ASISA
Association for
Savings & Investment
South Africa

ASISA GUIDELINE FOR ASSESSING DISABILITY DUE TO PULMONARY DISORDERS

Date of first publication: 28 July 2021

Date of last update: 31 March 2026

1. INTRODUCTION

1.1. Pulmonary disorders, along with low back pain, psychiatric disorders and cardiac disease, are leading causes of disability. Pulmonary disorders are increasing annually as evidenced by days off work and the number and monetary value of claim payouts.

1.2. There are a number of non-medical reasons that contribute to disability claims, such as:

1.2.1. Employer anti selection.

1.2.2. Employers may need to reduce staff numbers for various reasons and, if this is done by way of a disability claim, the impression of a more sympathetic approach by the employer and a better financial settlement for the employee is created. Employees can often be persuaded to lodge a disability claim based on medical history, despite the fact that they are still able to work productively.

1.2.3. Unfavourable working conditions. It is well known that the number of disability claims can be influenced by low job dissatisfaction, unpleasant working conditions or menial job tasks. Recent legislation, such as the Employment Equity Act, has addressed this problem by requiring employers to accommodate workers with impairments to enable them to continue working gainfully.

1.3. Objectivity of medical reports is another factor to consider. The clinical reports insurance companies receive often do not contain objective opinions or findings, but instead vague and self-reported details of the patient's symptoms. This can lead to extended periods of absenteeism from work and the premature and incorrect labelling of patients as permanently disabled.

1.4. In an effort to address this problem, insurance companies often endeavour to obtain objective opinions from specialists not involved in the insured's treatment and ask for an opinion on impairment only and not disability.

2. BACKGROUND TO THE GUIDELINE

2.1. There are often differences of opinion between the clinician and the insurance medical advisor that may cause frustration and unhappiness for all parties concerned. Concerns are often expressed about the complex nature of pulmonary disorders and the specialised

investigations that need to be undertaken to evaluate claims.

2.2. The former Life Office's Association ("**LOA**"), via its medical and underwriting committee, initiated contact with the S.A. Thoracic Society ("**SATS**") with the aim of addressing the concerns that existed. This was done by means of a workshop to refine specific recommendations.

2.3. The ultimate goal was to provide guidelines that could standardise the approach to claims based on a pulmonological condition. The workshop that was held addressed areas of differences by way of literature reviews and presentations with recommendations on each topic. After discussion, recommendations were drafted reflecting the decisions made by the participants.

2.4. The participants in the workshop were medical advisors from insurance companies representing the LOA and pulmonologists representing SATS. The guidelines for assessing disability were reviewed by the participants, as well as members of the SATS Council. Alterations were included and the final document was accepted and submitted for publication.

2.5. The LOA guideline has been used as a basis for this **Guideline for Assessing Disability due to Pulmonary Disorders** ("**Guideline**") and updates and revisions were made with input from members of the ASISA Medical & Underwriting Committee, as well as the ASISA Claims Standing Committee.

2.6. This Guideline accordingly aims to:

2.6.1. provide guidance regarding the distinction between impairment and disability;

2.6.2. make it clear that medical practitioners can only express an opinion regarding impairment and not disability (which is the function of the insurer);

2.6.3. provide guidelines for the assessment of disability due to pulmonary disorders;

2.6.4. provide a high-level overview of the different types of cover available;

2.6.5. provide guidelines on permanent and total disability;

2.6.6. provide an overview of policy terms and conditions for pulmonary disorders;

2.6.7. providing guidelines for reasonable treatment for certain pulmonary disorders;

2.6.8. providing guidelines for assessing and evaluating respiratory functional impairment;

2.6.9. providing guidelines regarding the clinical report;

2.6.10. providing protocol guidelines for evaluating potential claims and the roles of different role players.

2.7. This Guideline is being shared with ASISA members and the public at large for their consideration and voluntary implementation and is non-binding on ASISA members.

2.8. Please note that this Guideline contains references to source material that was available at the time of drafting this Guideline. It is the responsibility of Members to stay abreast and take cognisance of any amendments or additions to the source material from time to time.

3. DISTINGUISHING BETWEEN DISABLITY AND IMPAIRMENT

It is vitally important in the context of insurance disability claims to distinguish between the concepts of "impairment" and "disability", because impairment doesn't necessarily equate to disability. Factors like motivation, technology and accommodations can influence how impairment impacts an individual's life and work. Assessing disability accordingly requires a more comprehensive and functional approach than measuring impairment.

