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:	CX7349	**Date:**	19 August 2022
Code sections:	Key Code Promise 1 and sections 8.2, 8.3, 8.4, 8.5, 8.6, 8.7, 8.9, 8.14, 8.16, 8.19, 8.20, 8.22, 8.24, 8.26, 11.1 [1]		
Investigation:	A consumer-reported alleged Code breach		

The alleged Code breach:

The Consumer obtained a Life Insurance policy with an Income Protection (IP) and Total and Permanent Disability (TPD) benefit. The policy was issued by a Life Insurance Company that is a subscriber (the Subscriber) to the Life Insurance Code of Practice (the Code). The policy was owned by the Consumer.

The Consumer lodged an IP claim on 19 September 2018, which the Subscriber declined on 23 March 2019. The Consumer lodged a complaint about the declined claim with the Australian Financial Complaints Authority (AFCA), which resulted in the claim being accepted.

The Consumer lodged a TPD claim on 15 October 2020. In November 2020 the Consumer contacted the Life Code Compliance Committee (Life CCC) to allege that the Subscriber breached numerous Code sections in its assessment of ongoing IP benefits. This was in relation to sections 8.2, 8.3, 8.5, 8.6, 8.7, 8.9, 8.14, 8.19, 8.20, 8.22, 8.24, 8.26 and 11.1 of the Code.

On 2 July 2021, the Consumer submitted further concerns in relation to the assessment of the TPD claim, alleging breaches of Key Code Promise 1 and sections 8.5, 8.7, 8.24 of the Code.

In September 2021, the Subscriber closed the TPD claim with no formal decision made. In response, the Consumer lodged a second complaint with AFCA relating to the handling of the TPD claim.

The Life CCC sought information from the Subscriber about its compliance in relation to the Consumer's allegations. In response, the Subscriber acknowledged breaches of sections 8.2 and 8.16 in relation to the IP claim and section 8.4 in relation to the TPD claim.

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

This was on the basis that:

- the Consumer's IP benefits in relation to their premiums were payable in December 2019; but the premium waiver was not initiated until November 2020 (section 8.2)
- the Subscriber had responded to the Consumer's request for information on the TPD claim after the required timeframe of ten business days (section 8.4)
- the Subscriber failed to inform the Consumer that Unexpected Circumstances (UC) applied to the IP claim within the required two-month timeframe (section 8.16)

The Life CCC notes that the acknowledged breaches of sections 8.4 and 8.16 were identified by the Subscriber as a result of its review of the matter and were not part of the Consumer's allegations.

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

The Life CCC determined that the Subscriber:

- was in breach of section 8.2 of the Code, that the allegation was proven in whole and that the breach amounted to serious non-compliance with the Code,
- was in breach of section 8.4 of the Code and that the allegation was proven in whole,
- was in breach of section 8.16 of the Code, that the allegation was proven in whole and that the breach amounted to serious and systemic non-compliance with the Code, and
- was not in breach of Key Code Promise 1 and was not in breach of sections 8.3, 8.5, 8.6, 8.7, 8.9, 8.14, 8.19, 8.20, 8.22, 8.24, 8.26 and 11.1 of the Code and that the allegations were unfounded.

The Life CCC findings and conclusion:

Section 8.2

Section 8.2 of the Code requires a subscriber to consider all the features of the relevant policy. This ensures that the consumer is claiming for all available benefits.

The Consumer's policy provisions stated that the policy premiums would be waived when an IP benefit was payable. The Consumer's IP benefits were payable in December 2019. However, due to an oversight by the Subscriber, the Consumer's benefits were not identified until November 2020, 11 months later.

As a result, the Life CCC determined that the Subscriber was in breach of section 8.2 of the Code, that the allegation was proven in whole.

Serious non-compliance

The Life CCC further determined in accordance with Charter clause 7.4(b)(iv)[3] that the Subscriber's breach of section 8.2 of the Code amounted to serious non-compliance with the Code.

