Life Insurance Code of Practice

# Annual Industry Data and Compliance Report 2020–21

March 2022

LIFE CODE COMPLIANCE COMMITTEE

# Contents


| | |
|---|---|
| **Chair's message** | **3** |
| **Overview** | **5** |
| **About this Report** | **5** |
| Role of the Life CCC | 5 |
| Data collection process | 5 |
| Code Subscriber Snapshot | 6 |
| Life insurance business | 6 |
| Code compliance | 6 |
| Complaints | 7 |
| Key Observations | 8 |
| **Code compliance** | **12** |
| A snapshot of breach events | 13 |
| Breach event causes | 14 |
| Remediation of breach events | 15 |
| A snapshot of isolated breaches | 15 |
| Isolated breach causes | 17 |
| **Claims** | **18** |
| A snapshot of claims numbers | 19 |
| Claims withdrawn | 19 |
| Claims re-opened | 20 |
| Time to assess claims | 21 |
| Unexpected Circumstances | 23 |
| **Complaints** | **24** |
| A snapshot of complaint numbers | 25 |
| Top 3 complaint causes | 26 |
| Complaints relating to claims | 28 |
| **Appendix 1: Code subscribers in 2020–21** | **30** |
| **Appendix 2: Life insurance business data** | **31** |
| **Appendix 3: Comparative Code compliance data** | **34** |
| **Appendix 4: Comparative claims and complaints data** | **36** |

# Chair's message

**I am pleased to present the Life Code Compliance Committee's Annual Industry Data and Compliance Report (the Report) for the period 1 July 2020 to 30 June 2021.**

The Report aggregates data sourced directly from Code subscribers, together with data from the Committee's compliance monitoring work, to provide a snapshot of the life insurance industry and its compliance with the Life Insurance Code of Practice (the Code) during the reporting period.

The Committee was pleased to note an improvement in the quality of the data submitted by subscribers compared to previous years. Extensive engagement with subscribers throughout the 2020–21 Annual Data and Compliance Programme (ADCP) submission process has resulted in a more accurate and better quality dataset than previously, and has enabled us to provide a valuable overview of what the industry is doing well and where it needs to improve.

> The Report identifies an opportunity for improvement in subscribers' processes and controls, particularly in relation to annual notices, monitoring compliance, breach reporting and claims management.

This year we have taken the opportunity to improve the structure and content of the Report. This year's Report focuses on the key findings and trends from Code subscribers' self-reported breach, claims and complaints data, as well as learnings for subscribers. Data relating to the life insurance industry, along with supplementary information on Code compliance, claims and complaints, is included in Appendices to the Report.

While people-related issues were the main cause of breaches of the Code this year, failure and weaknesses in processes and systems impacted the majority of customers affected by Code breaches. The Report identifies an opportunity for improvement in subscribers' processes and controls, particularly in relation to annual notices, monitoring compliance, breach reporting and claims management.

**Processes for providing annual notices to customers**

More than 373,000 customers were impacted by failures in subscribers' systems and processes for managing compliance with section 6.3 of the Code regarding annual notices.

The potential for customers to be adversely impacted by not receiving their annual notice on time and with all the information they need is high. It could result in the customer's policy lapsing without their knowledge or customers continuing to pay for a policy that is inappropriate or unaffordable, particularly if they are paying for the policy via a direct debit facility.

### Processes for monitoring compliance and reporting breaches

A number of the section 6.3 breaches reported by subscribers were only identified as a result of the Committee's section 6.3 Own Motion Inquiry (OMI), undertaken in April 2021. This indicates that some subscribers may not have adequate processes in place to monitor their compliance with obligations in the Code.

### Complaints management processes

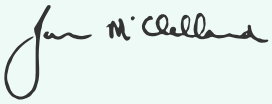
The 2020–21 data showed that almost half of all claims decisions were reversed when a customer made a complaint. This suggests that subscribers' processes for assessing claims in the first instance may be inappropriate or inadequate. Having a claim incorrectly declined, then being exposed to a potentially lengthy dispute resolution process, can cause severe detriment to a customer at a time when they are already vulnerable.

The Committee strongly encourages all subscribers to review the guidance and recommendations contained in the Report to assist them in improving their processes, compliance monitoring and overall Code compliance. Most importantly, better Code compliance will result in better outcomes for customers and life insurers alike.

We thank subscribers for their ongoing effort and commitment to helping us achieve a quality industry dataset through their positive response to the ADCP engagement process and willingness to improve their data collection and reporting. We appreciate the time and effort subscribers invest in our annual data collection program.

We also thank subscribers for their constructive feedback on the process and timing for our annual data collection program to ensure we minimise potential duplication of content and data submission timeframes with other regulatory data reporting obligations.

We look forward to further positive discussions with all subscribers as we prepare for the 2021–22 data submission.



Jan McClelland AM
**Independent Chair**
**Code Compliance Committee**

# Overview

## About this Report

### Role of the Life CCC

The Life Insurance Code of Practice is the life insurance industry's (subscribers) commitment to mandatory customer service standards. The Code is designed to protect consumers by:

1. Promoting high standards of service to consumers
2. Providing a benchmark of consistency within the industry
3. Establishing a framework from professional behaviour and responsibilities.

All life insurers who are members of the Financial Services Council (FSC) are required to adopt the Code. Compliance with the Code is monitored by the Life Insurance Code Compliance Committee (the Committee). The Committee is independent and plays a critical role in supporting the Code objectives and protecting the interests of customers. The Committee does this by:

- Monitoring, enforcing, and reporting on Code compliance
- Working collaboratively to improve Code standards and provide industry best practice.

Each year the Committee collects and reports on aggregated industry data and consolidated analysis of Code compliance by Code subscribers.

### Data collection process

Under its Charter, the Committee is required, each year, to collect and report on aggregated life insurance industry data.[1] The Report is based on data sourced directly from 25 subscribers who each completed a detailed data workbook that was developed in consultation with key stakeholders. The data submitted included for each distribution channel:

- the volumes and types of cover in force and business issued
- the volume of claims received, determined, withdrawn, re-opened
- the volume of claims assessed durations of determined and undetermined claims
- the number, nature, and outcome of customer complaints
- the number of types of breaches including sections of the Code and impacted[2] customers
- the number of claims and reason for determined and undetermined where Unexpected Circumstances applied.

The data provided by subscribers is complemented with additional data on subscribers' compliance with the Code, sourced either directly from subscribers or from the Committee's compliance monitoring work.

1 Life Code Compliance Committee Charter, clause 11(d).

2 Impacted customers also included customers who were potentially impacted by the breach.

# Code Subscriber Snapshot

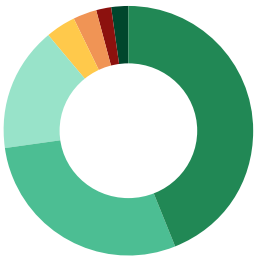
## Life insurance business

**24**
Code subscribers as of 30 June 2021

**32 million**
covers in force

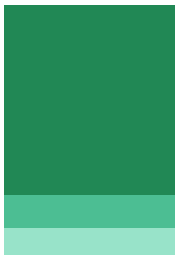
issued by **19**
subscribers

### Covers by type[3]



- **44%** Death cover
- **29%** Total and permanent disability cover
- **16%** Disability income insurance
- **4%** Consumer credit insurance
- **3%** Trauma insurance
- **2%** Accident insurance
- **2%** Funeral insurance

### Type of distribution



- **76%** Group
- **13%** Retail
- **11%** Direct

**110,488** claims were assessed
↓ 12% decrease from previous year

**94,688** claims determined
93% were accepted and 7% declined

## Code compliance

**429,347** customers impacted by a breach of the Code
↑ 197% increase from previous year

| Breaches related to | Customers impacted |
|---|---|
| Policy changes and cancellation rights: Chapter 6 of the Code | 374,523 (87%) |
| Policy design and disclosure: Chapter 3 of the Code | 29,154 (7%) |
| When you make a claim: Chapter 8 of the Code | 24,004 (5.6%) |
| Other chapters of the Code | 1,666 (0.4 %) |

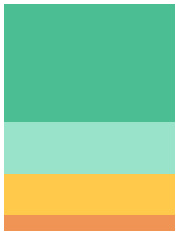
| Breaches caused by | Customers impacted |
|---|---|
| Process | 221,194 (52%) |
| Systems | 96,090 (22%) |
| People | 83,493 (19%) |
| Other | 28,570 (7%) |

3 All percentages are rounded off to the nearest whole number.

## Decrease in number of customers impacted by people-related breaches

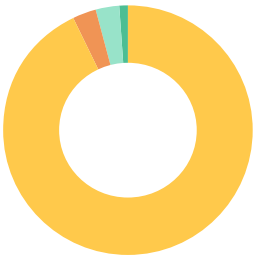
96,573 (67%) customers impacted by people-related breaches in 2019–20 vs 83,493 (19%) customers impacted by people-related breaches in 2020–21

## 419,627 customers impacted by 93 breach events[4]



52% processes
23% systems
18% people
7% other

## 9,720 isolated breaches[5]



93% people
3% processes
3% systems
1% other

## Most breach events required some form of remediation by subscribers. Of the 93 breach events which impacted 419,627 customers:

- **27** breach events impacting **223,603** customers were addressed through a process-related remediation
- **20** breach events impacting **123,020** customers were addressed through a system enhancement
- **42** breach events impacting **12,309** customers were addressed through a people-related remediation
- **4** breach events impacting **60,695** customers were addressed through 'other' remediation

# Complaints

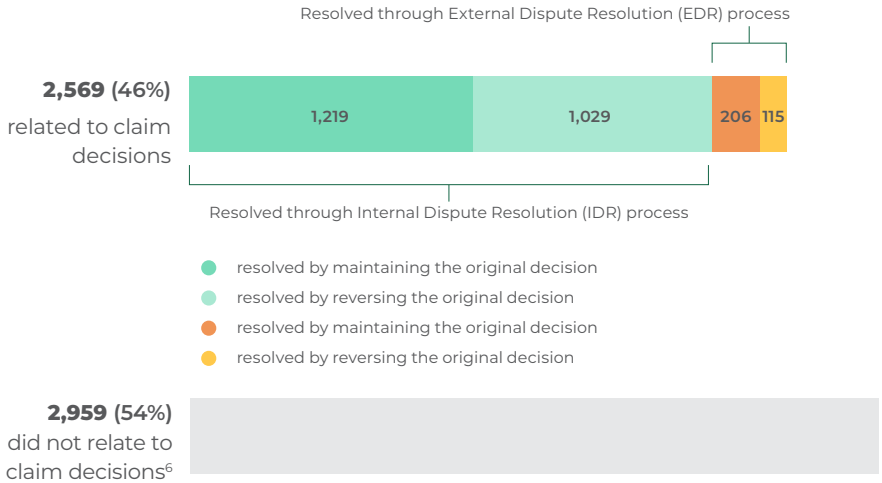
## 20,857 complaints reported by subscribers

↑463 (2%) increase from previous year

### Top 3 customer complaints:

1. **Policies**
   Policy changes or cancellations (8,287 or 40% of the total)
2. **Claims**
   (6,073 or 29% of the total)
3. **Service**
   (2,552 or 12% of the total)

### Subscribers also reported that of the 5,528 claims-related complaints resolved:




4 **A breach event** is an event that results in multiple breaches of a Code section from the same cause at the same point in time (for example, a system coding error impacting a template letter sent to multiple customers).

5 **An isolated breach** is a single breach resulting from a specific cause at a point in time and impacting one customer (for example, a claims officer declining a specific claim due to their mistaken interpretation of a process or circumstance).

6 Some non-exhaustive examples of claim-related complaints which do not relate to claim decisions may include complaints regarding the claims process or handling, assessment duration, benefit amounts etc.

# Key Observations

## 45% of claims decisions were reversed when a customer made a complaint

This year, subscribers reported that 1,144[7] (45%) of the 2,569 resolved complaints which related to a claim decision, were resolved by reversing the original decision in favour of the customer.

The rate of claims decisions overturned and admitted in favour of the customer following a complaint or request for a review suggests that subscribers have further work to do to ensure claims assessments are being appropriately and thoroughly considered in the first instance.

For customers, having their claim incorrectly declined and then being subjected to a potentially lengthy dispute resolution process can cause severe detriment. Furthermore, there may be customers who did not lodge a complaint following a claim decline who would have had a decline decision reversed had they done so.

**What subscribers can do:**

- Take an analytics-based approach to ensure that decisions to decline or overturn claims are centrally tracked and reviewed.
- Where recurring issues are identified, undertake a root cause analysis to understand the issues and identify opportunities for improvement.
- Implement appropriate improvements such as staff training, improved systems, processes, quality assurance or automation.

## Breaches relating to annual policy notices impacted the most customers

Breaches of section 6.3 of the Code impacted 373,343 (87%) of customers in 2020–21. Section 6.3 requires customers to be provided with an annual notice, in writing, prior to the anniversary of the policy. The number of customers impacted by breaches of section 6.3 rose by 291%, from 95,404 customers impacted in 2019–20.

The annual notice is an important source of information for customers regarding their life insurance policy, providing customers with clarity on the cost and level of their cover, enabling them to decide whether the product is still suitable for their needs. Failure to issue the annual notice on time, or failure to include all relevant information in the annual notice, can adversely impact customers and prevent customers from making an informed choice on the suitability of the life insurance policy.

> “
>
> The annual notice is an important source of information for customers regarding their life insurance policy, providing customers with clarity on the cost and level of their cover …

7 1,029 claims-related complaints regarding decisions were reversed through IDR and the remaining 115 claims-related complaints regarding decisions were reversed through EDR.

> While industry has improved over the last four years, the Committee continues to have concerns regarding the robustness of subscribers' processes and procedures for identifying and reporting breaches of the Code.

The Committee published a report on an Own Motion Inquiry (OMI) in February 2022. The OMI found that almost 200,000 customers were impacted by section 6.3 breaches in the 2019 and 2020 calendar years, with breaches being caused by systems issues, human errors, and failures in subscribers' management of their section 6.3 processes.

**What subscribers can do**

- Review, test and assess systems and processes regularly to ensure they are fit-for-purpose, sufficiently robust and capture all section 6.3 breaches and obligations.
- Consider adopting automated processes for issuing annual notices, with checks, tests and assurances in place to review the content of templates, communications and ensure the currency and accuracy of customers' postal and email addresses.
- Take prompt action to report identified breaches to the Committee, notify affected customers and rectify the breaches.
- Consider the Committee's section 6.3 OMI report and its 6 recommendations.

**↑291%**


**increase in customers impacted by section 6.3 breaches reported by subscribers in 2020–21**

## Breach identification and reporting could be further improved

The Committee recognises the efforts that subscribers have taken over the last four years to enhance their breach identification, recording and reporting capabilities in line with the requirements of the Code. While industry has improved over the last four years, the Committee continues to have concerns regarding the robustness of subscribers' processes and procedures for identifying and reporting breaches of the Code.

