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:	CX12375	**Date:**	1 May 2023
Code sections:	8.4, 8.17 and 9.10[1]		
Investigation:	A consumer-reported alleged Code breach		

The alleged Code breaches:

The Consumer is a member of a superannuation fund. As part of that membership, the Consumer obtained life insurance with a Total and Permanent Disability (TPD) benefit. The TPD policy was issued by a Life Insurance company that is a subscriber (the Subscriber) to the Life Insurance Code of Practice (the Code) and is a Group Policy owned by the superannuation fund trustee (the Trustee).

On 16 March 2018, the Consumer lodged the TPD claim with the Subscriber. As a result, the six-month timeframe commenced on 16 March 2018, and the Subscriber was required to issue a decision on the claim by 16 September 2018 unless Unexpected Circumstances (UC) applied.

The Subscriber issued the claim decline decision to the Trustee on 28 March 2019. Subsequently, the Trustee communicated the decision to the Consumer on 25 September 2019.

On 8 December 2021, the Consumer's Legal Representative (CLR) lodged a complaint with the Trustee in relation to the claim decline decision. On 4 April 2022, the CLR lodged a Code breach allegation with the Life CCC which alleged that the Subscriber had failed to respond to the CLR's complaint.

The Life CCC reviewed the Subscriber's compliance with sections 8.4, 8.17 and 9.10 of the Code. The Subscriber acknowledged that it had breached sections 8.4 and 8.17 of the Code. However, the Subscriber disagreed that it had breached section 9.10 of the Code.

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

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

The Life CCC determined that the Subscriber:

- was in breach of sections 8.4 and 8.17 of the Code and that the allegations were proven in whole.
- was not in breach of section 9.10 of the Code and that the allegation was unfounded.

The Life CCC findings and conclusion:

Section 8.4

Section 8.4 of the Code sets out two separate and independent requirements of the Code. Subscribers are required to provide consumers with an update on the progress of their claim at least every 20 business days (element 1). Subscribers are also required to respond to requests for information about the claim within 10 business days (element 2).

The Subscriber raised and acknowledged that due to the individual claims consultant's oversight, it did not provide the Consumer with an update on the claim at least every 20 business days on four occasions:

- 29 May 2018 to 11 July 2018
- 13 July 2018 to 13 August 2018
- 4 December 2018 to 8 January 2019
- 10 January 2019 to 17 February 2019.

Given the above, 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.

Remediation

The Subscriber has previously confirmed that, since 2021, it utilises a combination of the following processes and procedures to consistently comply with section 8.4 of the Code:

- The Subscriber has refined and provides continuous staff training.
- Management and senior leaders view the daily dashboard monitoring and reporting.
- The Subscriber's Claims Management System provides automated alerts in relation to Code timeframes to claims assessors.
- The Subscriber regularly reviews its procedures and monitoring to determine if further enhancements are required to ensure ongoing compliance with section 8.4.
- The Subscriber regularly engages with the Subscriber's own consumer advocates on the lines of communication to ensure consistent and ongoing compliance with section 8.4.

Section 8.17

Section 8.17 requires subscribers to provide a decision on the claim within six months unless UC applies. If UC applies, subscribers are required to inform consumers within six months of the reasons for the delay and their right to disagree with the reasons provided, which gives rise to a review.

[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.

As noted above, the Consumer lodged and the Subscriber received the TPD claim on 16 March 2018. The Subscriber was required to provide a decision on the claim by 16 September 2018, unless UC applied.

The Subscriber noted that UC applied, specifically UC definition (c)[3]. This was because it noted that there was outstanding medical information required to assess the claim. As a result, the Subscriber issued the UC letter on 23 August 2018. However, the Subscriber acknowledged that its UC letter did not comply with section 8.17 requirements.

The non-compliant UC letter did not inform the Consumer:

- of a delay
- of their right to disagree with the reasons for the delay
- that the Subscriber would conduct a review if the Consumer disagreed with the reasons for the delay.

As a result, the Life CCC determined that the Subscriber was in breach of section 8.17 of the Code.

Serious and systemic non-compliance

The Subscriber acknowledged that the breach of section 8.17 amounted to serious and systemic non-compliance with the Code. It noted that the breach occurred during the period from 1 July 2017 to 15 January 2020 where it did not have a compliant UC letter template as noted in the Life CCC's Claims and Complaints Handling Obligations Report.

Consequently, the Subscriber acknowledged that it had potentially issued non-compliant UC letters to a significant number of consumers during that period.

Given the above, the Life CCC determined, in accordance with the Charter clause 7.4(b)(iv)[4], that the Subscriber's breach of section 8.17 amounted to serious and systemic non-compliance with the Code.

