



**ASIC**

Australian Securities & Investments Commission

## REPORT 498

# Life insurance claims: An industry review

October 2016

### About this report

This report contains the findings of an industry-wide review of claims handling in the life insurance industry.

The purpose of our review was to determine if there were any systemic concerns that apply either to the industry as a whole or to particular insurers.

We focused on life insurance claims by policyholders, assessing the outcome of claims and details of disputes about claims, as well as reviewing information about insurers' policy documentation, information about claims staffing, systems and procedures, and sales practices.

### About ASIC regulatory documents

In administering legislation ASIC issues the following types of regulatory documents.

**Consultation papers:** seek feedback from stakeholders on matters ASIC is considering, such as proposed relief or proposed regulatory guidance.

**Regulatory guides:** give guidance to regulated entities by:

- explaining when and how ASIC will exercise specific powers under legislation (primarily the Corporations Act)
- explaining how ASIC interprets the law
- describing the principles underlying ASIC's approach
- giving practical guidance (e.g. describing the steps of a process such as applying for a licence or giving practical examples of how regulated entities may decide to meet their obligations).

**Information sheets:** provide concise guidance on a specific process or compliance issue or an overview of detailed guidance.

**Reports:** describe ASIC compliance or relief activity or the results of a research project.

### Disclaimer

This report does not constitute legal advice. We encourage you to seek your own professional advice to find out how the Corporations Act and other applicable laws apply to you, as it is your responsibility to determine your obligations.

Examples in this report are purely for illustration; they are not exhaustive and are not intended to impose or imply particular rules or requirements.

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## Executive summary

- 1 Life insurance is an important risk management tool for consumers, helping them to provide for themselves and their families in the event of death, illness, injury or disability. It provides support each year for thousands of consumers and their families at times of significant financial stress.
- 2 Industry statistics collected by ASIC for this review showed that where a decision has been made, the considerable majority of claims (approximately 90%) were paid in the first instance. Data from the Australian Prudential Regulation Authority (APRA) shows that, for the year ending 30 June 2016, at least \$8.2 billion in net policy payments were made by life insurers.
- 3 For consumers, the intrinsic value of an insurance product is in the ability to make a successful claim when an insured event occurs. Not being able to successfully claim on life insurance in these circumstances can be financially devastating for the consumer and/or their family.
- 4 In ASIC's view, good claims handling for insurance:
  - (a) is efficient, fair, reasonable and transparent;
  - (b) is based on the sale of products that are up to date and meet consumer needs, and products that are promoted in a way that facilitates consumer understanding of what is covered and what is not; and
  - (c) builds in feedback from consumer disputes into both claims handling processes and product design and promotion.
- 5 This review examined claims handling practices and claims outcomes in the life insurance sector. We sought to identify whether there were systemic issues across the industry, as well as more specific issues relating to particular products or insurers.
- 6 We also sought to identify whether data or industry indicators suggest the need for additional, more targeted reviews to better understand industry and consumer outcomes. As part of this work, we examined the incidences and extent of claims being declined, including whether claims are being improperly or unfairly declined.
- 7 We also required life insurers to undertake reviews of their claims handling systems with independent oversight, to identify whether there are any issues that they need to address in relation to declined claims and claims handling procedures. Several insurers had already commenced such reviews and, as appropriate, expanded the scope of their reviews to take into account ASIC's expectations (including a risk-based review of declined or withdrawn claims, going back at least five years).
- 8 These reviews are important, because they provide the industry with an opportunity to identify potential areas of concern and to take quick action in response. We will provide further reporting on these reviews when they become available, and the results will also inform our further work.

## Scope of our review

- 9 The four main types of life insurance products examined in this report are life (i.e. cover for death), total and permanent disability (TPD), trauma, and income protection.

Note: We did not examine investment-linked life insurance or other products issued by life insurers such as funeral insurance and consumer credit insurance. ASIC has examined funeral insurance and consumer credit insurance separately.

- 10 It is important to recognise that life insurance products are not standard, and there are key differences between insurers in products and also differences depending on the distribution channel. This means that even where the insurance is issued by the same insurer, there can be differences in insurance cover obtained through a superannuation policy (group), through an adviser (retail) or directly through the insurer or a third party without any personal advice (non-advised—sometimes called direct): see paragraph 72.
- 11 One important distinction between group life insurance and insurance sold outside of superannuation (i.e. retail and non-advised) is that both retail and non-advised life insurance are sold as *guaranteed renewable* products. This means that the life insurer must continue to maintain the life insurance product for as long as the policyholder pays their premiums. The law also prevents life insurers from changing the terms and definitions of a guaranteed renewable life insurance policy without the consent of the policyholder.
- 12 This is an important protection for policyholders, but it also contributes to a structural issue within the life insurance industry relating to legacy products. It is why policyholders may find themselves with policies that contain out-of-date medical definitions. However, this can work out favourably or unfavourably for the policyholder, depending on their circumstances.
- 13 Further, an insurance policy is priced according to the risks that it covers. Policies that cover more risks, or provide more generous cover for risks, will generally be more expensive than policies that cover fewer or narrower risks. The potential risks to be covered are complex and often defined very specifically.
- 14 For the purposes of our review, it was not relevant to explore the nature of these differences; however, these differences should be kept in mind when interpreting the information and data throughout this report.
- 15 Additionally, it is important to acknowledge that not all claims will be successful. The benefits available to a policyholder will be defined by the terms of the insurance contract, which sets the limit of the insurer's liability. Even though they may not be entitled to payment for a loss not covered by the contract, policyholders can (and do) lodge claims in these circumstances.

- 16 If a claim is declined because the condition is not covered by the policy, we think a critical distinction arises between claims for:
- (a) conditions that could not reasonably be expected to be covered under the policy; and
  - (b) conditions that the policyholder could reasonably expect to be covered.
- 17 There will also be a small number of fraudulent claims and it is important for insurers to have in place appropriate fraud risk management systems.

## Key findings

- 18 Our review did not find evidence of cross-industry misconduct across the life insurance sector in relation to life insurance claims payments and procedures. Overall, where a decision has been made, 90% of claims are paid in the first instance. For death claims where a decision has been made, on average 96% of claims are paid.
- 19 However, we did identify issues of concern in relation to declined claim rates and claims handling procedures associated with:
- (a) particular types of policies, notably TPD;
  - (b) particular insurers (typically for particular policy types); and
  - (c) particular causes for consumer disputes.
- 20 These concerns will be the subject of ASIC's further action on life insurance: see paragraphs 45–54 and Section E.
- 21 Although the considerable majority of claims are paid, we are concerned that in some cases, claims are being declined on technical or contractual grounds that are not in accordance with the 'spirit' or 'intent' of the policy.
- 22 We identified that fairness should be given greater consideration by insurers. Not all insurance claims will be successful, but an issue arises when a policyholder's reasonable expectations about policy coverage do not align with the technical wording in the policy.
- 23 On this point, a key challenge for the life insurance sector is how to deal with that small number of claims that may not technically be covered under the 'fine print', but under any reasonable consumer or community expectation should be paid. We found that ex-gratia (i.e. goodwill) payments were inconsistently applied across the sector.
- 24 Poor and/or inconsistent management of these relatively small numbers of claims can lead to very poor outcomes for consumers and significant reputational damage for insurers. This issue highlights the importance of an

insurer's 'claims philosophy' and how that philosophy aligns with the need to put policyholders first.

- 25 We have also obtained from insurers the preliminary results of their independent reviews. Most of these reviews are still underway, but indications that insurers have provided to date are that they have not identified significant concerns with claims decisions. If we identify concerns with an insurer as part of our follow up work, the fact that an insurer failed to identify these concerns despite conducting an independent review will be a significant consideration in determining the regulatory action that we take.

## Products

- 26 For the products we reviewed, declined claim rates were highest for TPD (average declined claim rate of 16%) and trauma cover (average declined claim rate of 14%). They were lowest for life cover (average declined claim rate of 4%) and income protection cover (average declined claim rate of 7%).

Note: ASIC is the source of all data in this report, unless otherwise specified. All ranges for claim outcome rates (e.g. maximum, minimum) disregard rates for insurers below certain thresholds (e.g. those with total claims during 2013–15 less than average minus one standard deviation or 20 total claims). Thresholds vary depending on circumstances.

- 27 Care should be taken when making comparisons (including with other jurisdictions) from the data provided in this review and further work is required so that more reliable comparisons can be made: see paragraphs 43–54. However, we note that the declined claim rates for life insurance in the United Kingdom are broadly similar to the data contained in this report, except for TPD where decline rates are higher in the United Kingdom (35.9%).

Note: See Association of British Insurers, [‘Protection insurers help more families than ever before with 350 payouts every day’](#), 17 August 2015.

## Distribution channels

- 28 Declined claim rates were higher for non-advised policies, compared with group and retail policies. The average declined claim rates in the retail and group channels were lower than for non-advised sales (7% and 8% compared to 12%).

