



## Disability income – Claims survey report



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## INTRODUCTION

Disability claims adjudication has presented a challenge to insurers worldwide in recent years. In an effort to learn what claims tools are both acceptable and effective in various markets, Munich Re prepared and sent questionnaires to disability carriers in ten developed markets. The questions in the survey covered nine different claims tools. Each tool was defined in order to clarify understanding of all the terms. Each company was asked to indicate whether it routinely employed the tools and what form this took. Respondents were also encouraged to provide additional comments that would be helpful in understanding how each tool was effectively used in each market. If some tools were not routinely used, we asked if they would be culturally acceptable in the respective market.

We have received a total of 65 responses from eight markets (Australia/New Zealand, Canada, France, Israel, the Netherlands, South Africa, the United Kingdom, and the United States).

The following is an analysis of the findings. On pages 3–9, the data on each claims tool are analysed and the results summarized. On pages 10–25, the data are analysed and summarized by market area. We hope that this report will provide the information necessary to begin considering what tools might be effectively transferred from one market to another.

## CLAIMS TOOLS

### INDEPENDENT MEDICAL EVALUATIONS

For the purposes of this survey, an independent medical evaluation is defined as “a medical analysis of an illness or injury by a physician consultant who is neither the examinee’s (claimant’s) treating physician, nor an employee of the insurer who requests the evaluation”.

We found that this was the most widely used of the nine claims tools evaluated. 94% of all respondents employ this tool on a routine basis and additional 5% do so occasionally.

The primary conditions that trigger a request for such an examination are conflicting medical documentation, subjective diagnoses, lack of referral to a specialist, known activities inconsistent with stated limitations, and duration of claim. One Canadian company noted that another time to use this tool was “when the attending physician has become the claimant’s advocate”.

Approximately one-third of all companies choose the examiner from a roster of available physicians and another one-third depend on their chief medical officers to make the selection. Most companies in the United Kingdom and some in the United States appear to rely on a third-party provider to find an appropriate assessor.

Australian, New Zealand, Canadian, and American companies are unanimous in requiring that a certified specialist in the branch of medicine on which the disability was based perform all independent examinations. Conversely, the Dutch market relies exclusively on general practitioners for this function. A majority of French and Israeli companies also use certified specialists, while the South African insurers are evenly split. Since the question was not asked in the United Kingdom, we are unable to determine the preference in that market.

The insurer’s medical consultant in the Canadian, Dutch, British, and American markets commonly reviews independent medical reports. The results of these examinations are routinely provided to the claimant’s primary caregiver for comment in Australia, New Zealand, Canada, the United Kingdom, and the United States. A majority of Canadian, French, and British companies are prepared to terminate benefits solely on the basis of an independent medical evaluation.

One Australian insurer provides its independent medical examiners with all prior medical documentation as well as the results of any investigations or surveillance. A Canadian company noted that it frequently uses independent medical assessment to influence a change in treatment. In Israel, the employment of this tool appears to be limited to claimants who have filed litigation.

## REHABILITATION AND VOCATIONAL ASSESSMENTS

For the purposes of this survey, rehabilitation is defined as “assistance provided to enable a claimant to return to work through retraining, financial means or counselling.”

Although this tool was used either on a routine or occasional basis by a majority (74%) of the companies surveyed, it is not globally available. It is noteworthy that the involvement of insurers in rehabilitation is extremely limited in France, Israel, and South Africa, but its use would apparently be culturally acceptable in each of these three markets.

Although five British insurers reported involving employees in a rehabilitative capacity, third-party vendors were more commonly used in all other markets. These vendors are assigned cases on the basis of expertise (speciality), past performance, location, and cost effectiveness. Since the claimant is not normally obliged to participate in rehabilitation programmes, most insurers listed motivation as the prime factor in selecting candidates. Other frequently mentioned criteria included the diagnosis, medical stability, claimant’s age, occupation, prior education, and the quality of transferable skills.

Companies were nearly unanimous in reporting that criteria are established and reviewed by a combination of medical personnel and claims professionals. One Dutch company routinely involves an employment expert in such reviews.

Slightly more than one-third of all companies believe that “own occupation” definitions tend to limit the use of rehabilitation services. One Canadian insurer suggested as many as 25% of its claims would be removed from consideration and one Australian and one American company thought it might be as high as 50%.

Approximately one-half (46%) of companies provide financial assistance for accelerating medical tests or procedures in order to enable the claimant to return to work more quickly. Only 32% of respondents agreed that completion of a vocational assessment implies termination of benefits if a suitable vocation, for which the claimant already qualifies, is identified, while 42% assist in paying for retraining to qualify for a new occupation identified by the vocational assessment.

Several Israeli companies stated that rehabilitation is primarily available through the National Insurance Institute, a government-sponsored programme to which all residents have access. A South African company suggested that a reason for limited use of rehabilitation services in that market is “claimants want their money with current high unemployment rates”.

## PSYCHIATRIC AND SOFT DIAGNOSIS CLAIMS

For the purposes of this survey, soft diagnosis claims are defined as “disabilities that are based on subjective symptoms and may include such diagnoses as fibromyalgia, chronic fatigue syndrome, chronic pain, and environmental diseases”. Psychiatric claims are “claims that are based on diagnoses identified through a DSM-IV”.

63% of all responding companies refer claims to a psychiatric consultant on a routine basis, while an additional 9% do so occasionally. Although this tool is available in all responding markets, it is used extensively in Australia, New Zealand, Canada, South Africa, and the United States. It appears to have limited application in Israel and the United Kingdom. The use of a consulting psychiatrist is acceptable in all markets, while the use of psychologists is condoned in Australia, New Zealand, Canada, France, and the United States. Psychiatric nurses suffice in Canada, the United Kingdom, and the United States. Only six respondents (one Canadian, one French, one Israeli, and three American) reported the availability of an internal consultant.

87% of companies using a psychiatric consultant refer claims based on “soft diagnoses” as well as those with of a more traditional psychiatric nature. It is interesting, however, that 54% require that their consultants make direct telephone calls to attending practitioners and approximately half (49%) expect them to become involved in recommending specific treatment plans.

85% of companies with a psychiatric consultant use psychological tests to assist in analysing disorders and 78% agree that such testing is accepted as an adjudication tool in their markets.

In addition to psychological testing, three Australian companies routinely request other tests (e.g. blood and urine) during independent medical evaluations. One Dutch company mentioned that it would be culturally unacceptable for its psychiatric consultant to either make telephone contact with attending practitioners or to become involved in recommending treatment plans.

## FIELD VISITS

For the purposes of this survey, field visits are defined as “when an employee or third-party vendor visits the claimant and frequently his attending physician and/or employer in an effort to better understand a disability claim” (e.g. to question the cause of the disability, the symptoms and limitations, daily activities, prognosis, and in doing so, is able to observe the claimant’s activities, mode of dress, and apparent physical and mental conditions).

