also gave the right to increase TPD cover. There was also one variety where trauma and TPD were mandatory and the guaranteed future insurability increased the basic sum insured which applied for all covers, though this variety did allow much lower increases than the other products.

22.6 Exclusions

Several products did not impose any exclusions.

Those that did apply exclusions were reasonably consistent in requiring the original policy to be accepted on standard terms. That is, if any special conditions or premium loadings were applied, guaranteed future insurability was not available at all.

Most also stated that any claim under the policy would remove the right to any further increases. Some broadened this to “eligibility to claim”, and some broadened it to refer to claims under any policy with that insurer.

In respect of the increase in sum insured, most products also exclude claims arising from suicide for 13 months after the increase. Two products also stated that for the first 6 months after the increase in sum insured, the increase would only apply for accidental death.

23. Premium waivers

Seven full-featured products offer some form of benefit which waives premiums during disablement. Most structure it as an option with an extra premium, though in one case it is included automatically if the “separate payment” form of TPD is purchased.

In most such products the insured must satisfy the normal TPD definition to trigger the waiver. Since the TPD benefit is paid TPD cover ceases, so the only remaining premiums are for the death cover and perhaps the trauma cover and premiums for other options. Most products will only waive the death cover premium.

In most forms the waiver expires around age 60 or 65. That is, it ceases before the ages at which the death cover becomes very expensive.

While most premium waiver options are only triggered by disablement, a few variations do occur. For example, MLC's Premium waiver option also waives premiums for 12 months following retrenchment. Also, quite separately from its premium waiver option, Asteron's Term Life Insurance automatically waives death cover premiums on terminal illness.

24. A plethora of options and automatic extras

Product designers can be quite inventive and so there are still many options and automatic extra benefits we haven't mentioned. However, most of them are unique to one insurer. Here is a very brief description of the much smaller number that occur from more than one insurer. All should be regarded as rare, none occurring on more than five products

24.1 Financial Planning Benefits

People receiving large claim payments may need financial advice about how to manage the money. Financial planning benefits reimburse the costs of consulting an accredited financial planner within 12 months of receiving the benefit. This reimbursement will be subject to some specified maximum, products using maxima ranging from \$500 to \$2,500. Some products restrict the claim types which can give rise to a financial planning benefit. Most allow the financial planning benefit to be claimed by the life insured on receipt of a terminal illness, TPD or trauma benefit, or by whoever receives a death benefit, but usually with a maximum of one claim in respect of each life insured.

Four products offer this benefit, all as an automatic extra benefit.

24.2 Children's Future Insurability

Children of the insured life may be listed in the policy. The insurer guarantees to offer each such child death cover up to a specified sum insured when they reach certain ages, usually commencing at 18 or 21. An extra premium is charged for each child. Two products offer this option.

24.3 Children's trauma insurance

In five products children of the insured lives may be insured for trauma cover within the policy. The sums insured allowed are low. A different set of trauma events applies to children's cover, including serious ailments that tend to occur only in childhood and excluding the events that are usually only encountered in the aged. Expiry ages for children's covers fall in the range 16 to 21.

Some products allow the insured child to convert to their own "adult" policy at the expiry of the children's cover without supplying evidence of health. Since the sum insured on the children's cover is low, this right has limited value to the customer. When the child becomes an adult, if they need trauma cover they will probably need to significantly increase the sum insured, and they would have to undergo the normal underwriting procedure for the increase.

Children's trauma cover is usually only available on varieties that can include trauma cover on the adult insured lives. Surprisingly, one product does allow this option on the variety that has no adult trauma cover.

24.4 Counselling

Two products include some level of access to counselling services as an automatic benefit. This service is available to immediate members of the insured life following their death and to the insured in the event of terminal illness, TPD or some trauma events. It is variously known as a grief

counselling service, bereavement counselling service (on death) or trauma counselling service (on terminal illness, TPD or trauma).

