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ABN 25 107 318 392

Trauma Insurance Claims Seminar Invitation

Introduction

Since the development of Trauma Insurance in Australia in the 1980s, the product has evolved at a great pace. Some of the challenges faced by claims assessors today stem from:

- Understanding what is covered under the contract and why the wording has evolved to what it is now.
- Having an insight into what might have been expected by the pricing actuary when originally pricing the risk.
- Identifying the objective evidence that is required to justify a claim.
- Knowing when a medical event has fulfilled the criteria for a valid claim.
- Being aware of the types of issues to look for in respect of non disclosure.

In many ways the modern Trauma contract is presenting quite new challenges to the claims assessor and with this in mind G&T Risk Management has pleasure in presenting, with the support of Munich Reinsurance Company of Australasia, a two-day training seminar in respect of Trauma Insurance Claims.

The program is aimed at all levels of claims assessors who are currently involved in the assessment of Trauma claims and covers 29 critical illness conditions. Each delegate will receive a CD with copies of technical papers relating to the topics.

The program is not intended to be an analysis of the legal interpretation of Trauma Insurance wordings but rather a practical guide for the claims assessor in respect of certain aspects of Trauma Insurance claims adjudication.

An example of the type of information provided through the training is shown later in this material.

The training program timetable can be seen overleaf.

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Program

Day 1	
8.45 – 9.00	Introduction & Welcome
9.00 – 10.30	Circulatory Disorders Part 1: Heart Attack, By-pass Surgery, Angioplasty, Primary Pulmonary Hypertension, Stroke.
10.30 – 10.45	Break
10.45 – 12.15	Circulatory Disorders Part 2: Heart Valve Repair/Replacement, Aorta Surgery, Open Heart Surgery, Cardiomyopathy.
12.15 – 13.15	Lunch
13.15 – 14.45	Neurological Disorders Part 1: Major Head Trauma, Coma, Multiple Sclerosis, Muscular Dystrophy.
14.45 – 15.00	Break
15.00 – 16.30	Neurological Disorders Part 2: Motor Neurone Disease Encephalitis, Dementia, Parkinson's Disease.
16.30 – 16.45	Close
Day 2	
9.00 – 10.30	Neurological Disorders Part 3: Paralysis, Blindness, Loss of Speech, Deafness.
10.30 – 10.45	Break
10.45 – 12.30	Tumours Part 1: Cancers, Leukaemia, Aplastic Anaemia, Benign Brain Tumour
12.30 – 13.30	Lunch
13.30 – 15.00	Tumours Part 2: Cancers, Leukaemia, Aplastic Anaemia, Benign Brain Tumour
15.00 – 15.15	Break
15.15 – 16.30	Miscellaneous: Major organ transplant (including waiting list), Severe Burns.
16.30 – 16.45	Close

Note: At this stage times are approximate and may be altered in the final program.

Qualifies for 12 CIP Points (ANZIIF)

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Trainer

Tony O'Leary has been involved in the pricing, product design, underwriting and claims of Trauma Insurance since the early 1980s. He has been involved in the production of underwriting and claims manuals as well as some of the early Trauma Insurance product development manuals.

Dates & Venue

The course will take place on the 4th & 5th August 2009 at Munich Re's offices at 143, Macquarie Street, Sydney, NSW 2000

Numbers

Numbers will be limited and if there is any over-subscription consideration will be given to running a second course.

Course Fees

$950 + GST per delegate

Lunch

A sandwich lunch will be provided by Munich Re

Registration

If you are interested in obtaining a seminar registration form, please email Tony O'Leary at toleary1@bigpond.net.au.

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Example of information provided using a sample definition

Multiple Sclerosis

Policy Definition:
The unequivocal diagnosis of Multiple Sclerosis as confirmed by a consultant neurologist and characterized by demyelination in the brain and spinal cord evidenced by Magnetic Resonance Imaging or other investigations acceptable to us. There must have been more than one episode of well-defined neurological deficit with persisting neurological abnormalities.

Background:
Multiple sclerosis (MS) is an incurable disease of the central nervous system, which can result in severe disability and sometimes premature death. It usually commences between the ages of 20 and 40 and is twice as common in females compared to males. It is estimated that there are 18,000 sufferers of MS in Australia and 2.5 million worldwide.

Much is unknown about the cause of MS but it is thought that there is a genetic susceptibility that combines with an environmental element, possibly a virus, to cause the condition. Interestingly, Tasmania has a higher incidence than mainland Australia.

In MS it is thought that the bodies own immune system attacks the nervous system. The myelin sheaths that protect the nerves are destroyed and replaced with scar tissue. This is why the condition is known as a demyelinating disease. The scar tissue is comprised of sclerotic patches of tissue known as plaques. These plaques appear in different locations of the nervous system and at different times. This is why the disease is known as multiple sclerosis and for a firm diagnosis it must be multiple in both time (more than one attack) and space (more than one area of the central nervous system affected).

