The Insurance Institute

Personal General Insurance

CIP-03 KEY POINTS

Advancing *Your* Career.

CHAPTER 5

TRAVEL

Travel insurance products are available from health and general insurers and also from **brokers**.

There are two types of travel insurance available to consumers and the cover they provide is similar:

- Single trip travel insurance
- Annual multi-trip travel insurance.

Wordings vary significantly in terms of scope of cover, exclusions limits and excesses. Because of this wide variety, advisers need to concentrate on the core elements of cover, and not the 'extras'.

Insurers adopt very different approaches in the structure of their wordings. Some rely on exclusions that relate to the policy as a whole, others tailor their exclusions to apply to particular sections.

Accident and medical

Personal accident benefits:

- Capital sums for death, loss of sight or limb(s), permanent total disablement
- Benefit varies from €5,000 to €40,000 (children under 16 have a restricted death benefit)
- A weekly benefit for temporary total disablement; benefit levels starting from €26 per week (104 weeks maximum up to the sum insured).

Medical expenses benefits:

- Emergency medical, surgical, hospital, ambulance and nursing fees, and charges incurred outside of the country of residence
- Accommodation costs plus air ambulance if necessary
- Benefit limits – €1,000,000 to €10,000,000.

Cover generally includes:

- Burial or return home of remains in the event of death

- If an in-patient for more than 10 days, costs for a friend or close relative to bring the policyholder home
- Repatriation costs
- Accommodation, food and nursing for 10 days after repatriation
- Companion to bring home children under 16, if the insured is unable to do so.

Hazardous activities are generally excluded, but some insurers will cover these on payment of an additional premium.

Cancellation and curtailment

Loss of deposits/cancellation cover:

- Irrecoverable unused travel and accommodation costs plus reasonable additional travel expenses for cancellation or curtailment through death, bodily injury or illness to the policyholder, travelling companion, close relative or associate
- Compulsory quarantine, witness or jury service, or unexpected redundancy
- Withdrawal of leave for members of the armed forces, emergency services or government departments
- Burglary, fire, storm or flood at their home
- Hijacking (some insurers only)
- Overall limits of (typically) €3,000 to €4,000.

Travel delay

The cover in respect of travel delay typically provides a fixed benefit following a delay of at least 12 hours as a result of industrial action, bad weather or mechanical breakdown of public transport.

Policies may also include a further payment in respect of accommodation and travel costs as a result of consequent missed connections or abandonment of the journey.

Personal liability

The personal liability section covers the insured's legal liability for third-party personal injury and damage to property, subject to a limit of indemnity, which is normally up to €3 million.

Baggage and extensions

- Theft or damage: single article €250 to €400; overall limit of €2,000 to €4,000 (valuables limit of €200 to €400 in total)
- Delay in arrival of baggage– for at least 24 hours; €130 to €200 for emergency purchases
- Personal money/credit cards – limit €65
- Loss of passport – limit €320 to €400.

Each insurer has its own unique exclusions for these covers, such as unattended valuables, money or credit cards.

Extra sections of cover available

- Emergency service

- Hospital benefit
- Missed departure
- Winter sports
- Golf cover
- Legal costs and expenses
- Kidnap and ransom.

PERSONAL ACCIDENT AND SICKNESS INSURANCE

The sum insured is paid if the insured suffers an accident or is off work due to sickness. The main underwriting considerations are the age, occupation, and existing medical condition or disability of the insured.

Personal accident and sickness policies are benefit policies, rather than policies of indemnity.

The trigger for these policies is an ‘accident’, normally defined as ‘a sudden and unexpected event occurring at an identifiable time and place’.

Personal accident and sickness cover is often offered by motor insurers under their comprehensive motor policy, however, stand-alone policies offer a greater range of benefits.

Personal accident

Chosen capital benefits (sums) for incidents occurring within 12 or 24 months of an accident:

- death
- loss of sight in at least one eye, or loss of one or more limbs
- permanent total disablement
- disappearance may be covered.

Conditions that apply generally:

- Obligation to notify insurer of material change in occupation or pastimes (continuing requirement).
- Pre-existing conditions may appear either as an exclusion or a condition.
- Obligation to notify insurer of any incident likely to give rise to a claim, and to arrange to see a medical practitioner as soon as possible.
- An age limit applies to household extensions e.g. 60 or 65.

Group personal accident policies can be purchased by companies to cover employees travelling or working on company business.

Sickness cover

Sickness insurance provides a weekly benefit if the insured suffers **temporary total disablement**.

Cover is normally subject to a time **franchise** of 7 days, and excludes illness contracted within 21 days of policy inception.

Blindness and paralysis may be offered as additional benefits under this cover.

Important considerations when advising the consumer

Advisers must exercise great care in relation to policy exclusions. Some insurers state that they apply even if the exclusion contributes to the event rather than causing it. A comparison of precise wordings is crucial.

Some insurers impose an age limit requirement or rely on a blanket exclusion for pre-existing illness or disability; others may consider the particular issues that arise with declared conditions.

HEALTH RELATED INSURANCE PRODUCTS AND SERVICES

Private health insurance is governed by a range of principles contained in the **Health Insurance Acts 1994–2016**, such as community rating.

In this section, we focus on health insurance products that are not governed by these Acts, and to which the principles set out in those Acts do not apply - these products are **risk-rated**.

