

Medical Under-Declaration

A Systemic Risk to Insurance Outcomes

How medical under-declaration is undermining insurance — and how we mitigate it.





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A promise at risk

Insurance, at its core, is a promise: when customers face their most vulnerable moments, the industry will be there to protect them. That promise stretches across every line of business, including life, health, and travel insurance.

Yet a silent challenge threatens to undermine that promise: **under-declaration**.

Under-declaration occurs when a customer provides incomplete or inaccurate information during the application or renewal process. It can relate to many aspects of risk, including lifestyle factors and travel details. It creates uncertainty for insurers while leaving customers exposed when they need protection most.

But nowhere is the impact more personal, or more profound, than in **medical under-declaration**.

Medical under-declaration happens when a customer provides incomplete or inaccurate health information during application or renewal. Because it relates directly to someone's health (their condition, past diagnoses, treatments or medications), the consequences can be far-reaching.

In travel insurance, travellers could face hospital bills abroad or, in the worst-case scenario, being stranded abroad and facing medical care bills. In health insurance, it can lead to disputes and delays when treatment is needed. In life insurance, it means grieving families may be left without financial support.



Importantly, medical under-declaration is rarely about fraud. More often, it stems from:



Confusion

People don't know what qualifies as a condition



Complexity

Jargon-heavy, binary questions that feel like traps



Cognitive gaps

Customers forget details or underestimate their relevance

The result is the same: a breakdown in trust at the moment it matters most, for customers and insurers alike.



Iain Howie
Managing Director –
Verisk Life, Health and Travel

“Medical under-declaration is a systemic challenge, with consequences that can impact the entire insurance value chain.

Consumers could be without support when they need it most. Distributors face reputational damage when products fail to meet expectations. Insurers need to contend with pricing mismatches, claims friction and regulatory scrutiny. For the industry, persistent under-declaration can erode trust and increase pressure from regulators and consumer advocacy groups.

Addressing this challenge will require a coordinated response across insurers, distributors, and industry bodies, but the rewards are significant: fairer pricing, smoother claims experiences, stronger regulatory confidence, and ultimately a more transparent and trusted insurance market that works better for everyone.”



The scale of the problem

It is tempting to treat medical under-declaration as a product-specific challenge — something that varies between insurance lines. But in reality, the patterns are remarkably consistent. Across life, health and travel, customers struggle with the same barriers: confusing terminology, unclear questioning, and the difficulty of recalling medical information under pressure.

To understand the scale of this issue in one part of the market, Verisk conducted an in-depth survey of senior leaders across the travel insurance sector. The findings offer a compelling case study for challenges seen across life and health insurance, too, as evidenced by those who work in the industry.

For insurers, this is also an issue of competitiveness: improved underwriting (and clarity) at the point of sale can be a key differentiator in a market where claims payments statistics are highly visible.

Prevalence: A growing pain point

In the travel sector alone, 87% of insurers say medical under-declaration is a pain point within their business, with more than half reporting that the issue is getting worse, increasing the risk of pricing mismatch. A striking 81% have seen increases since COVID-19, and 42% say the issue has intensified further in the past two years.

This is not isolated to one product line or distribution channel. Life and health insurers report similar patterns: customers misunderstanding what counts as a condition, omitting controlled illnesses, or assuming historic diagnoses are irrelevant.



“ The behaviours we see in travel mirror what we experience in life underwriting. People rarely intend to mislead; however, in some cases existing processes do not facilitate accurate disclosure.”



Jeff Cook

Head of Life and Health –
Verisk Life, Health and Travel

Precise non-disclosure rates can be difficult to verify; however, available data suggests it is a widespread problem. A survey from AllClear (UK travel insurance provider) found that about one in four customers do not declare all of their medical conditions when buying travel insurance. In life and health insurance, a 2021 study found that nearly half of UK adults with a mental health condition did not disclose it.

Customers may not realise that some conditions are relevant or may assume that conditions that are historic or under control do not need to be disclosed. They may also be concerned about the impact of these disclosures on premiums or could be uncomfortable disclosing sensitive conditions.

“We’re also seeing under-declaration become more challenging because chronic conditions are rising so quickly.”



