TRAVEL INSURANCE: Section 47 and Pre-Existing Conditions

Recommendation: That there be a standard, industry wide definition of a PEC – pre-existing condition – for travel insurance. That way, confusion will be removed and people can compare insurance policies with confidence and ensure they have the coverage for their needs.

Submitted by: [redacted], former academic, lecturer in business statistics, financial mathematics and quantitative methods.

Objective of this submission

What problem is this submission trying to solve?

It is very difficult to work out when a medical event or condition is deemed under Australian law to be *pre-existing* and when it is deemed as *non-pre-existing*. This submission aims to solve this confusion in regard to travel insurance.

It aims to:

> (a) Stop insurers being able to use the definition that best suits them when signing people up for travel insurance and
>
> (b) Stop insurers being able to use the definition that best suits them when a claim is made.

It aims to:

> Stop insurers insisting claimants sign a release of information document that gives an insurer unfettered access to whole of life medical records enabling them to cherry pick conditions they can link to a new condition.

It aims to:

> Ensure that Section 47 in the Insurance Contracts Act is adhered to by all insurance companies when it comes to pre-existing and non-pre-existing conditions.

It aims to:

> Ensure that ASIC and FOS properly oversee how insurers treat the issue of pre-existing conditions.

Who does it benefit?

This proposal benefits the many millions of Australians who are seeking the right insurance cover for their travel plans.

A standard definition of a PEC, and by default a standard definition of a non-PEC (non-pre-existing condition) will enable everyone to easily compare travel insurance policies.

This submission might also be applicable to other types of insurance where medical claims are involved, e.g. private health cover, or income insurance.

The submission may be useful for past claimants to seek redress from their insurance company and/or the Financial Ombudsmen Service if their claim was wrongly rejected when the insurer made extraneous or spurious links between a new condition and a known one.

Who will be against this proposal?

Insurance companies will be against this proposal as they will no longer be able to maximise their profits through

(a) Duping travellers into taking out expensive but unnecessary cover for so-called PECs and
(b) By minimising payouts by using selective definitions of PECs to minimise cover or refuse a claim outright.

What legislation is required?

This submission argues that it should be compulsory for every company offering travel insurance in Australia that every PDS and related documentation include the same definition of a PEC.

It will be essential that there is strong and effective policing by ASIC and FOS.

Terminology used

In this submission we use "PEC" to mean a *known* pre-existing condition. We use "non-PEC" to mean a condition that was *unknown* to the insured.

The following notes explain in plain language the difference between the two in the case of *travel insurance*. In particular, it explains how *Section 47* of The Insurance Contacts Act is there as a legal protection for *all travellers* against inadvertent or deliberate rejection of claims by insurance companies where a medical event should have been deemed as *non-pre-existing*.

It is hoped that the notes below provide a useful framework for the Commission in tackling this issue.

The legal parts in plain language

Travel insurance

Travellers take out travel insurance to cover the risk, financial or otherwise, of unforeseen and unexpected events (loss of baggage, cancellations, medical problems …).

Travellers take out a policy with an insurance company and a contract is agreed on.

The contract is normally defined by the general *product disclosure statement,* or *PDS*, plus a brief *certificate of insurance* for the particular individual.

Under the contract, the insured traveller has responsibilities and the insurance company has responsibilities.

Pre-existing condition v non-Pre-existing condition

As indicated above, in this submission we use "PEC" to mean a *known* pre-existing condition. We use "non-PEC" to mean a condition that was *unknown* to the insured.

The Australian Insurance Contacts Act states:

> *47 Pre-existing sickness or disability*
>
> *(1) This section applies where a claim under a contract of insurance is made in respect of a loss that occurred as a result, in whole or in part, of a sickness or disability to which a person was subject or had at any time been subject.*

> *(2) Where, at the time when the contract was entered into, the insured was not aware of, and a reasonable person in the circumstances could not be expected to have been aware of, the sickness or disability, the insurer may not rely on a provision included in the contract that has the effect of limiting or excluding the insurer's liability under the contract by reference to a sickness or disability to which the insured was subject at a time before the contract was entered into.*

The financial ombudsman, FOS, states:

> *Sickness and disability insurance policies commonly contain an exclusion for claims resulting from a condition that the consumer had before the contract of insurance was entered into (a 'pre-existing condition').*
>
> *Section 47 of the Insurance Contracts Act 1984 (the Act) limits the circumstances where an insurer can rely on such a provision. An insurer cannot rely on such a provision where the insured was not aware of, and a reasonable person could not be expected to have been aware of, the pre-existing condition (the Act uses the terms 'sickness' or 'disability').*

Section 47 effectively defines a PEC as: A sickness or disability which at the time when the contract was entered into the insured was aware of and a reasonable person in the circumstances could be expected to have been aware of.

