

# Insurance reports – Guidance for medical practitioners undertaking insurance reports

## (Supplementary information to FGS5 & 11)

March 2007

The professional fees committee has drafted this guidance to provide additional information on insurance fees and fee related issues, supplementary to fees guidance schedules 5 and 11. It should be noted that guidance on best practice and practical advice on the use of medical information in insurance can be found in the joint guidance document 'Medical information and insurance', which has been drawn up by the BMA and the Association of British Insurers (ABI).

### 1 Life assurance and income protection insurance

#### 1.1 Fees

Since 2002, the BMA has agreed fees with the ABI for reports and medical examinations undertaken for life assurance and income protection purposes. These fees are only binding for member companies of the ABI with whom the BMA negotiates nationally. In practice, the agreed fees are paid in almost every case as almost all life assurance business is undertaken by ABI member companies and members should insist on the agreed fee wherever possible. The fees, however, are not binding for GPs who may wish to seek a higher fee, but GPs wishing to do this should accept that such requests are likely to be unsuccessful and that refusal to carry out the work may affect the doctor/patient relationship.

The BMA currently has a five-year fee agreement with the ABI, with an increase in fees taking effect on 1 April each year until 2010 when the funding arrangements for the agreement will be reviewed. The agreement covers GP factual reports, supplementary reports and medical examinations, and the fees detailed below can be found in BMA fees guidance schedule 5.

Date	GP factual report (£)	Supplementary report (£)	Medical examinations (£)
1 Sept 2006	74.70	19.10	82.20
1 April 2007	79.20	20.20	87.10
1 April 2008	84.00	21.40	92.30
1 April 2009	89.00	22.70	97.80
1 April 2010	94.30	24.10	103.70

Where a patient fails to keep an appointment arranged for life assurance purposes, 50 per cent of the fee should be paid by the insurance company.

## 1.2 Principles agreed between the BMA and the ABI

Life assurance is important for patients, especially at significant points in their lives and the BMA agrees that the process of applying for life assurance should run smoothly, with the minimum of disruption to doctors and their patients. The following principles have been agreed between the BMA and the ABI, and are detailed in the agreement.

- That the information should be provided in the manner requested and should be as complete as possible. This would, thereby, prevent needless issuing of additional questionnaires or requests for clarification for further information on the original report, which do not command a further fee.
- That the report should be returned within 20 working days of receipt of the request. In return, insurance companies will not send reminders until 15 days have elapsed. The BMA acknowledges that insurance companies may ask for a more speedy response in exceptional circumstances, for example in connection with the completion of a loan. As this is outside the agreement the ABI acknowledges that a higher fee may be negotiated if GPs wish.
- When an insurance applicant is declined or postponed as a result of a medical disclosure that they have made on the application form the insurance company will give the reason for declination to the applicant. However, if a new or poorly controlled medical condition is revealed on the GPR or following a medical examination, and not disclosed on the application form, the insurance company will inform the GP.

### 1.3 Quality of reports

The completion of reports for life assurance purposes should comply with the following standards:

- the information should be provided in the manner requested and should be as complete as possible, providing a synthesis of essential details from the mass of undifferentiated information on the medical records
- reports may be completed electronically or by hand, provided the information is clear
- the provision of paper or electronic copies of the medical record is not appropriate and is not covered by the patient's consent to the report. Similarly, it is inappropriate for insurance companies to request a copy of a patient's record under the Access to Medical Records provision, rather than request the completion of the GP factual report
- GPs are responsible for the content of their report and must sign them whether or not practice nurses or administrators have a role in their completion.

### 1.4 Patient access to medical reports

Medical reports for life assurance purposes are covered by the Access to Medical Reports Act 1988. Under this Act, if a patient indicates that they wish to see the report before it is dispatched, the GP should refrain from sending it for 21 days from the receipt of the request for the report. It may be advisable to inform the insurance company if a request to see the report has been made. Once the patient has seen the report they may decide to withdraw their consent for it to be sent.

### 1.5 Targeted reports

A number of insurance companies have introduced targeted reports for life assurance and income protection. These reports are shorter than GP factual reports and require information on a single condition.