24.5 Accidental Death

Three products offer accidental death benefits. One has an option allowing the customer to purchase an additional sum insured which is only paid if death occurs due to an accident. Another has an automatic benefit increasing the death benefit by 50% if death is due to an accident. Another, is an automatic benefit which doubles the death benefit if death was due to a motor vehicle accident, but only where the insured was a driver or passenger, not a pedestrian. The last two are unusual in that they occur on no-frills products, which are usually free of such complications. All require death to occur within 90 days of the accident and significant exclusions apply.

Additional benefits on accidental death used to be more common. However, the financial needs of the insured's dependents are the same whether the insured dies by sickness or accident, so it is hard to view these benefits as anything other than a marketing gimmick. Their decline to minor significance should not be a cause for concern.

24.6 Loyalty Bonus/Continuity Discount

Colonial's product automatically includes a "Loyalty Bonus" which increases the sums insured by 5% without any increase in premium once the cover has been in force for 5 years.

Westpac's product includes a "Continuity Discount" which reduces the premium by 2% in its 2nd year, 4% in its 3rd year, and so on up to a maximum of 10% in the 6th and subsequent year.

At this point the reader might accuse me of arbitrarily grouping two different benefits in order to bypass my earlier statement that I would only list benefits occurring from two or more insurers. However, I hold that the grouping is sensible.

Both schemes are aimed at encouraging renewals. Though, given that these schemes would result in a first year "basic" premium that is a higher than a similar product that doesn't have such a scheme, perhaps it is more accurate to say that they aim to discourage the unprofitable potential customers who only want cover for say one or two years. Though one scheme increases the sum insured and the other reduces the premium, they do have the same aim.

25. Rating Factors

Premium rate tables were obtained for several of the products in this survey.

Premiums vary by age, sex and smoking status.

Most CIBs and premium tables obtained did not provide details of occupational loadings. From the very small sample that did, it appears occupational category is a very significant rating factor for TPD cover, but is not usually used for death cover and trauma cover, though one insurer did give a 5% discount on death cover for the top occupational category.

Most insurers adopt the definition that a non-smoker is someone who hasn't smoked at all in the last 12 months. Those claiming to be non-smokers may be asked to recertify their non-smoking status at policy anniversaries and moved to the smokers premium rates if they no longer satisfy the definition.

However, to be pedantic, most CIBs do not clearly indicate the definition used and we can only guess it from the questions asked of the applicant. For example, one CIB asks whether the insured has smoked during the last 3 years, and if they have quit it asks when they last smoked. This doesn't necessarily mean that their non-smoking definition requires the insured to not have smoked for 3 years. They may normally employ the 1 year requirement, but have asked for a longer history since during underwriting this data may be relevant in conjunction with other risk factors.

Having said that, most products do only ask about smoking in the last 12 months. One asks about 3 years and one asks whether the insured has ever smoked. One product uses 12 months on the variety which includes trauma cover but only 3 months for the variety without trauma cover.

There is also some variety in the substances involved. Four products ask vague questions of the form "Have you smoked in the last 12 months?" leaving the substance unclear. One product explicitly asks only about tobacco. 12 products ask about smoking "any substance" or "tobacco or any other substance." Two of the latter products ask broader questions, Asteron also asking about the use of "any nicotine replacement therapy product" and MLC also asking about the use of "any nicotine-containing product."

It is interesting to note that in the applications forms for two products the insured is asked to state whether she is left- or right-handed. Before flooding the editors with lists of research reports which conclude that there is no correlation between mortality and laterality (handedness), readers should note that the presence of this question does not prove it is being used as a rating factor for death cover. The insurers may simply be doing their own investigation as to whether claim rates for any of the covers vary by laterality. Also, when determining whether a hand injury constitutes grounds for a TPD claim, it may be relevant whether it is the dominant hand. The insurer may collect this data on the application to reduce the risk of fabrication later.

26. Adjusting premium scales

The insurer can adjust the premium rates for all in-force policies. It can also adjust the premium scale for just one particular rating group, such as all male smokers, but after the underwriting process has been completed it cannot single out a particular policy for harsher treatment.

In five products the insurer guarantees to give at least three months notice of any change to premium rates, though in one of those cases the insurer retains the right to make immediate changes in the event of war or invasion involving Australia.

