Voluntary Health Insurance Scheme

Preamble

1. The Voluntary Health Insurance Scheme ("VHIS") is a policy initiative introduced by the Food and Health Bureau ("FHB") of the Government of the Hong Kong Special Administrative Region ("Government") concerning indemnity hospital insurance plans ("IHIP") offered to individuals, with voluntary participation by insurance companies and consumers.

2. VHIS seeks to offer consumers an additional choice, so that the VHIS-insured can choose to use private healthcare services when in need. The Scheme offers a Standard Plan with basic standardised features for the insured, including –

(a) guaranteed renewal rights, despite changes to the health conditions of the insured, up to the age of 100;

(b) no lifetime benefit limit;

(c) cover for Pre-existing Conditions not known at time of joining; and

(d) cover for day case procedures like endoscopy provided medically necessary, etc.

The Scheme also allows VHIS Providers to offer "Flexi Plans" with enhanced protection for the insured provided generally all protection under a Standard Plan is preserved.

3. The Scheme is administered by FHB. Insurance companies seeking to offer VHIS-compliant products must first register as a VHIS Provider; the Standard Plan, along with Flexi Plans if offered, must each be certified as VHIS-compliant Certified Plans before so marketed. Applications for registrations and certifications will start on **1 December 2018**.

4. The Scheme will be fully launched, i.e. offered to consumers, as from **1 April 2019**. Premium paid on Certified Plans on or after 1 April 2019 may be eligible for tax deductions.

Scheme Documents

5. VHIS Providers must comply with all the scheme rules set out below (collectively referred to as "Scheme Documents") –

(a) **Registration Rules for Insurance Companies under the Ambit of the VHIS** –

Insurance companies must be successfully registered with FHB as VHIS Providers before they are allowed to sell Certified Plans.

(b) **VHIS Certified Plan Policy Template** – The policy terms and benefits of all Certified Plans – whether as Standard or Flexi Plans, must be based on this template.

(c) **Product Compliance Rules under the Ambit of the VHIS** – All insurance plans must be certified by FHB according to these Rules before they can be marketed as Certified Plans.

(d) **Code of Practice for Insurance Companies under the Ambit of the VHIS** – VHIS Providers must comply with the required practices stated in this Code which covers, among others, product offering, migration, sales and marketing, cooling-off period, and underwriting.

6. The Scheme Documents are non-statutory in nature. They should not supplant or conflict with any applicable statutes, laws, rules, regulations, codes or guidelines.

7. FHB may review and amend/update the Scheme Documents on a need basis. FHB may also offer clarification or elaboration on certain parts of the Scheme Documents (say, in the form of Frequently Asked Questions). Such information will not form part of the Scheme Documents but will provide guidance on the interpretation and/or elaboration.

8. FHB reserves the final right to –

(a) interpret the Scheme Documents, including the right to determine the meaning of the rules in both English and Chinese versions and to resolve inconsistency, if any, between the two versions of the same Scheme Document; and

(b) grant exemption from compliance with part of the Scheme Documents under exceptional circumstances.

Any determination made by FHB is conclusive.

Enquiries

9. Enquiries about the VHIS may be addressed to the VHIS Office of FHB via vhis_enquiry@fhb.gov.hk.

Code of Practice
for Insurance Companies under the Ambit of the Voluntary Health Insurance Scheme

Food and Health Bureau

Version as at 20 March 2019

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1. Background

Objectives

1.1 This Code of Practice for Insurance Companies under the Ambit of the Voluntary Health Insurance Scheme ("Code") is intended to –

(a) set out the required conduct and practices to supplement the "VHIS Certified Plan Policy Template";

(b) enhance transparency and accessibility of the VHIS market segment so as to assist consumers to make proper comparison among the VHIS-compliant Plans certified by FHB ("Certified Plans") and exercise informed choices;

(c) ensure fair treatment to consumers;

(d) facilitate compliance with the minimum requirements of the VHIS; and

(e) facilitate claim for tax deduction for the qualifying premiums paid by Policy Holders of VHIS policies.

Principles

1.2 The above objectives are to be achieved having regard to –

(a) the policy objectives of the VHIS;

(b) the need to observe the principles of fair trade and fair competition; and

(c) the need to strike a reasonable balance among consumer protection, consumer choices, commercial viability and market flexibility.

Application

1.3 This Code applies to all insurance companies ("Company" or "Companies") registered with FHB as VHIS Providers that are allowed to sell Certified Plans.

1.4 In the event that a Company ceases to be registered as a VHIS Provider, it is still required to continue to renew the policies issued under the Certified Plans according to the relevant requirements as stated in Part 4 of the VHIS Certified Plan Policy Template. As far as these policies are concerned, the Company is bound to continue to comply with this Code.

Relevant regulations and guidelines

1.5 Where appropriate, this Code should be read in conjunction with any applicable statutes, laws, rules, regulations, codes or guidelines, including but not necessarily limited to –

(a) Laws of Hong Kong, e.g.

(i) Insurance Ordinance (Chapter 41);

(ii) Inland Revenue Ordinance (Chapter 112);

(iii) Personal Data (Privacy) Ordinance (Chapter 486);

(iv) Competition Ordinance (Chapter 619);

(v) Prevention of Bribery Ordinance (Chapter 201); and

(vi) Anti-Money Laundering and Counter-Terrorist Financing Ordinance (Chapter 615);

(b) Guidelines issued by the Insurance Authority ("IA"), e.g.