The BMA's professional fees committee has not supported the introduction of these targeted reports, and therefore there is no fee agreement with the ABI. We would therefore suggest that doctors charge at their own rate for undertaking targeted reports. It should also be noted, however, that there is no obligation on the doctor to undertake this work, but where the work is declined the effect on the doctor-patient relationship should be considered.

## **1.6 The ABI**

The BMA has had a positive relationship with the ABI for a number of years and continues to meet on a regular basis. It should be noted, however, that the ABI is a trade body and not a regulator. Therefore, although the BMA informs the ABI of issues of concern, there is no guarantee that the ABI can resolve individual issues with insurance companies.

## **2 Travel insurance**

### **2.1 Fitness to travel certificates**

Insurance companies frequently ask doctors to provide a fitness to travel certificate for their patients. The BMA discourages doctors from signing certificates which indicate that the patient will be fit for the duration of the holiday. If the patient is subsequently taken ill while under such a guarantee there may be medico-legal consequences for the doctor. The association therefore advises that if certificates are provided, they should include words to the effect that 'based on information available in the medical notes, the patient appears to be fit to travel'. Fitness to travel certificates fall outside a GP's NHS terms and conditions and doctors can charge at their own rate for undertaking this work.

### **2.2 Verifying claims when patients are taken ill aboard**

Insurance companies frequently ask doctors to complete medical reports based on a patient's medical history, when taken ill abroad, and the company refuses to authorise payment of treatment until the report has been received. The ABI and BMA have joint guidelines regarding medical information and insurance. The guidelines state that consent is needed before information is disclosed to insurance companies for the purpose of verifying claims, for example before a company organises repatriation of a policy holder taken ill abroad. In such cases, the company must approach the policy holder for permission to release sufficient information to verify the claim. Evidence of consent must be provided to the policy holder's doctor in the usual way. If the policy holder is not competent to give consent, doctors may release information necessary to satisfy the claim provided that doing so is in the person's best interests and not contrary to his or her previously stated wishes.

Sometimes insurance companies need information about people other than the holder of the policy. This is most often the case with travel insurance, for example where a close relative of the policy holder becomes ill and the policy holder has to curtail a holiday and return home. In such cases insurance companies will want to confirm that the illness of the relative was sudden and unexpected and occurred at the time the policy holder claimed.

Depending on the nature of the policy, the company may also want to confirm that the condition was such that the policy holder was urgently required to attend the relative. If competent to give it, the relative's consent is needed before doctors can release information to verify the claim. If the relative is not competent, doctors may disclose relevant information to the company provided this is not contrary to their patient's wishes or interests. The insurance company will explain what information is required in each case.

The view of the professional fees committee is that if the above conditions are met then GPs should aim to cooperate with any reasonable requests. However, GPs should not be blackmailed with any threats that certain action will compromise the validity of the patient's insurance and the repatriation process and GPs are reminded that they are not bound by their terms of service to provide these reports, and are entitled to charge at their own rate. We would also advise that the doctor checks that the person requesting the report is who they claim to be and to ensure that they will respect the patient's confidence. In addition, if the report is to be faxed, we would advise that the report is first anonymised and the patient's identity sent separately. The recipient should be informed when the fax is being sent and asked to acknowledge receipt of the report.

### **3 Private medical insurance**

The BMA does not agree fees with private medical companies for medical reports on prospective subscribers for private medical insurance policies. In some cases, fees may be offered to GPs by the insurance company, but the association suggests that doctors charge at their own private rate for such work.

### **4 Accident/sickness insurance**

Short certificates of incapacity may be required for a patient to claim under accident/sickness insurance. The BMA's suggested fees for such services, which can only be provided by the patient's own GP or other attending doctor, are detailed in fees guidance schedule 11, part A. The fees from October 2006 are £14.50 for a straightforward certificate of fact and £24.50 to £51.50 for more complex certificates.

## **5 Further advice**

The BMA can provide advice to members, both through our askBMA service ([askbma@bma.org.uk](mailto:askbma@bma.org.uk) or 0870 6060828) and regional offices. At a national level, the professional fees committee continues to raise insurance concerns with the ABI and ensures fees for this work are in line with GPs' actual remuneration and comparable with market rates.