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SECTION 3

INCOME PROTECTION CLAIMS PAYOUT RATIO

—
2019 Claims
Report

FMI'S INCOME PROTECTION CLAIMS PAYOUT RATIO

Published claims payout ratios assist insurers to demonstrate their commitment to paying claims, and these figures are generally very high, especially for death benefits.

However, there are two points that need to be noted when considering a claims payout ratio:

1. WHAT BENEFIT IS THE CLAIMS PAYOUT RATIO BEING CALCULATED FOR?

Different benefits will have different payout ratios because of how the benefit works. Consider any benefit that pays out for your inability to work. In order for a claim to be successful on this benefit, the impact of your specific injury or illness needs to be considered against your own occupation, and it needs to be verified that the claim was not

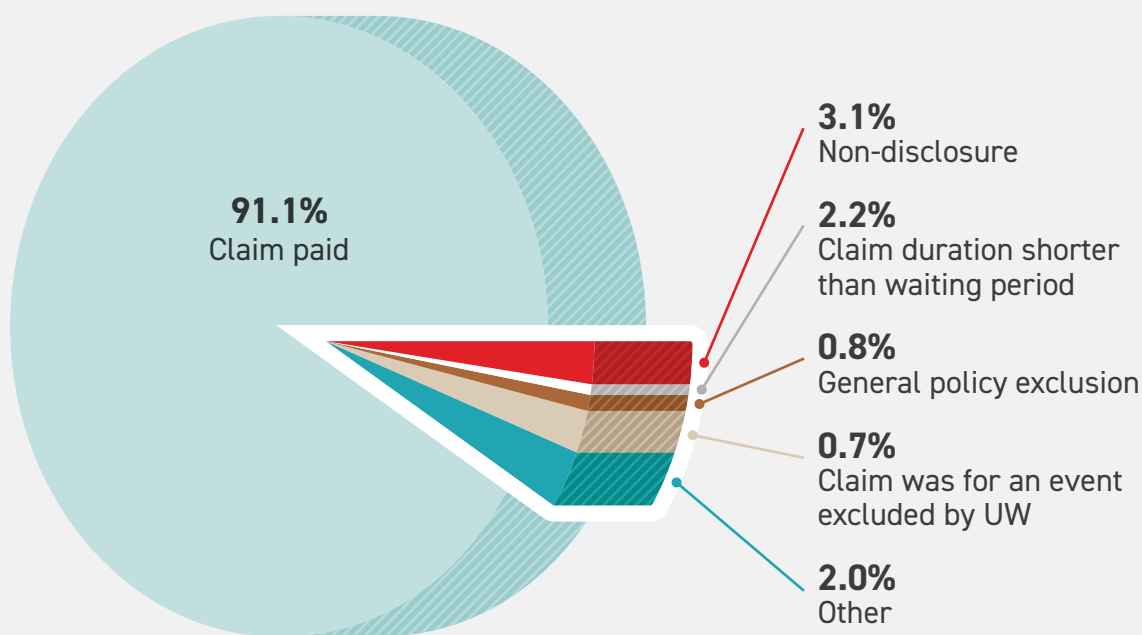
caused by an exclusion (either a standard exclusion or one added to the policy because the insured was in ill-health). Compare this to cover that pays out on death. Proving death is straightforward, and there are far fewer exclusions on death benefits. As such, you would expect death benefits to have a much higher claims payout ratio.

2. IS THE CLAIMS PAYOUT RATIO BASED ON ALL CLAIMS OR VALID CLAIMS ONLY?

Some published claims payout ratios may be calculated as a percentage of valid claims. It's not always clear how "valid" is defined, and it raises the question as to whether the claims payout ratio has been inflated by how a claim is deemed invalid.

The graph below offers reassurance around how FMI pays income protection claims, as well as having some important lessons to minimise risk of not having a claim paid.

BREAKDOWN OF ALL INCOME PROTECTION CLAIMS RECEIVED



91.1% OF ALL LODGED INCOME PROTECTION CLAIMS IN 2019 WERE PAID.

3. HOW TO ENSURE A POSITIVE CLAIMS EXPERIENCE

As we, at FMI, exist to pay claims, we explain reasons why lodged claims did not result in a payout and offer suggestions around how these risks can be managed.

