GOOD INSURANCE PRACTICE AND GENERAL PRINCIPLES OF INSURANCE BUSINESS

Insurance law and good insurance practice set various requirements to insurance companies. These guidelines offer an overview of how insurers can meet the requirements of insurance law and good insurance practice when granting consumers voluntary insurance policies, terminating them and settling compensation claims. They also seek to promote the use of mutually agreed and ethically sustainable principles and practices in insurance investigation. Unlike the principles of risk selection and claims handling (Section 1–2), the insurance investigation guidelines (Section 3) apply to both voluntary and statutory insurance.

These guidelines serve as recommended practices. They bring together and update three previous guidelines: the claims handling principles issued by the Federation of Finnish Insurance Companies in 1998, the general principles of selection of risk in insurance issued by the Federation of Finnish Insurance Companies in 2002, and the good practice guidelines for insurance investigation issued by the Federation of Finnish Financial Services in 2014. The updates acknowledge legislative changes and the code of practice in dispute resolution issued by the Finnish Financial Ombudsman Bureau (FINE) and the Insurance Complaints Board in 2017.

FINANCE FINLAND

5 April 2019

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General principles of risk selection in insurance

1 General principles of risk selection in insurance

Each insurer draws up its principles of risk selection to best reflect the company's business operations and mission. The risk selection principles determine what risks the company is willing to insure and on what terms. As the principles are company-specific, they differ between companies, just as insurance policies do. Whatever the principles, insurers must always offer factual cover if they claim in their marketing that an insurance policy includes one or more compensable insured events.

Together with its customer, the insurer must determine the customer's needs for insurance cover professionally, carefully and expertly. The insurer's objective is to make an insurance contract that meets the customer's needs. This is not always possible. If this is the case, the insurer can decline to make a contract for a reason related either to the insured risk or the customer.

In their risk selection principles, insurance companies must follow these general principles:

- No group of people may be placed in an unequal or inferior position due to their gender, race, ethnicity, religion, conviction, disability, age or sexual orientation. There are, however, acceptable reasons for treating different groups of people in a different manner.
- In personal insurance, the insured risk is largely determined by the insured person's age and health. For this reason, the policyholder's age and state of health affect both the extent of the insurance cover and the insurance premium. This means that insurance companies can charge a higher premium, include exclusion clauses or choose not to grant an insurance policy based on the customer's age and health.
- In insurers' risk selection principles, the following usually also have an effect on granting and pricing an insurance policy: the person's place of domicile, the extent of the insurance cover, the sum insured, the insured object and its purpose and location, the number of insurance policies held and the number of insured events occurred.

1.1 Insurer's right to reject an insurance application for a reason related to the customer

Insurance is essentially a contract based on trust. The insurer can therefore reject an insurance application for a reason related to the customer if the insurer believes that the prerequisites for a trust-based contract are lacking or that the risk related to the customer is too great. When making insurance contracts, insurers must also consider their responsibility in preventing insurance crime and money laundering.

Legitimate reasons for refusing to make an insurance offer or rejecting an insurance application include the following:

- The customer is in the insurance companies' mutual fraudulent claims register for having conducted insurance fraud or for having been reported to the police for suspected fraud.
- The insurer has legitimate reason to believe that the customer is operating on behalf of a person with whom the insurer will not make a contract.
- The customer has uncontested debt with the insurer or with another company belonging to the same group or financial consortium as the insurer.

- The customer has behaved in a threatening or otherwise disturbing manner in relation to the insurer's representative.
- The customer has neglected the obligations laid down in the insurance contract and the Insurance Contracts Act, for example by clearly neglecting to comply with the insurance policy's key precautionary guidelines or by giving the insurer incorrect information when making the contract.
- The customer has not provided the insurer with sufficient information about the insured object, the customer's health, or the origin of the funds invested in the insurance policy.
- In claiming compensation, the customer has given the insurer incorrect, incomplete or conflicting information that is relevant to determining the insurer's responsibility.
- The customer refuses to give the insurer the necessary authorisation to acquire information about the customer's state of health.
- The customer has repeatedly failed to pay insurance premium.
- The customer's health.

