Guidance – Transition and Early Adoption of Code 2.0

Version 1, April 2023

LIFE CODE COMPLIANCE COMMITTEE

Transition and early adoption of Code 2.0

The new Life Insurance Code of Practice (Code 2.0) will come into effect on 1 July 2023.

Following the Financial Services Council's (FSC) release of Code 2.0 in June 2022, we consulted with subscribers to understand any questions or obligations that required clarification. Our aim is to assist subscribers with a smooth transition to Code 2.0.

The Life Code Compliance Committee (Life CCC) welcomed the fact that Code subscribers wanted to adopt Code 2.0 prior to its implementation date. The Life CCC is supportive of early transition, providing subscriber's systems and processes are sufficiently aligned with Code 2.0 and they can meet their obligations.

However, there is one exception to early adoption. Chapter 8 of the current Life Insurance Code of Practice (Code 1.0) will continue to apply until and including 30 June 2023. Subscribers are also expected to monitor compliance with Code 1.0 obligations and report any breaches to the Life CCC.

The data collection programme for 2022-23 Financial Year will continue to be mapped to Code 1.0. For any early adopters, it is the subscriber's responsibility to map their reporting to Code 1.0.

Interpreting Code 2.0: common queries

Following the publication of Code 2.0, we have received queries from subscribers about our interpretation of certain clauses.

To help ensure a clear and efficient transition to Code 2.0, we have clarified our position on these clauses, and this is set out below.

As subscribers' transition to Code 2.0, we anticipate there will be further questions. We encourage subscribers to engage with us and we will continue to publish clarification to support the transition.

If Code 2.0 does not specifically reference an obligation, then subscribers should refer to the equivalent section in Code 1.0 as the minimum obligation.

Chapter 2

Clauses 2.1 – 2.10: Application to group policies

If a Product (Policy) is owned by a Group Policy Owner (the Fund) and provided under Group Policy arrangements, does Chapter 2 of Code 2.0 apply?

Clauses 2.1 – 2.5 and 2.7 – 2.9 do not apply to Group policies. The remaining clauses in Chapter 2 of Code 2.0 may apply depending on the way the policy is designed and the specific arrangement between the Group Policy Owner and the subscriber.

If, however, the obligations under the remaining clauses in Chapter 2 of Code 2.0 are not applicable to a subscriber's usual course of the business, then they would not apply to the subscriber.

Chapter 4

Clause 4.20 & 4.22: Timeframe to offer alternative terms

Clause 4.20 requires subscribers to accept an application for insurance within 5 business days of receiving all the information reasonably needed and completing all reasonable enquiries.

Clause 4.22 allows a subscriber to offer alternative terms when accepting an application for insurance.

What is the expected timeframe for clause 4.22 when a subscriber accepts an application for insurance and offers alternative terms?

When accepting an application for insurance and offering alternative terms under clause 4.22, subscribers should provide this in the timeframe under clause 4.20; within 5 business days of receiving all the information reasonably needed and completing all reasonable enquiries.

Chapter 5

Clause 5.5(c): All relevant benefits

At clause 5.5(c) of Code 2.0, it states that subscribers will tell consumers within 10 Business Days of the Claim Received Date about all relevant benefits under the Life Insurance Policy they are claiming on.

Can subscribers provide the same level of detail for 'all relevant benefits' as they currently do under section 8.3 of Code 1.0?

Subscribers should, at a minimum, provide the same level of detail regarding 'all relevant benefits' under clause 5.5(c) of Code 2.0 as they currently do under section 8.3 of Code 1.0.

Section 8.3 of Code 1.0 states "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."

Clause 5.21: Medical examinations

At clause 5.21, Code 2.0 refers to medical examinations and what subscribers will pay for. Are these examinations limited to the assessment of the claim only and do not apply to appointments involving treatments?

Yes – these examinations are limited to the assessment of the claim only.

Life insurers are currently prohibited by existing Commonwealth legislation from funding medical treatment as part of a rehabilitation programme.

Please refer to:

- section 126 of the *Health Insurance Act 1973 (Cth)*
- sections 15 and 16 of the *Private Health Insurance (Health Insurance Business) Rules 2017 (Cth)* in the context of section 121-5 of the *Private Health Insurance Act 2007 (Cth)*.

Clause 5.43: Appointing an investigator

Code 2.0, at clause 5.43, states that if we appoint an investigator, we will not allow them to conduct surveillance 'in a business premises – unless it is open to the public'.