3.1 NON-DISCLOSURE

Non-disclosure is the most common reason for claims not being paid. The best way to avoid having a claim declined for non-disclosure is to provide as much information as possible upfront and, when in doubt, disclose. Clients should disclose all health conditions in response to medical questions even if they or their adviser feel that it is irrelevant or immaterial, because ultimately, it is the underwriter who decides whether a health condition needs



to be taken into account to form the underwriting decision.

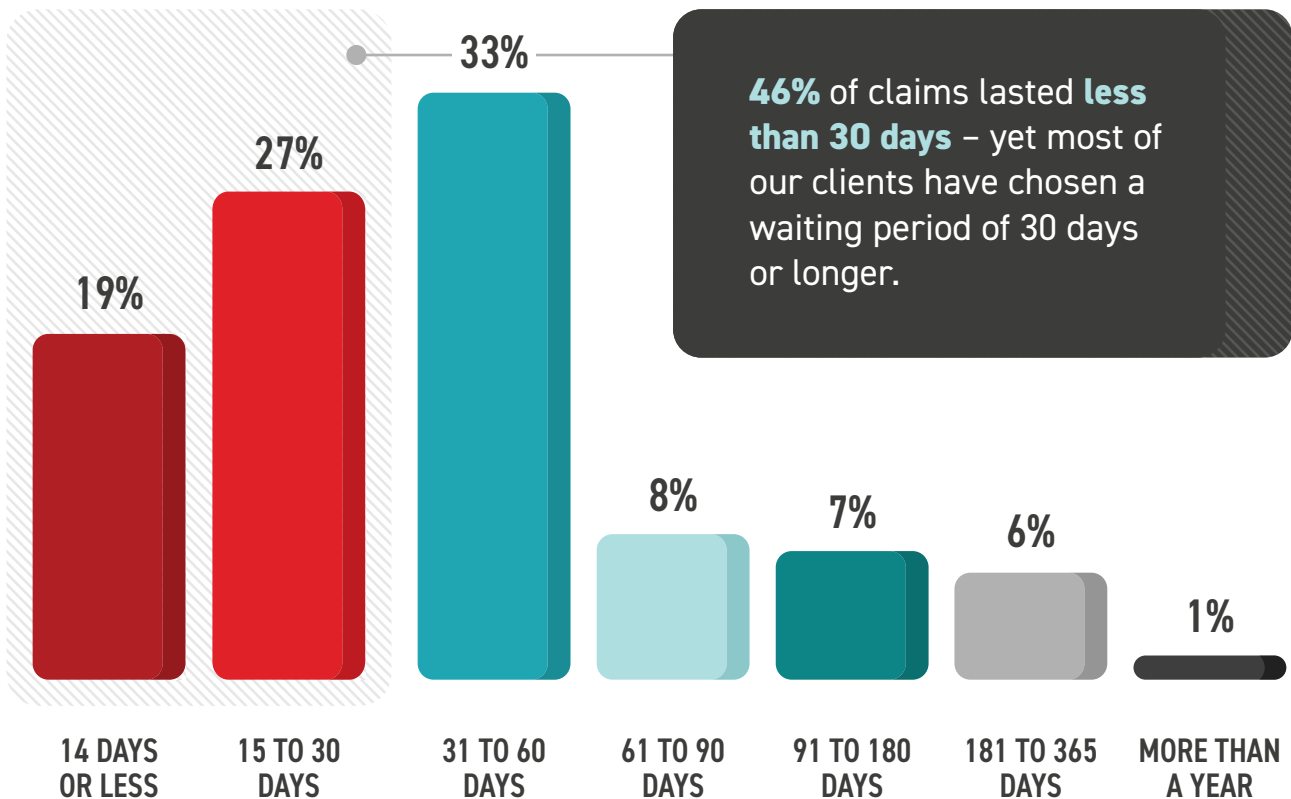
We offer tele-underwriting, which means the underwriter speaks directly to the applicant and helps ensure that all the correct information is collected and reduces the risk of the incorrect information being supplied.



3.2 THE IMPORTANCE OF SELECTING A SHORT WAITING PERIOD

One of the biggest decisions that needs to be made about income protection is which waiting period is selected. Selecting a longer waiting period is more affordable, but it does mean that you won't be able to claim if the period you are unable to work for is shorter than the waiting period.

THE IMPORTANCE OF A SHORT WAITING PERIOD



The number of lodged claims that didn't result in a payment because of the waiting period highlights the fact that clients often don't understand their policies.

