It's all about the claim

Our claims performance in 2019

Highlights

- We paid 94% of claims
- We helped 633 Members and their families by paying their claim
- We paid £2.4 million of benefit in 2019, up from £1.5 million in 2018, an increase of 60%
- We couldn't pay 43 claims - we explain why later in the report

The claim – it's what income protection is all about. Our Members want to replace their income if it stops due to illness or injury. We want to pay claims quickly and efficiently to support our Members so they can concentrate on getting better and continue to keep their lives colourful.

Why do our Members claim?

The most common reasons for claim were:

		of which...	
Cause	Total percentage	Short-term IP	Full-term IP
Accident and injury	35%	69%	31%
Musculoskeletal	23%	51%	49%
Mental health	12%	58%	42%
Surgical procedures	6%	53%	47%
Viral	5%	26%	74%

We're easy to deal with

We provide support from the moment we're told about a potential claim. Our flexible approach lets our claims specialists use their experience and knowledge to really understand the root cause of the claim to identify how we can help them. If the Member is happy to, we'll always speak over the telephone and send important documents by email, including using electronic signatures via Docusign and allow photographs of their certificates etc. to avoid any delays which post can cause.

We take pride in working directly with Members to get the right information to assess the claim quickly, and this is reflected in our performance:

- 30% of decisions to pay the claim were made within 7 hours
- 72% of decisions were made within 21 hours
- 80% of decision were made within 35 hours
- The average decision time for all claims, from receiving the claim request to making our decision, was 53 hours, or 7.5 days. This is due to delays from third-parties such as waiting on Doctor's reports from GP surgeries.

2019 in numbers

94% of claims paid

Youngest claimant - 18 years old

Oldest claimant - 67 years old

Average age of claimant - 44 years old

Average annual claim payment - £11,128

Average length of claim - 21 weeks

Longest claim - 30 years, 6 months

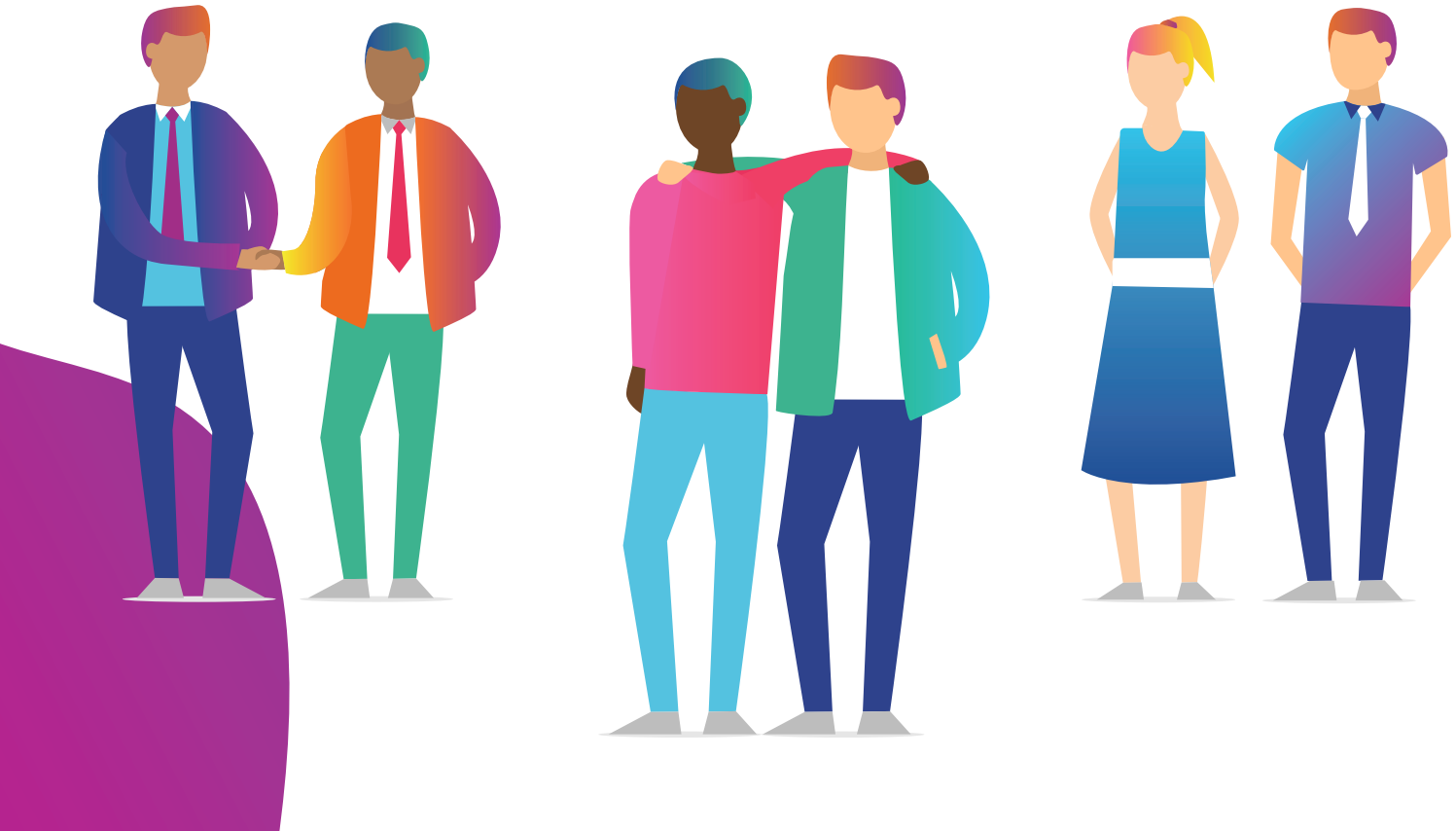
Claims are about more than paying benefit

