LIFE
CODE
COMPLIANCE
COMMITTEE

Notice of Determination

by the Life Code Compliance Committee (Life CCC) on alleged non-compliance with the Life Insurance Code of Practice by a subscriber

Reference:	CX4331	**Date:**	26 June 2019
Code sections:	8.17, 8.19, 8.15[1]		
Investigation:	A consumer-reported alleged Code breach		

The alleged Code breach:

The Consumer is a member of a superannuation fund. As part of their membership, the Consumer obtained life insurance including a Total and Permanent Disability (TPD) benefit. The life insurance was issued by a Life Insurance Company that is a subscriber (the Subscriber) to the Life Insurance Code of Practice (the Code), and the policy was owned by a Group Policy-owner (the Trustee).

We note that in this matter the Subscriber was required to communicate with the Trustee instead of the Consumer, as described under section 8.1 of the Code.[2] This meant that correspondence from the Consumer would be sent to the Trustee, who would then forward the correspondence to the Subscriber.

The Consumer lodged a TPD claim on 3 February 2017 and the Subscriber issued its first decline letter to the Trustee on 25 August 2017. However, the Subscriber had to review its decision as the Subscriber received additional documentation on 24 August 2017.

The Subscriber issued its second decline letter to the Trustee on 19 September 2017. On 10 October 2017, the Subscriber received a further medical report, with the Trustee requesting confirmation on whether the report changed the Subscriber's decision.

The Subscriber reviewed its decision for the second time and issued Procedural Fairness (PF)[3] to the Consumer's legal representatives on 2 January 2018. The Subscriber received the Consumer's response to PF on 24 January 2018 and communicated its third decline letter on 7 February 2018.

In January 2018, the Consumer's legal representatives made a referral to the Life CCC alleging a breach of section 8.17[4] of the Code on the basis that the Subscriber had not provided its decision on the claim within six months.

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[1] The Code sections are provided in full in the last section of the Determination.
[2] ibid.
[3] Procedural Fairness is a legal principle that ensures fair decision making. In relation to life insurance claims, it involves the insurer providing the insured with the reasoning for its planned decision on the claim, including all the information that the insurer relied on in making its decision.
[4] The Code sections are provided in full in the last section of the Determination.

As part of its review of the file, the Life CCC also raised possible breaches of sections 8.19 and 8.15 of the Code.

Findings in accordance with Charter clause 7.4(b)(iii)[5]:

The Life CCC determined that the Subscriber:

- was not in breach of section 8.17 of the Code and that the allegation was unfounded,
- breached section 8.19(b) of the Code and that the allegation was proven in whole,
- breached section 8.15 of the Code in relation to the second decline letter and that the allegation was proven in whole, and
- was not in breach of section 8.15 of the Code in relation to the first or the third decline letter and that the allegation was unfounded.

The Life CCC findings and conclusion:

Section 8.17

The Consumer lodged a TPD claim on 3 February 2017.

The insurer became a Subscriber of the Code on 30 June 2017, at which stage it was bound by all obligations of the Code. Any claim open on the date the Subscriber adopted the Code had the timeframes under section 8.17 reset to day 1 from the day it adopted the Code. Day 1 thus became 30 June 2017 and the Subscriber had to make a decision on the claim by 31 December 2017, unless Unexpected Circumstances applied.

As noted above, the Subscriber communicated its first decision to decline the claim to the Trustee on 25 August 2017. However, the Subscriber had to review its decision as the Consumer submitted additional information in support of their claim. The Subscriber then issued a second decline decision to the Trustee on 19 September 2017. Both of these decisions were within the six-month timeframe stipulated in section 8.17 of the Code.

Based on the Consumer's referral to the Life CCC, the Trustee did not communicate the first or second decision to the Consumer.

The Subscriber received an additional medical report on 10 October 2017, and once again reviewed its decision. The Subscriber subsequently issued its third decline decision letter to the Trustee on 7 February 2018, which was outside the initial six-month timeframe stipulated in section 8.17 of the Code.