Four products indicate that any change won't have effect until the next policy anniversary. The remaining products are unclear on this issue, raising the question as to whether a change can be implemented prior to the next policy anniversary.

If premiums are paid annually, it would seem harsh to apply a change part way through the policy year, asking the customer for an extra premium to cover the increase for the remainder of the year. The general understanding seems to be that the premium paid has purchased cover for the whole year and no further adjustments can be made.

However, if premiums are paid more frequently, say monthly, it seems that in most products the insurer retains the right to adjust the premium with effect from the next monthly premium due date. Off the record, some practitioners have suggested that while the CIB may confer this right, there is some doubt as to whether the insurer's administration systems could implementing a change to the monthly premium at any date other than the annual policy anniversary.

27. Adjusting Benefits

Occasionally insurers may bring out a new improved version of their term insurance product or make improvements to an existing version. Four products include some sort of indication that such improvements may be passed on to existing customers also.

The products from MLC and National Mutual guarantee that any improvements made to the product are automatically passed on to existing customer.

Lumley Life's product indicates that where benefit improvements are made for new policies without changing premium rates, the insurer will seek to pass on these benefit improvements to existing customers *where possible*. This wording recognises that sometimes it is impractical to pass on an improvement to existing customers. It also clearly does not cover the scenario where the

existing product is closed to new business and replaced by a new term insurance product with a different premium scale.

The product from American International Insurance takes a different approach, indicating that where the benefits provided under the plan change, the insurer will give the customer the option to change to the new plan. This recognises that while a benefit review usually results in an improvement to the total package of benefits, it can also involve trimming some particular benefits or removal of some options, or might involve a premium increase. Thus there may be individual customers for whom the “upgrade” is really a downgrade. Giving each customer the choice whether to upgrade seems the fairest approach.

In the last decade the product feature most commonly varied is probably the list of trauma events, and the variations have usually lengthened the list of trauma events or broadened the definitions. This is also arguably the area where insurers suffer most from a paucity of reliable claims data. This situation is not helped by the frequent changes to definitions which ensure that all but the very recent claims data relates to an outdated set of trauma event definitions.

Also, in the discussion of Fabrizio (1994), several speakers expressed concern about the potential for unexpected variations in trauma claim rates due to changes in medical technology and suggested that it would be more appropriate to implement trauma cover in a manner similar to general insurance contracts, with the insurer retaining the right to review definitions at each policy anniversary.

Yet now, almost a decade on, only two products give the insurer the right to alter the trauma definitions after the policy is sold. The CIB for NRMA Term Life Insurance indicates:

“The Trauma and Trauma Plus options are intended to provide a benefit to assist recovery after the life insured suffers a specified trauma. For this reason we need to regularly review the:

- definitions of the specified trauma conditions; and
- the trauma conditions themselves;

in the light of medical advances and treatment.”

(NRMA Term Life Insurance CIB p6)

The product from MLC adopts a similar condition on its “Critical Illness Standard” trauma cover but not on its higher level “Critical Illness Plus” cover.

The right to vary the trauma events and definitions is certainly a valuable right to the insurer and could be used to control unexpected increases in claims costs for particular trauma events. It can also be in the interests of the customer. Some trauma events are specific medical procedures. If those procedures become outdated then it is sensible to remove them from the list of trauma events, otherwise the product will be encouraging people to opt for the outdated medical procedure in preference to the improved modern procedure.

28. Cooling off period

The cooling off period for life insurance contracts was previously implemented by the Insurance Contracts Act 1984. It is now controlled by Division 5, Sections 1019A and 1019B of the Corporations Act 2001, these sections having been introduced by the amendments to that act implemented by the Financial Services Reform Act 2001.

Section 1019B(1) states that during the cooling off period,

“the client has the right to return the financial product to the responsible person and to have the money they paid to acquire the product repaid.”

For a life insurance contract, the responsible person is the insurer. Section 1019B(3) states the cooling off period is 14 days,

“starting on the earlier of:

- (a) the time when the confirmation requirement (if applicable) is complied with; or
- (b) the end of the 5th day after the day on which the product was issued or sold to the client.”

