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:	CX 4333	**Date:**	12 June 2019
Code sections:	8.17[1]		
Investigation:	A consumer-reported alleged Code breach		

The alleged Code breach:

The Consumer is a member of a superannuation fund. As part of his 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).

The Consumer lodged an initial TPD claim on 24 September 2015 (the first claim). The first claim forms were incomplete. The Subscriber requested further information on 30 September 2015. By 20 January 2016 the Consumer had requested the claim be put on hold. The Consumer, through his legal representatives, then lodged new TPD claim forms, including additional information in support of the claim, in May 2016 (the second claim).

In January 2018, the Consumer's legal representatives made a referral to the Life CCC alleging a breach of section 8.17[2] of the Code on the basis that the Subscriber had not provided its decision on the claim within six months.

Findings in accordance with Charter clause 7.4(b)(iii)[3]:

The Life CCC determined that the Subscriber breached section 8.17 of the Code and that the allegation was proven in whole.

The Life CCC findings and conclusion:

The Consumer lodged separate TPD claims in September 2015 and May 2016.

[1] The Code sections are provided in full in the last section of the Determination.
[2] The Code sections are provided in full in the last section of the Determination.
[3] 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.

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.

On review of the key dates and facts of the case, it was noted that the Subscriber provided its decision on the second claim to the Group Policy-owner – in this case, the Trustee - on 2 February 2018.

In cases where there is a Group policy, the communication arrangements can require the Subscriber to communicate with the Group Policy-owner instead of the Consumer.[4] In this matter, all correspondence on the claim was required to be sent to the Trustee, who was the Group Policy-owner.

Given that the decision was provided after 31 December 2017, this meant that the Subscriber did not meet the six-month timeframe provided by section 8.17 of the Code.

Unexpected Circumstances

However, if Unexpected Circumstances applied, the Subscriber would have twelve months to provide its decision on the claim.

In response to Life CCC enquiries, the Subscriber stated its view that Unexpected Circumstances applied in this claim as:

- the claim was lodged more than 12 months after the date of disability and there were delays in obtaining the information necessary for the assessment of the claim (Definition A),
- the Subscriber had not received the Employability Assessment (EA) report (Definition C), and
- the Consumer requested a delay in the process as she declined a telephone interview for the Employability Assessment (Definition G).

The Life CCC was satisfied that Definition C of Unexpected Circumstances applied as there was a five-month delay in receiving a medical report, which led to a four-week delay in relation to receiving the Consumer's EA report as the Subscriber required the information in the medical report to request the EA report.

While the Consumer's claim was lodged more than 12 months after the date of disability, the Life CCC determined that Definition A did not apply as the Subscriber did not prove that there were reasonable delays relating to obtaining evidence from the intervening period. Delays in relation to obtaining information will not qualify under Definition A unless the delays relate to obtaining evidence from the intervening period.

The Life CCC further determined that Definition G did not apply as the delay requested by the Consumer amounted to the Consumer choosing to complete an Education, Training and Experience form in writing instead of via a telephone. This choice by the Consumer was not sufficient to amount to a requested delay.

[4] Section 8.1 of the Code.

While Unexpected Circumstances applied, the Subscriber did not notify the Trustee about the Unexpected Circumstances. As a result, the Life CCC determined that the Subscriber was in breach of section 8.17 of the Code.

Serious or systemic non-compliance

The Life CCC further determined in accordance with Charter clause 7.4(b)(iv)[5] that the Subscriber's breach of section 8.17 of the Code amounted to serious and systemic non-compliance with the Code, as the Subscriber did not have adequate arrangements to ensure compliance with section 8.17 of the Code.

The breach was serious as the deficiency in the Subscriber's section 8.17 compliance process was not detected by the Subscriber until the Life CCC's investigation of the specific Code breach allegation.

The breach was systemic as, prior to 1 July 2018, there was a gap in the Subscriber's compliance process in relation to section 8.17 where the Subscriber did not advise the policy owner/consumer that Unexpected Circumstances applied on a claim in 95% of relevant claims.

The Life CCC notes that the Subscriber has since created an Unexpected Circumstances template letter and remediated its section 8.17 compliance process.

Key Learnings

Section 8.17 of the Code requires the Subscriber to notify the Trustee or the Consumer of Unexpected Circumstances, including the reasons for the delay, the fact that the Consumer can disagree with the reasons provided and that the Subscriber will review this if the Consumer disagrees.

The Unexpected Circumstances notification also has to be communicated prior to the expiry of the six-month timeframe. In the case of a Group policy, the communication arrangements can require the Subscriber to communicate with the Group Policy-owner instead of the Consumer.[6]

Relevant Code Section

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 8.1:

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

[5] 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.
[6] Section 8.1 of the Code.

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**.

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.