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:	CX4293	**Date:**	8 November 2019
Code sections:	8.17 and 8.4[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 which included Total and Permanent Disability (TPD) and Income Protection (IP) cover. 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 Subscriber in this Matter had an outsourcing agreement with the Trustee which allowed the Subscriber to contact the Consumer directly.

The Consumer initially lodged a TPD claim in 2014 but withdrew the TPD claim and lodged an IP claim in August 2015. The Subscriber subsequently accepted the Consumer's IP claim in November 2015.

The Consumer subsequently lodged a second TPD claim in November 2016, and the Consumer's legal representatives lodged a complaint with the Subscriber on 4 October 2017 regarding the Subscriber's failure to communicate a decision on the Consumer's second TPD claim and stated that the Subscriber was in breach of the Code.

The Subscriber responded to the complaint on 22 November 2017 and noted that Unexpected Circumstances applied in this claim. As a result, the Subscriber stated that they were not in breach of the Code.

On 23 November 2017, the Consumer's legal representatives made a referral to the Life CCC alleging a breach of section 8.17 of the Code on the basis that the Subscriber had not provided its decision on the claim within six months.

After receiving the Subscriber's initial response to the investigation, the Life CCC identified that the Subscriber may also have been in breach of section 8.4 of the Code and made further enquiries into the Subscriber's processes in relation to providing the Consumer with an update on the claim at least every 20 business days.

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

The Subscriber subsequently accepted the claim and notified the Consumer's legal representatives of the claim acceptance on 27 March 2018.

Findings in accordance with Charter clause 7.4(b)(iii)[2]:

The Life CCC determined that the Subscriber was:

- not in breach of section 8.17 of the Code, and the allegation was unfounded, and
- was in breach of section 8.4 of the Code, and the allegation was proven in whole.

The Life CCC findings and conclusion:

Section 8.17

The Consumer lodged a second TPD claim in November 2016.

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.

The Life CCC's investigation did not cover the Consumer's first TPD claim as the first TPD claim was lodged in 2014 and was withdrawn in 2015, prior to the Subscriber's adoption of the Code.

On review of the key dates and facts relating to the second TPD claim, it was noted that the Subscriber provided its decision on the second claim to the Consumer's legal representatives on 27 March 2018, outside the six-month timeframe provided by section 8.17 of the Code.

Unexpected Circumstances

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

The Subscriber stated that Unexpected Circumstances applied (Definition C) on this claim as the Subscriber was awaiting a medical report from the Consumer's treating doctor.

The Subscriber requested the medical report on 30 August 2017 but only received the report on 8 March 2018. The Subscriber has confirmed that it followed up the outstanding information from the doctor by telephone every 3-5 working days. The doctor was the Consumer's treating Psychiatrist and there was no indication that the medical report from the doctor was not reasonably requested.

The Life CCC was satisfied that Definition C of Unexpected Circumstances applied as the Subscriber had not received the requested medical report by 31 December 2017.

Informing the Consumer of Unexpected Circumstances

The Consumer lodged a complaint with the Subscriber on 4 October 2017 regarding the time taken to provide a decision on the claim. The Subscriber responded to the complaint on 22 November 2017 and noted that Unexpected Circumstances applied as the Subscriber was still

[2] 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.

waiting for medical reports from the Consumer's doctors. As a result, the Subscriber noted that they had twelve months to provide a decision on the Consumer's claim.

The Subscriber has since put forward its 22 November 2017 complaint response letter as the letter that notified the Consumer of the existence of Unexpected Circumstances. The Consumer in this matter had complained about Unexpected Circumstances prior to the notification of Unexpected Circumstances.

As a result, the Subscriber's Unexpected Circumstances notification to the Consumer was also a complaint response letter and referred the Consumer to the Superannuation Complaints Tribunal (SCT) instead of offering the Consumer the option of disagreeing with the reasons given for Unexpected Circumstances. This was not typical of the normal Unexpected Circumstances notification to a consumer, which is usually performed by the Subscriber's claims assessor managing the file, as part of the standard management of a claim. However, in this situation, the Unexpected Circumstances reason had already been reviewed by the Subscriber's complaints team, and was therefore incorporated in the complaint response letter.

Given the circumstances, the Life CCC determined that the Subscriber was not in breach of section 8.17 of the Code as the Subscriber provided its response to the complaint and its Unexpected Circumstances notification within the same letter, resulting in the Subscriber referring the Consumer to the SCT instead of its own complaints process.

Section 8.4

As part of the Life CCC's review of this Matter, the Life CCC raised a potential breach of section 8.4. The Life CCC has previously determined that section 8.4 creates two separate obligations for Subscribers.

Firstly, section 8.4 requires Subscribers to provide an update on a claim at least every 20 business days unless otherwise agreed. Secondly, section 8.4 requires Subscribers to respond to requests for information within ten business days.

In this Matter, the Life CCC only assessed as relevant the Subscriber's compliance with obligation one of section 8.4 of the Code.

On review of the file, the Life CCC noted that the Subscriber did not provide the Consumer with an update on the claim between 14 July 2017 and 29 August 2017, a period of 32 days. The Subscriber has acknowledged a breach of section 8.4 of the Code in this instance.

The Subscriber noted that the breach occurred as it was waiting for information from the Consumer's employer but had not received a response. As a result, the Subscriber did not view an update to be necessary.

Serious or systemic non-compliance

In response to the Life CCC's enquiries relating to the adequacy of its processes and procedures relating to section 8.4, the Subscriber conducted an audit and identified that it had recorded over 6,800 breaches of section 8.4 between 1 July 2017 and 31 December 2018. Given the persistent and significant number of breaches identified, the Life CCC determined, in accordance with Charter clause 7.4(b)(iv),[3] that the breach of section 8.4 of the Code amounted to serious and systemic non-compliance with the Code. The number of breaches

[3] 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.

also indicated that the Subscriber's arrangement to ensure compliance with section 8.4 of the Code was inadequate.

The Life CCC noted that the majority of the Subscriber's section 8.4 breaches occurred prior to 30 July 2018. In addition, the Subscriber was able to demonstrate that its compliance rate for section 8.4 had steadily improved following implementation of additional compliance processes and procedures, with a 99% compliance rate in December 2018.

Remediation

Regarding section 8.4, the Life CCC notes that the Subscriber has implemented additional Code training for its staff, improved its processes and procedures, and currently runs exception reporting to identify breaches of section 8.4 of the Code. The Life CCC considers the new processes implemented by the Subscriber to be sufficient to ensure adequate compliance in the future.

Regarding section 8.17, the Life CCC recommended that the Subscriber amend its complaints process to specifically exclude using its complaint response template to notify consumers of Unexpected Circumstances on a file.

Key Learnings

Section 8.4 of the Code creates an obligation for the Subscribers to keep the Consumer (or Trustee) updated every twenty business days, unless otherwise agreed. An update should be provided even if the Subscriber is currently waiting for additional information. The Life CCC encourages Subscribers to proactively discuss with the Consumer how often the Consumer would prefer to be updated.

Regarding section 8.17, whenever Unexpected Circumstances apply on a file, this is most appropriately notified to consumers via a Subscriber's Unexpected Circumstances template letter as part of its claims process.

Relevant Code Section

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 8.4:

Prior to making a decision on **your** claim, **we** will keep **you** informed about the progress of **your** claim at least every 20 **business days** unless otherwise agreed with **you** or the **Group Policy-owner**. **We** will respond to **your** requests for information about **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.

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 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.