## Insurers

- 29 As a proportion of their share of claims, some insurers declined more claims than others. A small number of insurers had substantially higher declined claim rates in one or both of the following categories:
- (a) for certain types of covers, particularly TPD (three insurers had 37%, 25% and 24%, compared to an industry average of 16%) and trauma

(three insurers had 31%, 25% and 21%, compared to an industry average of 14%); and

- (b) for certain types of distribution channels, particularly non-advised (three insurers had 29%, 22% and 20%, compared to an industry average of 12%) and group (two insurers had 23% and 18%, compared to an industry average of 8%, with all other insurers having 10% or less).

- 30 Across the insurers we reviewed, the overall declined claim rate was approximately 9%. However, there was often wide variation between insurers across different products, with some insurers having significantly higher than average declined claim rates for some products. Some insurers had significantly lower than average rates for other products.
- 31 For TPD cover in particular, there was a wide variation between insurers with declined claim rates of between 37% and 7%. This significant variation suggests that for those insurers with markedly higher rates of declined claims for particular products, further work needs to be done to review whether some claims are not being paid in some circumstances where they should be.
- 32 The Productivity Commission has considered loss ratios in life insurance: see Productivity Commission, [\*How to assess the competitiveness and efficiency of the superannuation system\*](#) (PDF 2.64 MB), August 2016, pp. 150–151. Their draft report notes Mercer’s submission that over the longer term the loss ratio is typically around 85% for life and TPD cover, and 80% for income protection cover. However, the report recognises limitations with this indicator which need to be taken into account when interpreting results.
- 33 For example, measures in any one year are of little interpretive value, as year-to-year measures will depend significantly on the pricing cycle, the timing of significant events, and time lags between when claims are made and premiums paid out. It may also be difficult to get consistent data and data may not be comparable across members and funds.

## Disputes

- 34 Not surprisingly, the dispute data from our review indicated that most disputes arise at the time of a claim. This is when a policyholder is likely to become aware of limitations with their policy, including a misalignment between what they understood the policy to cover and its actual cover.

Note 1: ‘Dispute data’ is defined in this report to mean data on complaints about life insurance policies in the period 1 January 2013 up to the end of March 2016 based on reports of misconduct lodged with ASIC, and complaints made by policyholders to the following external dispute resolution (EDR) schemes or consumer advocacy groups and provided to ASIC for the purpose of this review: Financial Rights Legal Centre Inc., Legal Aid NSW, Public Interest Advocacy Centre Ltd, Financial Service Ombudsman Limited (FOS) and the Superannuation Complaints Tribunal (SCT).



Note 2: As consumers may raise their dispute with any one or more of the above organisations, dispute data from these organisations may overlap.

- 35 Of all life insurance disputes, 72% were claims-related: see Figure 18. From our analysis, there is a 2% likelihood that the average claim will result in a dispute dealt with through the insurer's internal dispute resolution (IDR) process and a 0.9% chance that it will result in a dispute lodged with either FOS or the SCT: see paragraph 173.
- 36 Of the claims-related disputes we looked at (see Figure 19), most disputes related to the evidence the policyholder was required to provide to the insurer to assess their claim (which can also lead to a declined claim) (25%), the timeframes taken by an insurer to assess a claim (22%) and the fact of the declined claim itself (including disputes over policy definitions) (12%). The dispute data also showed that a substantially higher than average number of disputes about evidence, delay and policy definitions involved a small number of insurers.
- 37 Our review found that while out-of-date medical definitions do exist in life insurance policies, they cause only a small proportion of the disputes that arise in life insurance claims.
- 38 The case studies we reviewed provided examples of some situations where claims were not paid and/or there were procedural issues with claims assessments (e.g. the degree of evidence required by insurers in assessing a claim). Although these case studies are not typical of general experience, they help to highlight the areas where industry practice could be improved, in terms of both claims outcomes and procedural issues. They also highlight that FOS, the SCT and consumer legal services play an important role in intervening in and, in the case of FOS and the SCT, reviewing claims decisions.

## **Sales practices**

- 39 Of all disputes, 3% specifically involved sales practices, with other disputes involving eligibility (5%) and pre-existing conditions (3%), both of which are closely related to sales practices in that they are likely to involve representations made to policyholders at the point of sale that do not align with the claims outcome. This usually only becomes apparent when a claim is declined.

## **Claims procedures**

- 40 As well as finding that most life insurance disputes are about claims procedures, we also found that claims procedures can be complicated for consumers and can lead to adverse outcomes.

- 41 We found that deficiencies in claims procedures are adversely affecting policyholders' experiences and claims outcomes, particularly the evidence required to assess a claim and delays in claims decisions and payments.
- 42 We identified that there is scope to raise standards and improve consistency. Improvements to claims handling procedures so that they are less complicated for consumers could improve both consumer outcomes and consumer understanding of insurance, and help to build trust and confidence in the industry.

### Claims data: Limitations

- 43 A key observation from ASIC's review is that there is clear need for better quality, more consistent and more transparent data about insurance claims. Current data limitations mean that:
- (a) it is difficult to compare and assess declined claim rates and other key measures of claims performance across insurers;
  - (b) it is more difficult for insurers, including boards and senior management, to assess the performance of their own claims handling and claims outcomes; and
  - (c) it is very difficult for consumers and other stakeholders to assess the claims outcomes and performance of the life insurance sector, including trends over time, undermining insurer accountability and consumer trust.
- 44 As far as we are aware, this is the first time that this type of data has been collected. Many insurers found it challenging to provide the data requested by us in the review. Life insurers will have to continue to invest in their systems to be able to provide robust and granular data. This data will then be more useful in identifying trends and issues within a product, an insurer or the industry as a whole. Quality data will provide management with important insights into portfolio experience, and the ability to enhance claims handling procedures.

#### UK publication of claims rates

In the United Kingdom, the Association of British Insurers publishes claims payout rates annually. This has required standardisation of definitions and aims to improve transparency for consumers.

## Proposals to improve claims handling and consumer outcomes

- 45 As a result of this review, we have set out a number of key areas of action for ASIC and insurers, with a view to improving claims handling outcomes for consumers:
- (a) establishing, with APRA, a new public reporting regime for life insurance industry claims data and claims outcomes;

- (b) recommending to Government the strengthening of the legal framework covering claims handling;
- (c) recommending the consumer dispute resolution framework for claims handling be strengthened;
- (d) undertaking targeted follow-up ASIC reviews on areas of concern, including for individual insurers with high decline and dispute rates, as well as a new major review of life insurance sold directly to consumers without personal advice; and
- (e) strengthening industry standards and practices, including through extension and enhancement of the new Life Insurance Code of Practice (Code).

### **Public reporting of life insurance claims**

- 46 To improve public trust, there is a clear need for better quality, more transparent and more consistent data on life insurance claims. Our review found that data limitations, including inconsistent policy definitions across insurers, mean that care must be taken with current comparisons and follow-up work will be required to better understand the claims performance of particular insurers or policies.
- 47 ASIC and APRA will work with insurers and other stakeholders during 2017 to establish a consistent public reporting regime for claims data and claims outcomes, including claims handling timeframes and dispute levels across all policy types. Data will be made available on an industry and individual insurer basis.

### **Strengthening the regulatory framework for claims handling**

- 48 Currently ‘handling insurance claims’ is explicitly exempted from the conduct provisions of the Corporations legislation. ASIC is recommending that this exemption be removed by the Government and that more significant penalties for misconduct in relation to insurance claims handling are also included in the review of ASIC’s penalty powers.

### **Strengthening the dispute resolution framework for claims handling**

- 49 ASIC is recommending that the coverage of life insurance claims by dispute resolution schemes should be considered as part of the current inquiry into external dispute resolution (EDR) schemes (Ramsay Review). In particular, in paragraphs 55–68 we have highlighted the need to:
- (a) ensure better and more effective consideration of issues of fairness to supplement the existing jurisdiction; and

- (b) give better access to consumers with complaints about delays in claims handling and ensure better remedies when these complaints are found in favour of the consumer.

### **Follow up ASIC surveillances and reviews**

- 50 ASIC will target the areas of concern we have identified from our review, applying targeted surveillances of particular insurers that have the highest decline rates and highest proportional dispute numbers, and examining TPD claims procedures and timeframes.
- 51 We will also conduct a major review of the life insurance sold without personal advice (also known as 'direct' life insurance).