Pertinently, it effectively defines a non-PEC as: *A "sickness or disability" which "at the time when the contract was entered into, the insured was not aware of, and a reasonable person in the circumstances could not be expected to have been aware of".*

Thus it is these two definitions that are used to resolve a dispute over a medical claim.

In particular, from Section 47, under the legislation an insurer will not refuse coverage for a non-PEC by reference to a known PEC, that is, "*by reference to a sickness or disability to which the insured was subject at a time before the contract was entered into".*

Difficulties in understanding insurers' definitions of PECs and non-PECs

<u>Definition of a PEC and a non-PEC</u>

Section 47 refers to "*sickness or disability"*. Insurers use the word *"condition".*

Using plain and familiar language it would seem easy to define what is a PEC, that is, a pre-existing condition. An example of a PEC might be long term high blood pressure. An example of a non-PEC might be early stage cancer which may have been present but unknown at the time the policy was activated.

However, insurers seemingly include almost any kind of illness or operation or any medical procedure or incident or affliction.

Thus insurance companies use a plethora of definitions for "pre-existing condition". There may be two or more definitions given in a PDS; the online activation of a policy might give other definitions; the call centre staff helping to activate a policy might give further definitions, the claims staff or CMO (Chief Medical Officer) might add more. These definitions might be similar, they might or might not overlap, and they might not be exhaustive and thus not cover all possibilities.

Travellers wanting insurance thus find it is almost impossible to understand the concept of a PEC.

At the same time insurers give dire warnings about non-disclosure or failure to disclose. For example, Allianz writes: "If you have not disclosed other pre-existing medical conditions, or have not answered all medical assessment questions in a complete and honest way, this may invalidate this Medical Terms of Cover letter and the policy cover provided."

Yet there is no clarity about whether anything and everything from the past is deemed to be a *condition* or whether an affliction that is with you all the time is deemed to be a *condition*.

For example, if someone has had their tonsils or appendix removed three years ago is that a PEC? If someone had a knee replacement 20 years ago, is that a PEC? If someone had asthma as a child, is that a PEC? Is someone uses insulin, is that a PEC? If someone had chicken pox as a child, is that a PEC? Is someone has a non-life threatening syndrome or allergy, is that a PEC?

Following are examples of confusing definitions and statements from relating to PECs and non-PECs regarding the complementary credit card travel insurance, for which it is the underwriter. They have been encountered in PDSs, from policy activation staff, from claims staff and from the online activation process:

- A condition of which you are aware before taking out insurance
- A condition for which you require prescribed medication (e.g. blood pressure, cholesterol, asthma)
- A condition for which your medication has been changed in the last 24 months
- A condition for which you have been hospitalised (overnight) in the last 24 months
- Not PEC if not receiving medication or hospitalised in the last 24 months.
- An operation like a knee reconstruction is PEC if recent and still recovering. But non-PEC if done some years ago and walking is fine and there is no medication and no hospitalisation, no crutches, no follow up treatment
- If someone has not been hospitalised for a condition for over two years and no change to or new medication for it, then it is not a PEC.
- If you have sought any medical advice on an issue, it must be declared.
- If you have any kind of medical issues, you need to declare it
- We generally give a ball park of medical issues two years prior to the policy being issued.
- You do not need to specify every single thing you have had, just the two years prior to activation: you would not put down that you had measles as a child.

This confusion of definitions by insurers may be deliberate, enabling insurers to use their preferred definition in a selective way in order to:

(a) *Maximise premiums paid by duping consumers into taking out extra coverage often at great expense for so-called PECs when there is no need to.*

And

(b) *Minimise payouts by using a definition of a PEC that minimises the amount of a claim or rules out coverage totally.*

An example of the misuse of Section 47 could be a traveller declaring childhood asthma as a PEC but catching pneumonia while travelling and the insurance company refusing coverage for the pneumonia by linking it to the previous asthma problems and claiming the two are related respiratory conditions.

