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:	CX7690	**Date:**	27 March 2023
Code sections:	8.4, 9.12, 9.13[1]		
Investigation:	A consumer-reported alleged Code breach by a Code subscriber.		

The alleged Code breaches:

The Consumer holds a non-superannuation life insurance policy that includes Trauma and Terminal Illness (TI) and which was issued by the Subscriber.

The Consumer lodged a Trauma claim with the Subscriber on 26 October 2018. This claim was declined on the basis that the Consumer's medical condition was not one of the specified medical events covered under the Trauma benefit.

The Consumer's health deteriorated further over time and as a result, on 23 October 2019, the Consumer lodged a TI claim with the Subscriber. This claim was declined on 24 August 2020 on the basis that the Consumer did not meet the criteria for being "terminally ill" to the extent required by the policy definitions. However, the Consumer's illness did eventually meet the required criteria for terminal illness and the Subscriber accepted a TI claim on 17 May 2022.

Following the decline of the TI claim on 24 August 2020, the Consumer lodged a complaint with the Subscriber on 1 September 2020 in relation to its decision. The Consumer requested a review of the decision and provided further evidence to support the review.

On 10 May 2021 the Consumer wrote to the Life CCC alleging that the Subscriber did not provide a written response to their complaint within the 45-calendar day timeframe specified in section 9.12 of the Code.

Based on the above allegation, the Life CCC commenced an investigation into the Subscriber's compliance with section 9.12 of the Code as well as the related section 9.13 of the Code.

The Subscriber acknowledged that it had breached sections 9.12 and 9.13 of the Code as it did not manage the Consumer's request to review the declined TI claim as a complaint. In

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

preparing its response to the breach allegation the Subscriber identified that it had also breached section 8.4 of the Code during the assessment of the Consumer's claim.

From the dates provided above subscribers may note a protracted investigation for this matter. This was the result of the Consumer having an open dispute with the Australian Financial Complaints Authority (AFCA) at the time of the Code breach allegation, the complexity of the matter resulting in multiple requests for information as well as the Subscriber requesting additional time to review if the breach of section 8.4 of the Code constituted a significant breach of the Code.

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

The Life CCC determined that the Subscriber:

- was in breach of section 8.4 of the Code and that the allegation was proven in whole
- was in breach of section 9.12 of the Code and that the allegation was proven in whole
- was in breach of section 9.13 of the Code and that the allegation was proven in whole.

The Life CCC findings and conclusion:

Section 8.4

Section 8.4 of the Code requires a subscriber to provide a consumer with updates on their claim at least every 20 business days unless otherwise agreed and to respond to requests for information about a claim within 10 business days.

In reviewing the breach allegation, the Subscriber identified that during the ten-month claim assessment period, from 23 October 2019 to 24 August 2020, it had breached section 8.4 of the Code.

The subscriber failed to provide claim updates to the Consumer at least every 20 business days on four occasions:

(a) Between 17 January 2020 and 16 March 2020 (41 business days)
(b) Between 16 March 2020 and 8 May 2020 (37 business days)
(c) Between 8 May 2020 and 19 June 2020 (30 business days)
(d) Between 19 June 2020 and 24 August 2020 (46 business days).

Based on the above, the Life CCC determined that Subscriber was in breach of section 8.4 of the Code and that the allegation was proven in whole.

The Subscriber investigated the breach in accordance with its breach management policy. This included a review to assess the likelihood of other potential breaches of section 8.4. The Subscriber concluded that the breach was the result of human error isolated to the one policy and to the one consumer. The Subscriber informed the Life CCC that its system correctly generated tasks to the claims assessor to provide the updates, but these were incorrectly closed on the four occasions by the claims assessor. No further details could be provided as to why this occurred as the claims assessor was no longer with the organisation.

[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.

Section 9.12

Section 9.12 of the Code creates an obligation for a subscriber to provide a final response to a complaint in writing within 45 calendar days, where possible. This section also specifies the information that must be provided to the consumer within the complaint response letter.