### **Strengthening industry standards and practices**

- 52 ASIC has made a number of recommendations for the insurance sector to undertake, including to:
  - (a) immediately review the currency and appropriateness of policy definitions;
  - (b) examine and ensure advertising and representations about the cover align with the definitions and the policy, and report any discrepancies to ASIC;
  - (c) ensure that claims timeframes are consistent with industry standards and expected claims timeframes are adequately communicated to policyholders; and
  - (d) ensure that incentives and performance measurements for claims handling staff and management do not conflict with the obligation to assess each claim on its merit.
- 53 These recommended responses should supplement the development of and compliance with the new Code, to improve claims handling standards. As part of the ongoing development of the Code, we note that industry could consider seeking approval of the Code under ASIC's [Regulatory Guide 183 Approval of financial services sector codes of conduct](#) (RG 183), as a signal to consumers that this is a code they can have confidence in.
- 54 As noted earlier, in parallel with our review, life insurers have initiated independent reviews of their claims handling processes to identify whether there are any issues that to be addressed in relation to declined claims and claims handling practices and procedures. Most of these reviews are still underway. The results from these reviews will also inform any further work.

## ASIC's regulatory coverage of life insurance claims

- 55 Assessing conduct around claims handling in the insurance industry requires consideration of how claims handling is covered under the various laws administered by ASIC. In particular, there are significant limitations in relation to the financial services laws that apply to claims handling.
- 56 As a result, we have identified some areas for reform, most of which can be considered as part of existing policy processes: see Section E.
- 57 'Handling insurance claims' is explicitly excluded from the definition of a financial service in the Corporations Regulations 2001 (Corporations Regulations), and is therefore outside the scope of the *Corporations Act 2001* (Corporations Act).
- 58 Claims handling matters outside the scope of the Corporations Act include:
- (a) negotiations on settlement amounts;
  - (b) interpretation of relevant policy provisions;
  - (c) estimates of loss or damage and value or appropriate repair;
  - (d) recommendations on mitigation of loss and increases in limits or different cover options to protect against the same loss in the future; and
  - (e) claims strategy (e.g. the making of claims under an alternative policy).

### Effect of the claims handling exclusion: Examples

This exclusion restricts ASIC's ability to take action for conduct such as:

- incentives for claims handling staff and management, including whether they are in conflict with the insurer's obligation to assess each claim on its merit;
- surveillance practices by investigators, particularly for mental health claims; and
- unnecessary or extensive delays in handling claims.

- 59 While ASIC's licensing powers are available when there is a breach of the duty of utmost good faith, we would only typically use our broad licensing powers against an insurer when there is serious and systemic misconduct. For other types of misconduct, our other sanctions (e.g. penalties) are not available for breaches of the duty of utmost good faith: see paragraphs 139–148 for a further explanation of these issues.
- 60 We have also identified that there is scope for introducing and/or increasing appropriate penalties for relevant breaches of the law. In some cases, penalties that apply to other sectors do not exist for life insurance (e.g. penalties for directors of managed investment schemes). This could be considered in the review of ASIC's enforcement regime (including penalties

and breach notifications under the financial services licensing framework) announced by the Government following the Financial System Inquiry (FSI).

#### Key obligations of insurers and policyholders

Insurers and policyholders have significant reciprocal obligations under the *Insurance Contracts Act 1984* (Insurance Contracts Act), which are founded on principles of, among other things, honesty and fair dealing.

The duty of utmost good faith is an implied term in insurance contracts that requires each party to act towards the other party with the utmost good faith.

Disclosure obligations also apply to policyholders (to inform the insurer of all matters known to them, or that they could reasonably be expected to know, that would be relevant to the insurer's decision about whether to insure them and, if so, the terms on which this is done) and insurers (to clearly inform policyholders in writing of their duty of disclosure).

## Dispute resolution and ASIC's role

- 61 ASIC is Australia's corporate, markets, financial services and consumer credit regulator. Part of our role is to ensure that Australian financial services (AFS) licensees, including life insurers, comply with the financial services laws.
- 62 One general obligation is for AFS licensees to have in place adequate dispute resolution systems, which includes:
  - (a) internal dispute resolution (IDR) procedures that comply with standards and requirements made or approved by ASIC; and
  - (b) membership of an external dispute resolution (EDR) scheme, such as the Financial Ombudsman Service (FOS), that is approved by ASIC.
- 63 Consumers must first try to resolve their dispute through the IDR scheme; if they are still unhappy, they can then take their dispute to the EDR scheme.
- 64 EDR schemes like FOS play a vital role in the broader financial services regulatory system by providing a forum for consumers to resolve complaints that is quicker and cheaper than the formal legal system, while creating an opportunity to improve industry standards of conduct and relationships between participants and consumers.
- 65 The Superannuation Complaints Tribunal (SCT) is also available to deal with disputes from members about superannuation trustees and group policy life insurers. The SCT is not an EDR scheme as defined by the Corporations Act; rather, it has been established as a statutory tribunal.
- 66 Taking regulatory action for individual disputes may not be an effective way to deal with systemic issues, and in many circumstances, schemes like FOS

may be best placed to pursue resolve these disputes so that ASIC can pursue underlying systemic risks.

- 67 The reduction of systemic risks is one objective of the Corporations Act, which ASIC regulates: see s760A. As such, we generally refer individual disputes to the appropriate EDR scheme (e.g. FOS). This applies not only to life insurance disputes but to disputes in other sectors of the financial services industry.
- 68 To ensure that ASIC is aware of any systemic risks that may arise within EDR schemes, these schemes must report systemic issues to ASIC. The SCT has a statutory breach reporting responsibility to ASIC under which it is required to report any breaches to us that it identifies in carrying out its role.

## What we did in this review

- 69 Our review covered 15 insurers, selected on the basis of market share and diversity: see Table 1. Together these insurers cover over 90% of the market by premiums collected.

**Table 1: Insurers covered in ASIC's review**

Company	Company
<ul style="list-style-type: none"> <li>• AIA Australia Limited</li> <li>• Allianz Australia Life Insurance Limited</li> <li>• AMP Life Limited</li> <li>• Clearview Life Assurance Limited</li> <li>• Colonial Mutual Life Assurance Society Limited</li> <li>• Hannover Life Re of Australasia Ltd</li> <li>• Macquarie Life Limited</li> <li>• Metlife Insurance Ltd</li> </ul>	<ul style="list-style-type: none"> <li>• MLC Limited</li> <li>• OnePath Life Limited</li> <li>• St Andrew's Life Insurance Pty Ltd</li> <li>• Suncorp Life &amp; Superannuation Limited</li> <li>• TAL Life Limited</li> <li>• Westpac Life Insurance Services Limited</li> <li>• Zurich Australia Limited</li> </ul>

- 70 We have not identified the insurers in our findings in this report. The purpose of our review has been to inform us about industry trends and the insurers and/or policy types we need to target for further work. As such, conclusions cannot be drawn from the rates and incidences of declined claims alone and/or dispute summaries, as this does not provide enough information about the processes and reasons for the claims being declined.
- 71 For our initial review, we focused on the following six areas, covering the three-year period from 1 January 2013 to 31 December 2015:
- analysis of rates of claims accepted, withdrawn and declined;
  - analysis of data relating to disputes about life insurance claims to identify the main reasons for disputes, particularly for declined claims (referred to in this report as 'dispute data': see paragraphs 88–92);

- (c) assessment of policy definitions to examine any potential concerns about appropriateness, currency and consistency;
- (d) assessment of industry claims handling procedures to examine consistency and any potential areas of deficiency;
- (e) review of the overall claims handling systems of insurers, including staffing structures and resources; and
- (f) review of sales practices as they relate to claims outcomes.

72 We assessed claims outcomes and trends by distribution channel for the three main channels:

- (a) *group cover* made available to members of superannuation funds, employees and members of master trusts (group policies);
- (b) *individual cover* sold by financial advisers (retail policies); and
- (c) *individual cover* sold directly by insurers or third parties (e.g. through a call centre or online) without advice (non-advised policies).

Note: 'Non-advised' includes where general advice or factual information was provided to the policyholder at the point of sale. It does not include sales with personal advice.

73 We reviewed data and information provided by the 15 insurers, and supplemented this with a targeted review of PDSs and policy documents prepared for consumers, with a focus on policy definitions, to compare their scope and how they are interpreted by insurers during the claims process.

74 The dispute data we analysed included:

- (a) complaints to FOS and the SCT;
- (b) complaints to consumer advocacy groups and legal services; and
- (c) reports of misconduct lodged with ASIC.

75 While the focus of our review was on claims-related disputes, we also identified and reviewed other areas of disputes such as those relating to sales practices.

76 We also looked at whether:

- (a) claims handling procedures were fair, reasonable and understandable to policyholders; and
- (b) sales practices may have contributed to a mismatch between policyholders' reasonable expectations about policy coverage and the actual cover they hold.



## **Independent reviews**

- 77 In April 2016, we wrote to the 15 insurers selected for our review to ask each of them to conduct an independent review to examine:
- (a) the integrity of their claims handling systems, including policies and procedures, remuneration practices for claims handling, and key performance indicators;
  - (b) product design processes, including current policy definitions;
  - (c) declined or withdrawn claims going back at least five years, to ensure that policyholders had not been inappropriately denied claims; and
  - (d) whether there was an appropriate mechanism for FOS or the SCT to review denied claims for any unresolved disputes.
- 78 All of the insurers we contacted as part of this review agreed to undertake independent reviews of their claims and procedures.

