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:	CX4472	**Date:**	13 November 2019
Code sections:	8.13, 8.16, 8.17, 8.18, 8.20[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 Total and Permanent Disability (TPD) and Income Protection (IP) benefits. 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 28 September 2016 which was closed on 24 April 2017, prior to the Subscriber's adoption of the Code.

The Subscriber noted that the claim was closed as the Subscriber had not received the information that it required for the assessment of the claim, being the Consumer's Workers Compensation file and the clinical records from the Consumer's psychologist.

The Subscriber's claims system recorded the claim as 'claim declined' by mistake when the claim was migrated to its claims systems from a legacy system. As a result, in January and February 2018, the Subscriber mistakenly informed the Consumer that the claim had been declined.

The Subscriber became aware of the error in May 2018 and has since confirmed that the Consumer's claim was not declined. Instead, the wrong claim status was provided to the Consumer.

The TPD claim was subsequently re-opened by the Subscriber on 6 July 2018 after the Subscriber received the information that it required. The Subscriber subsequently assessed and accepted the claim and communicated this decision to the Trustee on 17 September 2018.

In addition to the TPD claim, the Consumer lodged an IP claim on 8 November 2017. The Subscriber received the preliminary information on the claim on 15 November 2017 but was unable to admit liability after the initial assessment of the claim.

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

Instead, the Subscriber made benefit payments to the Consumer on a good faith basis without the admission of liability, and the Subscriber notified the Consumer of this on 15 January 2018.

The Subscriber continued to assess and pay the Consumer's monthly IP benefits without the admission of liability and subsequently accepted the IP claim on 13 July 2018.

In May 2018, the Consumer's legal representatives made a referral to the Life CCC alleging breaches of sections 8.17 and 8.16 of the Code on the basis that the Subscriber had not communicated its decision on the TPD and IP claims within 6 and 2 months respectively.

In addition, the Life CCC reviewed the Subscriber's claim acceptance letter and noted that the letter did not contain the information stipulated in the Code around seeking financial advice. As a result, the Life CCC also raised possible breaches of section 8.13, 8.18 and 8.20 of the Code.

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

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,
- was not in breach of section 8.16 of the Code and that the allegation was unfounded,
- was in breach of section 8.13 of the Code and that the allegation was proven in whole,
- that section 8.20 of the Code was not applicable in this matter and that the allegation was unfounded, and
- was not in breach of section 8.18 of the Code and that the allegation was unfounded.

The Life CCC findings and conclusion:

Section 8.17

Section 8.17 of the Code requires a subscriber to communicate its decision on lump sum claims within six months, unless Unexpected Circumstances applies.

The Consumer lodged a TPD claim on 28 September 2016. As noted above, the Subscriber has stated that the TPD claim was closed on 24 April 2017 and only re-opened on 6 July 2018, after the Subscriber received the Consumer's clinical records and Workers Compensation file.

However, based on the information available it appears that the Consumer's legal representatives were under the impression that the Consumer's TPD claim was being assessed between 24 April 2017 and 6 July 2018.

The Life CCC reviewed the matter and noted that:

- The Subscriber's response to the Life CCC noted that the Subscriber was actively following up the clinical records that it had requested between 24 April 2017 and 6 July 2018.
- The Subscriber acknowledged that it received further documentation from the Consumer's legal representatives in May 2017, resulting in a further assessment of the TPD claim and a request for additional information.
- An email from the Consumer's legal representatives to the Subscriber dated 31 January 2018 references a telephone conversation on 7 June 2017 in which the

[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.

Subscriber advised the Consumer's legal representatives that it was assessing the TPD claim.

- The Consumer's legal representatives requested multiple status updates on the claim between 24 April 2017 and 6 July 2018.

While the Consumer's TPD claim was closed, the Subscriber received and requested additional information in relation to the Consumer's claim, including requesting additional medical reports and asking the Consumer to sign additional authorities.

In the Life CCC's view, this meant that the Subscriber was actively assessing the claim when it adopted the Code on 30 June 2017, even though the claim was closed on its system. Any claim being assessed 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.

As a result, the Life CCC determined that the section 8.17 timeframe in this matter should begin on 30 June 2017, when the Subscriber adopted the Code.

While there is no indication that the Subscriber in this instance deliberately closed the claim on its system while actively assessing the claim as a way to avoid compliance with the timeframes in section 8.17 of the Code, the Life CCC notes that Subscribers are not entitled to close a claim in order to avoid their obligations under Chapter 8 of the Code.