Does this include places where the public can enter subject to existing agreements or arrangements for services? For example, could it apply to gyms, stores, and workplaces?

Subject to legislation, an investigator can conduct surveillance in places that the public can access, such as gyms and stores.

For surveillance in workplaces, it depends on the type of workplace and whether there are any existing restrictions that exclude other members of the public from accessing the venue.

For example, an investigator would be able to attend a restaurant to conduct surveillance on a restaurant worker. However, the investigator would not be able to attend the restaurant kitchen to conduct surveillance on the restaurant worker. Similarly, an investigator would not be able to attend an office where a security pass is required.

Clause 5.47: Timeframes and Circumstances Beyond Our Control (CBOC)

Clause 5.47 refers to timeframes that apply unless there are Circumstances Beyond Our Control (CBOC).

When there are CBOC, are subscribers only required to issue CBOC letters for clauses 5.48 and 5.49 and not for clause 5.50 of Code 2.0?

Yes – consistent with our interpretation of Unexpected Circumstances (UC) letters issued under sections 8.16 and 8.17 of Code 1.0, subscribers must send CBOC letters for clauses 5.48 and 5.49 of Code 2.0, but not for clause 5.50.

However, subscribers must also send CBOC letters under clause 5.60: where CBOC is likely to continue beyond 12 months and a subscriber believes that a decision cannot be issued within 12 months.

In this case, as stated at clause 5.60(c), subscribers are required to send CBOC letters before the end of 12 months.

Clause 5.48: Reasonable enquiries

At clause 5.48, it states, '… we will obtain all the information we reasonably need, complete all reasonable enquiries, and make a decision on your claim within 2 months of: a) the Claim Received Date, or b) if later, the end of the waiting period your policy specifies.'

Can 'reasonable enquiries' include a referral to a reinsurer as footnoted in section 8.15 of Code 1.0?

Yes – referrals to reinsurers constitute 'reasonable enquiries'.

In Code 2.0, the phrase 'reasonable enquiries' appears in four clauses (4.20, 5.48, 5.49 and 5.50) and in definition (b) of Circumstances Beyond our Control.

Referrals to reinsurers constitute 'reasonable enquiries' in all instances of this phrase.

Clause 5.57: Reopened or reassessed claims

Clause 5.57 states:

‘If we close or decline your claim, you or the Policy Owner can ask us to reopen or reassess it. If you do, we will treat it as a new claim with a new Claim Received Date, and the timeframes under the Code will restart from the date the request to reopen or reassess the claim is received.’

Should a reopened or reassessed claim under this clause be treated as ‘a new claim’ only for the purposes of restarting the two-month and six-month timeframes (under clauses 5.48 and 5.49)?

Whilst the timeframes restart, subscribers must still meet their claims-handling obligations under chapter 5 of Code 2.0.

Subscribers should continue to provide updates every 20 business days, and they should send a CBOC letter if they are unable to make a decision on the claim within two, six or twelve months.

Clause 5.57: Applying 5.5 and 5.12 to reopened or reassessed claims

Under clause 5.57, because a reopened or reassessed claim had been completed previously, would clauses 5.5 and 5.12 not apply?

Clauses 5.5 (information required to be provided to consumers within 10 business days of receiving the claim) and 5.12 (asking for consent to collect information about the consumer) would not apply to a reassessed or reopened claim.

This is because subscribers would have requested this information or provided the information previously.

Clause 5.57: Reopened or reassessed claims with expression of dissatisfaction

Is a request to reopen or reassess a claim distinct from a request to reopen or reassess a claim that includes an expression of dissatisfaction (under RG271)? Should it be recorded separately?

Yes – it is distinct and should be recorded separately.

A reopened or reassessed claim that came from a complaint should be recorded under clause 7.7 of the Complaints section.

Clause 5.58: Underwriting exclusions

At clause 5.58(b) of Code 2.0, it states that if a pre-existing condition is the reason for declining a claim, we will explain the medical connection between the pre-existing condition and the claim.

Does this apply to claims that were declined due to underwriting exclusions?

If a claim was declined due to an underwriting exclusion rather than a pre-existing condition exclusion, there is no requirement to provide the information under clause 5.58(b) of Code 2.0.

The clause only applies to claims that are declined due to pre-existing condition exclusions in the general terms and conditions of the standard form contract, not exclusions applied following the underwriting process.

Clause 5.59: Circumstances Beyond Our Control (CBOC) 12-month timeframe

Does the CBOC 12-month timeframe commence from the Claim Received Date or the end of the waiting period the policy specifies?