78% of companies reported using this tool on a routine or occasional basis, both the methods and the objectives vary significantly. While it appears that the primary purpose of such visits in the Netherlands and in South Africa is to evaluate the potential for rehabilitation and vocational assessment, their Canadian, British, and American counterparts tend to be more prone to investigation. The field visitation programmes in Australia and New Zealand seem to combine these two roles. Field visits in France and Israel are only used sparingly.

Australian, South African, British, and American companies are more likely to use third-party vendors (65%) to complete field visits, while Canadian and Dutch companies seem to prefer that employees (72%) carry out this function. The most frequently mentioned requirements for a field claims representative were extensive claims background, the ability to think on one’s feet, good communication skills, and an ability to negotiate. Several respondents mentioned good medical and contract knowledge, investigative or rehabilitative background, and an appreciation of time management.

Most companies with a field visitation programme (75%) did not expect their adjudicators to conduct field visits or require that medical practitioners be contacted (71%). Conversely, a majority of companies (55%) require that employers be contacted. An overwhelming majority (93%) do not permit the field claims representative to make final decisions on benefit eligibility. A similar proportion of companies (95%) believe that field visits are beneficial to the adjudication process.

One Australian company remarked that “costs, time, and workloads restrict our activities in this area.” A Canadian company reported that “a vast majority of our field visits are unannounced.” An Israeli company expressed concern that this tool “may not be culturally acceptable in Israel with emphasis on agent/broker attitudes about it.” Finally, a British company provide the comment that “field visits are integral to good claims management.”

## INVESTIGATIONS AND SURVEILLANCE

For the purposes of this survey, surveillance is defined as “the intention to document the activities of a claimant through videotaping methods conducted over several days in order to prove or dispute a claim”. An investigation is defined as “obtaining information about a claimant by questioning individuals with knowledge about his limitations or activities (e.g. the attending physician, the employer, neighbours and co-workers)”.

87% of all reporting companies conduct investigations and surveillance on either a routine or an occasional basis, and this is done extensively in all markets included in the survey. Companies typically refer claim files for surveillance if they suspect claimants are working, if their activities do not seem consistent with their stated limitations, or if there is difficulty in contacting them by telephone. Most companies (86%) conduct surveillance for three to five days, and a slight majority (58%) report using the tool at least monthly.

81% of respondents expressed a willingness to share surveillance costs with other insurers, and 69% are prepared to terminate benefits solely on the basis of surveillance. Slightly more than half (52%) provide copies of the surveillance reports to attending physicians and invite comment. Only 27% of companies have established an internal fraud unit; moreover, this figure is skewed by the American market, where 85% of respondents have established such units. Mandates for such units range from investigating allegations that claimants are working (Australia) to advising on criminal prosecution and preparing exhibits for court (United Kingdom), to complying with the law of most jurisdictions (United States).

One New Zealand company reported that it is illegal to videotape claimants in that county, making surveillance a somewhat less than effective claims tool. In Canada, the United Kingdom, and the United States, companies frequently use surveillance in conjunction with independent medical evaluations. One French respondent volunteered that there is a nationwide fraud service available to insurers, and one Israeli company suggested that cost was the primary reason that it rarely uses surveillance.

## LUMP-SUM SETTLEMENTS

For the purposes of this survey, a lump-sum settlement is defined as “payment by the insurer of a specific sum of money in lieu of monthly disability benefits in exchange for the claimant’s agreement to release the insurer from further liability”.

A lump-sum settlement offer is one of the less frequently used claims tools, with only 42% of respondents employing it on a routine basis. An additional 35% reported some experience with such offers. Objectives differ widely, from a simple commutation of benefits (Australia, New Zealand) to a method to negotiate disputed liabilities (Canada and the United States), settling litigated claims (France) and resolving claims when emigration is contemplated (United Kingdom).

An overwhelming majority (81%) of companies prefer to use employees rather than third parties to negotiate lump-sum settlements, and 77% would expect claims professionals to conduct such discussions. Other qualities desired in negotiators included a legal background, an understanding of actuarial calculations, and some knowledge of relevant tax laws. All companies agreed that the amount of any proposed lump-sum settlement would be based on the present value of future expected payments, giving due consideration to mortality. The average “payout” ranged from a high of 60–70% of that figure (Australia) to a low of 20% (Israel).

Although the proceeds of a lump-sum settlement are taxable in some markets and non-taxable in others, it is not clear whether a commutation of benefits alters the tax status. Only 20% of companies indicated that they are in a position to offer structured settlements such as an annuity. This latter figure does not include companies in the British market, where the question was not asked.

An Australian company stated that it considers the moral implications of a lump-sum settlement offer, noting that it must be in the interests of the claimant. Several Canadian and one British company emphasized the need for negotiations to be conducted on a face-to-face basis.

## FUNCTIONAL CAPACITY EVALUATIONS

For the purposes of this survey, a functional capacity evaluation is defined as “the objective testing of a person’s abilities and limitations in work-related tasks”. All surveyed markets reported some use of this tool. 60% of companies use functional capacity evaluations routinely while an additional 32% do so on an occasional basis. A majority of companies use this tool frequently in all markets, an exception being the United Kingdom, where only 13% of companies categorize their usage as routine.

The most common criteria used to determine the potential need for a functional capacity evaluation are lack of objective reasons for stated limitations or restrictions, observations do not support the degree of disability claimed, and rehabilitation within the original occupation is unlikely. Other factors considered include age, duration of disability, and potential for retraining. One French company often integrates this test with an independent medical evaluation.

67% of companies use special firms for functional capacity evaluations, 30% use rehabilitation firms and 3% use occupational therapists. A bare majority (56%) of respondents expect a worksite assessment as part of the evaluation, and less than half (44%) are inclined to use a rehabilitation firm to implement recommendations from the assessment. Although 33% of companies agreed that the employment of this tool is limited by “own occupational” definitions of disability, one Canadian and one Dutch company emphasized that this is not the case if claimants are being evaluated for a return to work in their own occupation. This question was not asked in the United States.

Three Australian companies suggested that the employment of this tool was significantly restricted by “own occupational” definitions (estimates of 95%, 80%, and 50% respectively). One Canadian and one British company agreed that this was a highly cost effective claims tool.

### **INDEPENDENT ACCOUNTING EVALUATIONS**

For the purposes of this survey, an independent accounting evaluation is defined as “a forensic audit of a claimant’s financial records in order to determine the correct level of residual disability benefits payable”. An independent financial assessment is made to verify the accuracy of the claimant’s accounting books and records and is generally done by a certified public accountant that is knowledgeable in disability contracts.

This claims tool is only used extensively in Australian (62% of companies), Canada (100% of companies), and the United States (64% of companies). One company in France and two in the United Kingdom reported limited experience with independent accounting evaluations. There are also indications that the tool would be culturally acceptable in Israel and in South Africa.

Companies were unanimous that the independent evaluator be a certified public accountant with a good understanding of both the disability industry and the provisions of insurance contracts. Most companies (87%) reserve the use of forensic audits for problematic files. Most of those who do employ the tool (72%) do so both for residual disability contracts and for business overhead expense policies. All companies expressed a belief that the tool is being used successfully, a strong majority (81%) stating it has been “very” successful.