Following the Committee's commencement of the OMI into section 6.3 of the Code, there was a significant increase (291%) in customers impacted by section 6.3 breach reporting in the 2020–21 reporting period. In addition, subscribers noted that many of these breaches were identified directly as a result of the Committee's OMI.

This suggests that some subscribers may not have had robust systems in place to identify and report these matters prior to this being highlighted by the Committee through the OMI process. While evidence of this issue has only been identified in relation to section 6.3 of the Code, the Committee is concerned that there might be other areas of the Code where subscribers are not conducting adequate compliance monitoring.

The Code is a voluntary Code that is based on a self-regulation model. The Committee reminds subscribers that self-regulation is a privilege, not a right, and that self-regulation can only work if subscribers to the Code have robust processes and procedures in place to identify, report and remediate breaches.

The Committee encourages subscribers to review why these breaches were not identified prior to the Committee's OMI and to conduct a root and branch review of their breach identification processes to ensure that there are no other unknown gaps. The Committee will continue to conduct further OMIs and targeted inquiries into key areas of the Code and continue to closely monitor subscribers' compliance with the Code.

### What subscribers can do

- Ensure regular senior oversight of breach data, analysis and remediation strategies.
- Consider how internal audit can test breach identification, recording and reporting approaches.
- If necessary, engage external expertise to assist in establishing compliance monitoring frameworks.

**↑197%**

**increase in the number of customers impacted by breaches in 2020-21**

## Inadequate processes impacted the highest number of customers

This year, breaches caused by process failures contributed to an increase of 197% in the total number of customers impacted by breaches, up from 144,423 in 2019-20 to 429,347 customers in 2020-21. Process-related breaches impacted more than 200,000 (52%) of all customers impacted by breaches in 2020-21. By comparison, people-related breaches impacted the majority (67%) of customers impacted by breaches in 2019-20.

The increase in the number of customers impacted by process-related breaches was primarily due to process failures by three subscribers, resulting in almost 99% of the customers impacted by process-related breaches. This demonstrates the substantial customer impact process-related breaches can have, highlighting the importance of subscribers taking steps to ensure that such breaches do not occur.

### What subscribers can do

- Ensure new processes are sufficiently tested prior to implementation with ongoing monitoring and quality assurance mechanisms to identify problems or unintended consequences.
- Where appropriate, automate processes and internal controls to minimise errors.
- Regularly review existing processes and controls to identify issues and opportunities for improvement. Consider using internal audit functions to assist where necessary.
- Provide ongoing systems and process training to staff to ensure that they understand and comply with internal guidelines and Code requirements at all times.

## No improvement in the number of claims determined within the Code timeframes

Although Code subscribers assessed fewer claims in 2020–21 compared with 2019–20, there was not a corresponding decrease in the percentage of claims assessed outside of the timeframes required by the Code.

With substantially fewer claims for subscribers to assess and determine this year, it is concerning that there was no improvement in the assessment timeframes, and that assessment timeframes for income-related claims have been increasing over the last four years.

A fair, transparent and thorough claims process is important. The claims process for a customer often occurs during an extremely stressful and challenging period of their life. They may have no income, or are dealing with illness or injury, and so unnecessary or unexplained delays have the potential to exacerbate already difficult situations.

### What subscribers can do

- Closely review the root causes of assessment delays to identify why they are occurring and how best to address them.
- Ensure staff have the training, tools and resources required to assess claims efficiently and effectively. This may include a triage model with more complex matters being considered by specialised teams or more experienced staff.
- Consider where automation of low-value or repetitive steps can assist in reducing assessment timeframes.

## Subscribers improved their categorisation of complaints and classification of Unexpected Circumstances

Subscribers were able to provide a specific cause for 96% of complaints this year compared with 92% in 2019–20. The Committee's introduction of two new categories for complaint causes in this year's ADCP led to a 49% decrease in the number of complaints that were unable to be categorised. Uncategorised complaints accounted for just 4% of all complaints received in the period. The Committee acknowledges that subscribers' complaints recording and reporting capability has improved in the four years since we began collecting the data, which has led to a consistent downward trend in the number of uncategorised complaints over this time.

Subscribers were also able to provide reasons for the application of Unexpected Circumstances[8] for more claims this year. Only four subscribers who accounted for only 3% (420 out of 12,494) of claims were unable to do so. This was an improvement from last year, when five subscribers (who accounted for 7% of claims) could not provide reasons for the application of Unexpected Circumstances. The Committee encourages subscribers to continue to review and improve on their complaints and claims assessment processes so that they can understand customers' pain points and why delays are occurring and take steps to prevent them where possible.

Further analysis of subscribers' self-reported data on Code breaches, claims and complaints is provided further below.

**8** Chapter 15 of the Code provides eight definitions of circumstances where 'Unexpected Circumstances' could apply to a claim: (a) The subscriber was notified of the claim more than 12 months after the later of the date of disability or the end of the waiting period and there are reasonable delays obtaining evidence necessary for the assessment of the claim; (b) The subscriber was not reasonably satisfied that based on the information received within six months that the consumer's claim met the requirements under the Total and Permanent Disability (TPD) policy; (c) The subscriber had not received reports, records or information reasonably requested from an Independent Service Provider, person or entity (which includes a doctor, a government agency or a Reinsurer); (d) The Policy-owner or Group Policy-owner has disputed or taken a protracted period to consider the Subscriber's decision; (e) The Consumer's Representative have not responded to the Subscriber's reasonable enquiries or requests for information/documents in relation to the claim; (f) The Subscriber experienced difficulties in communicating with the Consumer due to circumstances beyond the Subscriber's control; (g) There is a delay in the claims process as a result of the Consumer's request; (h) The Subscriber reasonably suspected fraud or non-disclosure which requires further investigation.

# Code compliance

## Breaches have impacted approximately 2.4 million customers in the last four years.

Data overview

**2,414,268**

customers impacted by 708 breach events and 34,104 isolated breaches in the four years since subscribers first began reporting breach data to the Committee

**93**

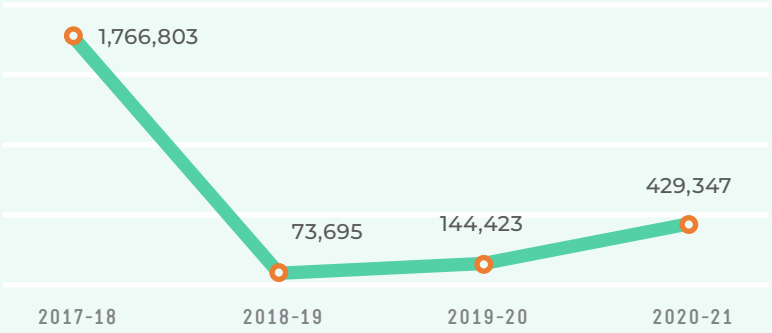
breach events of the Code in 2020-21
↓ from 350 in 2019–20

**9,720**

isolated breaches of the Code in 2020-21
↑ from 4,975 in 2019–20

The majority of all the self-reported breaches occurred as part of a breach event, where a single cause led to multiple breaches of a Code section.

### Code compliance breaches 4-year history




**2017–18**

had the highest number of customers impacted, when **1,766,803** customers were impacted by breaches that occurred as a result of subscribers having difficulty transitioning to the Code.

### Top 5 breach event types in 2020-21:

1. When you make a claim
2. Policy changes and cancellation rights
3. When you buy insurance
4. Policy design and disclosure
5. Complaints and disputes/ Sales practices and advertising

### Top 5 isolated breach types in 2020-21:

1. When you make a claim
2. Access to information
3. Policy changes and cancellation rights
4. When you buy insurance
5. Policy design and disclosure

**429,347**

customers impacted in 2020-21

# A snapshot of breach events

Subscribers reported 93 breach events this year. This amounted to a decrease of 73% when compared to the 350 breach events reported last year[9] and the lowest number reported by subscribers since 2017–18, the first year of formal operation of the Code. In that time, we have seen subscribers report a total of 708 breach events to the Committee (**Figure 1**). Eight of the 93 breach events were also reported by subscribers to a regulator.

**56%**

**of breach events related to chapter 8 of the Code**

## The number of customers impacted by breach events rose 200%

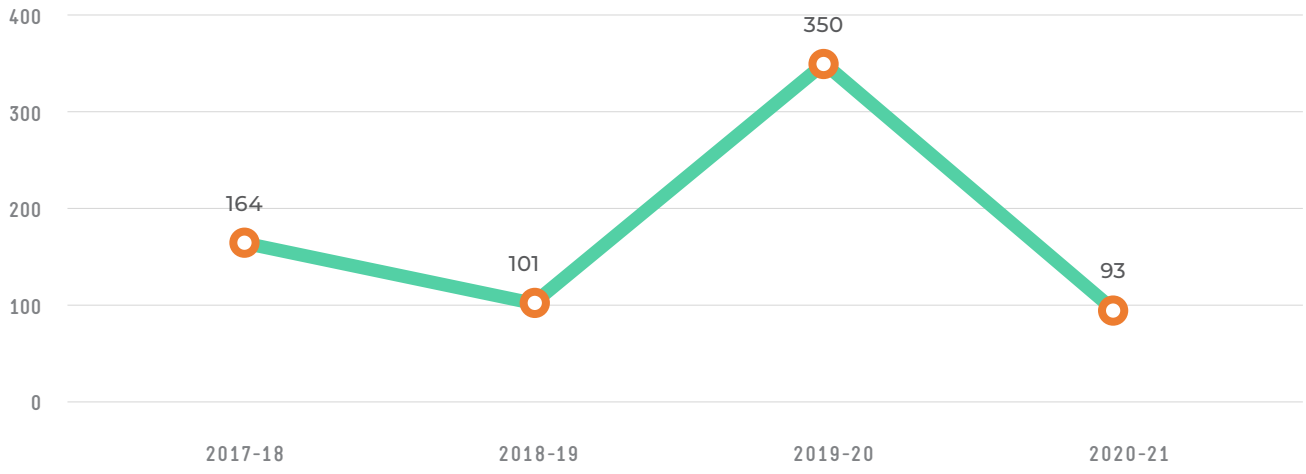
Despite the reduction in breach event numbers this year, there was an increase of 200% in the number of customers impacted. Breach events impacted 139,448 customers in 2019–20. This rose to 419,627 customers impacted by breach events in 2020–21. The increase was primarily related to an increase in the number of customers impacted by breaches of section 6.3 of the Code. More detail about this is included below.

## Most breach events related to the Code's claims obligations

Most (56%) of the breach events related to chapter 8 of the Code, which sets out subscribers' obligations when customers make a claim. Breach events associated with chapter 6, which concerns policy changes and cancellation rights, accounted for 29% of all breach events. The remaining Code chapters accounted for single-digit breach events.

FIGURE 1.

**Breach events reported by Code subscribers, 2017–18 to 2020–21**




9 In 2019–20, 76% of all breach events recorded were attributable to just two subscribers, with one of those subscribers accounting for 237 breach events.

## Section 6.3 breaches continue to be an issue even four years after Code adoption

Section 6.3 breaches made up 66% of the customers impacted in the 2017–18 reporting period. Subscribers noted that these were breaches related to their transition in adopting the Code. While breaches of section 6.3 decreased in 2018–19, the number of customers impacted by section 6.3 breaches has continued to steadily increase in the following two reporting periods. This trend concerns the Committee and we expect subscribers to take steps to review their section 6.3 systems and processes to ensure that they are robust and compliant with the Code.

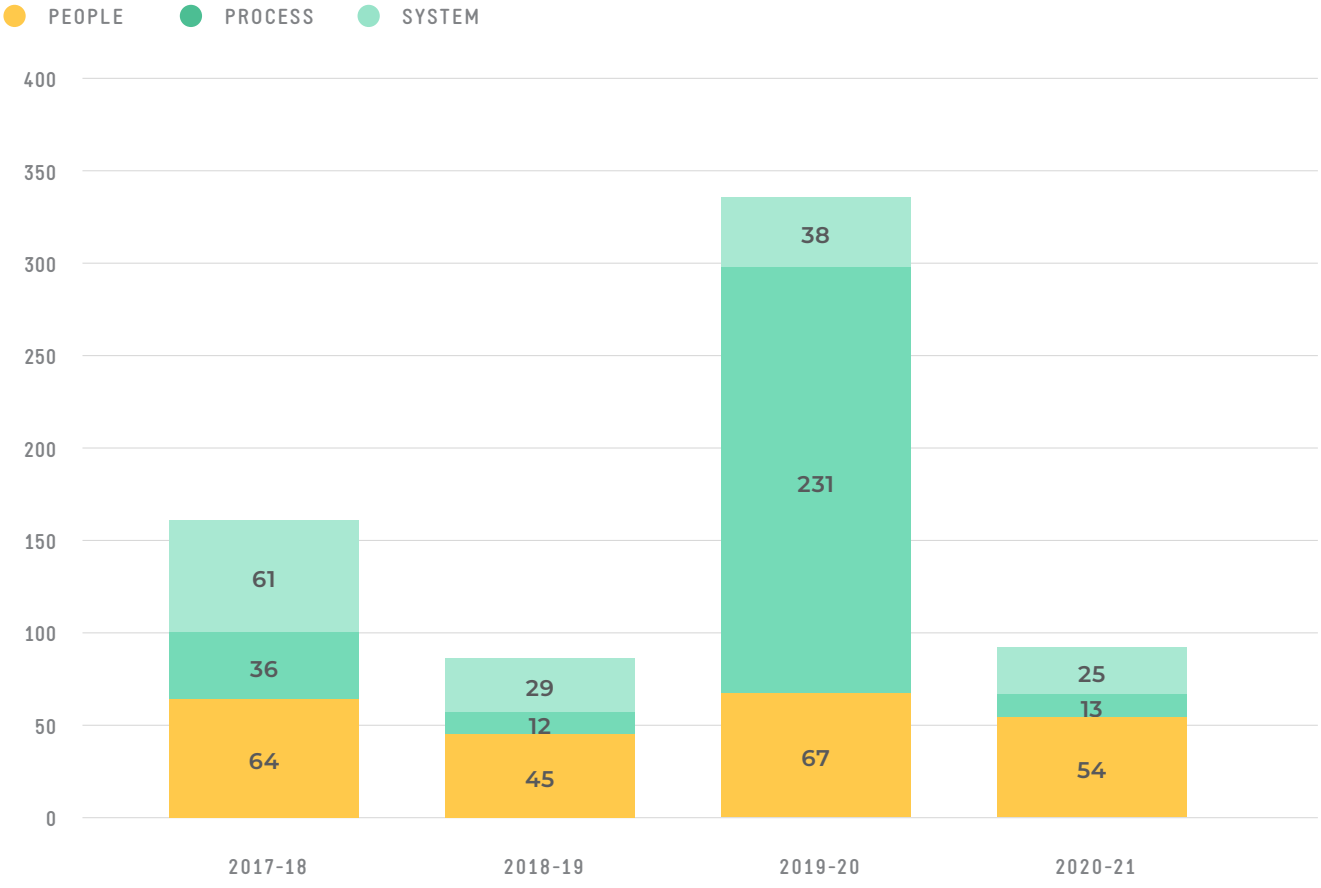
## Breach event causes

While process failures led to the highest number of customers impacted this year, people-related issues caused 54 (58%) breach events reported by subscribers. This included people-related issues caused by human error, staff not following established processes and procedures, and resourcing issues. Issues associated with people have caused the highest number of breach events for three of the last four reporting periods, with process and system issues also causing high numbers of breach events each year (**Figure 2**).