[redacted] advice about declaring any known PECs

Examples of advice encountered from [redacted] about declaring PECs include the following:

- If you don't want the cover you don't need to declare it
- Even though the PDS says under insurance contracts act "you must be honest and disclose to us" you don't have to declare everything. You don't get penalised for that; some people don't even want to disclose their conditions. That is not a problem.
- How do you know what you should seek cover for: if you want cover for your conditions, is it a PEC only for the last two years or is it a PEC beyond two years?
- The 24 months is just part of it. If you have had anything to do with major organs, abdomen, … there is no time limits; even if you had it 10 years ago, it is still a PEC.
- PECs include back pain for which you require frequent pain relief, even if it happened 10 years ago. Or organ with hospital stay, with surgery, joints, neck, shoulder, … Anything to do with your brain, back, spine, or abdomen.
- It is not that complicated applying for coverage for PECs: the online system will decide whether or not there is a premium to pay.
- The online system says: "Do you have any PEC conditions?" but no definition of a PEC is given.
- It is very clear that you would only click you had a PEC condition if you had been taking medication or been hospitalised in the last two years.
- Someone with a 10 year old knee replacement: no need to declare it or take coverage out as they would be covered as any problems with it would be unexpected, even hospitalisation!
- Based on the medical history rule of current medication or two years hospitalisation, for anything further than two years if you don't expect something to go wrong, you don't need to declare it and it will be covered.
- You put items into the system and the system would ask questions about it.
- When you are doing the online medical you must mention everything!
- There is a duty of disclosure document. If you don't declare a condition you don't regard as PEC you won't have cover for it!
- If you only mention five things but you forgot to mention a sixth one, the claims team will sort it out when a claim is made.
- The online system will ask if you had an implant. If you say No, you are not telling the truth but if you say Yes you get a whole lot of questions and the implant of ten years ago is deemed to be PEC by the online system.
- Anything unforeseen that is unexpected would be deemed to be an accident and you would be covered as you do not expect your implant to fall apart on your holiday.
- If you make a claim the claims department will contact your doctor to determine if PEC or not.
- If you say No to any PECs you are not going to get penalised for doing that, for not declaring it, provided you know you are not covered.
- If someone is not aware and not having a diagnosis of a condition then it is not PEC and no need to declare it.

Recommendation:

There needs to be a standard, industry wide definition of a PEC. That way, confusion will be removed and people can compare insurance policies with confidence.

Online systems are very limited and provide questionable results about whether a condition should be declared.

Resolution of a medical claim involving a non-PEC – What should happen but might not!

If the insured submits a claim involving a condition or event that they believe is non-PEC, the resolution process should be relatively straightforward for the insurer.

The insurer has duty of care for the insured and should take timely action to determine:

(a) if the new condition is serious enough to warrant coverage, and

(b) if the new condition is one of which the applicant and any reasonable person could not have been aware.

If both of these are true, the coverage should be provided by the insurer.

Responsibilities of the claimant:

The insured must assist the insurer and provide sufficient information for them to make a decision in regard to (a) (for example, by obtaining a doctor's report in the foreign country) and in regard to (b) (for example, allowing the insurer to speak with the insured's Australian doctor and/or associated medical personnel).

The insured does not have to provide the insurer with information or assistance that go beyond the requirements of Section 47.

Responsibilities of the insurer:

The insurer has *duty of care* for the insured and must act in a timely manner to make a decision as to whether to *accept* a claim or to *reject* it. The insurer must act quickly and decisively enough so that the insured receives proper treatment, and takes proper action, either at the expense of the insurance company (if the insurer agrees to coverage) or at their own expense (if the insurer rejects coverage). Otherwise, a person's health and life may be threatened.

Once (a) has been satisfied to the insurer, under (b) the insurer needs to confirm with sufficient confidence that the new condition is not a PEC according to Section 47.

The insurer should not delay or refuse coverage by insisting that the insured provide information that under the legislation cannot be applied to decision making under Section 47. Medical information about known PECs, whether declared or not by the insured, is irrelevant as Section 47 stipulates that coverage cannot be denied *by linking ("reference to") a new sickness or disability* to a known PEC.

As coverage for a new condition cannot be denied by linking it in either a direct or indirect way to a known PEC, then gathering information about any known PEC is of no assistance to the insurer but would be time wasting and frustrating for the insured, and possibly compromising the insurer's duty of care to the claimant.

Section 47 guards against insurers denying coverage by making extraneous or spurious links, directly or indirectly, to a known PEC.

For example, a case of pneumonia to a traveller is a new condition and insurance cover cannot be refused because:

- the insured had declared childhood asthma when applying for insurance, or

- the insurer requests past medical history from the insured and discovers reference to the childhood asthma, or
- the insurer asks the insured various questions, one of which is about asthma

The history of asthma is not a grounds for refusal of coverage for the new condition of pneumonia.

