



**HEALTH FUNDS ASSOCIATION
OF NEW ZEALAND INC.**

Health Funds Association of New Zealand Inc.

**CODE OF PRACTICE
FOR HEALTH INSURANCE
UNDERWRITERS**

PREAMBLE

The Health Funds Association of New Zealand has adopted this Code of Practice as the basis of the self-regulatory procedures members voluntarily adopt as underwriters engaged in the health insurance industry.

In agreeing to abide by this Code, members of the Association are mindful of their responsibilities to members of the public, to ensure there are clearly defined protections and means of redress, for any person who believes a member of the Association has not acted in accordance with this Code.

The enactment of and compliance with this Code of Business Practice, does not over-ride in any way whatsoever Association members' responsibilities under the Fair Trading Act 1986, the Commerce Act 1986, the Consumer Guarantees Act 1993, the Privacy Act 1993, the Human Rights Act 1993, the Insurance Intermediaries Act 1994, the Insurance Companies Deposits Act 1953 and the Insurance Companies (Ratings and Inspection) Act 1994.

Since this Code became effective in July 1992, the Insurance and Savings Ombudsman was appointed in 1995 and the Insurance and Savings Ombudsman's Office became operational in March 1995

Adopted July 1992

Amended June 1995

Amended May 1998

Definitions

“Association” means the association established under the Rules of Association of the Health Funds Association of New Zealand Incorporated.

“Code” means the Code of Practice for Members of the Health Funds Association of New Zealand Incorporated.

“Member” means a member of the Association and, unless the context otherwise requires the expression, includes Full Members and Associate Members.

“Underwriter” means any independent organisation, whether incorporated or not, that carries on the business of undertaking medical health insurance in New Zealand for individuals or groups of individuals.

CODE OF BUSINESS PRACTICE

BACKGROUND

- 1.1 This Code of Practice has been prepared by the major health insurers active within New Zealand, with the assistance of the Commerce Commission.
- 1.2 Medical insurance is a complex subject that embraces a wide range of choices that are difficult for the lay person to evaluate. The industry believes that it is crucially important that consumers are provided with clear information about both the benefits and limitations of the policies on offer so that an informed choice can be made.
- 1.3 This Code has been developed to inform consumers of their rights and reasonable expectations.

2.0 INTRODUCTION

- 2.1 This Code of Practice came into force on 1 December 1992.
- 2.2 It also applies to every person (whether an employee, an individual, a body corporate or an association of persons) who sells or offers for sale a health insurance policy with the authority of any of these insurers.
- 2.3 This Code imposes minimum standards of business practices for various activities that form part of the selling process for health insurance.
- 2.4 The list of organisations marketing insurance that this Code applies to may be modified as and when they leave or join the Association.

3.0 PURPOSE

- 3.1 The purpose of observance of this Code is:
 - 3.1.1 To meet the information needs of clients and potential clients, and to ensure that they are fully, fairly and adequately informed as to:
 - a. The identity of the insurer
 - b. The terms of the insurance
 - 3.1.2 To ensure those persons promoting, marketing and selling health insurance do so in a responsible manner and in good taste.
- 3.2 Any activity that forms part of a selling process for health insurance and that is not specifically governed by this Code shall be conducted in a manner consistent with the purpose of this Code as set out above.
- 3.3 For ease of reference this Code has been divided into a number of sections. These sections are not mutually exclusive and specific information, if it is required to be in a particular format by virtue of one section of the Code, should also be given in that format if it is used elsewhere in the selling process.
- 3.4 In addition to this Code organisations must comply with all other applicable rules of law.
- 3.5 Health insurance within New Zealand is operated by Industrial and Provident Societies, Companies and Friendly Societies. As such the exact legal nature of the relationship between the insurer and

the insured is dependent on the legal status of the insurer. Companies have customers while Societies have members.

3.6 In this document the same terms have been used to describe the agreement between the insurer and the insured, whether the agreement is based on contract or membership.

4.0 HOPE AND FEAR

4.1 Health and the provision of medical treatment are issues of concern to all clients and potential clients.

4.2 The industry realises that ill health and the cost of treatment are issues that need careful presentation. All industry members undertake to exercise good taste in marketing health insurance.

