# CTF Life Claims Procedure – FAQ


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# Claims Principles - FAQ

**What is 'Utmost Good Faith" of an insurance contract?**

- The term "Utmost Good Faith" means 最高誠信 in Chinese.

- The belief of Utmost Good Faith is a fundamental principle in insurance industry. In this sense, every person who enters into a contract with an insurer has a legal obligation to be honest and accurate to disclose his/her information.

- This principle serves as a foundation of the insurance contract which helps to ensure fair dealing between the insurer and the applicant/policyholder. If the applicant/ policyholder fails to meet his/her obligation, the insurer may void the policy issued.

**What is meant by "Duty of Disclosure"?**

- The applicant/policyholder (or the representative of the insured e.g. spouse, juvenile, etc.) has a duty to disclose all material information to the insurer at the time of insurance application.

**When is duty to disclose required for insurance contract?**

- "Duty to disclose" is a legal term that refers to the obligation of an applicant/ policyholder to provide all material information to the insurer. Such obligation is required under the following scenarios:-

    - New insurance application;
    - Reinstatement of a policy;
    - Addition of benefits to a policy;
    - Extension or change (increase) of benefit level or coverage;
    - During the policy period (If the previously non-disclosed information during the application is disclosed after the policy effective, the premium or policy terms may be adjusted accordingly)

**What must be disclosed for an insurance contract?**

- All material information or facts that are within applicant's/policyholder's knowledge or should be within his/her knowledge.

- If the applicant/policyholder is wondering whether the facts are material or not, these information should be disclosed.

**What is "Misrepresentation"?**

- "Misrepresentation" refers to any false, incorrect or misleading statements made by the applicant/policyholder to the insurer during his/her application.

- Misrepresentation can be intentional or unintentional. In either case, such information can have impact on the policy's coverage and benefits.

Examples:

- failing to disclose a pre-existing medical condition
- providing inaccurate information about smoking or alcohol consumption habits
- misrepresenting the income or occupation

- If the insurer discover that an applicant/policyholder made a material representation in his/her application and was being misled to come up to the underwriting decision, the insurer have the right to deny the claim and rescind the policy from inception.

**What is 'material facts'?**



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# Claimable Amount Estimation (CAE) and Pre-authorization (PA)

**What is the TAT of the service? How do I receive the CAE result?**

- Normally, the case result will be sent to the email written on the service request form in 5 working days. We recommended that the email address should be written in block letters and in clear manners to avoid mis delivery.

**What is included in the result?**

- Name of the insured, policy number, estimated medical expenses, estimated claimable amount and estimated out of pocket amount will be shown in the result letter.

**How to submit the application?**

- Currently, the only application channel is email to CTFLife.PA@ump.com.hk with subject includes “CAE application”.

**What is the benefit for applying CAE?**

- CAE provide an estimation on how much can be claimed on single policy, helping client and agent to budget and plan for follow-up claims.

**What is the difference for applying CAE via network doctor/ non-network doctor?**

- In principle, the claims procedure remains the same for network doctor and non-network doctor. However, as we have agreed fee with panel doctor, most surgeries are within Reasonable and Customary, thus, we recommend client to consider using network doctor before commit to planned surgeries.

**Is CAE suitable for urgent admission?**

- No. CAE is designed for planned surgery that is not urgent, for urgent medical need to admit to hospital, we recommend not to apply CAE.

**What is Pre-authorization service?**

- Pre-authorization service is a pre-surgery/ pre-admission assessment by claims department, provide an assessment on the claimable amount and medically necessary based on the given medical information. For approved case, claims team will offer a Guarantee of Payment service with approved amount to the healthcare service provider (Day procedures centre/hospital) so that the client can focus on recovery and not to worry about the finance.

**How to apply the service?**

- Currently, there are 2 types of application, network doctor application/ non-network doctor application:
  1. Network Doctor:
     - Our network doctors have the PA service request form ready at their clinic/ centre, client need to show their medical card and state to the client staff their intention for “Pre-authorization” service.
     - After fill-in the service form, the network clinic to submit the application for you.

  2. Non-network doctor:
     - Please bring along the PA service request form to on your visit to your attending doctor. Then follow the instruction to email to CTFLife.PA@ump.com.hk or fax to (852) 3468 2603.

**What is the TAT of the service?**

- Normally, the result will be sent to client in 4 working days after we received your application.

**Do I need doctor to fill-in the form in order to use the service?**

- Yes, the application required your attending doctor. There are some medical information requires your attending doctor to provide.