The Subscriber conducted a review and found no prior breaches of a similar nature, noting that this breach was an isolated incident. Due to the length of the delay (11 months), the

[2] The Life CCC is bound by its Charter to use the terminology 'the reported allegation was proven in whole or in part or was unfounded.' This in essence requires the Life CCC to state if it determined there was a breach or not. The Life CCC will explain its determination in plain language in the body of the Determination.
[3] The Life CCC is bound by its Charter to state, where applicable, whether it finds that a subscriber is responsible for serious and/or systemic non-compliance with the Code.

Subscriber acknowledged that the breach amounted to serious non-compliance with the Code. The Subscriber has paid interest to the Consumer in accordance with section 57 of the Insurance Contracts Act.

Section 8.4

Section 8.4 of the Code sets out two separate and independent requirements. Subscribers are required to provide consumers with updates on their claim at least every 20 business days (first element); and, to respond to requests for information about the claim within 10 business days (second element).

The Subscriber acknowledged a breach of the second element of section 8.4. The Consumer requested information on 25 October 2020 and the Subscriber responded on 20 November 2020, 20 business days outside the 10 business day timeframe.

The Subscriber reported that the breach was an isolated incident. The breach was attributed to an oversight by the claims assessor and had no material impact on the overall assessment of the claim.

The Life CCC determined that there was a breach of section 8.4 of the Code and that the allegation was proven in whole.

Section 8.16

Section 8.16 of the Code sets out four separate and independent obligations. In this matter, the breach allegation related to the third element of section 8.16, which requires subscribers to inform a consumer if Unexpected Circumstances (UC) apply within two months of being notified of the claim.

The Subscriber received the Consumer's IP claim on 21 September 2018. Under section 8.16, the Subscriber was required to provide a decision on the claim within two months of that date (21 November 2018), unless UC applied. The Subscriber acknowledged the breach of section 8.16 of the Code as it failed to inform the Consumer that UC applied prior to the expiry of the two month timeframe on 21 November 2018. The decision to decline the claim was communicated to the Consumer on 23 March 2019.

The Life CCC determined that the Subscriber was in breach of section 8.16 of the Code and that the allegation was proven in whole.

Serious and systemic non-compliance

The Life CCC further determined in accordance with Charter clause 7.4(b)(iv)[4] that the Subscriber's breach of section 8.16 of the Code amounted to serious and systemic non-compliance with the Code

The Subscriber acknowledged that the breach of section 8.16 amounted to serious and systemic non-compliance with the Code. This resulted from an audit conducted in mid-2019 in response to the Life CCC's Claims and Complaints Handling Obligations review. The Subscriber identified 45 other instances where a UC letter had not been provided to consumers as required.

[4] The Life CCC is bound by its Charter to state, where applicable, whether it finds that a subscriber is responsible for serious and/or systemic non-compliance with the Code.

The Subscriber has since implemented several processes and controls to manage its obligations under section 8.16 of the Code, including refresher training and additional quality monitoring.

Remaining sections

In this matter the Consumer made other Code breach allegations relating to the Subscribers conduct. The Life CCC reviewed these Code breach allegations and determined that the Subscriber was not in breach of Key Code Promise 1 and sections 8.3, 8.5, 8.6, 8.7, 8.9, 8.14, 8.19, 8.20, 8.22, 8.24, 8.26 and 11.1 of the Code.

The table below provides by further details on the Consumer's allegations and why the reasons for the Life CCC's decision.

Section 8.3
Section 8.3 requires a subscriber to explain the cover and claims process to a consumer within 10 business days of being notified about the claim. The Consumer alleged there was a breach of section 8.3 on or around 17 August 2020. However, the Life CCC notes that, as of 17 August 2020, the Subscriber had provided its decision on the IP claim and the TPD claim had not yet been lodged. As there was no undetermined claim at that point, section 8.3 did not apply.
Section 8.5
Section 8.5 requires subscribers to only ask for and rely on information and assessments relevant to the consumer's claim and policy and to explain to the consumer why it is requesting this information. The Subscriber's information requests consisted of medical and financial information which were relevant to the claim and were required to assess the claim. The Life CCC's review of the Subscriber's correspondence did not identify any evidence that indicated the Subscriber failed to provide reasons for the information it was requesting.
Section 8.6
Section 8.6 enables a subscriber to ask a consumer to provide a general authority so the subscriber can obtain additional information it reasonably believes is relevant to the assessment of a claim. The Consumer alleged that the Subscriber used the general authority without their consent to seek information from healthcare providers that may have been irrelevant to their claim. The Life CCC's review of the claim found the Subscriber used the general authority to obtain information in accordance with that authority and did not seek information from healthcare providers that was irrelevant to the claim.
Section 8.7