It is recommended that the following generally accepted definitions are applied:

3.1. Impairment

3.1.1. The World Health Organisation ("**WHO**") defines "*impairment*" as "*any loss or abnormality of psychological, physiological or anatomical structure or function.*"[1] In essence, this is a medical concept describing an alteration in an individual's health status. Impairment is assessed by medical means after a diagnosis has been made and appropriate treatment given.

[1] World Health Organisation. International Classification of Impairments, Disabilities, and Handicaps Geneva, Switzerland: World Health Organisation; 1980.

3.1.2. The American Medical Association ("**AMA**") Guides define "*impairment*" as a "*significant deviation, loss, or loss of use of any body structure or function*".

3.1.3. For purposes of assessing impairment, it is important to have regard to those activities of daily living a person can perform and those which the person cannot perform.

3.1.4. It is also important to recognise that "normal" is not a fine point or absolute. Normality is often within a range, e.g. with vision or hearing and can vary with age, gender and other factors. Interpretations of normal that are too strict can result in over- or underestimation of the degree of impairment.

3.2. Disability

3.2.1. The WHO defines "*disability*" as "*any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being*."[2]

3.2.2. The AMA defines "*disability*" as "*an alteration in the individual's capacity to meet personal, social or occupational demands or statutory or regulatory requirements because of an impairment*".[3] It also defines "*disability*" as "*an umbrella term for activity limitations and participation restrictions*".

3.2.3. The definitions used by the American Thoracic Society ("**ATS**") are wider and less specific. They do note that "*impairment*" is a purely medical concept, and that "*disability*" is the total effect of the impairment on the person's life.[4] [5]

3.2.4. From the above, it is clear that, whereas the determination of impairment requires a purely medical assessment, a disability assessment is a more comprehensive assessment of the capacity of the person, taking various factors into account. Disability is therefore contextual, and for a disability to exist, an

[2] World Health Organisation. International Classification of Impairments, Disabilities, and Handicaps Geneva, Switzerland: World Health Organisation; 1980.
[3] Guides to the Evaluation of Permanent Impairment, Fourth Edition. American Medical Association; 1995.
[4] Evaluation of impairment/disability secondary to respiratory disease. A statement of the ATS. Am Rev Respir Dis. 1986; 133:1205-9.
[5] It is important that Members keep up to date with any amendments to the definitions of "impairment" and "disability" by the WHO, the AMA and the ATS respectively, as well as updates to their Guides on the topic.

impairment must be present together with barriers to full participation in society. An impairment *per se* is not necessarily a disability.

3.2.5. In assessing disability, the extent of a person's impairment has to be evaluated in the context of their job function, the definition of disability in the policy contract and personal factors, such as education and experience.

3.2.6. It follows that no medical practitioner is in a position to express an opinion on disability. The practitioner may be fully informed regarding the medical condition and its effects of the activities of daily living, but he/she usually does not have sufficient information as outlined below, to determine disability, e.g. information regarding:

3.2.6.1. the insured's working history, previous occupations, qualifications, experience etc;

3.2.6.2. the relevant job description; and

3.2.6.3. the policy terms and conditions (including definitions).

3.2.7. The doctor involved should therefore only supply the insurer or employer with detailed medical information and express an opinion on functional impairment due to the illness/disease and not on disability.

3.2.8. The examining doctor should inform the patient that the decision on disability will be made by the insurer concerned. This will be done by the insurer's doctors, legal advisors, claims assessors and other relevant persons.

4. ASSESSING DISABILITY

4.1. As has already been stated, disability is determined through a functional assessment that goes beyond establishing medical impairment.

4.2. It is recommended that the insurer takes the following into consideration when addressing disability claims:

4.2.1. relevant factors regarding the insured, such as gender, age, qualifications, experience and previous occupational history;

4.2.2. the insured's job description. Occupations can be classified into a number of categories, but are generally split into manual, supervisory or administrative functions;

4.2.3. the disability terms and conditions of the policy contract;

4.2.4. the insured's medical impairment and whether medical treatment will result in improvement of the impairment.

4.3. It becomes important to have a full description of the insured's functional capacity and the effect that the impairment has on activities of daily living.

4.4. It is also important to establish whether the necessary adaptations or accommodations have been put in place at the workplace to enable the insured to continue in the particular job.

