HEALTH INSURANCE

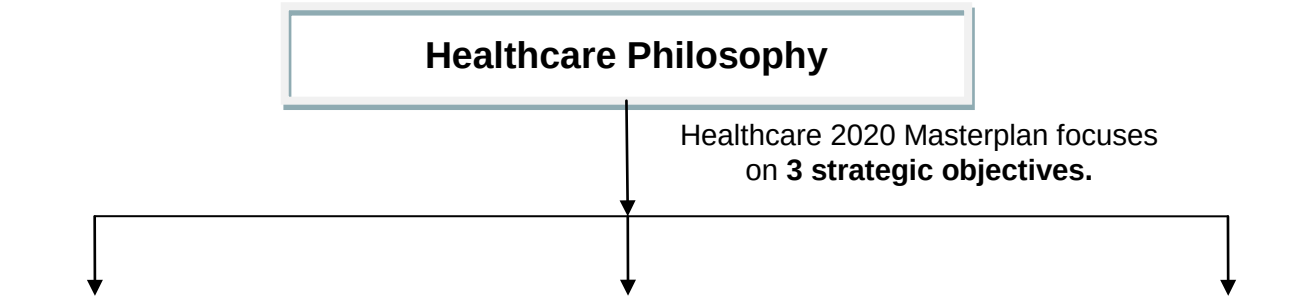
(5th Edition), Supplementary Notes - Version 1.3

Chapter Review

Chapters 1 to 15

Chapter 1 – Overview of Healthcare Environment in Singapore

1. Rising healthcare cost is a concern for most governments. The challenge faced by most governments is how to **balance the rising expectations for quality healthcare, and yet keep cost affordable.**



Enhancing Accessibility

- Healthcare infrastructure will be ramped up, with plans to **increase acute-and community hospital beds** by 2020.
- MOH is building up its **manpower capability & building a strong core** of healthcare professionals to support infrastructure expansions eg:
  - Providing flexi, part-time in the community through its Place & Train Programme.
  - New remuneration framework for senior doctors to better recognize doctors in their diverse roles in clinical care, education, research & administration.
- MOH actively drives innovation & productivity in both public & ITLC sectors to **simplify** workflow process so that healthcare workers can focus on caring for their patients.

Enhancing Quality of Care

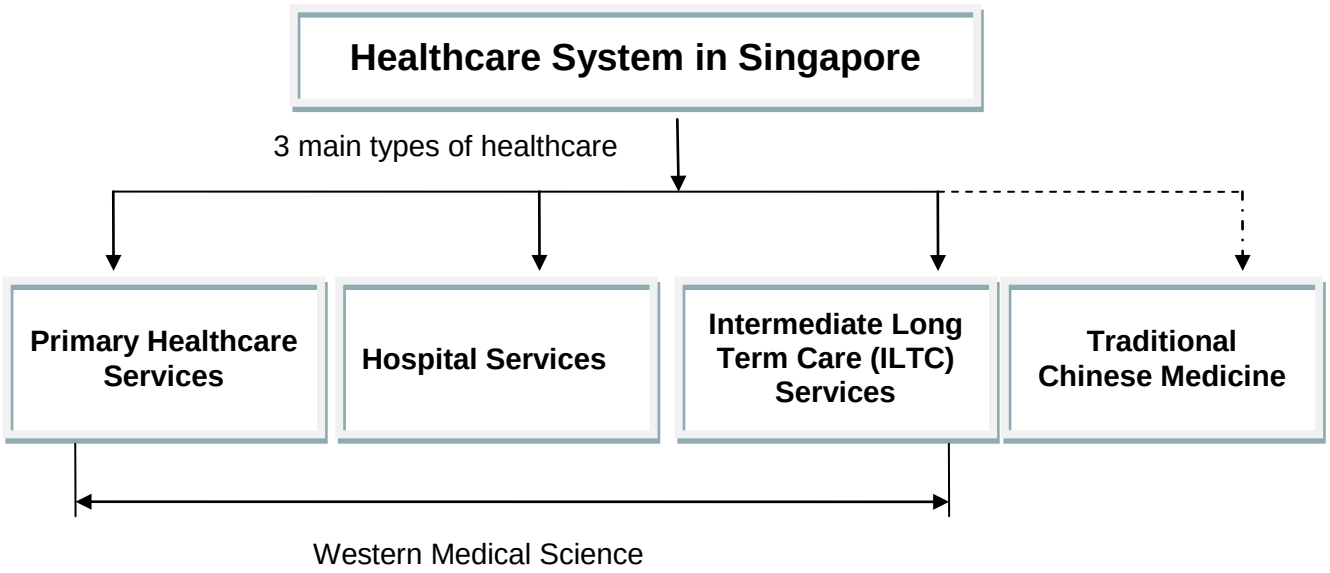
- MOH will move away from doctor-centric services & adopt a multi-disciplinary team approach to enhance chronic disease management. Eg healthcare clusters.
- MOH will enhance primary care as Singapore's population ages so that residents can be better cared for in a community. Egs:
  - **Strengthening primary healthcare providers, such as polyclinics & GPs;**
  - **Building more polyclinics.**

Ensuring Healthcare Remains affordable

The Government has enhanced support for Singaporeans in the following ways:

- Increasing Government share of national healthcare expenditure - thro enhanced **subsidies** for services in SOCs & drugs in public hospitals and list of subsidized drugs.
- Medisave expanded to use for **more** types of outpatient treatment.
- Enhancing **collective responsibility** for healthcare through MediShield Life. The **Government bears** most of the cost of this universal coverage.

2. Healthcare System in Singapore consists of :



2a. **Primary Healthcare Services**

- Provided by both public and private sectors. It involves provision of **basic medical treatment, preventive healthcare and health education.**
- In public sector, primary healthcare services are provided through network of outpatient polyclinics . Under **Community Healthcare Assist Scheme** (CHAS), lower-to-middle income household can receive subsidized treatments at GPs and dental clinics, without the need to travel to Polyclinics.
- The Scheme also covers treatment for Chronic Disease Management Programme (CDMP) such as **diabetes, hypertension, root canal treatment and crowning**.
- Patients under CHAS can also enjoy **subsidized rates** at Specialist Outpatient Clinics.

2b. **Hospital Services**

- There are 9 public hospitals and within these public hospitals, choices of different types of ward accommodation. 81% of public hospital's beds are B2 and C which are **heavily subsidized**. 19% with lower subsidy at 20% for Class B1 and **no subsidy** for Class A wards.
- Government has restructured all its acute hospitals and specialty centres to run as private companies, **wholly owned by Government**, to allow **greater autonomy** and **flexibility**. Commercial Accounting Systems have been introduced to give a accurate picture of operating costs, instilling **greater** financial discipline and accountability.
- Public hospitals received annual government subvention or subsidy for the provision of subsidised medical services of patients. These are to be managed like **not-for- profit organisations.**

2c. **Intermediate & Long Term Care (ITLC)**

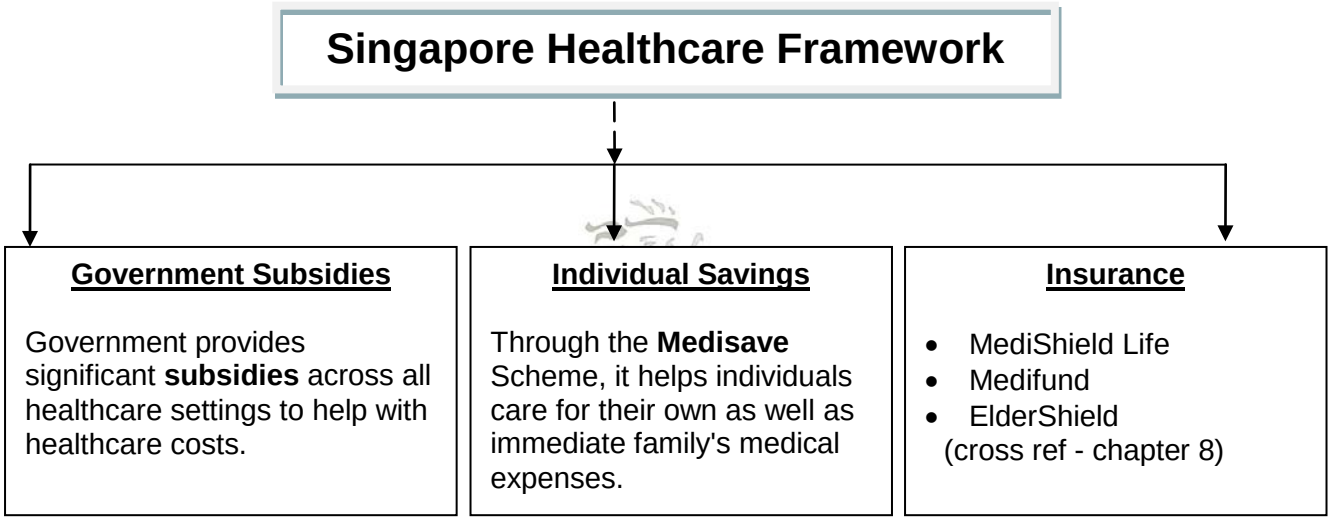
ITLC services are for people who need further care after discharge from acute hospitals as well as community dwelling seniors who may need assistance with their **activities of daily living**. This can be through:

a) **Home-based services,** which are provided within their homes of frail and home-bound elderly.

b) **Centre-based healthcare services**, which cater to older persons who require care services during the day, usually on a regular basis, located within the community. This allows working caregivers to drop their seniors at during work.

c) **Residential ILTC services**, comprises community hospitals, chronic sick hospitals, nursing homes, inpatient hospices and sheltered home for the ex-mentally ill patients.

3. Singapore Healthcare financing framework comprises of Government subsidies, individual savings and insurance.



4. The Singapore Government provides universal coverage through these multiple layers of protection:

a) **Government Subsidies**
- Government subsidies across primary, acute rehabilitative and nursing care; and
- Universal access, but no 100% subsidy to avoid over-consumption.

b) **Compulsory Healthcare Savings**
- Individual medical savings accounts - Medisave.

c) **Risk-Pooling via Insurance Schemes**
- National basic health insurance scheme - MediShield Life;
- Private health insurance for additional coverage - Medisave approved Integrated Shield Plans (IPs); and
- Severe disability insurance for old age- ElderShield and ElderShield Supplements.

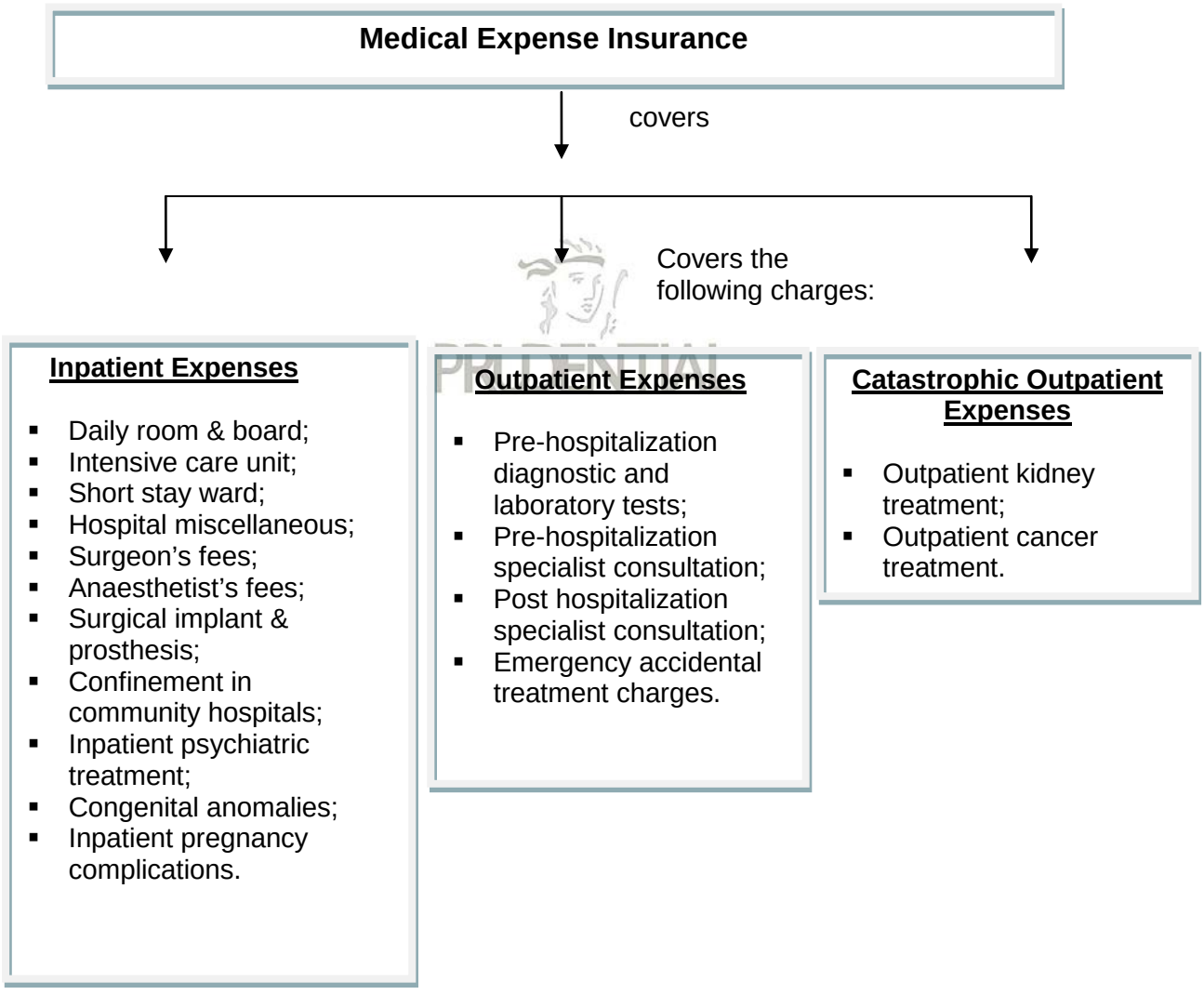
d) **Ultimate safety net for the needy**
- Endowment fund set up by the Government for needy Singaporeans through Medifund.

Chapter 2 – Medical Expense Insurance

1. There are broadly 3 categories of Health Insurance which can provide:
   - A **reimbursement** for the cost of medical treatment or nursing care; or
   - A periodic **income** upon disability or hospitalization; or
   - A **fixed cash** amount upon disability or suffering from a major illness.

2. **What is a Medical Expense Insurance (MEI)?**
   Also known as Hospital and Surgical (H&S) Insurance, which provides inpatient and some outpatient benefits. Examples of MEI include MediShield Life, Private Integrated Shield Plans and managed healthcare schemes.

3.



Please note the following covered expenses below:

3a. **Inpatient Expenses**

a. Daily Room and Board Charges refers to the charges for **standard room accommodation**, **meals** and **general nursing services** incurred while insured is hospitalized.

b. Intensive Care Unit Charges – charges incurred during the confinement in the ICU of the hospital.

c. Short –stay ward – incurred during confinement in the short stay ward in an **accident** and **emergency** dept of a hospital for inpatient monitoring and treatment up to 24 hrs to allow doctor to decide whether to discharge the patient or further admitted as an inpatient.

d. Hospital Miscellaneous Expenses includes services and supplies (other than room and board and general nursing care):
- **Laboratory services;**
- **X ray examinations;**
- **Medicines and drugs;**
- **Surgical dressings;**
- **Operating room expenses;**
- **Oxygen and their administration; and**
- **Ambulance service.**

e. Surgeon's Fees – surgeon's fees for surgery, includes day surgery and gamma knife.

f. Anaesthetist's Fees – for the supply and administration anaesthesia.

g. Surgical Implant & Prosthesis - actual costs of surgical implant of **artificial devices** used to replace missing part of a body.

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h. Confinement in Community Hospital – charges incurred for **accommodation**, **meals** and **general nursing** services. A referral from the attending physician from the hospital is required and the admission to the community hospital must be within a time frame following his discharge from the hospital.

i. In-Hospital Psychiatric Treatment – must be received as an inpatient of the hospital. A **waiting period** may apply. Treatment for self inflicted, suicide, drug addiction or abuse of drug or alcohol is excluded.

j. Congenital Anomalies – inpatient treatment of any congenital anomalies, including hereditary conditions. A **waiting period** apply.

k. Inpatient Pregnancy Complications – inpatient treatment for pregnancy complications. **Waiting period** apply. This benefit may be restricted to the following pre- defined list of complications:
- Ectopic pregnancy;
- Pre- eclampsia or eclampsia;
- Disseminated intravascular coagulation;
- Miscarriage after 13 weeks of pregnancy(not resulting from voluntary or malicious act);
- Antepartum haemorrhage;
- Intrauterine death;
- Choriocarcinoma and hydatidiform mole;
- Acute fatty liver pregnancy;
- Breech delivery and placenta previa and postpartum hemorrhage.

3b. **Outpatient Expenses**

a. Pre-hospitalization Diagnostic and Laboratory Test Charges
Charges incurred for diagnostic and laboratory tests as prescribed by the attending physician. This benefit is payable if incurred within a specified number of days before the date of **hospitalization**.

b. Pre- hospitalization Specialist Consultation Charges
Charges incurred for consultation of a specialist as recommended by the attending physician. This benefit is payable if insured is **hospitalized** or undergoes days surgery **within** a specified number of days from the date of consultation of the specialist.

c. Post – Hospitalization Specialist Consultation Charges
Charges incurred for follow up treatment after hospitalization, eg physiotherapy etc. This benefit is payable for up to a **specified** number of days after his discharge from the hospital.

d. Emergency Accidental Treatment Charges
Charges incurred for emergency outpatient treatment of **accidental** bodily injuries, within **24 hours** of the accident.

3c. **Catastrophic Outpatient Expenses**

a. Outpatient **Kidney** Treatment Charges
Charges incurred for kidney dialysis at a legally registered dialysis centre. Includes examinations and tests ordered by the physician. Exclude purchase or rental of the dialysis machine.

b. Outpatient **Cancer** Treatment Charges
Charges incurred for chemotherapy, radiotherapy, immunotherapy and/or stereotactic radiotherapy, provided by the hospital.

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4 . **Other Benefits Under MEI**

1. Major Organ Transplant

Where the insured person is a recipient	**Where the insured person is a donor**
Refers to the **cost** of **surgeries** for the transplantation of **kidneys, lungs, heart, liver** or **cornea**, where the insured person is the recipient of any of the organs. It also includes the **costs** of immunosuppressant drugs where are part of the treatment to reduce rejection episodes.	Covers charges for major organ transplant operations of the **kidney, or liver** where the insured person is a living donor, provided: I. Transplant is carried out in a hospital in **Singapore**; II. Recipient of the organ must be insured person's **family member**; III. The recipient's kidney or liver failure is first diagnosed by the attending physician, or the symptoms of which first appeared, after a **waiting period** of **24** months.

2. Specific Disease Insurance
   Provides a lump sum payment in the event of the diagnosis from the specific disease covered by the policy.

3. Miscarriage Benefits
   Not applicable to **willful termination** of a pregnancy that is not medically necessary but provides reimbursement in the event of a miscarriage or **ectopic** pregnancy.

4. Private Nursing Home Care
   Pays for the cost incurred in hiring the services of a fulltime/ part time qualified nurse in the insured's home for the **continuing treatment** of a medical condition which is covered under the policy for which the insured person has been hospitalized.

5. Daily Hospital Cash
   A daily cash benefit is payable to the insured if he is hospitalized as a result of an injury or illness. (refer chapter 6)

6. Emergency Overseas Medical Treatment
   Refers to the costs incurred for an emergency inpatient treatment **outside** of Singapore. Benefit is subject to **reasonable and customary charges** for equivalent medical treatment in Singapore.

7. Emergency Medical Evacuation
   Refers to costs incurred for overseas medical evacuation if the insured person **cannot** obtain treatment needed locally and has to be evacuated to the nearest suitable hospital or **repatriated** to his home country to that he can be treated in familiar surroundings, near to his family.

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8. Final Expenses Benefit
   Death occurring during **hospitalization** or within a specified number of days after hospital discharge, and provided death is a result of the cause of the **hospitalization**. In the case of an Integrated Shield Plan, the final expenses benefit is usually a **waiver** of deductible and co-insurance components up to the stated amount in the policy.