**58%** **of all breach events were caused by people-related issues**

FIGURE 2.

**Top 3 breach event causes, 2017–18 to 2020–21**



## Remediation of breach events

All but two of the 93 breach events included some form of remediation by the subscriber. At the time of collating the data, subscribers had completed remediation for 69 of the breach events. System enhancements occurred for 20 breach events. Additional resourcing was used to remediate 16 breach events, remedial staff training was used to remediate 12 breach events, and training for staff on Code compliance process and procedures was used to remediate 14 breach events.

## A snapshot of isolated breaches

The number of isolated breaches almost doubled this year. Subscribers reported a total of 9,720 isolated breaches – 95% more than the previous year and the second highest number since 2017–18. Two subscribers accounted for 62% of all the isolated breaches this year (**Table 1a**). Each isolated breach impacted a single customer.

In the four years since the Code came into formal operation, subscribers have reported a total of 34,104 isolated breaches.

TABLE 1a.

**Number of customers impacted by Code subscribers' isolated breaches over the last four reporting periods**

| Subscriber | 2017-18 | 2018-19 | 2019-20 | 2020-21 |
|---|---|---|---|---|
| A | 200 | 40 | 29 | 9 |
| B | 2,484 | 1,037 | 536 | 125 |
| C | | 1 | - | 10 |
| D | 236 | - | 1 | 112 |
| E | | 3 | - | 4 |
| F | 126 | 436 | 70 | 808 |
| G | 38 | 18 | 15 | - |
| H | 2 | - | - | - |
| I | 1,982 | 675 | 632 | 4,563 |
| J | 43 | 245 | 253 | 556 |
| K | 811 | - | - | - |
| L | - | 18 | - | - |
| M | 16 | 6 | 9 | 83 |
| N | 847 | 7,158 | 1,400 | 1,488 |
| O | - | 856 | 922 | 913 |
| P | 663 | 937 | 941 | 795 |
| Q | | 10 | 12 | 188 |
| R | 30 | 12 | 15 | 15 |
| S | - | - | 5 | - |
| T | 437 | 24 | 71 | 33 |
| U | 11 | 1 | 53 | 7 |
| V | - | 6 | 11 | 11 |
| **Grand Total** | **7,926** | **11,483** | **4,975** | **9,720** |

“

… the majority of isolated breaches recorded this year (93%) related to the Code’s claims obligations, set out in chapter 8 …

Isolated breaches were of a different nature to breach events. As has been the case in recent years, the majority of isolated breaches recorded this year (93%) related to the Code’s claims obligations, set out in chapter 8 (**Table 1b**). Most isolated breaches of chapter 8 related to sections:

- 8.15, which requires subscribers to inform customers of the claim decision within 10 business days of gathering all required information (2,615 isolated breaches)
- 8.4, which requires subscribers to keep customers informed of the progress of a claim every business 20 days (2,168 isolated breaches)
- 8.3, which states that subscribers must, within 10 business days of being notified of a claim, explain the cover and claim process (1,355 isolated breaches)
- 8.17, which covers subscribers’ obligations to customers when assessing non-income related claims (1,041 isolated breaches)
- 8.16, which covers subscribers’ obligations to customers when assessing income-related claims (778 isolated breaches).

TABLE 1b.

**Isolated breaches by Code chapter over the last four reporting periods**

| Isolated Breaches - Number of impacted customers | | Isolated Breaches (2020-21) | | Year on year ranking | | | |
|---|---|---|---|---|---|---|---|
| Section Name | Chapter | Impacted customers | % of total | 20-21 | 19-20 | 18-19 | 17-18 |
| When you make a claim | 8 | 9,030 | 93% | 1 | 1 | 1 | 1 |
| Access to information | 14 | 225 | 2% | 2 | 4 | 3 | 5 |
| Policy changes and cancellations rights | 6 | 144 | 1.5% | 3 | 5 | 5 | 7 |
| When you buy insurance | 5 | 141 | 1.5% | 4 | 2 | 2 | 2 |
| Policy design and disclosure | 3 | 92 | 1% | 5 | 9 | | 6 |
| Complaints and disputes | 9 | 65 | <1% | 6 | 6 | | 4 |
| Consumers requiring additional support | 7 | 11 | <1% | 7 | 8 | | 8 |
| Sales practices and advertising | 4 | 10 | <1% | 8 | 3 | 4 | 3 |
| Code objectives | 1 | 1 | <1% | 9 | - | - | - |
| Information and education | 11 | 1 | <1% | 10 | 10 | | - |
| Standards for third parties dealing with underwriting or claims | 10 | | | | 11 | | - |
| Monitoring, enforcement and sanctions | 13 | | | | 7 | | - |
| **Grand Total** | | **9,720** | **100%** | | | | |

# Isolated breach causes

As occurred with breach events, the main cause of isolated breaches this year was people-related issues. Subscribers attributed 93% of all isolated breaches to people, making this the top cause for the fourth year in a row.

As seen in the previous year, human error was once again the biggest contributor, causing 37% of all people-related isolated breaches, followed by staff failing to adhere to established processes or procedures, and resourcing issues (each accounting for 29% of all isolated breaches with a people-related cause) **(Figure 3)**.

With the exception of skills and training, there were significant increases in the numbers of isolated breaches with a specific people-related cause compared to the previous reporting period. According to subscribers, human error caused twice as many breaches this year as last year,  while breaches caused by a failure to follow process/procedure rose by 77%.

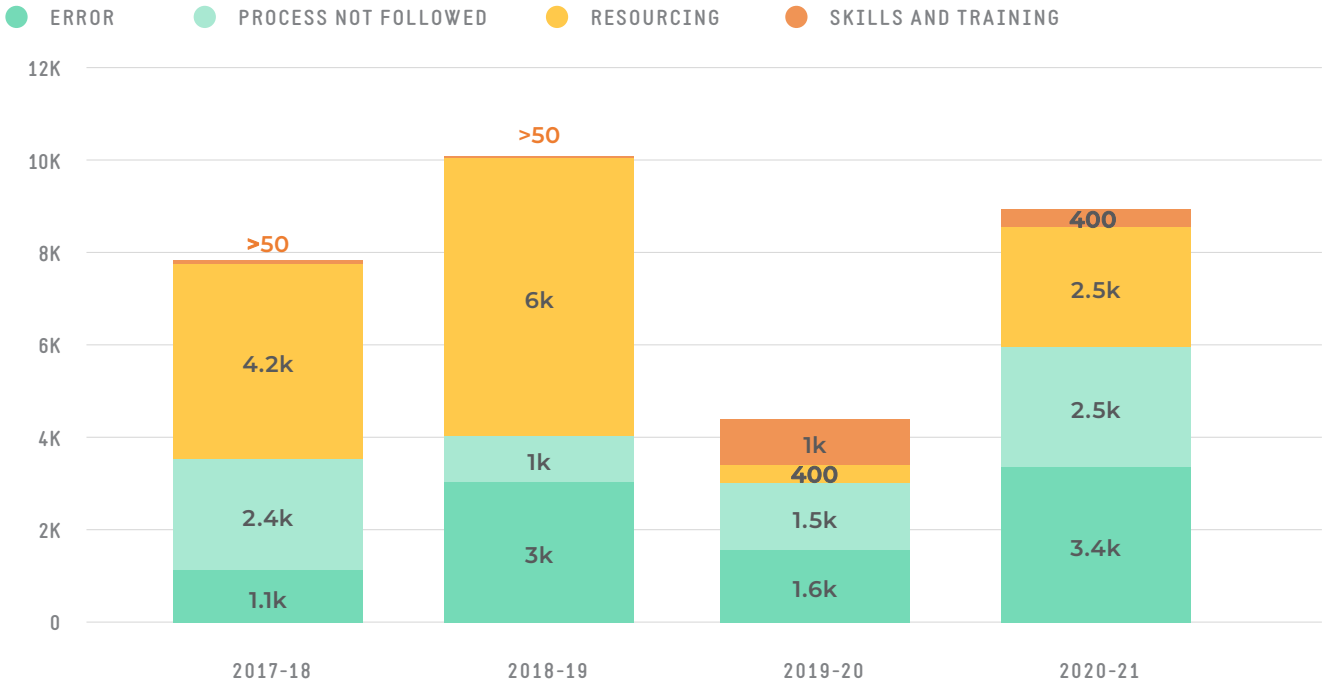
> According to subscribers, human error caused twice as many breaches this year as last year...

The biggest change was in the number of isolated breaches caused by resourcing issues, which increased by 2,213 almost 600% from the previous year.

Feedback from subscribers about why they reported so many more isolated breaches with a people-related cause includes difficulties recruiting, training, managing and monitoring a remote workforce during the COVID-19 pandemic. Some subscribers also said resourcing issues, such as moving staff to meet resourcing needs in specific business areas without adequately training them, was a common isolated breach cause.

FIGURE 3.

**Isolated breaches caused by people-related issues, 2017–18 to 2020–21**



# Claims

## Claims issues still feature prominently in self-reported and alleged Code breaches, as well as in customer complaints.

Customers expect life insurers to process claims in a fair and timely manner and advise them if this is not possible. Improving claims standards was a pivotal driver for the Code's creation, as these are the standards that keep subscribers accountable at a time when customers are at their most vulnerable.

Subscribers provided data on the 110,488 claims they assessed during the year, including the time taken to determine them. They also included information on the number of claims withdrawn and re-opened, as well as the reasons for applying Unexpected Circumstances to some claims.

### Data overview 2020-21

**110,488**
claims assessed by subscribers
↓ 12% compared to 2019–20

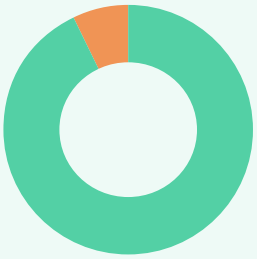
**94,688**
claims determined by subscribers
↓ 13% compared to 2019–20

**17,618**
undetermined claims that were received in previous years but remained open at the beginning of 2020–21

**Top 3** claim types across all distribution channels:

1. Disability Income Insurance (DII)
2. Total and Permanent Disability (TPD)
3. Death

Claims outcome



**93%** claims accepted

**7%** claims declined

**↓ 52%**
decrease in Consumer Credit Insurance (CCI) claims received

**5,779**
claims withdrawn
6% of all claims received

**15,800**
claims yet to be determined
as at 30 June 2021

# A snapshot of claims numbers

Subscribers assessed 110,488 claims in 2020–21. This is 15,392 (12%) fewer than in 2019–20. The claims included 96,380 claims that were received during the year as well as 17,618 undetermined claims that were received in previous years but remained open at the beginning of 2020–21.

That 12% fewer claims were lodged this year may be due to the total number of covers in force falling by 20% in 2019–20, when millions of covers were cancelled following the introduction of the *Protecting Your Super* and *Putting Members Interests First* laws to protect consumers' superannuation funds from being eroded by insurance premiums.[10]

The number of claims determined by subscribers during the year was 94,688 – a decrease of 13% from the number of claims determined in 2019–20. Subscribers accepted 93% of all determined claims and declined the remaining 7%. As at 30 June 2021, subscribers were yet to determine 15,800 claims.

In terms of benefit type, the highest proportion of claims received across all distribution channels was for Disability Income Insurance (DII). Despite representing 16% of covers in force, DII accounted for 37% of all claims received. Claims for Total and Permanent Disability (TPD) and Death cover were the next most common, respectively accounting for 21% and 16% of total received claims. Together, disability cover (DII and TPD) accounted for 58% of all claims received during the year.

There were reductions in the number of claims received across all benefit types except Funeral insurance, which saw a slight rise of 1% on the previous year. Consumer Credit Insurance (CCI) recorded the sharpest drop in claims received, falling by 52%. This is most likely a flow-on effect caused by CCI covers in force falling by 25% in 2019–20 as a result of market volatility in response to regulatory reform (such as the Australian Securities and Investments Commission's (ASIC) ban on cold-call sales of CCI in late 2019). Claims for Death cover also recorded a decrease of 21%. (See **Figure 17** in Appendix 4 for more detail.)

## Claims withdrawn

Subscribers reported that 5,779 claims (6% of all claims received) were withdrawn during the year. Of these, 46% were withdrawn by the subscriber and 39% by the customer or their authorised representative. The remaining 15% were withdrawn for 'other' reasons.

The benefit types with most claim withdrawals were DII (51%), followed by TPD (27%) and Death (9%).

The distribution channel with the greatest proportion of withdrawn claims was Group (68%), followed by Retail (15%), Direct (third party) (9%) and Direct (8%).

**↓ 21%** **decrease in**
**Death claims received**

10 LCCC Annual Industry and Data Compliance Report 2019–20, page 6.

# Claims re-opened

This year, the Committee asked subscribers to provide more granular data about the outcome of re-opened claims. Requested data included information on how many of these re-opened claims were admitted, declined, undetermined and withdrawn. Subscribers were also asked to report on the reasons for admitting or declining re-opened claims.

Subscribers re-opened 2,123 claims. Of these:

- 1,525 (72%) were admitted
- 318 (15%) were declined
- 107 (5%) were withdrawn
- 173 (8%) were undetermined as at 30 June 2021.

## Admitted re-opened claims

Of the 1,525 re-opened claims that were admitted, subscribers admitted 68% of them having received additional information about the claim. A further 22% were subsequently admitted following a review or lodgement of a complaint about the claim; and the remaining 10% were admitted due to other reasons.

### Re-opened claims that were admitted upon receipt of additional information

The fact that most re-opened claims were subsequently admitted when customers provided additional information highlights the importance of subscribers working closely with customers during the claims process to be able to efficiently obtain all the information needed to assess the claim. We suggest that subscribers ensure they provide clear and accessible advice to their customers about what information must be provided at the outset to enable the claim to be assessed.

Re-opened Trauma claims were most frequently admitted, accounting for 82% of all admitted re-opened claims, followed by re-opened DII claims (80%). Consistent with the assessment requirements of Trauma and DII, most of these re-opened claims had originally been closed because the customer or their representative had not provided the information required to assess the claim on an ongoing basis.

### Re-opened claims that were admitted after a review was requested or a complaint lodged

Subscribers re-opened 485 claims following a request to review the claim or a complaint about the claim. Of these, 337 (69%) were admitted, accounting for 22% of all re-opened admitted claims for the year. Six subscribers (excluding reinsurers) admitted almost three-quarters of the 337 claims.

The Committee suggests that subscribers closely examine any claim that has been re-opened and admitted after a complaint or a request to review the claim. It may be that claims staff are incorrectly assessing the claim at the outset through lack of experience or technical competency, indicating the need for better oversight and training.