The term **waiting period** itself can mean different things on different insurance benefits.

While there are cases where a longer waiting period is the appropriate cover for a client's needs, the implications of this choice need to be understood upfront to avoid being disappointed at claims stage.

“

*Some of our claimants understand their waiting period as how it works on medical aid benefits, where a **waiting period** typically refers to the period from the inception of cover where you cannot claim on that policy. On income protection benefits, a **waiting period** is the minimum period in consecutive days that you need to be unable to perform your occupation due to an injury or illness before you can claim. So not only do clients need to know the waiting period that applies to their policy, they also need to understand how it is applied at claim stage.* ”

- Magda Briers,
FMI Head of Claims.

WHAT ARE THE WAITING PERIOD OPTIONS?

We offer a 7-day waiting period to self-employed individuals, listed salaried professionals and commission earners.

You are **2x** more likely to have a claim on a **7-day waiting period** than on a 30-day waiting period.

A 30-day waiting period is usually selected for non-professional, salaried individuals. This may be as a result of having 30 days' sick leave available. However, if you've used your sick leave,

you may have to take unpaid leave, which leaves you exposed if you are still in your waiting period. That's why we offer a 14-day waiting period for most salaried individuals.

Only **67%** of claims that were for longer than 14 days were also for **31 days or longer**, which demonstrates the value of the 14-day waiting period option.

Whilst employee benefits may include income protection, it is typically with long waiting periods and there are instances where only lump sum cover is provided.

With **87%** of our claims lasting less than **90 days**, it demonstrates the ineffectiveness of employee benefits with long waiting periods.

If affordability is an issue, we do allow clients to split their cover across different waiting periods, which allows them to take some level of cover on a shorter waiting period. This is also helpful where people are earning income

from different sources (e.g. basic and commission) or for business owners where they don't necessarily need their full income from day one if they have other staff.



YAMANGALISA
(30, BUSINESS OWNER)

Non-smoker, Rating category A, Occupation class 1,
5% Compulsory premium pattern, 5% ABI

ALL COVER ON 7-DAY WAITING PERIOD:

- Cover: R30 000 per month

Premium: R349

OR

SPLIT COVER OVER DIFFERENT WAITING PERIODS:

- R10 000 (7-day waiting period) **R116**
- R10 000 (14-day waiting period) **R92**
- R10 000 (30-day waiting period) **R47**

Premium: R255

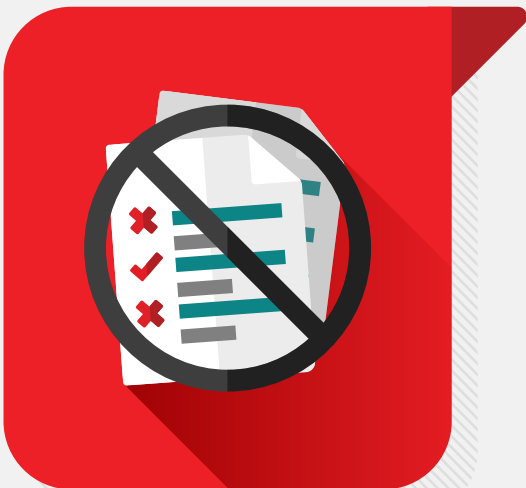


3.3 UNDERSTANDING POLICY EXCLUSIONS

It is important that you understand that there are general exclusions that apply to everyone. This is not a common reason for declining a claim on FMI Individual benefits but more commonly occurs when a claimant attempts to claim on an older generation product that was sold with



reduced underwriting, which resulted in additional general exclusions being imposed. In addition, after going through the underwriting process, additional exclusions may apply depending on your health and risk profile.



3.4 INSUFFICIENT EVIDENCE SUBMITTED OR CLAIMANT ELECTS TO WITHDRAW THEIR CLAIM

In a handful of cases, clients will lodge a claim and then won't complete the process. An example of this is where someone plans to go for surgery, submits a claim and then decides against the surgery.

3.5 THE CLAIM HAPPENS OUTSIDE OF THE PERIOD OF COVER

At application stage, some individuals choose to have their policies to commence at a future date beyond the free cover period we offer. In these circumstances there is a period of no cover between acceptance and cover commencement



and a claim event in this period will be declined if a claim is lodged*.

*THIS APPLIES TO ALL BENEFITS.