Press Release

SVS PUBLISHES NEW PENDING REGULATIONS TO CLARIFY MASS INSURANCE SALES

- *Regulates the sale and purchase of life, health or disability insurance, in order to improve the consideration of pre-existing conditions at the time of contracting the respective coverage.*
- *Improves the quality of information provided to customers when purchasing health insurance, credit-related insurance and insurance purchased online.*
- *These circulars and regulations will be available on the SVS website until March 23rd, and are open for comment from the market.*

Over the last few years there has been a strong increase in the sale of mass insurance, making it possible for many people to now access this type of insurance, when they were not able to before. This rise in sales has benefited the development of the insurance market.

Nevertheless, the Superintendencia de Valores y Seguros (SVS) has identified some problems with the availability of information, underwriting and purchase of these products, and sees the need to improve conditions in the sale of mass insurance and the public's right to information, and to improve current regulations overall.

These modifications will be available to the public and open for comments and observations from January 30th to March 23rd.

I. REGULATIONS ON THE PURCHASE OF INSURANCE (UNDERWRITING AND PRE-EXISTING CONDITIONS)

The SVS is aware of the difficulties that have arisen from the application of exclusions for pre-existing conditions in the sale of life, disability and health insurance. This is due to the use of health declarations that are vague with respect to pre-existing illnesses, as well as insufficient risk underwriting processes.

The pending regulations establish that:

1. Companies that sell life, disability or health insurance, whether individual or group, and that apply coverage exclusions for pre-existing conditions, must as a minimum:

a) Use a health statement that clearly and precisely specifies the illnesses that are understood as pre-existing conditions and which may not be covered by the insurance plan. These should avoid using broad definitions or general situations of exclusion for pre-existing conditions.

b) Ensure that the health declaration form is completed and signed directly by the policyholder.

c) In the event that the policyholder declares any of the illnesses considered to be pre-existing conditions, the company must, within a period of five business days, inform the policyholder whether or not coverage has been approved, under one of the following terms:

i. The company approves coverage without restrictions, not applying exclusions for pre-existing conditions.

ii. The company approves coverage, but excludes compensation payments for claims directly associated with the declared illness. The company may only consider this exclusion for a maximum of two years from the date the insurance plan is contracted.

iii. The company asks for additional information in order to make its decision. In this case, it must also inform the client whether or not he or she will have coverage during the period of analysis. This period of analysis must not exceed 10 business days.

iv. The company rejects coverage.

The company may not begin charge the insurance premium until it has accepted coverage.

2. Companies that do not apply a risk underwriting process or whose current process does not comply with the minimum requirements indicated in the previous number, may not apply coverage exclusions for pre-existing conditions.

3. In the event that the applicant does not declare a pre-existing condition, the company may only apply exclusions for pre-existing conditions if it has objective and indisputable information that demonstrates that the applicant was aware of the existence of said condition, such as diagnosis reports from the attending physician, clinical records, exams and their corresponding result reports. In any case, no exclusion for pre-existing conditions may be applied after a period of 5 years following the date on which the insurance is contracted.

II. CATASTROPHIC HEALTH INSURANCE

Some problems have been detected in the area of catastrophic health insurance due to the complex information provided to the clients at the moment of contracting the insurance plan, whether by the insurance companies, their agents or intermediaries, generating expectations and complaints about the actual coverage which does not conform to the conditions of the products offered.

Therefore the SVS believes it appropriate to provide instructions for standardizing this information, in order to guarantee that the public has sufficient knowledge regarding the conditions of the types of coverage offered.
This reduces the risk of erroneous decisions about health insurance coverage and its relation to the health care system that the policyholder belongs to (Isapre-Fonasa).

Insurance companies must publish an obligatory inscription with the following information:

IMPORTANT
By contracting this health insurance policy, you must be aware of the following:

1. This catastrophic insurance plan is voluntary, and only provides compensation for medical expenses when these exceed a determined amount of money (deductible or excess).

2. This insurance plan does not substitute coverage given by ISAPRE or FONASA.

3. Before contracting this policy, it is important that you are informed and clearly understand the following aspects:

- Duration of this contract or policy
- How and under what conditions this contract may be renewed
- How the cost of this insurance is readjusted, in the case of renewal
- In which cases **THIS INSURANCE WILL NOT BE PAID** (for example, previous or pre-existing disability or illnesses).

Without prejudice to other related regulations, publicity for this type of insurance must not give erroneous or misleading information to the public, especially regarding the how the insurance policy works; possession of other health care coverage – ISAPRE or FONASA-; procedures to determine the amount of compensation that will be paid in the event of a claim; work methods and application of the deductible or excess; and exclusions of coverage.

III. TRANSPARENCY IN THE PURCHASE OF INSURANCE ASSOCIATED WITH OTHER FINANCIAL PRODUCTS: MODIFICATIONS TO CIRCULAR NO. 1759, of 2005.

The pending circular establishes the need to provide the client with a separate and independent insurance proposal or application for each insurance policy, in order to differentiate information related to other operations, business or associated products, and limit its content exclusively to the coverage purchased by the policyholder.

Additionally, it establishes an obligation to provide information in a contract appendix, instead of a coverage certificate as is currently used, about the intermediation commission or any other commission for the client, intermediary or any other related person or persons, including commission for turnover, production, contingency and receipt of payment.

IV. RIGHT TO CANCELLATION: MODIFICATIONS TO CIRCULAR NO. 1457, of 1999.

This pending circular establishes the obligation to provide information in the insurance proposal or application regarding the group insurance contract, its conditions and how it works.

Also for group insurance, which has been purchased by the individual policyholder simultaneously or in conjunction with a loan operation, identifying the designated beneficiary to the insured debtor or his or her legal heirs, as is the case, this must contemplate the policyholder’s right to cancel the insurance, without cause or penalty, within 5 days following the contracting of the loan, or from the insurance underwriting, whichever comes last.

This is aimed at giving the policyholder enough time to reflect on his or her decision and at avoiding the sale of voluntary insurance tied to loans that the people need to access.

V. ONLINE INSURANCE SALES

This change reinforces the clients' rights in the advertising and offer of insurance online, modifying Circular 1587, of 2002, and establishing that the right to cancellation (of the insurance contract) must be informed at the same time as the insurance policy is sent by Internet.

Santiago, February 4, 2009