5. Key Features Of Medical Expense Insurance

Features of Medical Expense	Details
What are the limits on the covered expenses?	2 ways: • "**As Charge**" Benefits • Imposed **Sub- Limits** Note that payment is on a **reimbursement** basis, hence insurer will reimburse the actual amount incurred or the maximum limit stated in the policy, whichever is **lower.**
Forms it can be purchased	• **Standalone;** • **Rider** (not common in Singapore).
Family coverage	• **5%** discount given even if the spouse or only 1 child is covered. • Family members **need not** be covered under the same plan to enjoy the discount.
Expense participation	3 methods are : 1. Deductibles : a **flat dollar** amount paid by insured. 3 Types of Deductibles : • Per Annum; (least restrictive); • Per Disability Per Year; • Per Disability Per Claim. 2. Co insurance: a **specified percentage** in excess of deductibles. 3. Pro- ration factor : when insured is admitted to a ward higher than the plan's entitlement, a **percentage** is applied on the actual charges incurred and covered under the policy, hence benefit is reduced. In this way it **ensures fairness** such that a policy owner who pays a lower premium for a lower plan should be encouraged to use the services available only on the selected plan. **Note : Know the egs in the text for calculating deductibles and co- insurance at page 28-29.**

Benefits limits	Define : **Lifetime limit** Often set at a very high amount eg. S$1m. The maximum total amount of all reimbursements that the insurer is liable to the insured throughout **insured's lifetime.** **Annual Limit** The maximum **annual** reimbursements by the insurer as stated in the Benefit Schedule of the Policy. **Event Limit** Maximum amount payable in respect of any one **disability** or **illness** as defined in the policy.
Geographical Limit	• Most Individual Expense Insurance Policies will **automatically terminate** if insured resides outside Singapore for more than 180 days. • Treatment overseas are based on **reasonable** and **customary** charges.
Waiting Period	Define waiting period: A period of time stated in the policy which **must pass** before the coverage can begin. A waiting period **protects** members within the portfolio, by ensuring individuals are not able to make claims shortly after joining and then cancelling their membership. This plan is subject to a waiting period. However waiting period does not apply to **accidental injury.**
Age limit	Minimum: 15 days old. Maximum: 75 years old.
Premium	**Age band basis.** i.e if the person crosses to the next age band, he has to pay a higher premium, based on the new age band he falls under.
Guaranteed Renewability	Insurer **cannot** terminate as long as insured pays the premium.
Exclusions	• to avoid policy owner receiving reimbursement **twice**; for the same charges or making a **profit**; • to make premium more **affordable**; • to define more clearly the medical care and treatment; • to avoid the policy owner selecting against the **insurer**.

Co- Ordination Of Benefit Clause	Prevents the insured from making a **profit.** Total claims made by the policy owner will be equal to the total medical expense incurred.
Underwriting	**<u>Individual MEI</u>** The main source of information for individual Medical Expense Insurance is the **proposal form**. **<u>Group MEI</u>** For group coverage, employer is required to complete the **Group Fact Find form**. For small group of less than 10 members, individual employees to complete **health declaration form**.
Healthcare Subsidy	• Citizens enjoy heavy subsidy in class **B2 and C** wards. • PRs received significant subsidy. Foreigners – not subsided at all.
Termination of Cover	Apply to both individual and group policies: • death of the insured person; • **date on which insured enters full time military service except during National Service reservist duty;** • end of policy eg (80 yrs old) • policy is terminated; • policy is expired; • total claim amount reached **lifetime limit**. Apply to group policies: • date of cessation as an employee.
Claims	Forms to be submitted to insurer are : • **Claims form;** • **Physician statement;** • **Original bills.** Must notify insurer within a specified period (90 days) after incurring medical costs.

Chapter 3 – Group Medical Expense

1. What are the characteristics of Group Insurance?

   - **Master Contract** - issued under a single contract kept by policy –owner.
   - **Minimum Underwriting** – Health declaration form or waive all underwriting requirements and rely on pre-existing condition exclusion clauses to prevent anti-selection.
   - **Experience rating** – underwritten based on past claims experience.
   - **Cost effectiveness** – low cost due to savings in administrative costs in view that only one group policy is issued.
   - **Plan Continuation** – renewable on a yearly basis.
   - **Eligibility requirements** – full time work; part time excluded.
     Must be **actively at work**.

2. Ministry of Manpower requires every employer to purchase a minimum medical insurance coverage for their foreign workers and domestic workers. It is for their medical bills incurred and inpatient care and day surgery. The minimum amount from 1 Jan 2020 is $15,000 for new applications and renewals.

3. Group Medical Expense Insurance policies are often purchased by employers as part of their employee benefits to attract and retain their employees. Group policies can also be extended to cover the employees' immediate family members. For example, after the employees have been confirmed, new dependents like **spouse** can be included at any time within **30 days** after marriage and **child** at any time between **15 and 30 days** after birth.

4. Compulsory Vs Voluntary

	Compulsory	**Voluntary**
Characteristics	All employees must be covered under the same plan, and premium has to be paid by the **employer**.	No need for full participation (min 75% participation). **Employees pay part of the premium.**
Advantages	• Ease of administration since no payroll deductions to monitor; • Lower costs – less administrative work; • **Employer** retains greater control.	Employer • Employees pay part of the cost; • **Generates interest & appreciation**; Employees • **Employees** have some form of control over the plan; • Lower premium than buying individually.

5. Differences between Individual and Group Insurance.

	Individual Insurance	Group Insurance
Eligibility	Needs only be insurable to be granted coverage.	Only members who belong to the group and are **actively at work** are covered.
Contract	Each individual policy gets a policy contract.	One master contract is issued.
Choice Plan	Has the right to select the coverage.	May not have the choice to select the coverage in a compulsory plan.
Underwriting	**Individual health and financial status are evaluated.**	**Gender and age distribution of the group, occupation mix and past claims experience.**
Termination of Cover	Either individual or insurer chooses to terminate it.	Coverage for him stops when he leaves the group.
Premium	Cost of coverage is higher. Premium is **age related.**	Cost of coverage is lower. Premium is **unit related.**

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6. Portable And Transferable Medical Benefits For Employees

To incentivize employers to make the move towards enhancing the portability of inpatient/hospitalization medical benefits for their employees, Singapore Government has revised the tax policy to allow employers implementing any of the following 3 portable medical benefits to enjoy higher tax deduction for medical expenses of up to **2%** of total employees' remuneration:

a) Portable Medical Benefits Scheme (PMBS);

b) Transferable Medical Insurance Scheme (TMIS);or

c) Provision of Medisave-Approved Integrated Shield Plan (IP).

6a) **Portable Medical Benefits Scheme (PMBS)**

- **This scheme rides on the Medisave/MediShield framework**. Employer makes monthly contribution to employees' Medisave accounts that can be used to purchase any one of the Medisave approved medical insurance policies to cover their hospitalization needs, instead of providing Group Medical Insurance coverage.

- Advantage is that the employee can **continue** to be covered even though he may be unemployed or is in between jobs. Coverage continues as long as premium is paid regardless of employment status.

- To enjoy the 2% tax deduction, following **conditions apply**;
  - Must cover at least **20%** of the local employees;
  - For full time employees, the additional monthly contributions to Medisave accounts should be at least 1% of each employees' gross monthly salary, subject to a min of $16 per calendar year.
  - For part-time employees, the additional monthly contributions to Medisave accounts should be based on 1% of their gross salary for the calendar month.

However, for employers who choose not to implement either PMBS or TMIS, their tax deductibility in respect of medical expenses will be maintained at **1%** of total employees' remuneration.

6b) **Transferable Medical Insurance Scheme (TMIS)**

TMIS is an enhancement of the existing employer sponsored Group Medical Expense Insurance outside of the CPF Medisave framework. It is basically an employer-sponsored Group Medical Insurance programme with the following 2 additional features:

- Continuation of coverage; and
- Transferability

1. **To qualify for TMIS, the employer must**:
   - have a group size of **11** or more employees;
   - **take up** a group Medical Expense Insurance plan (MEI);
   - insure at least **50%** of its local employees, subject to a minimum total of 11 employees;
   - pay **100%** of the premium for the group Medical Expense Insurance coverage;
   - **not to** give employees the option to be insured under the group insurance plan.

2. Two Features under the TMIS

Previous Employer's TMIS Plan **Continuation Of Coverage Benefits**	**New Employer's TMIS Plan** **Transferability of Benefits**
Employees to enjoy hospitalization coverage from their termination of employment (voluntary or otherwise) up to a max period of **12 months** (not exceeding age 62).	Employees who resign from one company, which holds a TMIS policy, and joins another, who also holds a TMIS policy will enjoy these benefits: I. **automatic coverage** under the new employer's group plan, without the need to provide evidence of good health; II. Waiver of any exclusion on pre- existing medical conditions if the employee has been continuously insured under a TMIS plan for **12 months** whether with the prior employer or new employer. However, if the employee is hospitalized for a **pre existing** condition when he joins the new employer within the first **12 months**, he will enjoy a **lower** benefit of either the new employer's TMIS plan or prior employer's TMIS plan. Refer to eg 3.1 in pg 52 of text.

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3. Medical Expenses that qualify under TMIS Special Benefits:
   - Daily room and board charges;
   - ICU;
   - Miscellaneous hospital services;
   - In- hospital doctor's visits;
   - Inpatient and outpatient benefits.

   All pre/post hospitalization outpatient, emergency outpatient accident and outpatient kidney dialysis/cancer treatment are **not eligible** for TMIS benefits, even if they can be reimbursed under TMIS Plan.

4. To be eligible for the TMIS benefits, an employee must be:
   - **Below** statutory retirement age (62 years from 1 Jan 1999). However since 1 Jan 2012, employers are now required to offer re employment to eligible employees who turn 62 years, up to 65 years;
   - Singaporean or PR based in Singapore;
   - Working **full time** with the same employer;
   - Working on a permanent employment contract or on a temporary contract, with a term of **24 months** or more.

5. To verify the eligibility of an employee under the TMIS, any employer has to issue a Transferable Medical Insurance (TMIC) at the request of an employee upon termination of his employment. The TMIC must be submitted to the insurer when the employee submits a claim for Continuation Benefit, or to the new employer's insurer should a claim arising from a pre existing condition be made within 12 months of joining the new employer.

6. PMBS Versus TMIS

	PMBS	**TMIS**
Who purchases the Policy?	**Employees** purchase policy on his own from the contributions made by his employer to his Medisave account.	**Employer** purchases the policy.
What type of medical plan can be purchase?	Only a Medical Insurance policy approved under the **Medisave Scheme.**	**Any** group Medical Expense Policy, other than those approved under the Medisave Scheme.
Coverage	**Lifetime** for most private Integrated Shield Plans. Coverage **continues** when the employee is between jobs or out of job as long as premium is **paid.**	**Expires** at statutory retirement age. Coverage continues up to a **max** of 12 months from the date of termination of a job.
Deductibles and Co-insurance	**Apply. However riders can be purchased to offset them.**	**Unlikely to apply as Group MEI rarely have these features.**
Pre existing Illness.	**Excluded**	**Waive**r on pre existing conditions where employees change jobs and where both employers provided TMIS benefits.
Who have control over the policy?	**Employees**	**Employer**

6c. **Provision of Integrated Shield Plan**

- With effect from the Year of Assessment 2008, employers providing employees with a Shield Plan (i.e MediShied Life or Medisave-approved Private Integrated Shield Plan) can claim tax deduction for medical expenses incurred, up to **2%** of their total employees' remuneration, if they meet the following:

    - Provide Shield plans for at least **20%** of their local employees;

    - Pay Shield plan premiums on behalf of their employees directly to the insurer or reimburse the premiums into their respective employees' Medisave accounts.

  Tax deduction **excludes** premiums for Riders on Shield Plans that cover deductibles and co- insurance payments.

Chapter 4 – Disability Income Insurance

1.

Disability Income Insurance →

Also known as :

- Permanent Health Insurance;
- Income Protection ;
- Income Replacement.

Why?

- Often sold as **Income Protection** product as it helps to replace a portion of the insured's income that he loses if he becomes **incapacitated and unable to work** as a result of a*s a* result *of* accident or sickness.
- Known as **Permanent Health** Insurance because insurer cannot cancel the policy no matter how many times the insured makes a claim. Policy will continue to pay until insured returns to work, dies or policy ends whichever happens first.

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DI will pay if insured is totally disabled and unable to work.

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4 definitions of Total Disability

1. **Own Occupation**
   - Insured's inability to perform own occupation.
2. **Modified Own Occupation**
   - Insured's inability to perform any gainful occupation or similar occupation for which he is reasonable suited by reason of education, training or experience.
3. **Any Occupation**
   - Insured's inability to perform any occupation.
4. **Severe Disability**
   - Insured's inability to perform at least 3 of the 6 ADLs – washing, dressing, feeding, toileting, mobility, transferring (follows the definition of Long Term Care Insurance in Chapter 5)

Qn : Which of the above definition is the most restrictive ?

Answer: **"Any Occupation"**

2. The main difference between Disability Income (DI) and Total Permanent Disability (TPD) lies in the purpose:

   - DI - provides income to the insured when he is **unable t**o go to work.
   - TPD - serves to **accelerate** death benefit under a Life policy.

3. Other differences between Disability Income and Total and Permanent Disability Benefit:

Criteria	**Disability Income Insurance**	**Total and Permanent Disability Benefit**
Form	Stand- alone policy or rider.	Incorporated into Life Insurance Policies.
Maximum Sum Assured	**Up to specified percentage of the salary.**	**Not pegged to salary.**
Escalation and Partial Benefit	Available	Not available
Deferred Period	Available (can choose)	Usually a 6-month waiting period.
Available to who	**Working adults with earned income salary.**	**No restriction on non working people.**

4. Compute total amount received from the DI Policy, given the following information:

   Monthly Income: $5000
   Escalation Benefit: 5% per year
   Effective Benefit Period: 30 Years

   Answer
   Monthly Benefit: $3750 ($5000 x 75%)
   Yearly Benefit: $3750 x 12 = $45,000
   Total Benefit Payable: $45,000 x 66.4388 (table A1 – 5%;30 Yrs) = **$2,989,746**

5. Definitions, Features and Benefits under Disability Income:

Recurrent Disability (Linked Claims)	In the event if the insured who has been receiving disability benefits under a DI Policy, returns to work, but suffers a relapse within a certain period (usually 180 days), insurers will **waive** the deferred period and benefits payments will **recommence** immediately. It is treated as a continuation of earlier claim.
Benefit Period Vs Deferred Period/Elimination Period	**Benefit Period** The **longer** the benefit period, the **higher** the Premium. **Deferred Period(DP)** • The **longer** the deferred period, the **cheaper** the premium. • Shortest(DP) - suitable for : **Self Employed;** • Longest (DP) – suitable for : **Budget Conscious.**
Total Disability Benefit	• Pays up to **75%**of insured average income prior to his disability. • Not 100% payment so that insured has incentive to go back to work.
Partial Disability Benefit	• Also known as "**Rehabilitative Benefit** ". • It provides a **reduced** benefit if insured is able to work at a reduced income of 75%% of his pre-disability income. This reduced benefit is based on this formula: Pre-disability Earnings – Present Earnings X TDB Pre-disability Earnings **Note : Please know the e.g at page 67 of text**
Rehabilitation Expense Benefit	Pays for rehabilitation costs incurred. Limited to a per disability basis. Includes • **Training courses**; • **Medical aids** (e.g wheelchairs); and • **Workplace modifications**.

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Escalation Benefit	Useful to hedge against **inflation.** Note: Please know this e.g at page 69 of text: Compute escalation benefit, and partial disability benefit given the following: Eddy was disabled on 30 June 2011 and he qualifies for a DI payment. He opted for a 3% escalation benefit per annum and a 6 month deferred period. Insurer makes first payment on 1.1.2012 for $6000. (75% of his monthly salary of $8000). He found a job that pays him $2000 a month on 1.2.2013. QN : How much should insurer pays him on 1.1.2013? **Ans: $6,180** ($6000+$6000x3%) escalation benefit kicked in on the second year. QN: How much should insurer pays him on1.2.2013? **Ans : $4,635** Partial disability calculated as: $8,000 - $2000 x $6,180 $8000
Waiver of premium	• Premium would be **waived** during DI benefit payment period (applies to both Total and partial disability) • For annual premium, waiver will come in at next Premium Due Date even though DI payment has started. No refund of premium.
Death Benefit	A **lump** sum amount is paid to insured dependants.
Limitation of Disability Clause	Disability benefit payable will be reduced by income received from Work Injury Compensation, any continuing salary or other income derived by insured's occupation. However benefits will not be reduced by payment from **Total Permanent Disability Benefit.**
Premium	• Level premium; • Premium waived during benefit period; • Guaranteed renewable.

Surrender value	No
Assignment	**Not allowed**
Tax	Benefits **Not Taxable**
Grace Period	Policy will lapse if premium is not paid within the **30 days'** grace period.
Underwriting Requirements	**<u>Individual</u>** Proposal form plus • **Computerized payslip or** • **Certified letter from company, on company's letterhead, or ;** • **Notice of Assessment ;** • **CPF Statement (6 months);and** • **Large Amount questionnaire (if annual benefit is more than $60,000);** • **Medical Tests based on age and amount**. **<u>Self Employed</u>** Proposal form plus • **Notice of Assessment for the last 3 years, or** • **Audited company's account for the last 3 yrs;** • **Medical test based on age and amount;** • **Large Amount questionnaire (if annual benefit is more than $60,000).**
Underwriting Considerations	**1. Occupation** To measure : • Higher risk of disability from accident or sickness. • Degree of **incapacity** to return to work. Insurers have a rating structure depending on the class of occupation. Some insurers may issue the policy for white collar occupations **2. Benefit Amount** To assess benefits proposed are **reasonable** based on the type of occupation and stated earnings. **3. Benefit Period** The duration that the insurer needs to pay out the benefits. To determine the terms of **acceptance.**

	4. Deferred Period A shorter deferred period has a higher element of moral hazard.

6. Differences between Cessation of Benefits and Termination of Cover.

Cessation of Benefits	Termination of Cover
▪ Insured is fit to **return** to work; ▪ When death occurs; ▪ Benefit period has **expired**.	▪ Policy reached **expiry** date; ▪ Premium is not paid within **grace** period; ▪ Insured dies or reached the expiry age; ▪ Resides outside Spore for an aggregate of **more** than a specified no. of days (eg 300 days) within a policy; ▪ Insured is **not employed** in a full time occupation or profession for a continuous period of a specified number of days (except if he is disabled).

PRUDENTIAL

7. Group DI can be issued as a Standalone or Rider. However the group must have a **Group Term Life Policy** before they are eligible for DI Policy.

   Group Long Term Disability Income policies are bought by employers to cover **senior management employees**. Benefits are payable if the disability is long term, hence there is a waiting period.

8. Claims procedures for individual or group disability income are **similar**. Insured must notify insurer within a specified period of time (e.g **60 days**) from the date of commencement of disability. Documents insurer ask for includes:
   - Claim form (personal particulars, details of his occupation and disability);
   - Claimant 's statement;
   - Clinical Abstract form;
   - Physician's statement;
   - NRIC/ birth certificate;
   - Evidence of earnings;
   - Letter from company certifying that the insured's services has been terminated;
   - Medical certificates;

- Laboratory tests results;
- Police report if disability is due to accident;
- Incident report (if incident occurs at the workplace).

9. Foreign Residency During Claims Period
   If insured resides outside of Singapore while the benefits are payable, following conditions apply:
   - Insurer must be notified of the change in residence within **30 days** of change;
   - Insurer must **approve** the new country of residence;
   - Insurer has determined that the evidence which can be submitted to make a claim under the policy from the new country of residence, is of **similar** (or better) standard, as compared that which would be available if the insured were to remain in Singapore.
   - Insurer has determined that the expertise and facilities for the care, treatment and rehabilitation of the insured in the new country of residence, are **similar** (or better) standard, as compared to those which would be available in Singapore.
   - Insurer reserves the right to require an **independent** examination of the insured by its preferred doctor as and when reasonable.

If any of these conditions are not satisfied, insurer reserves the right to **suspend** the benefits payable, until such time the insured returns to Singapore and the insurer receives satisfactory evidence to resume payment of benefits.

