Guidance Note No. 8

Interpreting and applying section 8.15 of the Life Insurance Code of Practice

Overview

Section 8.15 of the Life Insurance Code of Practice (the Code) deals with subscribers'[1] obligation to communicate claim decisions to customers[2] in a timely way.

This Guidance Note explains how the Life Code Compliance Committee (Life CCC) interprets the obligations in section 8.15, as well as what information and evidence we will ask subscribers to provide when we investigate potential breaches of these obligations.

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

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

LIFE CODE COMPLIANCE COMMITTEE

SEPTEMBER 2022

Code section 8.15

SECTION 8.15 STATES:

> *Once **we** have all the information **we** reasonably need and have completed all reasonable enquiries to assess **your** claim, including **your** response to the evidence **we** are basing **our** decision on if **we** have presented this to **you**, **we** will let **you** know **our** decision on your claim within **10 business days**.*

Code section 8.15 applies when assessing all claims, including claims made by a life insured, policy-owner, group policy-owner or third-party beneficiary.

When the section applies

Code section 8.15 applies when assessing all claims, including claims made by a life insured, policy-owner, group policy-owner or third-party beneficiary.

When investigating a potential breach of section 8.15, the Life CCC may also investigate, where relevant, whether there has been a breach of related sections of the Code, including sections 8.7 and 8.19 of the Code.

Interpreting the obligation

Section 8.15 sets out the requirement that subscribers must issue a decision on the claim to the customer within **10 business days** of receiving the information it reasonably needs and having completed all reasonable enquiries. This includes a customer's response to procedural fairness and responses from Reinsurers.

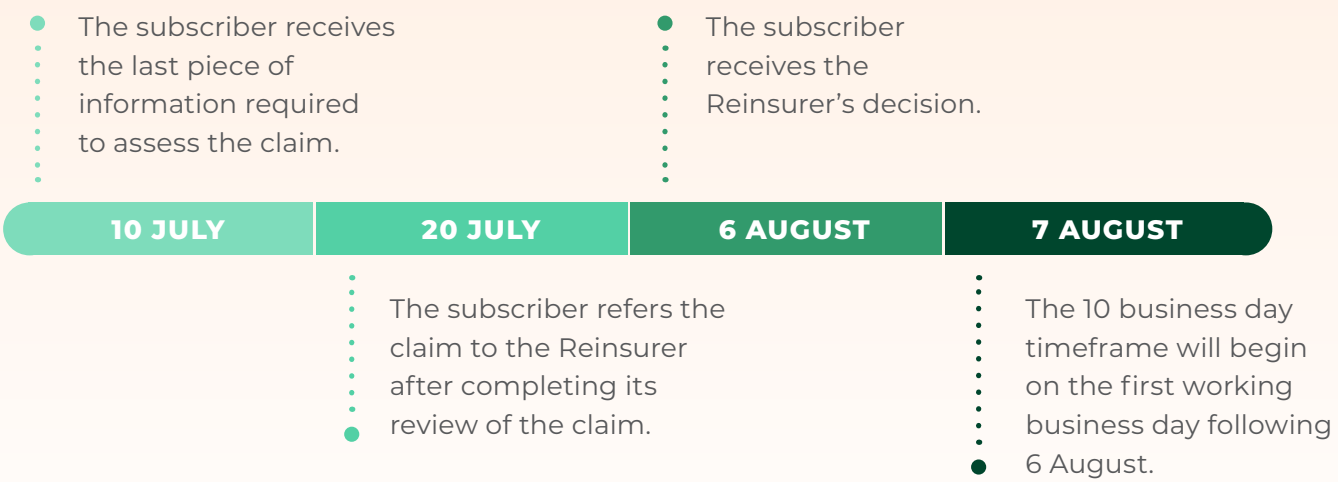
Subscribers must issue a decision on the claim to the customer within 10 business days ...

10 business day timeframe trigger

The Life CCC considers that the 10 business day timeframe begins on the first business day after the subscriber has received the last piece of information it reasonably required and completed all reasonable enquiries, whichever occurred later.

> **The Life CCC considers that the 10 business day timeframe begins on the first business day after the subscriber has received the last piece of information …**

EXAMPLE OF 10 BUSINESS DAY TIMEFRAME TRIGGER:



To ensure compliance with the 10 business day timeframe, the Life CCC considers it best practice for:

- Subscribers to provide their claims assessors with tools such as a checklist of typical information requirements (or actions required) for each product or benefit type to assist claims assessors with identifying the information reasonably required to assess each claim.
- Subscribers have a claims management system that automatically tracks the 10 business day timeframe from the time the claims assessors confirm that all information has been received, and provides a prompt for letting customers know the claim decision.
- Subscribers' claims management system tracks the progress of claims and provides alerts to claims assessors, reducing the likelihood of human error.