For term insurance, complying with the confirmation requirement would involve notifying the customer that the application has been accepted and would usually involve supplying the policy document. The policy document will usually consist of a generic document suitable for most customers purchasing that particular product, and a schedule listing the details specific to that policy, such as the insured lives, the sums insured, the options selected and any special conditions imposed due to underwriting.

Most of the products surveyed state that they provide a cooling off period of 14 days from the day the customer receives the policy document and related material. One product measures the cooling off period from the earlier of the day the customer receives the policy document and 5 days after the date the insurer issued it. Another uses similar wording with “5 days” replaced by “5 business days.”

Four products use longer periods. Two use 21 days from the day the customer receives the policy document, one uses 28 days from that date, and one uses 28 days from the day the insurer issues the document.

29. Availability of policy documents

Two insurers, ING and Lumley Life, have made the policy document available in the CIB. This proved very useful. In situations where the brief plain English “Key Features Statements” required by ASIC were unclear on more complex issues, the legalistic policy document would usually clear up any confusion. It is possible that making the full policy document available to the customer in advance would result in a smaller proportion of policies being returned during the cooling off period.

While no consistent attempt was made to obtain policy documents from other insurers, sometimes when quizzing customer inquiry staff about ambiguities in CIBs I asked whether I could obtain a copy of the policy document. The answer was always no. This did not appear to be a secrecy issue. Rather, the answer was usually that the customer inquiry staff could not access policy documents, so the only way to obtain them was to buy the product.

This does not appear sensible. The policy document is the contract, the CIB merely being a summary. If a potential customer inquires about an ambiguity or contradiction in the CIB, it would seem imperative that the customer inquiry staff have access to the policy documents to attempt to resolve the question.

30. Further discussion on early payments and separate payments

In the discussion of TPD cover, trauma cover and LIE cover, one aspect mentioned was whether the benefit was structured as an early payment of part or all of the death benefit or a separate payment from the death benefit. The other obvious question is: Which form is best? This is another issue which, if analysed thoroughly, could probably fill a paper, but here are a few brief comments.

Amongst insurers, there seems to be a preference for the early payment form, this preference being extreme for trauma cover and LIE cover.

Perhaps the major reason for this is that it eliminates a major source of potential claim disputes. For example, some trauma events are life threatening situations, so it would not be uncommon to encounter situations where insured lives die shortly after a trauma event. However, some trauma events are quite subjective, so it is possible for an insured life to experience a severe trauma-like event but to die before sufficient medical evidence could be obtained to determine whether they satisfied the policy’s trauma event definition.

If the trauma benefit is in early payment form, the above scenario causes no problems. If the insurer pays a trauma benefit and then a reduced death benefit, they pay the same amount as if the trauma claim is ignored and the full death benefit is paid. However, if the trauma benefit is in separate payment form, the beneficiaries can collect a larger total benefit if they can successfully argue that the insured did satisfy the trauma definition before they died. Technically, the extra costs involved, including the legal costs involved in disputing unreasonable claims, can be built into the trauma cover premium rates, which are higher for the separate payment form. The public relations costs are more difficult to quantify.

As noted previously, while survival periods are not commonly imposed on trauma cover, the two products that do offer it in separate payment form both require the insured to survive 14 days after the trauma event for a claim to be paid. This allows time for more accurate diagnosis and reduces the risk of disputed claims.

The risk of disputed claims is much lower for TPD cover. The requirement to be unable to work for a continuous period of 6 months gives plenty of time for accurate diagnosis. As noted previously, more insurers are willing to offer the separate payment form on TPD cover than on trauma cover. In the light of these remarks, it is again surprising that most insurers do not carry the 6 month requirement through to LIE cover, or that more do not impose longer required survival periods on their trauma cover.

All the other arguments seem to favour the separate payment form.

The separate payment form seems to better meet clients' needs. The fact that the insured has experienced some form of disablement or trauma does not mean that the needs of her financial dependents after her death are reduced. A form of benefit that reduces the death benefit available to those dependents seems intrinsically flawed. A numerical example may clarify the difficulties here.