**485**

**claims were re-opened by subscribers following a request to review the claim or a complaint about the claim**

# Time to assess claims

The Code sets out timeframes in which subscribers must make a decision about claims. For income-related[11] claims, an initial decision is required within the later of two months from the date the subscriber is notified[12] of the claim or two months after the end of the waiting period.[13] For non-income related claims, subscribers have six months from the later of being notified of a claim or the end of any waiting period to make a decision.[14]

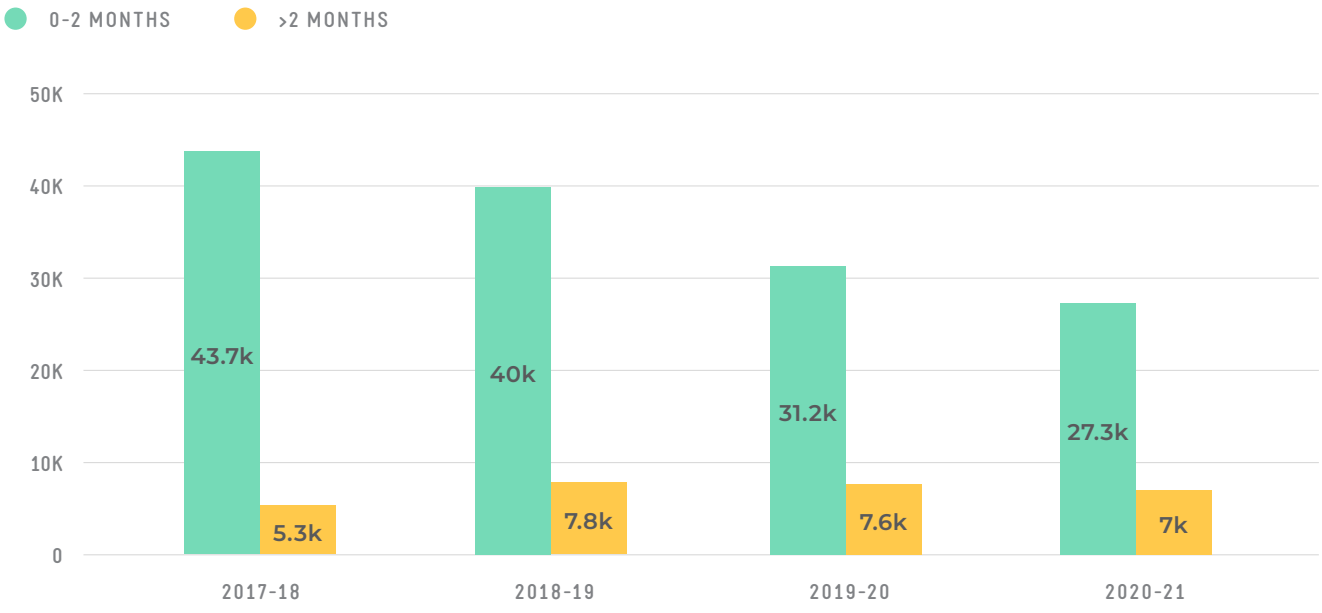
## Claim decision timeframes

In 2020-21, subscribers assessed almost 15,400 (12%) fewer claims than in 2019–20, yet in 2020–21, 20% of all decisions for income-related claims were made later than the required two months, while 12% of all decisions for non-income related claims were made later than the required six months, showing no improvement from the percentages in 2019–20.

Over the last four years, the number of income-related claims finalised within two months has steadily decreased (**Figure 4**), while for non-income related claims, subscribers had been steadily increasing the number finalised within six months until this year, when there was a 15% decrease in the number finalised compared to the previous year (**Figure 5**). The benefit types where decisions about non-income related claims most commonly took more than six months were TPD, Death and Trauma (**Figure 6**).

FIGURE 4.

**Four-year comparison of decision timeframes for determined claims (income-related)**




**11** For the purposes of the ADCP, income-related claims are the number of claims reported under the Disability Income Insurance (DII) benefit type.

**12** 'Notified' is not defined in the Code and is measured to be the date the claim was 'Received' by the subscriber. For more information, refer to the Life CCC's approach in its Annual Industry Data and Compliance Report 2017-18: https://lifeccc.org.au/app/uploads/2019/04/Life-insurance-Code-of-Practice-Annual-Industry-Data-and-Compliance-Report-2017-2018.pdf

**13** Life Insurance Code of Practice Chapter 8 – Section 16 – When you make a claim.

**14** Life Insurance Code of Practice Chapter 8 – Section 17 – When you make a claim.

FIGURE 5.

**Four-year comparison of decision timeframes for determined claims (non-income related)**

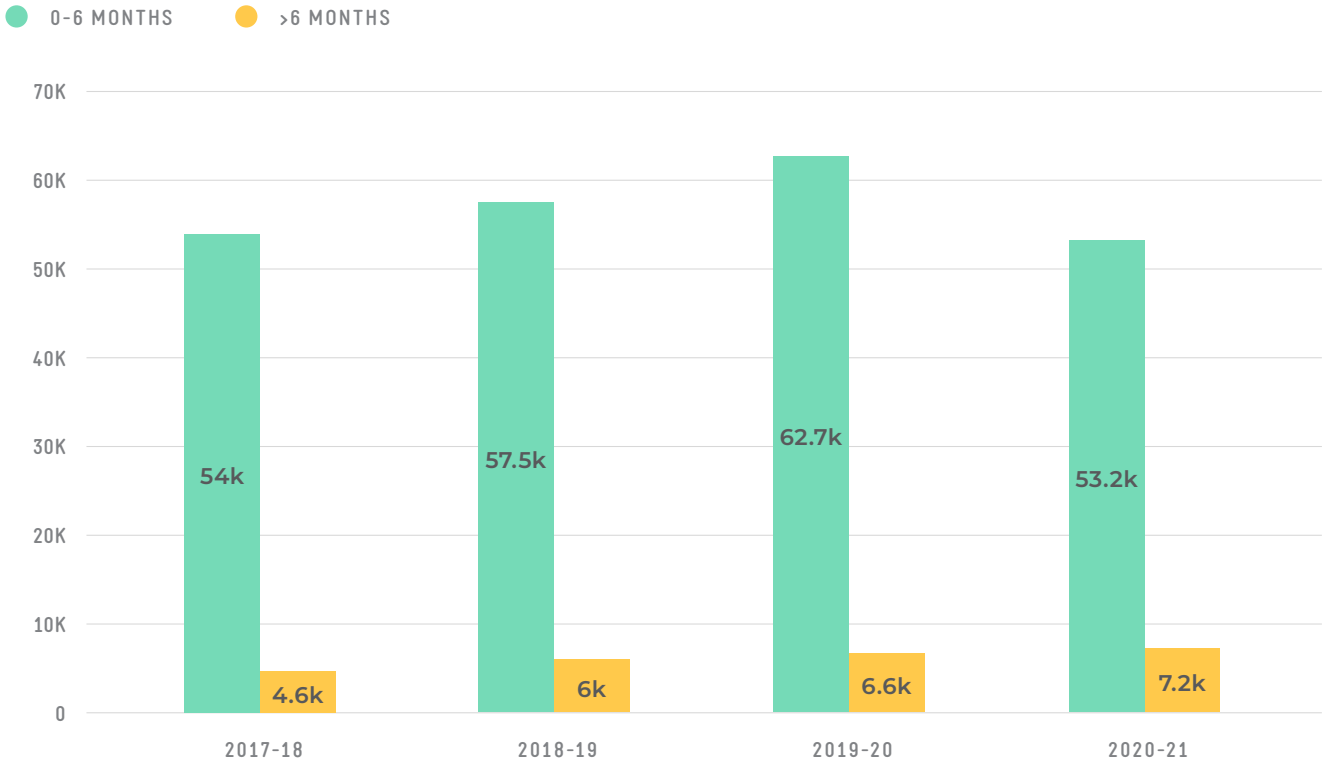
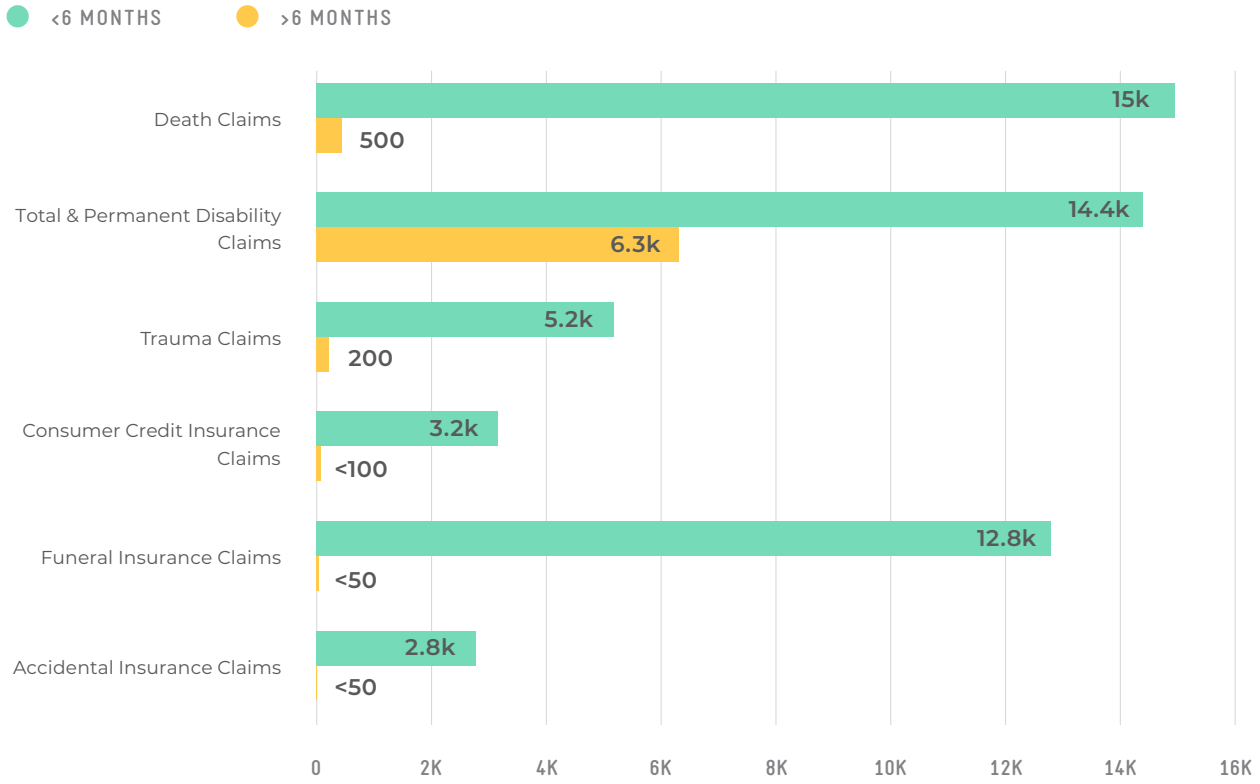



FIGURE 6.

**Decision timeframes for determined claims by benefit type (non-income related)**



# Unexpected Circumstances

The Code provides for a longer claim assessment duration of up to 12 months where Unexpected Circumstances apply. The Code requires subscribers to tell the customer why the delay has occurred and keep them informed about the progress of their claim. If Unexpected Circumstances do not apply, a subscriber must provide a decision within two months for income-related claims or six months for lump sum claims. Exceeding this timeframe without Unexpected Circumstances would result in a breach of the Code.

## Reasons for applying Unexpected Circumstances to claims

Subscribers were asked to provide the combined number of **determined claims** during 2020–21 and **received** and **undetermined claims** as at 30 June 2021 where Unexpected Circumstances applied. They were also required to give specific reasons (as set out in Chapter 15 ('Definitions') of the Code) for applying Unexpected Circumstances to these claims.

This was the second year the Committee has asked subscribers to provide this data, and we were encouraged to see an improvement in the number of subscribers who were able do so.

Out of 12,494 claims, subscribers were able to provide information on 97% of claims:

- In 5,232 (42%) of these claims, subscribers applied Unexpected Circumstances because they had not received the necessary information from the customer, the customer's representative or another third party within the required timeframe.[15]
- In 2,347 (19%) of these claims, subscribers applied Unexpected Circumstances because they were notified of the claim more than 12 months after the date of the disability or end of the waiting period (whichever is later) and there were reasonable delays in obtaining evidence necessary for the assessment of the claim.[16]
- In 2,063 (17%) of these claims, subscribers applied Unexpected Circumstances to a Total and Permanent Disability (TPD) claim because they were not reasonably satisfied that the information provided met the requirements of the policy.[17]

Regrettably, one subscriber this year was unable to classify/record the reasons for applying Unexpected Circumstances on any of the claims where this occurred, due to limitations in its current claim system. The Committee will continue working with this subscriber to resolve the issue.

**15** Unexpected Circumstances definition (c).

**16** Unexpected Circumstances definition (a).

**17** Unexpected Circumstances definition (b).

# Complaints

## Complaints are a valuable source of information for subscribers about what they need to do to facilitate better customer outcomes.

We continue to see a year-on-year increase in the number of complaints received and assessed by Code subscribers, and this year was no different.

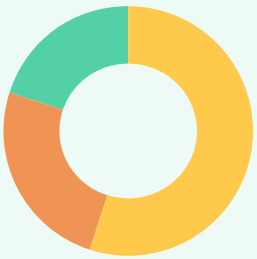
### Data overview 2020-21

**20,857**

complaints reported by subscribers

↑ 2% compared to 2019–20

#### Complaints by distribution channel



**55%** Retail

**25%** Direct (including third party)

**20%** Group

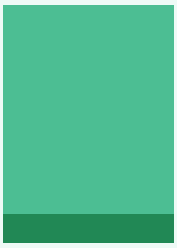
#### Top 3 complaint causes:

1. Policies
2. Claims
3. Service

#### Top 3 complaints by benefit:

1. Disability Income Insurance (DII)
2. Consumer Credit Insurance (CCI)
3. Total and Permanent Disability (TPD)

#### Dispute resolution process



**88%** Internal Dispute Resolution (IDR)

**12%** External Dispute Resolution (EDR)

**5,528**

claims-related complaints resolved (79% of the 6,997 claims-related complaints received)

**781**

complaints unable to be categorised

**↓49%**

reduction in the number of complaints that were unable to be categorised

# A snapshot of complaint numbers

Subscribers received and assessed 463 more complaints this year than last year – an increase of just over 2%. This year, for the first time, subscribers were asked to include detailed information about complaints relating specifically to claims, including how those complaints were resolved.

Despite the relative stability in overall complaint numbers since last year, there was some movement in the number of complaints by distribution channel. Complaints about cover distributed via the Retail channel increased by almost 20%, while complaints about cover distributed directly (by subscriber and third parties) fell by almost the same amount.

