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:	CX7111	**Date:**	28 February 2022
Code sections:	8.7, 8.17[1]		
Investigation:	A consumer-reported alleged Code breach		

The alleged Code breach:

The Consumer is a member of a superannuation fund. As part of that membership, the Consumer obtained life insurance with a Total and Permanent Disability (TPD) benefit. The life insurance policy 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's legal representatives (CLR) submitted a TPD claim to the Trustee on 13 January 2020 and the Trustee lodged the claim with the Subscriber on 29 January 2020. Under section 8.17 of the Code, the Subscriber was required to provide its decision on the claim within six months of lodgement, on 29 July 2020. The CLR lodged a Code breach allegation against the Subscriber on 15 July 2020 and alleged that the Subscriber was in breach of section 8.17 of the Code as the Subscriber had not provided a decision within the six-month time frame. The Subscriber subsequently provided its claim decision to the Trustee and the CLR on 21 August 2020.

As part of its review of this matter, the Life CCC also raised possible breach of section 8.7 of the Code by the Subscriber in the management of this claim.

The Life CCC contacted the Subscriber and made further inquiries in relation to the Subscriber's compliance with sections 8.17 and 8.7 of the Code. In response, the Subscriber has acknowledged breaches of sections 8.17 and 8.7.

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

The Life CCC determined that:

- the Subscriber was in breach of section 8.7 of the Code and that the allegation was proven in whole, and

[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 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:

Section 8.7

Section 8.7 requires a subscriber to request the information that it needs to assess a claim as early as possible and to avoid multiple information requests where possible.

The Subscriber acknowledged that it was in breach of section 8.7 of the Code as during the assessment of the claim there were three instances where the Subscriber did not request the information it required as early as possible:

- The Subscriber received the claim on 29 January 2020, but the claims assessor did not attempt to obtain the initial information the Subscriber determined it needed to assess the claim until 9 March 2020 (a total of 40 days later).
- The Subscriber requested the Consumer's workers compensation file via a third-party service provider on 30 March 2020. On 31 March 2020 the third-party service provider advised the Subscriber that it required a specific privacy authority from the Consumer prior to obtaining the workers compensation file. The Subscriber did not ask the Consumer for this authority until 4 June 2020 (a total of 65 days later).
- On 1 July 2020, the Subscriber noted that as part of its assessment of the claim it required an opinion from its internal rehabilitation specialist team but the referral to this team was not made until 10 August 2020 (a total of 40 days later).

These delays were attributed to oversights caused by the claims assessors managing the claim at the time.

As a result, the Life CCC determined that the Subscriber was in breach of section 8.7 of the Code and that the allegation was proven in whole.

The Life CCC further determined that the breach of section 8.7 amounted to serious non-compliance of the Code due to the length of the delay, a total of 145 days, caused by the claims assessors' oversights.

The Subscriber noted in its review that the circumstances leading to the delays were isolated incidents specific to this claim. The Subscriber performed Quality Assurance (QA) reviews on individual claims assessors (including the assessors who handled this matter) and identified 15 breaches of section 8.7 from a total of 1,992 claims. This represented less than 1% of the claims reviewed and did not indicate that the Subscriber's breach of section 8.7 was systemic in nature.

In addition, the Life CCC reviewed the subscriber's framework for section 8.7 compliance and was satisfied that the Subscriber had adequate processes in place. The Subscriber's processes to enable compliance include automated preventative tasks and reminders, internal monthly reporting, a claims QA process and training and refresher training for its staff.

Section 8.17

Section 8.17 of the Code requires a subscriber to provide its decision on a lump sum claim within six months, unless Unexpected Circumstances applies. If Unexpected Circumstances applies, the subscriber has 12 months to provide its decision on the claim.

The Subscriber received the Consumer's claim from the CLR on 29 January 2020. That meant that the Subscriber had to provide its decision on the claim by 29 July 2020, unless Unexpected Circumstances applied. The Subscriber provided its claims decision to the Trustee and CLR on 21 August 2020, almost four weeks after the applicable decision date.

The Subscriber acknowledged that it was in breach of section 8.17 and confirmed that Unexpected Circumstances did not apply in this claim as the main reasons for the delay were within the Subscriber's control. The Subscriber advised further that its internal compliance monitoring identified this as a breach of section 8.17 of the Code at the time and reported it internally.

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.

The breach of section 8.17 stemmed from the three occasions where the Subscriber did not request information it required to assess the claim as early as possible. The result was a total delay of 145 days in the management of the claim, representing a large portion of the 205 days the Subscriber took in total to assess the claim.

As the circumstances leading to the delays were within the Subscriber's control, the Life CCC also determined that the breach of section 8.17 amounted to serious non-compliance with the Code.

Key learnings

Section 8.7 of the Code creates an obligation for subscribers to request the information they require as early as possible. The claims assessors who handled the claim in this matter did not meet this obligation on three separate occasions, which the Subscriber has attributed to human error.

Consumers who lodge life insurance claims are often experiencing financial and non-financial stress. Avoidable delays such as the delays in this matter are not acceptable and likely result in financial and non-financial harm to the consumer.

To minimise the risk of human error in processing of claims, subscribers should have systems and processes in place to support claims assessors in meeting the requirements of the Code. This could take the form of automated tasks and reminders at key steps of the claims process that are aligned to the Code timeframe and information requirements, ongoing supervision and compliance training for staff, and monitoring of claims processing to enable early identification of errors and potential breaches of the Code and timely remediation of identified errors and breaches.

Relevant Code Sections

Section 8.7:
We will request the information **we** need as early as possible and will avoid multiple information requests where possible.

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.

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.