As another example, a traveller seeks medical treatment overseas and are diagnosed with pancreatic cancer. To the traveller and their partner this is a new condition and insurance cover cannot be refused because:

- the insured had declared back problems when applying for insurance,
- the insurer requests past medical history from the insured and discovers reference to the back problems and skeletal X-rays
- the insurer asks the insured various questions, one of which is about back problems and skeletal X-rays.

The history of back problems is not a grounds for refusal of coverage for the new condition of cancer.

In simple terms, the insurer merely has to judge *if the new condition is one of which the applicant and any reasonable person could not have been aware*.

It is noted that the insurer will not always be able to make a decision where they are 100% confident and may have to make a judgement on the basis of the probabilities. Under duty of care, they should give the benefit of any doubt to the claimant.

Before travel: Taking out travel insurance

When a policy holder activates a travel insurance policy before travel they:

A. Will declare any known PECs and decide to either:
   (i) Pay an extra premium to the insurance company for coverage for those known PECs
   (ii) Not pay an extra premium and to self-cover for known PECs

or

B. Will not-declare any known PECs, either:
   (i) Intending to self-cover should a known PEC event occur while travelling
   (ii) Intend to convince the insurance company, “fraudulently”, “dishonestly”, … that they were unaware of any known PECs before activating the policy

and

C. Cannot declare any unknown PECs:
   (i) If they don’t know about a condition that they have but which is there but is unknown to them, they clearly can’t declare it. (For example, cancer and arthritis can develop over a longish period, but the insured is totally unaware of it.)
   (ii) They clearly can’t declare a brand new non-existent condition that will happen in the future. (For example, a broken ankle.)

Notes on the above:

Section 47 is the legislation that ensures fair treatment of travellers under C(i) and C(ii), that is, for events that are totally unexpected.

The definition of what is a known PEC may be badly defined in an insurer's PDS, so in applying for coverage the insured might inadvertently omit a known PEC or, at the other extreme, add conditions, events or illnesses that do not need to be declared as they do not fit the definition of a PEC.

Under A and B, it is quite possible that, with all good intentions, a traveller could omit one or more known PECs. For example, they might declare eight, but in fact there is a ninth and a tenth that they had totally forgotten about. This would be picked up by the insurer's investigation if or when a claim is made.

Option B(ii) is a risky choice for travellers as the insurer has the right to investigate as to whether or not the insured was aware of a condition.

It would be unusual for a traveller to take out insurance under either A(i) or A(ii) and also B(i), that is, declare some known PECs but deliberately not declare other known PECs.

During or after travel: Making a claim arising from an event– What should happen but might not!

When a policy holder experiences a serious medical condition while travelling, the activation of a claim should follow according to the PEC and non-PEC options given above as chosen by the traveller.

A(i): The insured submits a claim that it was a known PEC covered by the extra premium.

A(ii): The insured does not submit a claim.

B(i): The insured does not submit a claim.

B(ii): Even though the PEC was known to them, the insured submits a claim and claims that it was a new condition and not a known PEC.

C(i): The insured submits a claim and claims that it was a new condition and not a known PEC.

C(ii): The insured submits a claim and claims that it was a new condition and not a known PEC.

It is under situations B(ii), C(i) and C(ii) where Section 47 applies as in all three cases a new condition is claimed by the insured to be non-pre-existing.

B(ii) is a critical area for insurers as they have to avoid paying out on a fraudulent claim.

C(i) and C(ii) are critical areas for the insured as they have to ensure the insurance company does not wrongly reject their claim.

In all three cases, that is, situations B(ii), C(i) and C(ii):

- The claimant must assist the insurance company with their claim to the point where a decision by the insurer can be made according to the legislation.
- That is, the insurer has to have enough information to be able to decide whether *"at the time when the contract was entered into, the insured was not aware of, and a reasonable person in the circumstances could not be expected to have been aware of, the sickness or disability"*.
- The insurer may ask the claimant for more information, but the claimant can refuse if that information is deemed by the insured to be irrelevant to the claim. The information requested might be over-reaching, time wasting, could compromise the privacy and future of the claimant or could be used contrary to the legislation. In particular, the insured may refuse to complete a signed Release of Information or ROI document enabling the insurer to access their full medical records.
- The insurer should not withhold or refuse coverage purely because the claimant refuses to provide all the information requested of them when the insurer already has sufficient information in their hands.
- Extra medical information collected by the insurer may be deemed to be of no value as they cannot refuse coverage *"by reference to a sickness or disability to which the insured was subject at a time before the contract was entered into."*

To stress, it is contrary to the legislation ("illegal") for insurers to rule out legitimate C(i) and C(ii) and deny coverage by making extraneous or spurious reference, directly or indirectly, to a known PEC.