Insurers have the right to access the customer's credit information when considering whether to grant an insurance policy. This right is granted because the Insurance Contracts Act states that insurers can make the payment of insurance premium a prerequisite for the commencement of the cover only for a particular reason. As such, having a payment default in the credit information register is not an impediment to receiving insurance coverage, but it may lead to the insurer invoking a cash payment clause. This means that the insurer's responsibility only commences after the customer has paid the insurance premium.

Insurers can, however, refuse to make an insurance contract due to payment defaults if it can be objectively stated that the customer will neglect premium payments in the future. Such assessments must be made on a case-by-case basis based on the customer's payment default history. The assessment must consider, for example, the quality, number and claimants of the outstanding payments and payment defaults. In such cases, insurers aim to refer the insurance application to a customer service unit where a staff member can go over the conditions on which the insurance policy can be granted together with the customer.

1.2 Terminating an insurance policy

1.2.1 Termination during the insurance period

The insurer is only entitled to terminate an insurance policy during the insurance period if the policyholder fails to pay the insurance premium or if there is another reason determined in the Insurance Contracts Act. For example, the insurer can terminate the policy if either the policyholder or the insured has given incorrect or incomplete information when making the insurance contract or wilfully caused the occurrence of an insured event. However, the insurer cannot terminate an insurance policy during the insurance period if the insurer is entitled to recover the premium through execution, without any court judgement or decision.

The insurer can only terminate a life insurance policy if the policyholder or the insured has given incorrect or incomplete information in the health declaration or failed to pay the premium.

A life insurance policy terminated on grounds of failed premium payments can, however, be reinstated if the policyholder pays the premium within six months of the termination.

1.2.2 Termination of an automatically renewed policy at the close of the insurance period

The insurer is entitled to terminate an automatically renewed non-life insurance policy at the close of any insurance period. In an automatically renewed non-life insurance policy, the contract is automatically renewed after the close of an insurance period (usually one year), unless the contract is terminated by either the insurer or the policyholder. As in granting an insurance policy, also in terminating an insurance policy the insurer has the right to refuse to continue the contract based on a reason related to the insured risk on the basis of its principles of risk selection. For example, the insurer can terminate an automatically renewed non-life insurance policy due to the policyholder's unusual pattern of risk, if it deems the risk too high to be insured.

Of personal insurance policies, accident insurance, health insurance and automatically renewed traveller's insurance can also be terminated at the close of the insurance period, but not on the grounds that the health of the insured has deteriorated or that an insured event has occurred.

Whenever the insurer terminates an insurance policy, it must have a relevant reason.

Sometimes the termination can concern all the policyholders of a certain class of insurance. Examples of such rare cases include the following:

- The insurer wishes to remove an unprofitable insurance policy from its product range. However, the primary method of increasing the profitability of a loss-making policy should be raising the insurance premium or changing the policy conditions if this is permitted by the Insurance Contracts Act.
- The insurer wishes to make major amendments to the terms and conditions of an insurance policy that affect the main content of the insurance policy or remove a benefit that has had a prominent position in the policy's marketing efforts. In such cases, the Insurance Contracts Act requires that the policies must be terminated.

The grounds of termination can also be a reason related to an individual customer that makes it impossible to continue a trust-based contract. Such customer-related reasons to terminate a policy at the close of an insurance period are the same as the above-mentioned examples of the insurer's right to refuse the renewal of a contract.

1.3 Notifying of decisions

The insurer must handle insurance applications, inquiries and requests for change speedily. If the insurer rejects an insurance application or terminates an insurance policy, it must inform the customer of the reason. If so required by the Insurance Contracts Act, the insurer's decision must also include instructions for appeal.

Claims handling principles

2 Claims handling principles

2.1 General principles

For claims handling to be successful, it is vital that insurers ensure that their customers know the rights and responsibilities of both parties – the insurer and the policyholder – and provide correct information both before taking out an insurance policy and during the insurance period. In particular, it is essential that the policyholder knows the following:

- When and on what grounds the insurance policy will come into force and remain valid.
- What the policy covers and what are its major exclusions.