PRUDENTIAL

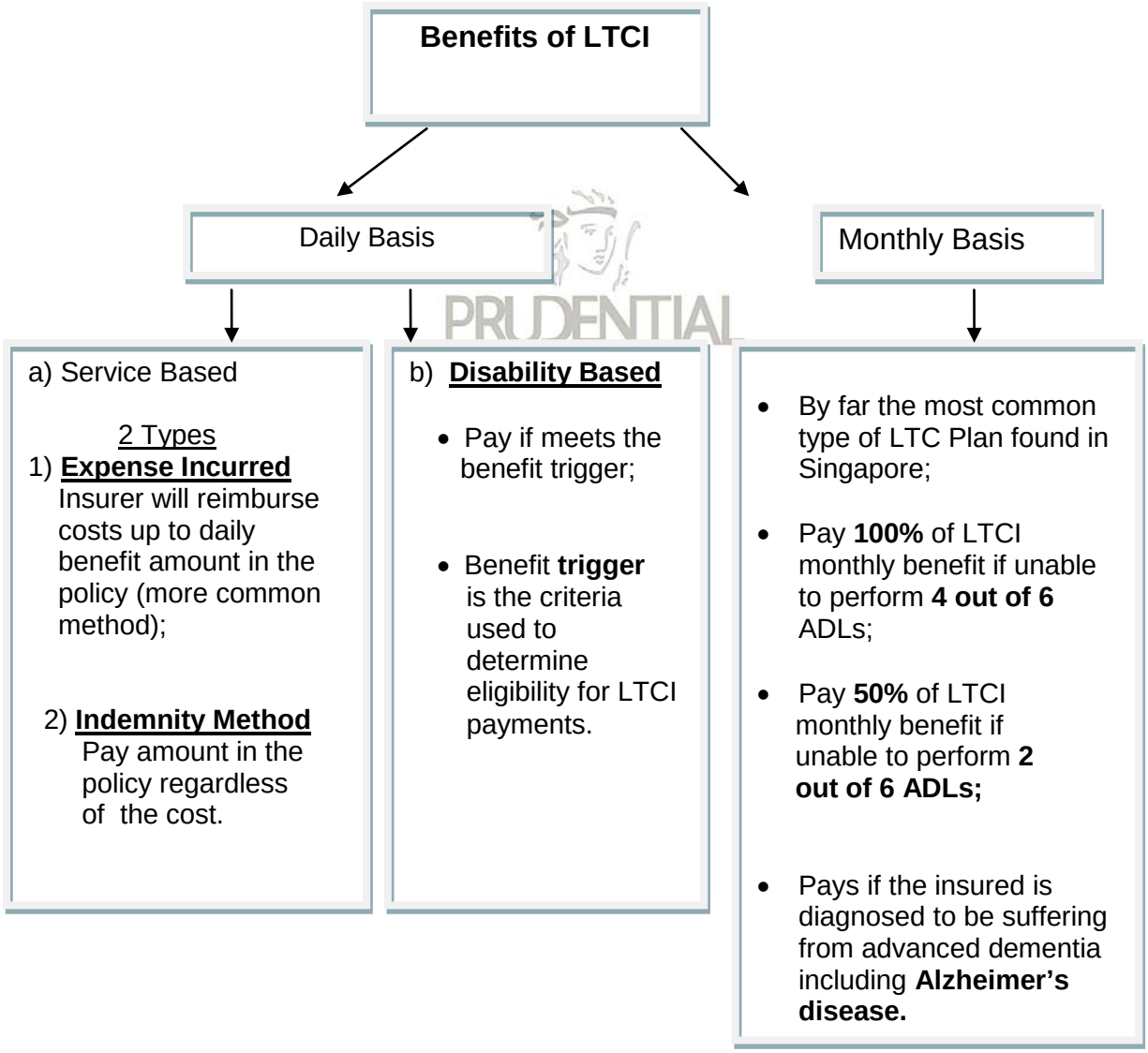
Chapter 5 – Long Term Care Insurance

1. Objective of Long Term Care Insurance (LTCI) is to meet costs of care to a person who as a result of accident, sickness is physically impaired and unable to function independently. They need assistance to perform the most basic **activities of daily living** (ADLs). It pays in addition to other insurance policies, eg MediShield Life.

2. Although this product is meant for the elderly, the young should buy for 2 reasons:

   - **Cheaper** Premium;
   - **Higher** chance of being accepted.

3. Benefits offered under LTC Insurance



4. Insured **need not be** hospitalized to be eligible for LTC benefits. He can use the benefits he received under his LTC to pay for the costs of engaging a maid or to pay for the costs of staying in a nursing home. However, he must meet the following criteria:

Criteria for payment of LTCI Benefit
1a. Meets the definition of inability to perform Activities of Daily Living: ▪ **Washing / Bathing** The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash by other means. ▪ **Dressing** Ability to put on, take off, secure and unfasten all garments, any braces, artificial limbs, or surgical or medical appliances. ▪ **Feeding** Ability to feed oneself once the food has been prepared and made available. ▪ **Toileting/Continence** Ability to use the lavatory or otherwise manage bowel and bladder functions through the use of diapers and urinary catheters, so as to maintain a satisfactory level of personal hygiene. ▪ **Mobility;** Ability to move indoors from room to room on level surfaces. ▪ **Transferring** Ability to move from a bed to an upright chair or wheelchair vice versa. 1b. Advanced Dementia, or dementia arising from **Alzheimer's disease** is covered. The important issues are that dementia must arise from an organic reason and that the insured requires continual supervision.
2. Meets the deferred period requirement. Most insurers have a Deferred Period of **<u>90 days</u>** commencing from the first day of any continuous period of inability to perform ADLs. This is to ensure that short term claims are avoided and therefore, reduce the premium costs.
3. Do not cover **pre- existing illness** that was not disclosed in the proposal form. If disclosed, insurer may reject the application or accept the application: • at standard premium rates; • at substandard premium rates (higher premium); • with exclusions.

5. Other benefits payable under LTCI are:

   - Death Benefit
     Small death cover ranging from an e.g $5000 to 6 times the LTC monthly benefit;
   - Hospital Room and Board Benefit
   - Surgical Procedure Benefit
   - **Financial Assistance with Adaptation Benefit**;
     A specified sum, such as 2 times the monthly benefit, is payable if the use of **assistive devices** is deemed necessary (eg wheelchair);
   - **Extended Care Benefit**
     An extra specified sum, such as extra monthly benefit, is payable every 3 to 5 years;
   - Rehabilitation Benefit
     A **reduced benefit** (e.g 50% of the insured amount) when the insured makes partial recovery (such as if he is unable to do 2 instead of 3 ADLs).

6. Among the features of LTC Insurance given in the text at page 89, please know the following:

   - Offered on a **stand-alone** basis or as a **rider** to a plan.
   - It is issued on a **guaranteed renewable basis**.
   - There is **no cash value or paid up value** (with exception of Eldershield which has a paid-up value) at any time.
   - Policy is **non-participating** and does not share in the divisible surplus of the insurer.
   - Premiums are **level** and usually not guaranteed for the policy period and can be adjusted by the insurer.
   - If insured recovers from his disability, payments will **stop.** However, the insured can choose to continue his policy by continuing to pay the premiums, provided he has not reached maximum limit under his policy.

7. Among the exclusions given in the text at page 89, please know the following:
   - All pre-existing illness;
   - Self inflicted injury;
   - Alcoholism or drug abuse;
   - Acquired Immune Deficiency Syndrome (AIDS) or infection by any human immunodeficiency virus (HIV), **except where the infection is due to blood transfusion or resulting from infection incurred by medical staff** after the issue date;
   - Participation in a felony, riot or insurrection.

Chapter 6 – Other types of Health Insurance

This chapter covers the following health insurance product:

1. Critical illness Insurance;
2. Hospital Cash (Income) Insurance;
3. Medical Expense Benefits Under Travel Insurance;
4. Group Dental Care Insurance.

1. Critical Illness or Dread Diseases(DD)

1.

Dread Disease or Critical Illness

Purpose

2 types

- **Acceleration Benefit;**
- **Additional Benefit;**

Which is often known as "Packaged Policy"?
Ans : **Acceleration Benefit**

- Provides a **lump sum** benefit upon diagnosis of any **one** of the critical illness;
- It is a **hybrid** of life and health insurance;
- Can be sold as a **stand-alone** policy (individual or group)or as a **rider** to other policy;
- Before 1 August 2014, CI Insurance Policies cover only a maximum of 30 out of 37 critical illnesses. From 1 August 2014, CI benefits offered under new individual or group insurance policies may be launched under **2 changes**:
  i. revised standardised definitions of the 37 severe critical illnesses (appendix 6a).
  ii. flexibility for more medical conditions to be covered. Insurers not only can offer CI Insurance Policies covering **beyond 37** (30 previously), but also offer single illness CI Plans. Definitions for additional CI not covered by the 37 standardised definitions will be set by individual insurers.

  CI using the old definitions will no longer be sold from 15 Feb 2015.

2. Eligibility criteria for payment of Critical Illness Benefit.

   a. Policy must be in force;

   b. Life insured has not reached **expiry age** of Critical Illness Cover;

   c. Critical Illness must be one that is **covered;**

d. Critical Illness must meet the **definition** in the policy;
The definition of critical illnesses a as specified in the policy forms an important part of the policy, as they will determine whether a claim is payable. Important to explain to prospective client, to ensure he understands the benefits will be paid only if the disease qualifies and meets the definitions as specified in the policy. .

e. Critical illness must meet **conditions** set down by insurer. The diagnosis of the CI must be made by registered medical practitioners, which excludes physicians who are themselves (life insureds), their spouses and other lineal relatives of theirs;

f. Must meet the **waiting period** of **90 days** from the date of issue or reinstatement;

g. Must meet the **survival period** of usually **30 days**, (although can be as short as 7 days) from date of occurrence of a critical illness. It applies to Additional Type only.

3. Among the features of Critical Illness Insurance (CI) given in the text at page 98, please know the following:

- Can be issued as a **stand-alone basis** or as a **rider** to a basic policy. It does not pay upon the life insured's death or total and permanent disability;
- CI rider has **no cash value**;
- CI rider is automatically **terminated** once the basic policy is surrendered or converted into an extended term policy;
- Stand –alone term CI Policy does not acquire cash value, and thus has no non forfeiture option;
- Can be packaged or attached to a Life, Endowment or Investment Linked Policy;
- Packaged CI Policy which accumulates cash value (e.g whole life type of CI Policy) also provides non forfeiture options. However, CI cover may be terminated once any non forfeiture option is exercised except **Paid Up Option**;
- Assignment may/may not be allowed;
- Maximum age entry (eg 55 years) and minimum age entry (eg 1 year), subject to a lien;
- There is a minimum (eg $10,000) and maximum (eg $1,000,000) sum assured restriction;
- Cover will expire at age 65 years, or a whole life cover may be provided.

4. There are 2 types of Critical Illness Covers;
   - Acceleration Benefit; or
   - Additional Benefit

a) Acceleration Benefit Critical Illness Cover

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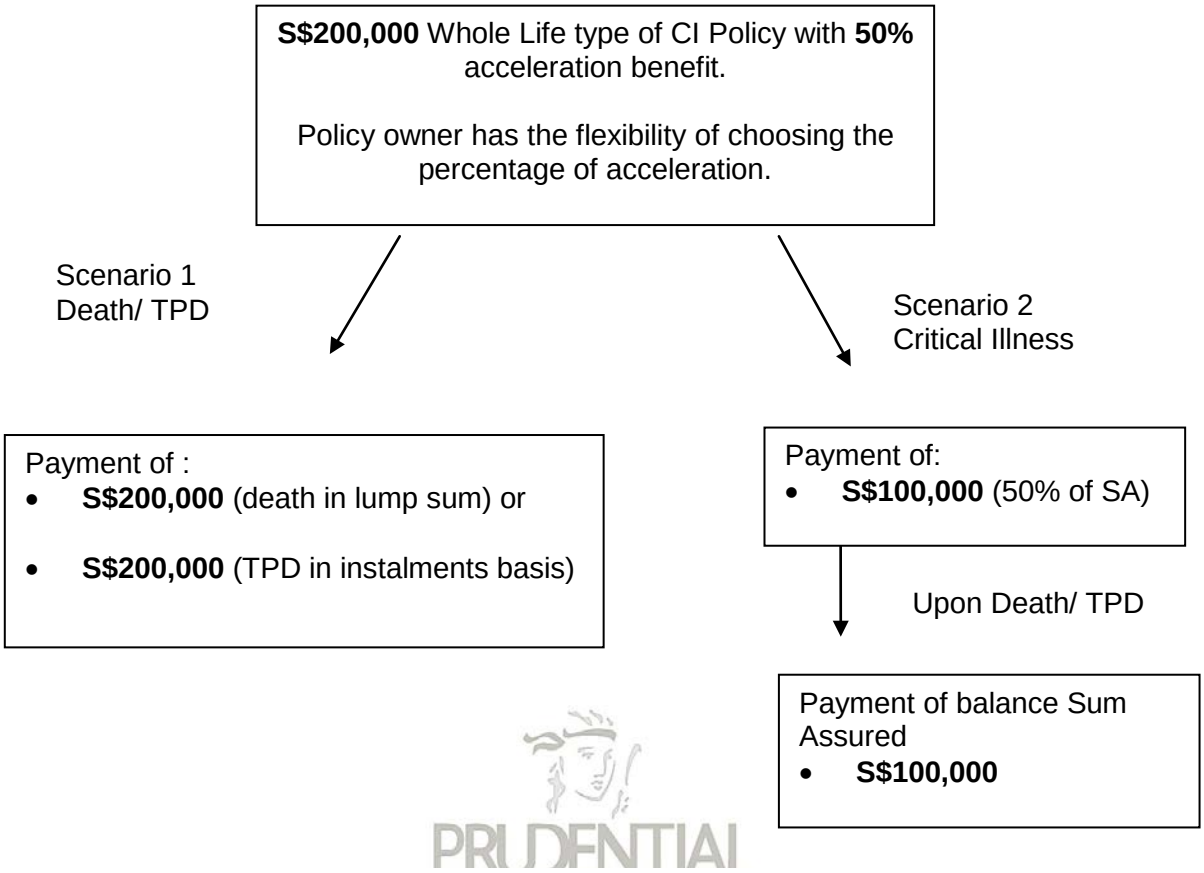


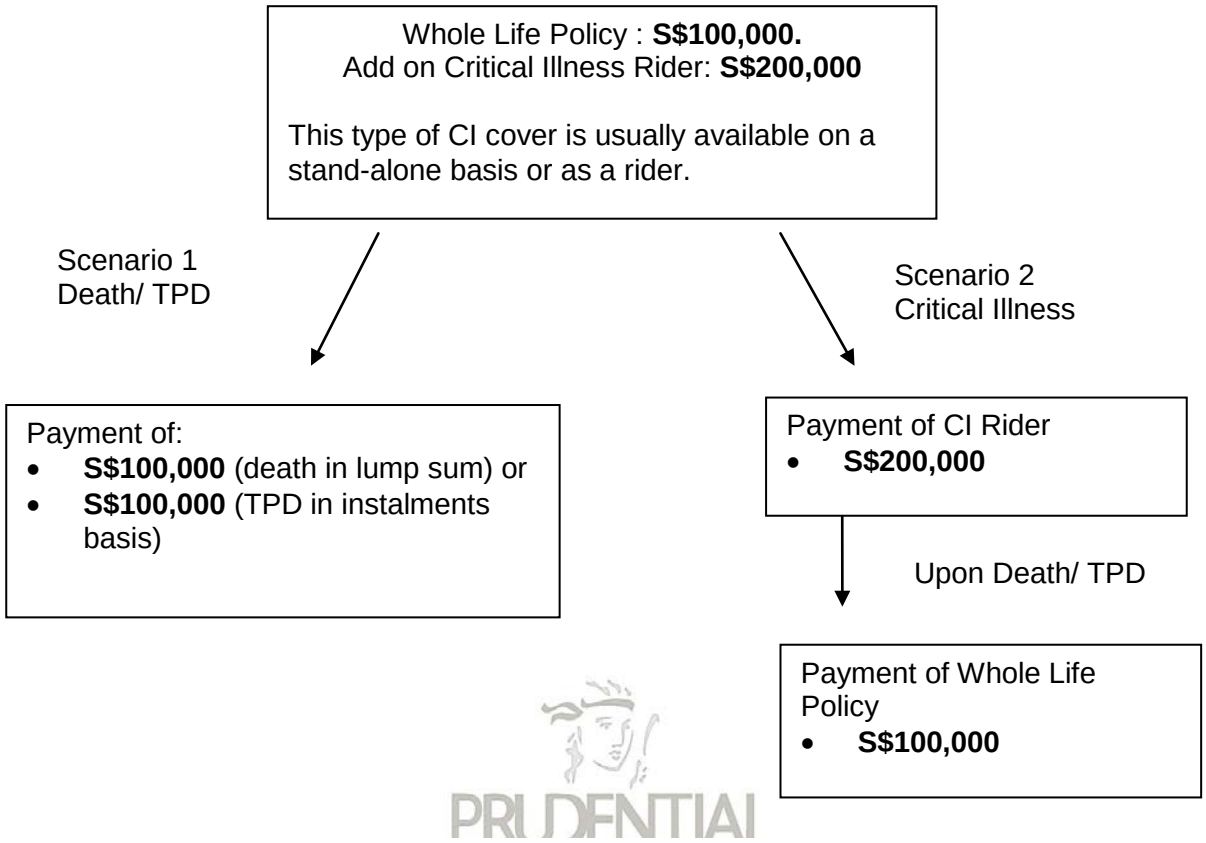
Note :

- Policy owners who opt for less than 100% of acceleration, should attached a **Critical Illness Waiver of Premium Rider** so that the future premiums on the balance sum assured will be waived.

- The cover for this type of CI Policy may be up to age of 100 years, or depending on the type of life policy to which is packaged/attached.

- Depending on what type of policy CI cover is attached to, if the basic policy has no cash value (eg term policy), then there is no non-forfeiture option under the policy to keep it in force, unlike Whole Life or Endowment Policy which has acquired cash value, the insurer can make use of automatic premium loan to keep the policy in force should policy owner defaults in premium payments.

b) Additional Benefit Critical Illness Cover.



Note :

- This rider pays **in addition** to the sum assured of the basic policy it is attached.
- The term of this rider can be **shorter,** but not **longer t**han that of the basic policy. Usually expires at the age of 65 years. The sum assured of the rider can be higher than the basic policy (e.g **5 times** that of basic sum assured)
- Policy owners should attached a **Critical Illness Waiver of Premium Rider** so that they need not worry about the premium payments for the basic policies to which CI rider is attached to.

5. Differences between Severity Based Critical Illness Plan and Normal Critical Illness Plan is that Severity Based CI

    - pays claims during the early stages and less severe critical illness. Benefits are claimable at different stages of the illness, from **early** to **intermediate** to **advanced** and **terminal**. It pays a percentage of the sum assured as a **lump sum** payout to the policy owner. The progressive lump sum payment, subject to a monetary cap of each severity level, pays up to the total sum assured.
    - Offered as a term plan or a rider;
    - Offered from age **1 to age 75;**
    - Premium is **higher** than normal CI plan.

6. Multiple Pay Critical Illness Plan
   Allows **more than one** critical illness claim on the policy. A second or even third claim is allowed if the medical condition deteriorates or if a different medical condition occurs. Waiting period of the second and subsequent claims is usually **waived.**
   Eg: Total payouts of up to 200% of sum assured. So if the sum assured is $100,000, the plan can pay up to $200,000.

7. CI Polices usually have a built-in death benefits payable, hence they will come under the **Nomination of Beneficiaries framework**. Insured who is a policy owner can make a nomination at the age of 18 years and above. 2 options available are Trust Nomination or Revocable Nomination.

8. **Termination Of Cover**
    - valid CI claim has been made,
    - basic life policy to which it is packaged matures or CI rider expires;
    - non-payment of premiums, insured dies
    - policy is converted into **Extended Term Insurance Policy**.

9. In the event of a claim, insured must submit:
    - **Claimant Statement** - completed by insured;
    - **Attending Physician's Report;**
    - Proof of Critical Illness **eg histology report;**
    - Written notice of claim must be submitted within **60 days** of diagnosis of CI or performance of surgery;
    - Claimant's form must be submitted **15 days** from the date the insurer sent it out;
    - Proof of CI must be submitted within a specified period (**60 days**) from the date of diagnosis of CI.

10. Group Critical Illness Policy:
    - Will expire at age **65** regardless of whether it is issued as an Acceleration or Additional type.
    - Can be issued as a package policy or as a rider.

2. Hospital Cash (Hospital Income) Insurance

1. Pays a daily benefit upon hospitalization regardless of whether it is due to injury or sickness. This amount has **no direct co- relation** to the actual amount of medical fees incurred. However for sickness, a waiting period of **30 days** from issue/ reinstatement date applies. Waiting period does not apply to **injury.**

2. Hospital Cash :
   - Pays daily;
   - Limited by specified no. of days per hospitalization;
   - Limited by a **lifetime limit.**
   - It pays **on top** of other benefits received from medical insurances.
   - Must be confined in hospital for at least **6 to 24** hours.
   - Premium is on **age band basis**.
   - There is a "**No Claim Discount**" given for policy that is inforced for a consecutive period of insurance and free of any claim. A certain percentage (eg 25%) will be deducted from the next renewal premium.

3. Standalone Policy is more attractive than as a Rider in these ways:
   - **Double Payment –** if stays in ICU;
   - **Triple Payment** – hospitalized due to accident or insured is hospitalized overseas;
   - **Get Well Benefit;**
   - **Rehabilitation Income;**
   - **Free Accidental Death Benefit.**
   - **Involuntary loss of employment benefit** (in excess of 30 days)- waiver of premiums (up to 6 months).

4. Hospital Cash Policy is usually not written due to its small premium, however **pre-existing** medical conditions are permanently excluded under the policy.

5. Claims
   Require to submit the following:
   - **Claim form;**
   - **Hospital discharge summary bills;**

   Additional documentary evidence:
   - Attending Physician's Report;
   - Other relevant supporting documents.