Consider how an intelligent customer may determine the required sums insured. Perhaps they believe they require \$100,000 on trauma or TPD to cover such costs as rehabilitation, carrying out modifications to their home to assist in coping with a disability, and any medical costs not covered by Medicare or their health insurance. They also believe their dependents will need \$500,000 after their death. In reality they may also have significant savings which will reduce these needs, but we'll ignore that complication for the moment.

If they can purchase both trauma and TPD cover on a separate payment basis, they simply purchase \$100,000 cover for both those benefits and \$500,000 death cover. However, if they can only obtain these benefits in early payment form, they will need to purchase \$100,000 of TPD and trauma cover and \$700,000 death cover. This ensures that if they have both a TPD claim and a trauma claim, each of \$100,000, the death sum insured is \$500,000 after the reductions have been implemented. However, if they die before any other claims occur, the benefit is \$700,000, so they have effectively been paying for more cover than they need.

Buybacks on the early payment structure can reduce this problem, but appear to be a complicated way to partially solve a problem that could be more simply and thoroughly solved by using the separate payment structure. Since the insured life needs to survive for a year after the TPD or trauma claim to exercise the buyback, she may find that she has inadequate death cover in the year following her TPD or trauma claim, when her risk of death may be quite high. Buybacks may also introduce a significant selection risk for the insurer.

Incidentally, any discussion of the best way to meet clients' needs must also touch on the issue of Disability Income Insurance (DII). This product is generally far better at meeting clients' needs since it also provides benefits for the far more common *temporary* disablements, while TPD cover only covers *permanent* disablements. DII also provides a benefit in the form of a regular income, which is usually easier for clients to cope with than a lump sum benefit. However, insurers are unwilling to offer DII to customers with volatile income levels. TPD cover is not an ideal solution, but for some customers it is the only solution they can purchase.

The separate payment form appears to be simpler to cost than the early payment form, particularly if the early payment form also involves buybacks.

The separate payment form is much simpler to explain than the early payment form. Ambiguities were far more likely to arise in CIBs when dealing with the early payment form and the buybacks which may be provided with that form.

In particular, it seems preferable to not allow the customer to “mix and match”. The scenario where TPD was in early payment form but trauma was in separate payment form, and the reverse scenario, tended to cause particular confusion in CIBs, particularly so if both those covers could convert to LIE cover. If a choice of both forms is offered it is simpler to use the approach adopted by for example AMP, where the customer either has all covers in early payment form or all covers in separate payment form. (This description is still not quite true, since in the separate payment form, the terminal illness remains an early payment of the death benefit.)

31. Multiple Lives

It was noted earlier that many products allowed multiple insured lives. In a small number of cases, a closer reading of the CIB seems to indicate that the while two insured lives can be listed on the application, the insurer would actually create two separate policies. However, in most cases the insurer would be creating a single policy with two or more insured lives.

In most cases, CIBs are very vague on the issue of multiple insured lives. They indicate that multiple insured lives are possible, usually state the maximum allowed, though in some cases this was inconsistent with the number which could be listed on the application form, and indicated that savings would result due to only having to pay one policy fee.

Apart from mentioning these features, most CIBs seem to be written assuming there is only one insured life. (Most of this paper has been written in a similar vein.) For example, many CIBs indicate that the policy ceases on the death of the insured life, but fail to mention what happens if there is more than one insured life. Presumably the intention is that the policy continues for the remaining insured lives, though this is not usually stated.

It is also unclear what happens if the insured life who died was also the sole policy owner. While there may be established legal principles to deal with this situation, the CIBs give no hint of what they are. Unless the policy owner thoughtfully dealt with ownership of the policy in her will, there is a risk that on her death the policy on the remaining lives will have an inappropriate policy owner or owners.

Lumley Life’s solution to the above is to effectively unravel the multiple life policy on the first death. Death of any insured life triggers a 60 day option during which each surviving insured life can replace their cover by a new individual policy, ensuring that they can each choose an appropriate policy owner and beneficiaries.

