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:	CX15952	**Date:**	12 June 2024
Code sections:	8.17 and 9.10 of the 2016 Code[1]		
Investigation:	A consumer-reported alleged Code breach by a Code subscriber		

The alleged Code breach:

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

On 17 September 2021, in response to a Consumer inquiry, the Subscriber created a claim file and sent the relevant forms for a TPD claim to the Consumer. The claim file was subsequently closed on 12 November 2021 due to non-receipt of the initial claim forms.

The Subscriber re-opened the claim file when it received the claim forms on 24 December 2021. Between 7 January 2022 and 17 June 2022, relevant information and updates were exchanged between the Subscriber and the Consumer. The Subscriber admitted the TPD claim on 25 July 2022.

On 20 September 2022, the Consumer's Legal Representative (CLR) lodged a complaint against the Subscriber via the Trustee in relation to an interest payable on the TPD Benefit. In the complaint letter, the CLR indicated that the TPD claim was lodged around September 2021 and that the claim was approved ten months later when it should have been approved within three months of lodgement. As per the Subscriber's obligation under the Code, claim decision timeframe for TPD is six months from claim lodgement.

On 20 December 2022, the CLR raised a code breach allegation to the Life CCC alleging that the Subscriber was in breach of section 9.10 of the Code due to Subscriber's failure to respond to the Consumer's complaint within the required 90-day timeframe.

During the investigation, the Subscriber also raised a potential breach of section 8.17 of the Code. As a result, the Life CCC investigated the Subscriber's compliance with this section, in addition to the Consumer's Code breach allegations under 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 section 9.10 of the 2016 Code and that the allegation was proven in whole.
- was in breach of 8.17 of the 2016 Code and confirmed the reported breach by the Subscriber as proven in whole.

The Life CCC findings and conclusion:

Section 9.10 of the Code

Section 9.10 of the 2016 Code creates an obligation for a Subscriber to assist the Trustee in responding to a complaint in writing within 90-calendar days of the Trustee receiving the complaint (element 1). It also requires the Subscriber to provide the information required under section 9.10(a) to (d) of the Code within its final complaint response letter (element 2).

Complaint lodgement

The CLR lodged the complaint with the Subscriber via the Trustee on 20 September 2022. The Subscriber confirmed it received the complaint from the CLR on that same day. To be compliant under section 9.10, the Subscriber needed to provide its final complaint response to the CLR by 19 December 2022.

Breach of section 9.10 of the Code

The Subscriber provided its complaint response to the CLR on 14 February 2023. It took the Subscriber 147 calendar days to respond to the complaint, 57 calendar days over the required 90-calendar day timeframe (element 1).

The Subscriber also acknowledged that its staff did not use the correct complaints letter template (element 2). The oversight occurred despite the Subscriber having a compliant template consistent with the information required under section 9.10 (a) to (d).

Consequently, the Subscriber acknowledged its breach of section 9.10 of the Code.

Cause of the breach

The Subscriber attributed the breach primarily due to human error and also processes not being followed. Its complaint process requires the initial involvement of its administration staff to review complaints from the Subscriber's managed inbox and upload documents to the Subscriber's system once the claim the complaint relates to has been identified.

The complaint process was not followed and the complaint was inadvertently forwarded to the wrong team and the complaint letters were not uploaded into the Subscriber's system. A similar incident occurred when the CLR followed up with the Subscriber on the outcome of the complaint, with no tasks created for the Claims Consultant to review the complaint in a timely manner. The appropriate complaint letter template was also not followed. This was attributed to human error.

[2] The Life CCC is bound by its Charter to use the terminology 'the 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.

The Subscriber considered this breach to be an isolated incident that impacted one consumer and was limited to one policy. As such, the Subscriber considered the breach did not amount to serious or systemic non-compliance with the Code.

Section 8.17 of the Code

Section 8.17 consists of four elements required for Subscribers to meet their obligations under the Code. One of these elements requires Subscribers to inform the Consumer when Unexpected Circumstances (UC) applies to their claim, including the reasons for the delay, before the expiration of the relevant six-month timeframe (element 3)[3].