The Life CCC notes that the Code is silent as to the application of section 8.17 of the Code when a claim decision is reviewed. This is irrelevant for the second decline decision, as it was communicated within the required six-month timeframe.

However, this issue was considered by the Life CCC in relation to the third decline decision. Given that the Subscriber issued PF as part of its third decision review, this points towards the decision being a new and separate decision.

In the Life CCC's view, this should qualify as circumstances justifying a 'reset' of the six-month timeframe in section 8.17 of the Code, with the Subscriber having six months to provide a decision, beginning from the date it received the additional medical report (10 October 2017).

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[5] The Life CCC is bound by its Charter to use the terminology 'the reported allegation was proven in whole or in part or was unfounded.' This in essence requires the Life CCC to state if it determined there was a breach or not. The Life CCC will explain its determination in plain language in the body of the Determination.

As the Subscriber provided its third decline on 7 February 2018, which was within six months of 10 October 2017, the Life CCC determined that the Subscriber was not in breach of section 8.17 of the Code in relation to any of the three decline decisions.

The Life CCC notes that although the claim was 'reset', this does not mean that Subscribers should take six full months to review the claim. In such a circumstance, given that a Subscriber will already have had the opportunity to assess a claim and make a prior decision, the Life CCC's expectation is that the majority of claim decision reviews will not require the full six-month timeframe.

Section 8.19

Section 8.19 creates two separate obligations for Subscribers. The first obligation is in relation to the Subscriber providing the information in section 8.19(a) to (c) to the Consumer when the Subscriber declines a claim. This communication must be in writing.

The second obligation is in relation to the Subscriber providing the information and documents that it relied on in making its decision to decline the claim to the Consumer within 10 business days, if requested by the Consumer.

The Life CCC's investigation in this matter was limited to obligation 1 of section 8.19 of the Code.

The Subscriber sent decline letters to the Trustee on 25 August 2017, 19 September 2017 and 7 February 2018. The Life CCC reviewed all three declines letters and noted that the letters did not include the information in section 8.19(b) of the Code, specifically that the Subscriber will provide the information that it relied on within 10 business days if requested.

As a result, the Life CCC determined that the Subscriber was in breach of section 8.19(b) of the Code.

The Subscriber's decline letter template was amended in December 2018 and is now compliant with section 8.19(b) of the Code.

The Subscriber acknowledged that prior to the amended template, it was likely that all of its claim decline letters omitted the appropriate wording as required by section 8.19(b) of the Code.

Accordingly, the Life CCC determined in accordance with Charter clause 7.4(b)(iv)[6] that the Subscriber's breach of section 8.19(b) of the Code amounted to systemic non-compliance with the Code. Given that the absence of the section 8.19(b) wording was unlikely to cause actual or potential financial loss to Consumers directly, the Life CCC determined that there was no basis to conclude that the breach amounted to serious non-compliance with the Code.

Section 8.15: First decline letter

Section 8.15 requires Subscribers to communicate a claim decision within 10 business days of receiving all the information that the Subscriber reasonable needs to assess the claim.

In this matter, the Subscriber issued its first decline letter on 25 August 2017. As the Subscriber received all the information that it reasonably needed to assess the claim on 14

[6] The Life CCC is bound by its Charter to state, where applicable, whether it finds that a subscriber is responsible for serious and/or systemic non-compliance with the Code.

August 2017, the Subscriber had 10 business days starting from 15 August 2017 to communicate its decision on the claim.

The Subscriber communicated its decision to the Trustee on 25 August 2017, which was within 10 business days of 15 August 2017 and the Life CCC determined that in relation to the first decline letter, the Subscriber was not in breach of section 8.15 of the Code.

Section 8.15: Second decline letter

The Subscriber issued its second decline letter on 19 September 2017. This was more than 10 business days after the Subscriber received additional information from the Consumer on 24 August 2017. As a result, the Life CCC determined that in relation to the second decline letter, the Subscriber was in breach of section 8.15 of the Code.

The breach occurred because the Subscriber's claims assessor who made the first decision (TM) went on leave after issuing the first decline letter, and the file was handled by a new claims assessor who referred the file for internal legal advice as they were not familiar with the file.

