

Mackay

ON MONEY

BY FINANCIAL PLANNER CHRIS MACKAY

On the same morning as I took an exam in order to continue to practice as a financial adviser from July next year, I had the occasion to bare my upper left arm to a very pleasant pommy phlebotomist at the pathology lab.

Along with a PSA test (guys – that’s the one providing an update of your prostate health and which could show early indications of prostate cancer), I had my cholesterol checked out as well.

Part of our financial advice practice is involved in helping our clients buy the right type, quality and amount of insurance coverage they need and also help them select the most appropriate company’s policy conditions given the clients’ circumstances.

A relatively recent insurance innovation has been Trauma or Critical Care insurance. This is sometimes referred to as Living Assurance, meaning one does not have to be dead to collect. It usually pays out a tax free lump sum in the event of someone suffering from a serious cancer, stroke, heart attack or coronary artery bypass surgery and another

20 or 30 serious lurgies or events.

All policies are not equal though. An objective insurance broker will be able to provide some independent comparative commentary on the various Trauma policies on the market. Some I have analysed are really terribly inferior when looking at what is otherwise available. One well known Aussie bank’s product I looked at recently was similarly priced but covered only a small percentage of conditions which the specialist insurance company products cover. Possibly because bank tellers are not brokers and deal with one product only, often their bank’s definitions of what constitutes a Trauma condition are not kept up to scratch by being consistently improved, driven often by brokers’ feedback on what is required to become “best of breed”.

Our practice has helped plenty of clients

with Trauma claims totalling many millions of dollars.

Heart attack, bypass surgery and stroke are three events which have triggered a fair amount of those claims.

So what has this got to do with cholesterol tests?

When clients are applying for Trauma cover, they may be requested to have a blood test including testing their cholesterol levels. Health questions usually also require clients to disclose any previous cholesterol results (and indeed any blood tests), especially if outside the recommended ranges. Often I have found people have no idea what their cholesterol is or was. Doctors often do not tell their patients what the results were, which is why I advise people to compile their own medical file. When having a blood test, we suggest they request a copy for their own



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records, and then hold on to them for future cross referencing.

So what is cholesterol all about and why does it affect the buying of insurance?

Well here's a bit of a "heads up", not from a GP but from an insurance company perspective. This comes compliments of the Chief Underwriter of OnePath Life NZ Ltd, Sanjay Lal.

"HOW HIGH CHOLESTEROL AFFECTS INSURANCE COVER

High cholesterol, also known as Hyperlipidaemia or Hypercholesterolaemia is an important risk factor for cardiovascular disease. It is a common problem which can have a significant impact on the terms of cover than an insurer can offer.

To most of us, cholesterol is thought of as the hard waxy stuff that clogs our arteries leading to heart attacks and strokes. While this holds true, cholesterol is an important substance, without which we would not survive. It is an essential component of cell walls, various hormones and is a component of bile aiding digestion.

As most people are aware, too much cholesterol can build up within the walls of arteries forming plaques. This is part of the disease process doctors refer to as atherosclerosis. The consequences of atherosclerosis are either a progressive obstruction leading to conditions such as stable exertional angina (chest pain on exertion due to reduced blood flow to the heart through narrowed coronary arteries), or a heart attack (myocardial infarction), or stroke (CVA). In the latter two conditions, an atherosclerotic plaque may rupture, triggering a cascade of events and resulting in a blood clot forming and completely blocking off the artery. In turn, this can result in the death of the tissue being supplied by the blocked vessel. A heart attack occurs when heart muscle dies, or a stroke occurs when brain tissue dies. Other conditions high cholesterol may lead to include kidney disease and peripheral vascular disease.

While the physiology of cholesterol is quite complex, in broad terms, one needs to understand cholesterol is transported around the body bound to what are known as lipoproteins. This is where the terms some readers may have heard of known as the 'good' and 'bad' cholesterol come in. Good cholesterol (known medically as HDL) is protein which takes cholesterol away from blood vessel walls back to the liver to be disposed of. Bad cholesterol (known as LDL and triglyceride) is the stuff which ends up blocking our arteries.