(i) Guideline on the Use of Internet for Insurance Activities (GL 8);

(ii) Guideline on the Corporate Governance of Authorised Insurers (GL 10);

(iii) Guideline on Underwriting Long Term Insurance Business (other than Class C Business) (GL 16); and

(iv) Guideline on Minimum Requirements for Insurance Brokers;

(c) Codes and Guidelines issued by the Hong Kong Federation of Insurers ("HKFI"), e.g.

(i) The Code of Conduct for Insurers;

(ii) The Code of Practice for the Administration of Insurance Agents;

(iii) Cooling-off Period; and

(iv) Direct Marketing, e.g. circular on "Recent convictions under the direct marketing regime" issued on 12 October 2015;

and

(d) Codes and Guidelines issued by the Office of the Privacy Commissioner for Personal Data, e.g.

(i) New Guidance on Direct Marketing.

1.6 Companies bound by this Code should continue to comply with the applicable statutes, laws, rules, regulations, codes or guidelines.

Role and responsibility of FHB

1.7 The Voluntary Health Insurance Scheme Office ("VHIS Office") of FHB is responsible for administering the VHIS and handling enquiries and complaints related to the compliance of the VHIS, enforcing VHIS-specific provisions under this Code and making referrals to other authorities or organisations including IA as necessary.

1.8 For greater transparency and accountability, FHB reserves the right to disclose in public and report to the Legislative Council updates as necessary on the implementation status of the VHIS and this Code.

Role of IA

1.9 In accordance with the Insurance Ordinance (Chapter 41), IA is responsible for regulating and supervising the insurance industry for the promotion of the general stability of the insurance industry and for the protection of existing and potential policy holders. One of its major functions is to promote and encourage the adoption of proper standards of conduct and prudent business practices by authorised insurance companies.

1.10 Complaints that may amount to suspected "misconduct" of insurance companies as defined under section 41P of the Insurance Ordinance (Chapter 41) may be referred to IA.

1.11 IA may also provide guidance to the insurance industry on businesses relating to individual IHIP (whether they are Certified Plans or otherwise).

2. Product availability for application

Principles

2.1 The Standard Plan should be widely available for application.

2.2 Availability of Flexi Plans should hinge on market initiatives. Proper flexibility should be allowed to promote product innovation, competition and choices.

Requirements

Availability of Certified Plans for new application

2.3 Companies are required to make available a Standard Plan duly certified by FHB for new application at all times when they are registered as a VHIS Provider.

2.4 Companies are allowed to offer Flexi Plans or not, and the number of Flexi Plan on offer is not restricted. After offering a certified Flexi Plan in the market, the Company concerned is allowed to cease receiving applications for such Flexi Plan at its discretion, but is required to continue to renew the policies issued under the Certified Plans according to the relevant requirements as stated in Part 4 of the VHIS Certified Plan Policy Template.

New application

2.5 Companies are required to consider applications for Certified Plans in relation to persons to be insured who are –

(a) Hong Kong residents[1]; and

(b) aged between 15 days and 80 years[2].

2.6 Companies are required to consider applications for Certified Plans that involve –

(a) more than one Policy Holder per policy; or

[1] Including holders of Hong Kong Identity Card, and children who are Hong Kong residents and under the age of 11.

[2] This requirement may be exempted for the Certified Plans of which the product design is targeted at particular age groups, such as people in younger ages.

(b) Policy Holder and Insured Person not being the same person,

unless a Company adopts Underwriting practices that do not accept (a) and/or (b) above. In such cases, the Company should explain the reason to the consumers, consistently apply the relevant practices, and ensure that the relevant information is readily accessible at least through their company websites.

2.7 Companies are not allowed to receive applications for Certified Plans that involve more than one Insured Person per Certified Plan coverage.

2.8 All applications for Certified Plans are subject to Underwriting. Companies are allowed to impose Premium Loading and/or Case-based Exclusion(s) when accepting an application, declining an application, or postponing handling of an application due to missing information.

Plans for renewal

2.9 For policy holders who have signed up for existing individual IHIP policies before the implementation of the VHIS[3], the Company concerned should offer them a Standard Plan or a Flexi Plan option for renewal (see Section 3 for details).

2.10 For Policy Holders who have signed up for the existing Standard Plan policies, the Company concerned should offer the Standard Plan for renewal, but is allowed to offer Flexi Plans as an additional option(s) for renewal.

2.11 For Policy Holders who have signed up for the existing Flexi Plan policies, the Company concerned should offer the Flexi Plan for renewal. The Company should also offer the Standard Plan as the fall-back renewal option if a Policy Holder refuses to accept the Flexi Plan offered for renewal.

2.12 Companies should ensure that the plans offered for renewal are duly certified on the date of policy renewal according to Part 4 of the VHIS Certified Plan Policy Template.

[3] Unless otherwise specified, existing individual IHIP policies in this document refer to those policies effective on or before 31 March 2019.

Offering of other insurance plans

2.13 Companies are allowed to offer other insurance plans to the applicants of Certified Plans. However, Companies are not allowed to require uptake of such other insurance plans as the prerequisite for accepting applications for Standard Plan. In other words, uptake of other insurance plans must be optional for the Standard Plan applicants.

2.14 The restriction in Section 2.13 does not apply to Flexi Plans.

2.15 Companies are not allowed to offer any insurance plan with product design contradictory with the VHIS objectives to the applicants of Certified Plans as the prerequisite for accepting application. A pertinent example is an insurance plan offering cash benefit payable only upon the use of public healthcare services in Hong Kong which contradicts with the VHIS objective to relieve the public healthcare system.