As the second decline letter was sent and signed off by TM, it appears that TM reviewed the additional material and drafted the second decline letter when she returned from leave. The Life CCC was satisfied that this was an isolated incident that occurred due to the specific facts of the file. The Life CCC therefore determined in accordance with Charter clause 7.4(b)(iv)[7] that there was no basis to conclude that the Subscriber's breach of section 8.15 of the Code amounted to serious or systemic non-compliance with the Code.

Section 8.15: Third decline letter

The Subscriber issued its third decline letter on 7 February 2018, after the Subscriber received an additional medical report on 10 October 2017. However, the Subscriber issued PF on 2 January 2018, which the Consumer responded to on 24 January 2018. As a result, the Subscriber's 10 business day timeframe began on 25 January 2018.

The Life CCC determined that in relation to the third decline letter, the Subscriber was not in breach of section 8.15 of the Code as the Subscriber communicated its decision on the claim on 7 February 2018 which was within 10 business days of receiving the information that it reasonably required to assess the claim.

Key Learnings

The Code is silent as to the applicable timeframe when a claim decision is reviewed. The Life CCC's view is that the timeframe in section 8.17 is 'reset' when the circumstances indicate that there was new information for the Subscriber to consider and base its decision on, resulting in a new and separate decision. The Life CCC expects that in the majority of claim decision reviews, a Subscriber will be able to provide a decision to the Consumer well before the six-month timeframe expires.

In dealing with claims, Subscribers should be mindful of related obligations under other sections in Chapter 8 of the Code such as section 8.15, which require subscribers to communicate a claim decision within 10 business days of receiving all the information that the Subscriber reasonable needs to assess the claim.

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[7] The Life CCC is bound by its Charter to state, where applicable, whether it finds that a subscriber is responsible for serious and/or systemic non-compliance with the Code.

In this instance, the first and second decline letters were not communicated to the Consumer by the Trustee. The Life CCC notes that if a decision to decline a claim is communicated to the Consumer and the Consumer lodges a complaint in relation to the decision to decline the claim, the relevant timeframe will be governed by Chapter 9 of the Code as the matter in that instance will be handled as a complaint.

Relevant Code Sections

Section 8.1:

If **your** claim is covered by a **Group Policy**, **we** may be required to provide the communications referred to below to the **Group Policy-owner** (for example, the superannuation fund trustee which owns **your Life Insurance Policy**) in accordance with section 2.13. The **Group Policy-owner** will then communicate with **you** and assist with **your** claim. When **you** make a claim, **we** and/or the **Group Policy-owner** will let **you** know who will be in contact with **you**.

Section 8.15:

Once **we** have all the information **we** reasonably need and have completed all reasonable enquiries to assess **your** claim, including **your** response to the evidence **we** are basing **our** decision on if **we** have presented this to **you**, **we** will let **you** know **our** decision on **your** claim within ten **business days**.

Section 8.17:

For all claims other than income-related claims, **we** will let **you** know **our** decision no later than six months after **we** are notified of **your** claim or six months after the end of any waiting period, unless **Unexpected Circumstances** apply. Depending on **your** policy, **our** decision may be a requirement that **you** undertake a period of rehabilitation or retraining, or it may be a final decision on **your** benefits. Where **Unexpected Circumstances** apply, **our** decision will be made no later than 12 months after **we** are notified of **your** claim. **We** will let **you** know the reasons for the delay, and if **you** disagree **we** will review this. If **we** cannot make a decision within 12 months, **we** will give you details of **our Complaints** process.

Section 8.19:

If **we** decline **your** claim **we** will let **you** know **in writing**:

a) the reasons for **our** decision;

b) that **you** have the right to copies of the documents and information **we** have relied on, and if

c) **you** request **we** will provide **you** (or **your** doctor, where appropriate) with copies within ten **business days**, in accordance with the Access to Information section of the **Code**; and

d) that **you** have the right to request a review if **you** disagree with **our** decision, and **we** will give **you** details of **our Complaints** process.