The primary reason this tool is not used more frequently may be the type of disability contracts available in various markets. Unless companies experience a significant number of claims with residual disability benefits or with business overhead expense reimbursements, it is unlikely that the need for independent accounting evaluations will arise.

### **TELEPHONE CLAIM INQUIRIES**

For the purposes of this survey, a telephone claim inquiry is defined as “what is used in many claims cases as an inexpensive way to communicate with the insured (his attending physician or his employer) in order to inquire about the said disability and any pertaining information that can be obtained through a telephone call”.

78% of respondents indicated that they had had some experience with this tool, with 63% reporting routine use and an additional 15% stating that it is employed occasionally. There are indications that the tool is culturally acceptable in all markets, with the possible exception of the Netherlands.

A minority of companies (46%) attempt to make telephone contact with all disability claimants, while the balance (54%) do so only on problematic files. The criteria used by companies in the latter category include the need to clarify claims documentation, random samples, and public relations. One British company attempts to reach claimants during working hours if there are suspicions that they may have returned to their place of employment.

Once telephone contact has been initiated, 67% of respondents expect claims adjudicators to maintain regular telephone communication. 69% of companies believe their telephone inquiry programmes are operating on a “very successful” basis.

One Australian company noted that “this tool should be used more but is constrained by lack of human resources and staff training”. A Canadian company observed that “this tool is valuable in attempting to manage expectations and to get claimants focused on a return to work plan”. A British company believes that “adjudication has become more efficient since fewer letters need to be sent”.

## CLAIMS TOOLS USED IN

### AUSTRALIA AND NEW ZEALAND

These two markets have been combined for several reasons. We assume that there are similarities in the adjudication of claims in the two areas. More importantly, however, since relatively few New Zealand companies reported, we were concerned that the data might not be statistically valid.

Australia and New Zealand employ a wide variety of claims tools extensively. The respondents reported using each of the surveyed tools in the following manner. We have commented on what appear to be interesting and relevant factors in each of the categories.

#### – Independent medical evaluations

100% of companies use them routinely. It is noteworthy that most independent assessors are chosen either by the insurer's chief medical officer or from a roster of specialists. Certified specialists perform all evaluations. Most of the reports are neither reviewed by the insurer's medical consultant nor forwarded to the attending practitioner for comment. Benefits are usually not terminated solely on the basis of a report from an independent medical examiner.

#### – Rehabilitation and vocational assessments

88% of companies use them routinely; 6% use them occasionally. Only third-party providers render this service. Most reports are reviewed by both medical and claims personnel. Although financial assistance is available to accelerate medical tests or procedures, only about half of the companies subsidize retraining. Benefits may not be terminated when a vocational assessment identifies an occupation for which the claimant already qualifies.

#### – Psychiatric and soft diagnoses claims

75% of companies use a psychiatric consultant routinely; 19% use them occasionally. Although both psychiatrists and psychologists are used, all are external to the companies for which they provide the services. "Soft diagnoses" claims, as well as claims with traditional psychiatric diagnoses, are referred for psychiatric review. One-third of the companies report that consulting psychiatrists routinely make telephone contact with attending practitioners, while about half will become involved in recommending specific treatment plans. Psychological testing is routinely used and is accepted as a legitimate adjudication tool in this market.

#### – Field visits

69% of companies use a field claims visitation programme routinely. The purposes of these visits range from identifying candidates for rehabilitation to evaluating the severity of the claimant's limitations. About two-thirds of the visits are carried out by third-party vendors and one-third by company employees. Generally speaking, claims adjudicators are not expected to participate in field visits, and field claims personnel do not visit either medical practitioners or employers. Although field claims representatives are encouraged to make recommendations, they do not have the authority to make final decisions concerning benefit eligibility.

– **Investigations and surveillance**

94% of companies use them routinely. Files are usually referred for investigation to determine if a claimant is working or if there are concerns that his activities are not consistent with his stated limitations. A typical surveillance will last three to five days, and surveillance is conducted routinely. Most insurers are prepared to share the costs of surveillance, and a slight majority of companies will terminate benefits solely on the basis of surveillance. One-third of reporting companies provide the attending physician with a copy of the surveillance report. 19% of respondents have established internal fraud units.

– **Lump-sum settlements**

50% of companies use them routinely; 19% use them occasionally. Employment of this tool is considered for resolving contentious claims or minimizing costs when it is obvious that a claimant will never return to work. Approximately 80% of settlement offers are negotiated by company employees (usually claims professionals) and the balance by third-party providers. One company estimates that most offers fall between 60–70% of the present value of future expected payments. Currently, no companies provide structured settlements (annuities) to accommodate lump-sum offers.

– **Functional capacity evaluations**

56% of companies use them routinely; 38% use them occasionally. Criteria for this tool (conflicting medical data) are usually established by professional claims personnel. Approximately one-half of these evaluations are completed by special firms and the other half by rehabilitation vendors. About one-half of the insurers expect a worksite assessment to be included in the evaluation. Slightly over half (57%) of companies engage rehabilitation firms to implement recommendations emanating from functional capacity evaluations.

– **Independent accounting evaluations**

50% of companies use them routinely; 19% use them occasionally. Evaluators are expected to be certified public accountants with a working knowledge of disability insurance contracts. Approximately two-thirds of respondents use this tool only on problematic files while the other one-third choose files on a random basis. The tool is used to evaluate claims on both residual disability and business overhead policies. Companies are unanimous that the tool is working well.

– **Telephone claim inquiries**

81% of companies use them routinely; 6% use them occasionally. One-half of reporting companies expect claims adjudicators to make telephone contact with all disability claimants, while the other half use this tool only for problematic cases. Criteria used by the latter category of carriers includes diagnosis, age, claim duration, and the need to clarify claims documentation. Once telephone contact has been initiated, 77% of carriers expect it to be maintained on a regular basis. One company stated that the tool should be used more but is constrained by the lack of human resources and staff training.

## CANADA

Canada employs a wide variety of claims tools extensively. The respondents reported using each of the surveyed tools in the following manner. We have commented on what appear to be interesting and relevant factors in each of the categories.

### – Independent medical evaluations

100% of companies use them routinely. Most of the independent assessors are chosen from a roster of specialists. Certified specialists perform all evaluations. All reports are reviewed by the insurer's medical consultant, and 83% of respondents forward them to the attending practitioner for comment. Benefits may be terminated solely on the basis of a report from an independent medical examiner.

### – Rehabilitation and vocational assessments

100% of companies use them routinely. Third-party providers render this service almost exclusively. Most reports are reviewed by both medical and claims personnel. Although financial assistance is available to accelerate medical tests or procedures, only about half of the companies subsidize retraining. Two-thirds of the reporting companies terminate benefits when a vocational assessment identifies an occupation for which the claimant already qualifies.

