Guidance Note No. 5

Interpreting and applying Life Insurance Code of Practice section 8.16

Overview

Section 8.16 of the Life Insurance Code of Practice (the Code) deals with subscribers'[1] obligations to customers[2] when assessing all income-related claims.

This Guidance Note explains how the Life Code Compliance Committee (the Committee) interprets the obligations in section 8.16, as well as what information and evidence we will ask subscribers to provide when we investigate potential breaches of these obligations.

1 'Subscriber' in this Guidance Note means the entity that is bound by the Code, as described by section 2.1 of the Code.

2 'Customer' in this Guidance Note means a life insured, a policy owner, or a third-party beneficiary as defined by section 2.6 of the Code.

LIFE CODE COMPLIANCE COMMITTEE

SEPTEMBER 2021

Code section 8.16

SECTION 8.16 STATES:

> *For income-related claims, **we**[3] will let **you** know **our** initial decision no later than two months after **we** are notified of **your** claim or two months after the end of any waiting period (whichever is later), unless **Unexpected Circumstances** apply. 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.*

When the section applies

Code section 8.16 applies when assessing all **income-related claims**. This includes income-related claims made by individual life-insured customers, group policy-owners (trustees) and third-party beneficiaries.

Where there is a potential breach of section 8.16, the Committee may also consider, where relevant, whether there has been a breach of related sections of the Code, including sections 8.14, 8.15, 8.18 and 8.19.

Committee's interpretation of 'notified'[4]

The Committee recognises that subscribers measure claim duration timeframes from the date they 'receive'[5] a claim, rather than the date they are 'notified' of a claim or a potential claim. This is because subscribers only have the information that they require to assess a claim when the claim is received, not when the claim is first notified. Accordingly, when assessing whether the subscriber has responded within the required timeframe, the Committee considers the term "notified" to be the same as "received" and the timeframe to commence on the day the subscriber received the claim.

3 **We, us** and **our** are defined in the Code as the entity that is bound by the Code and includes the entity's **Authorised Representatives** but not an authorised representative of a company related to the entity.

4 **Claim notified** - refers to the initial contact made by the claimant in respect of a potential claim. This could take the form of a physical submission or a telephone call.

5 **Claim received** - The point in time when sufficient information (not necessarily all information) is received to allow a subscriber to commence the assessment of a claim.

Interpreting the Obligation

Section 8.16 sets out four separate elements for subscribers: two **timeframe** elements and two **information** elements. A failure to meet the requirements of any of the elements constitutes a breach.

As section 8.16 covers claims with and without Unexpected Circumstances, not all elements are applicable to every single claim, and this will depend on the individual circumstances of each claim.

Element 1.
Timeframe for claims decisions where Unexpected Circumstances do not apply

For claims where Unexpected Circumstances do not apply, the subscriber must inform the customer of their initial decision[6] about the claim no later than two months after the claim is received, or two months after the end of any waiting period, whichever is later.

Claim declines must be communicated in writing (section 8.19), and the Committee considers that best practice would be for claim acceptances to be communicated in writing as well. When communicating a claim decision to the customer, subscribers should also comply with the other relevant sections in Chapter 8 of the Code such as sections 8.18 and 8.19.

NON-COMPLIANCE EXAMPLE

The subscriber fails to inform the customer of the reasons for Unexpected Circumstances applying to the customer's claim.

Element 2.
Timeframe for claims decisions where Unexpected Circumstances apply

For claims where Unexpected Circumstances apply, the subscriber must inform the customer of the decision on the claim no later than 12 months after the claim is received. If a decision cannot be made within 12 months the subscriber will give the customer details of its Complaints process. Where Unexpected Circumstances continue to apply beyond 12 months (and section 8.14 therefore applies), then a subscriber would not have breached section 8.16 of the Code.

GOOD PRACTICE EXAMPLE

The subscriber's internal processes prompt case managers to proactively consider the application of Unexpected Circumstances to a claim and inform customers before the expiration of the two month timeframe and as early as possible in order to keep the customer informed.

6 The Committee considers the term 'initial decision' as it is used in section 8.16 to mean the subscriber's decision to admit the claim and commence payment of monthly benefits to the customer. The term 'initial' is used as, in effect, every month a decision is made about whether or not to pay a monthly benefit. The initial decision could also encompass the decision to decline the claim.