The objective of claims handling is to offer policyholders the compensation that they are entitled to according to the law and their insurance contract. Policyholders must be offered all compensations that they are entitled to, even if they did not know to apply for them. All customers must be treated justly, equally and fairly.

The insurer must treat information provided by the customer confidentially and in accordance with secrecy requirements.

Claims handling builds on the premise that claimants provide correct and complete information. If, however, the insurer finds that the claimant has acted in bad faith, it is the insurer's responsibility to prevent fraud and attempted abuse. The insurer can reduce or reject insurance compensation due to fraud. The insurer can also report any criminal activity to the police.

2.2 Claiming compensation

After an insured event has occurred, the insurer provides the policyholder information about the insurance cover and the compensation claim process. The insurer instructs policyholders so that they know what information and which documents they must provide to the insurer for claims handling. The insurer also ensures that the policyholder is aware that the claim will expire if the policyholder does not present the compensation claim or damage report to the insurer within the time prescribed in the Insurance Contracts Act. The insurer also seeks to discuss the facts of the insured event together with the policyholder so that it can acquire enough information to determine whether the damage will be compensated and in what amount, and whether further clarification will be needed when the policyholder claims compensation. This ensures that the compensation decision can be made without delay.

Claimants may receive compensation for a single insured event from various insurance policies. For this reason, the insurer and claimant must work together to find out which policies cover the event. If necessary, the insurer should also instruct the claimant to claim compensation from other insurers as well.

If the claimant can claim compensation from either their own property insurance policy or from the damaging party's general liability insurance, the insurer must explain the key differences between the grounds for compensation in property insurance and liability insurance and instruct the claimant on how to claim compensation. The claimant then

decides whether to claim compensation from their own property insurance or from the party that caused the damage or loss.

When inspecting the damage or otherwise, the insurer must ensure that the claimant understands the insurer's role in the situation. For example, the insurer must inform the claimant about who commissions the repairs and other work done under the insurance compensation – the claimant or the insurer – and who is thus responsible for overseeing the work.

The claimant may submit the compensation claim to any of the insurer's offices or to any of the insurer's representatives.

2.3 Claims handling

When the insurer receives a compensation claim from a customer, it must begin handling the claim without delay for all insurance policies that entitle the claimant to compensation for the insured event. If possible, the insurer should make requests for any further clarification at one go. If the insurer does request further clarification, it must also inform the claimant that its decision depends on the documents requested. The insurer must independently acquire any further clarification that it has better access to.

The insurer can give the compensation decision in writing, over the phone or electronically. If a claim is rejected, the insurer must give the rejection in a permanent form if requested.

The insurer must pay the compensation due under an insurance contract on account of the occurrence of an insured event or notify the claimant that no compensation is paid, without delay and not later than one month from the receipt of the documents and information requested. If the amount of compensation is not undisputed, the insurer must pay the undisputed part of the compensation within the above-mentioned period. The compensation decision must inform the claimant that receiving the undisputed part in no way affects their right to receive possible additional compensation.

The claims handling process must not be delayed due to uncertainty over which insurance policy covers the compensation or which insurer is eventually liable to compensate for the loss.

If the claims handling is delayed, the insurer must inform the claimant of the delay and its reasons. If the payment of a compensation or benefit is delayed, the insurer must pay penalty interest unprompted in accordance with the law and the insurance terms.

The insurer must base its compensation decision on valid legislation, the insurance contract and established compensation practices. Ambiguous clauses must be interpreted in the claimant's best interest.

The compensation decision must clearly indicate what the compensation consists of. If the decision is negative, includes conditions or in some other way diverges from the compensation claim, the insurer must justify its decision carefully. If the insurer rejects the claim on various different grounds, it must offer all the reasons for the rejection at once.

If the insurer intends to amend a decision regarding an annuity, the policyholder must be given a chance to be heard on the matter before a new compensation decision is made.

2.4 Appealing

If the insurer rejects a compensation claim or its decision differs from the compensation claim, the decision must include instructions for appeal.