The Consumer's claim was initially stored in a legacy claims system and transitioned to the Subscriber's claims system in December 2017. This resulted in an error regarding the status of the claim which will be further discussed as part of the Life CCC's investigation into the Subscriber's compliance with section 8.13 of the Code below.

The Subscriber provided its decision on the claim on 14 September 2018, which was not within six months of 30 June 2017. As the Subscriber's view was that the claim was closed, the Subscriber did not rely on Unexpected Circumstances. As a result, the Life CCC determined that the Subscriber was in breach of section 8.17 of the Code.

Further, the Life CCC determined in accordance with Charter clause 7.4(b)(iv)[3] that there was no basis to conclude that the Subscriber's breach of section 8.17 of the Code amounted to serious or systemic non-compliance with the Code.

In the Life CCC's view, the cause of the breach was limited to the specific facts of the matter. The Life CCC notes that if the Subscriber had kept the claim open, the claim likely fell under Unexpected Circumstances as the Subscriber had not received the Consumer's Workers Compensation file and clinical records.

If the claim was kept open and Unexpected Circumstances was appropriately identified and notified to the Consumer, it was likely that the Subscriber would have complied with section 8.17 of the Code as the delay was outside the Subscriber's control.

The Life CCC notes that the delays in the claim would have occurred even if the Subscriber kept the claim open and applied Unexpected Circumstances to the claim, and there was no evidence of any actual or potential financial loss suffered by the Consumer as a result of the Subscriber's breach of section 8.17 in this instance.

[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.

Section 8.16

Section 8.16 of the Code requires a subscriber to communicate its initial decision on income-related claims within two months, unless Unexpected Circumstances applies.

Based on the information available, the Subscriber received the IP claim on 15 November 2017. The Subscriber was unable to admit liability after performing the initial assessment as the Consumer's legal representatives requested that the IP claim be backdated to April 2015.

However, the Subscriber decided to make benefit payments to the Consumer on a good faith basis without the admission of liability on 15 January 2018. The Subscriber continued to assess and pay the Consumer's IP benefits on a monthly basis without the admission of liability, and subsequently accepted the IP claim on 13 July 2018 after receiving additional information from the Consumer.

In the Life CCC's view, the decision to pay out the IP claim on a good faith basis without an admission of liability amounts to an initial decision on the claim. As the Subscriber communicated this decision within two months of receiving the claim on 15 November 2017, the Life CCC determined that the Subscriber was not in breach of section 8.16 of the Code.

Claims assessor's mistake: sections 8.13 and 8.20

The Subscriber informed the Consumer's legal representatives on four occasions that the Consumer's TPD claim was declined; on 8 January 2018, 24 January 2018, 6 February 2018 and 9 February 2018.

As noted above, the Subscriber closed the claim on 24 April 2017 as the information that it had requested had not been received. However, the reason for the closure of the TPD claim was mistakenly recorded as declined in its system due to an administrative error when the claim was migrated to its claims systems from a legacy system.

The Subscriber has confirmed that the TPD claim was never actually declined by the Subscriber and has acknowledged that the wrong claim status was provided to the Consumer's legal representatives on four occasions.

As a result of the error, the Life CCC investigated the Subscriber's compliance with sections 8.13 and 8.20 of the Code.

Section 8.13

Section 8.13 creates an obligation on a subscriber to promptly address any errors or mistakes once the subscriber becomes aware of the error or mistake.

In this matter, the Subscriber's mistake occurred on 8 January 2018, when it first informed the Consumer's legal representatives that the claim was declined. The Consumer's legal representatives requested a copy of the decline letter, which the Subscriber provided to them on 24 January 2018.

However, the letter that the Subscriber put forward as the decline letter was the letter from the Subscriber in April 2017 noting that the claim was closed as the Subscriber did not have all the information that it required to assess the claim. The Life CCC notes that this does not amount to a decline of the claim.

The Consumer's legal representatives responded on 31 January 2018 and asked for written confirmation of the status of the claim, noting that the Subscriber did not provide a decline

letter. The Consumer's legal representatives clearly raised an issue with the letter provided to them. In response, the Subscriber emailed the Consumer's legal representatives on 9 February 2018 and confirmed that the claim was declined.

The Subscriber has stated that it only became aware of the error on 9 May 2018, after receiving a call from the Consumer's legal representatives who were seeking a copy of the decline letter.

