LIFE CODE COMPLIANCE COMMITTEE

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:	CX18075	**Date:**	26 February 2024
2016 Code[1]:	8.3, 8.4, 8.5, 8.7, 8.9(f), 8.15, 8.16, 8.17, 8.23 and 8.28[2]		
Investigation:	Self-reported non-compliance by a Code subscriber		

The alleged Code breach:

On 26 September 2022, a Life Insurance Company that is a subscriber (the Subscriber) to the Life Insurance Code of Practice (the Code) self-reported a breach of sections 8.3, 8.4, 8.5, 8.7, 8.9(f), 8.15, 8.16, 8.17, 8.23, and 8.28 of the Code.

The Life CCC initially received a Code breach allegation from a customer on 12 April 2021 which alleged the Subscriber did not meet the Code's claim timeframes when assessing a customer's claim. The investigation resulted in the Life CCC determining serious and systemic breaches of sections 8.4, 8.5, 8.7 and 8.17 of the Code.

As part of the investigation, the Subscriber reviewed the claims assessor's portfolio of 110 claims between 1 August 2019 and 7 September 2021. The review identified a total of 296 breaches across sections 8.3, 8.4, 8.5, 8.7, 8.9(f), 8.15, 8.16, 8.17, 8.23, and 8.28 of the Code.

This led the Subscriber to report a new breach (this Matter) to the Life CCC due to the cumulative number of breaches and proportion of impacted claims identified across the claims assessor's portfolio. The breach was attributed to human error and underperformance of the individual claims assessor over a prolonged period.

The claims assessor's portfolio was managed by a third-party claims administrator which provided claims assessment services for the Subscriber's income protection and total and permanent disability policies for members of a Superannuation Fund (the Trustee), in the Group channel.

[1] The 2016 Life Code of Practice applied between 1 July 2017 – 30 June 2023
[2] The Code section/s are provided in full in the last section of the Determination

Findings in accordance with Charter clause 7.5(b)(iii)[3]:

The Life CCC assessed the matter and confirmed the self-reported breach of sections 8.3, 8.4, 8.5, 8.7, 8.9(f), 8.15, 8.16, 8.17, 8.23 and 8.28, as assessed by the Subscriber.

The Life CCC findings and conclusion:

As noted above, the Subscriber reviewed the claims assessor's portfolio as part of the Life CCC's separate investigation (CX7628) into a customer's Code breach allegations. The review involved 110 admitted claims managed by the claims assessor between 1 August 2019 and 7 September 2021. The review identified 296 breaches.

The breaches are noted in the table below by impacted Code section:

Code Section	8.3	8.4	8.5	8.7	8.9(f)	8.15	8.16	8.17	8.23	8.28	Total
Breach Count	62	79	13	39	8	64	5	24	1	1	296

The claims assessor was employed by the Subscriber's third-party claims administrator. The third-party claims administrator assessed total and permanent disability (TPD) and income protection (IP) claims in the Subscriber's Group channel. The Subscriber attributed the breach to human error and underperformance of the individual claims assessor over a prolonged period of time.

Given the above, the Life CCC confirmed the Subscriber's self-reported breach of sections 8.3, 8.4, 8.5, 8.7, 8.9(f), 8.15, 8.16, 8.17, 8.23 and 8.28 of the Code.

Serious non-compliance

The breaches amounted to serious non-compliance for the following reasons:

- The non-compliance impacted a material proportion of claims within the claims assessor's portfolio over a significant period (two-years).
- The breach impacted a large cohort of customers.
- More than $26,000 in interest payments were paid to 52 customers due to Code-related delays and financial detriment.

As a result, the Life CCC determined that the Subscriber's breaches of sections 8.3, 8.4, 8.5, 8.7, 8.9(f), 8.15, 8.16, 8.17, 8.23 and 8.28 of the Code amounted to serious non-compliance with the Code.

Systemic non-compliance with sections 8.3, 8.4, 8.5, 8.7, 8.15 and 8.17 of the Code

The breaches of sections 8.3, 8.4, 8.5, 8.7, 8.15 and 8.17 amounted to systemic non-compliance for the following reasons:

- A substantial number and high proportion of breaches were identified from the review of 110 claims. The breaches are noted in the table below by impacted Code section and proportion of impacted claims.

[3] 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.

Code Section	8.3	8.4	8.5	8.7	8.15	8.17
Breach Count	62	79	13	39	64	24
Breach count as % of total claims reviewed	56%	72%	12%	35%	58%	22%

- The Subscriber became aware of performance related issues affecting the claims assessor in April 2019. However, non-compliance continued until the claims assessor ceased employment at the Subscriber in September 2021, more than two years later.
- The Subscriber attributed the breaches to a single root cause – the human error and the underperformance of a single claims assessor over a prolonged period.

  Additionally:

  - The Subscriber acknowledged that 59 breaches of section 8.4 were part of significant breach CX6318. The significant breach affected the Subscriber's Group channel between 1 July 2018 and 28 February 2020 and was caused by inadequate processes and preventative controls.
  - The Subscriber acknowledged that 22 breaches of section 8.15 were part of significant breach CX11134. The significant breach affected all channels between 1 March 2020 to 31 October 2021 and was caused by errors in the Subscriber's reporting.