Jack Farrall
Head of Travel and Pet –
Verisk Life, Health and Travel

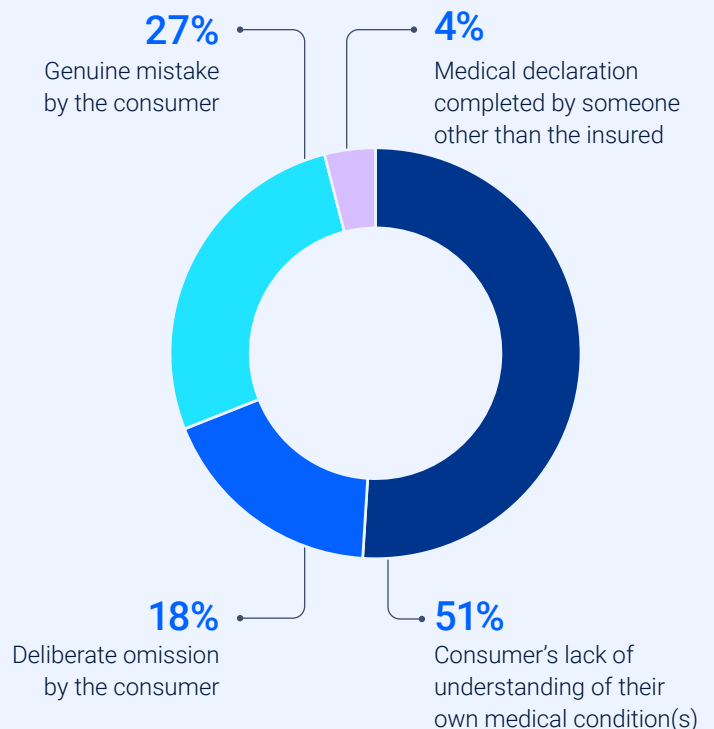
More customers are living longer with multiple managed illnesses, and those conditions feel ‘routine’ to them - which makes them less likely to declare. That means insurers are operating with less accurate information than they need.”

Caused by misunderstanding, not malice

Verisk’s travel survey makes something very clear: customers are not typically trying to game the system. Instead, they are confused by the process.

The top cause identified by insurers is customers’ lack of awareness of their own conditions (51%), and genuine mistakes (27%) were cited far more often than deliberate omissions (18%). The problem is a lack of understanding about what constitutes a medical condition, especially if these conditions are under control or have already been treated.

Critically, 59% of insurers admitted they are unsure whether proxy declarations (such as a spouse or child filling out the form) make the problem worse. This uncertainty reflects a serious blind spot in industry data capture.



Data as of September 2025



Jeff Cook
Head of Life and Health –
Verisk Life, Health and Travel

“ This is just the tip of the iceberg. The reality is, the industry doesn’t fully understand how big the iceberg of medical under-declaration really is. Such statistics can only reinforce that it is alarmingly common.”

The impact on claims: A problem at the worst moment

Under-declaration is often invisible until it surfaces at claim stage – when the stakes are highest.

The impact of medical under-declaration on claims is not consistent. While almost half (47%) of travel insurers report no increase in claims exposure, 30% report higher volumes of cancellation and emergency claims where non-disclosure is identified during a claim. This divergence highlights a lack of clarity around how and when medical under-declaration can result in measurable claims costs.

Furthermore, almost half (49%) say partial declarations and full non-disclosures are equally problematic, while a third (33%) say partial declarations alone cause the most difficulty.

This creates an undesirable situation: even customers who believe they have fully disclosed their medical history may still see their claims denied or adjusted.

The industry’s blind spots

Perhaps most telling of all are the gaps the survey revealed in insurer processes and data capture:

 2/3

of travel insurers do not record who makes the medical declaration – whether it is the traveller or a proxy – which restricts their ability to assess how and where mis-declarations may occur.

 42%

offer auto-renewals that include updated medical declarations, leaving many customers carrying outdated information forward.

These fragile points in the process exist across other lines of business: life insurers face inconsistencies in adviser-captured disclosures, and health insurers see gaps in historic conditions carried over across renewals. These gaps make it harder for insurers to even understand the true scale of this escalating problem, let alone address it.

The data tells a clear story. This isn’t primarily about dishonesty. The dominant driver is confusion and complexity: customers don’t know what counts as a condition, processes are inconsistent, and industry language can be difficult to understand.

The industry cost

While medical under-declaration leaves consumers exposed at their moment of need, insurers face their own challenges – primarily rising costs and reputational risk.

Every claim that must be denied or adjusted because of missing information creates a visible point of friction. Many insurers now publish their claims payment statistics, which means each denied claim carries implications for market competitiveness. In life and health especially, where policies are typically bought through agents or brokers, a poor claims experience can affect distribution and premium revenues.