Communicating the decision

While section 8.15 of the Code does not specify how subscribers should inform the customer about the claim decision, subscribers must communicate the decision to decline a claim to the customer in writing as required under section 8.19 of the Code.

The Life CCC considers communicating a decision to accept a claim in writing would be best practice – even if the subscriber has verbally informed the customer of the decision. This expectation is outlined in Guidance Notes 5 (section 8.16) and 6 (section 8.17) available on the Life CCC's website.

Best practice examples

- ✔ Having received all the information it needs and having completed all reasonable enquiries to assess the customer's claim, the subscriber notifies the customer in writing within 10 business days that their claim has been accepted.
- ✔ The customer calls the subscriber's contact centre to enquire about the status of their claim. The subscriber advises the customer over the phone that their claim has been accepted, then follows this up with a letter/email to the customer confirming the claim acceptance.

Life CCC's interpretation of 'reasonable enquiries'

In the context of section 8.15 of the Code, the Life CCC considers an 'enquiry' to be a request for additional information or clarification of information already provided. These 'enquiries' include external enquiries made to third parties who are not employed by the subscriber and internal enquiries made to individuals who are employed by, or contracted to the subscriber.

What constitutes a 'reasonable enquiry' depends on whether the information or opinion sought is reasonably necessary for the subscriber to assess and determine the claim. This means that enquiries such as the subscriber's internal Quality Assurance (QA) process do not qualify as 'reasonable enquiries' under section 8.15.

Examples where it was not a 'reasonable enquiry'

- ✖ The subscriber advises that it was reviewing the information available but did not obtain any new information or undertake any new steps as a result.
- ✖ The subscriber advises that there was a case conference between two claim assessors.

The table below includes examples of external and internal enquiries that the Life CCC considers as 'reasonable enquiries'.

Examples of reasonable enquiries made externally	Examples of reasonable enquiries made internally
Seeking a medical opinion from the customer's treating doctor	Referral to the following: • Chief Medical Officer • Legal team • Accountant/Financial team • Rehabilitation team
Requesting a medical report from a medical specialist	Requesting files from its archive after the subscriber has received new information/ evidence to re-open a claim
Asking for the customer's employment information from the customer's employer	Referral to an outsourced claims management function
Referral to the Reinsurer for their review	

The above lists are not exhaustive and what constitutes a 'reasonable enquiry', made both internally and externally, will depend on the circumstances of each case.

Subscribers typically issue a Procedural Fairness (PF) letter to customers if, based on the information and evidence available, they may issue an unfavourable decision on the claim …

Application of section 8.15 to Procedural Fairness (PF)

As mentioned above, section 8.15 explicitly states that a customer's response to procedural fairness ("…*including* ***your*** *response to the evidence* ***we*** *are basing* ***our*** *decision on if* ***we*** *have presented this to* ***you***…") constitutes a reasonable enquiry.

Subscribers typically issue a Procedural Fairness (PF) letter to customers if, based on the information and evidence available, they may issue an unfavourable decision on the claim or if they require additional information from a customer before making a decision.

The purpose of the PF letter is to:

1. Provide the customer with copies of all the information and evidence that the subscriber will be relying on in reaching its decision.
2. Clearly set out the reasons why the subscriber may make an adverse decision, or why they require additional information from a customer.
3. Provide the customer with an opportunity to provide further comment or submit any additional information in support of their claim.

What does this mean and how does this work?

There are 3 steps in the PF timeline:

Steps in the PF timeline		Does the 10 business day timeframe in section 8.15 apply?	
STEP 1	Decision to issue PF	✖	
STEP 2	Issuing PF	✖	
STEP 3	Post-PF	✔	in three scenarios below

1 DECISION TO ISSUE PF

The 10 business day timeframe in section 8.15 does not apply in circumstances where a subscriber is yet to issue PF on the claim. This is because the subscriber has not completed all reasonable enquiries to trigger the obligation to inform a customer of its decision on the claim. A reasonable enquiry includes the process of issuing PF and receiving the customer's response to PF.

2 ISSUING PF

Typically, subscribers provide customers with one month to respond to PF by submitting any further or additional information in support of their claim. As a result, the 10 business day timeframe in section 8.15 does not apply during the PF period. This is because the subscriber has not completed all reasonable enquiries to trigger the obligation to inform a customer of its decision on the claim.

The Life CCC's recommendation:

- ✔ If PF is required on the claim, the Life CCC considers it best practice if subscribers issue a PF letter to the customer within 10 business days of receiving the information required.
- ✔ After the PF response has been received, and no further information or reasonable enquiries are required, the Life CCC considers it best practice if subscribers issue the decision as soon as practical and within the 10 business day deadline.

3 POST-PF[3]

SCENARIO 1

The 10 business day timeframe in section 8.15 will commence on the next working business day of the subscriber receiving the customer's response to the PF letter.