2.16 Where a consumer takes out both a Certified Plan and another insurance plan, the respective premiums charged and any discount provided should not be intended by the Company to contravene the relevant laws on tax deduction for Certified Plans particularly the definition of qualifying premiums (see Inland Revenue Ordinance (Chapter. 112) for details).

Plans targeting at particular age groups or client groups

2.17 Subject to FHB's approval, Companies are allowed to offer Flexi Plans that are targeted at particular age groups (e.g. people in younger ages) or client groups (e.g. members of the same association). Under these circumstances, the Companies concerned are allowed not to consider applications from people not fitting the definition of the targeted age groups or client groups. Nevertheless, the Companies concerned are required to renew the policies issued under the Certified Plans according to the relevant requirements as stated in Part 4 of the VHIS Certified Plan Policy Template, irrespective of whether the Policy Holders or Insured Persons continue to fit the definition of targeted age groups or client groups upon policy renewal.

2.18 If any forms of discounts, gifts or other privileges offered to the Policy Holders or Insured Persons will or may be withdrawn when the Policy Holders or

Insured Persons no longer fit the definition of targeted age groups or client groups upon policy renewal, Companies should make this known to the consumers during the selling process and upon enquiry.

3. Migration arrangement

Principles

3.1 Policy holders who have signed up for existing individual IHIP policies before the implementation of the VHIS ("existing IHIP policy holders" in short) will be entitled to a one-off Migration facilitation offered by the relevant Company concerned. Companies should commit to offering each such existing IHIP policy holder a VHIS-compliant product option as soon as possible after the Company has registered with the Government as a VHIS Provider. This commitment will be open for ten years since the full implementation of the VHIS on 1 Apr 2019.

3.2 The Migration arrangement(s) should be transparent and fair to the existing IHIP policy holders.

3.3 Companies are under no obligation to offer Migration facilitation to policy holders other than the existing IHIP policy holders, estimated to be around 2.3 million in numbers in 2016[4].

Requirements

3.4 Companies should provide the following Migration arrangements to their existing IHIP policy holders –

(a) Same plan with VHIS features incorporated, without Re-underwriting –

(i) Under this arrangement, existing IHIP policy holders will be offered the same plan with the incorporation of VHIS features for renewal, which may be a Standard Plan or a Flexi Plan. No Re-underwriting is allowed[5]. In other words, though the Standard Premium of the plan may be adjusted by the Company, no premium adjustment based on change in health condition of individual insured person is allowed. However, if an existing IHIP policy holder does not accept the Standard Plan or Flexi Plan so offered, his/her IHIP policy may be terminated;

[4] The corresponding number of insured persons is about 2 million in 2016, with the difference from 2.3 million being due to the fact that some people hold more than one policy.

[5] Except in cases where the existing policy provisions do not provide renewal guarantee.

(ii) Companies are required to offer all existing IHIP policy holders belonging to the same Portfolio[6] the same Certified Plan for renewal. This Migration principle of offering the same Certified Plan for a group on a Portfolio basis is designed to avoid unfair practices upon renewal;

(iii) If the plan offered is a Flexi Plan, Companies are required to allow the existing IHIP policy holders, who decline the offer, to renew their policies into the Standard Plan policies; and

(iv) The Waiting Period for Unknown Pre-existing Conditions under the policy terms and conditions of the plan after Migration is counted from the inception date of the existing IHIP policy;

and/or

(b) Different plan with VHIS features incorporated, subject to Re-underwriting –

(i) Under this arrangement, existing IHIP policy holders will be offered a different plan incorporating VHIS features, which may be a Standard Plan or a Flexi Plan. If existing IHIP policy holders opt to switch to the new Certified Plan, the existing IHIP policies will not be renewed. Re-underwriting is allowed which may be carried out for each policy or selected policies in the same Portfolio. However, if the Company wishes to carry out Re-underwriting for selected policies only, the criteria of selection for Re-underwriting should not be based on whether an insured person has made claims previously;

(ii) Companies are required to offer all existing IHIP policy holders belonging to the same Portfolio the same new Certified Plan. This Migration principle of offering same Certified Plan for a group on a Portfolio basis is designed to avoid unfair practices upon the switching to the new Certified Plan;

(iii) Companies are required to allow existing IHIP policy holders to opt to stay insured with the existing IHIP policies according to the existing policy provisions;

(iv) If the Company rejects an application after Re-underwriting or the existing IHIP policy holder concerned refuses to accept the application result and Underwriting decision, the Company is required to allow him/her to stay insured with the existing IHIP policies according to the existing policy provisions;

(v) The Waiting Period for Unknown Pre-existing Conditions under the policy terms and conditions of the plan after Migration is counted from the inception date of the new policy, or an earlier date offered by the Company; and

[6] See Annex B for the definition of Portfolio.

(vi) In any case, Companies are required to offer at least the Standard Plan for all existing IHIP policy holders.

3.5 There is no restriction on the number of designated Certified Plans to be offered to the same Portfolio.

3.6 The cooling-off period in this Code applies to the Migration arrangement in Section 3.4(b), whilst not mandatory for all policy renewals including the Migration arrangement in Section 3.4(a). Details about the cooling-off period are provided in Section 4.14 to Section 4.15 and **Annex A**.