Disability terms and conditions

4.5. The specific wording regarding the disability cover set out in the policy contract will differ from one insurer to another, but, in general, three different types of cover are available:

4.5.1. **Own occupation**

A claim will ordinarily be considered when the insured cannot perform his own specific job as was described and stated at the time of issue of the policy contract. A policyholder will receive benefits if the insured is unable to work in their "own occupation", regardless of whether they find employment in another profession. This is generally the most expensive type of cover.

4.5.2. **Own or similar occupation**

A claim under the policy contract will typically be considered when the insured is unable to perform his/her own occupation and is also incapable of performing a similar occupation that he/she may reasonably be expected to follow, taking into account factors such as education, training and experience. It is often this definition that leads to misunderstandings and unhappiness, especially where a medical practitioner declares someone unfit to perform an occupation without having information regarding the disability terms and conditions.

4.5.3. **Any occupation**

This is an extremely wide definition, and a claim will only be considered when the insured is unable to perform even the most menial of tasks in any type of occupation. This is ordinarily the cheapest form of insurance and qualifications, experience, previous occupations and other related aspects are usually irrelevant.

Permanent disability

4.6. The concept of permanence is of crucial importance to assessments of permanent disability.

4.7. A permanent impairment is ordinarily classified as an impairment that has become static or stabilised during a period of time sufficient to allow maximal recovery or improvement and is unlikely to change in spite of reasonable surgical or medical treatment. This concept of "*optimal*" in this case is similar to the AMA's expression of maximal medical improvement[6]. As discussed later in this Guideline, many policies require that a condition be permanent before disability benefits become payable.

4.8. Reasonable treatment will depend on the risks attached to such treatment, the degree of success that can be expected undergoing such treatment and what the average reasonable patient with a similar condition would be prepared to undergo.

COPD

4.9. It is recommended that the following forms of treatment be considered "reasonable" for chronic pulmonary disorders and that the Guidelines below for Chronic Obstructive Pulmonary Disease ("**COPD**") as suggested by the South African Thoracic Society ("**SATS**") be followed.

SEVERITY OF DISEASE	DEFINING CRITICAL FEATURES	TREATMENT RECOMMENDATIONS
Mild COPD (GOLD	Confirmed spirometric post-bronchodilator obstruction	Short acting bronchodilator (SABA or SAMA) as needed for

[6]The AMA defines "maximum medical improvement" as a condition or state that is well stabilized and unlikely to change substantially in the next year, with or without medical treatment. This definition is crucial in determining t he level of permanent or partial impairment and the amount of benefits a worker can receive.

A)	(commonly will have mild to moderate severity of lung function (FEV1 >50%)[7]; minimal symptoms on effort (mMRC<2), CAT<10[8]; infrequent exacerbations (1 per year)[9]	symptomatic relief
Moderate COPD (GOLD B)	Confirmed spirometric post-bronchodilator obstruction (lung function may be preserved or significantly reduced, FEV1 >50%)[10]; significant symptoms on effort (mMRC ≥2), or CAT >10; infrequent exacerbations (1 per year)	Long-acting bronchodilator either LAMA or LABA; if inadequate response, try alternative agent or add a second bronchodilator; if no symptomatic benefit, withdraw second agent[11]
Severe COPD (GOLD D)	Confirmed spirometric post-bronchodilator obstruction (commonly will have severe lung function reduction FEV,<50%)[12]; severe symptoms on effort (mMRC ≥2), CAT >10;	Single bronchodilator LAMA[13]; dual bronchodilator: LAMA/LABA or alternatively LABA/ICS[14]; if not responding to dual agents, referral to specialist is advised[15]

