

Chapter 17

Claims handling for long-term care insurance



17.1 Providing information to claimants, dealing with claims and warranties in policies

17.1.1 **R** When an *insurer* or *managing agent* receives a claim under a *long-term care insurance contract*, it must respond promptly by providing the *policyholder*, or the *person* acting on the *policyholder's* behalf, with:

- (1) a claim form (if it requires one to be completed);
- (2) a summary of its claims handling procedure; and
- (3) appropriate information about the medical criteria that must be met, and any waiting periods that apply, under the terms of the *policy*.

Responding to a claim

17.1.2 **R** As soon as reasonably practicable after receipt of a claim, the *insurer* or *managing agent* must tell the *policyholder*, or the *person* acting on the *policyholder's* behalf:

- (1) (for each part of the claim it accepts), whether the claim will be settled by paying the *policyholder*, providing goods or services to the *policyholder* or paying another *person* to provide those goods or services; and
- (2) (for each part of the claim it rejects), why the claim has been rejected and whether any future rights to claim exist.

Rejecting a claim

17.1.3 **R** An *insurer* and a *managing agent* must not unreasonably reject a claim.

Cases where rejection of consumer’s claim is unreasonable: contracts or variations before 1 August 2017

17.1.4 **R** For contracts entered into or variations agreed before 1 August 2017, except where there is evidence of fraud, an *insurer* and a *managing agent* must not reject a claim for:

- (1) (in relation to contracts entered into or variations agreed on or before 5 April 2013) non-disclosure of a fact material to the risk which the *policyholder* could not reasonably have been expected to disclose; or
- (2) misrepresentation of a fact material to the risk, unless the misrepresentation is negligent; or

- (3) breach of warranty, unless the circumstances of the claim are connected to the breach, the warranty is material to the risk and was drawn to the *policyholder's* attention before the conclusion of the contract.

Cases where rejection of consumer’s claim is unreasonable: contracts or variations on or after 1 August 2017

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- (1) Cases in which rejection of a *consumer's* claim would be unreasonable (in the *FCA's* view) include, but are not limited to rejection:
 - (a) for misrepresentation, unless it is a “qualifying misrepresentation” in ■ **ICOB 8.1.3R**;
 - (b) where the claim is subject to the Insurance Act 2015, for breach of warranty or term, or for fraud, unless the *insurer* is able to rely on the relevant provisions of the Insurance Act 2015; and
 - (c) where the *policy* is drafted or operated in a way that does not allow the *insurer* to reject.
- (2) The Insurance Act 2015 sets out a number of situations in which an *insurer* may have no liability or obligation to pay. For example:
 - (a) section 10 provides situations in which an *insurer* has no liability under a *policy* due to a breach of warranty;
 - (b) section 11 places restrictions on an *insurer's* ability to reject a claim for breach of a term where compliance is aimed at reducing certain types of risk; and
 - (c) sections 12 and 13 provide for the extent to which a *firm* is entitled to reject fraudulent claims.

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For contracts entered into or variations agreed on or after 1 August 2017, a rejection of a *consumer policyholder's* claim for breach of a condition or warranty (that is not subject to and within section 10 or 11 the Insurance Act 2015) is unreasonable unless the circumstances of the claim are connected to the breach.

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An *insurer* must ensure that any condition or warranty included in a *long-term care insurance contract* with a *consumer*:

- (1) has operative effect only in relation to the types of crystallised risk covered by the *policy* that are connected to that condition or warranty; and
- (2) is material to the risks to which it relates and is drawn to the *customer's* attention before the conclusion of the contract.