Under-declaration also creates operational strain. At the point of claim, missing information complicates adjudication, slows decision-making, and makes it harder for insurers to fulfill their core purpose of paying valid claims. In some cases, insurers even absorb part of the cost of undeclared conditions for the sake of customer experience, which adds pressure to sustainability models.

But better disclosure isn't only a risk-mitigation exercise; it's an opportunity. When insurers have a more complete picture of a customer's health, they can price more accurately, offer more appropriate or inclusive cover, and make business decisions with greater confidence.



How do we address it?

The problem of medical under-declaration won't be solved by any single tweak. It requires a systemic change: practical reforms in insurer processes, underpinned by insights from behavioural science.

The industry perspective

Insurers are already trying to improve the accuracy of medical declarations, but there's no single approach across the market.

The table below highlights some of the most common approaches alongside Verisk's perspective, shaped by market data, behavioural science, and insights from our travel, life and health experts.

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THE POTENTIAL SOLUTION

1. Rethink the wording

Many insurers rely on broad questions such as "Do you have any pre-existing medical conditions?". But as Paul Tyson, former Managing Director at The Idol, explained, this can be too broad for customers, increasing the risk of misunderstandings. Instead of one vague question, The Idol introduced five simple, specific ones. The impact was impressive: 100% of customers engaged with the process, and sales conversion didn't fall, while the proportion of policies where medical conditions were properly disclosed and underwritten increased by 30%.

VERISK'S POSITION

Simplifying wording is a great step – particularly if done collectively, so customers aren't confronted with vastly different terminology from insurer to insurer. However, there is an important balance to strike: simplifying the language without adding any unnecessary complexity. The goal is to help customers understand what's being asked – not to overwhelm them. This is why we continually refine the language used in Verisk's tools: to reflect the latest insights about how people read, interpret and respond to health-related questions.

THE POTENTIAL SOLUTION

2. Make it easier to find conditions

Customers often struggle to recall medical terms – but they remember what medication they take or which part of their body is affected. To make disclosure easier, some suggest alternative search methods such as medication searches, symptom-based prompts, body-system filters, common-condition lists, and AI-powered suggestions that translate everyday language into clinical terms. These tools promise to offer multiple, intuitive ways for customers to find and declare conditions accurately – but success depends on how well they are used.

3. Shorten the lookback period

There is clear behavioural logic behind shorter lookbacks: people simply remember recent events more accurately. However, from a risk assessment perspective, shortening the lookback period for important conditions to only 1 or 2 years does not capture the full risk. It is up to insurers to decide whether standard underwriting for those conditions will lead to larger loss ratios. A shorter lookback also means collecting less data, which could have pricing and profitability implications.

VERISK'S POSITION

There is real value in making conditions easier to find, but some approaches can create problems of their own. Medication-based searches can lead customers down the wrong path. Risk assessment is based on the underlying medical condition, rather than the medication itself, which may be used to treat a range of conditions. This makes it difficult to identify the 'correct' condition from medication alone, which raises the risk of misclassification or unnecessary screening.

Where we see potential is in guided, conversational journeys that help customers think about their health in layman's terms. Verisk is actively exploring technologies that support this – including AI-enabled questioning that adapts to a customer's responses – because the goal isn't to introduce an innovative search method, but to build journeys that genuinely improve accuracy.

Our stance is a balanced one: shorter lookbacks can improve accuracy but should be aligned with each insurer's business strategy. Verisk's role is to support insurers with tools and insights that work across whichever lookback period they choose.

THE POTENTIAL SOLUTION

4. Record who's making the declaration

Verisk's survey found that more than 60% of insurers don't record who makes the medical declaration, whether it's the policyholder, a family member or a third party such as a travel agent. Proxy declarations introduce a higher risk of omission or misunderstanding, particularly when the person completing the form doesn't fully know the applicant's medical history. Capturing this data could provide valuable insight into when and where under-declaration occurs.

5. Help customers understand why disclosure matters

Even the best-designed journeys can only go so far if customers don't understand why they should disclose. A cross-sector campaign led by the ABI, government, or industry alliances could elevate awareness, build trust, and remind customers that honest disclosure is about safeguarding themselves and their families.

VERISK'S POSITION

It's useful to understand who is completing the health declaration – particularly in travel, where it's common for someone else in the household to fill in the details on behalf of the traveller. That knowledge can highlight where misunderstandings came from and help insurers design more supportive journeys for proxies.

That said, this is an area where insurers ultimately hold the cards. In life and health insurance, information about who is declaring is usually known. Our view is simple: if capturing this detail helps an insurer improve the accuracy of declarations, it's a useful addition – and insurers know their own business models best.