It is also a failure of duty of care on the part of the insurer to delay proper health and medical attention for the insured in any way.

The insurer should take timely action to determine:

> *(a) if the new condition is serious enough to warrant coverage, and*
>
> *(b) if the new condition is one of which the applicant and any reasonable person could not have been aware.*

The actions by the insurer will be deemed to be unconscionable and the insurer should be penalised accordingly if they:

- do not proactively and in a timely manner use their own resources and knowledge to help them make a judgement about whether or not the condition is non-PEC
- do not proactively assist the insured to provide useful information for judgement about whether or not the condition is non-PEC
- do not provide coverage the moment the requisite conditions for C(i) and C(ii) have been met and/or
- insist on the insured providing further medical records or information that the insurer knows cannot, under the legislation, assist the insurer come to any other conclusion than to provide coverage.

Disputing a claim with the FOS – What should happen but might not!

The insured can lodge a dispute with FOS Financial Ombudsman Service if they believe that their situation falls under either C(i) or C(ii) and one or more of the following situations existed:

- the insurer had denied coverage

- the insurer was not proactive in seeking relevant information to assess the claim of non-PEC
- the insurer did not act in a timely manner
- the insurer provided coverage different from what should have been provided had the insurer acted proactively and immediately under duty of care obligations.

In assessing the dispute, the FOS's role is simple and has three parts.

First, FOS needs to answer this question:

> *Q1. Did the insurer have enough information for them to be able to conclude that "at the time when the contract was entered into, the insured was not aware of, and a reasonable person in the circumstances could not be expected to have been aware of, the sickness or disability"?*
>
> If Yes, the insurer cannot deny coverage under the legislation and the insured's claim is upheld by FOS and a settlement amount awarded.

Second, FOS needs to answer this question:

> *Q2. Were the actions of the insurer timely and proactive in assessing the claim on the non-PEC?*
>
> If No, the insurer is penalised accordingly and a settlement amount awarded to the insured.

Third, FOS needs to answer this question:

> *Q3. Did the insurer refuse coverage to the insured by reference to a sickness or disability to which the insured was subject at a time before the contract was entered into?*
>
> If Yes, the insurer is penalised accordingly and a settlement amount awarded to the insured.

What should happen but might not! – Failure by ASIC and FOS

Both ASIC and FOS have been derelict in their duties to oversee the issues of PECs, non-PECs and Section 47.

We have already made submissions to the Commission about ASIC and FOS.

For ASIC, see: Reference number [redacted]

For FOS, see: Reference number [redacted].

As a result of their failures it is likely that many Australians (many thousands) have had claims wrongfully dismissed.

The Commission may have the power to investigate wrongful decisions by insurers and/or by ASIC and, in particular, FOS which seems to support large businesses ahead of the general public. Can the Commission have these wrongs corrected?

Here is an example of a possible wrong decision. From a letter to Traveller in The Age - March 5, 2018, illustrating where a new condition has been spuriously linked to a declared conditions, and coverage refused.

BREATHLESS ACCOUNT

While touring Greece my wife collapsed with a bacterial infection that led to pneumonia. She was treated in a third-world-standard public hospital short of pillows and toilet paper, where family sleep in the shared ward to supplement the shortage of nursing staff. Conditions were appalling.

We were abandoned by RACV insurance despite my calls for help. It was a terrifying situation exacerbated by not speaking the language. I then had to transfer my wife back to Athens and stay at a hotel for 10 days before she could return home.

It was only after we arrived in Melbourne 18 days later that we were advised our claim was denied. This was based on my wife's disclosure that years ago she had asthma but was now clear.

Two respiratory specialists stated that bacterial pneumonia is not asthma, but RACV dismissed our claim as it falls within the definition of a respiratory disease. Break a leg and it's straight forward, but an illness is easy to challenge and dismiss. We are down $35,000.

Lance Sterling, Burwood, VIC

There are at least three areas where ASIC and FOS are not overseeing insurance companies and failing to meet the expectations of the public. These failures are outlined below.

The Insurance Council of Australia has also failed in ensuring that insurance companies abide by the codes of conduct, for example, through ethical behaviour, applying the rule of what is reasonable (for insurers as well as the insured) and ensuring that unqualified staff do not make judgements or provide advice.