In the Life CCC's view, the Subscriber was made aware of the error on 31 January 2018, when the Consumer's legal representative informed the Subscriber that the letter provided was not a decline letter. This should have triggered the Subscriber to conduct a review of the letter provided to the Consumer's legal representatives, allowing the Subscriber to confirm and address the error promptly.

As the Subscriber only addressed the error in May 2018, the Life CCC determined that the Subscriber was in breach of section 8.13 of the Code, as it did not address the error promptly.

Further, the Life CCC determined in accordance with Charter clause 7.4(b)(iv)[4] that there was no basis to conclude that the Subscriber's breach of section 8.13 of the Code amounted to serious or systemic non-compliance with the Code.

The Subscriber has noted that the claims assessor who responded to the request from the Consumer's legal representatives was new and inexperienced. In the Life CCC's view, a more experienced assessor would have likely been able to identify and address the error at or around 31 January 2018. The Subscriber has confirmed that additional training has been provided to this assessor.

The Life CCC also notes that while the error does not reflect well on the Subscriber, there was no evidence that the breach caused any actual or potential financial loss to the Consumer.

Section 8.20

Section 8.20 requires a subscriber to have claims assessors who are appropriately skilled and trained to make objective decisions. The claims assessors will only make claims decisions once appropriately trained and a subscriber will not have monetary incentives based on declined or deferred decisions.

The Life CCC initially raised this section as it was unclear if the claim was actually declined by the Subscriber. As noted above, the Subscriber confirmed that the claim was never declined. Instead, the error revolved around the incorrect provision of the claim status by the Subscriber's claims assessor.

As there was no objective claim decision made by the claims assessor's status updates on 8 January 2018, 24 January 2018, 6 February 2018 and 9 February 2018, the Life CCC determined that section 8.20 was not applicable in this matter.

The Life CCC notes that the conduct in question was addressed as part of the Life CCC's investigation of the Subscriber's compliance with section 8.13 of the Code above.

[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.

Section 8.18

If a subscriber accepts a lump sum claim, section 8.18 of the Code requires the subscriber to '*suggest **you** seek financial advice to help manager your claim payment*.' The Code defines '***you***' as a Life Insured, Policy-owner, or a Third Party Beneficiary, as relevant to a particular section of the Code.[5]

In this instance, the policy was owned by the Trustee and the Subscriber's arrangement with the Trustee was for the Trustee to provide the financial advice wording to the Consumer.

The Life CCC reviewed the Subscriber's claim acceptance email to the Trustee and noted that the emails did not include the financial advice wording. However, the Trustee's claim acceptance letter to the Consumer did include the financial advice wording.

The Life CCC considers that best practice would be for the Subscriber to include the financial advice wording in its claim acceptance email to the Trustee. However, as the Consumer received the financial advice wording, there was no breach of section 8.18 of the Code in this instance.

Key Learnings

The Life CCC considers that Subscribers should have robust training programmes in place for new or inexperienced staff, and to closely supervise and monitor such staff to identify and remediate any breaches as early as possible. The Life CCC notes that the Code does not contain any exceptions to its obligations in relation to new or inexperienced staff.

In relation to section 8.18 of the Code, the Life CCC notes that best practice for Subscribers would be to enable compliance with the obligations under the Code via its own processes and procedures.

While Subscribers may enter into arrangements to comply with an obligation under the Code through the processes of a third party, the Life CCC notes that the third party is not bound by the Code. As a result, any failure by the third party will result in a breach of the Code by the Subscriber.

For related discussion and interpretation of compliance with section 8.18 of the Code, subscribers are encouraged to review the Life CCC's Case Study 2019-2.

Relevant Code Sections

Section 8.13:

If **we** become aware of any errors or mistakes in **your** claim or the information **we** have asked for, **we** will address these promptly. **We** may require additional information to implement corrections.

Section 8.16:

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

[5] See Chapter 15 of the Code, Definitions.

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 8.17:

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 8.18:

If **we** accept **your** claim and it includes a lump sum payment, **we** will suggest **you** seek financial advice to help manage **your** claim payment. For an income-related claim, if **we** offer to pay **you** a lump sum instead of ongoing payments in order to finalise **your** claim, **we** will suggest that **you** seek financial and legal advice before accepting **our** offer

Section 8.20:

Our claims assessors will be appropriately skilled and trained to make objective decisions. They will not make claims decisions on **our** behalf until they have demonstrated technical competency and an understanding of all relevant law, the **Code** and relevant **FSC** Standards and Guidance. Remuneration and entitlements to bonuses will not be based on declined claims or deferrals of decisions

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.