4.3 Insurers will ensure that they are factually accurate at all times and do not raise unwarranted hopes or fears to their clients or potential clients about any matter relating to health insurance.

5.0 THE SELLING PROCESS

5.1 The selling process for health insurance involves one or more of the following activities.

5.1.1 Awareness advertising: Promotions which are designed to generate client awareness but do not enable a person to apply directly for health insurance.

5.1.2 Promotional Brochures: Publications which are designed to promote particular insurance policies but do not enable a person to apply directly for insurance.

5.1.3 Direct Marketing: Any promotional item that by design enables a person to apply directly for insurance.

5.1.4 Proposal: The form clients use to apply for health insurance.

5.1.5 Insurance description: One or more written documents, together containing essential information about the insurance.

5.1.6 A "Free Look" Arrangement: An arrangement providing a clearly stated period of not less than 14 days from the date the full health insurance description is received by the client, during which time the insurance may be cancelled by the client on the basis of a full refund of all amounts paid in respect of the insurance.

5.1.7 Employee or Intermediary Involvement: All activities of the employees or intermediaries of health insurers.

5.2 While the other activities mentioned above may or may not occur during the selling process, the proposal and the insurance description must be part of the sales process of any health insurance policy.

6.0 AWARENESS ADVERTISING REQUIREMENTS

6.1 Awareness advertising must:

- a. Include the name of the advertiser;
- b. Include the name of the underwriter whose health insurance is being advertised;
- c. Identify the general nature of any health insurance being promoted;

- d. Not be misleading or give unrealistic expectations.

7.0 PROMOTIONAL BROCHURE REQUIREMENTS

- 7.1 Promotional brochures must include the following general provisions.
 - 7.1.1 The full name(s) and address(es) of all parties involved in the promotion must be clearly stated.
 - 7.1.2 The date from which the brochure applies must be shown.
 - 7.1.3 The particular insurance being promoted must be identified.
 - 7.1.4 Any person quoted in a testimonial must be identified by name. A testimonial must be relevant, factual and authorised. The insurer shall retain all testimonials used for promotional purposes.
 - 7.1.5 The contents of a brochure must not be misleading or give unrealistic expectations.
- 7.2 Promotional brochures must include the following specific provisions.
 - 7.2.1 Benefits: Brochures must give an accurate indication of the maximum sums payable for any specified class of benefit. This will usually be given in terms of the net sum payable to a client.
 - 7.2.2 Where benefits are subject to internal schedules, usual and customary charges as deemed by the insurer or any other caveat or restriction, the brochure shall include a statement which draws a potential client's attention to the existence of the limit on benefits.
 - 7.2.3 In order to distinguish the benefit limits from the maximum benefits information about them must be given in the same field of vision, in print of at least equal size, in a contrasting print style or heavier density print
- 7.3 The brochure will inform clients that details of the schedule are available for inspection on request. This information shall be in the same field of vision as the main benefit listing.
- 7.4 Accident Cover
 - 7.4.1 The policy's benefits in relation to claims resulting from accidents are to be stated and any particular procedures that must be followed for accident claims must be noted both on promotional brochures and on claim forms.
 - 7.4.2 The benefits offered by a policy in relation to the user charges imposed for treatment funded by the Accident Compensation Corporation (or its successors) are to be stated in a similar manner to all other benefit classes.
- 7.5 General exclusions that apply to any policy shall be printed clearly and unequivocally on the brochure.
- 7.6 Term of cover
 - 7.6.1 Health insurance is usually an annual insurance the terms of which can be changed from time to time. The brochure must therefore be endorsed that terms are subject to change on an annual basis or from time to time, and this endorsement will be printed in a similar manner to the requirements of 7.2.3.
 - 7.6.2 Terms and benefits that will be available to an insured after the expiry of a specified period, such as cover of pre-existing health conditions or reference to premium changes at a specified ages must also be stated clearly.

8.0 PREMIUMS

- 8.1 Premiums and any other charges payable by a client shall always be expressed inclusive of GST.
- 8.2 A potential client shall be given written details of the premium required for a particular health insurance in conjunction with the "free look" offer.
- 8.3 Where advertisements or promotional brochures give premium details for any policy, such details shall be representative of the premiums generally applicable to that policy.
- 8.4 Clients and potential clients must be informed of the method of making changes to premiums.