Application forms indicate that where there are multiple insured lives they each have their own sums insured, a factor usually overlooked in the rest of the CIB. For example, where TPD cover in early payment form is added, many CIBs state that on payment of a TPD benefit, *all* the other sums insured are reduced by the TPD benefit paid. While it is possible to do this, the intention was probably that only the sums insured *for that particular insured life* would be reduced by the amount of the TPD benefit paid.

32. Fallen by the wayside

We have already mentioned the following previously common features as now being rare.

- Large range of premium frequencies.
- Reversion to level sum insured if two consecutive CPI increases refused.
- TPD benefits paid by instalments.

- Accidental death options.

Here are a few other features which used to be encountered on term insurance in the 1980s but which are no longer encountered or seen only rarely.

32.1 Policy establishment fees.

As with most regular premium life insurance products, the insurer incurs acquisition expenses which significantly exceed the first premium, so there is a “new business strain”. In fact, in the early 1980s the problem appeared to be worse for the modern term insurance than for the traditional term insurance it was replacing. The traditional term insurance had a level premium, but no surrender value, so the customer who had purchased the traditional term insurance was unlikely to lapse it to switch to a different insurer. By contrast, the modern term insurance contained no disincentive for the healthy to switch to a different insurer when lower premiums could be obtained. Insurers were expecting higher lapse rates on the modern contract and so had to plan to recoup the new business strain over a shorter period.

Many tried to do this by having a policy establishment fee, a one-off dollar amount charged at the outset. The fee would both reduce the size of the new business strain and hopefully reduce the incentive to frequently switch between insurers. Indeed, if all insurers set policy establishment fees at the level of the acquisition expenses incurred, this probably would be more equitable to the customers and far less risky for the insurers.

Unfortunately, it seemed most customers disliked paying a one-off up front fee, but tended not to notice if an equivalent amount in present value terms was hidden, spread over many years, as part of the normal annual premium. So if some insurers had policy establishment fees, those that didn't had a significant marketing advantage. Policy establishment fees virtually disappeared from the landscape by the end of the 1980s.

32.2 Cancellable versions

In addition to the guaranteed renewable version, some insurers offered a cancellable version of term insurance. Under the cancellable policy, the insurer retained the right to re-underwrite the policy on each renewal date and to refuse to renew the policy. The insurer could offer this policy to people it was unwilling to insure on a guaranteed renewable basis.

The existence of the cancellable policy allowed otherwise uninsurable lives to obtain death cover. However, the death cover obtained was rather tenuous, because if the insured life developed some serious life-threatening illness, the insurer would almost certainly discontinue the policy at the next renewal date.

Unfortunately, when insurers did exercise their right to cancel, the insured lives tended to complain that the insurer was being discriminatory, rather than thanking the insurer for having been so helpful in providing several years of cover to a substandard insured life who would otherwise not have been able to buy any cover at all.

Insurers recognise public relations problems when they see them. There is no evidence in CIBs of cancellable versions still being written.

32.3 Preferred lives

As well as the rating categories of smoker/non-smoker, some insurers experimented with a 3rd rating category known in the industry preferred lives, though several other marketing names were used. This category had far more stringent health conditions. These varied by insurer but tended to contain requirements such as never having smoked, limited use or no use of alcohol, taking regular exercise but avoiding dangerous sports, and having favourable scores on other health metrics such as body mass index and blood pressure.

While people satisfying the requirement would be expected to have lower mortality than the average non-smoker, the issue was whether the lower mortality would offset the extra costs of

initially underwriting them, checking whether they still satisfied the conditions at each policy anniversary and detecting fraud.

Apparently, it didn't. Premium scales obtained from insurers now only contain smokers and non-smokers rates.

33. Relationship to disability income insurance

For nine products the CIB for term insurance also included Disability Income Insurance (DII).

In many cases there were no special links between the two products. The insurer had simply chosen to present the two most common risk products in a single CIB. Usually there was a single application form covering both products. This complicates the process, since some customers will only be purchasing one product while some will purchase both, and the application has to indicate which questions apply to each product. No matter how well the instructions are written, the error rate in form completion is likely to be higher than the scenario where separate CIBs and separate application forms were used for term insurance and disability income insurance.