As a result, the Life CCC determined that the Subscriber's breaches of sections 8.3, 8.4, 8.5, 8.7, 8.15 and 8.17 of the Code amounted to systemic non-compliance with the Code. The Subscriber has acknowledged that these breaches amounted to systemic non-compliance with the Code.

Remediation

In April 2019, the Subscriber identified that the claims assessor was experiencing performance and personal issues. The Subscriber provided Code-related training and support to the claims assessor on 14 May 2019, 21 August 2020, and 21 April 2021. The claims assessor ceased employment at the Subscriber's Third-party claims administrator on 7 September 2021 following formal performance management.

The Subscriber's review of the claims assessor's portfolio identified 52 customers were impacted by unreasonable claim delays. In each case, the Subscriber paid the customers interest per the *Insurance Contracts Act 1984*. These payments included:

- As of 28 November 2022, $26,369.45 was paid across 49 customers.
- By 22 December 2022, three customers owed compensation of less than $5 received letters to organise interest payments to nominated charities in line with ASIC Regulatory Guide 277.

As of 1 July 2023, the Subscriber and the Trustee did not renew their contract with the third-party claims administrator. This meant that from 1 July 2023, the Subscriber and the Trustee reverted to a more traditional claims assessment model whereby all life insurance claims from members of the Trustee were managed directly by the Subscriber. This decision was taken in view of a changing regulatory landscape and to better benefit member claimants by leveraging the Subscriber's scale and expertise.

Prior to 1 July 2023, the Subscriber took several actions to remediate the breaches. These included:

- The development of new reporting to provide better portfolio oversight and increase the ability to identify trends.
- The introduction of a milestone review process within the Subscriber's third-party claims administrator to provide specific claim timeframe touchpoints reviewed by the Subscriber and its third-party claims administrator.
- Updates to process documents to better reference consequences in the event of significant non-compliance, including removal of claims portfolios and authorities.
- Enhanced quality assurance processes for the claims assessment model across the Subscriber and its third-party claims administrator.
- Significant breaches which coincided with this matter were closed, with remediation completed and determinations issued for cases CX6318 and CX11134.

Given the actions from the Subscriber outlined above, we are satisfied that the Subscriber has sufficiently remediated the breaches.

Key learnings

This case was initially brought to the Life CCC's attention because of a customer's complaint. It was only after the Life CCC requested further auditing that the Subscriber identified and reported the true extent of the claims assessor's non-compliance over a prolonged period.

The Subscriber outlined several actions it took to remediate the breaches and ultimately terminated its claim handling arrangement with the third-party claims administrator. However, the prolonged non-compliance, even after non-compliance was initially detected, shows there were deficiencies in the Subscriber's and its third-party claims administrator's arrangements for monitoring, root cause analysis and breach remediation mechanisms.

Subscriber's must ensure they constantly review their existing arrangements to ensure they are fit for purpose and can prevent similar non-compliance to minimise the impact on customers.

By reverting to a more traditional claims handling model, the Life CCC expects the Subscriber to avoid similar issues in the future.

Relevant Code Sections

Section 8.3

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.

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 8.5

We will only ask for and rely on information and assessments that are relevant to **your** claim and policy, and **we** will explain why **we** are requesting these. This can include, for example, financial, occupational and medical information. If **you** disagree with the relevance of any information, **we** will review the request, and if **you** are not satisfied with **our** review **we** will tell **you** how **you** can make a **Complaint**.

Section 8.7

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

Section 8.9(f)

For income-related claims (such as income protection or business expense cover):

a) information may need to be provided on an ongoing basis in order to review **your** entitlement to benefits or to calculate **your** payments. This can include financial as well as medical information;

b) **we** will not require **you** to get ongoing statements from **your** doctor more frequently than reasonably necessary to assess **your** condition, so that **we** can determine **your** ongoing entitlement to benefits. For monitoring purposes, **we** may seek information from **your** doctor every six months, even if **your** condition is stable;

c) **we** will not request a medical statement from **your** doctor for the sole

d) reason of processing **your** regular payment;

e) **we** will only request financial information in circumstances where it is required to assess **your** eligibility to claim or to calculate **your** entitlement; if **you** disagree with the relevance of any requested information, **we** will review this; and

f) if **your** payment is going to be delayed, **we** will notify **you** prior to this and let **you** know the reasons for the delay.

Section 8.15

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 ten **business days**.

Section 8.16

For income-related claims, **we** will let **you** know **our** initial decision no later than two months after **we** are notified of **your** claim or two months after the end of **your** waiting period (whichever is later), unless **Unexpected Circumstances** apply. 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.

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.

Section 8.23

If **we** identify that **your** income-related claim payments are coming to an end, **we** will contact **you** to confirm when the last payment is to be made, either:

a) at least 30 days in advance of the last payment if **your** benefit period is expiring; or

b) as soon as possible if **we** have received information that has caused **us** to cease all future payments.

Section 8.28

We will ask **you** to provide documentation to support this, but will only ask for information that is reasonably necessary to assess **your** request, such as:

a) for Centrelink clients, **your** Centrelink statements; or

b) financial documents including bank statements.

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 de-identified Determination is issued in accordance with clause 7.5 of the Life CCC's Charter in order to assist all subscribers in understanding their Code obligations.