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:	CX14597	**Date:**	9 July 2024
Code sections:	[1]8.4, 8.5, 8.7, 8.13, 8.15, 8.16 of the 2016 Code		
Investigation:	Significant Breach and non-significant breaches reported by a Code subscriber		

The alleged Code breaches:

A Life Insurance Company that is a subscriber (the Subscriber) to the Life Insurance Code of Practice (the Code) reported a significant breach of section 8.4 and non-significant breaches of[2] 8.4, 8.5, 8.7, 8.13, 8.15, 8.16 of the 2016 Code on 27 July 2022.

The breaches related to an Income Protection (IP) claim lodged on 11 December 2020. The claim decision was not communicated until 11 May 2022 - 17 months after the claim was lodged. The delay was caused by claim related tasks being incorrectly closed in the Subscriber's claim management system. The Subscriber acknowledged that there had been a Significant Breach of the obligation in section 8.4 of the 2016 Code to provide an update on the progress of the claim every 20 business days. The Subscriber also acknowledged breaches of sections 8.5, 8.13, 8.15 and 8.16 of the 2016 Code. The Claimant was a Retail customer of the Subscriber.

The root cause of the breaches was found to be the incorrect actions of the individual claims assessor (CA) to close tasks that had not been undertaken. This meant that the customer did not receive update(s) on the progress of the claim and that there was a delay in decisions being made.

As a result of the above, the Life CCC expanded its investigation beyond the specific circumstances of the Subscriber's self-reported breaches. The Life CCC also investigated the Subscriber compliance with sections 8.20 of the 2016 Code in relation to the training of claims assessors and 13.3(a) of the 2016 Code in relation to having appropriate systems and processes in place.

The expanded investigation focused on the Subscriber's breach identification and reporting process under sections 8.20 and 13.3(a). As part of the investigation, the Life CCC reviewed

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

the subscriber's skills and training compliance frameworks and processes that claims assessors undergo and found no evidence that it was inadequate.

As such the Life CCC observed there was no evidence which indicated that the Subscriber breached sections 8.5, 8.13, 8.20 and 13.3(a) of the 2016 Code.

The Subscriber acknowledged that it had breached sections 8.4, 8.7, 8.15 and 8.16 of the Code.

Findings in accordance with Charter clause 7.4(b)(iii)[3]:

The Life CCC assessed the matter and confirmed the following:

- the reported breach of section 8.4 of the 2016 Code was significant, as assessed by the Subscriber.
- the reported breach of sections 8.7, 8.15 and 8.16 of the Code was not significant, as assessed by the Subscriber.

The Life CCC findings and conclusion:

Section 8.4

Section 8.4 of the Code requires the subscriber to provide a consumer with updates on their claim at least every 20 business days unless otherwise agreed and to respond to requests for information about the claim within 10 business days.

The subscriber acknowledged that it breached the 20-business day timeframe under section 8.4 on five occasions over the period from 28 January 2021 to 19 January 2022. The cause of the breach of section 8.4 for all five events was attributed to the performance of the individual CA who handled the claim.

Our investigation found that the CA closed the relevant tasks in error. These included critical decision timeframe tasks, such as the 20-business day customer claim update tasks, decision reminder tasks, and the internal stakeholder review tasks necessary to progress the claim. This meant that the customer did not receive the required updates, there was a delay in decisions being made and communicated, and there was a significant delay in the payment of the IP claim that was eventually accepted by the Subscriber. There was also a failure to request information in a timely manner.

The Subscriber reviewed the CA's entire portfolio and has confirmed that no other breaches of a similar kind have been identified. Additionally, appropriate management action was taken by the Subscriber with respect to the CA.

Given the above, the Life CCC confirmed the Subscriber's reported significant breach of section 8.14 of the 2016 Code.

Section 8.7

[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.

Section 8.7 requires a subscriber to request the information that it needs as early as possible (element one) and to avoid multiple information requests where possible (element two).