Element 3.
Informing customers when Unexpected Circumstances apply to their claim

When Unexpected Circumstances applies to a customer's claim, the subscriber must inform the customer before the expiration of the relevant two months timeframe, preferably **in writing**, using a template letter:

- of the subscriber's view that Unexpected Circumstances apply
- of the reasons for Unexpected Circumstances
- that the customer can disagree with the reasons given for the delay
- that the subscriber will review this if the customer disagrees with the reasons for the delay and
- that the subscriber must provide a decision on the claim within 12 months from the date that the claim was received and preferably include the date in the Unexpected Circumstances notification letter for clarity.

The subscriber must inform the customer that Unexpected Circumstances applies to the claim within the initial timeframe; i.e. no later than two months from the date that the claim was notified to the subscriber, or two months after the end of any waiting period.

The subscriber should view the timeframes in section 8.16 as the maximum allowed timeframe and inform the customer of Unexpected Circumstances as early as possible.

The Committee notes that subscribers are not required to use template letters to inform customers about Unexpected Circumstances. However, the Committee considers the use of an appropriately worded template to be the best way to reduce risk of non-compliance.

NON-COMPLIANCE EXAMPLES

- ✖ The subscriber advises the customer within the six month timeframe that Unexpected Circumstances apply to the claim but does not explain why, or let the customer know that they have the right to request a review if they disagree.
- ✖ The subscriber fails to provide the customer with the details of its complaints process when a claim with Unexpected Circumstances exceeds the 12-month timeframe.

CLAIMS LODGED BY A GROUP-POLICY OWNER ON BEHALF OF A CUSTOMER

When Unexpected Circumstances applies to a claim lodged on behalf of a customer by a group-policy owner such as a superannuation fund trustee, the subscriber must advise the group-policy owner, preferably **in writing**, of the information outlined in the bullet points above.

If the group-policy owner fails to pass this information on to the customer, the subscriber will not be in breach of section 8.16.[7] The Committee also expects subscribers to use best endeavours to have agreements in place that enable subscribers to monitor group-policy owners' performance.

This could amount to agreements with the group-policy owner to provide regular updates regarding Code compliance, or a process where the subscriber regularly reviews its group-policy owner's compliance with the obligations in section 8.16 of the Code.

7 As group-policy owners are not subscribers to the Code, there is no obligation for them to pass this information on to the customer.

Element 4.
Informing customers of the complaints process if a decision about a claim cannot be made within 12 months

In cases where Unexpected Circumstances applied to the customer's claim, but the subscriber was unable to communicate a decision about the claim within 12 months, the subscriber should advise the customer of this in writing and provide the customer with details of the subscriber's complaints process.

As a matter of transparency and customer service, while not explicitly stated as a requirement in section 8.16, the Committee expects the subscriber to explain to the customer why a decision has not been made within the 12-month timeframe as part of the subscriber's communication with the customer.

GOOD PRACTICE EXAMPLES

- As part of its process for advising the customer that Unexpected Circumstances apply to the claim, the subscriber sends a letter that explains why Unexpected Circumstances have been applied and advises the customer that they have the right to disagree with the reasons provided and request a review.
- The subscriber notifies the customer in writing before the expiration of the 12-month timeframe that a claim decision will exceed the 12-month timeframe, provides reasons for the delay and includes in that correspondence the details of the subscriber's internal dispute resolution process.
- For Group policies, subscribers will be compliant with 8.16 if the initial decision on the claim is communicated to the policy-owner (the Trustee) within the timeframe in section 8.16 of the Code. The Trustee will then review the claim decision and communicate the decision to the Customer. While subscribers do not have direct control over the Trustee's handling of the claim, good practice for subscribers could include requesting that Trustees agree to claims standards and provide agreements as part of the policy in relation to the timeframe of the Trustee's review and communication of the claim decision.

In addition, where the subscriber is prevented from communicating their decision within 12 months from the date the claim was received due to circumstances outside the subscriber's control, the Committee will also consider the application of section 8.14 of the Code.

Key differences between section 8.16 and section 8.17

The obligations created by sections 8.16 and 8.17 of the Code are similar but there are two specific differences, as outlined below. A detailed interpretation of section 8.17 can be found in Guidance Note No. 6, 'Interpreting and applying Life Insurance Code of Practice section 8.17'.

