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:	CX13430	**Date:**	20 June 2023
Code sections:	8.17[1]		
Investigation:	A consumer-reported alleged Code breach		

The alleged Code breach:

The Consumer is a member of a superannuation fund. As part of that membership, the Consumer obtained a Total and Permanent Disability (TPD) policy that was issued by the Subscriber and owned by the superannuation fund trustee (the Trustee).

The Consumer's legal representatives (CLR) lodged a TPD claim with the Trustee on or around June 2021. The Subscriber received the claim from the Trustee on 25 August 2021.

The CLR made a referral to the Life CCC on 10 May 2022 and alleged that the Subscriber failed to provide a decision on the claim within the six months timeframe set out in section 8.17 of the Code.

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

The Life CCC determined that the Subscriber was not in breach of section 8.17 of the Code and that the allegation was unfounded.

The Life CCC findings and conclusion:

Section 8.17

Section 8.17 of the Code requires a subscriber to communicate its decision on a TPD claim within six months, unless Unexpected Circumstances (UC) applies. If UC applies, the subscriber has 12 months to provide its decision on the claim.

As the Subscriber received the TPD claim on 25 August 2021, the Subscriber had to provide a claim decision by 25 February 2022, unless UC applied.

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

TPD Benefit components

The TPD benefit held by the Consumer consisted of three components:

1. 60% of the default cover: This portion of the TPD cover was automatically provided to the Consumer as part of their membership to the superannuation fund. In the event of a claim, the eligibility for the benefit under this cover is assessed based on the 'Any Occupation' disability definition.
2. 40% of the default cover: The eligibility for the benefit under this cover is assessed based on an 'Everyday Working Activities' disability definition.
3. Additional cover: This component refers to the TPD cover that the Consumer requested as a top-up to the default cover. It required full underwriting. In the event of a claim, the eligibility for the benefit under this cover is assessed based on the 'Any Occupation' disability definition.

Claim on TPD components

In the given scenario, the Consumer could meet the eligibility criteria for the 'Any Occupation' disability definition but not for the 'Everyday Working Activities' disability definition.

Furthermore, the assessment process for the default cover differed significantly from that of the additional cover. The additional cover underwent full underwriting, making its assessment distinct.

In this case, the Consumer made claims for all three components simultaneously. Due to the aforementioned differences in eligibility criteria, the Subscriber needed to assess the eligibility for each component separately but concurrently.

Subscriber's claim decision on the TPD components

The Subscriber provided the following claim decisions on the three components to the Trustee:

1. On 21 December 2021, the Subscriber informed the Trustee that the claim for the first component was accepted, four months after the claim was lodged. This decision was within the six-month timeframe specified in section 8.17 of the Code.
2. On 21st December 2021, the Subscriber notified the Trustee that the Consumer did not meet the eligibility criteria for the 'Everyday Working Activities' definition, resulting in ineligibility for the second component. This decision was communicated four months after the claim was lodged and fell within the six-month timeframe mentioned in section 8.17.
3. On 21 December 2021, the Subscriber submitted the claim assessment for the third component to the Trustee. However, due to concerns regarding potential non-disclosure and misrepresentations in the Consumer's original insurance application, further review of the cover under this component was necessary. The Trustee was informed about the situation and provided with the reasons for potential delays.

   A 'show cause' letter was sent to the Consumer on 31 May 2022, providing an opportunity for them to address the concerns raised. However, after consideration, the Subscriber ultimately declined the claim on 26 August 2022 (12 months after receiving the claim).

The Subscriber maintained regular contact with the Consumer throughout the process and provided regular updates regarding the claim on the third component.

Based on the above, the Life CCC has determined that the Subscriber's handling of the Consumer's claim cannot be deemed as a breach of section 8.17 of the Code.

Key learnings

This matter brought to light a unique claim situation that was not explicitly covered by the Code. It underscored the importance of Subscribers adhering to the existing claim standards outlined in Chapter 8 of the Code, at a minimum, in the absence of specific provisions for uncommon claim scenarios.

As a result of this case, the Life CCC recommends that Subscribers, in cases where a claimant's TPD cover consists of both default and underwritten components, treat each cover component as a separate claim. By doing so, Subscribers can ensure they fulfil their obligations as outlined in Chapter 8 of the Code and provide a fair and transparent claims assessment process for their policyholders.

Relevant Code Section

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 within 12 months, **we** will give you details of **our Complaints** process.

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.