[7] Lung function is not used to grade the severity of COPD or inform therapy. The severity of obstruction will provide guidance as to how severe the airflow limitation is but correlates poorly with symptoms and mortality.
[8] The mMRC evaluates dyspnoea on effort, and the CAT (COPD assessment test) is a composite score of symptoms including cough, dyspnoea, etc.
[9] Exacerbations are loosely defined as significant symptoms warranting additional treatment with corticosteroids and or antibiotics.
[10] Lung function is not used to grade the severity of COPD or inform therapy. The severity of obstruction will provide guidance as to how severe the airflow limitation is but correlates poorly with symptoms and mortality.
[11] Theophylline can be considered for moderate or severe COPD based on availability of alternative inhaled therapies.
[12] Lung function is not used to grade the severity of COPD or inform therapy. The severity of obstruction will provide guidance as to how severe the airflow limitation is but correlates poorly with symptoms and mortality.
[13] If Initiating therapy, start with LAMA. If previously on a single agent, use dual bronchodilator.
[14] Dual bronchodilator (LAMA/LABA) is the first-choice recommendation for dual agent, as there is a greater reduction in exacerbations compared to LABA/ICS with less risk of pneumonia [rate ratio 0.89 (0.83–0.96)] NNT 20 (95% CI, 13–44) (72). The cost of LAMA/LABA is significantly higher than LABA/ICS which should be considered in the treatment choice where resources are limited.
[15] in the severe group, see Table for suggested 'phenotyping options' to guide add-on therapy at specialist level.
COPD, chronic obstructive pulmonary disease; FEV1, forced expiratory volume in one second; mMRC, modified Medical Research Council; SABA, short acting beta-2 agonist; SAMA, short acting muscarinic antagonist; CAT, COPD Assessment Test; LAMA, long-acting muscarinic antagonist; LABA, long-acting beta-2 agonists; ICS, inhaled corticosteroids; NNT, number needed to treat.

	frequent exacerbations: 2 outpatient or 1 inpatient in past 12 months	

Treatment approach according to 'Phenotypes' in severe COPD

CLINICAL PHENOTYPE	MANAGEMENT STRATEGY
Dyspnoea phenotype	With increasing dyspnoea, one should increase bronchodilator therapy
Exacerbator phenotype	LAMA or combination long-acting bronchodilators → add on ICS and/or Roflumilast and/or a macrolide
Co-existing asthma (blood eosinophil count >300/mm)	Consider ICS
Severe/very severe COPD + chronic bronchitis phenotype & frequent exacerbations	Consider adding roflumilast or a macrolide

Asthma

The guidelines below for chronic asthma suggested by SATS may be used as a basis for recommended treatment:

INTERMITTENT	CHRONIC PERSISTENT		
Mild	**Mild**	**Moderate**	**Severe**
I	**II**	**III**	**IV**
Daytime symptoms* ≤2/week	Daytime symptoms 3-4/week	Daytime symptoms >4/week	Daytime symptoms Continuous
Night symptoms** ≤1/month	Night symptoms 2-4/month	Night symptoms >4/month	Night symptoms Frequent
PEF ≥80%	PEF ≥80%	PEF 60-80%	PEF <60%

* Any cough, tight chest and wheeze.
** Any cough tight chest, wheeze and night working.

Total disability

4.10. It is recommended that a person is only considered to be totally disabled when he/she is unable to perform a substantial percentage of his/her occupation despite optimal treatment. Disorders that are treatable will in general not be considered to be total or permanent.

Availability of employment

4.11. Disability insurance only covers a person's ability to work and not the availability of alternative employment or the ability to commute to work. The unavailability of another job within a company or in the open labour market is therefore irrelevant in terms of disability insurance.

5. ASSESSING RESPIRATORY FUNCTIONAL IMPAIRMENT

It is recommended as follows:

5.1. The examining doctor will be expected to do a thorough and objective evaluation of the patient's condition and its effect on functional capacity and in all cases should refrain from expressing an opinion on disability.

5.2. This evaluation should include:

5.2.1. A detailed history of the patient's pulmonary condition, including the symptoms associated with respiratory dysfunction, as well as a history of tobacco use, usually given in pack-years of cigarette smoking and an occupational and environmental history of exposure to substances that could affect the lungs.

5.2.2. A complete systemic respiratory examination of the patient. Other systemic conditions that may contribute to the patient's respiratory problems should be described in the report.

5.2.3. Basic special investigations to help assess the degree of pulmonary dysfunction.

5.2.4. Completion of a medical report which should meet the minimum standards as described below. If the doctor finds a need for an evaluation by a different specialist or other allied health professional / rehabilitation specialist, this should be mentioned in the report for the insurer to consider.

Special investigations

5.3. When an insurance company refers an insured for a second objective opinion, the basic medical examination and special investigations should already have been done to help establish a proper clinical diagnosis and the degree of respiratory dysfunction. It is recommended that the following investigations are carried out in order to make a judgement on the degree of functional impairment:

5.3.1. **Chest X-Ray**

The initial examination should include postero-anterior and lateral views of the chest taken in full inspiration. It should be noted that chest x-rays often correlate poorly with physiologic findings in diseases with air flow obstruction such as asthma and emphysema.

5.3.2. **Lung function testing**

5.3.2.1. The quantitative basis on which an evaluation of the respiratory impairment rests is physiological testing of pulmonary function. Simple spirometry should be performed on equipment that has been calibrated according to acceptable standards.