High levels of bad cholesterol may be caused by a poor lifestyle with a high saturated fat intake, little exercise, too much alcohol, diabetes etc, or may also be an inherited condition which, despite optimal lifestyle management, may require medication to lower cholesterol levels. High levels of good cholesterol can be associated with being physically fit, eating a Mediterranean type diet or being female.

The current guidelines for cholesterol levels are below. In an ideal world, the higher the HDL and the lower the LDL and triglyceride, the better. In some conditions, such as known coronary artery disease (CAD), post-coronary artery bypass graft or stent, the ideal parameters are even lower

(see figures in parentheses), or higher if HDL:

- Total cholesterol
<5.0 mmol/L (<4.0 if known CAD)
- HDL (good)
>1.0 mmol/L (>1.1 if known CAD)
- LDL (bad)
<3.0 mmol/L but some say <2.5 (<2.0 if known CAD)
- Triglyceride (very bad)
<2.0 mmol/L (<1.7 if known CAD))
- Total/HDL ratio
<4.5 (<4.0 if known CAD)

Continued on page 20...

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A disclosure statement is available on request and free of charge.

...continued from page 19

While insurance underwriters look at all the cholesterol parameters, most underwriting guides favour the use of the total/HDL ratio to determine whether loadings [extra premium] should apply.

In assessing the vascular disease risk posed by an individual's cholesterol levels, the underwriter not only looks at the overall cholesterol profile, but at other risk factors such as how high the LDL and triglyceride levels actually are, the ratio of the total cholesterol to the bad cholesterol, whether there is a family history of premature heart attack, stroke, high blood pressure, BMI [Body Mass Index], diabetes, smoking and alcohol intake. In general, the more risk

factors there are, the greater the level of risk posed. For example, a Type-2 diabetic with high blood pressure and high levels of LDL has a much higher risk of having a heart attack and would attract a much higher loading than, say, a fit athlete with no risk factors other than a high LDL level. Because of the complexity of risk assessment, the reinsurer underwriting manuals now have

"...most underwriting guides favour the use of the total/HDL ratio to determine whether loadings [extra premium] should apply."

risk calculators allowing the underwriter to calculate a loading which takes all the cardiovascular risk factors into account.

Treatment of unfavourable cholesterol and lipid profiles may be lifestyle/dietary based or medication based. Sometimes adverse cholesterol profiles can be very difficult to manage and hence, input from a cardiologist may be required. Underwriters do take this into account and may actually be able to offer review periods for any loadings or exclusions placed because of adverse cholesterol profiles. This would only happen if the client can show a significant improvement with respect to ideal targets and compliance with treatment over time."

For the year ended September 30 last, my research from the Insurance Savings and Investment Association website indicates \$91.5 million was paid out in Trauma claims. This is significant dosh and our firm's clients have had claims which have been part of this total.

As an aside, here's an example of why not all Trauma policies are as good as others.

Firstly there is the premise that obviously one has to comply with the definition in order to get paid out on a Trauma claim.

A few years ago, one of my clients got turned down for a heart attack claim because his doctor had not requested a blood test straight away after his patient presented with symptoms that looked like a heart attack had been bad. An immediate blood test will measure certain enzymes and markers and these along with ECG tests can confirm whether a heart attack has actually occurred or whether it may simply be bad angina pains for example. Anyway the doctor was slack and we will never know whether his patient ever had a myocardial infarction or not. As it turns out, a year or so later, my client had coronary bypass surgery so eventually collected the Trauma claim in full.

No company's policy would have paid out without that blood test. But the example of good wording versus bad wording is that some policies (often banks') require the occurrence of "a history of typical prolonged chest pain" for example, plus blood test markers and ECG changes in order to justify a claim. Now apparently about 25 per cent of all heart attacks are known as "silent" which means no chest pain at all. So despite a client having a "heart attack" according to all the other medical markers, the policy will not pay out.

The moral of the story: See a financial adviser who buys independent research of the market and can offer not one but a number of companies' insurance products.


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