Section 8.7 requires subscribers to request information as early as possible and to avoid multiple information requests where possible.

The Consumer alleged that the Subscriber made multiple unreasonable requests for information and failed to request information as early as possible.

The Life CCC's review of both the IP and TPD claims did not find any evidence that the Subscriber did not request the information it needed as early as possible or failed to avoid making multiple information requests.

Section 8.9

Section 8.9(a) to (f) of the Code sets out the obligations that subscribers are required to comply with when assessing income-related claims. The Life CCC's review was in relation to section 8.9(b) to (e).

Section 8.9(b) to (e) notes that the subscriber:

(b) will not require the consumer to get ongoing statements from their doctor more frequently than reasonably necessary to assess their condition
(c) will not request a medical statement for the sole purpose of processing the consumer's regular payment
(d) will only request financial information in circumstances where it is required to assess the consumer's eligibility or to calculate their entitlements
(e) will review a request for information if the consumer disagrees.

The Life CCC's review of the file showed no evidence that the Subscriber had: required the Consumer to get ongoing statements from their doctor more frequently than reasonably necessary; requested a medical statement for the sole purpose of processing the Consumer's regular payment; requested financial information where it was not required to assess the Consumer's eligibility to claim or calculate their entitlement; nor failed to review a request for information when the Consumer disagreed with the request.

Section 8.14

Section 8.14 requires subscribers to make all efforts to meet the timelines required by the Code.

The Life CCC found no evidence in its review of the file that the Subscriber did not make all efforts to meet the required timelines. It notes that UC applied to the Consumer's IP claim and that the circumstances were outside the Subscriber's control.

Section 8.19

If a subscriber declines a claim, section 8.19 requires the subscriber to inform the consumer in writing of the reasons for the decision, that the consumer has the right to copies of the information relied on and that the consumer has a right to request a review.

The Consumer alleged that the Subscriber withheld his ongoing IP benefit on the basis that the information did not meet their regular care definition and that this amounted to a

breach of section 8.19 of the Code.
We note that section 8.19 is not relevant in this matter as the withholding of the ongoing Consumer's IP benefits is not a decline of his claim. As a result, the Life CCC found no evidence that the Subscriber was in breach of section 8.19 of the Code.

Section 8.20

Section 8.20 requires a subscriber to have claims assessors that are appropriately skilled and trained to make objective decisions.

The Consumer alleged that the Subscriber's assessors had inadequately considered the information provided by them, consistently demonstrated a poor understanding of the Code and failed to make objective decisions.

The Subscriber confirmed that all assessors undergo formal induction training when they begin the role, which includes formal classroom-based training, online learning and on-the-job practical experience.

Assessors are initially subject to having 100% of their work reviewed and are continually assessed for competency. A delegated authority (DA) will be granted if they meet strict criteria which is assessed by the Subscriber's Insurance Risk team. DAs are granted on both the grounds of complexity and sums insured; that is, they are progressive. Assessors are re-evaluated annually to ensure their competency is maintained.

Based on the Life CCC's review of the file, it did not identify any evidence that the claims assessor in this matter was not appropriately skilled or trained to make objective decisions.

Section 8.22

In cases where the policy states that income-related claim payments will continue after a period only if additional or different requirements are met, section 8.22 requires a subscriber to give at least three months' notice of this and to explain what is changing and any additional information that the subscriber needs.