Ensuring customers submit accurate information begins with examining how the questions are asked at the point of sale. While broader industry education is important, insurers have the greatest influence through the design of their customer journeys. For example, well-structured questions and clear prompts help customers understand what is being asked of them in practical terms - and why it's important to them. Verisk's global expertise means it is well placed to help insurers improve these journeys - from refining questioning to providing insights to make disclosure clearer and more consistent.

New approaches, such as using technology to access or verify self-declared health information, where appropriate and with customer consent, could also support more accurate disclosure.

The behavioural science perspective

Will Trump, a behavioural scientist and founder of Unconventional Wisdom, has spent his career applying behavioural science to insurance, reinsurance, and financial services. His expertise highlights what so many in the industry see each day: under-declaration is not a question of dishonesty, but one of human behaviour.

Consumers do not usually set out to deceive their insurer. Instead, they face complex, jargon-heavy forms, have to make decisions under time pressure, and often default to the path of least resistance. Behavioural science shows us that even small adjustments to language, framing, and process design can significantly improve disclosure rates, as the journey better supports natural human decision-making.



FIVE WAYS BEHAVIOURAL SCIENCE CAN IMPROVE DISCLOSURE

1. Give a reason why

People are more willing to disclose information when they understand the purpose behind a question.



Less effective

“We need this information to decide if we can insure you.”



More effective

“We ask these questions to make sure your cover protects you if something unexpected happens.”

2. Avoid signalling the ‘right’ answer

Yes/no questions subtly suggest there’s a ‘correct’ option, and people will often choose the path of least resistance. By contrast, ranges or multiple-choice options prompt honesty and reduce the fear of giving the ‘wrong’ answer.



Example

“Which of the following best applies to you?”

- Regular smoker
- Occasional smoker
- I quit smoking in the past year
- I quit smoking more than a year ago
- I have never smoked

3. One thing at a time

Consumers struggle when faced with long, compound questions. Breaking questions into smaller, simpler steps reduces cognitive load and makes honesty easier. Each question answered builds momentum and disclosure.

4. Use plain English

Industry jargon alienates customers. People don't think in medical classifications — they think in everyday terms. Plain language turns a confusing process into one people can actually navigate.

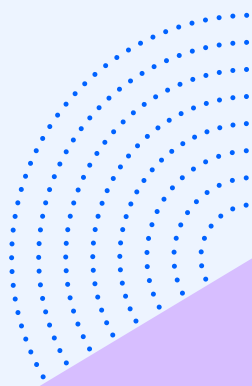


Example

Replace "Transient Ischaemic Attack" with "mini stroke" or "TIA (also known as Transient Ischaemic Attack)."

5. Smooth the journey

Abruptly handing customers off to third-party tools or separate platforms can break trust. Customers want to know why they are moving to another environment. Bridging transitions keep customers engaged and reduce drop-off.



From tweaks to transformation

Individually, these might sound like small changes. However, improving disclosure is not about any single intervention but offering a combination of approaches that can be applied consistently across the insurance value chain.

Clearer communication and education, better process and product design, more intuitive wording and simplification, and insights from behavioural science all have a role to play. Together, these elements can support customers in providing more accurate information and help insurers build more effective and reliable underwriting processes. This creates journeys that enable customers to provide complete and accurate information, while giving insurers the clarity they need to assess risk appropriately. For insurers, the benefits are clear: improved pricing accuracy, greater claims predictability, and stronger customer relationships – as well as reduced reputational and regulatory risk. Customers can also benefit from the assurance that their policy will provide the protection they expect, minimising the risk of unexpected gaps and unpleasant surprises when they need to make a claim.

Improving disclosure is not a task any one organisation can solve alone. Verisk invites insurers, regulators, and partners to collaborate on practical reforms, from terminology alignment to behavioural design principles and data-driven insight sharing.



If you would like to be part of this initiative, to test ideas, share insight, or help shape industry-wide standards, we invite you to join the conversation. Together, we can design declaration journeys that are clear, fair, and human-centred - across life, health, and travel insurance.

Please reach out to one of our experts:



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Discover more

Verisk Life, Health, and Travel helps insurers turn inclusivity from a cost burden to a profitable growth strategy. Our Risk Rating Tool is an automated medical risk rating system used worldwide, delivering instant, consistent quantification of risk associated with existing medical conditions.

 [verisk.com](https://www.verisk.com)

 contactus@verisk.com

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