### – Psychiatric and soft diagnoses claims

100% of companies use a psychiatric consultant routinely. Although psychiatrists, psychologists, and psychiatric nurses are used, 86% are external to the companies for which they provide the services. "Soft diagnoses" claims, as well as claims with traditional psychiatric diagnoses, are referred for psychiatric review. All of the companies report that consulting psychiatrists routinely make telephone contact with attending practitioners, while 83% will become involved in recommending specific treatment plans. Psychological testing is routinely used and is accepted as a legitimate adjudication tool in this market.

### – Field visits

100% of companies use a field claims visitation programme routinely. The purposes of these visits are primarily investigative in nature. Most attempt to evaluate the severity of the claimant's limitations. About one-half of the visits are carried out by third-party vendors and one-half by company employees. Generally speaking, claims adjudicators are not expected to participate in field visits. Field claims personnel do, however, visit both medical practitioners and employers on a routine basis. Although field claims representatives are encouraged to make recommendations, they do not have the authority to make final decisions concerning benefit eligibility.

### – Investigations and surveillance

100% of companies use them routinely. Files are usually referred for investigation to determine if a claimant is working or if there are concerns that his activities are not consistent with his stated limitations. One company reports that "Internet browsing" often leads to questions about a claimant's activities. A typical surveillance will last three to five days, and surveillance is conducted routinely. Most insurers are prepared to share the costs of surveillance, and all respondents will terminate benefits solely on the basis of surveillance. Two-thirds of reporting companies provide the attending physician with a copy of the surveillance report. None of the respondents have established internal fraud units.

**– Lump-sum settlements**

100% of companies use them routinely. Employment of this tool is considered to resolve contentious claims or to minimize costs when it is obvious that a claimant will never return to work. Approximately two-thirds of settlement offers are negotiated by company employees (usually claims professionals) and the balance by third-party providers. One-half of the responding companies provide structured settlements (annuities) to accommodate lump-sum offers.

**– Functional capacity evaluations**

100% of companies use them routinely. Criteria for using this tool (conflicting medical information, observation does not support degree of disability claimed) are usually established by professional claims personnel. All of these evaluations are completed by special firms, and all insurers expect a worksite assessment to be included in the evaluation. 80% of companies engage rehabilitation firms to implement recommendations emanating from functional capacity evaluations.

**– Independent accounting evaluations**

100% of companies use them routinely. The evaluators are expected to be certified public accountants with a working knowledge of disability insurance contracts. 86% of respondents use this tool only on problematic files, while the other 14% choose files on a random basis. The tool is used to evaluate claims on both residual disability and business overhead policies. Companies are unanimous that the tool is working reasonably well.

**– Telephone claim inquiries**

100% of companies use them routinely. 83% of reporting companies expect claims adjudicators to make telephone contact with all disability claimants, while the other 17% use this tool only for problematic cases. Criteria used by the latter category of carriers include diagnosis, age, claim duration, and the need to clarify claims documentation. Once telephone contact has been initiated, 83% of carriers expect it to be maintained on a regular basis. One company stated that the tool is valuable in attempting to manage expectations and to get claimants focused on a return-to-work plan.

## FRANCE

France tends to rely heavily on the medical and investigative aspects of claims adjudication with less emphasis on rehabilitation and field claim visits. The respondents reported using each of the surveyed tools in the following manner. We have commented on what appear to be interesting and relevant factors in each of the categories.

### – Independent medical evaluations

100% of companies use them routinely. It is noteworthy that most independent assessors are chosen by the insurer's chief medical officer. Two-thirds of the respondents use certified specialists perform these evaluations while the other one-third use general practitioners. One-half of the reports are reviewed by the insurer's medical consultant, but only 25% are forwarded to the attending practitioner for comment. Benefits may be terminated solely on the basis of a report from an independent medical examiner. One company uses its chief medical officer to perform independent medical evaluations.

### – Rehabilitation and vocational assessments

20% of companies use them routinely. Only third-party providers render this service. Most reports are reviewed only by medical personnel. Financial assistance is not available to accelerate medical tests or procedures, and responding companies will not subsidize retraining. Benefits may be terminated when a vocational assessment identifies an occupation for which the claimant already qualifies.

### – Psychiatric and soft diagnoses claims

60% of companies use a psychiatric consultant routinely; 20% use them occasionally. Although both psychiatrists and psychologists are used, 80% are external to the companies for which they provide the services. "Soft diagnoses" claims, as well as claims with traditional psychiatric diagnoses, are referred for psychiatric review. One-third of the companies report that consulting psychiatrists routinely make telephone contact with attending practitioners, but none become involved in recommending specific treatment plans. Psychological testing is routinely used, but opinion is equally divided about its acceptance as a legitimate adjudication tool in this market.

### – Field visits

20% of companies use a field claims visitation programme occasionally. The primary trigger for these visits appears to be a lack of objective medical findings. These visits are carried out by company employees. Generally speaking, claims adjudicators are not expected to participate in field visits, and field claims personnel do not visit either medical practitioners or employers. Although field claims representatives are encouraged to make recommendations, they do not have the authority to make final decisions concerning benefit eligibility.

**– Investigations and surveillance**

80% of companies use them routinely; 20% use them occasionally. Files are usually referred for investigation when there are suspicions of fraud. A typical surveillance will last three to ten days, and surveillance is relatively rare. One-half of insurers are prepared to share the costs of surveillance, and 80% will terminate benefits solely on the basis of surveillance. 40% of reporting companies provide the attending physician with a copy of the surveillance report. None of the respondents have established internal fraud units.

**– Lump-sum settlements**

60% of companies use them routinely. Employment of this tool appears to be reserved for resolving litigated claims. Approximately one-half of settlement offers are negotiated by company employees (usually lawyers) and the balance by third-party providers (usually outside lawyers). Currently, two-thirds of companies that use this tool provide structured settlements (annuities) to accommodate lump-sum offers.

**– Functional capacity evaluations**

100% of companies use them routinely. Criteria for this tool (conflicting medical information) are usually established by the insurer's chief medical officer. Almost all of these are conducted by rehabilitation vendors. About three-quarters of the insurers expect a worksite assessment to be included in the evaluation. None of the responding companies engage rehabilitation firms to implement recommendations emanating from functional capacity evaluations.

**– Independent accounting evaluations**

20% of companies use them routinely. Evaluators are expected to be certified public accountants with a working knowledge of disability insurance contracts. The employment of this tool is reserved for problematic cases. The responding companies indicate that the tool is working well.

**– Telephone claim inquiries**

40% of companies use them routinely. It appears that this tool is reserved for problematic cases. Criteria used are limited to the need to clarify claims documentation. Once telephone contact has been initiated, respondents expect it to be maintained on a regular basis.

## ISRAEL

Israel, like France, relies heavily on the medical and investigative aspects of claims adjudication with very little apparent use of insurer-sponsored rehabilitation, field claims visits, or telephone communication with claimants. The respondents reported using each of the surveyed tools in the following manner. We have commented on what appear to be interesting and relevant factors in each of the categories.