The insurer should always instruct claimants who are unhappy with the compensation decision to first contact the insurer. For this reason, the decision must always include the contact information the claimant can use to get further information about the decision. The insurer must reply to all rehandling requests and, if necessary, instruct the claimant about the practicalities of the appeal procedure, such as the use of the legal expenses insurance.

If the claimant finds the decision erroneous or an error is found in some other way, the insurer must correct the decision without further delay.

The instructions for appeal introduce the Finnish Financial Ombudsman Bureau FINE, the boards that issue recommendations for resolutions (the Insurance Complaints Board, the Investment Complaints Board and the Consumer Disputes Board) and the court proceedings, including the relevant time limits. The appeal instructions for boat insurance claims must mention that in order to take the claim to court, an average adjustment must have been made.

Claimants have the right to access documents that are used as the basis of the compensation decision and that pertain to themselves.

Good practice guidelines for insurance investigation

3 Good practice guidelines for insurance investigation

3.1 Purpose of insurance investigation

Insurance frauds, financial crimes and other cases of abuse cause significant losses to Finnish insurers and their policyholders. Policyholders must be able to rely on the fact that insurers prevent and investigate these cases and limit the losses that policyholders may incur as a result of fraudulent claims. In the context of these guidelines, insurance investigation refers to the investigation of suspected insurance fraud, which entails the investigation of an insurance claim and the surrounding circumstances.

Fraud and abuse prevention is part of insurers' social responsibility. In their own work, insurers must devise ways to reduce the opportunities for insurance fraud. They must also detect, investigate and, where needed, report the detected fraud to authorities.

Insurers' own investigation operations are crucial for deterring insurance fraud, as they

- prevent attempted fraud against insurance companies by increasing the risk of being caught
- reduce the financial benefit gained by the fraudster, making it less tempting to commit fraud
- provide information on how insurers' products, policy conditions, work processes and other working methods should be upgraded to reduce opportunities of committing fraud and abuse, and
- provide insurers with information to assess claims and to decide on whether an investigation request is filed to the police to initiate pre-trial investigation.

The objective of these guidelines is to describe the established good practice in insurance investigation and thereby ensure that no one will be suspected of fraud without reason. Moreover, the aim is to advance compliance with generally accepted and ethically sustainable principles in insurance investigation.

3.2 Investigating staff

Insurance investigation is conducted by specifically appointed insurance investigators, who use both in-house and outside specialist resources in their work. Insurance investigators must have police training or other training and experience adequate for the task.

In addition to insurance investigation, insurance investigators also engage in other activities which are not governed by these guidelines.

3.3 General principles governing insurance investigation

The objective of insurance investigation is to find out what has actually happened. All circumstances revealed in the investigation, whether positive or negative for the parties involved, must be taken into account with equal weight.

The methods used in the investigation, including information gathering, must be in reasonable proportion to both the nature and the extent of the case at hand.

What needs to be taken into account in the investigation is that the parties to the insurance contract are not to be seen as each other's opponents. The claimant or the claimant's representative must be reserved an opportunity to be heard. This practice may be deviated from for investigative reasons.

Insurance investigation must take into account the claimant's situation and circumstances, such as health, age, experience, education, language skills and other personal qualities which may have an impact on the person's chances of influencing the processing of the case.

Insurance investigation may not discriminate against anyone on the basis of gender, age, ethnic or national origin, nationality, language, religion, conviction, opinion, health, disability, sexual orientation, or any other personal characteristic.

No investigation may unduly weaken the position of the party entitled to compensation or benefit. Sometimes insurance investigation may result in a finding that there is no reason to suspect any party of fraud, abuse or any other improper action. At other times investigation may reveal that no compensable damage, loss or injury has occurred or that while the occurrence has not been proved, there are not sufficient grounds to file an investigation request to the police. In such cases, insurers must deny the claim without undue delay, specifying the reasons for the denial.

No investigation may unduly delay the processing of the underlying claim at the insurance company.

Every insurance investigation must take account of privacy protection – notably provisions of the Data Protection Act – in the processing of personal data. The provisions on domestic peace and other objects of legal protection ensured by the constitution must also be observed.