The CBOC 12-month timeframe commences from the later of the two dates.

Clauses 5.5, 5.48, 5.49, 5.59, 5.60: Definition of 'Claim Received Date'

The Claim Received Date is defined in Code 2.0 as "…The date a life insurer records it has received the first piece of information, but not necessarily all information, to allow it to commence the assessment of a claim…"

What constitutes 'the first piece of information' to allow a subscriber to commence an assessment of a claim?

This depends on a range of factors, including the type of claim, the communication between the member and the subscriber, and the subscriber's own assessment criteria.

A claim is 'received' by a subscriber when it receives the first piece of information that enables it to start the assessment of that claim. For example, this could be in a form of a 'tele-claim' that has been conducted.

In considering the 'Claim Received Date', subscribers should take a broad approach that covers the different types of claims, scenarios, and information requirements.

Chapter 5 Claim timeframes

When going down an adverse path on a claim under Group Policy arrangements, a subscriber's decision is not communicated directly to the member until the Group Policy Owner affirms the decision.

Occasionally misalignment between the subscriber and the Group Policy Owner may cause unintentional delays. There is currently no provision for Circumstances Beyond Our Control for when a Group Policy Owner disputes a subscriber's decision.

Does the subscriber's communication to the Group Policy Owner constitute communication of the decision?

Yes – communication of a claim decision to the trustee constitutes a communication of the decision.

The assessment timeframe stops when the subscriber issues its decision to the trustee.

The Code only considers compliance with the claim assessment timeframes. If the trustee delays communicating the claim decision to the consumer, the subscriber has not breached the Code.

Depending on the circumstances of the delay, CBOC reasons under section 5.59(a), (b) and (f) could also apply.

Chapter 7

Clause 7.2: Complaints process

At clause 7.2, it states, 'If you make a Complaint to us and we are unable to resolve it when you first contact us, we will explain our Complaints process to you and we will tell you how you can access the Code, in line with clause 1.3. We will acknowledge your complaint within 24 hours (or 1 Business Day) or as soon as practicable.'

What constitutes 'first contact' in this context?

When a consumer makes a complaint with a subscriber, they must acknowledge it within 24 hours (or 1 business day) of receipt, or as soon as practicable, in accordance with the clause 7.2 of Code 2.0.

Consumers can make complaints through various channels, such as phone, email, and social media. The first contact between the consumer and subscriber may vary depending on the method and substance of the complaint. The Life CCC aims to establish a consistent approach to clause 7.2 that applies to all complaints, irrespective of the type or method of lodgement.

According to the plain English interpretation, 'first contact' occurs when the consumer makes a complaint, and the subscriber has an opportunity to respond. The Life CCC has interpreted 'first contact' to be the 24 hours (or 1 business day) from when a consumer first makes a complaint to the subscriber. If the subscriber cannot resolve the complaint within this timeframe, they must explain their complaints process to the consumer and how they can access the Code, in accordance with clause 1.3.

Steps for transition

Transitioning to a new Code of Practice can be challenging, particularly for insurers that need to adjust policies and practices to meet new requirements.

Here are six steps that can assist subscribers to be ready for Code 2.0 and make sure their systems and processes are working to ensure compliance.

Step 1: Be familiar with the new Code

It is crucial to know and understand the new requirements. Read Code 2.0 in its entirety and pay attention to changes from the previous Code.

Step 2: Assess current compliance

Identify any areas where current policies and practices may not align with the requirements of the new Code. Develop a plan to address any gaps in compliance.

Step 3: Develop a transition plan

Develop a transition plan for all necessary changes. The plan should include responsibilities and timelines for changes, as well as milestones for progress.

Step 4: Implement changes

Implement the changes required to comply with the Code 2.0. Update all policies, systems and procedures, training practices and communicate this to staff.

Step 5: Monitor compliance

Regularly monitor compliance with the new Code, tracking any breaches or potential breaches. Ensure that all staff members are aware of the new requirements and are trained on complying with Code 2.0.

Step 6: Report to the Life CCC

Report on compliance with the new requirements. This may include submitting evidence of compliance and reporting on breaches or potential breaches. The Life CCC encourages subscribers to err on the side of caution by seeking guidance from the Life CCC if they are unsure whether they have complied with or breached their obligations under Code 2.0.

By following these steps, subscribers can ensure compliance with Code 2.0 and maintain the high standards of ethical conduct expected by the Life CCC.