However, consistent with the trend in the previous year, complaints about cover distributed via the Retail channel remained the highest out of the three distribution channels with 11,421 complaints (or 55% of the total), followed by Direct (including third party) with 5,324 complaints (or 25% of the total) and Group with 4,112 complaints (or 20% of the total).

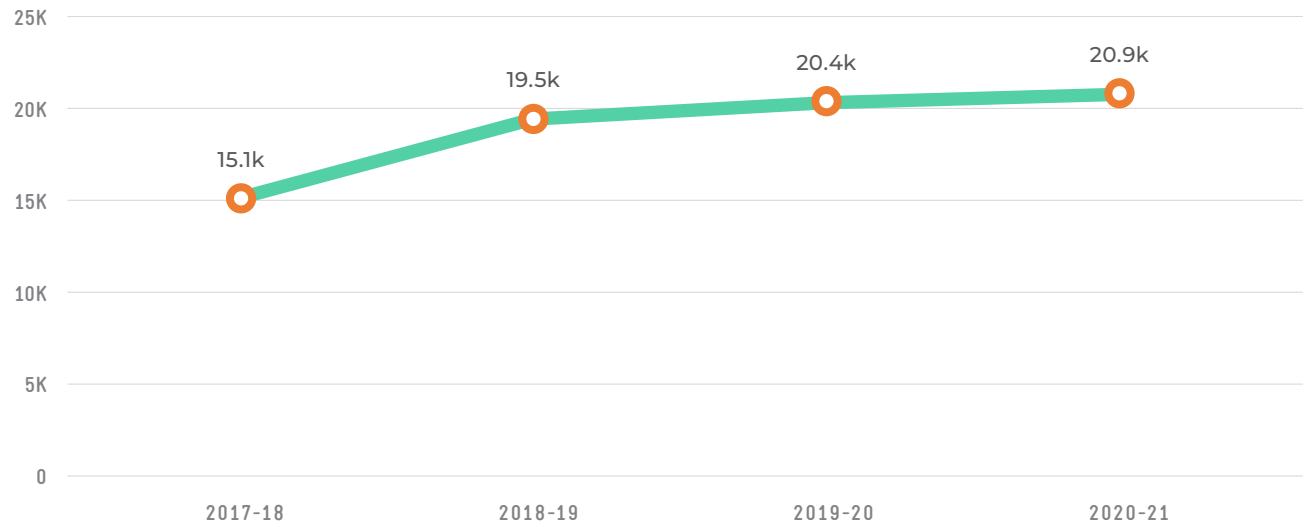
In the four years since the Committee began reporting on complaints data, there has been a steady increase in the number of complaints received by subscribers (**Figure 7**).

Complaint categorisation improved markedly with the introduction of a new 'service related' category for complaint causes this year. The Committee also introduced a new 'products/multiple benefits' category for benefit types, which led to a 49% reduction in the number of complaints that were unable to be categorised and helped subscribers to improve their complaints recording and reporting capabilities.

Where subscribers reported that they were unable to categorise 1,545 complaints in 2019–20, this dropped to 781 this year, so that uncategorised complaints accounted for just 4% of all complaints. Without the two additional complaint categories, 46% of the total number of complaints received would have been unable to be categorised.

FIGURE 7.

**Number of complaints received by subscribers in the four years to 30 June 2021**



# Top 3 complaint causes

Policy and claims-related issues continue to attract the highest number of customer complaints, as has been the case each year since 2017–18. The newly introduced category of service-related complaints was the third most cited cause of customer complaints.

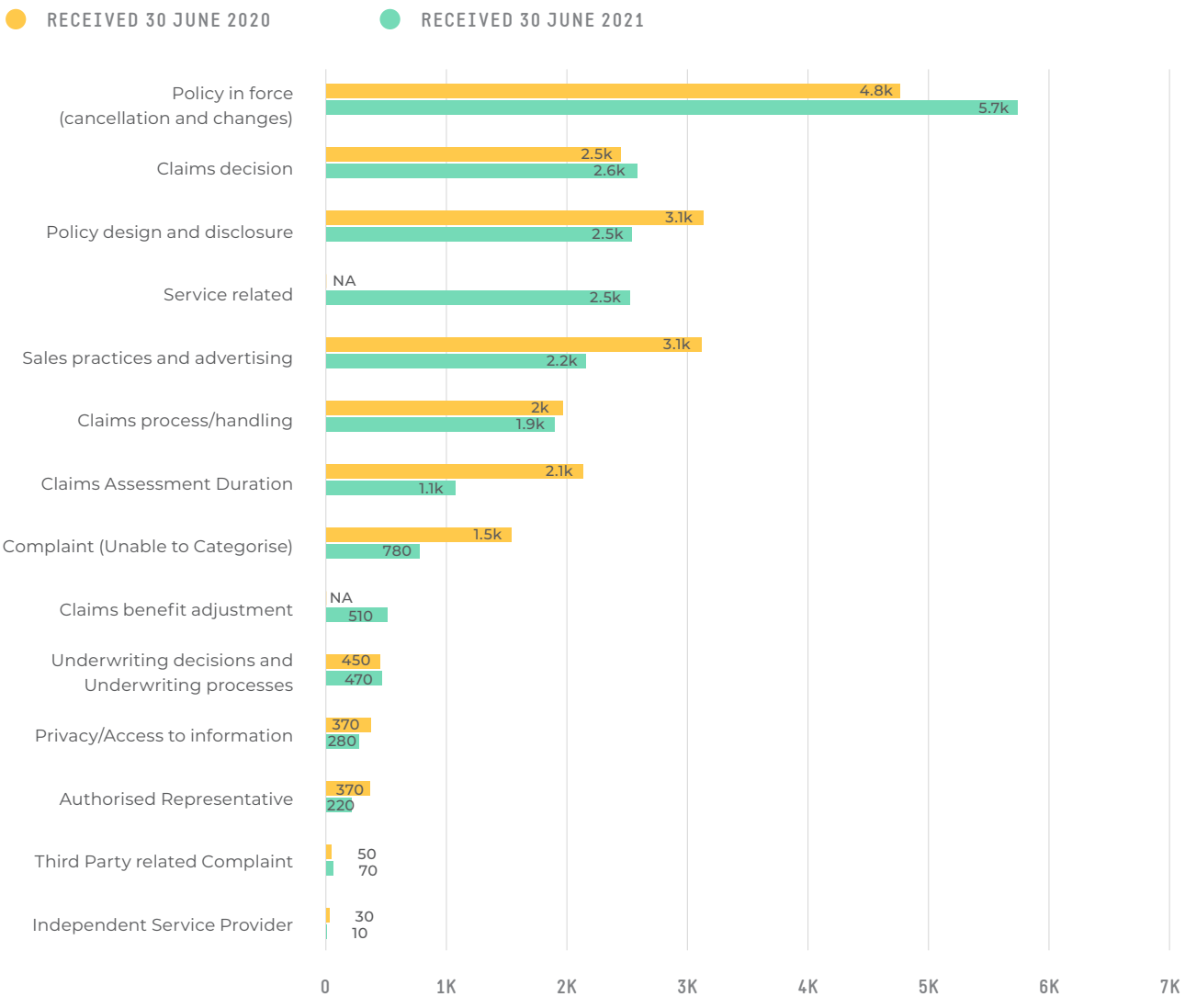
**40%** **of total complaints were policy-related**

## 1. Policies

Policy-related complaints rose 5% in 2020–21, accounting for 8,287 complaints (40% of the total). Complaints relating to 'Policy in force' – namely, policy changes or cancellation – accounted for the highest number of all complaints, with 5,746 (28% of the total). This has been the top cause of customer complaints each year since 2017–18, accounting for a total of 20,309 complaints since the Committee started collecting data from subscribers (**Figure 8**). There were also 2,541 complaints related to policy design and disclosure in 2020–21 (12% of the total).

FIGURE 8.

**Number of complaints received by cause, 30 June 2020 and 30 June 2021**

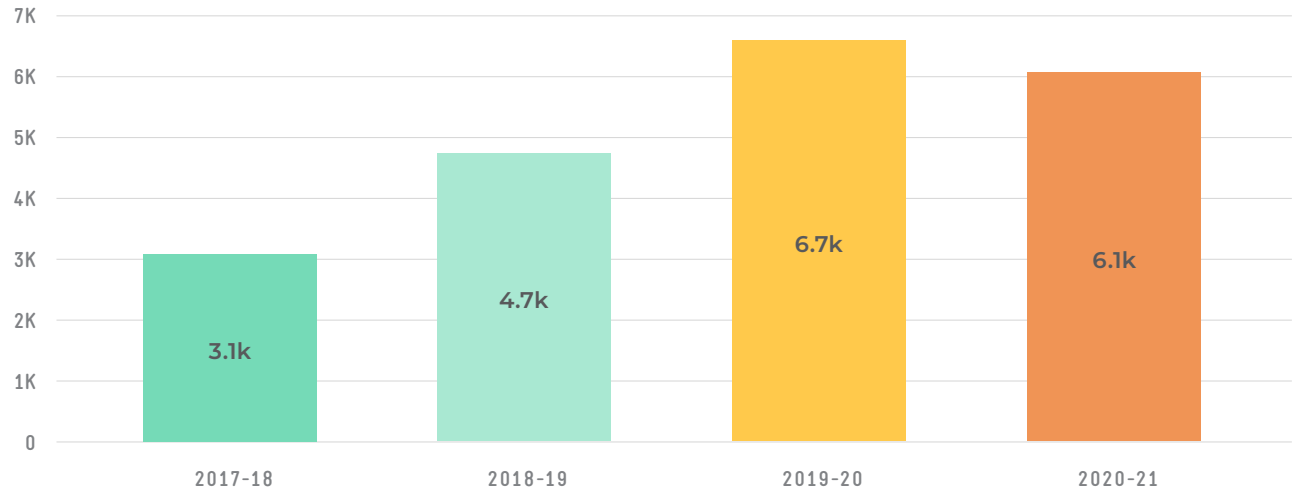


## 2. Claims

Claims-related complaints were once again the source of the second highest number of complaints for the year. Together, complaints about claims totalled 6,073 (29% of all complaints). This is slightly fewer (7%) than the number of claims-related complaints recorded last year. The sub-categories for claims-related complaints were expanded in 2020–21 to include 'Claims benefit adjustment' as a complaint-cause option. Subscribers recorded a total of 510 complaints under this category – 8% of all claims-related complaints. Of all claims-related complaints, 56% related to DII and 30% related to TPD cover. This is not surprising given that, together, these two cover types accounted for 58% of claims received across all distribution channels in 2020–21 (**Figure 9**).

FIGURE 9.

**Claims-related complaints in the four years to 30 June 2021**




## 3. Service

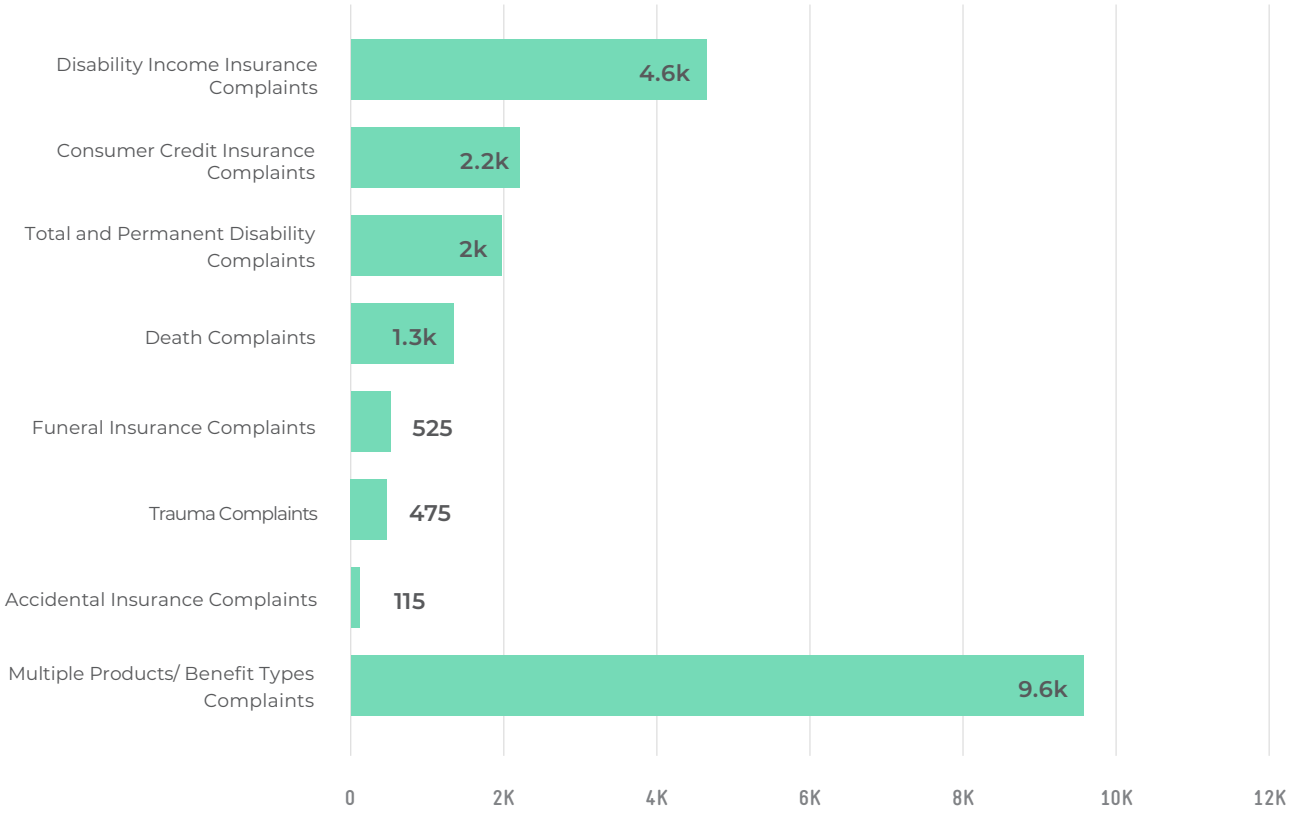
Complaints about the level of service provided to customers have previously been captured under the 'Unable to categorise' option; however, following feedback from subscribers, the Committee added service-related complaints as a separate complaint category in the 2020–21 ADCP. This resulted in subscribers nominating service as the cause of 2,552 complaints (12% of the total).

## Complaints received by benefit type

On their own, DII, CCI and TPD were the benefit types that received the highest number of complaints this year, with DII accounting for 22% of the total, CCI accounting for 10.6% and TPD accounting for 9.5% (**Figure 10**). Almost half (46%) of all complaints this year related to multiple products/benefit types; however, as subscribers did not provide specific information about which products or benefit types these complaints included, the Committee is mindful that the findings in **Figure 10** may not be a true reflection of which products or benefit types received the most complaints.

FIGURE 10.

**Complaints received by benefit type**




# Complaints relating to claims

This year, the Committee asked subscribers to provide more granular data about customer complaints relating to claims. Requested data included information on how many of these complaints were withdrawn, undetermined, resolved (including the resolution method) and specifically about claim decisions. The detailed findings from this data are provided on the following pages.