3.7 Companies should make known to their existing IHIP policy holders of the availability of Migration arrangements and the associated Underwriting arrangement through at least one accessible means, such as company website, email notification or letter of notification.

3.8 Companies should provide easily accessible channels with trained staff to handle enquiry about Migration arrangements.

4. Sales and marketing

Principle

4.1 Companies should provide clear, accurate, non-misleading and easily accessible information of the VHIS and Certified Plans to consumers for them to make informed choices.

Requirements

Accuracy of information

4.2 Companies should ensure that all sales and marketing materials, including but not limited to contents on the company website, leaflets and other printed and online materials, are –

(a) accurate and in a non-misleading manner;

(b) in Chinese and English (except for social media and advertisement);

(c) in plain language; and

(d) provided with available access to complete information in case complete information cannot be readily available due to space constraints (e.g. printing of website address for full details of information on advertisement or leaflets).

4.3 Companies should ensure consumers, Policy Holders and Insured Persons can easily distinguish terms and benefits under Certified Plans from non-VHIS products across all sales and marketing materials.

Access to information

4.4 In the course of marketing Certified Plans, Companies and their sales representatives should exercise due diligence in explaining the key product and premium information of Certified Plans to consumers.

4.5 Companies should provide an easy access to essential information so that consumers can easily enquire about the information of the VHIS and the Certified Plans, e.g. –

(a) Companies' registration status as a VHIS Provider;

(b) Product and premium information of Certified Plans on offer;

(c) Underwriting factors, material facts and information of consumers for Underwriting purpose;

(d) Eligibility for tax deduction; and

(e) Complaint handling procedures.

Examples of easy access include company website, communications with sales representatives and service representatives, and enquiry telephone hotline.

Company participation in the VHIS

4.6 Upon successful registration as a VHIS Provider, Companies should disclose their registration status to consumers at least through their company websites.

4.7 Upon cessation of registration as a VHIS Provider, insurance companies should immediately disclose this change to consumers at least through their company websites.

Product information

4.8 Companies should make known to consumers an up-to-date list of Certified Plans available at least through the company website.

4.9 For each Certified Plan, Companies should disclose the following product information –

(a) Whether the plan is a Standard Plan or a Flexi Plan;

(b) The certification status with the certification number issued by FHB;

(c) The policy terms and conditions and the benefit schedule;

(d) The enhanced and exempted features vis-à-vis the Standard Plan in the case of a Flexi Plan;

(e) The restrictions on territorial scope of cover, Lifetime Limit, healthcare services providers and ward class, if any, in the case of a Flexi Plan; and

(f) The option about Deductible and Coinsurance, if any, in the case of a Flexi Plan.

Premium information

4.10 Companies should disclose the following premium information of each Certified Plan –

(a) Standard Premium Schedule (showing rates excluding levy collected by IA) by age, gender and other factors (e.g. smoking habit) at least through the Company's website;

(b) Definition of age (last birthday, next birthday or nearest birthday);

(c) How premium discount if any (e.g. no claim discount) operates in broad terms;

(d) Levy collected by IA (or link to the relevant webpage); and

(e) Other fees and charges (or link to the relevant webpage), if any.

4.11 If Companies will or may cease offering any forms of discounts, gifts or other privileges to the Policy Holders or the Insured Persons under certain circumstances (e.g. the circumstances related to the Flexi Plans targeted at particular age groups or client groups as stated in Section 2.18), Companies should explain the relevant arrangements to the consumers during the selling process and upon enquiry.

Disclosure obligation for Underwriting

4.12 Companies should inform applicants of their obligation to disclose personal information and material facts for Underwriting, and the possible consequences of material non-disclosure, misrepresentation and fraud.

4.13 Where Companies stipulate in the VHIS Certified Plan Policy Template that the Companies may withhold part of premium refund for reasonable administration charges, the Companies should explain the relevant practices and calculation to the applicants upfront.

Cooling-off arrangements

4.14 Companies should inform applicants that under the Standardised Policy Terms and Conditions, the Policy Holder has the right of cancelling the policy with full refund of paid premium during the cooling-off period. The cooling-off period gives VHIS Policy Holders a chance to re-think within a reasonable period of time their decision to purchase a Certified Plan, and obtain a full refund of premium paid if no benefit

payment has been made, is to be made or impending. The cooling-off period is applicable to all Certified Plans[7].

4.15 The cooling-off period lasts for 21 days (or a longer period offered by Companies) after the delivery of policy or the issuance of notice to the Policy Holder or the Policy Holder's representative stating that the policy is available and when the cooling-off period would expire, whichever is the earlier.

Period of cover

4.16 Subject to request from the applicant and acceptance by the Company, the first Policy Year may last for less than 12 months. In such event, the Company concerned should explain the following to the consumers during the selling process and upon enquiry accordingly –

(a) That the benefit limits and cost-sharing requirements of the shortened first Policy Year should not be affected, including –

(i) the benefit coverage, benefit amount and benefit limits as shown in the Benefit Schedule;

(ii) Coinsurance; and

(iii) Deductible;

(b) That the Waiting Period for Unknown Pre-existing Conditions should not be affected (i.e. the Insured Person can enjoy 25% reimbursement for unknown Pre-existing Conditions upon renewal after the first Policy Year which is less than 12 months); and

(c) Whether the calculation of discounts (e.g. no claim discount) will be affected, if any.