Our claims specialists are trained to consider our Members' needs as widely as possible and are ready to go beyond our plans' terms and conditions to provide support on a case by case basis. Examples of this support are:

- Paying for private treatment such as physiotherapy, steroid injections or psychological therapy rather than waiting for treatment on the NHS
- Arranging vocational support to assist return to work plans to ensure a sustainable and successful return for the long-term
- Career coaching or analysis of transferrable skills for Members who can't perform their "own occupation" but could work in alternative roles and need support to achieve this
- Supporting independent medical examinations for Members who are not being seen by a specialist and whose recovery is slow or not progressing. Such interventions help to provide advice on future treatment and how this could impact on return to work plans or quality of life in the future

Other examples of looking after our Members, in ways that some insurers wouldn't include:

- Paying a claim for a Member who was suffering no illness herself but was unable to work following her 2 year old son being diagnosed with a brain tumour, requiring a long-stay as an inpatient. Whilst the Member was not prevented from working herself, the situation regarding her son's health was stressful and could have resulted in the Member stopping work to care for her son whilst he was an in-patient. Specialist care was required which was not close to where the Member lived, so we paid for the Member to stay at the hospital. It was important to pay the claim to support the Member and avoid potentially health related issues that could have resulted in their own claim
- Arranging private psychological therapy allowing the Member to skip lengthy NHS waiting lists resulting in a quicker return to fitness
- With career coaching and vocational support such as CV writing, confidence building, interview techniques etc., we were able to support a Member get back to work on a part time basis after they had been claiming IP benefits for 11 years. The Member continues to receive partial benefit, and their personal esteem and confidence have increased after such a lengthy period of not working. We will continue to support their recovery as their cover is due to end when they become 60 in a couple of years
- We don't automatically refuse claims just because of an exclusion. We will always consider the reason the exclusion was applied and the reason the Member was off work



Why we haven't been able to pay all claims

We want to pay all claims and it's disappointing that we weren't able to pay 43 claims in 2019. We want to lower the amount of claims we don't pay and so we're working with Advisers to help improve the underwriting process and the questions we ask. We want to be transparent about why we haven't paid some claims - here's the reasons why:

Non-disclosure – 25 cases

Our claims specialists work with Members to identify relevant non-disclosure. It is always disappointing to discover that we were not provided with all the necessary information asked for in the application. Once we know about additional information that should have been disclosed, it can unfortunately result in the claim being declined. To accurately assess each application it is vital that we are provided with comprehensive answers to all questions. The biggest reason for us declining some claims was non-disclosure. We'll be working on this area with Advisers throughout 2020 by releasing new material to help Advisers understand the underwriting process and what information is needed during an application.

Non-disclosure fits into 1 of 3 categories:

Careless – 19 cases

These were cases with an understandable and honest oversight, but had we had the right information it would have changed the underwriting decision. To resolve these cases, different options were provided to the Member, including adding an exclusion for the newly discovered medical condition, and cover continuing without the claim being paid. If these options didn't suit the Member the plan was cancelled and all the premiums that had been paid were refunded to the Member.

Reckless – 3 cases

This applies to Members who had complete disregard for the question or the accuracy of their answer and would have known the answer they gave was relevant and important, if we had known the correct details we would have fundamentally changed our decision. These cases were cancelled and no premiums were refunded.

Deliberate – 3 cases

This applies where the Member would have known that the information they had provided was incorrect and was relevant to us. This can be seen as an attempt to commit fraud, these cases were cancelled and no premiums were refunded.

No loss of income - 9 cases

A fundamental requirement for a successful claim is not just being unable to work – there must be a loss or reduction in income. In these cases there was no financial loss so no reason to pay the claim.

Plan criteria not met – 6 cases

For a Member to make a successful claim they need to show us how their circumstances have changed related to their cover, for example:

- Illness/Injury prevents the Member from performing all the expected duties of their normal occupation
- Working at least the minimum hours each week prior to the claim
- Providing evidence of income

Reasons why claims were not paid included:

- Medical evidence not supporting the Member's inability to work once the deferred period had finished
- Member was not working the minimum hours each week when they made a claim
- Not being registered with a UK GP when the plan was applied for and when they made a claim
- No proven trading history for 6 months – this is important where the Member is self-employed. At the time of claim the Member had only been self-employed for a week with no evidence of work in the previous 6 months before claiming
- The Member was already unemployed when the Member suffered their injury

Claims caused by excluded conditions – 3 cases

Our approach to underwriting allows us to insure Members who, because of their medical history, may not have been able to obtain cover elsewhere. We can exclude certain conditions from any cover we offer and offer a reduced premium because of the exclusion. This means we cannot consider any claim where the cause is directly linked to the excluded condition. But remember just because a Member has an exclusion it doesn't mean any claim will be rejected.

Contact us.

We're here to help.

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We're here

Monday - Friday 9.00am to 5.00pm

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