9.0 GROUP POLICIES

- 9.1 Group policies shall be marketed in accordance with the provisions of this Code.
- 9.2 Any changes to premiums, benefits and exclusions produced as a result of the difference between an individual and group policy shall be clearly brought to the attention of the potential client.
- 9.3 A client or potential client must be informed of any change in premium arising as a consequence of joining or a leaving a group scheme.

10.0 DIRECT MARKETING AND TELEMARKETING

- 10.1 Direct marketing must satisfy the requirements for promotional brochures as described in Clause 7.
- 10.2 Telemarketing must satisfy the requirements for (as far as is reasonably practical) the proposal process as described in Clause 12.
- 10.3 Telemarketing shall only be carried out using fully scripted telephone calls that comply with this Code.
- 10.4 All telephone marketers must clearly disclose their identity and state the purpose of their call at the commencement of the call.
- 10.5 Offers or solicitations must not be made in the guise of research or a survey when the real purpose is to sell a policy or product.
- 10.6 All documents confirming the contact must contain means for the consumer to contact the telemarketer person making the call or, in the case of an appointment to visit the home, a contact point must be given so that the appointment may be altered or cancelled.
- 10.7 The caller must provide the recipient with a clear opportunity to refuse any appointment or offer. A definite refusal must be accepted. People must not be subjected to harassment either through high pressure selling tactics or excessive attempts to persuade them to change their minds.
- 10.8 Telephone calls to private homes should only be made at reasonable times, normally between 8.30 am and 8.00 pm, unless the caller is justified in believing that a call at another time would be more convenient and acceptable.
- 10.9 Senior citizens must not knowingly be called after dark.
- 10.10 Calls should be avoided on Sundays and public holidays.
- 10.11 Unsolicited approaches by telephone on private business must not be made to people at their place of work.

10.12 Unlisted or unpublished numbers should not be called.

11.0 COMPARATIVE ADVERTISING

11.1 Comparative advertising is advertising that promotes the advertiser's own products by comparing and contrasting its products against those of a competitor or competitors.

11.2 It is acknowledged that comparative advertising imposes higher ethical standards on an insurer than merely promoting one's own product.

11.3 An insurer using this method of advertising will ensure that it is factually accurate about its own product and about any representations it makes about a competitor's product (whether or not that competitor is identified by name).

11.4 An insurer using this method of advertising must ensure that it does not mislead by omission, either about the advantages of a competitor's product or the disadvantages of its own product.

12.0 THE PROPOSAL PROCESS

12.1 The proposal process must include the signing by the client of a completed application form.

12.2 A written description of the health insurance must be provided to the client. It may be provided separately, in one or more of the selling process activities described in this Code, as part of the application form, or in any combination of these three options. The information contained in the written description must be current at the date the client completes and signs the application form.

12.3 On acceptance of a proposal the insurer must provide a complete written description of the policy that includes the following information:

12.3.1 The name and address in New Zealand of the underwriter issuing the insurance;

12.3.2 The premiums to be paid;

12.3.3 The frequency of the premium payments;

12.3.4 The period for which premiums cease (if applicable);

12.3.5 A description of the policy's benefits;

12.3.6 A general statement of the circumstances which may restrict or invalidate the receipt of benefits by the policyholder;

12.3.7 Information identifying the waiting or no claim periods for which the insurance policy gives no benefit;

12.3.8 If premiums may be altered at the initiative of the underwriter a statement of how and when this may occur;

12.3.9 A statement describing the circumstances that will cause the insurance policy to terminate;

12.3.10 Advice on where a specimen of the appropriate insurance agreement is available;

12.3.11 A breakdown of charges which are separately identifiable;

12.3.12 The duration of any "free look" period;

- 12.3.13 The date on which, or circumstances required before, insurance cover will commence;
- 12.3.14 The written description must be accurate and must not be misleading or give unrealistic expectations;
- 12.3.15 Refer to the existence of this Code.
- 12.4 The application form must include:
 - 12.4.1 A declaration for the potential client to sign requiring the client to affirm:
 - a. That the client is signing on behalf of all family members included on the application form; and
 - b. That the client has disclosed the state of health of all persons included in the application; and
 - c. That the client has disclosed whether any person included in the application is suffering from any pre-existing condition.
 - 12.4.2 Adjacent to the declaration must be a warning that; "Failure to make this declaration truthfully may invalidate your insurance";
 - 12.4.3 A section inviting the potential client to provide details of the date of the last doctors visit and the reason for the visit;
 - 12.4.4 A section inviting the potential client to provide details of any pre-existing condition they suffer from;
 - 12.4.5 A statement inviting them to supply similar details for all other family members included in the application.