The symptoms will vary depending on the part of the nervous system affected. Some examples are: -

- *Impaired vision*
- *Weakness and paralysis of muscles*
- *Numbness*
- *Loss of balance and muscular co-ordination*

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- *Slurred speech*
- *Bladder and bowel problems*
- *Memory loss*
- *Depression and mood swings*

Diagnosis is made on symptoms and can be confirmed by MRI scanning showing signs of plaques of demyelination in the brain. Examination of the cerebrospinal fluid can also provide clues as to the diagnosis with different levels of protein being present and also the presence of oligoclonal banding indicating abnormal immune response. Testing Visual Evoked Responses (VERs) which, when impaired, can also be a pointer to a diagnosis of MS. Auditory Evoked Response testing can also be used but this is not as common in medical practice as VERs.

Sometimes the first sign of multiple sclerosis is a condition called retrobulbar or optic neuritis.

There appear to be various forms of multiple sclerosis some of which have a rapid progression and others a much more gradual course with long periods of remission. Most cases will undergo a relapsing, remitting course with the remissions often becoming shorter as time progresses. There is no curative treatment but drugs can be used to minimise and control symptoms and improve periods of remission. New drugs are being tried all the time with varied success.

Pricing:
The original pricing is likely to have been based on Australian population incidence data of Multiple Sclerosis then adjusted for the definition requiring persisting neurological abnormalities.

There may also have been some adjustment for the selection effect in that those with early neurological symptoms should have been underwritten-out. The incidence rates will reflect the higher levels of diagnosis in female lives.

Whilst the condition onset is more common between ages 20 and 40 it can occur at any age without the necessity of a long lead-in time.

Evidence Required:
The wording indicates that there is a requirement for a report from a Consultant Neurologist and that this report should unequivocally confirm the diagnosis of

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Multiple Sclerosis. This means that the diagnosis needs to be definite rather than possible or probable for a claim to be considered. This is an important point as there are a number of other diagnoses that might produce similar symptoms.

The wording also requires evidence of plaques of demyelination which would be shown on a MRI scan. The MRI scan is considered to be the gold standard scanning investigation for multiple sclerosis but other scanning techniques, such as CT scans, can show the demyelination plaques. These other scans are not as accurate as MRI scanning in that plaques are not always identified but once a plaque has been shown then it would be considered to be an accurate determination. Therefore, evidence on other scans would be acceptable evidence for this part of the definition.

There are a number of other criteria that are used in the overall diagnosis of multiple sclerosis including clinical signs and symptoms, Visual Evoked Responses and examination of the protein in the cerebrospinal fluid. These tests are used as an adjunct to the scans already mentioned with any diagnosis usually being made using all the criteria together.

The final criteria in the wording require more than one episode of well-defined neurological deficit with persisting neurological abnormalities. The types of neurological abnormalities seen in multiple sclerosis are quite wide-ranging depending on the areas of the nervous system affected by the demyelination. Typical neurological abnormalities have been outlined earlier.

The wording requires that the neurological deficit be initially well defined. This should be taken to mean that vague symptoms would not qualify in this respect. The persisting neurological abnormalities are not defined by the wording to have to be of any particular degree of severity or even well defined but must persist. Persisting symptoms can be interpreted as meaning those that continue but do not necessarily have to be permanent or of any particular degree of severity.

Some companies link the persisting neurological abnormalities to activities of daily living or to a permanent impairment relating to a percentage of function defined in the American Medical Association publication 'Guides to the Evaluation of Permanent Impairment'. This publication provides some objective criteria in the measurement of disability. Care should be taken to ensure referral is made to the specific edition of the publication mentioned in the policy wording. To date there have been six editions published.

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Non Disclosure:
Often multiple sclerosis will present with generalised neurological symptoms some time prior to the definitive diagnosis being made. Therefore the claims assessor should look out for any attendances in respect of such symptoms.

A further example of a condition that might precede a diagnosis of multiple sclerosis is retrobulbar neuritis, a form of optic neuritis, which is often the presenting sign of multiple sclerosis. Again any attendance for or diagnosis of retrobulbar neuritis should have been disclosed. Other types of visual disturbances that might be associated with multiple sclerosis are nystagmus and diplopia.

A family history of multiple sclerosis is considered to be a possible risk factor for the development of the condition in the insured and therefore any mention of family history should be considered in conjunction with the questions asked on the application form and the answers provided.

Partial Payment
Some companies will offer a partial payment of benefit on diagnosis of multiple sclerosis without the requirement for persisting neurological symptoms.