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# Medical - FAQ

**What are the different types of medical/hospital benefits?**

- Different medical/hospital products in each insurer may carry varying features, definitions and exclusions whilst benefits are payable upon hospitalization or receiving day surgery services in specified conditions
- In general, insurer may offer coverage for a variety of product types:

| | |
|---|---|
| Hospital Income | • Pay a fixed amount for each day of hospitalization subject to specified benefit limits |
| Hospital Reimbursement | • In-patient or day surgery service<br>• Benefit is to reimburse medical expenses actually incurred subject to specified benefit limits<br>• Reimbursed amount no greater than actual expenses |
| Hospital Surgical Benefit | • Pay a fixed amount when a particular medical/surgical procedure is performed |

- Some medical/hospital products may incorporate other specific features i.e. a small compassionate death benefit, medical evacuation services, panel network services, pre & post medical consultation benefits, pre-approval services, etc.

**What is Voluntary Health Insurance Scheme (VHIS)?**

- The Health Bureau of Hong Kong launched the Voluntary Health Insurance Scheme (VHIS) in April 2019. It aims to instigate minimum standards for individual medical insurance plans with greater transparency for an insured.

- Insurers participating in the VHIS ("VHIS Providers") offer individual indemnity hospital insurance plans that are certified by the Health Bureau of Hong Kong to comply with the minimum requirements of the scheme in product design ("Certified Plans").

- Moreover, VHIS Providers must comply with a set of Code of Practices covering sales and marketing, handling of applications, after-sales services, etc.

- For details, please refer to the Official Homepage of the Voluntary Health Insurance Scheme (VHIS) https://www.vhis.gov.hk/en/

**What is 120 days exclusion clause for non-VHIS medical plans?**

- Depending on the plans purchased, the "120 Days Clause" for non-VHIS medical benefit generally exclude treatment/ surgery for an illness primarily related to the specified organs: tonsils, adenoids, hernia, cataract, tonsils, adenoids, hernia, cataract, sinus related conditions, piles/ fissure/ fistula-in-ano/ rectal prolapse or a disease peculiar to the female generative organs.

- If treatment for an illness/condition affects the specified organs, it would fall under the exclusion as well.

- The 120 days counts backward from the earliest treatment/surgery date established in relation to the claimed illness. We shall look for when the treatment/surgery commence, not the hospitalization date or duration.

**What is the meaning of Confinement?**

- 'Confinement' for a medical/hospitalization insurance plan usually defines, any continuous period of hospitalization as an in-patient whilst 'Per Confinement' is the limit of coverage for each hospital admission.



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# VHIS – FAQ

**What is the definition of "Hospital"?**

- With effect from 1 Apr 2023, hospital shall mean an establishment duly constituted and registered as a hospital under the laws of the relevant territory in which it is established, which is for providing Medical Service for sick and injured persons as Inpatients, and which –
    - has facilities for diagnosis and major operations, or is a public hospital as defined in the Hospital Authority Ordinance (Cap. 113 of the Laws of Hong Kong) or a hospital for which a licence is issued under the Private Healthcare Facilities Ordinance (Cap. 633 of the Laws of Hong Kong) ;
    - provides twenty-four (24) hours nursing services by licensed or registered nurses;
    - has one (1) or more Registered Medical Practitioners; and
    - is not primarily a clinic, a place for alcoholics or drug addicts, a nature care clinic, a health hydro, a nursing, rest or convalescent home, a hospice or palliative care centre, a rehabilitation centre, an elderly home or similar establishment.

**What is the definition of value-added tax ("VAT") and goods and services tax ("GST")?**

- VAT and GST shall mean value added taxes, goods and services taxes or other taxes, duties or levies of a similar nature, which may be charged or imposed by the relevant tax or similar authorities or governmental departments on the expenses incurred for Medical Services rendered with respect to a Disability.

**Are VAT and GST levied on medical fees and expenses charged by the authorities in the locality where the medical service is rendered covered by VHIS?**

- With effect from 1 Mar 2022, eligible Expenses shall include the VAT and GST (if any) charged or imposed on the expenses incurred for Medical Services rendered with respect to a Disability.
- Any VAT and GST which is refunded to the Policy Holder or Insured Person (as the case may be) shall not be recoverable under the Terms and Benefits.

**How would the VAT and GST be payable?**

- Where the VAT/GST is incurred on an itemised basis, the VAT/GST associated with a specific benefit item shall be counted towards the Eligible Expenses payable under that particular benefit item.
- 
- Where the VAT/GST is incurred in a lump sum without itemised breakdown, such lump sum shall firstly be allocated to the relevant expense items on a pro-rata basis. This means that the portion of VAT/GST corresponding to expense items other than Eligible Expenses shall not be claimable. After that, the VAT/GST allocated to a particular Eligible Expense item shall be added to the expense of that item and then claimed against the corresponding benefit item of a VHIS Policy.