Permanent health insurance

Permanent health insurance (PHI), more commonly called 'income protection', provides a regular income if the policyholder suffers a loss of earned income by being unable to work due to sickness, accident or disability lasting longer than the 'deferred period' (typically 13, 26 or 52 weeks).

Benefits are capped at a maximum of 50–75% of gross income (less any social welfare or other entitlements), and are payable for as long as the individual suffers a loss of earned income and is deemed unfit to return to work.

In order to make a claim on a PHI plan, a person's illness status must match the definition specified in the policy terms and conditions issued by their insurer.
Common definitions included on an income protection policy are:
1) Own Occupation
2) Suited Occupation

If a policyholder's PHI claim is successful, the insurer will pay the pre-determined percentage of the policyholder's gross salary (depending on the insurer). The policyholder's PHI policy will not interfere with any State benefits they may be entitled to.

PHI policies are heavily underwritten at the point of sale. They usually have extensive exclusions and restrictions on the payment of benefit, e.g. where the illness giving rise to the claim arises from self-inflicted injury, drug or alcohol abuse, a pre-existing condition or participation in certain dangerous pursuits or criminal acts.

PHI policies may be of two different types:

- The premium is fixed and guaranteed for the term of the policy
- The premium is fixed for a certain initial period, e.g. 5 or 10 years, after which the PHI provider may 'review' the premium.

PHI policies offer a ‘waiver of premium’ option.

While individuals can take out PHI policies, most people who have this cover obtain it through a group scheme.

Hospital cash plans

Hospital cash plans are benefit plans and they do not provide indemnity for the costs incurred for medical treatment.

The only provider of hospital cash plans in Ireland is Hospital and Medical Care Association (HMCA). HMCA offers its products to approximately 600 professional or membership groups.

Hospital Cash Plans vs HSF Health Plans

Hospital cash plans:

- are available exclusively to members of an association
- are risk-rated i.e. require a completed questionnaire and medical underwriting
- provide tax free cash towards unexpected medical expenses
- are paid directly to the policyholder
- reimburse policyholders for expenses incurred for hospitalisation (e.g. consultants’ fees during hospitalisation).

HSF Health Plans:

- are available to all individuals (irrespective of their age or occupation) and corporates
- are low-cost policies
- do not require health questionnaires or medical examinations when gathering information
- cover policyholders’ everyday medical expenses (e.g. GP, dental, optical and physiotherapy)
- do not cover costs incurred in a hospital as a private patient.

Dental insurance products

There are currently three providers of dental insurance plans to individual consumers – Vhi Healthcare, Allianz Care and DeCare Dental.

Private health insurers sometimes include dental benefits as part of a health insurance product, such as cover for emergency dental treatment and many routine treatments.

However, the cover under dental insurance tends to be broader and include:

- Annual maximum
- Investigative and preventative treatments:
  - Examinations
  - Scaling and polish
  - Radiographs (x-rays)
- Basic restorative treatments – 3-month waiting period:
  - Restoration (fillings)
  - Pre-fabricated or stainless steel crowns
  - Sealants
  - Space maintainers
  - Periodontal treatment
  - Simple tooth extraction
  - Emergency treatment
- Major restorative treatments – 12-month waiting period:
  - Endodontic therapy on primary teeth
  - Root canal therapy
  - Prosthetic services
  - Crowns, inlays and onlays
- Orthodontics – 24-month waiting period.

All dental insurance premiums are billed net of tax relief, which is deducted at source by the insurer.

International health insurance for expatriates

International health insurance is designed for consumers who are working, travelling or studying abroad for 6 months or more. However, they are not emigrating permanently and they intend to return to Ireland in the short to medium term. They differ from travel insurance in that they cover elective treatment and provide a longer duration of cover with more comprehensive benefits.

The features of an international health insurance product are as follows:

- medical, hospital expenses and dental treatment expenses (often optional)
- maternity cover / plan (often optional)
- emergency medical transfer, evacuation and repatriation
- repatriation of mortal remains/local cremation/burial
- temporary return to home country
- wellness benefits – optical and audiology.

Key questions an adviser must ask relate to the countries to be visited, the time to be spent abroad, the ages of the insureds, and whether the insured's employer already has a global travel policy in place and whether the consumer has private health insurance.

There is no one standard approach in the market when moving from a domestic health insurance product to an international health insurance product when looking for continuity of cover.

PAYMENT PROTECTION INSURANCE

Payment protection insurance (PPI) cover enables a borrower to insure their loan repayment(s) if certain events should occur that may negatively impact their ability to pay these loans/debts.

These events can include the following:

- death
- accident and sickness
- critical illness
- disablement
- redundancy/job loss.

Although the policy is purchased by the borrower, the benefit paid in the event of a claim goes to the company that extended credit to the consumer.

PPI usually covers minimum loan (or overdraft) payments for a finite period (typically 12 months). After this point the borrower must find other means to repay the debt.

Eligibility to claim on a PPI policy is subject to strict criteria.

Payment will not normally be made if the claimant:

- is aged under 18 or over 65
- works less than 16-18 hours per week
- is aware that they may become unemployed
- takes voluntary redundancy
- is self-employed and goes out of business
- is a temporary/contract worker and loses their job
- is aware, or should be aware, of an existing medical condition
- is unable to work because of certain common conditions, such as stress or backache
- makes a claim during the first 3 or 6 months of taking out the policy.