### – Independent medical evaluations

75% of companies use them routinely; 25% use them occasionally. It is noteworthy that most independent assessors are chosen from a roster of specialists. Evaluations may be performed by certified specialists, general practitioners, or occupational specialists. Three-quarters of the respondents do not have the reports reviewed by their internal medical consultant nor do they forward them to the attending practitioner for comment. The respondents are split on whether benefits are terminated solely on the basis of a report from an independent medical examiner. It appears that the primary employment of this tool is to secure a medical opinion on litigated claims.

### – Rehabilitation and vocational assessments

This tool is not usually sponsored by private insurers in Israel. Rehabilitation is apparently available primarily through the National Insurance Institute, a government-sponsored programme to which all residents have access.

### – Psychiatric and soft diagnoses claims

50% of companies use a psychiatric consultant routinely. While both psychiatrists and psychologists are used, the majority is internal. "Soft diagnoses" claims, as well as claims with traditional psychiatric diagnoses, are referred for psychiatric review. Psychiatric consultants do not routinely make telephone contact with attending practitioners nor become involved in recommending specific treatment plans. Psychological testing is used and is accepted as a legitimate adjudication tool in this market.

### – Field visits

This tool is used by 25% of the respondents, but most visits are conducted in company offices. Neither attending physicians nor employers are normally contacted. One company expressed concern that this tool "may not be culturally acceptable in Israel with emphasis on agent/broker attitudes about it".

### – Investigations and surveillance

75% of companies use them routinely. Files are usually referred for investigation to determine if claimants are working or if there are concerns that their activities are not consistent with their stated limitations. It is unclear how long typical surveillances will routinely last or how frequently they occur. All respondents are prepared to share the costs involved, and three-quarters will terminate benefits solely on the basis of surveillance. None of the reporting companies routinely provides the attending physician with a copy of the surveillance report nor have any established an internal fraud unit.

**– Lump-sum settlements**

75% of companies use them routinely; 25% use them occasionally. Employment of this tool is considered when requested by the claimant or to minimize costs when it is obvious that a claimant will never return to work. One-half of the respondents use employees (usually claims professionals) to negotiate these settlements, while the other half prefers third-party providers. Currently, no companies provide structured settlements (annuities) to accommodate lump-sum offers.

**– Functional capacity evaluations**

50% of companies use them routinely; 25% use them occasionally. Criteria for this tool (conflicting medical data) are usually established by medical staff. All respondents use special firms to undertake these evaluations. Only one of the reporting companies expects a worksite assessment to be included in the evaluation. Since there are few private rehabilitation firms in this market, companies do not normally engage them to implement recommendations emanating from functional capacity evaluations.

**– Independent accounting evaluations**

This tool is not currently used in this market. Opinion is divided on whether it would be culturally acceptable.

**– Telephone claim inquiries**

25% of companies use them routinely; 25% use them occasionally. It appears that this tool is reserved for problematic cases. Criteria used are limited to the need to clarify claims documentation or if there are suspicions that the claimant may be working. Respondents do not expect telephone contact with claimants to be maintained on a regular basis.

## NETHERLANDS

The Netherlands employs a wide variety of claims tools extensively. The respondents reported using each of the surveyed tools in the following manner. We have commented on what appear to be interesting and relevant factors in each of the categories.

### – Independent medical evaluations

100% of companies use them routinely. It is noteworthy that most independent assessors are chosen from a roster of general practitioners that are available to perform such evaluations. Most of the reports are reviewed by the insurer's medical consultant, but they are not forwarded to the attending practitioner for comment. Benefits are usually not terminated solely on the basis of a report from an independent medical examiner.

### – Rehabilitation and vocational assessments

100% of companies use them routinely. Both employees and third-party providers perform this service. Most reports are reviewed by medical personnel, claims personnel, and employment experts. Financial assistance is available to accelerate medical tests or procedures, and companies are prepared to subsidize retraining. Benefits are not always terminated when a vocational assessment identifies an occupation for which the claimant already qualifies.

### – Psychiatric and soft diagnoses claims

100% of companies use a psychiatric consultant routinely. These consultants tend to be psychiatrists who are external to the companies for which they provide the services. "Soft diagnoses" claims, as well as claims with traditional psychiatric diagnoses, are referred for psychiatric review. Consulting psychiatrists do not make telephone contact with attending practitioners nor do they become involved in recommending specific treatment plans. There is a strict separation between attending practitioners and consulting physicians in this market. Psychological testing is not routinely used and is probably not acceptable as a legitimate adjudication tool.

### – Field visits

100% of companies use a field claims visitation programme routinely. The purposes of these visits are primarily to determine the potential for rehabilitation services and vocational assessments. Although third-party vendors are available in this market, the usual practice is for employees to conduct these visits. Generally speaking, claims adjudicators are not expected to participate in field visits, and field claims personnel do not visit either medical practitioners or employers. Although field claims representatives are encouraged to make recommendations, they do not have the authority to make final decisions concerning benefit eligibility.

### – Investigations and surveillance

100% of companies use them occasionally. Files are usually referred for investigation when there are suspicions of fraud. It is unclear how long typical surveillances will routinely last, but they are seldom used. It is not the practice to share the costs involved, but companies will terminate benefits solely on the basis of surveillance. Reporting companies do not provide the attending physician with a copy of the surveillance report. None of the respondents has established internal fraud units.

**– Lump-sum settlements**

100% of companies use them occasionally. Employment of this tool is usually reserved for resolving litigated claims. Almost all settlement offers are negotiated by company employees (usually claims professionals or internal lawyers). Currently, no companies provide structured settlements (annuities) to accommodate lump-sum offers.

**– Functional capacity evaluations**

100% of companies use them routinely. Criteria for this tool (when rehabilitation to the original occupation is not possible) are usually established by both medical and professional claims personnel. These evaluations tend to be done by special firms and are expected to include a worksite assessment. The reporting companies do not engage rehabilitation firms to implement recommendations emanating from capacity evaluations.

**– Independent accounting evaluations**

This tool is not currently used in this market. There is no clear indication whether it would be culturally acceptable.

**– Telephone claim inquiries**

This tool is not currently used in this market. There is no clear indication whether it would be culturally acceptable.

## SOUTH AFRICA

South Africa is another market that relies heavily on the medical aspects of claims adjudication. It appears that the tools of rehabilitation, field claims visits, and investigations are used sparingly. The respondents reported using each of the surveyed tools in the following manner. We have commented on what appear to be interesting and relevant factors in each of the categories.

### – Independent medical evaluations

100% of companies use them routinely. It is noteworthy that most independent assessors are chosen either by the insurer's chief medical officer or from a roster of specialists. One-half of the respondents use certified specialists to perform these evaluations, while the other half use general practitioners. Most of the reports are neither reviewed by the insurer's medical consultant nor forwarded to the attending practitioner for comment. Benefits are usually not terminated solely on the basis of a report from an independent medical examiner. One company suggests that the market needs to use this claims tool more frequently.