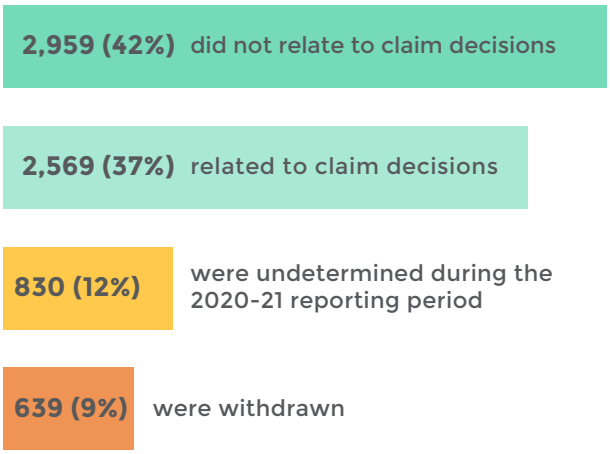
## Claims-related complaints assessed

The total number of claims-related complaints assessed (received and including undetermined claims-related complaints carried over from the previous reporting period) was 6,997.[18] While cover distributed by the Group channel generated the fewest complaints overall each year, it accounted for almost two-thirds (61%) of all complaints relating to claims.

**18** While there were 6,073 claims-related complaints recorded in this reporting period as noted in page 27, this year the Life CCC also requested subscribers report on the total number of undetermined claims-related complaints carried over from the previous reporting period, if applicable. As a result, for the purposes of analysing the data in relation to the outcome of claims-related complaints, the total number of claims-related complaints is the sum of the claims-related complaints received within the reporting year and the undetermined claims-related complaints carried over from 2019-20 to result in 6,997 claims-related complaints.

## Outcome of claims-related complaints

**Of the 6,997 claims-related complaints received:**




### Complaint outcomes about claim decisions

Of the 2,569 complaints about claim decisions which were resolved, 1,144 (45%) were resolved by reversing the original decision while 1,425 (55%) were resolved by maintaining the original decision. The Committee is concerned with the percentage of decisions that were overturned industry wide and reiterates the need for subscribers to improve on their claim assessment and decision-making processes.

As with the high volume of re-opened claims that were subsequently admitted by subscribers, it appears that claims staff are failing to correctly assess the claim, either due to a lack of experience or technical competency, or because subscribers are not providing sufficient oversight, support or training to these staff, or a combination of both.

### Dispute resolution processes

Most of the complaints about claim decisions were managed via subscribers' IDR process without needing to be escalated to the Australian Financial Complaints Authority (AFCA) for EDR. This was the case both for complaints where the matter was upheld (resolved in favour of the subscriber) and for complaints where the matter was reversed (resolved in favour of the customer).

There were 2,248 (88%) complaints regarding a claim decision which was resolved through the subscribers' IDR processes, while only 321 (12%) were resolved through EDR process. This suggests that subscribers have effective IDR frameworks in place for managing customer complaints.

### Ex-gratia payments

The claims and complaints data collection was expanded this year to include information about claims, and claims-related complaints, that involved subscribers providing ex-gratia payments to customers. Claims-related complaints that were resolved and resulted in some sort of ex-gratia payments accounted for 15.5% of the total number of these complaints (855 out of 5,528). A single subscriber accounted for 567 (66%) of the total number of claims-related complaints which resulted in ex-gratia payments.

# Appendix 1

## Code subscribers in 2020–21

As at 30 June 2021, there were 24 subscribers to the Life Insurance Code of Practice, one less than the previous year. The Colonial Mutual Life Assurance Society (trading as CommInsure) ceased to be a Code subscriber on 31 March 2021 after the life insurance business was transferred to AIA Australia Limited. However, as they were a subscriber for the majority of the reporting year, they submitted data for the period 1 July 2020 to 30 March 2021, which has been included as part of this report. The data for the period 1 April 2021 to 30 June 2021 has been included in the data reported by AIA Australia Limited.

Five Code subscribers are specialist reinsurers, meaning that they only insure the risk taken on by other life insurers and do not issue life insurance cover directly to customers, and one subscriber is categorised as an 'other industry participant'.

| | |
|---|---|
| 1 | AIA Australia Limited |
| 2 | Allianz Australia Life Insurance Limited |
| 3 | Asteron Life & Superannuation Limited |
| 4 | ClearView Life Assurance Limited |
| 5 | EMLife Pty Ltd (Code subscriber since 14 March 2018)[19] |
| 6 | General Reinsurance Life Australia Ltd |
| 7 | Hallmark Life Insurance Company Ltd |
| 8 | Hannover Life Re of Australasia Ltd |
| 9 | HCF Life Insurance Company Limited (Code subscriber since 1 July 2018) |
| 10 | Integrity Life Australia Limited (Code subscriber since 1 July 2018) |
| 11 | MetLife Insurance Limited |
| 12 | MLC Limited |
| 13 | Munich Reinsurance Company of Australasia Limited |
| 14 | NobleOak Life Limited |
| 15 | OnePath Life Limited (a company of Zurich Australia Limited) |
| 16 | Pacific Life Re (Australia) Pty Ltd (Code subscriber since 19 February 2020) |
| 17 | QInsure Limited (Code subscriber since 15 September 2017) |
| 18 | Resolution Life Australasia Limited (formerly AMP Life Limited) |
| 19 | RGA Reinsurance Company of Australia Limited |
| 20 | SCOR Global Life Australia Pty Ltd |
| 21 | Swiss Re Life & Health Australia Limited |
| 22 | TAL Life Limited |
| 23 | Westpac Life Insurance Services Limited |
| 24 | Zurich Australia Limited |

**19** Claims Service Provider

# Appendix 2

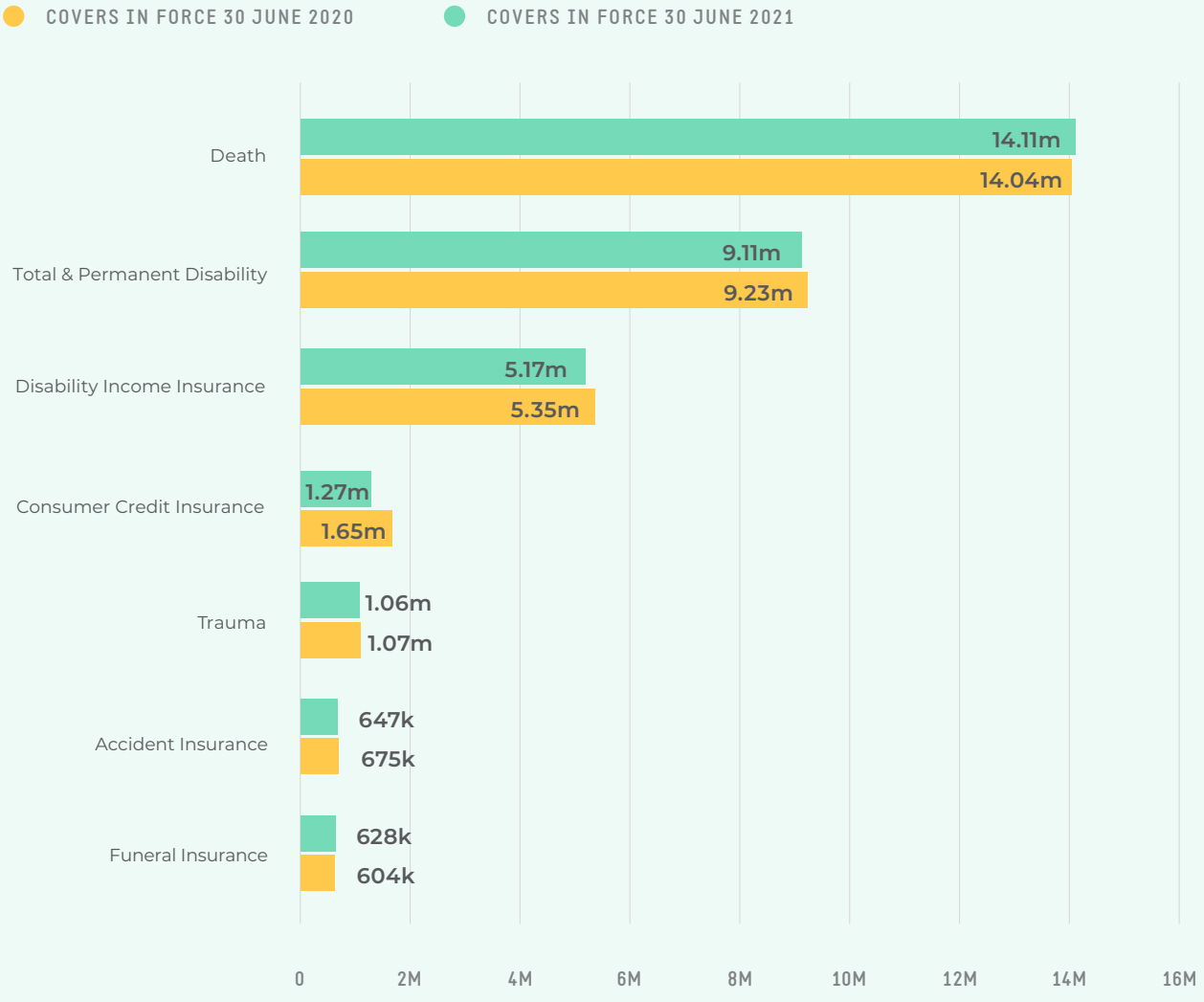
## Life insurance business data

### Covers in force

To understand the type of life insurance cover that Australians have, the Committee collects data each year on the number of cover types in force. A cover type is an insurance benefit that falls under a life insurance policy. One policy may have more than one benefit (covers in force). One customer may have more than one policy or more than one cover in force.

FIGURE 11.

**Covers in force, 30 June 2020 and 30 June 2021**

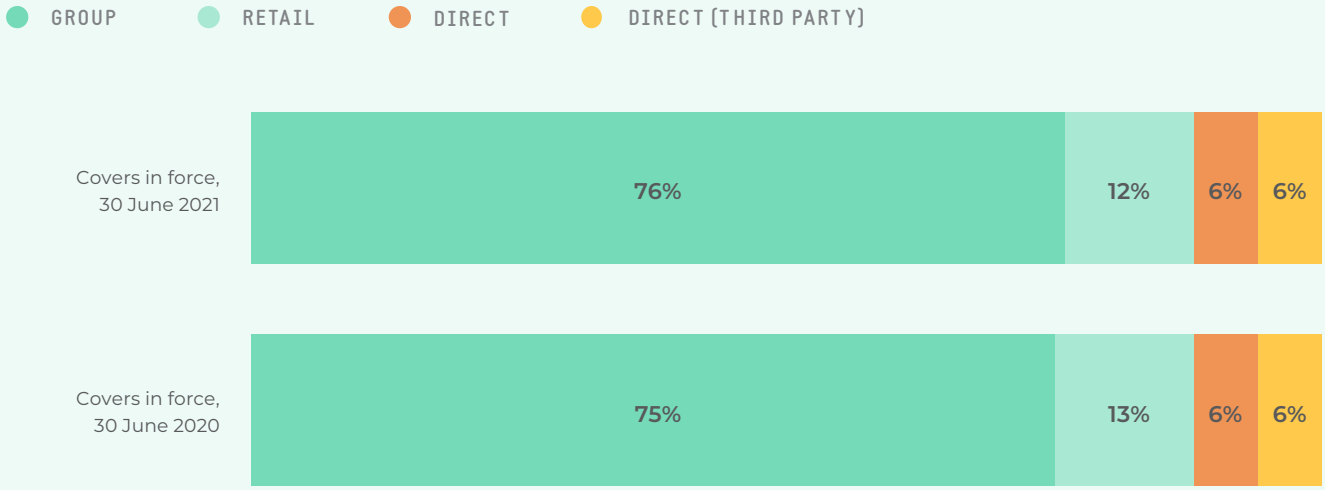


## Distribution

During the year, 18 subscribers issued new life insurance business. Subscribers used three distribution channels: **Group**, **Retail** and **Direct** (which includes direct distribution by the subscriber itself, its authorised representative[20] and third parties). There were 155 benefit types written across all distribution channels in 2020–21. The number of covers in force decreased across all channels, with the biggest decline in the Direct and Retail distribution channels.

FIGURE 12.

**Covers in force by distribution channel, 30 June 2020 and 30 June 2021**



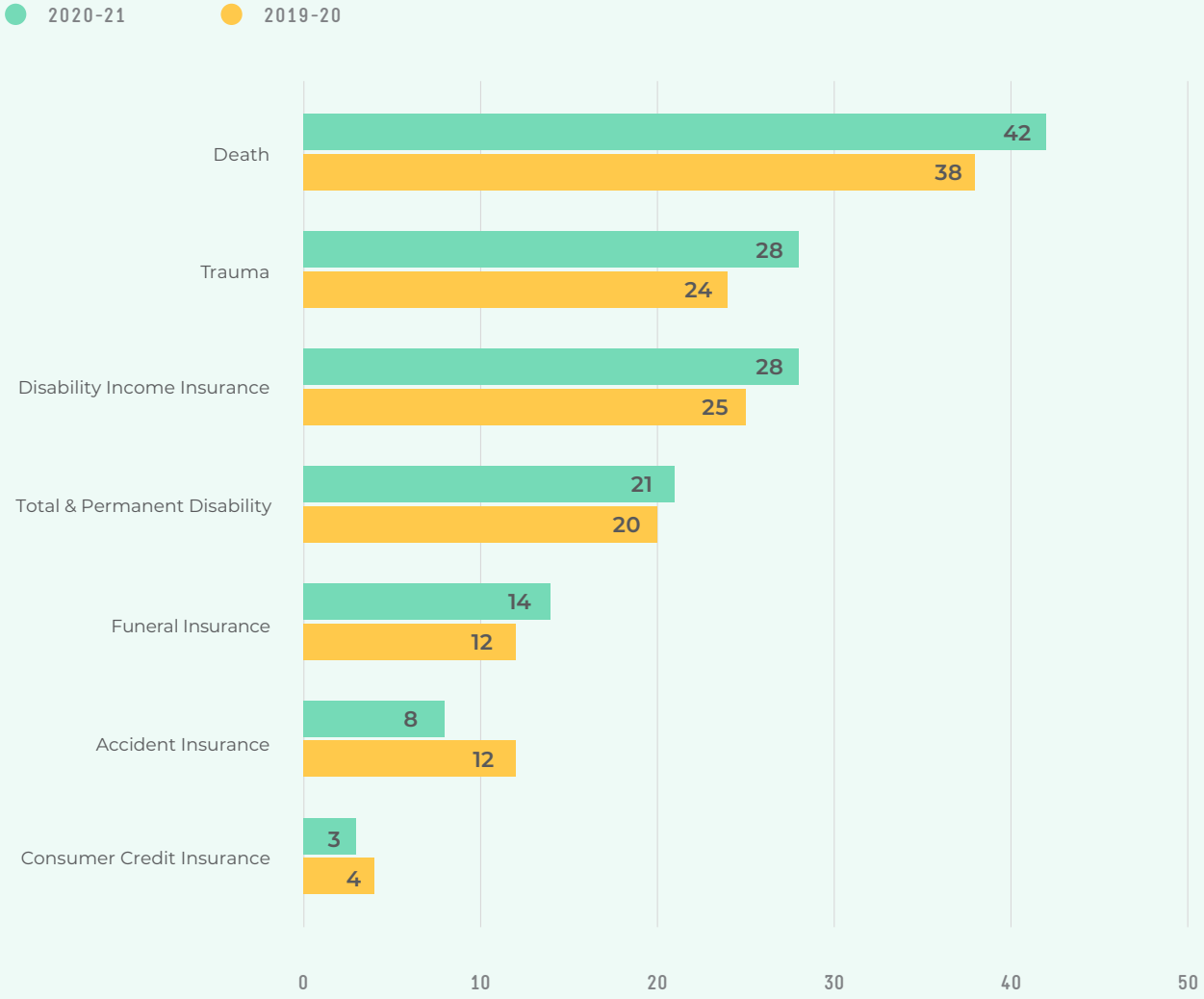

Some subscribers distributed their own branded products via third parties but most of the cover sold through Direct (third party) distribution comprised of white-label products. Subscribers offered 144 different white-label benefit types in 2020–21 compared to 135 in 2019–20 – an increase of 7%.