The Subscriber noted that the Consumer's policy does not have any provisions where additional or different requirements are required after a defined period. As a result, section 8.22 did not apply.

Section 8.24

Section 8.24 of the Code requires subscribers to be empathetic in claims management and to treat the consumer with compassion and respect.

The Consumer's allegation of a breach of section 8.24 related to their notice to the Subscriber of their mental health challenges and financial uncertainty due to delays in benefit payments. The Consumer was also their family's sole income provider.

Based on the Life CCC's review of the file, there was no evidence that the Subscriber was not empathetic in its management of the claim nor that it had failed to treat the Consumer

with compassion and respect. There was also no evidence to indicate the Subscriber was disrespectful, uncompassionate or antagonistic.

Section 8.26

Section 8.26 of the Code sets out four separate and independent elements that subscribers are required to comply with for income-related claims. This includes:

(a) identifying ways that the subscriber can support the consumer's recovery,
(b) collaborating with the consumer's doctor, other healthcare provider and employer to optimise their health outcome,
(c) ensuring that the consumer has a primary contact person for the duration of the claim, and
(d) promoting best-practice rehabilitation and injury management.

The Consumer alleged that the Subscriber failed to process income protection payments in a timely manner and to support their recovery at the early stage of their claim.

Based on the Life CCC's review of the file, there was no evidence that the Subscriber did not seek to perform the four requirements in section 8.26. The Consumer was unreceptive to the Subscriber's actions and frustrated these efforts by failing to provide, and subsequently withdrawing, the authority for the Subscriber to contact the Consumer's doctors.

Section 11.1

Section 11.1 of the Code requires subscribers to make its customers aware of the Code, including providing information about the Code on its website and in relevant marketing documents.

The Subscriber has confirmed that its website has a dedicated page relating to the Code and includes links to the Financial Services Council's website which has additional Code-related material. There was no evidence to indicate that the Subscriber failed to make its customers aware of the Code.

Key Code Promise 1

This requires subscribers to be honest, fair, respectful, transparent, timely, and where possible to use plain language in their communications with consumers.

The Consumer alleged the Subscriber breached Key Code Promise 1 by failing to provide transparency, clarity or communicate in plain language, failing to fairly and honestly consider the information provided and failing to treat the Consumer with respect and compassion.

Based on the Life CCC's review of the file, there was no evidence that the Subscriber failed to provide transparency, clarity or to communicate in plain language. The communications sent by the Subscriber to the Consumer which were reviewed were written in plain language and were sufficiently transparent and clear.

There was also no evidence that the Subscriber failed to fairly and honestly consider the information provided or failed to treat the Consumer with respect and compassion.

Key learnings for all subscribers

Although the Life CCC determined that the Subscriber in this instance did not breach the consumer protections set out in section 8.24, this case highlights the sensitivity and awareness required from all subscribers when dealing with consumers in vulnerable situations. The Consumer in this case specifically advised the Subscriber they were experiencing difficulties. In such circumstances, staff should show empathy, care and respect.

The Life CCC reminds subscribers that they should make efforts to identify and support consumers in vulnerable situations.

Subscribers should have policies and processes in place relating to different types of vulnerability, including mental health issues and financial hardship. Thoughtfully considered and robust policies and processes both protect and support consumers experiencing vulnerability and help staff manage these situations sensitively and appropriately.

Subscribers should have training in place and supervision and support to assist staff interacting with individuals in being aware of and alert to signs that suggest consumers might be experiencing vulnerability. This includes training staff in engaging with and listening to customers and learning to recognise certain signs during face-to-face or phone conversations with consumers, observing their behaviour, and inviting affected consumers to discuss their situation and hear about any assistance available to them.

Training might also involve making staff aware of the types of vulnerable circumstances consumers experience and the repercussions inadequate service could have on their lives. It is also important for subscribers to provide ongoing refresher training to staff to ensure that they maintain their awareness and skills in assisting vulnerable customers.

Relevant Code Sections

Section 8.2
When **you** make a claim **we** will consider all of the features of the **Life Insurance Policy** to which **your** claim relates in order to ensure **you** are claiming for all available benefits under **your Life Insurance Policy**. **We** will not discourage **you** from making a claim.