13.0 CERTIFICATES OF INSURANCE

- 13.1 Once an insurer has received a completed application form from a prospective client and has decided to accept the risk, then the insurer will provide an insurance certificate to the client.
- 13.2 This certificate shall include the following information:
 - 13.2.1 A unique membership or contract number to identify the client;
 - 13.2.2 The name and address of the client and other family members included in the policy;
 - 13.2.3 The date from which insurance cover commences;
 - 13.2.4 The date from which any benefits can be claimed (if different from the above);
 - 13.2.5 Any conditions from which all cover is excluded;
 - 13.2.6 Any pre-existing conditions from which the insured or other family member are suffering, for which cover is excluded or accepted.
- 13.3 A client will also receive either on the certificate of insurance or on an accompanying document:
 - 13.3.1 A customer service telephone number for the insurer;
 - 13.3.2 The address of the insurer for claims;
 - 13.3.3 Details of the procedure for making a claim.

14.0 FREE LOOK REQUIREMENTS

- 14.1 A "free look" arrangement must apply from the date the full written insurance description has been received by the client, and must be for a period of not less than 14 days. A "free look" arrangement is not required if a full written insurance description has been received by the client more than 14 days before the date on which the application form is signed and that description is still current at that date.
- 14.2 An insurance description sent by post to a client will be deemed to have been received by the client on the third day after the date of posting.
- 14.3 A "free look" arrangement must permit the client to cancel the insurance at any time during the free look period and receive promptly a full refund of all amounts paid in respect of the insurance.
- 14.4 Any client who is in receipt of a "free look" must also be given written information as to any restrictions or limitations on cover which apply to their particular contract, e.g. acceptance or exclusion of cover for pre existing conditions or duration of waiting periods if any.
- 14.5 The lodging of a claim by an insured within the "free look" period shall be deemed to be acceptance of the insurance offered.

15.0 REQUIREMENTS FOR EMPLOYEES AND INTERMEDIARIES

- 15.1 Each insurer will bring the Code to the attention of their employees and intermediaries and will require their agreement to comply with the Code as a term of either their employment or as a condition of doing business with them.
- 15.2 All intermediaries must comply with the provisions of the Code as it applies to Insurers in terms of the information they are required to give the potential client.
- 15.3 General Sales Principles
Intermediaries and employees must observe the following at all times:
- 15.3.1 Be fully aware of the content of this Code and fully comply with it;
- 15.3.2 Act with care, diligence and honesty in all dealings with clients and prospective clients.
- 15.3.3 Immediately identify themselves when making contact with a prospective client.
- 15.3.4 Ensure that, as far as possible, any health insurance proposed is suitable to the needs of the prospective client;
- 15.3.5 Give advice only on those matters in which they are competent, and seek or recommend other specialist advice if this seems appropriate;
- 15.3.6 Treat all information supplied by the prospective client as completely confidential to himself or herself and to the insurer to which the business is being offered;
- 15.3.7 When proposing replacement of an existing health insurance agreement, they must make it clear to the prospective client that replacement may involve another set of initial costs, and / or loss of protection for conditions developed since the insurance agreement was put in place.
- 15.4 Explanation of the Contract
Employees and intermediaries must be required to explain the provisions of the insurance which they are recommending to ensure as far as possible that the prospective client understands the insurance.
- 15.5 Disclosure of Underwriting Information

- 15.5.1 Employees and intermediaries must, in obtaining the completion of an application form or any additional documents, be required to make it clear that all the answers or statements are the client's own responsibility.
- 15.5.2 Employees and intermediaries must ensure that the consequences of non-disclosure and inaccuracies are pointed out to clients by drawing attention to, and explaining, the relevant statement in the application form.