There were increases in the number of white-label product types offered by subscribers: Trauma and Funeral products both increased 17%, DII products 12% and Death products 11%, while Accident insurance decreased by 33% and CCI by 25%. The number of third-party white-label products for which subscribers wrote business increased only slightly this year, from 65 to 67 (3%).

**20** The Code defines an authorised representative as 'a person, company or other entity authorised by us to provide financial services on our behalf under our Australian Financial Services licence, in accordance with the Corporations Act 2001. It does not include a person, company or entity that is an authorised representative of an Australian Financial Services licensee that is a related company to us.'

FIGURE 13.

**Number of third party product types offered, 30 June 2020 and 30 June 2021**



# Appendix 3

## Comparative Code compliance data

As an average, the industry reported 13.4 customers impacted for every 1,000 cover types in force. This varied considerably from subscriber to subscriber, with some subscribers reporting almost 288 customers impacted per 1,000 cover types in force, and some subscribers reporting as low as 0.02 customers impacted per 1,000 cover types in force (**Figure 14**).

While some variance is to be expected, the Committee is concerned with the considerable variance between subscribers. This may indicate that some subscribers are either performing significantly worse than average or may not have adequate processes in place to detect breaches.

FIGURE 14.

**Customers impacted per 1000 cover types in force, 30 June 2021**

| Subscriber | Customers impacted per 1000 cover types in force |
|---|---|
| A | 0.015 |
| B | 0.047 |
| C | 0.122 |
| D | 0.177 |
| E | 0.207 |
| F | 0.237 |
| G | 0.516 |
| H | 0.647 |
| I | 0.653 |
| J | 1.492 |
| K | 2.242 |
| L | 2.735 |
| M | 11.329 |
| N | 16.871 |
| O | 26.156 |
| P | 53.500 |
| Q | 112.990 |
| R | 235.535 |
| S | 287.630 |
| **Average number of customers impacted per 1000 cover types in force** | **13.416** |

FIGURE 15.

**Percentage of customers impacted by policy-related breaches versus other breaches over the last four years**

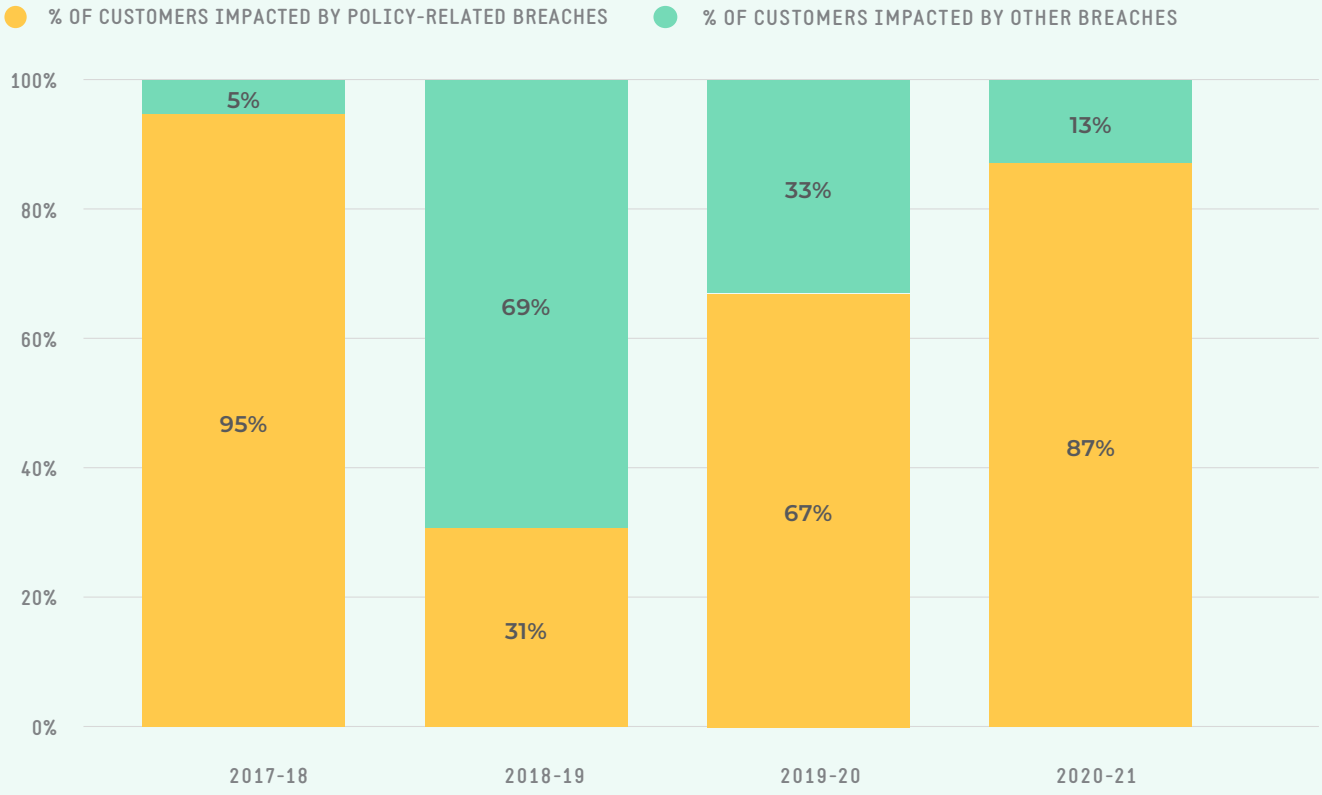
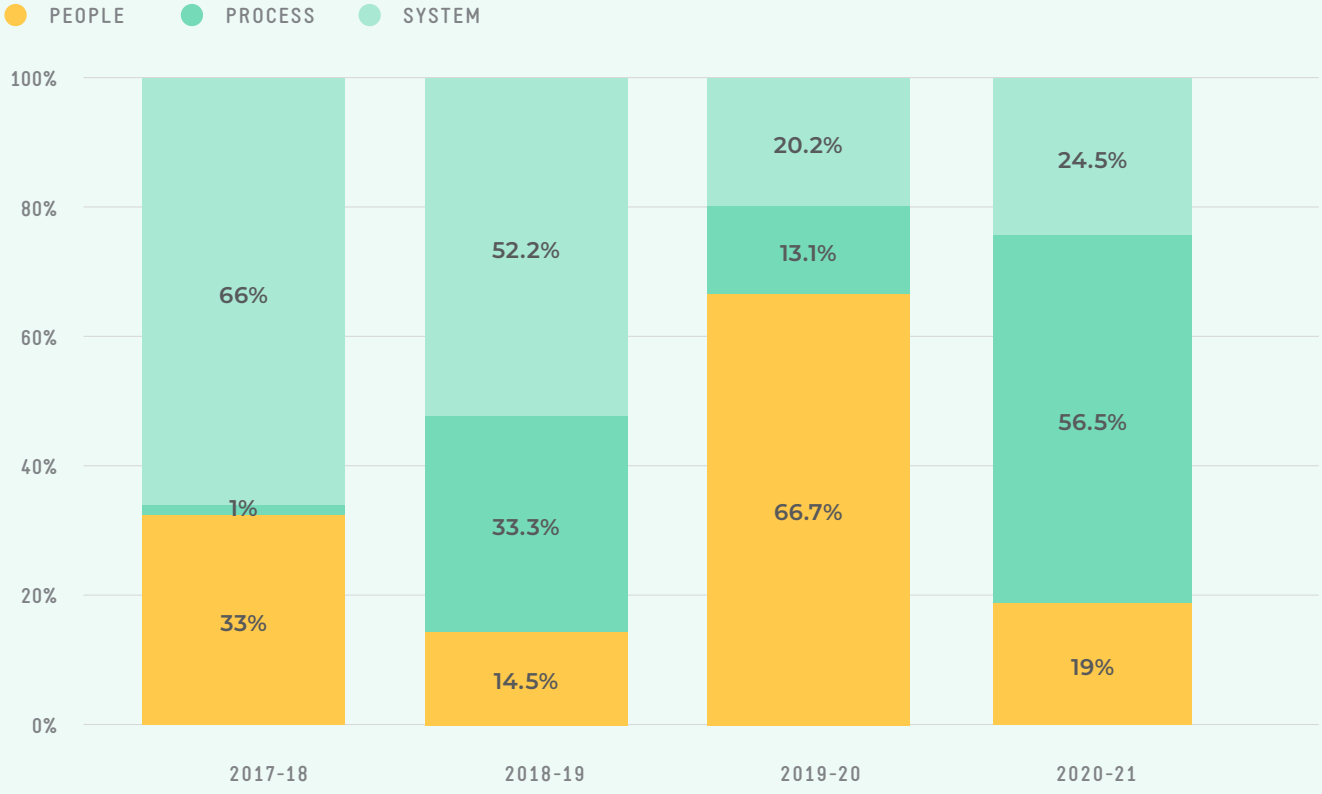



FIGURE 16.

**Percentage of customers impacted by the top 3 breach event causes over the last four years**



# Appendix 4

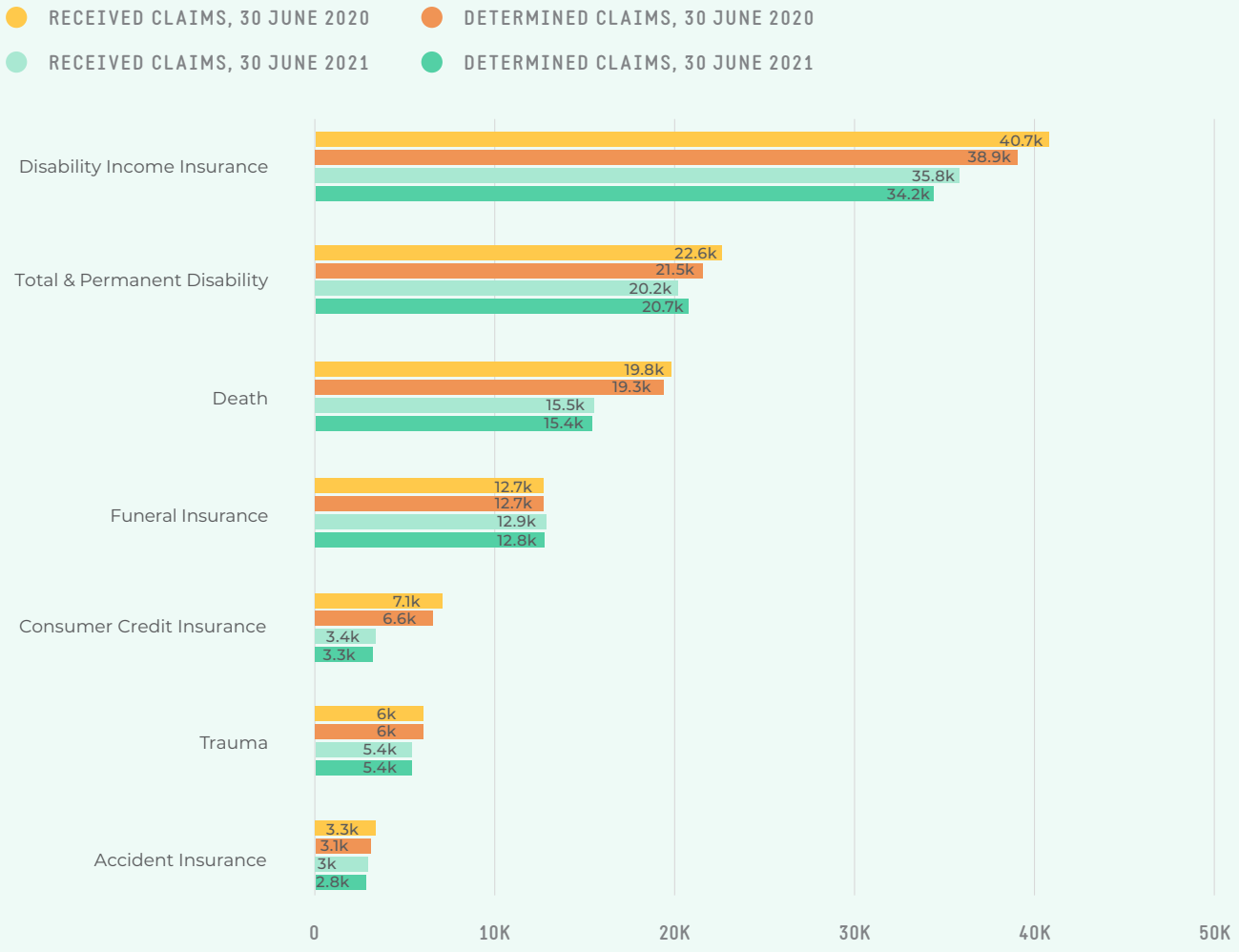
## Comparative claims and complaints data

### Claims by benefit type

As we have seen in previous years, the highest proportion of claims received across all distribution channels was for DII. Despite representing 16% of covers in force, DII accounted for 37% of all claims received. Claims for TPD and Death cover were the next most common, respectively accounting for 21% and 16% of total received claims. Together, disability cover (DII and TPD) accounted for 58% of all claims received during the year. There were reductions in the number of claims received across all benefit types except Funeral insurance, which saw a rise of 1% on the previous year. For each benefit type, subscribers finalised a similar number of claims as were received, resulting in a consistent number of claims in progress across all benefit types.

FIGURE 17.