SCENARIO 2

If the customer did not respond to PF by the due date, the 10 business day timeframe will automatically begin on the next working business day after the customer's response was due.

SCENARIO 3

If the customer has requested an extension to submit further information and the subscriber has granted this extension, the 10 business day will begin on the next working business day after the customer's response is received. However, if the customer did not respond to PF by the extended due date, the 10 business day countdown will automatically begin on the next working business day after the response was due (being the extended due date).

Non-compliance example

In a recent **case study** published by the Life CCC, the Subscriber reported that it had mistakenly regarded the issuance of a PF as a final claim decision for the purposes of measuring compliance with the section 8.15 timeframe.

The Life CCC determined that the Subscriber had breached section 8.15 of the Code, and that the breach amounted to systemic non-compliance with the Code because the Subscriber's processes were built on a flawed interpretation of this section over three years.

The Subscriber has now implemented system upgrades and aligned its interpretation and measurement of section 8.15 requirements with the Life CCC's view.

3 The 10 business day timeframe under section 8.15 will not apply from the date of the customer's response in scenarios 1 and 3 if the customer's response means that the subscriber reasonably requires further information or must undertake further reasonable enquiries before it can make a decision on the claim.

Demonstrating compliance

When the Committee receives an allegation that a subscriber has breached section 8.15, we will generally ask the subscriber to provide the following information and evidence:

INFORMATION OR EVIDENCE	WHAT WE WILL CONSIDER
Description of the processes and procedures in place for enabling compliance with section 8.15	• whether the subscriber has appropriately interpreted and applied section 8.15 • whether the subscriber has appropriate systems and processes in place to enable compliance with section 8.15 • whether the subscriber uses an automated claims handling system that tracks key deliverables at the 10 business day point of a claim and prompts claim staff to notify the customer of a decision about their claim • the adequacy of staff training, Quality Assurance and review programmes to ensure compliance with section 8.15 • the adequacy of monitoring/reporting functions (e.g. regular exception reporting or reviews) to accurately track claims assessors' compliance with section 8.15

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

Related Code sections

Where there is a potential breach of section 8.15, the Life CCC may also investigate whether there has been a breach of related sections of the Code. This includes the following sections:

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

- **Section 8.19**
  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 10 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.

Application of sections 8.7 and 8.19 to section 8.15 in a claim timeline

The claims handling obligations in chapter 8 are often interrelated with obligations in other sections of the Code. An example of this interrelationship is explained in the claim timeline below.

Claim timeline

STEP 1 **CLAIM RECEIVED**

When a subscriber receives a claim, it should complete its preliminary review as soon as possible. This review includes identifying the information and actions required to assess the claim at the initial stages.

STEP 2 **INFORMATION REQUESTED**

The subscriber is expected to request for information it reasonably requires as early as possible in a consolidated manner to avoid multiple requests for information (Section 8.7).

STEP 3 **INFORMATION RECEIVED**

The subscriber should review the information received as soon as possible (the Life CCC considers best practice would be to do so within five business days). A prompt review will assist the subscriber with identifying whether further information may be required to assess the claim and if so, request that information as early as possible.

STEP 4 **DECISION TO ISSUE PF**

If PF is required, the subscriber should issue PF to the customer as early as possible (the Life CCC considers best practice would be to do so within 10 business days of receiving all the information and completing all reasonable enquiries).

STEP 5 **PF RESPONSE RECEIVED**

In accordance with section 8.15, the subscriber must provide a decision on the claim to the customer within 10 business days of receiving the customer's response to PF, where no further information or reasonable enquiries are required.

STEP 6 **DECISION ISSUED**

If the subscriber issues a decision to decline the claim, the decision must be communicated in writing and include the information elements under section 8.19(a) to (c) of the Code.

Customer protections

The requirements in related Code sections 8.7 and 8.19 provide customers with a measure of protection and confidence that subscribers are assessing and progressing claims in a timely manner and providing important information where a decision is made to decline a claim.

These protections minimise the risk of an unreasonably protracted claims assessment and ensures that customers understand the reasons for the claim decline, and options which are available if they are dissatisfied with the claim decision.

As a result, the Life CCC recommends subscribers ensure that their claims assessors are appropriately skilled and sufficiently trained to:

- assess claims reasonably and in a timely manner by identifying and requesting the correct information at the initial stages of the claim assessment or doing so promptly where new issues impacting the claim occur.
- comply with internal processes and procedures by issuing decline letters (section 8.19) and ensuring that the claims assessors use the claims management system to record the correct timeframes and communication requirements for claims, particularly for claims where further information is reasonably required.