Territorial scope of cover

4.17 Companies should explain the following to the consumers during the selling process and upon enquiry –

(a) All benefits described in the Standard Plan are applicable worldwide except for psychiatric treatment; and

(b) For Flexi Plans with restrictions on territorial scope of cover,

(i) the definition of regions with restrictions and the benefit adjustment rules; and

[7] Except those offered for renewal, including renewal under the Migration arrangement.

(ii) the reduction must not apply to the Basic Benefits of the Flexi Plans, i.e. the coverage equivalent to the Standard Plan[8].

Choice of healthcare services provider

4.18 Companies should explain the following to the consumers during the selling process and upon enquiry –

(a) All benefits described in the Standard Plan are not subject to any restriction in the choice of healthcare services providers; and

(b) For Flexi Plans with restrictions in the choice of healthcare services providers,

(i) the list of selected healthcare services providers; and

(ii) the restrictions must not apply to the Basic Benefits of the Flexi Plans, i.e. the coverage equivalent to the Standard Plan[9].

Choice of ward class

4.19 Companies should explain the following to the consumers during the selling process and upon enquiry –

(a) All benefits described in the Standard Plan are not subject to any restriction in the choice of ward class; and

(b) For Flexi Plans with restrictions in the choice of ward class,

(i) the targeted ward class, and the details of benefit adjustment upon voluntary choice of higher ward classes;

(ii) the Company will guarantee that the benefit adjustment in (i) does not apply in the event of involuntary ward upgrade; and

(iii) the Company will guarantee that in the event of voluntary ward upgrade, the adjustment must not apply to the Basic Benefits of the Flexi Plans, i.e. the coverage equivalent to the Standard Plan[10].

[8] See Section 1(a), Part 6 of the VHIS Certified Plan Policy Template for details.

[9] See Section 1(c), Part 6 of the VHIS Certified Plan Policy Template for details.

[10] See Section 1(d), Part 6 of the VHIS Certified Plan Policy Template for details.

Deductible and other Coinsurance

4.20 Companies should explain the following to the consumers during the selling process and upon enquiry –

(a) The Coinsurance arrangement of Prescribed Diagnostic Imaging Tests under Standard Plan; and

(b) The Coinsurance and Deductible arrangements approved by FHB for eligible Flexi Plans, if any.

Eligibility for tax deduction

4.21 Subject to the rules on tax deduction to be promulgated by the Government, Companies should inform the consumers of eligibility of the Certified Plans for claiming tax deduction in the selling process and upon enquiry.

5. Application, underwriting and issuance of policies

Principles

5.1 Companies should inform or make known to the applicants of their rights and obligations in the applications and disclosure of personal information in accordance with the VHIS Certified Plan Policy Template, and the reasons for the Underwriting decision and application result.

5.2 The Underwriting process and practice that Companies adopt should be fair, objective, and consistently applied when assessing prospective Insured Persons with similar risk.

Requirements

Collection and use of information in the application documents

5.3 In designing the Underwriting questions for any application documents (including the application form, questionnaires, evidence of insurability, any documents or information submitted in relation to such applications), Companies should ensure that –

(a) the type and amount of personal information obtained from applicants for the Insured Person are relevant and sufficient for application processing and Underwriting;

(b) the application form is clear and succinct such that it can be easily understood by an average applicant (e.g. use of plain and jargon-free language, legible fine prints);

(c) the questions are specific, relevant and easy to respond to such that all material facts essential to Underwriting can be effectively collected (e.g. how questions should be answered are explained with illustrations);

(d) the inquired facts are within a well-defined period, including the period after the time of submission of applications and before the Policy Issuance Date or the Policy Effective Date (whichever is the earlier);

(e) the inquired medical history is well defined with respect to hospital admission, diagnoses, or signs and symptoms etc.;

(f) important information is prominently displayed and highlighted as appropriate to draw the attention of applicants (e.g. disclosure of health conditions to the best knowledge of the applicant, and possible consequences of non-disclosure); and

(g) sufficient time should be given for applicants to provide information which is not immediately available.

Disclosure of cooling-off rights on application form

5.4 Companies should announce cooling-off rights on the application form by prominently displaying a statement (see **Annex A**) immediately above the space for signature and where applicable clearly explained to applicants by insurance intermediaries.

5.5 The size of printing for the above-mentioned statement should be in bold type no smaller than the main font type used on the application form and the print size used for other declarations on the form. Furthermore, the font size should not be smaller than eight.

5.6 The statement should be communicated in the same language(s) as are used for all other sections of the application form.

Due process in underwriting

5.7 Upon the receipt of personal information of the Insured Person at the time of submission of applications that is material to Underwriting, Companies should assess the risks according to its Underwriting practice which should be fair, objective and consistently applied to assess applicants with similar risk.

5.8 Companies should make known to the applicants the health and non-health factors in general terms that may affect its Underwriting decision. Where the Underwriting involves risk assessment associated with occupation grouping and Place(s) of Residence, Companies should make known to the applicants the classification involved and implications to the Underwriting decision, including the rate of Premium Loading if applicable.

5.9 Where the Underwriting decision involves imposition of Case-based Exclusion(s), Companies should ensure that the scope of exclusion is clearly defined and specific to the underwritten information. Companies should apply Case-based Exclusion(s) on a particular health condition instead of the whole body part or signs and symptoms where possible.

5.10 Companies are allowed not to disclose information about their Underwriting practices that are proprietary and sensitive.