3.4 Investigation procedures

Insurance investigators acquire, analyse and document information. Insurance investigation provides both the insurer and the law enforcement authorities with information important for investigating the fraud and supports pre-trial investigation where needed.

In the context of these guidelines, law enforcement authorities refer to the police, the customs and the border guard. In its role as the complainant in the cases, the insurer has an independent right to investigate and bring charges for crime committed against itself.

Insurance investigators have the right to acquire information about the circumstances that impacted the conclusion of the insurance contract concerned, and about the occurrence of the insured event. This right applies to acquiring information from the policyholder, the policyholder's representative or any other party that is entitled to compensation or benefits as provided in the Insurance Contracts Act, policy conditions or elsewhere.

3.4.1 Interviewing the policyholder

The investigator may interview the policyholder, any other party entitled to compensation or benefit, or any other person that has information about the occurrence of the insured event. The interviewee must be informed of the interview in advance. This practice may be deviated from for investigative reasons.

The interview must be conducted in an appropriate manner and with due consideration of not only the person's circumstances but also the nature and extent of the occurrence of the insured event as well as any other circumstances that may be pertinent for the investigation. If necessary, an interpreter may be used. The interview may be recorded by technical means or in writing. The interviewee has the right to access any information recorded about the interview and attached to the claim documentation. Where needed, the document may be signed by both the interviewee and the interviewer.

3.4.2 Inspection of the scene of event

Before inspecting the scene of the insured event or any other location, it is advisable to notify the person involved or the person whose premises will be inspected. If necessary, the owner or occupant of the premises must be reserved an opportunity to be present at the inspection. These practices may be deviated from for investigative reasons.

When inspecting the scene or recording anything about the inspection, the investigator must always take into account the legal provisions on the breach of domestic peace.

3.4.3 Information acquired by technical means

Acquiring information by technical means poses a sensitive issue from the perspective of the privacy of the persons involved. That is why the need for this kind of information must be justified, and it is expedient to keep the volume of such information low. Yet in some cases, information acquired by technical means may provide evidence that is crucial to the investigation of the event. It is therefore sometimes well-founded to use technical means for intelligence purposes.

Investigators must take account of the provisions on eavesdropping, illicit observation and invasion of domestic premises set down in the Criminal Code.

For this reason, no person engaging in insurance investigation may ever

- use a technical device to listen to or record any conversation, discussion or other sounds of private life, where these are not intended for their knowledge, and which arise in domestic premises;
- use a technical device to eavesdrop or record any conversation even outside domestic premises that is not intended for their or any other third party's knowledge under circumstances where the speaker has no reason to believe that a third party can hear what is said;
- use a technical device to visually monitor or record any person in domestic premises or in a toilet, dressing room or a similar place; or
- use a technical device to visually monitor or record any person in an office, business premises, production facility, meeting place or the fenced yard of a similar location that is closed to the public where this violates the person's privacy.

Technical devices may be used to gather and record information on persons who are in public locations. These include the following:

a. roads, streets, pavements, squares, parks, beaches, sports grounds, water areas, graveyards, and other locations that are available to the public;

b. buildings, public transport vehicles and other similar locations such as bureaus, offices, stations, shopping centres, business premises and restaurants, which are available to the public, for example, during an event.

These are places or spaces which are freely available to the public and in which it is reasonable to expect that people are, based on general life experience, aware that they can be observed by others. When the target moves from a public location to domestic premises, the investigator must stop recording information with a technical device.

3.4.4 Information gathered from social media

During insurance investigation, insurance investigators may gather information from open and public sources such as the internet. Information acquired in this manner can be used to aid and direct the investigations, but its accuracy must be verified through available means. The information can be used during the claims decision process, but the decision may not be solely based on information acquired from social media.

3.5 Disclosure of information to other insurance companies

All insurance company personnel are subject to the obligation of professional secrecy which may be waived only if another piece of legislation so provides or if the customer concerned has explicitly consented to disclosure of confidential information.

Insurance companies are, however, legally entitled[1] to disclose confidential information to other insurance companies on fraud committed against them and on claims reported to them in order to promote a major interest that is important for deterring insurance fraud.