3. Medical Expense Benefits under Travel Insurance

1. The benefits offered by a Travel Insurance Policy include:

    1. Medical Expenses and Other Related Benefits
    2. Hospital Confinement Allowance;
    3. Emergency Medical Evacuation; and
    4. Repatriation.

1. Medical Expenses and Other Related Benefits

Reimburse most of the **overseas medical and treatment** as follows:

- **Medical expenses** such as clinical, hospital surgical nursing, ambulance and medical supply charges, emergency accidental and miscarriage expenses, including any follow – up medical expenses in **Singapore i**ncurred within a **certain period** (usually 31 days) after the insured returns from his trip.

- Expenses incurred for treatment by **Traditional Chinese Medicine** physician, including acupuncturist, bonesetter, chiropractor, herbalist or physiotherapist, up to a limit (e.g S$750)

The above is subject to an overall limit of indemnity (e.g S$2,000,000).
Lower limit will apply to a child (from one to 18 years) or elderly (above age of 70 years).

- Reasonable additional **accommodation** and **travelling expenses** incurred by insured person (and a travel companion if required) to remain in the overseas country of visit for medical treatment, up to a limit (e.g $25,000) and

- **Hospital visit** – accommodation expenses necessarily incurred by one relative or friend of the insured who has been hospitalized overseas for more than 5 days to visit and stay with him until he is medically fit to return home up to a limit (e.g S$10,000).

2. Hospital Confinement Allowance

This entitled the insured to claim if he is hospitalized abroad for:

- **A daily cash payment** (e.g S$200 per day);

- **Up to a certain period** (e.g 250 days) or

- **Up to a certain amount** (e.g S$50,000)

- **Double** benefit for overseas hospitalization in an intensive care unit resulting from an accident up a certain period (e.g 10 days).

For hospitalization in Singapore when treatment is sought within a certain period (e.g 7 days) upon return, the limits are lower (e.g S$100 per day payable up to 10 days).

The benefits are payable upon his return to Singapore, when he submits a claim with all relevant supporting documents.

3. Emergency Medical Evacuation

Emergency evacuation means that, in the event of a critical situation in which the insured person suffers a serious illness or injury abroad, and has to be **evacuated** to another place to seek emergency treatment, because local medical services are **inadequate** or **unavailable.**

Insured **must** contact a **specialist company** contracted by the insurer to provide emergency medical evacuation. Such specialist company shall then decide whether or not the insured requires emergency evacuation. A 24 hr multilingual hotline phone number of such specialist company is specified in the policy.

There is usually a maximum benefit limit (e.g S$500,000) payable for the lower coverage plan. However for the higher coverage plan, the coverage amount is usually unlimited.

4. Repatriation

- Emergency medical repatriation occurs when, as a result of an unfortunate illness or accident abroad, the insured has to be repatriated to his country of origin (e.g return to Singapore). The decision as to whether he should be repatriated strictly rests with the attending medical doctor or the insurer's contracted specialist company.

- Repatriation of remains means the transportation of and return of the **deceased** insured's mortal remains to his country of origin.

- There is usually a maximum benefit limit (e.g S$30,000) payable for the lower coverage plan. However for the higher coverage plan, the coverage amount is usually unlimited

2. **Exclusions**

Among the exclusions given in the text at page 115, please know the following:

- Driving or riding in any kind of race, engaging in any professional sport, ice or winter sport, mountaineering requiring the use of guides and ropes, or underwater activity involving the use of underwater breathing apparatus;

- Aerial activity other than air travel as a fare paying passenger in a licensed passenger-carrying aircraft;

- Any event including strike, riot, civil commotion, health threatening situation, natural disaster published by the mass media or through advisory of the authority, unless the policy already issued or the trip already commenced before the date of publication or advisory; or

- Travel booked or undertaken against medical advice, or for the purpose of obtaining or seeking any medical care or treatment abroad.

4. Group Dental Care

1. Group Dental Care:

    - Offered on a group basis **without underwriting**.
    - It can be a **rider** attached to a Group Hospital & Surgical or as a **Standalone** policy.
    - Coverage is usually on a 24 hrs worldwide basis, only employees who are **actively at work** are covered and it is usually on a **non contributory** basis.
    - Pre-existing **dental conditions** are covered as well.
    - Affected by the **Limitation Clause**, hence reimbursement will be affected by workmen's compensation or other dental plans.

2. Exclusions:
    - Dental procedures that are not specified in the schedule of allowances;
    - Hospital charges;
    - Injuries arising from war (declared or undeclared), revolution, or any warlike operation;
    - **Medicine given;**
    - Treatment which is purely cosmetic in nature;
    - Treatment resulting from self –inflicted injury, while sane or insane and
    - **Replacement of broken, lost or stolen dentures.**

3. Terminations:
    - The date of termination of the insured employee's active full time employment;
    - The date of termination of the policy;
    - The date of expiration of the period for which the last premium payment is made in respect of the insured employee's cover'
    - **The date on which the insured employee enters full time military, naval, air or police service, except during peacetime National Service reservist duty or training;**
    - The date of expiration of the period within which the insured employee reaches a specified age (usually age of 65 years)

4. Claims
   For employee who uses his **own dentist**, they need to pay first and file a claim with the insurer. Documents are:

    - **Claim forms**
    - **Original receipt & itemized bills.**

   For insurer that has its **panel of dentist**, employee need only produce the membership card whenever he visits the dentist and the **clinic will bill insurer directly.**

Chapter 7 – Managed Health Care (MHC)

1.

Managed Health Care (MHC)

Purpose

An overall **strategy** for containing medical care costs, while receiving appropriate medical care. It will pay for most of the medical bills when an individual sees a General Practitioner, specialist or receive treatment in a hospital.

3 components to contain and control Healthcare expenditure

Accessibility

- Easily accessible;
- Requires members to select one doctor to be their Primary Care Physician (PCP).

A primary care physician is usually a general practitioner. He is often known as:

✓ **Personal Physician**
Serves the member as his "personal physician", but also acts as the first contact with MHC.

✓ **Gatekeeper**
Member must obtain a referral from the PCP before seeing a specialist, hence called "gatekeepers".

Cost - 4 methods

- **Capitation;** Capitation means MHCO prepays their providers a **flat amount** for each member's medical care on a monthly basis.
- **Discounted fee for Service** (e.g discount of 10% on physician fees)
- **Salary;**
- **Fee schedule**.

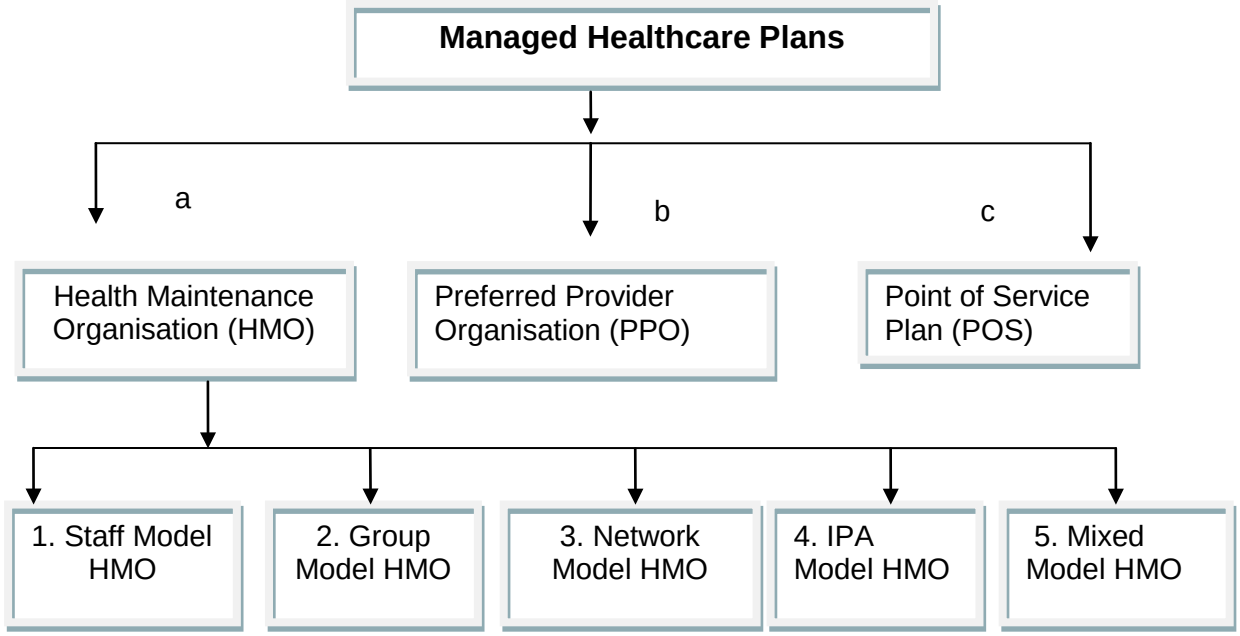
Quality of care.

Health care providers must possess requisite skills, training and licenses as MHCO is concerned about the quality of care for a good reputation as that is what attracts new members and keep existing ones.

Qn:
Which of the above payment methods used do not discourage the provision of unnecessary medical services?

Answer: **Discounted Fee For Service & Fee Schedule**

2. The three common types of MHC Plans are



1. <u>Staff Model HMO</u>

- HMO **employs** PCPs who usually work together in a centre to treat members who are only members of the HMO. Specialist care need is refereed to certain contracted specialist.
- Very **effective** in managing costs as have control over the physicians they employ. Compensates physicians on a predetermined salary.
- Physicians have no financial incentive to over treat the patients.

2. **<u>Group Model HMO</u>**

- Made up of **2 entities**: HMO is the organizational entity that runs the healthcare business and it will contract a large group medical practice to provide medical care services to its members.
- Same cost–management potential as Staff Model HMO as the group practice obtains all or a vast majority of its patients from the HMO, thus giving HMO a high degree of leverage over the negotiation of payments.

3. **<u>Network Model HMO</u>**

- Similar to Group Model HMO, except that in this model, it contracts with a relatively large number of group practices and even individual physicians.
- Physicians operate out of their own offices or facilities provided to them by their group practice. Physicians may provide services to more than one HMO.
- **Does not have** as tight control over utilization management as the above 2 models as physicians may treat patients on a fee for service basis and HMO arranges for hospital services rather than physicians.

4. **Independent Practitioners Association (IPA) Model HMO**
   - Also contract with other entities to provide medical care services to its members.
   - IPA physicians continue to develop their own private practices and in fact, HMO members represent only a small percentage of their patient list.

5. **Mixed Model HMO**
   - Combination of 2 or more of the above 4 types of plans.
   - They offer **broader** consumer choice of physicians and clinical settings.

2b. **Preferred Provider Organisations (PPOs**)

Similarities

PPOs are similar to HMOs in that they enter into contractual arrangements with healthcare providers who together form a "**provider network**". Physicians provide care at lower rate in exchange for more patients directed towards them.

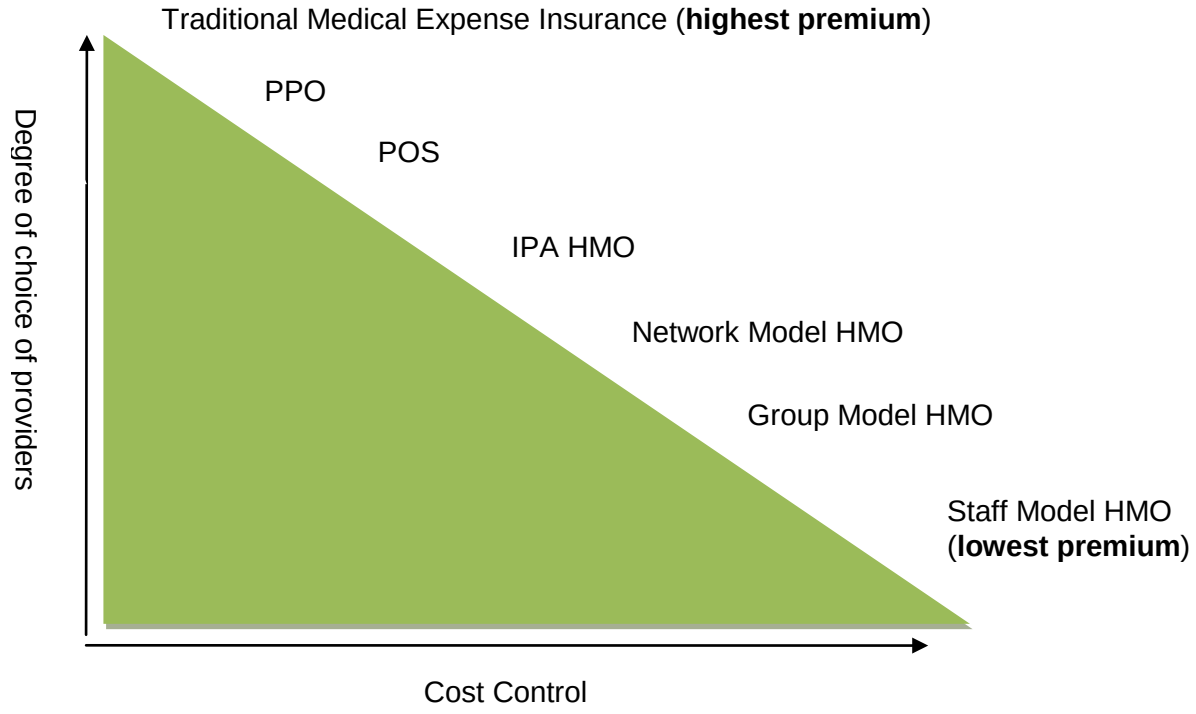
Differences

1. Unlike HMO, members do not have a PCP ("**gatekeeper**") and are not restricted to use only the provider network for their care, as they can choose to see a non network provider.
2. PPO member does **not** have to get a referral to see a specialist.
3. PPOs are less restrictive than HMO in the choice of healthcare providers. However they tend to require greater "out of pocket" payments from members.

PRUDENTIAL

2c. **Point-of- Service Plan (POS)**
   - **Combination** of a HMO and PPO.
   - Encourage, but does not require a member to choose a PCP.
   - Allows members to use a provider who is not in the network for his care, however he has to pay higher co-payments and/or deductibles than member who uses a PCP.
   - Known as point-of –service plan because, at the point when a member **needs** healthcare services, he can decide to stay in the network (to allow his PCP to manage his care service) or go outside of the network on his own, without a referral from his PCP.

3. Degree of Choice of Providers Vs Cost Control
   Know this diagram well for 3a and 3b



3a. In ascending order, list the models given below from the **most cost effective** to the **least cost ineffective.**

POS, Network Model HMO, IPA, Staff Model HMO, PPO

Answer: Staff Model HMO/Network Model HMO/IPA/POS/PPO

3b. In descending order, list the given models in question 3a from most flexibility to least flexible.

Answer: PPO/POS/IPA/Network Model HMO/Staff Model HMO

4. Revision of MHC Plans:

Clues		Model
1.	This model is most effective in managing cost.	**Staff Model HMO**
2.	This model is made up of 2 entities. The organizational entity that does everything it takes to run a healthcare business except actual practice of medicine.	**Group Model HMO**
3.	The physicians in this model develop their own private practices.	**IPA Model HMO**
4.	Offer combinations of a few HMOs. They offer broader choice consumer choice of physicians.	**Mixed Model HMO**
5.	This model contracts a large number of group practices, including individual physicians.	**Network Model HMO**
6.	Members do not have a PCP ("gatekeeper") and are not restricted to use only the provider network for their care.	**PPO**
7.	The members in this model do not need to choose how to receive services until they need them. Combination of HMO and PPO.	**POS**

5. Benefits offered include:
   - **Primary care;**
   - **Specialist care;**
   - **Hospital care;**
   - **Emergency care;**
   - **Preventive care;**

6. Like other types of traditional Health Insurance, elements of co-insurance and deductible may **be found** in MHC Insurance.

7. One **exclusion** under MHC Insurance Policy states that payment from MHC plans will be excluded by reimbursements from **Workmen Compensation** and other forms of insurance coverage.

8. Claims for MHC

In- the- network providers	Out-of-network providers
Members who use in-the-network providers need not file claims with the insurer	Members who use out-of-network providers need to file claims with the MHCO. Supporting documents to be submitted include: • Claimant's statement; and • Original itemized medical bill.

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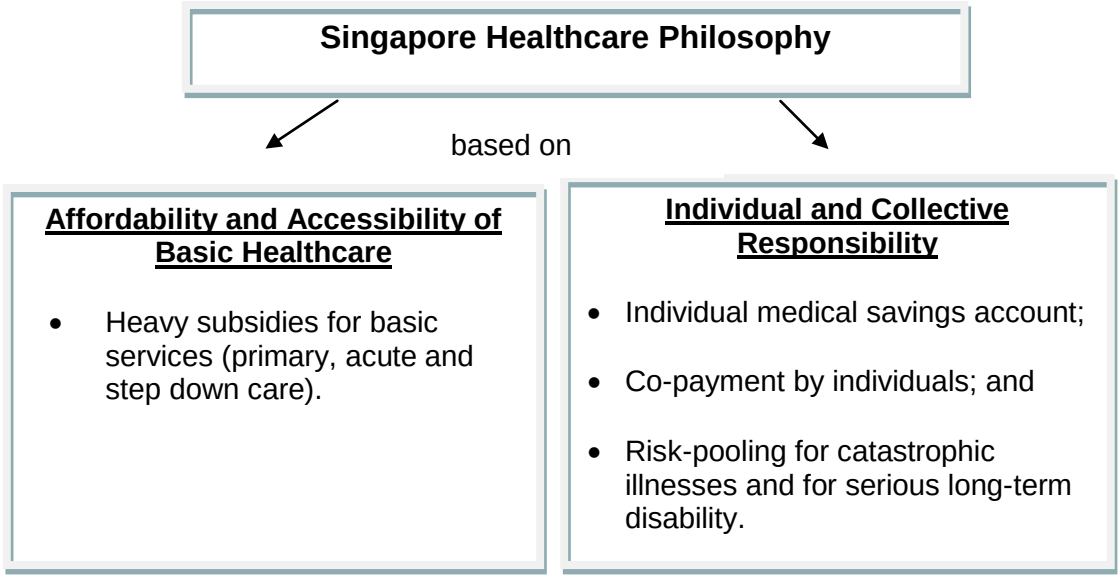
Chapter 8 – Healthcare Financing

1.



2. Government Subsidies include the following:

Government Subsidies		
In Public Hospitals		
Inpatient	Specialist Outpatient Clinics (SOCs)	Other services
• Ward classes differ only in the **physical amenities** and level of comfort, however the standard of medical care is the same regardless of the ward's class. • In Jan 2009, **means testing** in public hospitals was introduced to better target the **heavy subsidies** for class **B2 & C** wards at the lower-income group. The subsidy received depends on the **monthly income** of the patient. B2 or C class patients who require follow-up at the specialist Outpatient Clinic (SOCs) will continue to receive subsidies.	• Subsidy for lower-to-middle income is 70% & 60% respectively, while the rest of the subsidised patient is 50%. • For standard drugs: Lower-to middle-income receives a 75% subsidy; while the rest of the subsidised patient is 50%. • The eligibility for higher subsidy is based on the **household monthly income per person, or annual value of residence (for households with no income**) and is aligned with the eligibility for the Community Health Assist Scheme(CHAS).	• Day surgery and Accident & Emergency (A&E) services **are not means- tested.**

Government Subsidies	
Other Public / Community Services	
Government Polyclinics • Services provided is subsidised at about **50%. 75%** if the patient is a child or elderly. • Standard drugs - subsidy of **75%** for lower-to-middle income patients. Means-testing aligned to CHAS. • With CHAS, lower-to-middle Singaporeans will receive subsidised primary care at GPs and dental clinics in their neighbourhood.	**Voluntary Welfare Organizations(VWOs)** • Provides healthcare services such as renal dialysis, mental rehabilitation and nursing home care. • MOH funds **50%** of operating expenses of these VWOS and **90%** of their capital expenditure.

3. **CPF Healthcare Financing Schemes**
CPF Schemes which can be used to meet members' healthcare needs are:

A. Medisave;
B. MediShield Life;
C. Integrated Shield Plans and
D. ElderShield and ElderShield Supplement.

PRUDENTIAL

A. Medisave

1. National healthcare saving scheme where the amount contributed is from the CPF members and their employers. Amounts in the MA earn an annual interest rate of **4%** and can be used to pay for a member or their immediate family's medical expenses. Immediate family refers to spouse, children, parents and grandparents. **Grandparents** must be Singaporeans or Singapore Permanent Residents (SPRs).