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# Accidenity Indemnity & Personal Accident - FAQ

**What are the different types of accident benefits?**

- Accident benefits are titled with different names/packages in the insurance industry, and individual accident contracts may not carry identical features.

- Accident Benefits refer to a variety of insurance coverage for accidental events such as Accidental Death Benefit (ADB), Accidental Death and Dismemberment (ADD), Accidental Indemnity (AI) and Personal Accident (PA) benefits, etc.

- Major Accident Claim refers to the claiming for benefits from the insured/beneficiary for the major accident events. Such major accident events include:

    - Death and Dismemberment
    - Major Burn/Third Degree Burns
    - Broker Bone
    - Total and Permanent Disablement

- Depending on the plans purchased, benefits that to be claimed under Minor Accident Claim include:
    - Temporary Disablement (Temporary Total/Partial Disablement)
    - Double Indemnity
    - Medical Expenses
    - Hospital Indemnity/ Hospital Cash
    - Surgical Indemnity

**What is an "Accident"?**

- In general, the term "Accident" usually refers to an unfortunate event that is not expected.

**What is the meaning of "directly and independently of all other causes"?**

- "Directly and independently of all other causes" is a phrase that is common in an insurance contract for accident products. It aims to define the situations under which the insured is eligible for accident benefits.

- This phrase means that loss due to accident must be a result of "directly and independently of all other causes". In order for the accident to be covered by the insurance policy, it must be the sole cause of the injury, and no other contributing factors can be involved.

    - Example: If some diseases exist at the time of the injury, and such medical condition contributes to the loss, the loss may not be a result "independently of all other causes".

**What is an Injury?**

- In medical terms, an injury is defined as damage or harm caused to the body by an external force which may include physical wounds and broken bones, etc. Injuries can be classified into several types.
    - Example: blunt injury, penetrating trauma, explosive blast injury , burns and scalds etc.

- The severity of an injury can vary from minor to life-threatening, depending on certain factors such as the location and type of the injury, the extent of damage and the age and overall health of the insured. To define the severity of an injury, medical professionals usually perform a physical examination and may use diagnostic tests such as X-rays, CT scans, MRI, etc. to assess the extent of damage.



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# Disability - FAQ

**What are the different types of disablement /disability (傷殘/傷病) benefits?**

- Disablement/Disability benefits are named under different titles or packages in the insurance industry, and individual contracts may vary in the features. Basically, disablement/disability benefits are offered in the below main categories:

| | |
|---|---|
| Lumpsum Payment Benefit | Lumpsum payment upon disablement/disability of the insured |
| Waiver of Premium (WP) Benefit | To waive premium upon Disability of the Insured |
| Payor Benefit (PB) at Disability | To waive premium upon Disability of the Policyholder/Payor |
| Total and Permanent Disablement under the Accident Indemnity Contract | Total and Permanent Disablement under the Personal Accident Contract |

- Total and Permanent Disablement/Disability may be given different definitions in respective insurance contracts requiring a varying degree/extent of incapability within a certain period of time.

**What is Total and Permanent Disablement/Disability?**

- Total and Permanent Disablement/ Disability (TPD) is a type of disability insurance that provides benefits to the insured who becomes permanently disabled and unable to resume work.

- Depending on the benefits plans purchased, some insurance contracts may only cover disablement/disability resulting from an accidental injury, while others may cover disablement/disability caused by both accident and illness.

- Total and Permanent Disablement/ Disability may be given different definitions under their respective insurance contracts, requiring a varying extent of incapability within a specified period of time.

- Depending on the plans purchased, the occupation of the insured also plays an important role in determining the eligibility for total and permanent disablement/ disability benefits.

    - Examples:
        - the insured is incapable of performing “each and every duty of the insured’s regular occupation”, called ‘Own Occupation’;
        - the insured is unable to pursue his usual occupation, or any other similar occupation requiring similar skills, education, training and experience, called ‘Suited Occupation’; or
        - the insured is unable to perform “any occupation for profit, wage or compensation”, called ‘Any Occupation’

- The conclusion of “Disabled” or not may differ for two persons who have sustained the same nature and extent of severity because of their different occupations. However, some common factors are involved to determine if the insured meets the requirement of disablement/ disability:
    - The ability to substantially perform the duties of the insured’s previous or a similar occupation or business and to perform such adequately for a substantial period of time.
    - Whether the new/substitute occupation or business is comparable to the previous one, in respect of the insured’s education, training, experience and mental & physical capacities, and also in terms of earnings.



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# Critical Illness - FAQ

**What are Critical Illness benefits?**

- There are different generations of Critical Illness contracts which vary in their coverage. Therefore, it is important to compare the different features and coverage offered by individual contracts.