Remediation

In response to the Claims and Complaints Handling Obligations Report, the Subscriber confirmed in January 2020 that it had implemented various processes to ensure it complies with its obligations under section 8.17 of the Code.

These processes included:

- ensuring that it had compliant UC letter templates
- discontinuing the use of Procedural Fairness letters which it had previously relied on in informing consumers that UC applied to their claim.

[3] Chapter 15, Unexpected Circumstances definition (c): we have not received reports, records or information reasonably requested from an Independent Service Provider, your doctor, a government agency or other person or entity (including a Reinsurer).

[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.

Section 9.10

Section 9.10 of the Code has two elements. The first element requires a subscriber to respond to the trustee, where possible, within a timeframe that would allow the trustee to respond to the complaint within 90 calendar days. The second element requires a subscriber to provide the information required under section 9.10(a) to (d) of the Code.

The CLR alleged that the Subscriber had breached section 9.10 of the Code. This was because the Subscriber had allegedly failed to provide a final response to the complaint which was lodged on 8 December 2021.

However, the Subscriber noted that it did not receive the complaint from the Trustee, and that the Trustee handled the complaint themselves.

The Life CCC sought further clarification from the CLR on 21 April 2023. The CLR re-confirmed that they had only liaised with the Trustee, as the policy owner, throughout the claim assessment and complaints process. Given that, the CLR noted that they were unaware that the Trustee did not pass on the complaint to the Subscriber.

Given the above, the obligations under section 9.10 of the Code do not apply to the Subscriber.

As a result, the Life CCC determined that the Subscriber was not in breach of section 9.10 of the Code and that the allegation was unfounded.

Key learnings

In this matter, the Subscriber breached section 8.4 due to human error by an individual claims assessor across four separate periods within 10 months. While human error can occur, the Life CCC reiterates the need for subscribers to review their controls, monitoring and reporting to improve and reduce the risk of human error.

The Subscriber had also breached section 8.17 as its UC letter templates were non-compliant between July 2017 and January 2020. This breach was serious and systemic due to the lengthy period of non-compliance and the significant number of consumers potentially affected.

Unexpected Circumstances letters provide consumers with important information which includes the reasons for the delay in their claim assessment. This information allows consumers to plan and decide their next steps particularly if they are likely to experience financial difficulty while being on a claim. The failure to issue compliant UC letters meant that these importance consumer protections were omitted.

Although the Subscriber did not breach section 9.10 in this instance, the Life CCC was concerned to learn that the Trustee did not pass on the complaint to the Subscriber.

While Trustees are not covered under the Code, subscribers should regularly review the effectiveness of their processes and systems (including Trustee's processes and systems where possible), to ensure they remain fit for purpose and continue to deliver the best outcomes for consumers.

Relevant Code Sections

Section 8.4

Prior to making a decision on **your** claim, **we** will keep **you** informed about the progress of **our** 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 8.17

For all claims other than income-related claims, **we** will let **you** know **our** decision no later than six months after **we** are notified of **your** claim or six months after the end of any waiting period, unless **Unexpected Circumstances** apply. Depending on **your** policy, **our** decision may be a requirement that **you** undertake a period of rehabilitation or retraining, or it may be a final decision on **your** benefits. 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.

Section 9.10

Where possible, **we** will respond to the superannuation fund trustee so that it can provide a final response to **your Complaint** in writing within 90 calendar days of the superannuation fund trustee receiving **your Complaint**. **You** will be informed of:

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) that **you** may have the right to take **your Complaint** to the Superannuation Complaints Tribunal (**SCT**) if **you** are not satisfied with **our** decision and the timeframe within which **you** must take **your Complaint** to the **SCT**; and
d) contact details for the **SCT**.

Unexpected Circumstances means:

a) **your** claim has been notified to **us** more than 12 months after the later of the date of disability or the end of **your** waiting period, and there are reasonable delays obtaining evidence necessary for the assessment of **your** claim from the intervening period;
b) for a claim for total and permanent disability, **we** cannot reasonably satisfy ourselves on the basis of the information provided in the six months after the end of **your** waiting period that **your** condition meets the requirements of **your Life Insurance Policy**;
c) **we** have not received reports, records or information reasonably requested from an **Independent Service Provider**, **your** doctor, a government agency or other person or entity (including a **Reinsurer**);
d) the **Policy-owner** or **Group Policy-owner** has disputed or taken a protracted period to consider **our** decision;
e) **you** or **your Representative** have not responded to **our** reasonable enquiries or requests for documents or information concerning **your** claim;
f) there are difficulties in communicating with **you** in relation to the claim due to circumstances beyond **our** control;
g) there is a delay in the claims process that **you** have requested; or
h) the claim is fraudulent or **we** reasonably suspect fraud or non-disclosure that requires further investigation.

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.