Notification and explanation of application results

5.11 Companies should inform applicants of the application results within a reasonable time upon the completion of Underwriting. In the event that additional time is required for handling applications, Companies should notify applicants the delay of application results and, where necessary, the additional information required for processing the application.

5.12 Companies should explain to applicants the application results based on the Underwriting decisions and, upon applicants' request, provide written notice for such explanation. In the event that the reported health conditions lead to Premium Loading and/or Case-based Exclusion(s) or decline of application, Companies should notify applicants –

(a) The rationale of applying Premium Loading and/or Case-based Exclusion(s), or decline of application;

(b) Details of the Premium Loading and/or Case-based Exclusion(s) being applied (e.g. amount of loading attributable to different factors, health conditions resulting in such exclusion, extent of health condition/body part being excluded, possible complications that may be excluded from coverage, and whether exclusion is temporary or permanent); and

(c) Risk class information and the applicable Premium Loading for risk factors such as smoking habit, occupation or Place(s) of Residence where they are considered at the time of Underwriting.

5.13 Companies should provide easily accessible channels with trained staff for enquiry about and appeal against the application results or Underwriting decisions.

Issuance of policies and notification of cooling-off rights

5.14 Companies should ensure the policies are delivered to the Policy Holders within a reasonable period of time upon the acceptance of applications with first premium received.

5.15 Companies should ensure the cooling-off rights of Policy Holders of Certified Plans are highlighted when the policies are delivered.

5.16 Details of cooling-off period are provided in Section 4.14 to Section 4.15 and **Annex A**.

6. After-sales services

Principle

6.1 Companies should provide effective after-sales services to assist their Policy Holders to understand their rights under the Certified Plans, and handle complaints unique to Certified Plans.

Budget certainty and claimable amount estimate

6.2 Upon receipt from Policy Holders the estimated charges provided for non-emergency surgical procedures to be performed[11], Companies should provide to the Policy Holders upfront claimable amount estimates for the whole course of surgical procedures with reference to the insurance coverage.

6.3 Companies should inform Policy Holders that the claimable amount estimates remain estimates and do not constitute a liability. Claim decision will depend on the submission of all supporting documents as required for claim assessment in accordance with the policy terms and conditions and benefit entitlement in the Policy Year. The final claimable amounts and out-of-pocket expenses will be subject to the actual bill amounts and breakdowns as stated in the invoices or receipts issued by healthcare services providers.

6.4 If there is an option of higher benefits upon the use of selected healthcare services providers, Companies should inform the Policy Holders when providing the claimable amount estimate that the claimable amount may be subject to change if the Policy Holders use other healthcare services providers.

6.5 If the claimable amount estimate is subject to benefit reduction or limitation in relation to the regions where the eligible medical services are incurred, the choice of healthcare services provider or the choice of higher ward class, Companies should inform the Policy Holders of the impact when providing the claimable amount estimate.

[11] According to the Private Healthcare Facilities Ordinance, the licensee of a private hospital must put in place a budget estimate system to provide estimates of the fees and charges of the hospital for prescribed treatments and procedures.

Change of Policy Holder

6.6 Pursuant to the Standardised Policy Terms and Conditions, Companies should consider the request from Policy Holders for application of transfer of ownership at the time of policy renewal without any administration charge on the Policy Holder or transferee.

6.7 Companies should not refuse any application by the Policy Holders for the transfer of ownership to –

(a) the Insured Person if he has reached the age of 18 years;

(b) the parent or guardian of the Insured Person if he is under the age of 18 years; or

(c) any person whose familial relationship with the Insured Person is accepted by the Company according to its prevailing Underwriting practices.

6.8 As the right of Policy Holders under Section 6.7(c) depends on the Underwriting practices of individual Companies, Companies should make known to the Policy Holders about their practices and ensure that the relevant information is readily accessible by Policy Holders at least through their company websites.

6.9 Upon the change of Policy Holder, Companies should as soon as possible issue the new Policy Schedule or Supplement(s) to the new Policy Holder.

Facilitating claim for tax deduction

6.10 Companies should provide proof of premium payment to assist Policy Holders to claim tax deduction for the qualifying premiums of Certified Plans. The proof must show clearly the information required by the Inland Revenue Department for claiming tax deduction, including –

(a) the marketing name and certification number of the Certified Plan;

(b) the policy number;

(c) the names of the Policy Holder and the Insured Person;

(d) the amount of premium net of discount paid for each Insured Person of the Certified Plan;

(e) the benefit coverage period that the premium covers; and

(f) the premium payment date (i.e. the date when the premium is collected by the Company).

6.11 The proof of premium payment may be in the form of premium receipt or annual premium statement[12]. In any case, the proof has to be issued to the Policy Holders on or before end of April every year for the premium paid during the preceding 12 months ending March of the same year.

6.12 In the event of premium refund, Companies should provide within four weeks after making refund the relevant proof to the Policy Holders concerned. The proof should show clearly –

(a) the marketing name and certification number of the Certified Plan;

(b) the policy number;

(c) the names of the Policy Holder and the Insured Person;

(d) the amount of premium refunded;

(e) the benefit coverage period that the refunded premium covers;

(f) the date of refund; and

(g) the breakdown showing the date and amount of the premiums paid in respect of which the refund is made[13].

6.13 The required practices stated in Section 6.10 to Section 6.12 are subject to revision upon the advice from the Inland Revenue Department.