5.3.2.2. It must be noted that respiratory impairment may not necessarily be related to lung function. This is true in cases of occupational asthma, sleep disorders, bullous disease, recurrent pneumothorax, lung cancer or pneumoconiosis.[16]

5.3.2.3. As regards spirometry, forced vital capacity ("**FVC**"), forced expiratory volume ("**FEV**"), and the diagnoses of obstructive airways disease is

[16] Evaluation of impairment/disability secondary to respiratory disease. A statement of the ATS. Am Rev Respir Dis. 1986; 133:1205-9.

quantified.

5.3.3. **Diffusing capacity of carbon monoxide ("DCO")**

5.3.3.1. A single breath DCO should be used for the evaluation of impairment in those conditions when the diffusing capacity may be diminished. Measurement is particularly important in patients who have dyspnoea with relatively normal spirometry.

5.3.3.2. It is important that the patient should not have smoked for at least 8 hours before the test as carbon monoxide reduces the saturation of haemoglobin and causes a decrease in the DCO.

5.3.4. **Measured exercise capacity ("VO2")**

This may be undertaken under certain circumstances and often helps differentiate between pulmonary and cardiac conditions. Generally, VO2 should not be undertaken on patients with normal pulmonary function tests or those with severe impairments, as the additional information will not be useful in assessing the ability to carry out daily activities. Exercise capacity may also be useful to exclude malingering.

5.3.5. **Arterial oxygenation ("PO2")**

This is rarely undertaken due to its invasive nature.

Evaluating permanent pulmonary impairment

5.4. Where the policy definition requires an AMA assessment, it is recommended that the criteria as defined in the latest version of the AMA Guides to the evaluation Of Permanent Impairment are referred to.

5.5. Asthma may present particular problems in assessing impairment, due to its variable nature. Lung function tests may be normal between attacks. It may be necessary to do repeated tests over a period of time and take the frequency of attacks into consideration. Where occupational exposure is thought to cause the impairment, tests should be performed before and after work on at least 3 (three) occasions. Careful documentation is necessary and referral to an asthma expert may be indicated.

Correlation of functional impairment with ability to perform tasks

5.6. It is the responsibility of the insurer to correlate this information, and not the examiner, who should refrain from giving an opinion.

5.7. It is difficult to give precise guidelines or statistical correlations between results of measured tests of an individuals' ability to function. There are also many other factors that may contribute to a person's functional impairment. The following are general guidelines that may help to assess a person's ability to function:

5.7.1. In general, the FEV in the first second ("**FEV1**") correlates better with exercise capacity in persons with obstructive lung disease than the arterial PO2. In broad terms, persons with an FEV1 greater than 60% (sixty percent) of predicted are able to work whereas those with an FEV1 of less than 45% (forty-five) are generally unable to work. Most people with an FEV1 greater than 2 (two) litres are able to work.

5.7.2. Exercise capacity is measured by the uptake of oxygen (VO2) in mL(kg.min) or in METS. Exercise VO2 determinations can be undertaken on individuals who have mild or moderate (class 2 or 3) impairments. Those individuals with a VO2 of 25mL(kg.min) can perform most jobs. With a VO2 between 15 and 24 mL(kg.min) most sedentary and some light manual work can be undertaken whereas with a measurement of less than 15mL(kg.min) very few, if any, tasks can be undertaken. In general, a person can sustain a work level of 40% (forty percent) of measured maximum VO2 for an eight-hour period. The following table shows a relationship between work capacity and oxygen consumption.

Work intensity for 70 kg person	**Oxygen consumption**		**Excess energy expenditure**
Light work	7mL/kg	<0.5L/min	<2 METS
Moderate work	8-15mL/kg	0.6-1.0/min	2-4 METS
Heavy work	16-20mL/kg	1.1-1.5/min	5-6 METS
Very heavy work	21-30mL/kg	1.6-2.0/min	7-8 METS

Arduous work	>30mL/kg	.2.0L/min	>8 METS

5.7.3. Arterial PO2 of less than 55 mm Hg is strong evidence of a severe impairment.

5.7.4. A six-minute walk test may be used and the number of exacerbations per year should be noted.

Content of clinical report

5.8. The report has to be sufficiently detailed to provide adequate data to enable a third party to make an informed decision on an insured whom he/she has not examined clinically. It is recommended that the following data is included as a basic framework for a report.