2. **2 Changes from 1 Jan 2016** :

1. **Basic Healthcare Sum (BHS)**
   - Medisave Contribution Ceiling is the maximum balance a member can save in his Medisave Account (MA) will be renamed as the **Basic Healthcare Sum(BHS**) set at $49,800 (as of Jan 2016) for CPF member. If the member is of age 65 years & above in 2016, this sum will be his BHS for life. However if he is below age of 65 years, BHS applicable to him will be adjusted yearly in January. When a CPF member reaches the age of 65, the BHS for him will be fixed at the BHS that year and the amount will not change for the rest of his life.

   - Amount in the MA up to the BHS **cannot** be withdrawn. Medisave contributions will go into the MA until it reaches the BHS, any amount above the BHS will be automatically transferred to the members' Special or Retirement Accounts to boost his monthly payouts. If the member already met his Full Retirement Sum, amount will flow to his OA, can be withdrawn as cash from age 55.

2. **<u>Removal Of Medisave Minimum Sum</u>**
   - Medisave Minimum Sum has been **removed**, hence CPF member will no longer be required to top up his Medisave Account to the Medisave Minimum Sum when withdrawing his CPF Savings (OA & SA) at the age of 55 years. This provides **certainty** on how much a CPF member can withdraw from his OA & SA after the age of 55 years.

3. **Uses of Medisave**

Medisave can be used to pay for hospitalisation and selected outpatient treatment expenses (**up to the withdrawal limit**s) such as :

- Colonoscopies;
- Mammograms ;
- Chemotherapy and radiotherapy.

It can also be for the following subject to withdrawal limits and other conditions:

a. Inpatient Expenses - daily ward charges, doctor's fees & inpatient charges of medical treatment, investigations, medicines, implants, prostheses introduced during surgery.

b. Day Surgery And Surgical Operation. - CPF members **age 50** and above can use their Medisave to pay for their screening of colonoscopies & mammograms at approved medical centres up to specified limit.

c. Inpatient Psychiatric Treatment.

d. Inpatient Stay in Community/Convalescent Hospital & Inpatient Hospice and Approved Treatment in Day Hospital & Day Rehabilitation Centre.

e. Outpatient Treatment For Approved Chronic Disease Under **The Chronic Disease Management Programme (CDMP).**

1. Medisave can be used to pay for outpatient treatment for 19 approved chronic diseases under CDMP such as **diabetes, high blood cholesterol, hypertension or asthma**. These diseases can:
   - result in serious complications like heart disease, kidney failure and leg amputations if not well managed; and
   - have high cost of treating them over the long term if poorly controlled.
2. The aim of allowing Medisave use under CDMP is to :
   - lower long-term healthcare costs; and
   - improve care for patients with chronic diseases, resulting in better health outcomes.
3. Under CDMP, Medisave **can** be used to pay for :
   - **consultations;**
   - **drugs/medications (including non standard drugs);**
   - **laboratory tests;**
   - **diagnostic tests, eg eye screening, foot screening; and**
   - **allied health services, such as nursing and physiotherapy as referred by the doctor**.

4. Medisave **cannot** be used for the purchase of glucometers, glucometers strips, blood pressure monitoring equipment, wheelchairs, prostheses, or other home nursing equipment.

5. To avoid over-consumption patients must make a **15% cash** co-payment for all CDMP claims. The amount of Medisave that can be used for CDMP is **$400** per immediate family member's MA per calendar year, up to 10 MAs can be used for each claim.

f. Approved Outpatient Treatments
   - Approved vaccinations (e.g Hepatitis B, pneumococcal disease, Human Papillomavirus (HPV), vaccinations on National Childhood Immunization Schedule).
   - Screening mammograms;
   - Renal dialysis;
   - Cancer treatment (Chemotherapy, radiotherapy and related diagnostics); and
   - Outpatient scans required for diagnosis and/or treatment of a medical condition.

g. Maternity Charges & Assisted Conception Procedure Treatments
   - Medisave Maternity Package allows a female **CPF member or her family member** to use Medisave to pay for pre delivery expenses and delivery expenses (eg consultations and Ultrasound) and delivery expenses.

   - Couples can use their Medisave up to a lifetime limit of S$15,000 per patient to pay for **Assisted Conception Procedure** treatments which must be performed locally. Only Medisave accounts of **the patient and her spouse** can be used.

PRUDENTIAL

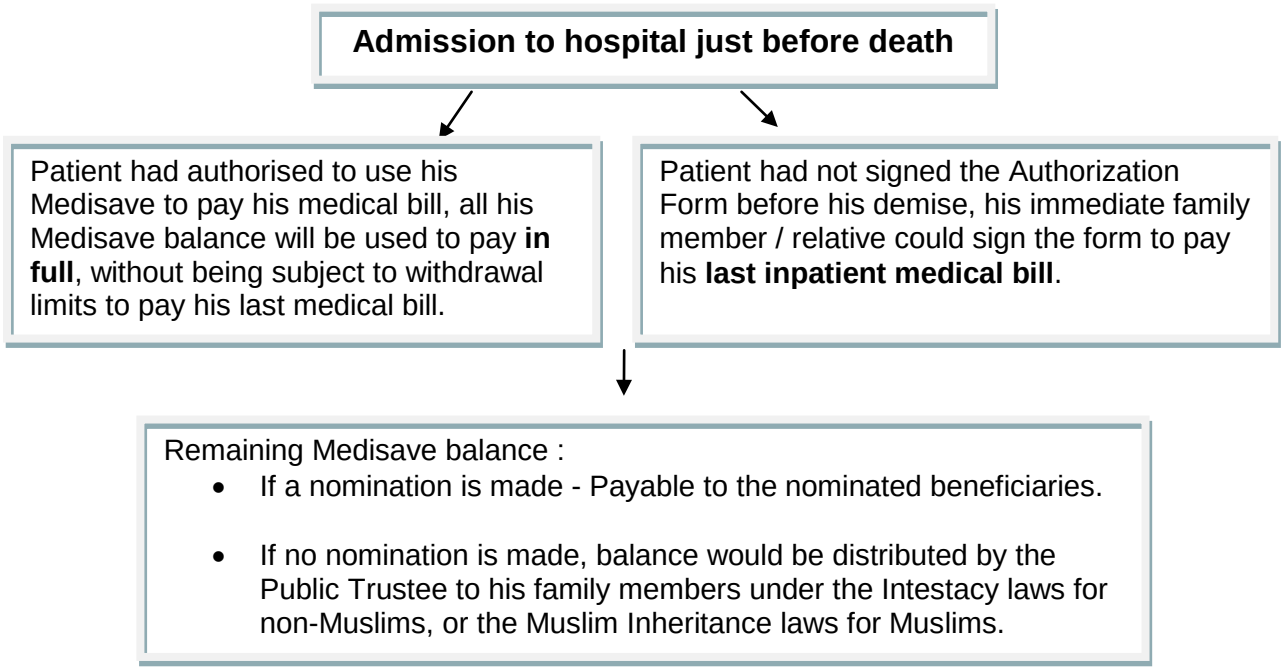
h. Buying Medical Insurance
   Medisave can be used to pay for approved Integrated Shield Plans , ElderShield and ElderShield Supplements from approved insurers. The use of Medisave to pay for insurance premiums is subject to withdrawal limits. (cover later).

4. Where Can Medisave Be Used?
   In all **public healthcare** institutions, as well as **approved private hospitals** and medical institutions.

5. Whose Medisave Can Be Used?
   - Patient's **immediate family members** (i.e spouse, parents and children) can use their Medisave to pay for the hospitalisation bill. Eg. 2 children can specify how much each will pay for their mum's hospitalisation bill.

   - If immediate family members' MAs is not enough to pay for the bill, then non immediate family members e.g brothers and sisters can appeal to help settle the bill. This option is only available if the patient qualifies under certain conditions, e.g stayed in **class B2** or **C ward of a public hospital** and has **exhausted** the moneys in his own and immediate family members' MAs.

6. Distribution of Medisave Upon Demise



B. MediShield Life

1. Unlike Medisave which is a **savings scheme**, MediShield Life is a basic healthcare insurance scheme which replaced MediShield on 1 Nov 2015. It is **compulsory** for all Singaporeans Citizens and SPRs, regardless of where they reside. They is no need to apply for MediShield Life, all are covered for life, in line towards universal insurance coverage from 1/11/2015.

2. It offers :
   - **Better protection and higher payouts** , so that patients pay less Medisave/cash for large subsidised hospital bills;
   - **For protection for all Singapore Citizens and SPRs**, including very old and those who have pre-existing illness;
   - **Protection for life**.

3. Benefits will be **enhanced** under MediShield Life, with **higher** claim limits and **lower** co-insurance rates, so that MediShield Life pays more and patients pay less. (Table at pg 24 of text).

4. MediShield Life premiums will be higher than MediShield premiums due to:
   a. Better benefits than MediShield;

   b. Cover Singaporeans with pre-existing conditions. Those with serious pre-existing conditions may have to pay additional premiums (of 30% of standard MediShield Life premiums) for 10 years . The additional premiums does not reflect actual costs of coverage as the Government bears most of the cost;

   c. More even distribution over lifetime : Premiums are higher during working age, so that premiums will rise lesser in old age.

5. **MediShield Life Subsidies**

MediShield Life Subsidies	
Type of Subsidy	**Subsidies Received**
Premium Subsidies **Criteria :** • For lower-to-middle income families; • Monthly income per person of **S$2,600** and below and living homes of an Annual Value (AV) of **S$21,000** and below. AV covers all HDB flats and some private properties. Those with more than 1 property will not be eligible for this subsidy.	**50%** of their premiums. PRs will received 1/2 the subsidy rate applicable to Singapore Citizens.

Pioneer Generation Subsidies • Pioneers refer to living Singaporeans who meet 2 criteria : a. Age 16 yrs and above in 1965 (born on or before 31/12/1949, which also means that they are 65 yrs and above in 2014); and b. obtained citizenship on or before 31 Dec 1986. (Pg. 41, 7.1)	• Between 40% & 60%; regardless of their household monthly income per person or AV of their home. • Will also received S$200 to S$800 a year in Medisave top-ups (depend on year of birth) for life, which can be used for their MediShield Life premiums. (Pg 42,7.1.3)
Transitional Subsidies To ease the shift to MediShield Life for all Singapore Citizens whose net premiums (after all the above subsidies) increase in comparison to MediShield premiums, regardless of their household income or AV of their home.	• Available for the first 4 years of MediShield Life; • 1st Year - Government will pay 90% of the net premium increase (after above subsidies); • 2nd to 4th years - Government will cover 70%, 40% & 20% of the net premium increase of MediShield Life.
Additional Premium Support Families needing assistance with their premiums even after above subsidies and Medisave use.	

PRUDENTIAL

6. **MediShield Life Claim Payouts**
   - It pays on a **reimbursement basis**, subject to the limits imposed on the covered medical expenses, as well as **deductibles, co-insurance** and **pro-ration factors**.
   - Deductible is the **fixed amount** payable by the insured once every policy year. However insured member **need not pay deductible** for outpatient treatments covered under MediShield Life.
   - Co-insurance is the **percentage** of the claimable amount which insured will have to pay on top of the deductible. The **larger** the bill, the **lower** will be the co-insurance payable.
   - Pro-ration is the **percentage** that the CPF Board will use to **pro-rate** a patient's bill to the equivalent full subsidy bill size. Thus bills incurred in Class A, B1 or B2 + wards in public hospitals /private hospitals are **pro-rated** to the equivalent B2/C (MediShield Life is sized for B2/C class wards in public hospitals) bills and then subject to the MediShield Life claim limits.
   - Hence with limits imposed on the covered medical expenses, as well as deductibles, co-insurance and pro-ration factors, the scheme will **never** pay the full bill (Eg 8.1 of text).

7. **MediShield Life Scheme Act**

Keys features of the Act are:

- Extension of lifelong, universal coverage and better benefits for all Singapore Citizens and SPRs;
- Establishment of the MediShield Life Council to review the administration of the Scheme in line with the policy intent;
- Providing for access to information to facilitate the extension of MediShield Life premium subsidies to eligible households and scheme administration; and
- Powers for the recovery of premiums from willful defaulters as a last resort, to ensure that the premiums are paid in a timely manner.

Section 10 of the MediShield Life Scheme Act 2015 states that :

1. Rights and benefits of an insured person arising from the insurance cover under the Scheme are **not assignable** or **transferable.**
2. Policy **does not** create any legal or equitable trust.
3. Section 73 of the Conveyancing and Law of Property Act (Cap.61) and Section 49L of the Insurance Act (Cap 142) **do not apply** to any policy under the Scheme;
4. The Insurance Act **does not** apply to the Scheme or anything under this Act.

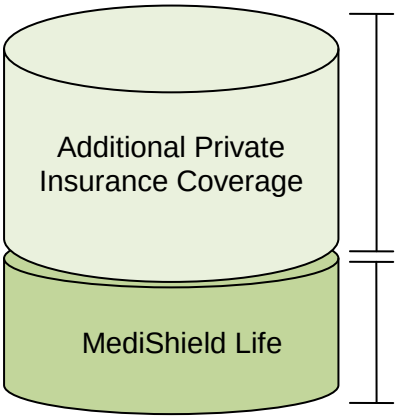
8. **MediShield Life Fund**

- MediShield Life is a **not-for-profit**, long term insurance scheme.
- Renewal of MediShield Life policy every year is **guaranteed**, regardless of whether they develop serious illness after they join.
- Premiums collected are put in the MediShield Life Fund, based on the actuarial principles and to be self-sustaining with each age group paying premiums to support its own current and future claims. Premiums are adjusted every 3 to 5 years, taking into account any variation in **claims experiences** and **benefits enhancement**.

C. Integrated Shield Plan (IPs)

1. IPs are Medisave-approved hospitalisation insurance plans, made up of 2 parts:

An Integrated Shield Plan has 2 parts:



- Provides **higher coverage** (e.g covers costs of private hospitals or Class **B1 or A** wards in public hospitals).
- Managed by a private Insurer.
- Enough to cover your large hospital bills in class **B2 or C** wards in public hospitals .
- Managed by CPF Board.

- On 1 Nov 2015, those who have IPs are covered under MediShield Life and there is no duplication of coverage between IPs and MediShield Life.
- The following plans are IPs:
  - AIA HealthShield Gold Max;
  - Aviva MyShield;
  - Great Eastern SupremeHealth;
  - NTUC IncomeShield;
  - Prudential's PruShield.

PRUDENTIAL

2. Insurance representative to highlight to client:

   a. If they wish to stay in private or subsidised ward in a public or private hospital and if they wish to choose their own doctors. From the usage of IP Policyholders, it seems to show that there is a significant degree of overconsumption in the purchase of IPs.

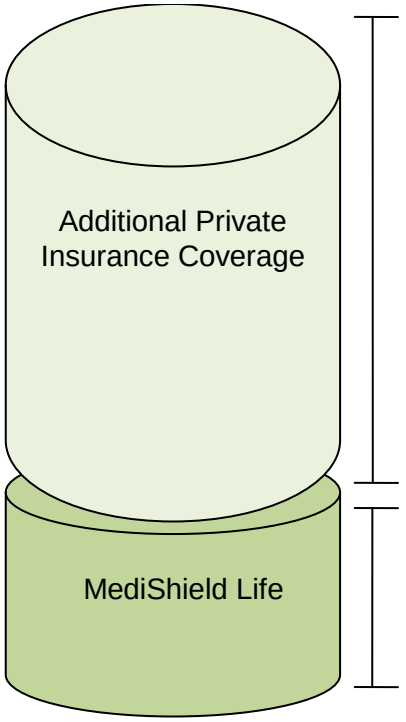
   b. Premiums for IPs are higher than MediShield Life and increase significantly as an insured persons get older and they are not guaranteed.

   c. The private component of the IPs premiums may not be fully payable by Medisave. Policyholders may have to pay part of their IP premium in cash.

   d. There are different benefits provided in the IP Policy and plans can be "as charged" or "non-as-charged" (sub limits imposed).

3. **Integrated Structure Of IPs**

1. An Integrated Shield Plan has 2 parts. The premiums paid to private insurers also comprises 2 parts:
   - Premium for MediShield Life component; and
   - Premium for additional coverage by the IP insurer.



Structure & Premiums
- IP policy holders will enjoy the benefits of MediShield Life within his IP Policy.
- He will pay **one** premium to his private insurer who will then arrange with CPF Board on the amount claimable under MediShield Life component.
- He need not liaise with both parties.

Coverage for IP
IP insurers are allowed to **risk-load** insured members with pre-existing conditions for the private insurance components of the IPs.

Coverage - MediShield ife
- He will be **covered for pre-existing conditions** for life under MediShield Life even though the condition may excluded by the IP Insurers.

PRUDENTIAL

2. A person insured under IPs will also be able to receive the applicable MediShield Life subsidies eg.
   - Premium Subsidies for lower-to-middle income;
   - Pioneer Generation Subsidies;
   - Transitional Subsidies.

   but will **not be eligible for Additional Premium Support**. Those who cannot afford to pay IP should remain on MediShield Life.

3. Changes to MediShield Life will affect private insurers. Increase in coverage in MediShield Life is expected to reduce claims from private insurance components of the IPs. However this does not mean that the private insurer will pay less. They will need to factor in **claims experience and medical inflation** along the benefits offered to decide on the level of premiums for additional private insurance coverage.

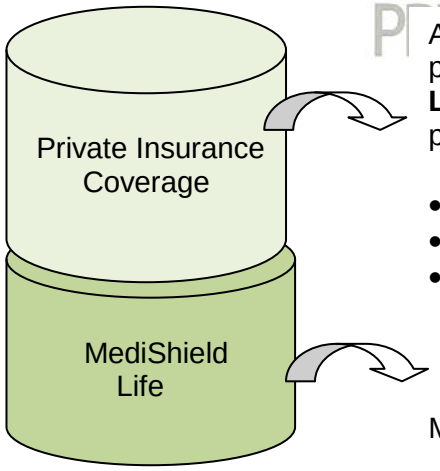
   IPs insurers have committed to leave the private insurance component of premiums **unchanged** for 1 year from the launch of MediShield Life. Nonetheless overall IPs premium will **increase** when MediShield Life is launched owing to the higher premiums for MediShield Life component of the IPs.

4. **Differences between CPF MediShield Life Scheme and IP**

MediShield Life	Integrated Shield Plan (IP)
Administrated by **CPF Board.**	Administrated and insured by only **insurers** as approved by MOH.
Designed for **B2 and C class** ward in public hospital stay.	Provides for enhanced coverage beyond MediShield Life with various plans types available for private and/or Class **B1/A** public hospital stays.
Covers all pre-existing conditions.	May decline or imposed with exclusions and/ or restrictions, arising from pre-existing conditions.
No maximum age limit.	May have a maximum entry age limit.
Sub-limits applicable.	Typically as charged basis, though insurers still offer sub-limits plans.
MediShield Life premiums are fully payable under Medisave.	Private insurance component of the IP premium is payable by Medisave up to the **Additional Withdrawal Limit**, the rest is payable by cash.

5. **Medisave Use for IP Premiums**

Integrated Shield Plan



Additional private insurance coverage premium can be paid by Medisave up to the **Additional Withdrawal Limit** (AWL). The AWL is set per insured person per policy year, as follows:

- Age Next Birthday (ANB) 40 and below : **S$300**
- ANB 41 to 70 years : **S$600**
- ANB 71 years and above : **S$900**

MediShield Life Premium is fully payable by Medisave.

6. **Riders**
   - IP Insurers are allowed to sell rider which pays for co-insurance and deductible portion of the IP payouts. These riders are **not approved** or regulated by MOH and cannot be paid using Medisave. Insurers are **not allowed** to market riders as part of IPs.

   - Agent should highlight distinction between IP and riders and share that riders can be paid using only **cash**. **Important to remind policyholders that rider premiums rise significantly with age. Instead of paying for a rider, the deductible and co-insurance portion incurred in the event of hospitalisation can be save for and paid via Medisave or cash.**

7. a. **Downgrading IP**
   - Can downgrade to a lower coverage plan within the same insurer at any point of time without underwriting.
   - Can downgrade to basic MediShield Life, without any exclusions imposed.

   b. **Switching Insurer for IP**
   - His original IP will **automatically terminated** when he switches to a new IP with another insurer.
   - IP with the insurer will have to undergo underwriting again. Hence he may **lose coverage** for his existing medical conditions covered by his original plan and may not be able to re-apply for his original coverage subsequently.

8. **Improvements to IP Regulatory & Accountability Framework**
   - Insurer's disclosure documents include:
     - Product Summary;
     - Proposal form;
     - Offer letter.
   - Insurers need to highlight:
     - **Distinction between MediShield Life and IPs;**
     - **Limitation of upgrading, switching and the option to downgrade and remain covered by MediShield Life;**
     - **Intermediaries selling IPs to undergo a minimum of 2 hrs of training on MediShield Life and IPs.**

PRUDENTIAL

9. All insurers will be required to offer Standard IP in 2016. Standard IP will provide adequate **"no frill" coverage at Class B1 level** and will serve as a benchmark for consumers to compare premiums offered by different IP insurers.

