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:	CX4539	**Date:**	29 July 2020
Code sections:	8.4, 8.17[1]		
Investigation:	A consumer-reported alleged Code breach		

The alleged Code breach:

The Consumer obtained multiple life insurance policies from a Life Insurance Company that is a subscriber (the Subscriber) to the Life Insurance Code of Practice (the Code). The policies included a Total and Permanent Disability (TPD) benefit.

On 7 July 2017, the Consumer's legal representatives lodged three TPD claims with the Subscriber. As the Subscriber had not received all the information that it required, the Subscriber was not able to provide a decision on the claims within six months and noted that definition (c) of Unexpected Circumstances applied.

However, the Subscriber informed the Consumer about the reasons for the delay on 21 March 2018, after the initial six month timeframe had expired. The Subscriber subsequently accepted the Consumer's claims on 31 July 2019 after receiving the information that it required to assess the claims.

The Life CCC received this allegation as part of the bulk referral received by the Life CCC from a plaintiff law firm in February 2018. As part of its review, the Life CCC also raised a possible breach of sections 8.4 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 8.4 of the Code and that the allegation was proven in whole, and
- was in breach of section 8.17 of the Code and that the allegation was proven in whole.

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

The Life CCC findings and conclusion:

Section 8.4

Section 8.4 of the Code sets out two separate elements for Subscribers. Firstly, to provide Consumers with updates on their claim at least every 20 business days unless otherwise agreed with the Consumer or the Group Policy-owner. The second element requires a Subscriber to respond to requests for information about the claim within 10 business days.

The Subscriber acknowledged that it breached section 8.4 of the Code in relation to failing to respond to the Consumer's request for information about the claim within 10 business days.

The Life CCC noted that the Subscriber was 20 business days overdue for a 14 March 2018 information request and 15 business days overdue for a 21 March 2018 information request. As a result, the Life CCC determined that the Subscriber was in breach of section 8.4 of the Code and that the allegation was proven in whole.

The Subscriber conducted a review of its compliance with section 8.4 of the Code and identified 10 other breaches of section 8.4 of the Code across its open claims. The Subscriber noted that the additional breaches were overdue for fewer than 10 business days.

The Subscriber has since implemented a system enhancement to ensure that a task reminder appears in the claims assessor's queue 7 days prior to the 10 business day response requirement and 3 days prior to the 20 day contact requirement. The Subscriber subsequently conducted a review of 3,250 requests for information in September 2019 and did not identify any further breaches of section 8.4 of the Code.

Section 8.17

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

The Subscriber received the Consumer's three TPD claims on 10 July 2017. Section 8.17 of the Code requires the Subscriber to provide its decision on the TPD claims by 10 January 2018, 6 months from the date that the Subscriber received the claims.

As at 10 January 2018, the Subscriber had not received all the information that it required to assess the claims. The Consumer's claims history was extensive as he moved interstate, resulting in double the number of doctors and specialists who treated the Consumer.

While the Subscriber noted that Unexpected Circumstances applied, the Subscriber acknowledged that it was in breach of section 8.17 of the Code as it did not notify the Consumer of the reasons for the delay within the timeframe provided by the Code. The Subscriber notified the Consumer of the delay on 21 March 2018, almost three months after the expiry of the initial timeframe.

The Life CCC reviewed the Unexpected Circumstances notification to the Consumer which stated that there were '*exceptional circumstances under the Code which afford an insurer additional time to assess the claim*'. The Life CCC did not consider this to be sufficient explanation of the reasons for the delay as it did not inform the Consumer of the existence of a delay and did not specify the reasons for the delay.

The Subscriber also acknowledged that it did not provide its complaints process to the Consumer after it was unable to communicate a decision on the claim within 12 months. The Subscriber noted that it provided its complaints process to the Consumer on 16 August 2018, which was after the 12 month timeframe had expired.

As a result, 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. In addition, the Life CCC was of the view that at the time of the breach, the Subscriber did not have adequate processes to enable compliance with section 8.17 of the Code.

The Life CCC noted that the Subscriber amended its Unexpected Circumstances notification process in July 2018, when it introduced a template Unexpected Circumstances letter. Prior to this, the Subscriber provided the Unexpected Circumstances notification as part of its regular updates on the claim.

The Subscriber has since also undertaken work to improve its information management systems and introduced diary-based tasks as an additional trigger for an automated reminder of activity required under sections 8.16 and 8.17 of the Code.

The Life CCC determined that the Subscriber's breach of section 8.17 of the Code amounted to serious and systemic non-compliance with the Code, as per clause 7.4(b)(iv) of the Life CCC Charter.

Key learnings

Subscribers should inform Consumers of Unexpected Circumstances as soon as the Unexpected Circumstances are identified. When Unexpected Circumstances apply, this provides the Subscriber with 12 months to provide its decision on a claim.

The Unexpected Circumstances notification should clearly inform the Consumer that there is a delay, and provide the reasons for the delay.

Relevant Code Sections

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.