Handling of enquiries and complaints about the VHIS

6.14 Companies should have in place internal procedures and provide easily accessible channels with trained staff to handle enquiries and complaints about the VHIS and Certified Plans.

6.15 Companies should make known to Policy Holders the availability of the following channels for making enquiries and lodging complaints at least through their company website –

(a) VHIS Office of FHB – for issues specific to the VHIS including product availability, features of Certified Plans and compliance with this Code;

[12] Companies should provide an annual premium statement showing all premium payment and refund records for the year of tax assessment ending March to the Policy Holders on request, despite the issue of premium receipt for each payment.

[13] In the event of premium refund, Companies should remind the Policy Holder to notify the Commissioner of Inland Revenue of such refund within three months from the date of refund if the Policy Holder has claimed tax deduction of the refunded premium.

(b) IA – for issues concerning the general conduct of insurance companies and intermediaries; and

(c) Inland Revenue Department – for issues concerning claims for tax deduction.

6.16 Companies should also make known to their Policy Holders the availability of alternative dispute resolution means, including but not limited to mediation and adjudication through the Insurance Complaints Bureau, and other means of mediation and arbitration as mutually agreed between Policy Holders and Companies, before a dispute is referred to a Hong Kong court.

Annex A - Details of disclosure of cooling-off rights and cooling-off period

1. The statement on the application form is as follows –

Cancellation Rights and Refund of Premium(s)

I understand that I have the right to cancel and obtain a refund of any premium(s) paid (less any market value adjustments, if any) and any levy by giving written notice. Such notice must be signed by me and received directly by [Insurer name] at [Address of the Company's Hong Kong Main Office] within [21 days, or longer if offered by the Company] after the delivery of the policy or issuance of a notice to the Policy Holder or the Policy Holder's representative, whichever is the earlier.

2. Details of cooling-off period are as follows –

(a) the cooling-off period is 21 days [or longer if offered by the Company] after the delivery of the policy or issuance of a notice to the Policy Holder or the Policy Holder's representative, whichever is the earlier;

(b) the notice should inform the Policy Holder of the availability of the policy and the expiry date of the cooling-off period. The notice should remind the Policy Holder that he has the right to re-think his/her decision to purchase the Certified Plan and to obtain a refund of premium paid if the policy is cancelled within the cooling-off period. The notice should also remind the Policy Holder to contact the Customer Service Department of the Company directly [service hotline number should be provided] if he does not receive the policy contract within nine days from the issuance date of the notice;

(c) the Companies should keep a copy of the notice or acknowledgement of receipt of policy delivery. In case of a reasonable complaint or dispute, the Companies will be required to produce evidence to show that the policy notice or policy has been delivered; and

(d) the Companies are advised to –

  (i) specify in their intermediaries' training materials and internal guidelines that insurance intermediaries must –

  - inform prospective Policy Holders of their cooling-off rights and the expiry date of the cooling-off period when Policy Holders sign their policy application forms; and
  - make all reasonable endeavour to deliver policies to the Policy Holders

within a period of time consistent with (b) above and (d)(ii) below after the policies are issued if they are vested with the obligation to deliver policies on behalf of the Companies;

(ii) devise internal control measures which will ensure and prove that –

- policies are delivered no later than nine days after the policy issuance date; or
- a notice to inform Policy Holders of the availability of the policies and the expiry date of the cooling-off period is issued no later than nine days from the policy issuance date; and

(iii) maintain records in respect of complaints or disputes for cases where Policy Holders seek refunds outside the period defined in (a) above but are refused by the Companies and to provide these records to FHB upon request.

3. The following statement must be included in a letter from Companies mailed direct to the Policy Holders, or a statement on the policy jacket or policy cover (either printed or by way of label) to remind the Policy Holders of their cooling-off rights at time of issuing policy –

Your Right to Change Your Mind

If you are not fully satisfied with this policy, you have the right to change your mind.

We trust that this policy will satisfy your financial needs. However, if you are not completely satisfied then you should –

- return the policy; and
- attach a letter, signed by you, requesting cancellation.

The policy will then be cancelled and the premium(s) paid (subject to market value adjustment, if any) and levy will be refunded.

These cancellation rights have the following conditions –

- your request to cancel must be signed by you and received directly by our [Address of the Company's Hong Kong Main Office] within [21 days, or longer if offered by the Company] after the delivery of the policy or issuance of a notice to the Policy Holder or the Policy Holder's representative, whichever is the earlier; and

- no refund can be made if a claim payment has been made.

Should you have any further queries you may contact [a responsible staff of the Company] and we will be happy to explain your cancellation rights further.

4. The size of the printing for the above statement should not be smaller than ten.

5. The statement should be communicated in the same language(s) as are used for all other communication at the time of policy issuance.

Annex B - Glossary

1. Case-based Exclusion(s)

The exclusion of a particular sickness or disease from the coverage of Certified Plan that may be applied by the Company based on a Pre-existing Condition or factors affecting the insurability of the Insured Person.

2. Certified Plans

Individual IHIP certified by FHB as VHIS-compliant, including the Standard Plan and Flexi Plans.

3. Coinsurance

A percentage of eligible expenses the Policy Holder must contribute after paying the Deductible (if any) in a Policy Year. For the avoidance of doubt, Coinsurance does not refer to any amount that the Policy Holder is required to pay if the actual expenses exceed the benefit limits of the Certified Plan.

4. Deductible

A fixed amount of eligible expenses that, in a Policy Year, the Policy Holder must pay before the Company shall reimburse the remaining eligible expenses.