16.0 CLAIMS PROCEDURES

- 16.1 The claims procedure will be fully explained to a potential client at the time they take out health insurance.
- 16.2 The client will be informed of the time period in which any claim must be received.
- 16.3 The client will be informed of the likely time period that processing any claim will take.
- 16.4 The client will be informed as to whether original receipts for treatment are required for the claim process.
- 16.5 Will be reproduced on each and every pro forma claim form.
- 16.6 Pre-authorised claims: If the policy contains provision to pay major claims directly to a health care provider then the above procedures will be followed as far as is reasonably practical.

17.0 INSURANCE UPDATING

- 17.1 Health insurance is normally an annual agreement, the terms of which may be updated and altered from time to time. Updating can include the alteration of the policy benefits and / or premiums.
- 17.2 In compliance with this Code, an insurer will advise a client in advance of any changes affecting his or her policy before the changes are due to take effect .

18.0 COMPLIANCE PROGRAMME

- 18.1 Each insurer will establish procedures within its organisation to ensure a high level of compliance with the terms of this Code.
- 18.2 The Chief Executive of the underwriter, or an appointee, will delegate appropriate staff to ensure that the organisation complies with the Code.
- 18.3 This program will be designed along sound Quality Assurance principles and pro-actively monitor compliance with the Code and client complaints to the organisation.

19.0 COMPLAINTS PROCEDURE

- 19.1 Any complaints from members of the public must in the first instance be lodged with the Underwriter in question. If a member of the public considers that their complaint has not been treated in accordance with the Code, and resolved satisfactorily by the insurer, then the complaint may be referred to the Insurance and Savings Ombudsman by or on behalf of the person provided that:
 - a. The Insurer concerned is a Participant of the Insurance and Savings Ombudsman scheme.

- b. The complaint has been fully considered by the Insurer named in the complaint and the complainant has not accepted as full settlement any observations made or conditions of settlement or satisfaction offered by the Insurer and deadlock has been reached or the Insurer has not advised the Complainant that deadlock has been reached within three months of the complaint being formally made.
- c. The Insurer does not have available an internal complaints procedure that is operated in a bone fide manner either in accordance with the Code or otherwise so far as to provide a fair and proper procedure for the consideration, settlement and satisfaction of complaints.
- d. The complaint is made to him or her not later than two months after the insurer has informed the Complainant that deadlock has been reached and informed the Complainant of the existence of the Insurance and Savings Ombudsman scheme and of the two month time limit on the lodgement of the complaint.

20.0 FINANCIAL DISCLOSURE

- 20.1 The financial stability of an insurer is an important factor in the consumer's choice of which insurer they select for their health insurance.
- 20.2 All insurers are currently controlled by the legislation relevant to their legal status, be it Industrial and Provident Society, Incorporated Society, Friendly Society or Company. In all cases this requires some form of annual reporting to the appropriate regulatory authority. These requirements are not directly comparable.
- 20.3 All insurers will make available on request to any client or potential client a copy of its audited financial statement for the last reported financial year.
- 20.4 Compliance with the Insurance Companies (Ratings and Inspection) Act 1994 compels those Members of the Association required to comply with the Act to disclose in writing the insurer's current rating or that, by election, the insurer is not required to have a credit rating.

21.0 ORGANISATION

- 21.1 This Code shall be operated by the Health Funds Association of New Zealand (HFANZ).
- 21.2 Any organisation qualifying for Membership or Associate Membership under the constitution of the HFANZ is invited to apply for membership and, if so accepted, will be obliged to comply with the Code of Practice

22.0 REVIEW OF CODE AND FUTURE ISSUES

- 22.1 This Code will be reviewed at regular intervals.

The Code applies to health insurance marketed by:

- AA-GIO Insurance Ltd trading as AA Insurance
- Aetna Health (NZ) Ltd
- Health Service Welfare Society Ltd
- The Education Benevolent Society (Inc) trading as EBS Health Care
- Independent Order of Odd Fellows of New Zealand Friendly Society - trading as I.O.O.F.
- Manchester Unity Friendly Society
- National Insurance Life & Health Ltd
- National Mutual Health Ltd
- New Zealand Police Health Plan Ltd.
- Public Service Investment Society trading as PSIS Health Care
- Southern Cross Medical Care Society trading as Southern Cross Healthcare
- Sovereign Assurance Company Limited
- Swiss Re Life and Health
- Union Medical Benefits Society - trading as UniMed