Table 2: Summary of issues, key findings, and further work

Issue	Findings	Further work
<b>1. Declined claim rates</b>	<p>Significant variations in declined claim rates suggest that some insurers (those with lower decline rates) may have better claims practices than others.</p> <p>Specifically, these variations in declined claims are:</p> <ul style="list-style-type: none"> <li>• by insurer (3% to 16% across all products);</li> <li>• by product: <ul style="list-style-type: none"> <li>– TPD, average 16% (range 7% to 37%);</li> <li>– trauma, average 14% (range 6% to 31%);</li> <li>– income protection, average 7% (range 3% to 16%); and</li> <li>– life, average 4% (range 1% to 13%); and</li> </ul> </li> <li>• by distribution channel: <ul style="list-style-type: none"> <li>– non-advised, average 12% (range 4% to 29%);</li> <li>– group, average 8% (range 7% to 23%); and</li> <li>– retail, average 7% (range 2% to 11%).</li> </ul> </li> </ul> <p>We also identified some substantial variations across insurers in withdrawn claim rates.</p>	<p>ASIC will:</p> <ul style="list-style-type: none"> <li>• undertake targeted surveillance work to examine the reasons for substantially higher than average decline rates and withdrawn claim rates for particular insurers, and consider regulatory options where these reasons cannot be justified (Stage 2, commencing now);</li> <li>• work with APRA, the insurance industry and stakeholders to establish a consistent public reporting regime for claims data and claims outcomes, including claims handling timeframes and dispute levels across all policy types; it is expected that data will be made available on an industry and individual insurer bases. This will help ASIC and APRA to monitor claims trends and identify any potential issues of concern from changes in data (Stage 2, commencing now); and</li> <li>• undertake further reviews across the industry on TPD claims files and systems, focusing on claims procedural issues (such as timeframes and evidence) and also any additional findings from our targeted work in Stage 2 (Stage 3, commencing mid-2017).</li> </ul>
<b>2. Reasons for declined claims</b>	<p>Most (72%) of the areas of concern for policyholders are claims related (excluding unspecified issues).</p> <p>The dispute data revealed that:</p> <ul style="list-style-type: none"> <li>• there is a correlation between dispute rates and declined claim rates;</li> <li>• two insurers had a level of disputes substantially disproportionate to their share of claims; and</li> <li>• disputes about mental health account for 6.4% of all disputes, with the top three claims issues being evidence, non-disclosure and delay (the first two issues were double the rate for mental health claims compared to all claims).</li> </ul> <p>Note: The top 10 claims-related issues were evidence (including evidence to support claims and claims surveillance), delay, claim underpaid, application of policy definitions (including pre-existing condition definition and TPD definition), eligibility to claim, non-disclosure, general denial of claim, limitation periods, claim overpaid, and reasons not provided for claims denial: see Figure 20.</p>	<p>ASIC will undertake targeted surveillance work to examine the reasons for substantially higher numbers of disputes for particular insurers than their share of claims, focusing on the areas of evidence and delay which had the highest numbers of disputes (part of Stage 2, commencing now).</p>

Issue	Findings	Further work
<b>3. Policy definitions</b>	<p>Policy definitions vary between insurers; while some variations are subtle, others are significant, which is likely to cause confusion and may not allow for simple comparisons by consumers.</p> <p>Because insurance is priced according to risk, less expensive policies will tend to have more stringent policy terms (e.g. only providing coverage for severe medical conditions). Policy definitions can also become out of date (however, this mainly arises in relation to trauma cover which is only offered in the retail and non-advised channels).</p> <p>Sometimes, consumers may purchase a policy that has out-of-date definitions at the point of sale. The sale of life insurance policies with such definitions is not a breach of the law on its own. However, it is poor practice and increases the risk of breaching the Australian Consumer Law.</p> <p>Consumers are more likely to find themselves with a policy that contains out-of-date definitions some years after the policy is initially obtained. Insurers may be limited in their ability to update definitions depending on the effect of the update on the consumer's cover. This 'legacy policies' issue is complex and was subject to commentary in the final FSI report in 2015.</p> <p>The dispute data indicates that:</p> <ul style="list-style-type: none"> <li>disputes about policy definitions (9% of all disputes) are less common than disputes about claims procedures (e.g. evidence and delay);</li> <li>over 50% of all disputes about policy definitions are about TPD and pre-existing conditions, with the rest (each 10% or less in the 2013–15 period) about specific conditions such as cancer, heart attack and stroke;</li> <li>some policy definitions may be out of date or not comprehensive enough to cover every scenario, meaning insurers either decline claims or pay claims on an ex-gratia or goodwill basis;</li> <li>changed or updated policy definitions generally do not apply to existing older policies; and</li> <li>medical advancements have led to defined events potentially no longer being traumatic, meaning that policyholders may receive payment despite sustaining minimal or no loss or impact.</li> </ul>	<p>We expect insurers to:</p> <ul style="list-style-type: none"> <li>review the currency and appropriateness of policy definitions, immediately and then every three years pursuant to the Code; and examine advertising and representations that they make about the scope of cover to ensure that the messages are aligned with the definitions and cover provided, and report any discrepancies to us.</li> </ul> <p>ASIC will conduct a follow-up review of the currency and appropriateness of policy definitions, after insurers' first three-yearly review stipulated in the Code (Stage 4, late 2019). We will consider options (including the need for law reform) if there are still concerns about the currency and appropriateness of policy definitions.</p>

Issue	Findings	Further work
<b>4. Claims procedures</b>	<p>Insurers' claims procedures generally require significant amounts of information and supporting evidence to make an assessment of the claim.</p> <p>Our review indicated that:</p> <ul style="list-style-type: none"> <li>the amount of evidence sought is a major source of dispute between insurers and policyholders, and there is a tension between insurers seeking relevant information and policyholders' perceptions that insurers may be delaying the payment of claims;</li> <li>fraud risk management by insurers is necessary and appropriate, but insurers need to be able to justify their file selections and the methods engaged in on a case-by-case basis, and ensure that investigators' actions meet appropriate conduct standards; and</li> <li>the timeframes for claims assessments contain numerous steps and factors, and are generally long.</li> </ul>	<p>We expect insurers to:</p> <ul style="list-style-type: none"> <li>develop consistent industry standards for claims timeframes which align with the conduct of a fair and reasonable insurer and ensure claims timeframes are consistent with these standards;</li> <li>consider the scope of the definition of 'unexpected circumstances' in the Code and how its use will be monitored and reported;</li> <li>ensure that expected claims timeframes are adequately communicated to policyholders;</li> <li>consider whether their processes adequately justify fraud risk mitigation (including surveillance, particularly for mental health claims) and include monitoring the conduct of fraud risk investigators; and</li> <li>require fraud risk investigators to follow consistent industry standards which set out fair and reasonable standards of conduct</li> </ul>
<b>5. Claims staff and systems</b>	<p>Insurers' systems vary significantly, including the ability to generate automated reports on requested data</p> <p>Other issues we identified are:</p> <ul style="list-style-type: none"> <li>insurers have faced difficulties in training and retaining skilled claims staff;</li> <li>while insurers are investing in both systems and people, this investment may need to be increased by some insurers to meet the future needs of customers, assurance, data reporting and timeframes; and</li> <li>some insurers have included incentives and performance measurements for claims handling staff and management that are in apparent conflict with their obligation to assess each claim on its merit.</li> </ul>	<p>ASIC will work with APRA, the insurance industry and stakeholders to establish a consistent public reporting regime for claims data and claims outcomes, including claims handling timeframes and dispute levels across all policy types. It is expected that data will be made available on an industry and individual insurer basis. This will help ASIC and APRA to monitor claims trends on an ongoing basis and identify any potential issues of concern from changes in data (Stage 2, commencing now).</p> <p>We expect insurers to:</p> <ul style="list-style-type: none"> <li>invest in systems and staff to meet future needs; and</li> <li>ensure that incentives and performance measurements for claims handling staff and their management are not in conflict with their obligation to assess each claim on its merit.</li> </ul>

Issue	Findings	Further work
<b>6. Sales practices and eligibility</b>	<p>Disputes about claims (particularly the ineligibility to claim) may indicate problematic sales practices for life insurance policies.</p> <p>We found that based on the case studies we reviewed, policyholders may purchase a policy without understanding the extent or limits of coverage at the point of sale, or may have been misled about coverage, and in some cases, policyholders may be unaware that they have even purchased the policy.</p>	<p>ASIC will conduct a thematic industry review of life insurance sales practices, focusing on sales of non-advised policies, and take enforcement action where necessary (Stage 2, commencing between now and January 2017).</p> <p>In advance of our review, we expect insurers to:</p> <ul style="list-style-type: none"> <li>• consider ASIC's previous work on sales practices in other areas and apply these principles to life insurance sales where appropriate; and</li> <li>• ensure that policy documents provided to policyholders (e.g. PDSs, application forms and claim forms) are clear and understandable.</li> </ul>

## A Background and methodology of our review

### Key points

In April 2016, we commenced an industry-wide review of life insurance claims handling practices to determine if there were any systemic concerns that apply either to the industry as a whole or to particular insurers or types of insurance policies. We also sought to determine whether there are indicators of potential risks or problems that warrant further, more focused examination.

