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:	CX4314	**Date:**	25 November 2019
Code sections:	8.17, 8.4, 8.7, 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).

The Consumer lodged a TPD claim in May 2014, and the Subscriber declined the claim in October 2015. The Subscriber subsequently re-opened the claim on 23 August 2016, following the receipt of a complaint from the Consumer.

The Subscriber sent Procedural Fairness (PF) to the Consumer on 20 January 2017, and the Consumer's legal representatives responded to PF on 15 February 2017. The Subscriber subsequently requested further information from two of the Consumer's treating doctors, which was received in early August 2017.

The Subscriber referred the claim for review on 27 September 2017 and referred the file for a case conference, which took place on 13 October 2017. However, the assessor failed to set a follow up requirement to action the outstanding tasks on the file and there was no action on the file until 8 January 2018, when it was determined that the file should be referred to the Chief Medical Officer (CMO) for review.

The CMO referral was made on 1 February 2018, but the medical information was only forwarded to the CMO on 7 March 2018. The CMO opinion was received by the Subscriber on 22 March 2018 and the claim was accepted on 24 March 2018.

Although the Subscriber accepted the claim on 24 March 2018, the Subscriber only communicated the claim acceptance to the Consumer's legal representatives on 10 April 2018.

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

In December 2017, the Consumer's legal representatives made a referral to the Life CCC alleging a breach of sections 8.7 and 8.17 of the Code. As part of its review of the file, the Life CCC also raised possible breaches of sections 8.4 and 8.15 of the Code.

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

The Life CCC determined that the Subscriber:

- breached section 8.17 of the Code and that the allegation was proven in whole,
- was not in breach of section 8.4 of the Code and that the allegation was unfounded,
- breached section 8.7 of the Code and that the allegation was proven in whole, and
- breached section 8.15 of the Code and that the allegation was proven in whole.

The Life CCC findings and conclusion:

Section 8.17

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 Subscriber has noted that Unexpected Circumstances did not apply on this claim. The Subscriber provided its decision on the claim on 10 April 2018. As a result, the Life CCC determined that the Subscriber was in breach of section 8.17 of the Code.

The Life CCC further 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 and systemic non-compliance with the Code.

The cause of the breach of section 8.17 was the claims assessor's failure to progress the claim appropriately. However, the claims assessor handling this file had moved into a new role prior to the Subscriber's adoption of the Code and only had a residual portfolio of six claims, including this Matter.

The Subscriber reviewed the five other claims and did not identify any other breaches of section 8.17. As a result, the Life CCC was satisfied that this was an isolated incident that was due to the human error of the Subscriber's claims assessor.

Section 8.4

The Life CCC determined that section 8.4 of the Code creates two separate obligations for subscribers. Firstly, section 8.4 requires subscribers to provide an update on the 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 the Subscriber's compliance with obligation one of section 8.4 of the Code.

[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.
[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.

The Subscriber provided a schedule of communication between the Subscriber and the Consumer's legal representatives which demonstrated that updates were made on a regular basis and within the 20 business day requirement under section 8.4. As a result, the Life CCC determined that the Subscriber was not in breach of section 8.4 of the Code.

Section 8.7

The Life CCC determined that section 8.7 creates two separate obligations for subscribers. The first obligation in section 8.7 requires subscribers to request the information needed as early as possible, while the second obligation in section 8.7 requires subscribers to avoid multiple information requests.

The Consumer's legal representatives submitted that the Subscriber was in breach of section 8.7 in relation to:

- a request for a medical authority on 10 April 2017 which constituted a multiple information request,
- a request for clinical records on 13 June 2017 which was not made as early as possible and constituted a multiple information request, and
- the Subscriber's CMO referral not being made as early as possible.

The Life CCC considered the submission above and noted that the request for a medical authority on 10 April 2017 and the request for clinical records on 13 June 2017 were both prior to the Subscriber's adoption of the Code on 30 June 2017 and were not covered by the Code.

In relation to the CMO referral, the Subscriber acknowledged that it did not make the request as early as possible, since it could have made the request in or around late August 2017. This amounted to a delay of around five months and occurred because the claims assessor failed to properly progress the claim. As a result, the Life CCC determined that the Subscriber was in breach of section 8.7 of the Code.

The Life CCC further 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 8.7 of the Code amounted to systemic non-compliance with the Code.

However, the Life CCC determined in accordance with Charter clause 7.4(b)(iv)[5] that the Subscriber's breach of section 8.7 amounted to serious non-compliance with the Code.

As noted above, the claims assessor in this Matter had a residual portfolio of six files, including this Matter. The Subscriber conducted a review of the five other files and identified two other breaches of section 8.7.

While there is no definitive number that would cause a breach to be systemic, the Life CCC noted that in this instance, three breaches were not sufficient for the Life CCC to deem that the breach amounted to systemic non-compliance with the Code.

The Subscriber's breach in this instance resulted in a delay of approximately five months. In the Life CCC's view, failing to request information that could have been requested five months prior amounted to serious non-compliance with the Code as this would have caused actual or potential financial detriment to the Consumer.

[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.
[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.

The Subscriber has confirmed that it will pay interest to the Consumer from 11 August 2017. This was a week after the Subscriber received the necessary medical evidence it required to assess the claim.

Section 8.15

The Consumer was insured under a Group Policy. Under the arrangement between the Subscriber and the Trustee, the Subscriber is able to communicate decisions on a claim directly to the Consumer, noting that the decision is subject to a Trustee review.

In this Matter, the Subscriber received the last piece of information that it required to assess the claim (the CMO report) on 22 March 2018 and determined to accept the claim on 24 March 2018. However, the Subscriber only informed the Consumer of the claim acceptance on 10 April 2018.

The Life CCC notes that the timeframe in section 8.15 is measured from when the Subscriber receives all the information that it reasonably requires assess the claim to when the Subscriber communicates the decision on the claim to the Consumer or Trustee, where appropriate. Deciding to accept or decline the claim does not fulfil the requirement under section 8.15 of the Code as the decision has to be communicated to the Consumer or Trustee.

As the Subscriber took more than 10 business days to communicate the decision on the claim to the Consumer after the Subscriber received all the information that it reasonably needed to assess the claim, the Life CCC determined that the Subscriber was in breach of section 8.15 of the Code.

The Life CCC further determined in accordance with Charter clause 7.4(b)(iv)[6] that there was no basis to conclude that the Subscriber's breach of section 8.15 of the Code amounted to systemic or serious non-compliance with the Code.

The Subscriber provided its decision to the Consumer in 11 business days, 1 business day over the 10 business day timeframe in section 8.15 of the Code. The Subscriber has since performed quality review checks and has not identified any other section 8.15 breaches for this claims assessor.

Key learnings

The Life CCC expects that Subscribers should conduct periodic reviews and run regular reporting on ongoing claims. A five month delay will amount to serious non-compliance with the Code as such a delay is likely to cause actual or potential financial detriment to Consumers.

In relation to section 8.15 of the Code, the Life CCC notes that the 10 business day timeframe in section 8.15 relates to the time between when the Subscriber receives all the information it reasonably needs and when the Subscriber communicates the decision on the claim to either the Consumer or Trustee, where appropriate.

Whether the Subscriber has all the information it reasonably needs or has completed all reasonable enquiries will be determined by the Life CCC on a case by case basis.

[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.

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 8.4:

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 8.7:

We will request the information **we** need as early as possible and will avoid multiple information requests where possible.

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.

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.