5.8.1. Identification:

- name;
- identity number
- age
- gender
- date of birth
- employer
- occupational history.

5.8.2. Detailed history and clinical findings.

5.8.3. Diagnosis.

5.8.4. Severity of the illness.

5.8.5. Treatment:

- dosage and types of medication
- duration
- possible surgical procedures
- hospital admissions
- other i.e. physiotherapy, rehabilitation.

5.8.6. Response to treatment.

5.8.7. Complications or other illnesses.

5.8.8. Prognosis.

5.8.9. The influence of the illness on activities of daily living.

5.8.10. Results of special examinations including lung function testing etc.

5.9. It must again be emphasised that the examining doctor should limit his/her comments to the clinical condition and impairments and not comment on the merits of the disability claim.

5.10. The independent medical examiner may, at his/her own discretion, wish to include a disclaimer to the following effect in his report.

"*The opinions rendered in this case are the opinions of this evaluator. This evaluation has been conducted on the basis of the medical examination and documentation as provided, with the assumption that the material is true and correct. If more information becomes available at a later date, an additional service/report/reconsideration may be requested. Such information may or may not change the opinions rendered in this evaluation. This opinion is based on a clinical assessment, examination, and documentation. This opinion does not constitute per se a recommendation for specific claims or administrative functions to be made or enforced*."

6. PROTOCOL FOR EVALUATING POTENTIAL CLAIMS

Roles of the different parties

6.1. The roles of the various people involved in the assessment can be summarised as follows:

The treating general practitioner or pulmonologist

6.1.1. The treating doctor should not be involved in assessing disability of his/her patient. The doctor may have been involved with his/her patient and their family for many years and it is possible that the treating doctor's views and opinions may not be objective.

6.1.2. A full report from the treating doctor should be obtained, but these reports should only be used to obtain a full history and cause of the illness.

6.1.3. The evaluating pulmonologist should act as an independent medical examiner to

assess the functional impairment.

6.1.4. It is recommended that the independent examiner informs the insured before the examination:

6.1.4.1. that the report will only be used as background information;

6.1.4.2. that he/she will not express an opinion on disability and will only provide clinical details on functional impairment;

6.1.4.3. that the final decision of disability lies with the insurance company.

The medical practitioner

6.1.5. As already noted, the doctors involved should only comment on impairment and not disability and explain that the final decision will be made by the insurer.

The occupational therapist

6.1.6. An occupational therapist ("**OT**") may be appointed by the insurer to assist with a functional capacity evaluation, particularly for occupational disability claims. The OT should be carefully briefed on what is required of them and should provide the insurer with a detailed report of the insured's abilities and limitations. This should be done via standardised testing, interviewing and through obtaining collateral information. The OT should provide feedback on the job match and whether any accommodations/adaptations would allow the insured to continue working, but should not give an opinion on the outcome of the claim. The cost of the OT evaluation is usually borne by the insurer.

The employer

6.1.7. The employer should supply full details of the job description of the employee and take into account the Labour Relations Act relating to workplace adaption and the possibility of redeployment within the workplace.

The insured

6.1.8. The insured should supply the insurer with complete and accurate details required by the insurer, usually by way of a standard form, to give the insurer the

necessary claim particulars.

The insurer

6.1.9. It is recommended that the insurer should standardise the requirements of claims assessments by obtaining reports containing the minimum information described above. This eliminates delays that can arise in obtaining further or more detailed information.

Costs

6.2. The costs of the initial investigations, i.e. by a general practitioner or specialist, are usually the responsibility of the insured/policyholder. If, however, the insurer requires a second opinion, this should be at the insurer's expense. It is accepted that preparing reports on impairment for insurers takes longer than a normal consultation, and therefore, it is recommended that the fee for this service be adjusted. The fee for an impairment evaluation conducted by a pulmonologist would generally include the clinical evaluation, lung function testing and effort ECG according to the Bruce Protocol. Please see this link for a description of the Bruce Protocol: https://en.wikipedia.org/wiki/Bruce_protocol.

DOCUMENT HISTORY

Date	Publication/amendment
28 July 2021	First published.
March 2026	Competition law review and general update.

RESPONSIBLE SPA AND COMMITTEES

Responsible Board Committee	Life and Risk Board Committee
Responsible Standing Committee	Claims Standing Committee Medical & Underwriting Standing Committee
Responsible Senior Policy Advisor	ASISA Point Person to the Life and Risk Board Committee