In our review, we focused on life insurance claims by policyholders. This included:

- assessing the outcome of claims and claims procedures;
- reviewing data from 15 insurers about policies, claims and claims-related disputes, as well as information about claims procedures, including internal reports on claims and the insurer's financial condition; and
- analysing data on claims-related disputes from information received by EDR schemes and consumer and legal advocacy services, and reports of misconduct lodged with ASIC.

This work accompanied an ASIC investigation into specific allegations raised in the media about the life insurance claims handling practices of a particular insurer.

## Background to our review

### Purpose of our review

79 The purpose of our review has been to identify any concerns with claims handling practices across the life insurance industry and determine what further steps may be appropriate.

80 In conducting this review, we want to ensure that:

- (a) there is better alignment between policyholders' expectations about the cover offered, and the circumstances in which they can claim; and
- (b) insurers do not adopt unfair practices when assessing claims.

Note: In this context, 'policyholder' means either the person who holds the life insurance policy (also known as the 'insured') or a superannuation fund member (under a group life insurance policy) even though the policy is held by the trustee.

81 Our review specifically focused on claims handling practices of insurers to identify:

- (a) systemic issues across the industry that require further scrutiny (e.g. policy definitions and their interpretation, timeliness of claims handling, evidence required for claims, and reasons for declined claims); and
- (b) particular insurers' practices and business models that require further scrutiny.

82 The next stages of our work will target the areas of concern and specific insurers we have identified, involve taking regulatory action where appropriate, and help improve the value and usefulness of life insurance products for consumers.

### **Concerns raised in the media**

83 In March 2016, the ABC Four Corners program and Fairfax Media publications jointly reported on a number of concerns about the life insurance claims handling practices of The Colonial Mutual Life Assurance Society Limited (trading as CommInsure).

84 These concerns included allegations relating to the following areas:

- (a) CommInsure's policy wording and definitions, including concerns about the currency of certain medical definitions used in their trauma policies (e.g. heart attack);
- (b) claims handling practices and procedures, including CommInsure's medical staff being pressured to change their opinions to delay or deny claims;
- (c) medical files and record keeping; and
- (d) the treatment of CommInsure's staff and governance.

85 Following the publication of these concerns, ASIC began a formal investigation into CommInsure. We will report separately on this matter.

86 In addition to our investigation of CommInsure, we initiated a review of claims handling practices across the life insurance industry (see paragraphs 99–102), which was designed to provide a more comprehensive review of the industry in addition to the targeted work we have already been doing on specific issues (particularly insurance in superannuation): see paragraphs 104–113.

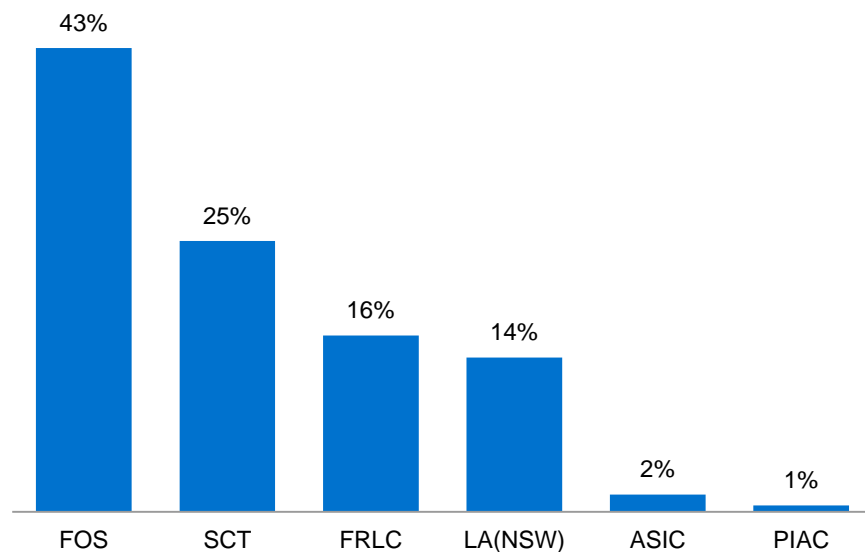
## Data reporting

- 87 Our review was based on a number of sources of information, including:
- (a) information obtained from reports of misconduct to ASIC;
  - (b) dispute data obtained from consumer advocacy groups and EDR schemes;
  - (c) information obtained from insurers under statutory notices issued by ASIC;
  - (d) preliminary findings obtained from insurers' independent reviews;
  - (e) information from our review of PDSs; and
  - (f) information from meetings and discussions with industry experts, insurers and other relevant stakeholders, including the Australian Prudential Regulation Authority (APRA), and data service providers.

### Dispute data

- 88 In the course of our review, we obtained, for the period from 1 January 2013 to end of March 2016:
- (a) data on individual disputes from:
    - (i) Financial Rights Legal Centre (FRLC);
    - (ii) Financial Ombudsman Service Limited (FOS);
    - (iii) Superannuation Complaints Tribunal (SCT); and
    - (iv) Public Interest Advocacy Centre (PIAC); and
  - (b) data on aggregated disputes from Legal Aid NSW (LA (NSW)).
- 89 This information comprised summaries of life insurance disputes lodged with or considered by each organisation irrespective of the outcome, including details of the dispute, type of cover (where known), and details of the insurer.
- 90 We also reviewed reports of misconduct and breach reports to ASIC relating to life insurance for the period 1 January 2013 to 14 March 2016.
- 91 In total, we reviewed 5,438 disputes.
- 92 Figure 1 summarises the proportion of disputes received from these various sources. Notably, reports of misconduct to ASIC form a very small proportion of these figures.



**Figure 1: Dispute data by source (2013–end March 2016)**

Note 1: See Table 10 in Appendix 2 for the complete data in this figure (accessible version).

Note 2: Data includes all disputes between 1 January 2013 and 29 March 2016, including for insurers outside the scope of our review. Due to rounding claims and dispute data, percentages may not always appear to add up to 100%.

Source: ASIC and external third parties

## PDS review

93 We also reviewed PDSs for 11 life insurance policies (six retail policies and five non-advised policies) and seven group life policies entered into by seven different superannuation trustees (issued by five life insurers).

94 In particular, we looked at the definitions identified in the dispute data and in public commentary as being potentially out of date—specifically, the definitions of:

- (a) heart attack;
- (b) severe rheumatoid arthritis;
- (c) multiple sclerosis;
- (d) stroke;
- (e) cancer—both general and specific.

95 We also reviewed the definitions for TPD and pre-existing medical conditions (typically used in non-advised policies).

96 We sought to identify the challenges that policyholders may face when trying to understand these policy definitions and in seeking to establish with the insurer that they have met the definition when making a claim.

## Information and data provided by insurers

- 97 We issued statutory notices to obtain information from 15 life insurers about their life insurance policies, as well as reports about their financial condition, claims experience and claims handling, including declined claims and related disputes.

Note: The financial condition report (FCR) must be prepared by the insurer's approved actuary and must provide an assessment of the key risks and issues affecting the financial condition of an insurer. This includes providing the insurer with implications of issues identified and, where these implications are adverse, proposing recommendations to address the issues: see APRA, [Prudential Standard LPS 320 Actuarial and related matters](#) (PDF 241 KB).

- 98 The 15 insurers we reviewed account for at least:
- (a) 94% of all the dispute data obtained; and
  - (b) 93% of the life insurance industry, based on total premiums received.

## Independent reviews by insurers

- 99 In addition to obtaining information from the 15 insurers, we requested that they initiate an independent review of their claims handling.
- 100 We requested that the independent reviews include the following broad elements:
- (a) an independent (third-party) reviewer with relevant experience in providing assurance;
  - (b) a review of the integrity of the insurers' claims handling systems, including policies and procedures, remuneration practices for claims handling, and key performance indicators;
  - (c) a review of product design processes, including the currency of policy definitions;
  - (d) a risk-based review of declined or withdrawn claims, going back at least five years, to ensure that policyholders had not been inappropriately declined claims; and
  - (e) an appropriate mechanism to have FOS (or the SCT) review denied claims for any unresolved disputes.

- 101 We will use the findings from these reviews to inform our further work.