Non-compliance examples

- ✖ The subscriber receives all the information required to accept a claim but communicates the decision outside the timeframe because the claims assessor incorrectly believed further information was required.
- ✖ Human error led to incorrect dates being input into a claims information system, causing multiple breaches of section 8.15 over one year.

The requirements in related Code sections 8.7 and 8.19 provide customers with a measure of protection and confidence

“The Life CCC recommends subscribers ensure that their claims assessors are appropriately skilled and sufficiently trained …

Appendix 1: Examples of section 8.15 breach matters received and reported to the Life CCC

Matter type	Nature of the breach	Life CCC's determination
Code breach allegation	[CX6590] The Subscriber accepted a claim in February 2020. As the final enquiry into it had been several weeks before in mid-December 2019, this placed it outside the 10 business day timeframe in section 8.15. The Subscriber attributed the breach to resourcing issues caused by higher levels of annual leave in the December-January period.	The Life CCC determined that the Subscriber had breached section 8.15. The Life CCC further determined that the breach amounted to serious non-compliance with the Code as the customer suffered financial loss as a result of the delayed decision.
Significant Breach	[CX6318] The Subscriber reported a significant breach of 8.15 (amongst other sections) due to a breakdown of processes it described as an "internal bottleneck". This resulted in 2,772 breaches of section 8.15, a breach rate of 14.9% - which was assessed and considered significant by the Subscriber.	The Life CCC confirmed the breach of section 8.15 was significant and was satisfied that the Subscriber had remediated the significant breach through enhancements of the Subscriber's claims system.
Significant Breach	[CX4684] The Subscriber reported two significant breaches of 8.15. The first significant breach (22 breaches) occurred due to it having incorrectly interpreted the section 8.15 obligation as commencing from the date the claim decision was made to the date the claim decision was communicated to the customer. The second significant breach occurred due to a system issue and impacted approximately 4,000 to 5,500 claims.	The Life CCC confirmed the two breaches of section 8.15 were significant. The Life CCC was satisfied that the Subscriber had remediated both significant breaches through system enhancements and implementation of additional preventative controls.

Matter type	Nature of the breach	Life CCC's determination
Code breach allegation	[CX4554] A customer raised a complaint with the Australian Financial Complaints Authority (AFCA) prior to the claim decision being made and the claims assessor mistakenly believed that a claim decision could not be communicated to a customer once they complained to AFCA.	The Life CCC determined that the Subscriber had breached section 8.15 due to the claim assessor's mistaken belief.
Code breach allegation	[CX4633] A claim had to be re-opened after the customer submitted new medical evidence for assessment. The delay in claim decision occurred because it took considerable time to retrieve the claim file from archives.	The Life CCC determined that the Subscriber had not breached section 8.15. It considered it reasonable to allow time for a subscriber to request files from archives and that this constituted a 'reasonable enquiry'.
Code breach allegation	[CX6197] The Subscriber's review of one breach uncovered breaches of section 8.15 across all channels. This was attributed to a backlog of work by a third party and a breakdown in internal processes – where decisions could only be communicated to customers after they had been signed off by the Claims Decision Committee.	The Life CCC determined that the Subscriber had breached section 8.15. Given that the breaches occurred over an extent period, the Life CCC determined that the breach amounted to serious and systemic non-compliance with the Code.
Significant Breach	[CX6339] The Subscriber reported a significant breach (16 breaches) of section 8.15 which was caused by system-related defects that arose when migrating to a new policy administration and claims management system over a one-month period.	The Life CCC confirmed that the breach of section 8.15 was significant. The Life CCC was satisfied that the Subscriber had remediated the significant breach through a combination of interim measures and implementation of additional preventative controls.

Matter type	Nature of the breach	Life CCC's determination
Monitoring	[CX4336] The Life CCC reviewed the Subscriber's compliance with section 8.15 in relation to the third decline letter. The Subscriber had received additional information from the Trustee on 20 November 2017 but only issued the decline letter on 22 December 2017.	The Life CCC determined that the Subscriber had breached section 8.15. This was because it noted that reviewing information does not constitute an act of asking for information. A subscriber's review of information received does not constitute a 'reasonable enquiry' under section 8.15.
Code breach allegation	[CX4393] The Subscriber received all the information reasonably required to assess the claim on 5 February 2018 but only communicated the decision to the Trustee on 26 March 2018. The Subscriber noted that it had arranged a case conference between two assessors to ensure a consistent approach – which constituted a "reasonable enquiry".	The Life CCC determined that the Subscriber had breached section 8.15, and that the breach amounted to serious non-compliance with the Code – due to the length of the delay to the customer's detriment. The Life CCC noted that the conference in this instance was not a reasonable enquiry as it did not further the assessment of the claim, nor did it obtain any new information or opinion that would have assisted in assessing the merits of the claim.

About the Life CCC

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

Guidance Notes

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

Life Code Compliance Committee
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