SECTION 8.16	SECTION 8.17
• Applies when assessing income-related claims. • The subscriber must inform the customer of the subscriber's initial decision about the claim no later than two months after the subscriber is notified of the claim, or two months after the end of any waiting period, unless Unexpected Circumstances apply.	• Applies when assessing all non-income related claims. • The subscriber must inform the customer of the subscriber's decision about the claim no later than six months after the subscriber is notified of the claim, or six months after the end of any waiting period, unless Unexpected Circumstances apply.

Case Study

The Consumer lodged an IP claim with the Trustee, with the Subscriber being notified of the claim shortly after. For the Subscriber to be compliant with section 8.16, it had to provide the Trustee with its decision within two months, unless Unexpected Circumstances applied.

The Subscriber provided its claims decision to the Consumer approximately 12 months after it was notified of the claim. However, the Subscriber considered that Unexpected Circumstances applied to the claim and this was communicated to the Consumer three months after it had been notified of the claim.

The Committee determined that the Subscriber was not entitled to rely on Unexpected Circumstances, as it had notified the Consumer outside of the two-month timeframe and was therefore in breach of section 8.16 of the Code. If the Subscriber had issued the Unexpected Circumstances letter within the two-month timeframe, it would have had 12 months in which to complete assessment of the claim.

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

The Committee considers that subscribers should view the timeframes in section 8.16 as a maximum allowed timeframe and always seek to handle claims efficiently.

Demonstrating compliance

When the Committee receives an allegation that a subscriber has breached section 8.16, we will generally ask the subscriber to provide the following information and evidence:

INFORMATION OR EVIDENCE	WHAT WE WILL CONSIDER
Description of the processes and procedures in place for enabling compliance with section 8.16	• whether a subscriber has appropriate systems and processes in place to enable compliance with section 8.16 • whether the subscriber uses an automated claims handling system that tracks key deliverables at the two and 12-month points in claims and prompts claims assessors to take the appropriate action (e.g. notifying customers of Unexpected Circumstances) • whether template letters[8] include all the information contained in section 8.16 of the Code, such as to advise customers when Unexpected Circumstances apply to a claim • the adequacy of staff training, Quality Assurance and review programmes to ensure compliance with section 8.16 • the adequacy of monitoring/reporting functions (e.g. regular exception reporting or reviews) to accurately track claims assessors' compliance with section 8.16 • whether the subscriber has appropriately interpreted and applied section 8.14[9]

In some cases, the Committee may ask for additional information and/or evidence.

> **Once we have all the information we reasonably need and have completed all reasonable enquiries to assess your claim … we will let you know our decision on your claim within ten business days.**

8 There is no obligation for subscribers to use template letters to inform customers about Unexpected Circumstances. However, the Committee considers the use of an appropriately worded template to be the best way to reduce risk of non-compliance.

9 Section 8.14 – Claims decisions and benefit payments - Life Insurance Code of Practice

Related Code sections

Where there is a potential breach of section 8.16, the Committee may also investigate, where relevant, whether there has been a breach of related sections of the Code, including but not limited to sections 8.14, 8.15, 8.18 and 8.19:

- **8.14**
  All efforts will be made to meet the timelines required by the Code. However, timeframes for making claims decisions can be affected by factors outside our control [Unexpected Circumstances]. Examples of this include the time taken by a superannuation trustee to review our decision or fulfil its legal obligations, or the time taken by you or your treating doctor to provide information. Where we cannot comply with a deadline required by the Code due to a delay that is out of our control, we will inform you of this and we or the Group Policy-owner will keep you informed of progress.

- **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.

- **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.

- **8.19**
  If we decline your claim we will let you know in writing: a) the reasons for our decision; b) that you have the right to copies of the documents and information we have relied on, and if you request we will provide you (or your doctor, where appropriate) with copies within ten business days, in accordance with the Access to Information section of the Code; and c) that you have the right to request a review if you disagree with our decision, and we will give you details of our Complaints process.

About the Committee

The Committee is the independent body responsible for the administration and enforcement of the Code. It acts in accordance with its Charter, which sets out the powers, duties, functions and responsibilities of the Committee, subject to any provisions in the Code.

Guidance Notes

Guidance Notes are subject to change by the Committee and this document reflects the Committee's views as at the date of publication. The Committee considers all matters on the basis of their individual circumstances and this document does not anticipate all possible issues that might come before the Committee.

Life Code Compliance Committee
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