### – Rehabilitation and vocational assessments

25% of companies use them occasionally. Only third-party providers render this service. Most reports are reviewed by both medical and claims personnel. Financial assistance is available to accelerate medical tests or procedures, and respondents are prepared to subsidize retraining. Benefits may not be terminated when a vocational assessment identifies an occupation for which the claimant already qualifies.

### – Psychiatric and soft diagnoses claims

100% of companies use a psychiatric consultant routinely. Only psychiatrists are used, and they are all external to the companies for which they provide the services. "Soft diagnoses" claims, as well as claims with traditional psychiatric diagnoses, are referred for psychiatric review. Three-quarters of the companies report that consulting psychiatrists routinely make telephone contact with attending practitioners and become involved in recommending specific treatment plans. Psychological testing is routinely used and is accepted as a legitimate adjudication tool in this market.

### – Field visits

50% of companies use a field claims visitation programme occasionally. The purpose of these visits tends to be limited to occupational therapy. All visits are carried out by third-party vendors. Generally speaking, claims adjudicators are not expected to participate in field visits, and field claims personnel do not visit medical practitioners. One-half of the respondents expect visits to employers. Although field claims representatives are encouraged to make recommendations, they do not have the authority to make final decisions concerning benefit eligibility.

**– Investigations and surveillance**

25% of companies use them routinely; 75% use them occasionally. Files are usually referred for investigation when there is a suspicion of fraud. A typical surveillance will last three to three days, and surveillance is conducted rarely. Most insurers are prepared to share the costs involved, but only one-quarter will terminate benefits solely on the basis of surveillance. No companies provide the attending physician with a copy of the surveillance report. None of the respondents has established internal fraud units.

**– Lump-sum settlements**

75% of companies use them routinely. Employment of this tool is considered as an option for resolving contentious claims or when a claimant is suffering from a terminal condition. Almost all settlement offers are negotiated by company employees (usually claims professionals). Currently, no companies provide structured settlements (annuities) to accommodate lump-sum offers.

**– Functional capacity evaluations**

75% of companies use them routinely. Criteria for this tool (diagnosis, age, occupation) are usually established by professional claims personnel. Almost all of these evaluations are done by special firms (occupational therapists). All respondents expect a worksite assessment to be included in the evaluation. Only one-third of companies engage rehabilitation firms to implement recommendations emanating from functional capacity evaluations.

**– Independent accounting evaluations**

This tool is not currently used in this market. Opinion is divided on whether it would be culturally acceptable.

**– Telephone claim inquiries**

25% of companies use them routinely; 50% use them occasionally. This tool appears to be reserved for problematic cases. The criterion applied is the need to clarify claims documentation. No responding companies expected telephone contact to be maintained on a regular basis.

## UNITED KINGDOM

The United Kingdom employs a variety of claims tools, but uses psychiatric consultants and lump-sum settlements sparingly. The respondents reported using each of the surveyed tools in the following manner. We have commented on what appear to be interesting and relevant factors in each of the categories.

### – Independent medical evaluations

87% of companies use them routinely; 13% use them occasionally. It is noteworthy that most independent assessors are chosen by third-party providers. It is not clear whether certified specialists or general practitioners perform the majority of evaluations in this market. 73% of respondents have these reports reviewed by their medical consultants, and 93% forward them to the attending practitioner for comment. Benefits may be terminated solely on the basis of a report from an independent medical examiner.

### – Rehabilitation and vocational assessments

33% of companies use them routinely; 47% use them occasionally. Approximately 71% of the reporting companies use third-party providers for this service while the remaining 29% use employees of the insurer. Most reports are reviewed by both medical and claims personnel. Financial assistance is available to accelerate medical tests or procedures, and respondents are prepared to subsidize retraining. The market is evenly divided about terminating benefits when a vocational assessment identifies an occupation for which the claimant already qualifies.

### – Psychiatric and soft diagnoses claims

15% of companies use a psychiatric consultant routinely; 7% use them occasionally. Although both psychiatrists and psychiatric nurses are used, all are external to the companies for which they provide the services. "Soft diagnoses" claims, as well as claims with traditional psychiatric diagnoses, are referred for psychiatric review. Two-thirds of the companies report that consulting psychiatrists routinely make telephone contact with attending practitioners, while all become involved in recommending specific treatment plans. Psychological testing is routinely used in this market, but opinion is divided about its legitimacy as an adjudication tool.

### – Field visits

80% of companies use field claims visitation programmes routinely; 20% use them occasionally. The purposes of these visits range from identifying candidates for rehabilitation to evaluating the severity of the claimant's limitations and attempting to manage expectations. About 60% of the visits are carried out by third-party vendors and 40% by company employees. Generally speaking, claims adjudicators are not expected to participate in field visits, and field claims personnel do not visit medical practitioners. A slight majority of respondents (53%) expect visits to employers. Although field claims representatives are encouraged to make recommendations, they do not have the authority to make final decisions concerning benefit eligibility. One company stated that visits tend to be unannounced, and a second observed that a field visitation programme is integral to good claims management.

– **Investigations and surveillance**

40% of companies use them routinely; 60% use them occasionally. Files are usually referred for investigation to determine if claimants are working, if there are concerns that their activities are not consistent with their stated limitations, or if fraud is suspected.

A typical surveillance will last two to three days, and surveillance is conducted routinely. Most insurers are prepared to share the costs of surveillance, and an overwhelming majority of companies (93%) will terminate benefits solely on the basis of surveillance. 60% of reporting companies provide the attending physician with a copy of the surveillance report. 20% of respondents have established internal fraud units with mandates ranging from making recommendations about criminal prosecution to preparing exhibits for court.

– **Lump-sum settlements**

73% of companies use them occasionally. Employment of this tool is considered when requested by the claimant or to minimize costs when it is obvious that a claimant will never return to work. All respondents stated that settlement offers are negotiated by company employees (usually claims professionals). It is unclear whether any companies provide structured settlements (annuities) to accommodate lump-sum offers.

– **Functional capacity evaluations**

13% of companies use them routinely; 67% use them occasionally. Criteria for this tool (conflicting medical information) are established by both medical personnel and professional claims personnel. All respondents stated that these evaluations are done by special firms. One-third of the insurers expect a work-site assessment to be included in the evaluation. Only 38% of companies engage rehabilitation firms to implement recommendations emanating from functional capacity evaluations.

– **Independent accounting evaluations**

13% of companies use them occasionally. Evaluators are expected to have an understanding of disability insurance contracts. This tool appears to be reserved for problematic cases. It is not clear whether this tool is used to evaluate claims on business overhead policies. There is no indication on how well this tool is working in this market.