10. **Claim process for MediShield Life/IP, Medisave and Non IP Insurer.**

Admission to hospital

↓

Sign the Medical Claims Authorisation Form to :
i. allow hospital to claim from his insurer;

ii. authorize CPF Board to pay hospital bill from his Medisave account, while the insurer settles the claim which may take some time.

↓

Pay a cash deposit with hospital

No ↙ ↘ Yes / No

1. Under IP Policy

Hospital will trigger a "Letter of Guarantee" (LOG) to waive the upfront cash required up to a cap of S$10,000. LOG is not applicable if hospitalised due to pre-excluded conditions.

2. Non IP Private Insurance

Need to show his insurance card provided by some insurers for certain Medical Expense Insurance Plans.

For claims from MediShield Life, IP/or Medisave :
Hospital will submit the claim on his behalf through the MediClaim online system.

↓

a. **For IP Claims**
Hospital will submit the claims electronically to the Insurers directly. IP will calculate how much to pay based on IP benefits, and CPF Board will calculate how much MediShield Life will pay. The eventual payment will be the higher of the 2 amount.

b. **For MediShield Life Claims without IP**
CPF Board will calculate how much MediShield Life will pay and settle the amount directly with the hospital.

c. **Medisave to pay for his bill**
Hospital will submit the claims electronically to CPF Board based on prevailing Medisave withdrawal limits.

↓

- Some hospital will sent the bill directly to the CPF members non IP Insurer or employer to work out the amount to bear.
- In other cases, insured member will have to submit the bill himself to the insurer.

Any outstanding amount not covered by the above, have to be settled in cash.

D. ElderShield & ElderShield Supplements

Plan	ElderShield
Purpose	A new **Severe Disability Insurance Scheme** to provide long term care to the elderly Singaporean to help defray out of pocket expenses in the event of severe disability. Any member who is a Singaporean or Permanent Resident who attains the age of **40 years** is automatically covered unless he opts out.
Plans	1. ElderShield 300 - launched in Sept 2002 Payout of **S$300** per month for maximum of **60 months** if unable to perform at least 3 ADLs. 2. ElderShield 400 - launched in 2007 Improved coverage of **S$400** per month for maximum of **72 months** if unable to perform at least 3 ADLs. Note : ADLs' definition is the same as Chapter 5. 3. ElderShield Supplement covers : • **increasing monthly payout;** • **extending payout period;** • **a combination of both.** Only existing ElderShield insured can purchase ElderShield Supplement. Premium can be paid from Medisave up to **$600** (per insured per calendar year) or by cash.

Premium	• Level premium, paid from Medisave;
	
	• Premiums payable up to age 65 yrs, but remains insured for life.
	
	• Premiums are not guaranteed, review every 5 yrs.
	
	• 2 types of premium plan available
	  • Regular Premium Plan;
	  • 10 year premium plan (Not available now).
	
	• Insured members who do not have sufficient Medisave, may use their spouse, children, parents or grandchildren Medisave to pay for their premiums.

Run By	• **Aviva Ltd** • **NTUC Income Insurance Co-Operative Ltd** • **Great Eastern Life Assurance Co Ltd**

Eligibility Criteria	• Waiting period of **90 days** from commencement date. • Scheme will pay (either $300 or $400) if insured is unable to perform at least 3 of the 6 ADLs. • Deferment period: **90 days** from claim date. Does not apply if insured suffers a relapse from the same cause within **180 days** of recovery, provided he has been disabled for at least 90 days during the first disability.
Claim	• Insured complete a **claim form**; • Insured has to make an appointment with one of the **insurer's** appointed assessors to have a medical assessment done. • It will cost **S$50** for assessment at the assessor's clinic and **S$150** if insured requires assessor to make a house call. The fees for the initial or subsequent assessments are borne by the **insurer** if the claims is assessed to be **payable**.
How are ElderShield Benefits Paid?	• Payable on a monthly basis • Premium waived during disability; • Payments **stop** if insured recovered from his disability, premium payment will resume. However he can still make a claim under his policy, as long as he has not claimed more than **60 months or 70 months** in total.(depending on his ElderShield Plan). • **Cash payout is not tied to institutional care. It can be used to pay for any expenses**.
Non forfeiture Option	Premiums are prefunded. Policy will be converted to a paid up policy should he decides to stop paying his premiums after the policy is inforce for a number of years. Insured will enjoy a **reduced benefits**.
Key Features	• Has a **minimum** (i.e 40 yrs old) and **maximum** entry age (i.e 64 years old); • **60 days'** free look period from commencement date; • **75 days'** grace period for payment of overdue premium; • Reinstatement allowed within **180 days** from the expiry of grace period, subject to evidence of insurability and payment of overdue premiums and interests; • When the insured is oversea at the time of claim, insurer has the right to compute the benefit payments to a single payment

	based on the PV of future benefit payments, or withhold the claim payment if it is unable to assess the claim after having made reasonable attempts to do so. • No surrender value.

4. Other Healthcare Financing Schemes for the Poor and Needy Singaporeans:
    1. **<u>Pioneer Generation Package</u>**
        1. **Outpatient Care**
            - **Additional 50% off :**
                - **subsidised services** at polyclinics and Specialist Outpatient Clinics (from Sept 2014).
                - **subsidised medications** at polyclinics and Specialist Outpatient Clinics (from Jan 2015).
            - Special subsidies at participating GP and dental clinics under CHAS (from Sept 2014).
            - Cash of S$1,200 a year for those with moderate to serve functional disabilities under the Pioneer Generation Disability Assistance Scheme (from Sept 2014).
        2. **MediShield Life** - Pioneer Generation Subsidies - cover earlier.
        3. **Medisave Top-ups** - From S$200 to S$800 annually for life (from July 2014) as follows:
            - Born 1934 and earlier - $800
            - Born 1935-1939 - $600
            - Born 1940-1944 - $400
            - Born 1945 - 1949 - $200
        4. **Pioneer Generation Disability Assistance Scheme** - Pioneers who need assistance in at least 3 of the ADLS (as defined earlier under ElderShield) will receive lifelong cash assistance of **S$100** each month to help Pioneers with their care expenses.

PRUDENTIAL

2. **Interim Disability Assistance Programme for the Elderly (IDAPE)**

    1. Those who are not eligible for ElderShield Scheme for 2 reasons; **age or health** can apply to IDAPE.

    2. It is a social scheme to help people cope with their medical expenses in the event they suffer a **severe disability.**

    3. Premiums need not be paid. Payments under the scheme depend on individual's per capita household income. (see table)

IDAPE Payout

Per Capita Household Income	IDAPE Payout (with effect from 1 July 2013)
S$0 to S$1,800	S$250 per month up to 72 months
S$1,801 to S$2,600	S$150 per month up to 72 months

An IDAPE applicant from a household with no income will qualify for the S$250 monthly payout if the annual value of his place of residence is $13,000 or lower.

    4. IDAPE is administered by NTUC Income. It is similar to ElderShield except for :

        a. To making a claim under IDAPE will be subject to a **means testing** administered by Ministry Of Heath Holdings(MOHH); and

        b. The recipient of the payout will need to pay only a nominal fee of **S$10** for a clinic assessment (or **S$40** if assessment is done at home) for each assessment in the event of a claim. The rest of the fees are subsidised by the Government.

PRUDENTIAL

3. **Medifund**

An endowment fund set up by the government to help the poor pay for their **hospital bills** that despite Government subsidies in public healthcare institutions.

Medifund Silver and Medifund Junior were set up in 2007 and 2013 respectively to target the elderly and children.

Patients unable to pay for their medical bills can apply for Medifund assistance through Medical Social Workers (MSWs) at the Medifund approved institutions .

Chapter 9 – Common Policy Provisions

Health Insurance policy is a **written evidence** of a contract between Insurer and Policyholder. It contains 7 sections. They are:

1. Policy Schedule
2. Insurance Clause and Definitions
3. General Conditions
4. Benefit Provisions
5. Exclusions
6. Claim Conditions
7. Endorsements

1. Policy Schedule

It contains details of the policy owner, insured person(s) as well as the insurance coverage. There is a clause in the **policy** stating that **this schedule** and the policy must be read "together as one contract". It includes:

- Policy number,
- Effective date of cover and expiry date of cover;
- Issue date;
- Currency;
- Name, NRIC, age gender of insured person;
- Name of plan, riders and premiums.

Adviser need to go through this schedule with the policy owner to ensure **no typographical error**.

2. Insuring Clause and Definitions

Insuring Clause	• Also known as the operative clause, it represents insurer's promises to pay. • Often viewed as the **foundation** of a Health Insurance Policy.
Definitions a) Accident	a) It means an incident caused by **accidental, violent, external and visible means.**
b) Day of Hospital Confinement	b) It refers to a full **24 hours** during a period of hospital confinement.
c) Medically Necessary Service, Supply or Day of Hospital Confinement	c) It means a service, supply or day of hospital confinement which is ordered by a physician and which is: • Provided for the diagnosis of direct treatment; • Appropriate and consistent with symptoms for treatment; • In accordance with accepted medical practices; • **Not of an experimental nature or research purposes**. The fact that the insured's physician prescribes a service supply or day of confinement does **not** automatically means is medically necessary.

d) Period of Hospital Confinement	d) It means a continual, medically necessary period of time during which an insured is confined to a hospital as a registered inpatient. Patients have to stay for a period of **6 to 24** hours before being considered hospitalized.
e) Pre existing condition	e) Defined as a condition which have existed and : • For which insured received **treatment** or medical advice; • In respect of which insured showed **symptoms**; • Of which insured was **aware;** • Of which insured should **reasonably** have been aware; Prior to the date policy issue or the date the cover was reinstated. **<u>Moratorium Underwriting</u>** Insured **does not need** to make medical declarations when he applies for cover. Pre-existing conditions **can be covered** after a continuous period of e.g 5 years from the effective date of coverage, reinstatement date whichever is later. For the specified years, insured must not have experienced any symptoms, seek consultation, received treatment or medication for the condition.
f) Usual, customary and reasonable charges	f) It refers to the **standard charge** for the provider and the amount does not exceed the amount usually charged in the same geographical area for an equivalent service.
g) Per Policy Year Limit	g) Maximum amount a MEI Policy will pay for an insured within each **policy year.**
h) Lifetime Limit	h) Maximum amount a MEI Policy will pay under **the policy**.

3. General Conditions

- Outlines the rights of both policyholder and insurer.
- It includes the following :

Entire Contract Clause	• Also known as "The Policy Contract Clause"; • In consideration of **first premium** received, insurer will start providing benefits; • In a Health Insurance Contract the **policy document**, **proposal form** and **endorsements** are the entire contract between insured and insurer.
Effective Date Of Cover	• For **sickness** – it will commence after the waiting period. • For **injury –** it will commence as at the effective date of insurance.
Premium Warranty Clause	Policy shall not be in force, **unless** premium is paid on or before the inception date of the policy.
Free Look Period	Policy owner may review within **14 days** from the receipt of the policy and return for a refund of premium (less medical fees incurred). The policy document is deemed to have received by the policy owner within **3 days** after Insurer dispatched it.
Actively At Work	**Not eligible** for cover if he is absent from work because of sickness, injury, on the otherwise effective date of coverage.
Renewal	Renewal Provision describes the circumstances which the insurer has the right : • **not to renew;** • **to cancel;** • **to increase the amount of premium payable.** HI polices can be issued on these basis: • Cancelable - Terminates the policy at any time for any reason. • Optionally Renewable - Refuse to renew the policy on certain dates, usually the policy anniversary or premium due date. • Conditionally Renewable - Refusal to renew cannot be related to insured's health, but rather age and employment status.

	• Guaranteed Renewable -Insurer relinquishes the rights to cancel the policy. Renewal is guaranteed as long as insured pays the premium. • Non renewable – examples are: Term Insurance, Travel Insurance, Student Personal Accident.
Mis-statement of age or sex	Insurer will adjust premium based on correct age or sex.
Grace Period	Usually **30 days** from premium due date. Coverage remains in force during grace period.
Reinstatement	This provision states that if certain conditions are met, the insurer will reinstate a lapsed policy for non premium payment, provided insured person pays any overdue premium and complete a health warranty.
Incontestability	This provision stops the insurer from repudiating liability under a policy purely on grounds of breach of utmost food faith, except fraud has been proven.
Co- Ordination Of Benefit	Also known as • **Over-insurance provision;** • **Contribution provision.** To prevent the insured from making a profit from sickness/illness. Will cause the insurer to **reduce** the benefits payable under the policy.
Cancellation	Allows the **insured** to cancel the policy by giving written notice to the insurer.
Change Of Plan	A MEI Policy has a provision to allow the insured to upgrade or downgrade the coverage plan, at the **insured's** expense. Any application of change should be submitted to insurer at least 30 days before the policy renewal date or Premium due date.
Currency	Payments of all claims and benefits will be made in **Singapore Currency.**

Last Payer Status	This clause appears in **MediShield and Private Integrated Shield** Plans where it states the insurer shall be the **last payer** reimbursing the claims if the insured has any other Medical Insurance, such as workman compensation. The insured person shall provide insurer with the full details of such other insurance policies or employee's benefit.
Policy Owner's Protection Scheme (PPF)	• Effected since 1 Jan 2012, to **protect policy owners** in the event of failure of a life or general insurer which is a PPF Scheme member. • The scope of this scheme includes individual and group short-term or long-term accident and health policies (e.g Hospital Cash, Medical Expense, Personal Accident, Disability Income, Long term Care Insurance.) • Is administered by the **Singapore Deposit Insurance Corporation.** Coverage for PPF is automatic and no further action is required from the policy owner.

4. Benefit Provisions

This provision is the **essence** of insurance policy. It set forth insurer's promises and each benefit is usually drafted in **utmost care.**

5. Exclusions

Exclusions refer to the circumstances under which the insurer will **not pay.** No benefits will be paid for charges which are in excess of the usual, customary and reasonable charges. **Sickness** contracted within the waiting period, pre-existing conditions are not covered.

6. Claims Conditions

- Includes provisions that define insured's obligation to provide **timely** notification of loss to the insurer.
- Physical Examination Provisions – usually included in most individual and group **Disability Income Policies**. After the insured submits a claim, the insurer has the right to have the insured person examined by a doctor of the **insurer's choice**, the **insurer's expense t**o validate claim.
- Mediation/Arbitration and Legal Actions Provisions
  - Health Insurance Policy will include a Dispute Resolution Clause. All dispute under the policy should be referred to **Financial Industry Disputes Resolution Centre Ltd** (FIDReC). If the dispute cannot be dealt with by FIDReC, it will be referred to and decided using **arbitration**, according to the Arbitration Rules of the Singapore International Arbitration Centre. Insurer will not be legally liable unless insured first received an award under arbitration.

- Where both **mediation and arbitration** fail to settle the dispute, the insured may seek legal actions against the insurer. Legal provision limits **the time** during which the insured who disagree with the insurer's claim decision has the right to sue for the rightful amount. The Policy states that no action in law or equity will be brought under the policy until after the expiration of **60 days** from the date a satisfactory proof of claim has been furnished to the insurance company.

7. Endorsements

An endorsement is a separate document that modifies the policy to which it is attached. Modifications can be:

- **Supplementary agreements** (e.g maternity benefits for attachment to Hospital and Surgical Policy).

- **Exclusions** (e.g exclude pre-existing conditions)

Chapter 10 – Health Insurance Pricing

1. 7 keys factors used to calculate Health Insurance Premiums are:

1. Morbidity Experience	The **primary** consideration for Health Insurance Pricing. It measures rate of sickness or failure of health.
2. Investment income	Increase in investment income will lead to a **decrease** in premium.
3. Operating expenses	Increase in operating expenses will lead to an **increase** in premium.
4. Medical Inflation	Medical inflation will lead to an **increase** in premium.
5. Scope of benefits	Increase in scope of benefits will lead to an **increase** in premium.
6. Insurer's Profit	Loading is added to net premium to provide a profit margin. Hence depending on company's profit strategy, it will affect this loading. **(increase premium**)
7. Modes of premium Payment	• Annually – once a year; • Bi- annually – twice a year; • Quarterly – once every 3 months; • Monthly – once a month (most expensive).

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2. Parameters For Premium Rating:
   1. Age
   2. Gender - **Women's** premium is higher than male for health insurance products.
   3. Physical Condition – refers to proposed health status of the proposed insured.(eg pre-existing conditions).
   4. Occupation – the higher the risk of injury or illness resulting from an occupation, the higher the insurance premium.
   5. Persistency – Refers to the percentage of policies renewed each year. If the persistency rate of a type of coverage is expected to be **high**, then the insurer will **reduce** the amount of premium charge.
   6. Claims Experience – Claims experience demonstrates the general health condition of the group and the propensity of the group members to file claim. Key factor for affecting premium rate charged for **group plans**.
   7. Participation Level – Low participation means there will be greater chance that a **higher** than normal proportion of **unhealthy** lives will seek coverage. This is called anti selection.
   8. Life Style - Can influence premium charge. Eg hazardous sport will call for extra premium. The most important lifestyle factor is smoking, which will attract a higher premium

Chapter 11 – Health Insurance Underwriting

1.

Underwriting

The main purpose of underwriting is a process to ensure premium charged **correspond** closely with the risk that each proposer represents.

2. Factors affecting Risk

Medical Factors	Non Medical Factors
1. **Medical History** Insurers review history of previous conditions to determine : • **Possibility of recurrence;** • **Effect of a medical history on proposer's general health;** • **Complications that may arise;** • **Normal progression of any impairment.** 2. **Current Physical Condition** The proposer's statement on a proposal and medical examinations results are the first indicators of present physical conditions, before underwriters request for other tests.	1. **Financial Factors** Important consideration in underwriting individual Disability Income Insurance. 2. **Occupational Factors** Accident hazards – eg painter Health Hazards –e.g handling asbestos will lead to respiratory failure. 3. **Age** Older – more thorough because of possibility of health problems. 4**. Avocations / Life Style Risk** a. Examples of Life Style risks - Drug abuse, hazardous occupations, multiple sexual partners. a. Habits Eg drinking and drug use.

3. **Factors that are specifically important for each type of Health Insurance Products**.

Health Insurance Plans	Factors
Medical Expense Insurance	• Medical history; • Current physical condition.
Disability Income Insurance	• Size and stability of earnings; • Overall financial situation; • Occupation risks – only white collar workers are permitted.
Long Term Care Insurance	• Detection of cognitive impairments; • Morbidity risk.
Critical Illness	• Medical history • Current physical condition • Smoking habit; • Family history.
Managed Healthcare	• For Individual – Medical history and current physical condition; • For Group – age and gender.

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4. **Types of Underwriting Methods for Medical Expense Insurance**

Full Medical Underwriting	Moratorium Underwriting
• Proposed insured **completes** a health declaration when he applies for cover. • Pre-existing conditions are **excluded**. Advantage • Insured has **certainty** as to what is covered at the point of joining rather than when he needs to make a claim.	• **No need** to fill in a health declaration. • Insurer will automatically **exclude** any pre-existing conditions (for which insured has been treated) during the 5 years immediately preceding the commencement date of cover. However, if insured does not have any symptoms, treatment etc for those pre-existing conditions for a continuous period (**usually 2 to 5 years**), then he is covered when the conditions recur, subject to the terms and conditions. Advantage • Provides only **basic information** about himself, but must understand that any pre-existing condition are excluded from cover, unless he can satisfy moratorium criteria for pre-existing condition (as per point above).

5. Group Underwriting Factors

1. Reason For Existence
The reason for the existence of a group applying for group coverage must be for some purpose **other than** for purchasing insurance. This is to prevent anti- selection. The group members must be actively at work on a full time regular basis and have a fairly predictable income.

2. Group Stability
An ideal group for insurers is one in which there is a steady flow of new members to replace those who leave, **but not** massive influx or outflow of members.

3. Group Size
Group size is important, as it provides a better spread and diversification of risk.

4. Insured company's nature of business
Certain lines of business are more risky than others.

5. Employee Classes
Over-representation by a **highly paid class** can result in higher than average medical claims. Over-representation by a class which the employees earn **low income** can result in a higher-than –desired rate of turnover.

6. Level of Participation
Especially in a contributory plan as members' participation is on a voluntary basis. Insurers normally specify a minimum participation level requirement of e.g **70% to 90%** to prevent anti- selection.

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7. Age and Gender
Age is important in underwriting, as it increases the mortality of the group. Gender in the form of ratio of males to females is important as **females** have **lower mortality rates**, but **higher morbidity rates** than males.

6. Sources of Underwriting Information

1. The **proposal** (application) form is the **primary source** of underwriting information for the insurer. It will form the contract and used as a basis when a claim is filed.