Chapter 15, Definitions: Unexpected Circumstances means:

a) **your** claim has been notified to **us** more than 12 months after the later of the date of disability or the end of **your** waiting period, and there are reasonable delays obtaining evidence necessary for the assessment of **your** claim from the intervening period;
b) for a claim for total and permanent disability, **we** cannot reasonably satisfy ourselves on the basis of the information provided in the six months after the end of **your** waiting period that **your** condition meets the requirements of **your Life Insurance Policy**;
c) **we** have not received reports, records or information reasonably requested from an **Independent Service Provider**, **your** doctor, a government agency or other person or entity (including a **Reinsurer**);
d) the **Policy-owner** or **Group Policy-owner** has disputed or taken a protracted period to consider **our** decision;
e) **you** or **your Representative** have not responded to **our** reasonable enquiries or requests for documents or information concerning **your** claim;

f) there are difficulties in communicating with **you** in relation to the claim due to circumstances beyond **our** control;
g) there is a delay in the claims process that **you** have requested; or
h) the claim is fraudulent or **we** reasonably suspect fraud or non-disclosure that requires further investigation.

The Life CCC's approach to interpreting section 8.17

The Life CCC considered section 8.17 and has developed the following approach to interpreting the obligation:

Section 8.17 of the Code creates four separate obligations for subscribers:

1. Inform the consumer of the subscriber's decision no later than six months after the claim is notified, or six months after the end of any waiting period, unless Unexpected Circumstances apply.
2. Inform the consumer of the subscriber's decision no later than 12 months after the claim is notified if 'Unexpected Circumstances' apply.
3. If 'Unexpected Circumstances' apply, the subscriber has to inform the consumer of the reasons for the delay, and that the consumer can disagree with the reasons. The subscriber will conduct a review if the consumer disagrees.
4. Provide the consumer with the subscriber's complaints process if a decision cannot be made within 12 months.

These four obligations are separate from each other, and it is possible for a Code subscriber to meet some but not all of the obligations and thus be in breach of section 8.17.

The term 'decision' means to: Admit/ decline a claim ('final decision') or commence rehabilitation or retraining for claims covered by section 8.17.

The term 'notified' is interpreted by the Life CCC to be the plain language meaning of the word. Claim 'notified' refers to the initial contact made by the claimant in respect of a potential claim. This could take the form of a physical submission (letter, email, etc.) or a telephone call. The Claim Notification Date is the date on which the claim was first notified. (The Life CCC is aware that subscribers may not be using the point in time as defined above for 'notified' to measure claim duration and is considering its further position on this matter.)

The Life CCC determined that Code subscribers have to inform consumers of the existence of 'Unexpected Circumstances' within the initial timeframe provided (six months) plus one business day if they want to rely on this exception for not meeting claim assessment timeframe obligations.

Code subscribers must inform consumers of the complaints process if 'Unexpected Circumstances' applies and a decision is unable to be made within 12 months plus one business day. The subscriber should also explain why it could not make a decision within those timeframes, though this is not explicitly stated in the Code obligation.

All communication required under section 8.17 is to be completed in writing.

Section 8.1 of the Code states that communications may be required to be provided to the Group Policy-owner if a claim is covered by a Group Policy. In that case, the Code subscriber will be required to direct all communication to the Group Policy-owner.

For a subscriber to be compliant with section 8.17, the subscriber has to inform the Group Policy-owner of the 'Unexpected Circumstances', the reasons for the 'Unexpected Circumstances', that the consumer has the right to disagree with the reasons for 'Unexpected Circumstances', and that the subscriber will review the reasons if the consumer disagrees.

As Group Policy-owners are not subscribers to the Code, whether or not the Group Policy-owner passes on this information to the consumer will not affect a subscriber's compliance with section 8.17 of the Code.

The Life CCC is the independent body responsible for the administration and enforcement of the Life Insurance Code of Practice (the Code). It acts in accordance with the Life CCC Charter, which sets out the powers, duties, functions and responsibilities of the Committee, subject to any provisions in the Code. This Determination is issued in accordance with clause 7.4 of the Life CCC's Charter in order to facilitate agreement between the Life CCC and the Subscriber on corrective measures and the relevant timeframes for their implementation.