The Consumer alleged that the Subscriber was in breach of section 9.12 of the Code as it failed to provide a final response to their complaint of 1 September 2020.

The Subscriber noted that after receiving the Consumer's complaint it reopened the claim, reviewed the claim with the new information provided by the Consumer and upheld its decision. The Subscriber then sent a letter to the Consumer on 8 October 2020 advising this outcome.

However, the Subscriber acknowledged that although it responded to the Consumer's complaint within the timeframe of section 9.12 its letter was not fully compliant. The letter did not include all the information elements required in sections 9.12(a) and 9.12(b) of the Code.

Given the above, the Life CCC determined that the Subscriber was in breach of section 9.12 of the Code and that the allegation was proven in whole.

The cause of the breach was due to some confusion, between the Subscriber's claims team and its complaints team, as to who was best suited to handle the issues raised by the Consumer. This uncertainty came about because historically claims related complaints were handled by the claims team, but this approach was reviewed in late 2021 when the Subscriber required all complaints in relation to declined claims to be handled by the complaints team.

The Consumer's concerns were ultimately handled by the claims team and consequently it was never registered as a complaint. This meant that the Subscriber's usual process for handling complaints was not followed, and the approved complaint letter templates were not used.

As part of its assessment of this breach, the Subscriber reviewed incident data from January 2020 to September 2021 to understand how many breaches occurred that related to complaints not being lodged by members of the claims team. Only the one incident, this matter, was identified.

The Subscriber also advised that since implementing the Australian Securities and Investments Commission's (ASIC) standard RG271 'Internal dispute resolution' in late October 2021, it has further strengthened its processes so that claim related complaints that either exceed 5 days or require a written response are now managed centrally by the dedicated Dispute Resolution Team.

Section 9.13

Under section 9.13, a subscriber must inform the consumer of the reasons for the delay before the end of the 45 calendar days timeframe if it becomes clear that the subscriber is not able to provide its final response within 45 calendar days (in compliance with section 9.12 of the Code.)

The Subscriber acknowledged that the Consumer's concerns were not managed as a complaint and the final response provided to the Consumer did not meet all the requirements

of section 9.12 of the Code. Hence, the Subscriber did not provide a compliant response within the timeframe, as is required by section 9.13.

As a result, the Life CCC determined that the Subscriber was in breach of section 9.13 of the Code and that the allegation was proven in whole.

Key learnings

It is crucial that we address the challenges faced by individuals who make a claim for a terminal illness benefit. The breaches in this matter only serve to highlight the difficulties that people with terminal illnesses face in accessing policy funds while they are still alive. As an industry, we owe it to these individuals to make the claims process as efficient and stress-free as possible.

Subscribers have a unique responsibility to assist those diagnosed with terminal illnesses. These individuals are dealing with overwhelming emotions and immediate needs, and it is our duty to ensure that they are not burdened with additional stress from a cumbersome claims process. A well-managed claims handling process with frequent updates to the claimant can go a long way in reducing uncertainty and stress.

We must remember that individuals diagnosed with terminal illnesses are going through an incredibly difficult time, and it is our responsibility to provide them with the support and care that they need. Every organisation should work together to create a claims handling process that is compassionate, efficient, and responsive to the needs of those who need it the most.

Relevant Code Sections

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 9.12:

Where possible, **we** will provide a final response to **your Complaint in writing** within 45 calendar days. **We** will tell **you**:

a) **our** final decision in relation to **your Complaint** and the reasons for that decision;
b) that **you** have the right to copies of the documents and information we relied on in assessing **your Complaint**, 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**;
c) **your** right to take **your** Complaint to the Financial Ombudsman Service (**FOS**) if **you** are not satisfied with **our** decision, and the timeframe within which **you** must take **your** Complaint to **FOS**; and
d) contact details for **FOS**.

Section 9.13:

If **we** are unable to respond to **your Complaint** within 45 calendar days, **we** will inform **you** of the reasons for the delay before the end of the 45 calendar days, and inform **you** of **your** right to take **your Complaint** to **FOS** if **you** are not satisfied, along with contact details for **FOS**.

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.