   Sections of a Proposal Form

   i. Heading and identification of the parties
      - States the names of the **insure**r and contact details.
      - "Particulars of the life to be insured" and "Particulars of the Proposer" serves 2 reasons. **Firstly** is to distinguished the proposer from others having a similar name, **secondly,** to provide relevant information to the underwriter to assess the risk.

   ii. Particulars of policy applied for
   Details of the policy and sum assured.

   iii. Information regarding past applications and existing policies
   Proposer needs to indicate whether he is purchasing this policy to **replace** an existing policy.

   iv. Personal health details and habits of the proposed insured
   This section is **critical** as it provides a detailed description of the proposed insured's medical history, physical conditions, habit etc.

   v. Declaration
   Serves the following purposes that the proposed insured:
      - has disclosed all material facts truthfully;
      - has not withheld any material facts;
      - is aware that the benefits may be lost if material facts are not disclosed;
      - agrees and authorizes insurer to release to any medical source or insurance office, any information concerning him, regardless of whether the proposal is eventually taken up.

2. The Agent's Statement – to indicate :
   - Knowledge of any information on the proposer that is **not in** the proposal form;
   - **Proposer's net worth**, earned income, income from other sources.

3. Medical Examinations /Tests
   Namely for these plans:
   - **Disability Income Insurance**
   - **Critical Illness Insurance**
   - **Long Term Care Insurance**

4. Attending Physician Statement
   To enable the underwriter to have a better insight into the applicant's **medical history** that is not available from the medical examination.

5. Supplemental Questionnaires
   e.g financial questionnaires are to gather information about net worth and unearned income.

7. Final Underwriting Decision

1. **Standard Risk**
   - Policy issued is based on premium rates stated in the rate book.

2. **Sub Standard Risk**
   The following can occurs:

   1. Modifications of cover
      - Specific Exclusions
        E.g. excluding disease of the intestines, commonly usually used in **Medical Expense Insurance.**

      - Extra Premium
        Usually used for these plans:
        Disability Income Insurance, Critical Illness Insurance.

      - Modifications of Benefits offered. E.g reduction in monthly benefits.

   2. Postponement
      Eg: going for an operation.

   3. Declined
      Usually for serious medical reasons.

8. Commencement of Risk

Risk commences when the applicant agrees to the terms stated in the letter of acceptance and pays **premium.**

Chapter 12 – Notice No: MAS 120 – Disclosure and Advisory Process Requirements For Accident And Health Insurance Products

1. This Notice covers the following products:

   - **A & H Policies; and**
   - **Life Policies with A & H Benefits.**

2. This Notice applies when a financial adviser provides advice or arranges contracts of insurance or both, in respect of accident and health insurance policies and life policies that provides accident and health benefits but **does not apply** where:

   - Such policies are in respect of **reinsurance o**f liabilities under insurance policies; and
   - Such policies provide that the accident and health benefits are paid out **only if** the insured becomes totally and permanently disabled, as defined under that policy.

3. This Notice comprises the following 2 parts:

   (a). Part 1 – Mandatory Requirements;

   i. Division 1: Disclosure requirements for accident and health policies;

   ii. Division 2 : Disclosure requirements for life policies that contains accident and health benefits;

   iii. Division 3 : Additional requirements for direct insurers;

   iv. Division 4 : Requirements on provision of advice relating to accident and health policies;

   v. Division 5 : Requirements on provision of advice relating to the life policies that contains accident and health benefits;

   vi. Division 6 : Offences relating to this Part;

   (b). Part 2 - Non- Mandatory Best Practice Standards on Information Disclosure and Provision of Advice.

4. This Notice shall come into effect on 1 April 2004.

Part 1 – Mandatory Requirements

Division 1: Disclosure Requirements for Accident and Health Policies

Please note : (Division 6) - Failure to comply with the following (Pt 1 to 4) are considered offences liable on conviction to a fine not exceeding S$25,000 or to imprisonment for a term not exceeding 12 months or both:

1. General Information about the A&H intermediary and the status of an A&H insurance Representative.

An A&H insurance intermediary shall disclose to the insured **in writing** its business name under which it conducts its insurance business, its business address and its telephone number and when there is a change in such information, to inform insured in writing.

2. Remuneration of the A&H Insurance Intermediary

An A&H insurance intermediary shall, upon the request of the insured, disclose **in writing** to the insured all remuneration, including any commission, fee, and other benefit, that it has received or will be receiving for providing advice on any accident and health policy.

3. Conflict of Interest

An A&H insurance intermediary shall disclose to the insured **in writing** any actual or potential conflict of interest arising from any connection to or association with any insurer, including any material information that may compromise its objectivity in advice provided.

4. Disclosure when Providing Advice

1. An A&H insurance intermediary shall disclose to the insured the following information. The insured can refers to an **individual or policy owner of a group policy**.
   For voluntary group to disclose to **each person** as if it is dealing with the individually:

   a) Nature and objective of the policy;

   b) Details of the insurer;

   c) Contractual rights and obligations;
   An intermediary to explain to the insured:
   - The party against which the insured may take action to enforce his rights with respect to the policy he has purchased;
   - An intermediary to explain to the insured that he (**insured**) is **responsible** for the accuracy and completeness of the information when applying for the policy and making a claim. Any misstatement or non disclosure of material facts may affect validity of the policy.
   - Amount and frequency over which the payment is to be made, and whether the premium rate is guaranteed or non-guaranteed

   d) Benefits of the Policy
   - Conditions under which the payment of policy moneys (guaranteed/non guaranteed) is to be made or not made to the insured;
   - Any lien on the policy.

e) Risks of the Policy
- Whether insurer may alter the terms of contract, and if so, what may be altered and under what conditions would the alterations be allowed;

- Whether insurer may decline to renew the policy or unilaterally terminate the policy.

2. Where a benefit illustration or a product summary in respect of accident and health policy prepared by the insurer or the A&H insurance intermediary is available, it shall be **furnished** and **explain** to the insured.

3. In the case of a **personal accident** policy, shall ensure that insured is aware that the policy moneys shall be payable in the event:
- **of an injury to, or disability as a result of accident;**

- **of death by accident;**

- **combination of above**.

Please note: (Division 6): Failure to comply with the following (Pt 4(4) to 6) are considered offences liable on conviction to a fine not exceeding S$12,500:

4. When an A&H insurance intermediary prepares a benefit illustration or a product summary, it shall be prepared in **accordance** to the industry standards, if any set for the insurers.

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5. Marketing Materials

Representatives shall only use marketing materials **approved** by the A&H Insurance Intermediary for which the representative acts.

6. Telemarketing and Direct Marketing

1. In the case of using telemarketing over the phone to solicit and close a sale, A& H intermediary shall, where no advice is provided, communicate to the insured a warning that:
- insured may wish to **seek advice** from an A&H insurance intermediary before purchasing the policy;

- in the event the insured choose not to seek advice, he should consider **suitability** of the policy; and

Intermediary **shall maintain** a record of all conversations made over the phone sufficient for the purpose of conducting audit checks where necessary.

2. In the case of marketing A&H policies using **direct response** advertising communications through any medium including mail, print, TV, radio and electronic media to solicit and close a sale, A& H intermediary shall include, in all its marketing materials a prominent warning that:

    - insured may wish to **seek advice** from an A&H insurance intermediary before purchasing the policy;

    - in the event the insured choose not to seek advice, he should consider **suitability** of the policy.

Division 2 : Disclosure requirements for Life Policies that Contains Accident and Health Benefits

This Division is somewhat similar to Division 1

Division 3 : Additional Requirements for Direct Insurers

1. When a direct insurer prepares a benefit illustration or a product summary for policies it underwrites, it shall be prepared according to **industry standards**, if any. This shall not apply to policies underwritten by insurers other than a registered insurer.

2. Any alterations made in the terms of the contract, the direct insurer **shall disclose and explain** the new terms and the manner in which insured may accept these new terms or the circumstances under which the insured will be deemed to have accepted the new terms. Such information should be furnished to the insured in writing **at least 30 days** before the variation or amendments take effect.

Division 4 : Requirements on Provision of Advice Relating to Accident and Health Policies

1. This Division shall **not apply** to:

    - Circumstances where no recommendation is made or where only factual information is provided with respect to any health policy; or
    - Any advice provided in respect of ElderShield Policy.

Please note: (Division 6): Failure to comply with the following in this Division are considered offences liable on conviction to a fine not exceeding S$12,500:

2. An A&H Intermediary shall have a **reasonable basis** for providing advice to the insured. For the purpose of ascertaining that the advice is reasonable, the representative shall give regard to the information such as the insured's objective, financial situation, particular needs, etc.

3. In providing advice on health policies to the insureds, A&H intermediary shall comply with
    a. Know- Your Client

    b. Needs analysis; and

    c. Documentation and record keeping.

3a. Know Your Client	
Individual	**Group**
• Objectives of insured; • Employment status; • Income; • Existing health insurance, including policy from CPF; • Any medical conditions; • Whether policy is to include dependants.	• Objectives of the insured; • Size and composition of the group including age, gender, income, occupation; • Claims history of the group; • Any medical conditions of members of the group.
A& H intermediary shall highlight in writing the following: a. information provided will be **the basis** on which advice will be made; b. any inaccurate or incomplete information provided may affect **suitability**.	

3*b. Needs Analysis*

- A&H intermediary shall analyze the information provided;
- Where the A&H Intermediary is unable to identify a suitable policy, it shall **inform** the insured accordingly.

Where an insured does not want to provide any information requested in (a), or accept the advice of the A&H insurance intermediary and chooses to purchase another policy which is not advised by the intermediary, then the intermediary:

- may proceed to the insured's request but it shall **properly document** the decision of the insured; and
- inform the insured that it is the **insured's responsibility** to ensure suitability of the policy selected.

3c. Documentation and Record Keeping

Before the insured signs on the application form for the purchase of a Health Policy or gives consent for withdrawal or surrender of a Health Policy, A&H Intermediary shall **furnish** to its insured a document containing a **summary** of the information gathered and the **basis of the advice** given and where applicable a statement that the insured does not want to provide information or received advice of the A&H insurance intermediary.

4. Switching of Accident and Health Insurance Policies

An A&H insurance intermediary shall not cause the insured to switch products that would be detrimental to the insured. The following are examples of detrimental switch:

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a. whether the insured **suffers** any penalty for terminating the original policy;

b. whether the insured will incur any transaction cost **without gaining** any real benefit;

c. whether the replacement policy confers a lower level of benefit at a **higher cost** or same cost; or the same level of benefit at a **higher cost**;

d. whether the replacement policy is **less suitable**.

An A&H insurance intermediary shall disclose to an insured, **any fee or charges** the insured would have to bear for switches, in order to ensure the insured is able to make an informed decision on whether to switch.

Division 5 : Requirements on Provision of Advice Relating to the Life Policies that Contains Accident and Health Benefits

This Division is somewhat similar to Division 4.

Division 6: Offences Relating to This Part

Covered in the respective parts above.

Part Two – Non Mandatory Best Practice Standards on Information Disclosure and Provision of Advice

1. Encourage to observe but **not a criminal offence**. They are:

    - Information disclosed in any advertisement should be in **plain language**, **jargons explained;**
    - Information provided should be sufficient (not limited to this Act) to help insured make an **informed decision**;
    - Information should **not be ambiguous**. It should be disclosed in an objective and unbiased manner. There should be a **reasonable basis** for expressing an opinion, and it should be unambiguously stated that it is an opinion;
    - Documents should be kept **up to date**.

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Chapter 13 – LIA & GIA Guidelines

1. This Chapter consists of:

   - LIA & GIA Guidelines on disclosure requirements for Accident and Health (A&H) products as specified in Appendix 13A;
   - LIA Guidelines on Needs-based Sales Process for Individual Health Insurance Products as specified in Appendix 13B;
   - GIA Guidelines on Needs-based Sales Process for Individual and Group Health Insurance Products as specified in Appendix 13C

LIA & GIA Guidelines on Disclosure Requirements for A&H Products – Appendix 13A

1. **Compulsory Documents to be presented to client at Pre-Sales Stage**

Documents at Pre-Sales Stage	
Individual (pg 241)	**Corporate (pg 246)**
• Your Guide to Health Insurance Insurer to reproduce in verbatim this document.	• Same (under voluntary plan) Insurer to reproduce in verbatim this document
• **Product Summary**	• **Same (under voluntary plan)**
• *To ensure proposers to sign the **proposal form t**o confirm that they are given a copy of the documents and that the contents of these have been explained to them.	• **Same except that members applying for insurance under **voluntary plans** shall be required to sign on the **Policy Health Declaration Form** and to confirm that they have read and understood these 2 documents.

2. **Specific Guidelines to Product Summary**
   1. Product Summary aims to provide prospective buyers with details on **key product information and features, contract provisions, or terms and conditions** that may affect their decisions to purchase the policy.

   2. ***For Individual Business**
      - To ensure proper disclosure and acknowledgment of information presented, the original signature of the **prospective client and the intermediary** must be obtained and both these endorsements must be made on the **front page of Product Summary**.
      - A copy of the duly signed Product Summary must be filed with the insurer for record purposes.

- Disclosures of distribution costs, charges & expenses in the "Product Summary" is **not mandatory**, however it should be clear in the document that such information will be made **available** at the client's request.

<u>For Corporate</u>
The final proposed terms are to be signed by the **client** or a legally appointed representative of the client and members applying for insurance under voluntary plans shall be required to sign on the **Policy Health Declaration Form**.

3. Product Summary comprises 2 sections for both Individual and corporate business:
   a. Product Information

   b. Key Product Provisions

Product Summary (pg 242,247)	
Product Information	**Key Product Provisions**
• Summary of benefits or covered events; • Benefits schedule table; • Premium rates; • Premium payment duration; • Duration of policy cover; • Definition of ADLs.	• Cancellation / Termination clause; • Renewability of Policy; • Premium guarantee; • Waiting period; • Benefits limitation; • Pre-existing conditions; • Deferment period; • Survival period.

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<u>For Individual Business</u>

3. <u>Application of the guidelines to direct marketing and telemarketing channels</u>

1. Most of which is similar to Chapter 12 (Division 1, Pt 6 of this Review).

2. In the case of direct marketing, the insurer must have **control over** the entire process, from publication and distribution of promotional materials to delivery of the policy document. For telemarketing, the insurer must have **sufficient control** over its telemarketing staff, or the telemarketing firm if the function is outsourced, such that the information conveyed on product features is **accurate**.

3. The insurers must make adequate arrangements to provide appropriate post-sales disclosures to policyholders who have purchased health insurance products through direct marketing or telemarketing channels. Such post-sales disclosures include a "**follow-up letter"** which:
   - advises the proposer to read the **<u>2 compulsory</u>** disclosure documents enclosed;
   - highlights to the proposer that he is entitled to a "**<u>14-day Free Look</u>**" period and can cancel his coverage without penalty within this period if he deems the product unsuitable;
   - requests the proposer to return the enclosed pre-pay reply card to the insurer to **confirm his receipt** of the disclosure documents.

4. With such procedures in place, the following standard disclosure requirements **will not apply** to direct marketing and telemarketing:

    - Having the proposer sign on the proposal form stating that he has been given the 2 compulsory disclosure documents, and that the contents of these have been explained to his satisfaction; and

    - Having the proposer sign on the first page of the Product Summary.

4. **Individual Business - Disclosure requirements for personal accident products** - Similar to Chapter 12, Division 1(Pt 4 (3) of this review)

5. **Individual Business**
Post-Sales Disclosure

1. **Continual disclosures** to be made to policyholders whenever there are modifications to the Product Information or Key Policy Provisions specified in the Product Summary. Circumstances that would require continual disclosure include:
    - Premium rates or premium rates table;
    - Policy benefits or coverage;
    - Exclusion clauses;
    - Change in definition of contract provision.

    Both the existing and modified benefits/terms need to be shown. In cases where some original benefits are withdrawn or new exclusions are added with no change in premium rates, this must be **highlighted** to the policyholders.

2. Insurers are required to give policyholders advance written notice of at **least 30 days** before the modifications take effect.

3. To modify any original terms of the original policy contract, insurer may:
    - obtain **written acceptances** of the modified terms from policyholders; OR
    - where no written acceptances of the modified terms is sought, the insurer must ensure that all of the following conditions are fulfilled:
        I. policyholders are given **the option** to reject the modified terms and cease cover;

        II. in the notification letter to policyholders:
            a. the modified terms must be **conspicuously indicated** on the front page of the notification letter,
            b. the modified terms must be highlighted in **bold print** on the notification letter and
            c. the print size of the modified terms **should not be smaller** than the rest of the text on the notification letter.

III. the following standard statement must be highlighted on the ratification letter:
" Please be advised that unless otherwise advised by the Owner of the policy, receipt of the renewal premium by the Company shall be construed as an acceptance of the modified terms and the modified terms shall take effect from the date of policy renewal". OR

" Please be advised that unless otherwise advised by the Owner of the policy by DD/MM/YY (expiry date of the advance notice), the modified terms shall take effect from DD/MM/YY(effective date of the modified terms)".

6. **Corporate Business**

1. Information to be disclosed to clients at the Pre Sales Stage:
    - Name of Insurer underwriting the product;
    - Duration of cover, premiums rates , benefit schedules, period of validity;
    - Key product terms and conditions
    - Whether premium rates and renewals are guaranteed;
    - Whether the product qualifies under TMIS;
    - Whether free look is applicable;
    - Upon request by the client, commission amounts must be disclosed

2. The rest covered above.

LIA Guidelines on Needs-Based Sales Process for Individual Health Insurance Products – Appendix 13B

1. The objective of the Guidelines is to set a minimum standard for the needs-based sales process for insurance representatives. It is important for a representative to obtain relevant information on a client, analyze the information before making appropriate recommendations on product suitability.

2. The Guidelines apply to:
   - **Health Policies** (including health insurance bundled with or riders to life policies) sold to individuals by insurance representatives i.e life insurance agents, general insurance agents, brokers, and representatives of financial representatives, banks and financial institutions.

3. **The following requirements:**
   a. **Disclosure of representative's status**
   b. **Use of fact find form**
   c. **Use of needs analysis/recommendation form**

   do not apply to:

   - Direct marketing (provided no advice has been given)
     - includes internet as a tool of DM, but not as an e-intermediary
   - Personal Accident Policy with or without Medical Reimbursement due to Accident only
   - Hospital cash due to Accident only
   - ElderShield, where advice is for a person who has previously opted out to re-opt into ElderShield.

PRUDENTIAL

Minimum Fact Find Form and Needs Analysis & Recommendation Form

1. The following forms appended below are adopted as the minimum industry standard:
   - "**Know Your Client" Form** (Individual Health Policies) – Appendix 1A of text.
   - **"Our Advice and Reasons Why" Form** – Appendix 1B

   Note: Insurer may incorporate the Fact Find Form and Needs Analysis & Recommendation for Life and Health Products into one form but the "**Application type"** is to be distinguished for life and health insurance. Fact Find and Need Analysis & Recommendation pertaining to Health Insurance is also required when a health product that is bundled with or riders to life policies.

2. Application Type for individual accident and health policies.
   "Application Type" in the fact find form is to be ticked by the client and signed off as follows:

   1. Type 1
   "**I/We have disclosed relevant information for comprehensive planning".**
   Meant for those who wish to **complete the fact find form in full**, so as to receive recommendations on product suitability.

   2. Type 2
   "I/We have disclosed relevant information for specific need(s) planning"
   Meant for those with **partial completion** of fact find form. Suitable for those who wish to receive recommendation on product suitability.

   PRUDENTIAL

   3. Type 3
   "I/We did not undergo any needs analysis in this review and it is my/our responsibility to ensure product suitability"
   Meant it is **mandatory to explain** product features, fees and charges to the client.

4. Minimum Requirements for each Application Type selected by the client.

Minimum requirements	***Application Type***		
	1	***2***	***3***
Personal Information	*Compulsory*	*Compulsory*	*Compulsory*
Dependent	*Compulsory*	*Good to have*	*Not applicable*
Existing health policies	*Compulsory*	*Good to have*	*Not applicable*
Personal priorities	*Compulsory*	*Compulsory*	*Not applicable*
Health conditions	*Compulsory*	*Compulsory*	*Not applicable*
Replacement of policy	*Compulsory*	*Compulsory*	*Not applicable*
Needs analysis	*Compulsory*	*Compulsory*	*Not applicable*
Recommendation	*Compulsory*	*Compulsory*	*Not applicable*
Client's choice of App. Type	*Compulsory*	*Compulsory*	*Compulsory*
Acknowledgement by client	*Compulsory*	*Compulsory*	*Compulsory*

Responsibilities of Life Insurer/Principal of Life Insurance Representative

- Insurer and principal of representative **shall keep** a copy of the Fact Find Form, Needs Analysis and Recommendation Forms for a length for necessary audit trail.
- Principal must ensure that a **register** is set up and maintained by itself or its distribution entity for audit by MAS. The register should reflect the "Application Type" chosen by the client.
- Insurer to ensure that it underwrites proposals submitted only if accompanied by the required form duly completed and **signed**.
- Intervention to rectify any erroneous recommendation is to be taken before the **expiry of the free-look provision.**

Responsibilities of Supervisors of Representative

- Supervisor of representative must sign off on the register as soon as practicable. Supervisor to ensure if applicable to his organizational structure, **to set up and maintain a Register** for the submissions of the said Forms by his representatives to be recorded.