5. Flexi Plan

Any individual IHIP under the VHIS framework with enhancement(s) to any or all of the protections or terms and benefits that the Standard Plan provides to the Policy Holder and the Insured Person, subject to the certification by FHB. Such plan shall not contain terms and benefits which are less favourable than those in the Standard Plan, save for the exception as may be approved by FHB from time to time.

6. Government

The Hong Kong Special Administrative Region Government.

7. Indemnity Hospital Insurance Plan

An insurance plan with classification of contract of insurance which –

(a) falls within Class 2 (sickness) of Part 3 of Schedule 1 to the Insurance Ordinance (Chapter 41) (or simply Class 2(sickness)), which provides for benefits in the nature

of indemnity against risk of loss to the Insured Person attributable to sickness or infirmity; or

(b) combines long term business and additional business of the nature in relation to Class 2 (sickness) following paragraph 3 of Part 1 of Schedule 1 to the Insurance Ordinance (Chapter 41), for example by writing an insurance policy with both life and medical coverage or writing a medical rider attached to and forming part of a life insurance policy.

8. Insured Person

Any person whose risks are covered by the Certified Plan, and named as the "Insured Person" in the Policy Schedule.

9. Migration

The process for existing individual IHIP policy holders and insured persons to transfer their plans to Certified Plans voluntarily.

10. Place(s) of Residence

The jurisdiction(s) in which a person legally has the right of abode. A change in the Place(s) of Residence refers to the situation where a person has been granted the right of abode of additional jurisdiction(s), or has ceased to have the right of abode of existing jurisdiction(s). For the avoidance of doubt, a jurisdiction in which a person legally has the right or permission of access only but without the right of abode, such as for the purpose of study, work or vacation, will not be treated as a Place of Residence.

11. Policy Effective Date

The commencement date of the part of policy issued under the Certified Plan which is specified as "Policy Effective Date" in the Policy Schedule.

12. Policy Holder

The person who is a legal holder of the Certified Plan policy and is named as the "Policy Holder" in the Policy Schedule.

13. Policy Issuance Date

The date of first issuance of the Certified Plan.

14. Policy Schedule

A schedule which sets out, among others, the Policy Effective Date, renewal date, the name and the relevant particulars of the Policy Holder and the Insured Person, the eligible benefits, premium and other relevant details.

15. Policy Year

The period of time the Certified Plan is in force. The first Policy Year shall be the period from the Policy Effective Date to the day immediately preceding the first renewal date as specified in the Policy Schedule (both days inclusive) within one year period; and each subsequent Policy Year shall be the one year period from each renewal date.

16. Portfolio

All policies of the same terms and conditions and benefit schedule. As an illustrative example, if an existing IHIP has three levels of coverage, namely "General ward", "Semi-private" and "Private", and each with an optional supplementary major medical ("SMM") rider, there will be six Portfolios as shown below –

(a) Portfolio one – "General ward";

(b) Portfolio two – "Semi-private";

(c) Portfolio three – "Private";

(d) Portfolio four – "General ward + SMM";

(e) Portfolio five – "Semi-private + SMM"; and

(f) Portfolio six – "Private + SMM".

17. Pre-existing Condition

Any sickness, disease, injury, physical, mental or medical condition or physiological degradation, including congenital condition, that has existed prior to the Policy Issuance Date or the Policy Effective Date in respect of the Insured Person, whichever is the earlier. An ordinary prudent person should be reasonably aware of a Pre-existing Condition, where –

(a) it has been diagnosed;

(b) it has manifested clear and distinct signs or symptoms; or

(c) medical advice or treatment has been sought, recommended or received.

18. Premium Loading

Additional premium on top of the Standard Premium charged by the Company to the Policy Holder according to the additional risk assessed for the Insured Person.

The level of Premium Loading is correlated to the risk class determined through Underwriting. One common form of Premium Loading is in a percentage of the Standard Premium.

19. Standard Plan

The insurance plan with terms and benefits equivalent to the minimum compliant product requirements of the VHIS, which are from time to time published and subject to regular review by the Government.

20. Standardised Policy Terms and Conditions for Certified Plans

The terms and conditions that apply to the Standard Plan and the part of Flexi Plans tantamount to the Standard Plan.

21. Standard Premium

The basic premium for the coverage under an insurance plan charged by the Company to the Policy Holder on an overall Portfolio basis, which may be adjusted in accordance with the age, gender and/or lifestyle factors of the Insured Person.

Standard Premiums also vary from one product to another and from one Company to another, depending on the cost factors and pricing strategy.

22. Underwriting / Re-underwriting

In the context of health insurance, the process by which a Company evaluates the risk of an Insured Person. The Underwriting result helps the Company decide whether to accept the application, and whether to introduce Premium Loading and/or Case-based Exclusion(s) in the insurance policy to manage risk.

Re-underwriting refers to the re-evaluation by a Company of the risk of an individual after he is insured with a policy.

23. Waiting Period for Unknown Pre-existing Conditions

A period after issuance of a VHIS policy during which the Policy Holder is not eligible for, partially or fully, benefit coverage of Pre-existing Conditions that the Policy Holder is not aware of and will not reasonably have been aware of. For the Standard Plan, the waiting period is set at three Policy Years, with reimbursement ratio at 0%, 25% and 50% for the first three Policy Years respectively. A shorter waiting period or higher reimbursement ratio is encouraged for Flexi Plans.