Claim notification

The Subscriber confirmed it sent the TPD claim forms to the Consumer on 17 September 2021 and subsequently closed the claim file on 12 November 2021 due to non-receipt of the initial claim documentation. On 24 December 2021, the Subscriber received the initial documents and re-opened the claim file. The claim received date is taken to be on 24 December 2021. As a result, the six-month timeframe commenced on 24 December 2021 and the Subscriber was required to issue a decision on the claim by 24 June 2022, unless UC applied.

Breach of section 8.17 of the Code

Following the allegation raised under section 9.10, the Subscriber conducted a review of the Consumer's claim file and identified a breach of section 8.17.

Based on the Subscriber's review, UC applied to the claim due to additional medical information needed to further assess the claim. However, the Subscriber failed to issue the UC letter to the Consumer within six months of receiving the TPD claim, leaving the Consumer unaware of the delay in the claim decision. The Subscriber admitted the TPD claim on 25 July 2022, approximately seven months after claim lodgement and four weeks over the required decision date.

Cause of the breach

The Subscriber attributed the root cause of the breach to human error. To ensure the UC letter is sent, a system-generated reminder task should remain visible in the Claims Consultant's workflow until the UC letter has been sent. However, the reminder task was inadvertently marked off as 'completed', and a second reviewer failed to set a new reminder task to prompt the Claims Consultant to send the letter.

While the Subscriber failed to notify the Consumer that UC applied, it continued to provide timely updates to the Consumer and the CLR. It identified one instance of this breach by the Claims Consultant and no further incidents were identified thereafter. The Subscriber considered the breach an isolated incident that did not amount to serious or systemic non-compliance with the Code.

Remedial actions

Following its complaint response on 14 February 2023, the Subscriber paid the Consumer interest of approximately $3,181 on 21 February 2023.

[3] Guidance Note No 6 (Interpreting and applying Life Insurance Code of Practice section 8.17)

The Subscriber provided feedback to all staff involved with the errors on the importance of following the existing processes and procedures that require:

- all incoming correspondence or communication be added to its system to prompt a workflow task to be raised and actioned to enable proper monitoring and oversight
- relevant UC letters be sent out to consumers within the stipulated claim timeframes
- the correct complaint letter template be used
- there is a daily review of its relevant mailbox to prevent missed emails.

As well as the feedback provided to the relevant staff, the Subscriber also upgraded its system to automate classification and labelling of documents and implemented a new platform to automate sending letters to consumers. Its compliance includes:

- a claim system which automatically prompts Claims Consultant to consider UC
- detailed onboarding and ongoing training to all staff regarding Code compliance
- extensive checks by its Quality Assurance Team to ensure systemic issues are identified.

The Subscriber also enhanced its complaints and claims handling processes to ensure adherence and alignment with the equivalent clauses under the 2023 Code[4].

Key learnings

The breaches that occurred in this matter, primarily due to human error, highlight the importance of a robust compliance framework. Such a framework should include regular audits, monitoring, and reporting to identify and mitigate staff errors during claims and complaints handling processes. Subscribers also need to ensure that their relevant staff adhere to approved processes and documentation.

While this matter initially stemmed from a complaint related to interest payable on a delayed claim decision, underlying issues with the Subscriber's claim handling processes were also brought to light. The Subscriber failed to notify the Consumer of the Unexpected Circumstances that applies which meant that critical information was missed. This left the Consumer unaware of the reason for the delay in the assessment of their claim. Missing out such critical information could lead to a consumer's inability to make informed decisions on their financial situation.

The Subscriber's payment of interest to the Consumer, due to the breaches, highlights the financial consequences of non-compliance and the potential for reputational harm to Subscribers. It underscores the importance of promptly delivering claim decisions to prevent escalation into complaints, which can be achieved by adhering to the Code. By doing so, Subscribers can foster consumer trust and confidence in the industry, prevent non-compliance, and affirm their commitment to mandatory customer service standards.

[4] The 2023 Life Code of Practice (Code 2.1.1) applies from 12 December 2023 onwards.

Relevant Sections of the 2016 Code

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 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**.

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.