Responsibilities of Life Insurance Representative

- To ensure that at each separate occasion of purchase, **his client and him sign off** afresh together on the Fact Find Form, "Our Advice and Reasons Why" Form. A copy of the Fact Find Form which was completed on an earlier occasion may be used, provided the information is still **current.**
- Ensure to provide a copy of the Fact Find, Needs Analysis and Recommendation Forms to the **client** and to his **supervisor** as soon as practicable.
- Treat information with confidentiality.

Remedies for Non-Compliance by Life Insurance Representatives

Representatives **found not** to have submitted duly completed and signed Fact Find Form, and Needs Analysis/Recommendation Form to the insurer for underwriting, or to the client, or to the supervisor will be penalized as follows:

- **1St offence – counseling**
- **2nd offence –re-training on HI**
- **3rd offence – letter of warning**
- **4th offence - 3 months suspension**
- **5th offence – termination of contract**

Insurer to ensure that supervisors validated the Recommendation Form submitted by their reps as soon as practicable and take appropriate and timely actions to **rectify an erroneous** recommendation made by their representatives.

GIA Guidelines on Needs-Based Sales Process for Individual Health Insurance Products For Individual Health Products - Appendix 13C

1. This Guideline for individual health product is similar to LIA Guidelines covered above except these areas:

<table>
<tr><th>LIA Guidelines</th><th>GIA Guidelines</th></tr>
<tr><td colspan="2">Application</td></tr>
<tr><td>1. The following requirements:
a. Disclosure of representative's status
b. Use of fact find form
c. Use of needs analysis/recommendation form

do not apply to:

• Direct marketing (provided no advice has been given)
- includes internet as a tool of DM, but not as an e-intermediary</td><td>Similar to LIA Guidelines</td></tr>
<tr><td colspan="2">Offence
Offence for not submitting duly completed Fact Find Form and Needs Analysis/Recommendation Form</td></tr>
<tr><td>• 1St offence – counseling
• 2nd offence –re-training on HI
• 3rd offence – letter of warning
• 4th offence - 3 months suspension
• 5th offence – termination of contract</td><td>• 1St offence – counseling
• 2nd offence –re-training on HI
• 3rd offence – letter of warning
• 4th offence - 3 months suspension
• 5th offence – Report to GIA-ARB Be permanently barred from selling health insurance.</td></tr>
</table>

GIA Guidelines on Needs-Based Sales Process For Group Health Insurance Products Appendix 13C– Pg 276

1. The Group Insurance Fact-Find Form (GIFF) serves as a means for the collection of certain basic information; needs analysis and documentation of any recommendation made.

2. Scope of Application
   The GIFF is applicable to all distribution channels for:

   - **Compulsory and voluntary or participatory programmes**
   - **Group health only**

   The GIFF do not apply to:
   - **Standard off the shelf packaged products where the benefits and premium rates are fixed and are intended for the clients to buy off the rack.**
   - **Standalone Group Personal Accident Products**

3. Signatory Requirements
   For **direct sale**s, the client's signature plus the insurance executive's signature as witness are to be appended. For sales made **via intermediaries**, the client's signature plus the intermediary 's signature to be appended.

4. Code of Conduct /Practice for Insurers
   - The contents in the GIFF serve as **minimum** industry standards.
   - Insurer must ensure that it will **not issue** any quotation and/or accept any application proposal form (except for off-the-rack package product), that is not accompanied by the GIFF duly **completed and signed.** Incomplete form or forms without required signatures are **NOT** to be accepted.
   - Holding insurer must provide all the information requested in the GIFF, particularly the **claims experience** of the policy for the period insured is with the holding insurer.

5. Documentation and Record Keeping
   Insurer shall keep the GIFF for a length of time for necessary audit trail.

Chapter 14 – Financial Need Analysis

1. Advantages of needs selling compared to product selling are:

   - **Service Oriented;**
   - **Not Pressure Selling;**
   - **Relationship Based.**

2. **Stage 1 – Fact-Finding**

Fact-finding is the process of obtaining answers to a series of questions about a prospective client's personal circumstances, finance ambitions etc to enable you to have a better understanding of the client's objectives, needs for a proper basis to recommend suitable Accident and Health (A&H) Insurance Products.

Basic Sections of a Fact Find Form

Sections	Purposes
a. Important Notice to Clients	Enables the prospective client to know: 1. Which intermediary's product the reps is selling; 2. Highlight to client the importance of completing Fact Find Form for **appropriateness** of product recommendation to his needs.
b. Application Type	**Type 1 :** **"I/We have disclosed relevant information for comprehensive planning"** Meant for those who wish to complete the fact find in full, so as to receive recommendations on product suitability. **Type 2 :** **"I/We have disclosed relevant information for specific need(s) planning"** Meant for those who do not wish to or unable to provide all information requested. Suitable for those who wish to receive recommendation on product suitability. **Type 3:** **"I/We did not undergo any needs analysis in this review and it is my/our responsibility to ensure product suitability"** Meant for those who already know which medical insurance product and the amount of coverage they want.

c. Personal Information	• Essential for **admin purposes** on the part of the company; • Provides reps with a **preliminary** assessment on type of products that will like likely be needed; • Age – needed or underwriting and **premium determination.**
d. Employment Details • Employed/ Unemployed • Monthly Income • Occupational Hazard	• Determines whether eligible for **DI ,** as Di is not issued to any unemployed person; • Determines the **deferred period** for DI, (self employed –shortest deferred period compared to one who is employed) • Determines **affordability;** • May need to ask for more details to assist in underwriting.
e. Details of Spouse & Dependant	• Identification in event of **claim;** • Premium determination (to cover dependant); • Occupational hazard of spouse; • Determines eligibility & whether a need to provide A& H cover for dependants.
f. Existing HI Polices	Serves as a **reference point** for further A & H insurance recommendations. Avoid replacement or caused insured to be over insured for those policies which is subject to Co- Ordination of Benefit Clause.
g. Personal Priorities	• Enables reps to know **client's** priorities with regard to A& H polices; • Help client to **re – prioritize** his needs based on overall profile of the client.
h. Health Condition	• Determines insurability and on what terms; • Obtain relevant reports for underwriting.

PRUDENTIAL

i. Replacement of Policy	Explain **consequences of** replacement. E.g: higher premiums, terms and conditions may be less beneficial.
j. Representative's Declaration	Information in Fact Find Form will be treated as confidential, use strictly for determining product suitability.

3. Stage 2 – Identifying and Quantifying Needs

Analyze information gathered during Fact-Find Stage. Examples:

- **Emergency Fund**
  - Useful to guard against breadwinner's loss of a job or short term disability.
  - If a client has no emergency fund, it may affect **ability to service** policies that he may purchase from you.

- 7 Life Stages
  - It has an **effect** on product recommendations;
  - Disability Income Insurance Policy is needed to protect income for all stages except childhood. However, it is not available to the unemployed.

PRUDENTIAL

- Dependants
  Provision should be made for **medical expenses** should dependant becomes disabled, it will be a financial burden to the family's finances.

- Clients' Existing Polices.
  If the prospective client has the given policies, you need to compare the benefits under his existing insurance with his current needs to see of the prospective client is sufficiently covered.
  - Disability Income;
  - Medical Expense Insurance;
  - Managed Healthcare ;
  - Critical Illness;
  - Long Term Care Insurance;
  - Hospital Cash Insurance

  } Covered in the respective chapters already

  - Work Injury Compensation Insurance
    Pays in the event of any accident resulting in hospitalization, permanent incapacity and/or death arising in the course of employment.

Quantifying Needs

1. Quantify **Maintenance cost** using the Total and Permanent Disability Benefit Method, given:

   Salary per month: $3000
   Expenses per month: $1,500
   Rate of return 5%; Inflation rate 2%
   Number of year income needed: 21

   Covered under the following:
   Group Term Life : $100,000
   His own existing life Insurance $50,000

   Answer: **$135,795**

   Workings:
   $1,500 X 12 = $18,000
   $18,000 X 15.8775 (table A2: 3%; 21 years) = $285,795
   $285,795 – ($100,000 + $50,000)
   = $135,795

2. Quantify **Medical Cost** given:

   Mr. Lim would like to based his average annual medical expenses to be $50,000
   He has the following policies to cover him:
   a) Group Policy (max payable) = $18,000
   b) Income Shield (total amount payable) = $7,000

   Answer : **$25,000**

   Workings:
   Average Medical Expenses = $50,000
   Less amount payable under Group Policy = $18,000
   Less amount payable under his MediShield = $7,000
   Hence shortfall = $25,000

3. Quantify the following **Hospital Cash Insurance** (per day) policy given:

   Monthly expenses: $5,000
   Existing Cash Benefit per month: $500

   Answers **:$150 per day**

   Workings:
   ($5,000- $500)/ 30
   = $150 per day

4. Stage 3- Product Recommendations and Presentation

1. Product Recommendations

2 basic principles:

- recommend products only if **client needs** them;
- recommend products which are most **suitable** for him, given the circumstances. Product suitability calls for good product **knowledge.**

2. Product Presentation

It is advisable to follow a **Systematic Process** for presenting your recommendations:

- **Purpose** of product;
- Description and **nature** of product;
- **Benefits** and limitations of product;
- Explanations on **options** within the product;
- Give **reasons** for recommendations;
- **Explain Benefit Illustration** and highlight guaranteed and non guaranteed;
- **Disclose** distribution costs, charges and expenses under the policy

PRUDENTIAL

5. Stage 4 – Client Review – Necessary because of :

- **Change** in client's circumstances ;
- **External development** such as changes in CPF ruling etc which can have an impact on the client's financial position;
- Original product purchased is **not sufficient** to cover all his needs;
- New product launch.

Chapter 15 – Case Studies

This chapter brings out 2 case studies; one on individual and the other on group.

Case Study

Individual	**Group**
1. Source of Information: **Fact Find Form** 2. After calculating maintenance cost, the most suitable product are : • **Disability Income Insurance** – must be employed • **TPD /Personal Accident Policy** – if unemployed 3. Products to meet Medical cost are: • **Medical Expense Insurance ;** • **Managed Healthcare Insurance ;** • **Long Term Care Insurance;** • **Cri tical Illness Insurance ;** • **Hospital Cash Insurance ;** • **Personal Accident Policy** (with medical expense benefit)	1. Source of Information: **Group Fact Find Form** 2. Determine Sum assured for Group Term Life Insurance in 2 ways: • **By Rank** Advantage: Easy to manage Disadvantage: Does not take into consideration the length of service of the staff. • **Number Of Times Of Employee Basic Salary.** Advantage: More equitable 3. Obtain the company's past 3 years of **claim history** for premium determination. 4. Client and representative must **sign** on the Group Fact Find Form to enable Insurer to give a quotation. 5. Rep to go through quotation, and once client accepts the quotation, reps to assists on the completion of necessary forms and to submit to insurer with **payment.**

Managed HealthCare	Medical Expense	Disability Income	Long Term Care	Critical Illness(CI)	Hospital Cash
Definition & Purpose					
Overall strategy for appropriate medical care yet containing medical cost. 3 components: 1. Accessibility PCP- are called "Personal Physician" , "Gatekeeper" 2. Quality of care 3. Cost 4 methods – • Capitation • Salary • discounted fee • fee schedule	Reimbursement benefits for specific medical expenses that result from accidental & sickness. - Inpatient Expenses (11 points) - Outpatient Expenses (4 points) - Catastrophic Outpatient - Kidney and - cancer treatment	Income replacement to safeguard one's earning capacity if one is totally disabled and unable to work. Also known as - Permanent Health Insurance, Income Protection, Income Replacement.	Pays daily or monthly benefits. Cover cost of care of person who is physically impaired and that no longer able to function independently and have to depend on others to help perform ADLs.	Lump sum upon diagnosis of one of 37 or more dread diseases or undergoing surgical procedure covered under the policy. New: Severity based CI Plans pay claim during early stages and severity of CI (% of SA). Premium is higher than normal CI. New: Multiple Pay CI	Daily cash benefit if one is hospitalized due of accident or illness
Premium					
Fixed Annual Premium	Age Band	Level	Level	Usually level and non guaranteed. For policies on yearly basis – age band	Age band
Waiting Period					
	Apply, but not to accidental injury	Can choose deferred period	90 days from inability to perform ADLs	• 90 days waiting period from date of issue /reinstatement • 30 days survival period from occurrence of CI	Apply, but not to accidental injury

Managed HealthCare	Medical Expense	Disability Income	Long Term Care	Critical Illness(CI)	Hospital Cash
Min /Max Age of Coverage					
	15 days -75 years old	Must be working	Min age – determine by insurer. Max : 70 to 75 yrs next birthday	Min age: 1 Max age : 55 cover may expire at 65 or whole life	Up to age 65 or 70 years old
Types					
• Staff HMOs • Group HMOs • Network HMOs • Independent Practitioners Association (IPA) • Mixed Model • Preferred Provider organizations (PPOs) • Point of Service Plans (POS)	• Other benefits under Med Expense (8 points. Impt to know: major organ transplant, miscarriage benefit, private nursing home, final expense). • Diff b/w indiv and Group Policy. • Diff b/w compulsory & voluntary plans • PMBS VS TMIS	• Total disability benefits. 3 Types - own occupation - similar occupation - any occupation • Partial disability benefit or Rehabilitation expense benefit • Escalation benefit • WP benefit • Death benefit	• Pays daily or monthly. Daily (2 methods) 1. Service Based 2. Disability Based (Benefit Trigger) Monthly (most common) 100% - unable to perform 4 out of 6 ADLs 50% - unable to perform 2 out of 6 ADLs. Alzheimer's disease covered • Hosp R&B • Surgical procedure • Financial. Assistance with adaptation • Extended care	• Acceleration i.e. advances sum assured plus bonuses • Additional i.e. pays out dread disease sum assured without touching death benefit. • Severity based CI Plan - pays out from early to intermediate to advanced and terminal. • Multiple pay CI - allows more than 1 CI claim.	• Daily benefit chosen at inception subject to specified no. Of days and lifetime limit. • Fixed cash amount is not related to actual cost incurred.

PRUDENTIAL

Managed HealthCare	Medical Expense	Disability Income	Long Term Care	Critical Illness(CI)	Hospital Cash
Features					
1. Standalone only 2. Expense participation - Deductibles - Co insurance 3. Can be extended to dependents.	1. Standalone or rider 2. 2 types - "as charged" benefits or sublimits imposed subject to per policy yr & per lifetime limits 3. Family coverage 4. Reimbursement 5. Expense participation ie. Deductible & co-insurance, pro-ration factor. Note insurers do not imposed deductibles on outpatient treatments. 6. Benefit Limits i.e. Lifetime, annual, event 7. Covered charges 8. Geographical limit (Policy terminates). 9. Guaranteed renewability basis 10. Co –ordination of benefit clause.	1. Standalone or rider 2. Mthly income 3. Ben may be level or increase at given rate 4. Ben include death, partial & total disability during benefit period 5. Guaranteed renewable 6. WP during benefit period 7. Rehabilitation exp benefit. 8. No surrender value 9. No assignment 10. 30 days grace period 11. Benefits - non taxable	1. Standalone or rider 2. Guaranteed renewable 3. Non-participating 4. Recover from disability, payment stop 5. No cash value or paid up value.	1. Standalone or Rider 2. Only 1 dread disease claim to be made on one policy 3. Lump sum upon diagnosis of DD 4. Policy must be in force 5. CI must be one that is covered. 6. Meets definition 7. Diagnosis meets conditions. 8. Limitation on total amt to minimize moral hazard (S$1m) 9. 24-hrs a day worldwide coverage 10. No surrender value 11. Assignment may or may not be allowed 12. For package DD Policies, DD cover will be terminates once NFO is exercised, except paid up option.	1. Standalone or rider. Standalone more attractive 6 points). 2. Fixed amt per day hosp benefit 3. Cap to max amt payable on single life 4. Ben not affected by payment from other med insurance policies 5. Mostly worldwide coverage 6. Hospital confinement (6 – 24 hrs) 7. Guaranteed renewable 8. No surrender value 9. No assignment 10. No claim discount given (25%)

PRUDENTIAL

Managed HealthCare	Medical Expense	Disability Income	Long Term Care	Critical Illness(CI)	Hospital Cash
Exclusions					
1. Pre-existing conditions 2. Congenital anomalies, hereditary conditions .Mental illness & personality disorders 3. Fertility-related 4. STD 5. AIDS & related 6. Self-inflicted 7. Drug or alcohol addiction 8. Private Nursing Charges 9. Kidney dialysis machine, iron lung, prosthesis 10. Private nursing 11. Civil commotion, riot, strike 12. Childbirth & related **13.** Reimbursement by Workmen comp	1. As in MHC	1. Pre-existing conditions 2. AIDS and related 3. Self-inflicted 4. Drug or alcohol indulgence 5. Invasion, riot, strike, civil commotion 6. Pregnancy or childbirth except where disability continues for more than 90 days after termination of pregnancy 7. Injuries while in service of armed forces (except for reservist training) 8. Aerial activity 9. Professional or hazardous sports	1. Pre-existing conditions 2. Mental or nervous disorders without demonstrable organic disease 3. AIDS & related except from blood transfusion or if medical staff is inflicted. 4. Self-inflicted 5. Drug or alcohol abuse 6. Felony, riot or insurrection 7. War or any act of war	1. Pre-existing conditions 2. Congenital or inherited disorder 3. AIDS or related 4. Self-inflicted 5. Drug or alcohol misuse 6. War & civil commotion 7. Flying other than a fare paying passenger.	1. As in MEI
Underwriting					
Important Factors in Underwriting. • Medical history • Current physical condition	Important Factors in Underwriting: <u>Individual</u> • Medical history • Current physical condition	Important Factors in Underwriting • Size & stability of earning • Overall financial situation	Important Factors in Underwriting • Detection of early cog impairment • Morbidity risk	Important Factors in Underwriting • Family history • Smoking habit • Medical history • Current physical condition	Not underwritten due to its small premium. Pre existing conditions are permanently excluded.

PRUDENTIAL

Managed HealthCare	Medical Expense	Disability Income	Long Term Care	Critical Illness(CI)	Hospital Cash
Sources of Underwriting • Individual - Proposal form • Group - Group fact find form - Individual health declaration form (for small group)	Source of Underwriting • Proposal form <u>Group</u> • Group fact find • Below 10 employees - Individual employee fills up health declaration form.	Source of Underwriting • <u>Individual</u> Proposal form - Computerised payslip/ letter from Company. - Notice of Assesssement - CPF Statement (6months) - Large amt questionnaire if benefit is more than $60,000 - Medical test • <u>Self Employed</u> Proposal form - Notice of Assessment or audited co a/c for past 3 years. - Large amt questionnaire - Medical tests	Source of Underwriting • Proposal form • Some may ask for detailed medical info or undergo clinical assessment	Source of Underwriting • Lower non medical limit compared to application for a life policy • Medical & family history • Occupational risk	

PRUDENTIAL

Managed HealthCare	Medical Expense	Disability Income	Long Term Care	Critical Illness(CI)	Hospital Cash
Termination of Cover					
	• Death of insured • Life time limit reached • Policy terminated • Non-payment of premium • Insured dies • End of yr expiry age reached • Date on which insured enters full-time military ser except NS reservist duty. • Leave employer/ policyowner (group)	• Policy expires • Non-payment of premium • Insured dies • Expiry age reached • Unemployed for more than specified time(except if he is disabled) • Resides outside Spore for an aggregate of more than 300 days within 1 policy yr.	• Policy expires • Nonpayment of premium • Reached max limit • Insured dies	• Valid DD claim made • Basic plan matures or expires • Policy lapse due to non-payment of premium • Surrender or convert to extended term under NFO. • Insured dies • Expiry age reached	• Per lifetime limit reached • Basic matures • Policy lapses due to non-payment of premium • NFO • Insured dies • Expiry age reached
Claims					
In-network care, no claims required. Out-of-network: • Claimant's statement • Original med bills	• Claim form • Physician Statement • Original med bills	• Claim form • Physician Statement • NRIC/BC • Evidence of present or pre-disability earnings • Letter from company • Copies of med certs & test results	• Proof of inability to perform ADLs on co. furnished forms • NRIC/BC • Proof of med examination • Death cert	• Claimant statement • Attending Physician Stt • Original bills • Proof of DD • Original policy doc • Written notice of claim submitted within 60 days of diagnosis. • Submission of claimant's form within 15 days after insurer sent out.	• Claim form • Original bills

PRUDENTIAL

Managed HealthCare	Medical Expense	Disability Income	Long Term Care	Critical Illness(CI)	Hospital Cash
				• Proof of CI submitted within 60 days from date of diagnosis.