Disclosure of information on claims reported to the insurance company and processing of such disclosed information are permitted as provided in the EU General Data Protection Regulation (GDPR).

Disclosure of information on crimes committed against the insurance company and the processing of such disclosed information are permitted as set down in the provisions on the fraudulent claims register. If an insurance company has reported a crime committed against it to the police or if a person has been convicted of fraud against an insurance company, information on the person in question may be recorded in the fraudulent claims register.

[1] See the EU GDPR, the Data Protection Act, the Insurance Companies Act, and the Act on Foreign Insurance Companies for more detailed information

3.6 Disclosure of information to the authorities

3.6.1 Law enforcement and prosecuting authorities

According to the Insurance Companies Act, insurance companies are entitled to disclose confidential information to law enforcement and prosecuting authorities for the prevention or investigation of a crime. Information on a person's health, however, may only be disclosed to law enforcement and prosecuting authorities to prevent, investigate and prosecute fraud committed against an insurer or an authorised pension provider.

This provision means that information may only be disclosed for the following reasons:

- to prevent a crime (during the collection of criminal intelligence); and
- to investigate a crime already committed (during pre-trial investigations, consideration of charges, or the processing of the case).

Information on a person's health, however, may only be disclosed in connection with fraud committed against an insurance company or an authorised pension provider.

Under the Police Act, the police are entitled, at the request of a commanding police officer, to get any confidential information needed to prevent or investigate a crime.

Under the same act, the police have an equal entitlement to information needed for police investigation if an important public or private interest so requires. A police investigation means an investigation which is by law to be performed by the police, but does not include a pre-trial investigation of an offence. The police carry out a police investigation if, for example, this is necessary to find a missing person or investigate the cause of a fire.

It is appropriate to document all disclosure requests coming from the police. The information is primarily disclosed in writing. In urgent cases, information may be requested over the telephone and in such cases, information may also be disclosed over the telephone.

Insurance investigators must work in cooperation with the police if an investigation request has been filed or will be filed for the case under scrutiny. Any facts and circumstances of importance arising in relation to the case during pre-trial investigations, consideration of charges, or court proceedings must be reported to the police or to the prosecutor.

3.6.2 Customs and border guard

Under the Customs Act and the Act on the Processing of Personal Data by the Border Guard, the Finnish customs and border guard have the same rights to get information from insurance companies as the police. Disclosure of information to the customs or the border guard follows the procedure described above in section 3.6.1.

3.6.3 Debt recovery authorities

Under the Enforcement Code, debt recovery authorities are entitled to obtain otherwise confidential information from insurance companies for the purpose of determining the financial standing of the debtor. Disclosure of information to debt recovery authorities may not be revealed to any party other than authorities.

3.6.4 Tax authorities

Under the Taxation Procedures Act, tax authorities have the right to obtain confidential information that is in the possession of or otherwise known to the insurer, unless the insurer's representative has the right to refuse to witness on the case.

Such information (identified by the person's name, bank account number, transaction details or similar data) may be needed for the processing of another case involving the taxpayer's taxation or appeal.

Even so, insurers may not refuse to disclose information on a person's financial standing if the information has an impact on the person's taxation.

3.6.5 Other authorities

As to disclosing information to official parties other than the authorities mentioned above, the insurance company must verify whether any specific piece of legislation grants a right or imposes an obligation to disclose information on a case that is subject to the duty of confidentiality.

3.7 Other provisions

Where needed, insurance investigators must on their own initiative provide reliable evidence of their identity to the person involved and to any other persons to be heard in the case, and also explain the provisions, contractual terms or other circumstances that regulate the operations of insurance investigators.

In their work, insurance investigators must behave so that the reputation and esteem enjoyed by the insurance sector and insurance investigators does not suffer.

Insurance investigators must on their own initiative inform their superiors of any financial interest or other circumstances that may either have an effect of their objectivity or cause doubt about the objectivity of the investigation. Such information is to be given before the interest is created or before the commencement of an investigation that may involve a conflict of interests.

Finance Finland
Itämerenkatu 11–13
FI–00180 Helsinki
Finland
www.financefinland.fi

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