**Number of claims received and determined as of 30 June 2020 and 30 June 2021, by benefit type**

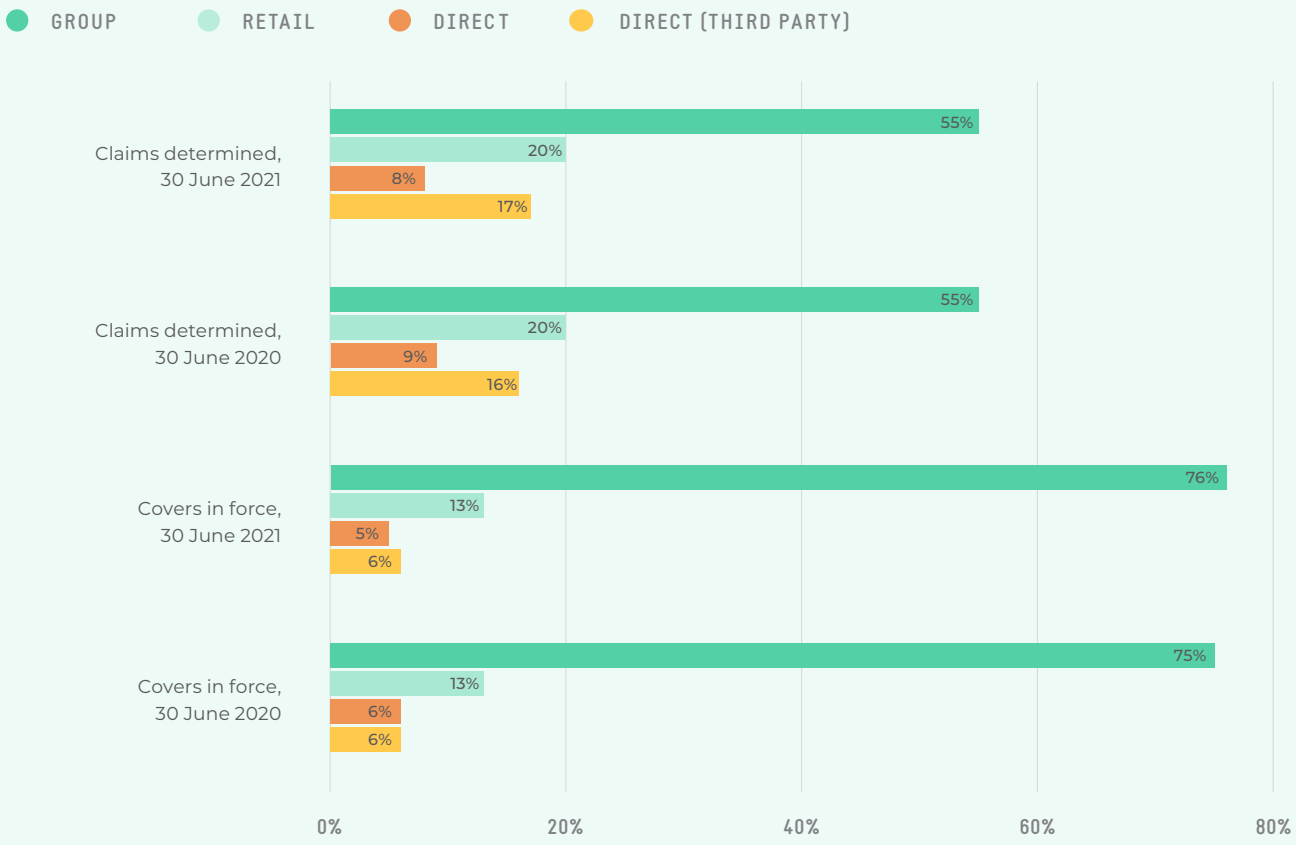


## Claims by distribution channel

There was minimal change to the percentage of covers in force and claims determined by distribution channel from the previous reporting period.

FIGURE 18.

**Percentage of covers in force and claims determined by distribution channel, 30 June 2020 and 30 June 2021**




## Complaints by distribution channel

Retail once again received the highest number of complaints out of the three distribution channels, despite accounting for only 13% of covers in force. With 11,421 complaints about products distributed via Retail, this channel accounted for more than half (55%) of all complaints received in 2020–21. This is an increase of 19% from the previous year.

After recording an 8% decrease last year, the number of complaints about cover distributed directly fell another 18% this year, from 6,536 in 2019–20 to 5,324 in 2020–21. Like retail-distributed cover, directly-distributed cover generates a disproportionately large share (25%) of complaints while representing only 11% of covers in force. Cover distributed by the Group channel continues to generate the fewest complaints each year, despite accounting for more than three-quarters of all covers in force.

Where we saw complaints about cover distributed via the Group channel increase by 55% last year, this year they remained relatively stable, decreasing by just 3%, down from 4,233 in 2019–20 to 4,112 in 2020–21.

FIGURE 19.

**Percentage of covers in force and complaints by distribution channel, 30 June 2020 and 30 June 2021**

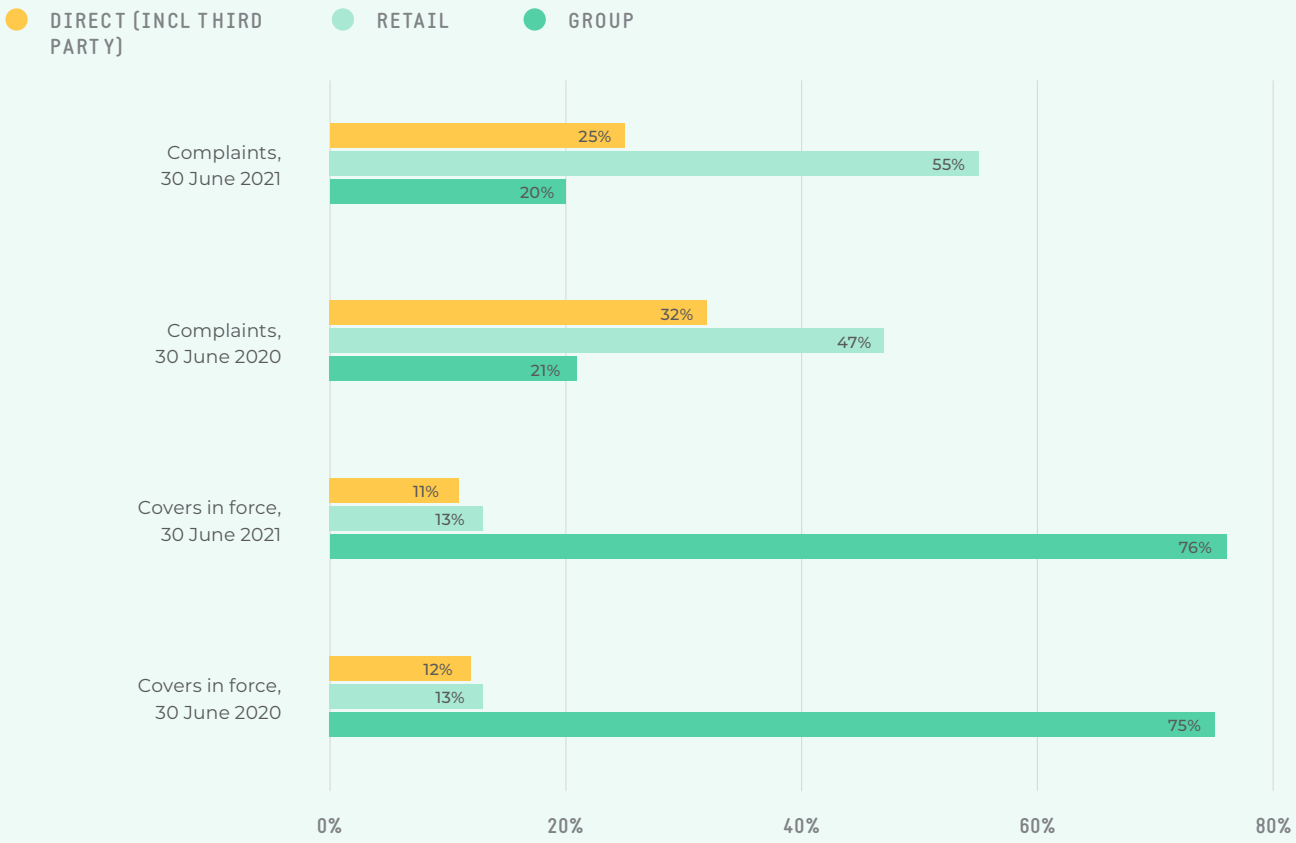



FIGURE 20.

**Breakdown of specific claims-related complaints in the four years to 30 June 2021**

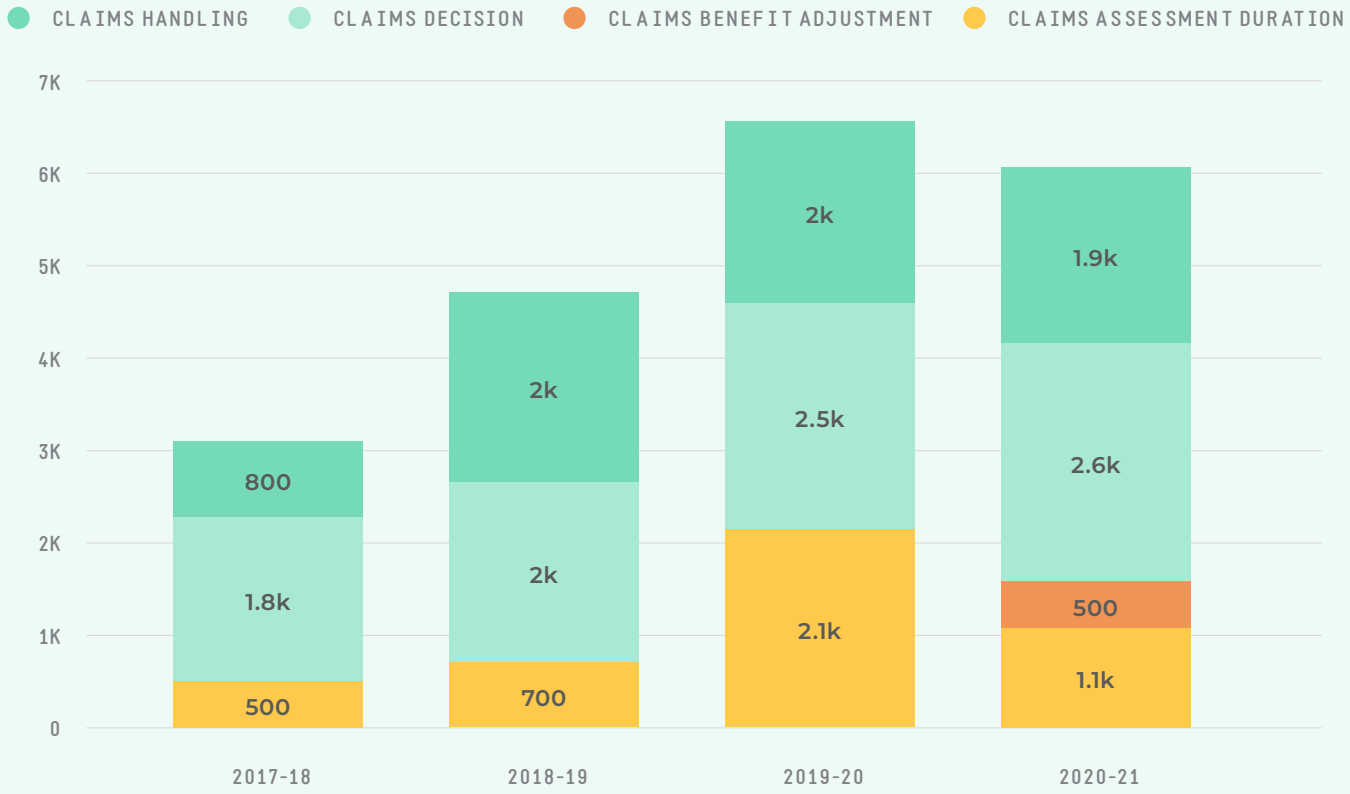
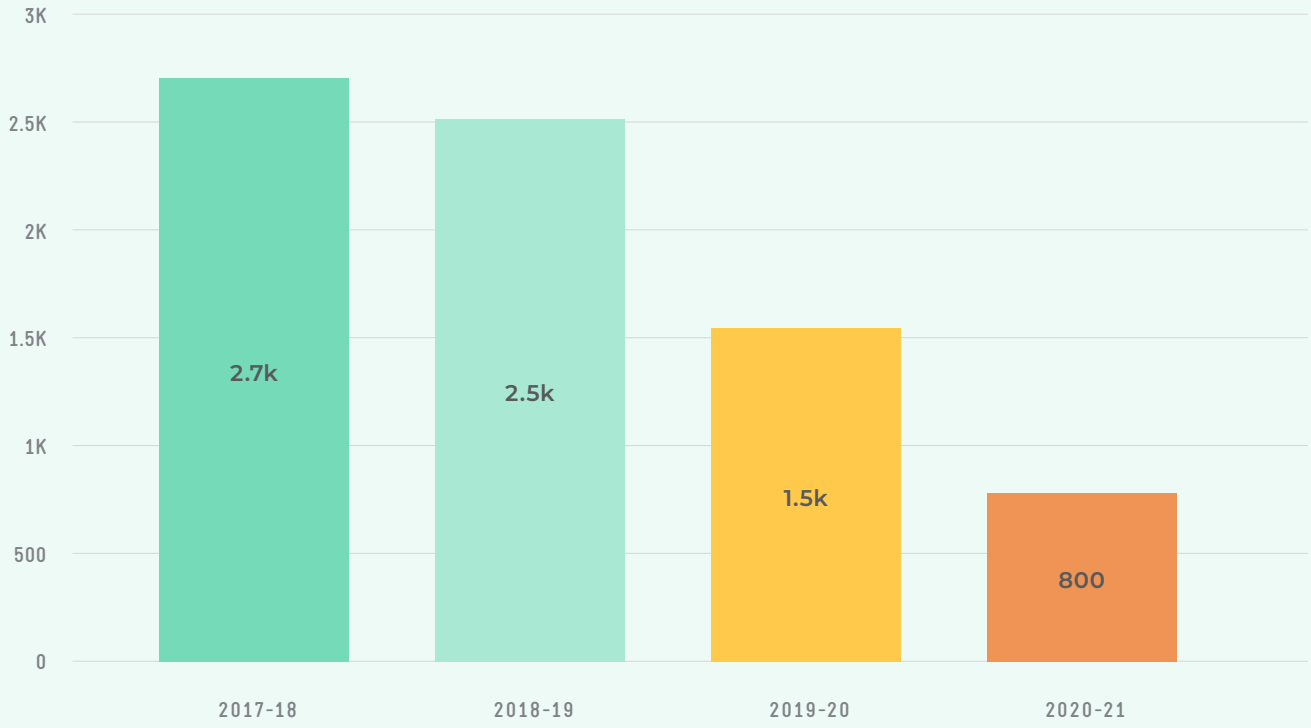


FIGURE 21.

Number of complaints whose cause was unable to be categorised for the four years to 30 June 2021



Life Code Compliance Committee
lifeccc.org.au