## Other information

- 102 We met with all the insurers included in this review, and obtained further information in these meetings about their systems and processes (as well as discussing the independent reviews).
- 103 We have also had meetings and discussions with industry experts and other relevant stakeholders (including APRA), as well as data service providers.

## Other work on life insurance

### Review of retail life insurance advice

- 104 In October 2014, we released a report on a surveillance we undertook to understand the personal advice consumers were receiving about life insurance from financial advisers. In that report, we expressed concerns about practices in the life industry such as unacceptable levels of poor-quality advice and a strong correlation between high upfront commissions and poor consumer outcomes, including where the recommendation was to switch products: see [Report 413](#) *Review of retail life insurance advice* (REP 413).
- 105 In REP 413, we recommended that insurers:
- (a) address misaligned incentives in their distribution channels;
  - (b) address lapse rates on an industry-wide and insurer-by-insurer basis (e.g. by considering measures to encourage product retention); and
  - (c) review their remuneration arrangements to ensure that they support good quality outcomes for consumers and better manage the conflicts of interest within those arrangements.
- 106 We are now collecting policy replacement data from insurers to inform further surveillance work of particular insurers and/or advisers.

### Insurance in superannuation

- 107 We are undertaking the following work, which specifically considers issues associated with insurance in superannuation and may expand on some of the issues raised in this report:
- (a) *Member experience project*—This project focuses on points at which policyholders are most vulnerable in the superannuation system, particularly disengaged members. Many of these points involve issues with insurance (e.g. being covered by insurance and not being aware of it, eligibility for cover ceasing, or a misalignment between actual cover and what was understood).
  - (b) *Effective disclosure project*—This project reviews disclosures by superannuation fund trustees to fund members, including disclosures such as significant event notifications, PDSs, and written reasons for decisions about insurance claims, and involves aspects of disclosure to members about insurance.
  - (c) *Insurance in super project*—We are undertaking ongoing work in relation to complaints handling and disclosure, as well as aspects of culture, incentives and conflicts.
- 108 We intend to make public statements about our findings for both the member experience and effective disclosure projects later in 2016.

## Add-on insurance products

- 109 We have undertaken a comprehensive review of the sale of add-on insurance policies sold through car dealers, including life insurance components of consumer credit insurance (car yard life insurance). Car yard life insurance is typically designed to repay the outstanding balance of a consumer's car loan in the event of death or major trauma.
- 110 In February 2016, we released [Report 471](#) *The sale of life insurance through car dealers: Taking consumers for a ride* (REP 471). REP 471 highlighted poor claims outcomes with consumers receiving back only 6.6% or 6 cents in claims for every dollar paid in life insurance premiums.
- 111 In September 2016, we released a further report into the sale of add-on general insurance products sold through car dealers, including consumer credit insurance, guaranteed asset protection insurance, mechanical breakdown insurance, and tyre and rim insurance: see [Report 492](#) *A market that is failing consumers: The sale of add-on insurance through car dealers* (REP 492). REP 492 showed that these products represent poor claims outcomes with consumers receiving back only 9% or 9 cents in claims for every dollar paid in premiums.

## Indigenous Outreach Program

- 112 In October 2016, as part of a broader project focusing on Indigenous policyholders' experience with life insurance products, ASIC's Indigenous Outreach Program will be surveying financial counselling agencies that provide services to Indigenous policyholders.
- 113 Through this survey, we hope to better understand the issues that Indigenous policyholders experience when making life insurance claims. We will review the data we collect to determine what practical steps ASIC might take to help reduce these barriers.

## B Industry snapshot: The life insurance market

### Key points

The life insurance industry comprises 29 insurers, five of which only write reinsurance business, and 12 friendly societies. The largest five companies account for 69% of the market by in-force annual premiums for total risk business.

Most in-force policies are for individual risk lump sum products (e.g. life and TPD cover), followed by group policies (a combination of lump sum and income products such as income protection), and individual income protection products.

Across the industry, there has been a steady growth in in-force policies over the past five years, with group policies the largest area of growth.

Life insurers, financial advisers, insurance brokers, and superannuation fund trustees are subject to a range of statutory obligations, with both APRA and ASIC overseeing compliance with these obligations.

The life insurance industry is establishing a set of minimum standards through a Life Insurance Code of Conduct (Code). We expect the industry to consider the findings of this report in their ongoing enhancement of the Code with the goal of meeting the standards in RG 183.

## Overview of the market

114 The Australian life insurance industry comprises 29 life insurers, of which the five largest account for 69% of industry assets by in-force premium. The industry includes:

- (a) six medium-to-large life insurers, four of which are affiliated with the major banks;
- (b) 10 insurance risk specialists and reinsurers;
- (c) one annuity provider;
- (d) nine small or 'niche' life insurers;
- (e) two other diversified life insurers;
- (f) one 'captive' life insurer; and
- (g) 12 friendly societies.

Note 1: A 'captive' life insurance company is a form of corporate 'self-insurance' where the captive life insurer provides life insurance products for its parent company or for a group of related companies.

Note 2: Life insurers must be registered with APRA under the *Life Insurance Act 1995* (Life Insurance Act). There are 29 life insurers registered with APRA: see [Registered life insurance companies](#), last updated 13 July 2016.

Note 3: See DEXX&R, [Life analysis report](#), June 2016. See also APRA, [Life insurance institution-level statistics](#), December 2015, p. 21, 'List of life insurers as at the financial year ended in 12 months to December 2015'.

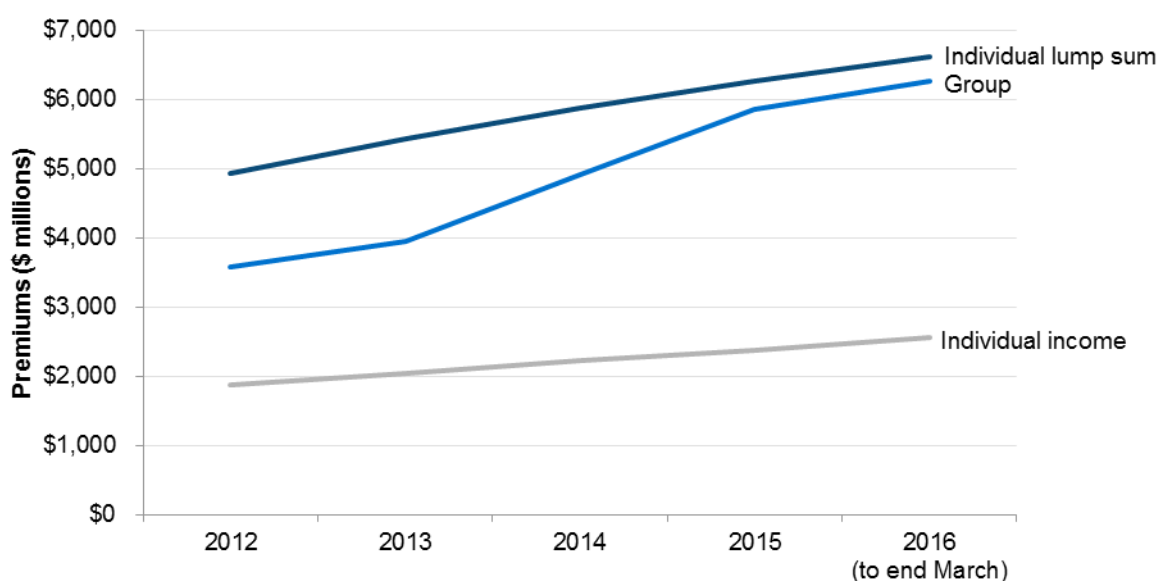
115 Across the industry, for individual and group risk products, the in-force annual premiums for the year ending June 2016 were approximately \$15 billion comprising:

- (a) \$6.51 billion for individual risk lump sum;
- (b) \$2.23 billion for individual risk income; and
- (c) \$6.11 billion for group risk.

Note: For the definitions of 'in-force annual premiums', 'individual risk lump sum', 'individual risk income' and 'group risk', see 'Key terms'.

116 This \$15 billion is an increase on \$14 billion for the previous year and indicates an annual growth rate of about 10%. The annual growth for in-force annual premiums for individual risk lump sum, individual risk income and group risk are shown in Figure 2.