- Critical Illness benefits are packaged with different product names in the market which may be offered in the following forms of benefit plans:
    - Accelerated Critical Illness benefit: It is a feature that allows the policyholder to receive a full or portion of the death benefit in advance if the insured is diagnosed with a critical illness. That is, an advance payment of the death benefit of the attached basic policy, provided that the insured is alive when he/she claims for the benefit.
    - Standalone Critical Illness benefit: It is a feature that provides coverage against specified critical illness. It pays a lump sum amount (not an advance payment of death benefit) upon the diagnosis of a covered critical illness without reducing the sum insured of the basic policy, provided that the insured is alive when he/she claims for the benefit.

- Early Critical Illness insurance product provides a limited or lump sum payment if the insured is diagnosed with early-stage critical illness. The claim payment is subject to a percentage of the sum insured which is based on the severity of the critical illness as defined in the benefit definition table

- Example: the early critical illness benefit may pay:
    1. 20% of the sum insured for the diagnosis of Carcinoma in Situ;
    2. 50% of the sum insured for Carcinoma in Situ of the Breast with Mastectomy; and
    3. 100% of the sum insured for Cancer.

- Tailor-made female critical illness product provides coverage for critical illness that is more prevalent with a woman. Apart from death and the usual critical illnesses, it covers illnesses such as:
    - Systemic Lupus Erythematosus (S.L.E.) With Lupus Nephritis Benefit
    - Carcinoma-in-situ of Breast or Cervix Uteri Benefit
    - Aplastic Anaemia Benefit
    - Congenital Anomalies Benefit
    - Complications of Pregnancy Benefit

- Multi-pay critical illness products provide multiple pay-outs if the insured suffers from more than one covered critical illnesses. The general features of this kind of policy includes:
    - Coverage continues after payment of the first critical illness claim
    - The Schedule of Living Benefit may be grouped under several categories and/or under different severity levels.
    - The contract wordings state the criteria/details of how a different and separate critical illness event will be payable such as the diagnosis dates, the remission periods and any specific provisions, etc.



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# Death Benefit - FAQ

**What is Death benefit?**

- Death benefits are the basic benefit in life insurance policies. A variety of policies that provide death benefit include whole life, endowment, term plans, etc. The product range also varies across insurance industry.

- Generally, the products are classified into 2 main types:
- Natural Death:
    - Payment of benefit upon proof of death, whether it is natural or accidental death.
    - Most of the plans (i.e. whole life, endowment and term) provide coverage for natural and accidental death
- Accidental Death
    - Payment of benefit only on death caused by accident
    - Accidental death benefit is available under Accidental Death policy, Accidental Death and Dismemberment policy and Personal Accident policy.

**How does a Death benefit operate?**

- In general, while the policy is inforce, the sum insured is payable upon death or accidental death of the insured.

- Other Death-related benefits payable:
    - The Payor Benefit (PB): is a benefit to waive the premium for the death of the Policyholder/Payor.
    - Terminal Illness Benefit: Some products may include a Terminal Illness Benefit payable upon being diagnosed of Terminal Illness. The amount payable could be an accelerated payment of Death Benefit, depending on the plan features.
    - Compassionate Death Benefit: A small amount death benefit, usually available under both accident and medical policies.

**What is proof of death?**

- In general, proof of death in life insurance claim requires the submission of death certificate the insured, which is issued by a local authority stating the date and cause of death, to confirm the death of the insured person.

- To claim the death benefits, the burden of proof is on the claimant to provide sufficient evidence (e.g. death certificate) whereas:-

- For accidental death claim, the following documents/information may be required:
    - Date, time and location of the accident;
    - Name(s) and address(es) of any other injured person(s) or witness(es);
    - A copy of police or accident report that describes the circumstances of the accident.

- For non-accidental death claim, the following documents/information may be required:
    - Medical records (including the name and address of the insured's usual attending doctor(s) and consultation history);
    - Name, address and qualification of the doctor/person certifying the death of the insured.
    - Certificate of burial/cremation is usually required to proof the insured's death as this services as a confirmation that the insured has indeed passed away, along with:-
        - Full name of the deceased, date of death, and the location of burial/cremation;
        - Name(s) and address(es) of witness(es) of the burial/cremation (if any)

- Does life insurance pay for death due to suicide within the first policy year?

- If the insured committed suicide within the first year of the issuance of his/her life insurance policy, most policies will pay out the death for suicide benefit just like any other cause of death.

- Paying suicidal death benefit is to follow the limited liability set forth in the Suicide Clause. Usually, the death benefit is the refund of premium, subject to the plan features.



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