Section 8.3
Within ten **business days** of being notified about **your** claim, **we** will explain to **you your** cover and the claim process, including why **we** request certain information from **you** and any waiting period before payments will be made. **We** will give **you** contact details that **you** can use to get information about **your** claim.

Section 8.4
Prior to making a decision on **your** claim, **we** will keep **you** informed about the progress of **your** claim at least every 20 **business days** unless otherwise agreed with **you** or the **Group Policy-owner**. **We** will respond to **your** requests for information about **your** claim within ten **business days**.

Section 8.5
We will only ask for and rely on information and assessments that are relevant to **your** claim and policy, and **we** will explain why **we** are requesting these. This can include, for example, financial, occupational and medical information. If **you** disagree with the relevance of any information, **we** will review the request, and if **you** are not satisfied with **our** review **we** will tell **you** how **you** can make a **Complaint**.

Section 8.6
Where **we** require information from other sources, such as **your** doctor, accountant or another health professional, **we** may ask **you** for a general authority to obtain information about **you** from them. **We** will only use a general authority to obtain information that **we** reasonably believe is relevant to **your** claim. **You** can instead authorise **us** to request particular information from particular sources. However, this may cause delays in the assessment of **your** claim or mean that **we** are unable to assess **your** claim, and **we** may require further authorities before **we** can progress the assessment of **your** claim.

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

Section 8.9
For income-related claims (such as income protection or business expense cover):

a) information may need to be provided on an ongoing basis in order to review **your** entitlement to benefits or to calculate **your** payments. This can include financial as well as medical information;
b) **we** will not require **you** to get ongoing statements from **your** doctor more frequently than reasonably necessary to assess **your** condition, so that **we** can determine **your** ongoing entitlement to benefits. For monitoring purposes, **we** may seek information from **your** doctor every six months, even if **your** condition is stable;
c) **we** will not request a medical statement from **your** doctor for the sole reason of processing **your** regular payment;
d) **we** will only request financial information in circumstances where it is required to assess **your** eligibility to claim or to calculate **your** entitlement;
e) if **you** disagree with the relevance of any requested information, **we** will review this; and
f) if **your** payment is going to be delayed, **we** will notify **you** prior to this and let **you** know the reasons for the delay.

Section 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 not have breached the **Code**.
If there are external impacts on timeframes, **we** will inform **you** of this and **we** or the **Group Policy-owner** will keep **you** informed of progress.

Section 8.16
For income-related claims, **we** 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 **your** 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.

Section 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.

Section 8.20
Our claims assessors will be appropriately skilled and trained to make objective decisions. They will not make claims decisions on **our** behalf until they have demonstrated technical competency and an understanding of all relevant law, the **Code** and relevant **FSC** Standards and Guidance. Remuneration and entitlements to bonuses will not be based on declined claims or deferrals of decisions.

Section 8.22
Your policy may state that **your** income-related claim payments will continue after a period of time only if additional or different requirements are met. **We** will give **you** at least three months' notice of this and explain to **you** what is changing and any additional information **we** need to assess **your** eligibility after the change takes effect.

Section 8.24
We acknowledge that claims time is difficult for **our** customers, and that empathy is required in **our** claims management. **We** will treat **you** with compassion and respect.

Section 8.26
For income-related claims **we** will:

a) seek to identify ways **we** can support **your** recovery at the early stage of **your** claim;
b) seek to collaborate with **your** doctor, other healthcare providers and **your** employer in ways which will optimise **your** health outcome;
c) ensure **you** have a primary contact person for the duration of **your** claim; and
d) if injured or ill, **we** will promote best-practice rehabilitation and injury management.

Section 11.1
We will make **our** customers aware of the **Code**, which will include providing information about the **Code** on **our** websites and in **our** relevant marketing documents.

Key Code Promise 1
We will be honest, fair, respectful, transparent, timely, and where possible we will use plain language in our communications with you.

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.