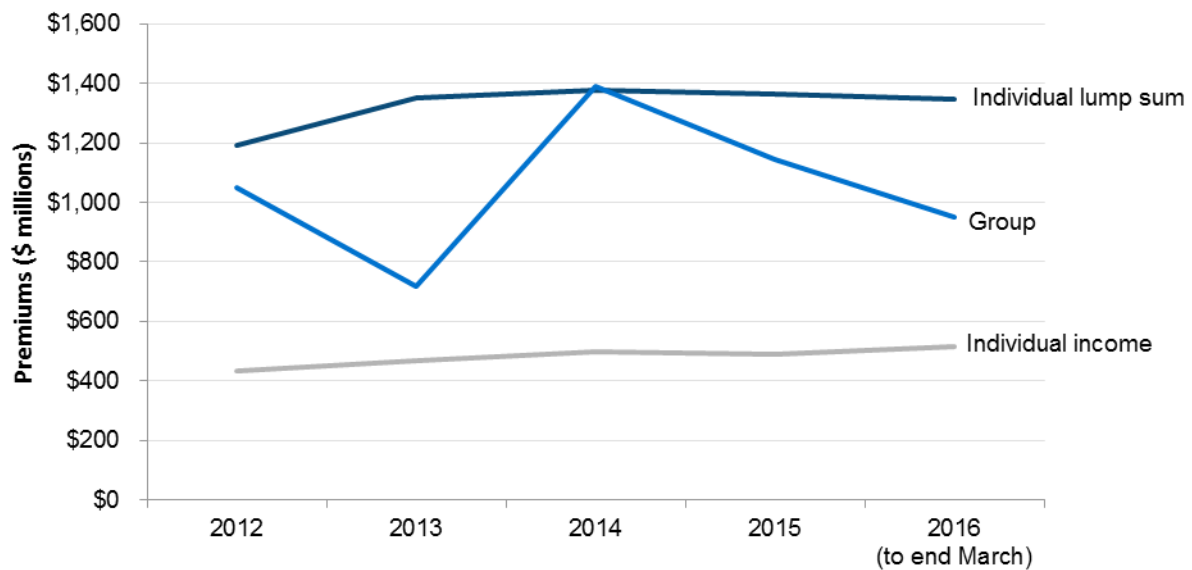
**Figure 2: In-force annual premiums for risk products (2012–end March 2016)**



Note: See Table 11 in Appendix 2 for the complete data in this figure (accessible version).

Source: Plan for Life, March 2016

117 Over the last five years, new annual premiums for risk products have fluctuated. Overall, there is a trend of annual growth of just under 14%: see Figure 3.

**Figure 3: New annual premiums for risk products—Individual and group (2012–end March 2016)**

Note: See Table 12 in Appendix 2 for the complete data in this figure (accessible version).

Source: Plan for Life, March 2016.

118 The APRA data available demonstrates that life insurance returns a significant benefit to the community. During the 2015–16 financial years, \$8.2 billion dollars in net policy payments were made by life insurers.

Note: See APRA, [Quarterly life insurance performance—June 2016](#) (PDF 720 KB), 16 August 2016 (QLIP June 2016), p. 9 and Table 1a.

## Types of products

119 The four most common types of life insurance products issued by life insurers are as follows:

- (a) *Life cover* (also known as ‘term life insurance’ or ‘death cover’)—This pays a set benefit amount on the death of the insured person. The benefit payment is made to the nominated beneficiary(s) on the policy or the insured’s estate. For insured benefits within superannuation, the benefit is paid to the trustee who decides whether to pay a benefit in accordance with the fund’s governing rules. Life cover may also include terminal illness cover, which pays the life insurance benefit when the policyholder is diagnosed with a terminal illness (generally, the policyholder can only claim with a prognosis of death within one to two years, depending on the policy).
- (b) *TPD cover*—This pays a lump sum benefit if the policyholder becomes seriously injured or ill and is unable to work again (either in their own occupation or in any occupation, depending on the cover).
- (c) *Trauma cover* (sometimes called ‘critical illness cover’ or ‘recovery insurance’)—This provides cover for a diagnosed specified illness or

injury, such as cancer or a stroke, which will significantly affect a person's life and their ability to earn an income.

- (d) *Income protection*—This replaces the income lost (generally up to 75% of the policyholder's pre-disability income) if the policyholder is unable to work for a certain amount of time (generally up to two years) as a result of injury or sickness.

120 Although these policies can be purchased as 'stand-alone' products, they are often 'bundled'. For example, TPD cover is usually bundled with life cover.

121 Our review does not include the following types of life insurance products:

- (a) funeral and consumer credit insurance, and
- (b) investment policies, whole-of-life insurance, endowment insurance and life annuities.

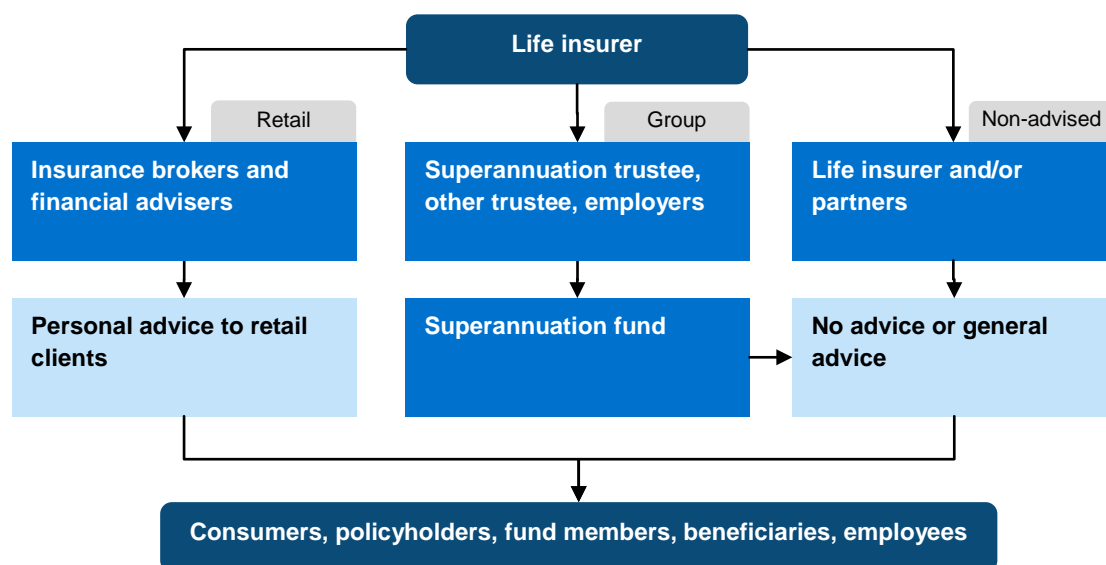
## How life insurance is distributed

122 Life insurance is distributed in three main ways:

- (a) *group*—as a group policy (e.g. purchased by the trustee of a superannuation fund, or an employer, with fund members/employees ultimately given the benefit of the cover under the policy);
- (b) *retail*—by financial advisers; and
- (c) *non-advised*—directly by insurers or their partners/affiliates.

123 Figure 4 shows the operation of these distribution channels and the types of advice and methods of sale that are typically involved for each channel.

**Figure 4: Distribution channels for life insurance in Australia**



Note: See paragraphs 124–133 for the text equivalent of this flowchart (accessible version).



## Non-advised

- 124 A policyholder may purchase life insurance directly from a life insurer, or through a sales partner or affiliate. This distribution model is generally fulfilled in one of the following ways:
- (a) online via a website or other digital technology (including digital advice);
  - (b) telephone sales (including inbound and outbound calls) managed by life insurers, their sales partners (e.g. a third party distributing the product under their own brand name or a third party marketing company) or affiliates;
  - (c) in branches of life insurers' partners or affiliates (e.g. bank branches); and
  - (d) by the use of other forms of advertising (e.g. mailouts).

Note: Even though there is no personal advice provided, the sales partner or affiliate typically receives a payment from the insurer(s) in connection with the policy sale under an arrangement that involves a level commission or sometimes an initial and renewal commission or it may be an activity based payment such as by call made or customer offered cover.

- 125 Life insurance distributed directly to consumers usually involves no personal financial product advice (recommendations or statements of opinion which are intended to influence someone about a financial product).

Note: See [Regulatory Guide 36](#) *Licensing: Financial product advice and dealing* (RG 36) at RG 36.23.

- 126 Instead, general financial product advice or factual information only is provided. General advice is limited to information about the life insurance product and its features and benefits as a whole, and does not take into account a person's objectives, particular circumstances (e.g. financial situation) and needs. If the advice is given having taken these factors into account then the advice is personal advice, which attracts a number of disclosure and other requirements.

Note: See [Regulatory Guide 175](#) *Licensing: Financial product advisers—Conduct and disclosure* (RG 175) for more indicators of what constitutes personal and general advice.

## Retail

- 127 Life insurance is also distributed by insurance brokers and financial advisers (who may or may not be affiliated with the insurer, such as financial advisers employed by banks). Under this distribution model, the broker or adviser typically provides personal advice to a retail client, taking into account their situation including their financial needs and the risks that the life insurance product should cover.

- 128 The adviser also typically receives payment from the insurer(s) in connection with the policy sale, under an arrangement that involves upfront and ongoing commissions: see paragraphs 88–106 of REP 413.