In four cases there was a much stronger link. If the applicant applied for both term insurance and disability income insurance they would be provided in a single policy with a single policy fee. In this case the insurer has no choice but to include both products in a single CIB with a single application form.

Given the above innovation, it is natural to ask whether term insurance and DII should now be regarded as a single product. The reader will no doubt be pleased to know that I still regard them as completely separate products, so I will not be subjecting the reader to a further 50 pages discussing the features of DII.

34. Final Comments

There is a tendency to dismiss term insurance as a simple product with little to interest the serious actuary. Indeed, as a few of the no-frills products demonstrate, it is possible to construct a very simple term insurance product. However, if this paper has done nothing else, I hope it has convinced readers that term insurance is often a very complex problem and that it contains many interesting actuarial problems which do not yet appear in the publicly available research.

In some cases, I hope it also causes actuaries to reconsider whether some of the term insurance products being sold are too complex. If actuaries employed by life insurance companies have some doubts on this issue, I recommend they phone their customer inquiry number pretending to be a potential customer and attempt to discuss the more complex aspects of their product.

35. Bibliography

Fabrizio, E and Gratton, W.K. 1994, 'Pricing Dread Disease Insurance', *Transactions of the Institute of Actuaries of Australia*, p292–468.

Insurance and Superannuation Commission. 1996. 'Circular to Life Insurance Companies and Life Brokers. Consumer Issues No G.I.1. Disclosure Requirements for Promotional Material in the Life Insurance Industry. February 1996.'

Customer Information Brochures

There appears to be no standard agreed format for referencing customer information brochures. They can be uniquely identified by the name of the insurer, the title of the brochure (often a product or product grouping), and the issue date. For clarity, the following list also shows the expiry date, which is often, but not always, 12 months later. Some insurers also give each brochure a sequence or issue number and where this occurs it has also been shown below. Where the commonly used name of the financial group which owns the insurer is not obvious from the insurer's name, the former is shown in brackets.

Insurer [Group]	Brochure Title	Issue Date	Expiry Date	Issue number
American International Assurance Co. (Australia) Ltd	Priority Protection	1/7/2003	10/3/2004	
AMP Life Limited	Firstcare Term Life Insurance	1/8/2003	31/12/2003	Issue 7d
AMP Life Limited	Risk Protection	1/7/2003	31/12/2003	Issue 11
Asteron Life Limited	Life Insurance	1/7/2003	10/3/2004	Issue No 1
Citicorp Life Insurance Limited	LifeTime Insurance	1/10/2002	30/9/2003	
Citicorp Life Insurance Limited	Your Life Protection Plan	1/10/2002	30/9/2003	
The Colonial Mutual Life Assurance Society Limited [Commonwealth/Colonial]	Colonial Personal Insurance Portfolio	1/10/2002	30/9/2003	Number 6
Cuna Mutual Life Australia Limited	MemberCare LifeInsure	15/12/2002	14/12/2003	
HCF Life Insurance Company Pty Limited	HCF Life	24/3/2003	23/3/04	
ING Life Limited	World of Protection	1/9/2002	31/8/2003	
Lumley Life Limited	Life Insurance	1/3/2003	31/12/2003	
Lumley Life Limited	Critical Illness Insurance	1/3/2003	31/12/2003	
MLC Limited [National]	Personal Protection Portfolio	1/10/2002	30/9/2003	Issue number 10
MLC Limited [National]	Life Cover Super	1/10/2002	30/9/2003	Issue number 10
The National Mutual Life Association of Australasia Limited. [AXA]	Risk Protection Package	18/8/2003	10/3/2004	
NRMA Life Limited	EasyLife Insurance	21/12/2002	20/12/2003	
NRMA Life Limited	NRMA Term Life Insurance	21/12/2002	20/12/2003	
St George Life Limited	Protection Choices	1/10/2002	30/9/2003	
Westpac Life Insurance Services Limited	Westpac Protection Plans	1/3/2003	29/2/2004	