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:	CX4312	**Date:**	26 September 2019
Code sections:	8.17[1]		
Investigation:	An AFCA referral of an 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).

The Consumer lodged a TPD claim on 16 February 2017, and the Subscriber received the claim on 23 February 2017. As the Subscriber adopted the Code on 30 June 2017, any timeframes under the Code began on 30 June 2017.

On 29 August 2017, the Subscriber issued an Unexpected Circumstances notification letter stating that they were unable to provide a decision on the claim as they required the Consumer to attend a neuropsychological assessment.

The Consumer responded on 1 September 2017 and informed the Subscriber that she did not wish to attend the neuropsychological assessment. The Consumer subsequently provided the Subscriber with a medical certificate on 24 October 2017 stating that she was unfit for the neuropsychological assessment. In response, the Subscriber requested the Consumer's doctor to provide additional information about the Consumer's incapacity.

In December 2017, the Consumer's legal representatives lodged a complaint with the then Financial Ombudsman Service (FOS – the predecessor organisation to the Australian Financial Complaints Authority), who referred the matter to the Life CCC.[2] FOS subsequently determined that the complaint was outside its terms of reference.

On 15 February 2018, the Consumer's legal representatives lodged a complaint with the Subscriber about the reasonableness of the neuropsychological assessment and submitted

[1] The Code sections are provided in full in the last section of the Determination.
[2] Under its Charter, prior to deciding to investigate a matter which is also the subject of a dispute before an external dispute resolution body, the Committee must await the final determination or findings of that body.

additional evidence supporting the Consumer's inability to undertake a neuropsychological assessment.

Following the complaint, on 1 June 2018 the Subscriber offered to conduct the Consumer's neuropsychological assessment in line with the tolerances of the Consumer via adjusted appointments which would limit the length of each appointment.

As the Consumer did not respond to this offer, the Subscriber closed the claim on 31 July 2018. In December 2018, the Consumer lodged a dispute at the Australian Financial Complaints Authority (AFCA) regarding the neuropsychological assessment requested.

The AFCA dispute was resolved in May 2019 upon the acceptance of an AFCA Recommendation confirming that the Consumer was unfit to undertake a neuropsychological assessment.

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

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

The Life CCC findings and conclusion:

The Consumer lodged a TPD claim on 16 February 2017.

The insurer became a Subscriber of the Code on 30 June 2017, at which stage it was bound by all the 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.

Section 8.17

Section 8.17 of the Code requires the Subscriber to communicate its decision on a lump sum claim within six months, unless Unexpected Circumstances applies. If Unexpected Circumstances applies, the Subscriber has six additional months to communicate its decision on the claim.

As part of notifying the Consumer of the Unexpected Circumstances, the Subscriber has to notify the Consumer of the reasons for the delay and inform the Consumer that the Consumer has the right to disagree with the reasons provided.

If a Subscriber is unable to provide a decision within 12 months, the Subscriber has to provide the Consumer with its complaints process. The Subscriber will be in breach of section 8.17 if it is unable to provide a decision within 12 months, unless the reason for the delay is outside of the Subscriber's control.

Unexpected Circumstances

The Subscriber put forward that definition (b) and (e) of Unexpected Circumstances applied. The Subscriber noted that it could not reasonably satisfy itself that the Consumer met the

[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.

requirements of their policy without the neuropsychological assessment, and further noted that the Consumer had not responded to its request to attend the neuropsychological assessment.

The Life CCC agreed that Unexpected Circumstances applied in this matter as the Subscriber was not able to reasonably satisfy itself based on the information provided that the Consumer's condition met the requirements of her life insurance policy.

The Life CCC noted that when the Subscriber sent the Unexpected Circumstances letter to the Consumer on 29 August 2017, the Subscriber was unaware that the Consumer might not have the capacity to attend the neuropsychological assessment and had not received any medical information supporting the Consumer's assertion of incapacity.

As Unexpected Circumstances applied, the Subscriber had until 30 June 2018 to provide its decision on the claim.

Notification of Unexpected Circumstances

The Life CCC determined that the Subscriber was in breach of section 8.17 of the Code in relation to the Subscriber's Unexpected Circumstances notification letter that was sent to the Consumer on 29 August 2017, as it did not contain all the information stipulated by section 8.17.

The Life CCC noted that the Subscriber's letter did not clearly state that there was a delay and did not inform the Consumer of their right to disagree with the reasons provided for the delay. Instead, the 29 August 2017 letter only informed the Consumer that the Subscriber required more information before it was able to make a decision on the claim.

The Life CCC's view is that a Subscriber must clearly inform the Consumer of the reasons for the delay and inform the Consumer of their entitlement to disagree with the reasons provided. Simply noting that the Subscriber will need more information before it can make its decision on a claim does not enable a Subscriber to meet its section 8.17 obligations.

Providing a decision within 12 months

As Unexpected Circumstances applied, the Subscriber had until 30 June 2018 to communicate its decision on the claim. As noted above, the Subscriber closed the claim on 31 July 2018 as the Consumer did not respond to the Subscriber's proposal to use adjusted appointments for the Consumer's neuropsychological assessment.

The Subscriber acknowledged that it did not communicate a decision on the claim within 12 months. While the delay in this matter was caused by multiple factors, the delay could be primarily attributed to the Subscriber's handling of the claim and the Life CCC determined that the Subscriber was in breach of section 8.17 of the Code in relation to failing to communicate the claims decision within 12 months.

Serious or systemic

The Life CCC further determined in accordance with Charter clause 7.4(b)(iv)[4] that the Subscriber's breach of section 8.17 of the Code amounted to serious and systemic non-compliance with the Code.

[4] 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.

The Subscriber's Unexpected Circumstances template letter did not clearly state that there was a delay in the assessment of the claim or inform the Consumer of their right to disagree with the reasons for the delay.

Given that the template letter was not compliant with the Life CCC's interpretation of section 8.17 of the Code, the Life CCC noted that it was likely that multiple Consumers were sent non-compliant letters and that the breach amounted to systemic non-compliance with the Code.

The Life CCC further noted that the Consumer in this instance suffered potential financial loss as a result of the delays experienced in her claim, amounting to serious non-compliance with the Code.

The Consumer initially lodged her claim in February 2017 prior to the Subscriber's adoption of the Code and her claim was only paid out by the Subscriber in May 2019. At the Consumer's request, the Subscriber paid interest on the claim for the period of the delay from October 2017 – May 2019.

The Life CCC is working with the Subscriber to amend its Unexpected Circumstances template letter in line with the Life CCC's interpretation of the requirements of section 8.17.

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 8.17:

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.