– **Telephone claim inquiries**

33% of companies use them routinely; 33% use them occasionally. 40% of reporting companies expect claims adjudicators to make telephone contact with all disability claimants, while the other 60% use this tool only for problematic cases. Criteria used by the latter category of carriers include difficulty in contacting claimant, suspicion that claimant is working, and the need to clarify claims documentation. Once telephone contact has been initiated, one-half of the responding carriers expect it to be maintained on a regular basis. One company stated that the tool could be used more effectively with better-staffed departments and less reluctance on the part of adjudicators to use the tool. Another company observed that adjudication has become more efficient, since fewer letters need to be sent.

## UNITED STATES

The United States employs a wide variety of claims tools extensively. The respondents reported using each of the surveyed tools in the following manner. We have commented on what appear to be interesting and relevant factors in each of the categories.

### – Independent medical evaluations

93% of companies use them routinely; 7% use them occasionally. Independent assessors are chosen from a roster of specialists by chief medical officers and by third-party vendors. Certified specialists perform all evaluations. 93% of all reports are reviewed by the insurer's medical consultant, and 86% of respondents forward them to the attending practitioner for comment. Most respondents (64%) do not terminate benefits solely on the basis of a report from an independent medical examiner.

### – Rehabilitation and vocational assessments

43% of companies use them routinely; 36% use them occasionally. Third-party providers render this service for 90% of the responding companies. Most reports are reviewed by both medical and claims personnel. Only one-third (33%) of the companies provide financial assistance to accelerate medical tests or procedures, but 55% subsidize retraining. Two-thirds of the reporting companies (67%) terminate benefits when a vocational assessment identifies an occupation for which the claimant already qualifies.

### – Psychiatric and soft diagnoses claims

79% of companies use a psychiatric consultant routinely; 7% use them occasionally. Although psychiatrists, psychologists, and psychiatric nurses are used, 77% are external to the companies for which they provide the services. "Soft diagnoses" claims, as well as claims with traditional psychiatric diagnoses, are referred for psychiatric review by 83% of the respondents.

75% of the companies report that consulting psychiatrists routinely make telephone contact with attending practitioners, while 50% will become involved in recommending specific treatment plans. Psychological testing is routinely used and is accepted as a legitimate adjudication tool in this market.

### – Field visits

86% of companies use a field claims visitation programme routinely; 14% use it occasionally. The purposes of these visits are primarily investigative in nature. Most attempt to evaluate the severity of the claimant's limitations and to manage expectations. About two-thirds (63%) of the visits are carried out by third-party vendors and one-third (37%) by company employees. Generally speaking, claims adjudicators are not expected to participate in field visits. Field claims personnel visit both medical practitioners (50%) and employers (65%) on a routine basis. Although field claims representatives are encouraged to make recommendations, they do not have the authority to make final decisions concerning benefit eligibility.

**– Investigations and surveillance**

79% of companies use them routinely; 21% use them occasionally. Files are usually referred for investigation if the policy is contestable, to determine if claimants are working or if there are concerns that their activities are not consistent with their stated limitations.

A typical surveillance will last one to five days, and surveillance is conducted routinely. Approximately two-thirds (64%) of insurers are prepared to share the costs involved, and 62% of respondents will terminate benefits solely on the basis of surveillance. Since this question was not part of the United States survey, what percentage of companies provide the attending physician with a copy of the surveillance report is not known. Since many states require insurance companies to maintain internal fraud units, 85% of companies in this market do so.

**– Lump-sum settlements**

29% of companies use them routinely; 50% use them occasionally. Employment of this tool is considered to resolve contentious claims, to minimize costs when it is obvious that a claimant will never return to work, or as an alternative to litigation. Approximately 77% of settlement offers are negotiated by company employees (usually claims professionals) and the balance by third-party providers. Only 22% of the responding companies provide structured settlements (annuities) to accommodate lump-sum offers.

**– Functional capacity evaluations**

50% of companies use them routinely; 29% use them occasionally. Criteria for this tool (conflicting medical information, observation does not support degree of disability claimed) are established almost equally by professional claims personnel and by chief medical officers. 69% of these evaluations are completed by special firms, and 45% of insurers expect a worksite assessment to be included in the evaluation. 45% of responding companies engage rehabilitation firms to implement recommendations emanating from functional capacity evaluations.

**– Independent accounting evaluations**

43% of companies use them routinely; 21% use them occasionally. The evaluators are expected to be certified public accountants with a working knowledge of disability insurance contracts. All responding companies use this tool only on problematic files. The tool is used to evaluate claims on both residual disability and business overhead policies. Three companies retain accounting consultants on their staff. 88% of companies report that the tool is working reasonably well.

**– Telephone claim inquiries**

93% of companies use them routinely; 7% use them occasionally. 50% of reporting companies expect claims adjudicators to make telephone contact with all disability claimants, while the other 50% use this tool only for problematic cases. Criteria used by the latter category of carriers include subjective diagnoses and the need to clarify claims documentation. Once telephone contact has been initiated, 43% of carriers expect it to be maintained on a regular basis.

# SURVEY FORMS

**INDEPENDENT MEDICAL EVALUATIONS**

We define an independent medical evaluation as “a medical analysis of an illness or injury by a physician consultant who is neither the examinee’s (claimant’s) treating physician, nor an employee of the insurer who requests the evaluation”.

Are independent medical evaluations routinely used in your market?

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If so, please answer the following questions. If not, please state whether, in your opinion, the use of this tool would be culturally acceptable.

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What condition(s) trigger a request for an independent medical evaluation?

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How is the independent examiner selected?

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Are all examiners certified specialists in the branch of medicine on which the disability is based or are general practitioners used?

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Are the written reports of all independent examiners reviewed and evaluated by the insurer’s medical consultants?

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Is the claimant’s attending physician provided with a copy of the independent examiner’s report?

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Is the attending physician asked to comment on the report?

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Are benefits terminated solely on the basis of an independent medical evaluation that fails to support disability?

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Please provide any additional comments that you believe would be helpful in understanding how this claim tool is effectively used in your market.

**REHABILITATION AND VOCATIONAL ASSESSMENTS**

We define rehabilitation as “assistance provided to enable a claimant to return to work through retraining, financial means or counselling”. We define vocational assessments as “formal testing to determine occupations for which a claimant may best be fitted”.

Are rehabilitation services and vocational assessments readily available and routinely used in your market?

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If so, please answer the following questions. If not, please state whether, in your opinion, the use of this tool would be culturally acceptable.

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Are most rehabilitative services provided by insurance company employees or by third-party vendors?

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What criteria are used to determine which claimants have the most potential to benefit from rehabilitative services?

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Who reviews these criteria? (Claims personnel or medical person)

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Does your company provide financial assistance for accelerated medical tests or procedures in order to enable the claimant to return to work more quickly?

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If a third-party vendor is usually used, on what basis is a specific vendor chosen for each file?

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Do “own occupation” definitions limit the files on which the use of vocational assessments is considered? If so, what percentage of claims is eliminated from consideration?

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Does completion of a vocational assessment imply termination of benefits if a suitable vocation, for which the claimant already qualifies, is identified?

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Does completion of a vocational assessment imply that any retraining required to qualify the claimant for a new occupation will be insurer-sponsored?