The subscriber acknowledged it breached element one of section 8.7 due to the delay in issuing the show cause letter, which was not sent until October 2021 despite being due in March 2021

Serious non-compliance with section 8.7

The breach of section 8.7 represented serious non-compliance with the 2016 Code due to a seven-month delay in issuing a show cause letter to the Customer between March 2021 (the earliest a request could have been made) and October 2021 (when the request was made). This delay meant that the Subscriber failed to meet the requirements under the Code 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 8.7 amounted to serious non-compliance with the Code.

Sections 8.15 and 8.16

Section 8.15 requires a subscriber to communicate a claim decision within 10 business days of making all reasonable enquiries and receiving all the information that the subscriber. reasonably needs to assess a claim.

Section 8.16 of the Code requires a subscriber to provide its decision on an income-related claim within two months unless Unexpected Circumstances (UC) applies. If UC applies, the subscriber has 12 months to provide its decision on the claim.

The Subscriber noted that the breaches of 8.15 and 8.16 of the Code were due to the flow-on effect from the Significant Breach of section 8.4, which impacted the claims handling timeframe on the following basis:

- in relation to section 8.15, the Subscriber failed to formally communicate its decision to the customer within 10 business days of receiving all relevant information in respect of the claim on two occasions, initially on 26 March 2021, regarding its decline decision, and additionally after the receipt of further information on 26 October 2021.
- in relation to section 8.16, the Subscriber failed to provide the Consumer with a decision within 2 months of the claim notification or within 2 months of the waiting period. In total, the subscriber took 17 months to accept and pay the claim.

Serious non-compliance with sections 8.15 and 8.16

The breach of sections 8.15 and 8.16 amounted to serious non-compliance with the 2016 Code. This was due poor workflow management and performance of the individual CA who handled the claim.

Given the above, the Life CCC determined that the Subscriber's breach of sections 8.15 and 8.16 amounted to serious non-compliance with the 2016 Code.

Remediation

The subscriber undertook the following actions to remediate the reported significant breach and nonsignificant breaches:

- made a $2,500.00 goodwill payment to the customer additional to the interest paid to the customer for the delays in the claim assessment and decision.
- conducted a review of the individual claims assessor's portfolio to identify whether other customers were impacted by similar actions.
- engaged internal management actions for the individual claims assessor responsible for the non-compliance in the matter.
- reassessed its complaints policy to identify opportunities for future process improvements.
- improved its identification and reporting process to avoid erroneous referrals to the Life CCC by reinforcing its Line 1 team's referral process.
- implemented a nine-month post-lodgement review of claims where a decision had been made.

Given the above, the Life CCC is satisfied that the Subscriber has adequately remediated the breaches and process issues in this matter.

Key learnings

Failures to meet communication timeframes can cause unnecessary frustration for a customer and increase the likelihood of complaints.

Complaints processes create additional work and expenses for insurers and cause unnecessary stress for a customer. There are both financial and reputational implications for the insurer.

In this matter, a claims assessor's error in closing all critical decision tasks on a claim led to a significant breach of section 8.4 and non-significant breaches of sections 8.5, 8.7, 8.13, 8.15, and 8.16 of the 2016 Code by the Subscriber. In recognition of the breach, the Subscriber made an ex-gratia payment to the affected customer, in addition to the interest payable on the claim in acknowledgement of the delays in the claim assessment and decision timeframe.

This case emphasises the need for subscribers to continually review the effectiveness of key controls. This ensures that any weaknesses in controls are identified early, and adjustments made to ensure compliance with the Code.

Relevant Code Section/s

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 8.13
If **we** become aware of any errors or mistakes in **your** claim or the information **we** have asked for, **we** will address these promptly. **We** may require additional information to implement corrections.

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 8.20
Our claims assessors will be appropriately skilled and trained to make objective decisions. They will not make claims decisions on **our** behalf until they have demonstrated technical competency and an understanding of all relevant law, the **Code** and relevant **FSC** Standards and Guidance. Remuneration and entitlements to bonuses will not be based on declined claims or deferrals of decisions.

Section 13.3(a)
We will:
a) have appropriate systems and processes in place to enable compliance with the **Code**;

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.