1. ASIC and FOS are allowing insurers to include clauses in their PDSs that clearly are in contravention of Section 47 and condoning them ignoring the legislation.

Section 47 is as follows:

47 Pre-existing sickness or disability

(1) This section applies where a claim under a contract of insurance is made in respect of a loss that occurred as a result, in whole or in part, of a sickness or disability to which a person was subject or had at any time been subject.

(2) Where, at the time when the contract was entered into, the insured was not aware of, and a reasonable person in the circumstances could not be expected to have been aware of, the sickness or disability, the insurer may not rely on a provision included in the contract that has the effect of limiting or excluding the insurer's liability under the contract by reference to a sickness or disability to which the insured was subject at a time before the contract was entered into.

Here is an exclusion clause in an Allianz PDS that seems to bypass this legislation, all under the eyes of ASIC and FOS.

Policy exclusions - what is not covered

The following exclusions apply to all the covers described in this **booklet**. As well as these exclusions, there are also specific exclusions applying to certain covers.

To the extent permitted by law:

1. we do not insure **you** for any event that arises directly or indirectly from, or is in any way connected with, any **pre-existing medical condition** of any person including **you**, **your travel companion** or a **relative** other than as provided in *'Part C - Benefits and cover'* of the **Activated Policy** under Benefit 4.1 f] on page 49 and Benefit 6.1.b] on page 52.

2. ASIC and FOS are allowing the insurers to insist on signed ROIs (release of information documents) whereby claimants give them unfettered access to whole of life medical records.

The following is from an Allianz ROI. By refusing to sign this document, Allianz might refuse coverage for the claimant.

This amount of information is not necessary to assess whether or not someone was aware of a brand new condition, under Section 47.

It is likely that the insurers trawl through these whole-of-life records to find spurious links to other conditions enabling them to rule out the new condition, yet this is against the legislation.

COMPANY		**EMAIL**	
FROM		**FAX**	
COMPANY		**EMAIL**	
DATE			
CASE NO		**NO. OF PAGES**	
SUBJECT	D.O.B		

I hereby authorise:

- **The release of any and all medical information in relation to me that is held by any hospital, organisation or individual to trading as and its local agent.**
- **to use or provide any medical information held about me to such persons as considered necessary to conduct and manage my claim or medical emergency, and**
- **to release any information, including medical advice or opinions, provided to them, to any persons that feel may benefit from the receipt of such information, in the carrying out of their duties in relation to me and my claim.**

A signed facsimile or photocopy of this document will constitute such an authority, and may be used in obtaining a copy of my HIC (Australian Health Insurance commission) records.

Signed, ___/___/_____

(Signature of patient, legal guardian or next of kin) (Date)

3. ASIC and FOS are not protecting the privacy of citizens.

Some millions of Australians might opt out of the MyHealthRecord system, yet ASIC and FOS are allowing insurers to gather whole-of-life medical records then hand them around.

The following is from an PDS. It clearly indicates why a claimant should not sign and ROI.

Privacy

To arrange and manage **your Base Cover**, **Activated Policy** and **Upgrade Policy** (in this Privacy Notice together "covers") (as relevant), we (in this Privacy Notice "we", "our" and "us" includes [redacted] trading as [redacted] and its duly authorised representatives) collect personal information including sensitive information from **you** and those authorised by **you** such as **your** family members, **travel companions**, **your** doctors, **hospitals**, as well as from others we consider necessary, including our agents.

Any personal information provided to us is used by us to evaluate and arrange **your** cover. We also use it to administer and provide the insurance services and manage **your** and our rights and obligations in relation to those insurance services, including managing, processing and investigating claims. We also collect, use and disclose it for product development, marketing, conducting research and analytics in relation to all of our products and services, IT systems maintenance and development, recovery against third parties, the detection and investigation of suspected fraud and for other purposes with **your** consent or where authorised by law.

This personal information is disclosed to third parties we engage or who assist us carry out the above functions or processes, such as travel agents and consultants, travel insurance providers and intermediaries, authorised representatives, other insurers, reinsurers, claims handlers and investigators, cost containment providers, medical and health service providers, **overseas** data storage and data handling providers, legal and other professional advisers, **your** agents, the [redacted] and its related and group companies, and our related and group companies including [redacted]. Some of these third parties may be located in other countries such as Thailand, France and India to name a few. **You** agree that while those parties will often be subject to confidentiality or privacy obligations, they may not always follow the particular requirements of **Australian** privacy laws.