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Please provide any additional comments that you believe would be helpful in understanding how this claim tool is effectively used in your market.

**PSYCHIATRIC AND SOFT DIAGNOSES CLAIMS**

We define soft diagnosis claims as “disabilities that are based on subjective symptoms and may include such diagnoses as fibromyalgia, chronic fatigue syndrome, chronic pain, and environmental diseases”. We define psychiatric claims as “claims that are based on diagnoses identified through the DSM-IV”.

Are psychiatric consultants routinely used in your market to evaluate claims based on “soft diagnoses” and psychiatric illnesses?

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If so, please answer the following questions. If not, please state whether, in your opinion, the use of this tool would be culturally acceptable.

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What qualifications are typically required in order for an individual to serve as a psychiatric consultant (psychiatrist, psychologist, psychiatric nurse)?

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Are most psychiatric consultants internal (insurance company employees) or external?

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Are only claims based on psychiatric illnesses referred to the psychiatric consultant or are claims based on “soft diagnosis” (as defined above) also referred for potential problems with psychological overlay?

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Does the psychiatric consultant make direct telephone contact with the attending practitioner in order to discuss the issues involved in the disability?

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Does the psychiatric consultant become involved in recommending specific treatment plans?

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Are psychological tests used for analysing psychiatric disorders?

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Are the results of psychological testing accepted as an adjudication tool?

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Please provide any additional comments that you believe would be helpful in understanding how this claim tool is effectively used in your market.

**FIELD VISITS**

We define a field visitation programme as “visits to a claimant, his attending physician, his employer, or other interested parties in an effort to better understand a disability claim”. These visits may be completed by an employee of the insurance company or by a third-party vendor.

Are field claims visits routinely used in your market?

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If so, please answer the following questions. If not, please state whether, in your opinion, the use of this tool would be culturally acceptable.

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For what purpose(s) are field claims visits usually undertaken?

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Who typically performs routine field visits (insurance company employee or a third-party vendor)?

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What qualifications are required in order to conduct field claims visits?

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Are claims adjudicators expected or required to conduct any field visits on their claim files?

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Do field claims representatives typically visit with attending medical practitioners as well as with claimants?

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Do field claims representatives typically visit with employers as well as with claimants?

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Do field claims representatives make the final decisions regarding benefit eligibility after completing a field visit?

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Have the results of such visits proven to be successful for your company?

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Please provide any additional comments that you believe would be helpful in understanding how this claim tool is effectively used in your market.

**INVESTIGATIONS AND SURVEILLANCE**

We define investigation as “the process of obtaining information about a claimant by questioning individuals with knowledge about his limitations or activities”. Third-party vendors usually conduct these investigations. We define surveillance as “documenting the activities of a claimant through videotaping methods”. Surveillance is usually conducted over several days by a third-party vendor.

Are investigations and surveillance routinely used in your market?

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If so please answer the following questions. If not, please state whether the use of this tool would be culturally acceptable.

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Under what circumstances is a file referred for an investigation or surveillance?

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During surveillance, for how many days is the claimant usually observed?

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How frequently is surveillance used?

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Are claims terminated solely on the basis of the results of either an investigation or surveillance?

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Do various disability insurers share costs of an investigation or surveillance on a mutual claimant?

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Are the results of the investigation or surveillance provided to the attending physician for comments?

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Does your company have its own special investigation unit that focuses solely on difficult cases involving fraud?

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If so, what is this unit’s specific mandate?

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Please provide any additional comments that you believe would be helpful in understanding how this claim tool is effectively used in your market.

### LUMP-SUM SETTLEMENTS

We define a lump-sum settlement as “payment by the insurer of a specific sum of money in lieu of monthly disability benefits in exchange for the claimant’s agreement to release the insurer from further liability”.

Are lump-sum settlements routinely used in your market?

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If so, please answer the following questions. If not, please state whether, in your opinion, the use of this tool would be culturally acceptable.

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Under what circumstances would a lump-sum settlement offer be considered?

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Would an insurance company employee or a third-party vendor usually negotiate a lump-sum settlement?

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If a company employee, what qualifications would be required?

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On what basis would the amount of the settlement offer be determined?

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What tax implications are there to the payment of a lump-sum settlement?

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Are lump-sum settlements made as structured settlements, such as an annuity?

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Please provide any additional comments that you believe would be helpful in understanding how this claim tool is effectively used in your market.

## FUNCTIONAL CAPACITY EVALUATIONS

We define a functional capacity evaluation as “the objective testing of a person’s abilities and limitations in work-related tasks”.

Are functional capacity evaluations routinely used in your market?

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If so, please answer the following questions. If not, please state whether, in your opinion, the use of this tool would be culturally acceptable.

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What criteria are used to determine which claimants should undergo a functional capacity evaluation?

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Who establishes these criteria?

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Are these evaluations done by rehabilitation firms or by special firms who focus solely on such assessments?

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Do these evaluations involve a worksite assessment that evaluates the physical demands of a claimant’s job?

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Do “own occupation” definitions limit the files on which the use of such evaluation services is used?

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If so, what percentage of claims is eliminated from consideration?

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Are rehabilitation firms usually used to implement recommendations from the functional capacity evaluation?

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Please provide any additional comments that you believe would be helpful in understanding how this claim tool is effectively used in your market.

## INDEPENDENT ACCOUNTING EVALUATIONS

We define an independent accounting evaluation as a “forensic audit of a claimant’s financial records in order to determine the correct level of residual disability benefits payable”. These assessments are completed by a certified public accountant who is neither the claimant’s accountant nor an employee of the insurer who requests the evaluation.

Are forensic audits routinely done in your market?

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If so, please answer the following questions. If not, please state whether the use of this tool, in your opinion, would be culturally acceptable.

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What criteria are used to select the independent accountant?

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Are independent forensic audits done only on problematic files or are they completed on a random basis?

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Are independent forensic audits used to determine the level of business overhead expenses payable on overhead benefit policies or are they limited to residual benefit policies?

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How successful have independent forensic audits proved in finding understated income or overstated expenses in claimants’ financial submissions?

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Please provide any additional comments that you believe would be helpful in understanding how this claim tool is effectively used in your market.

**TELEPHONE CLAIM INQUIRIES**

We define a telephone claim inquiry as “an investigative telephone call to the claimant, his attending physician, or his employer in an effort to better understand the disability claim”. The calls are an inexpensive method of communicating with the claimant and are usually conducted by the claim adjudicator.

Are telephone inquiry services routinely used in your market?

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If so, please answer the following questions. If not, please state whether, in your opinion, the use of this tool would be culturally acceptable.

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Does the claim adjudicator contact all claimants by telephone or are calls reserved for problem cases?

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If calls are completed on selected claims, what criteria are used to determine which claimants are called?

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Do claim adjudicators establish regular telephone communication with claimants?

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How successful have telephone claim inquiries proved in the disability claim adjudication process?

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Please provide any additional comments that you believe would be helpful in understanding how this claim tool is effectively used in your market.

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