### Group life insurance

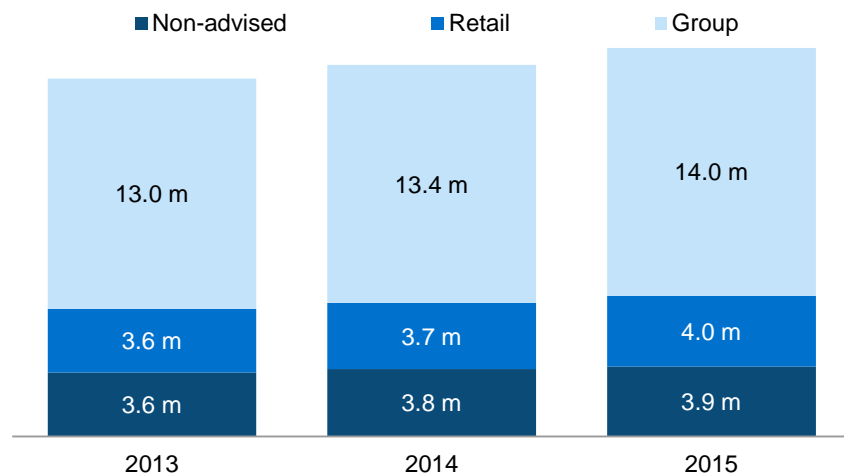
- 129 The most common form of group life insurance is available through superannuation. A superannuation fund member will often have a default level of life, TPD and income protection cover through their fund. A member may also be able to apply to increase their individual cover through the group cover. Under this arrangement, the superannuation trustee takes out a group policy that supports the benefit provided to members of the superannuation fund. The contract, or policy, of life insurance is between the life insurer and the superannuation trustee.
- 130 Under APRA's [Prudential Standard SPS 250 Insurance in superannuation](#) (PDF 41 KB), superannuation trustees are required to have an insurance management framework to manage making insured benefits available to members. At a minimum the insurance framework is required to formulate, review regularly and give effect to an insurance strategy for the benefit of members which documents how the trustee has considered the factors in s52(7) of the *Superannuation Industry (Supervision) Act 1993* (SIS Act).
- 131 No single model or design applies to all superannuation funds to meet these standards. The superannuation trustee:
- (a) decides the type and level of life insurance cover provided to their members; and
  - (b) forms part of the claims process, including reviewing the insurer's claims decisions.
- 132 Trustees offering default superannuation (MySuper products) are generally required to offer members death and TPD cover on an opt-out basis. There is no statutory minimum for TPD cover; however, there are minimum amounts specified for death cover: see Sch 1 to the Superannuation Guarantee (Administration) Regulations 1993. Members can usually opt to increase their cover, as well as opt-out of cover.
- 133 Other forms of group insurance are available through corporate or employer and other master trusts. As with superannuation funds, these types of group risk insurance involve a trust structure with a trustee and members or beneficiaries.

### Trends in distribution channels

- 134 Figure 5 summarises the data provided by the insurers we reviewed, over the 2013–15 period. There has been increase in life insurance policies being

issued across both the non-advised and retail distribution channels, increasing by approximately 9% and 12% respectively, over this period. The number of members covered by group life insurance policies also increased by 7.5%.

**Figure 5: No. of policies (non-advised and retail) and members (group) by distribution channel (2013–15)**



Note: See Table 13 in Appendix 2 for the complete data in this figure (accessible version).

Source: ASIC

## The regulatory framework for life insurance

135 Life insurers, financial advisers, insurance brokers, and superannuation fund trustees are subject to a range of statutory obligations, including:

- (a) the Corporations Act and Corporations Regulations;
- (b) the *Australian Securities and Investments Commission Act 2001* (ASIC Act);
- (c) the *Australian Prudential Regulation Authority Act 1998* (APRA Act);
- (d) the Insurance Contracts Act;
- (e) the *Life Insurance Act 1995* (Life Insurance Act);
- (f) the SIS Act and Superannuation Industry (Supervision) Regulations 1994 (SIS Regulations); and
- (g) the *Superannuation (Resolution of Complaints) Act 1993*.

136 The industry is regulated by both APRA (life insurers and superannuation fund trustees) and ASIC (life insurers, financial advisers, brokers, distributors, administrators and superannuation fund trustees) under the relevant legislation: see Table 3.

**Table 3: Regulatory framework for life insurance in Australia**

Legislation	Overview of requirements
Corporations Act: s764A, 766A, 912A, Pts 7.7, 7.7A and 7.9	<p>A life insurance product is a financial product. Insurers and advisers must hold an Australian financial services (AFS) licence, or be the representative of an AFS licensee, as they deal in a financial product (insurers) and provide financial product advice (advisers).</p> <p>AFS licensees must comply with various obligations under the Corporations Act and other financial services laws, including (but not limited to):</p> <ul style="list-style-type: none"> <li>• the general obligations in s912A to: <ul style="list-style-type: none"> <li>– provide financial services efficiently, honestly and fairly;</li> <li>– manage conflicts of interest;</li> <li>– ensure representatives are competent to provide financial services;</li> <li>– have an internal dispute resolution system and membership of an approved external dispute resolution system; and</li> </ul> </li> <li>• the financial services disclosure obligations in Pt 7.7 if the licensee is the providing entity.</li> </ul> <p>Part 7.7A introduced new conduct obligations for the provision of personal financial product advice to retail clients, such as the best interests duty and related obligations.</p> <p>Part 7.9 includes the product disclosure obligations.</p> <p>Under the Corporations Act, PDS disclosure and significant event notices for superannuation products are required to include information about insurance. Most superannuation products would have a shorter PDS (see Sch 10D).</p>
ASIC Act: s12CA, 12CB, 12DA and 12DB	<p>The consumer protection provisions in the ASIC Act operate to protect consumers from misleading and deceptive conduct or unconscionable conduct by AFS licensees and representatives in the provision of financial services. These provisions mirror the Australian Consumer Law in the <i>Competition and Consumer Act 2010</i>.</p>
Insurance Contracts Act: s13, 14, 14A and 29	<p>ASIC is responsible for the general administration of the Insurance Contracts Act, which regulates the content and operation of insurance contracts. It creates an implied contractual term that requires both the insurer and the policyholder to act towards the other, in respect of any matter arising under or in relation to the contract, with the utmost good faith. If reliance on a contractual provision by either the insurer or a policyholder would involve a failure to act with utmost good faith, the party cannot rely on that provision.</p> <p>The Insurance Contracts Act also sets out what consumers must do when applying for an insurance policy, including their duty to disclose to the insurer all relevant information about the risks the insurer is accepting. Section 29(3) allows an insurer to avoid a policy within the first three years where the policyholder fails to comply with their duty of disclosure even if the failure was not fraudulent. If the failure or misrepresentation was fraudulent, the contract can be avoided at any time.</p> <p>The <i>Insurance Contracts Amendment Act 2013</i> amended the remedies available for insurers under s29 in cases of non-fraudulent non-disclosure, so the insurer can, instead of avoiding the contract, alter the sum insured (s29(4) and (10)) or retrospectively vary the contract in such a way as to place the insurer in the position it would have been in if the non-disclosure or misrepresentation had not occurred: (s29(6), (7), (8) and (9)).</p>

Legislation	Overview of requirements
Life Insurance Act: s17(1), 16U, 180, 195, Pt 10 other than s206– 210.	<p>APRA supervises life insurers under the Life Insurance Act and the Life Insurance Regulations 1995. The Act prohibits a person from issuing or undertaking liability under a life insurance product or 'life policy' unless they are a life company registered by APRA under s21 or a friendly society.</p> <p>The Life Insurance Act gives ASIC specific administrative responsibilities for life insurance policies including their issuance, payment of policy money, unclaimed money and lost or destroyed policies. It also ensures that ASIC is made aware of certain significant events such as the transfer and amalgamation of life insurance business and winding up.</p> <p>ASIC also has specific remedies including the power to apply for a court injunction to restrain conduct. ASIC's administrative powers include reviewing and requiring production from a life insurance company of proposal and policy forms. ASIC has the power to require life insurance companies to provide us with a statement about unclaimed money held in retirement savings accounts and first home saver accounts.</p>
SIS Act: s52(7), 68AA, 101  SIS Regulations: regs 1.03C and 4.07D	<p>The insurance covenants in s52(7) of the SIS Act require the trustee to formulate an insurance strategy for the benefit of beneficiaries. This provision also requires a trustee to consider the cost to beneficiaries of insurance cover and only offer cover that does not inappropriately erode retirement benefits (s52(7)(c), and to do everything that is reasonable to pursue an insurance claim for a beneficiary if the claim has a reasonable prospect of success (s52(7)(d)).</p> <p>Also relevant is s68AA of the SIS Act, which requires MySuper members to generally be offered, on an opt-out basis, life and TPD cover.</p> <p>Further, s101 of the SIS Act requires trustees to establish arrangements for dealing with inquiries or complaints. In addition, SIS Regulations may have an impact on benefit design, particularly for TPD definitions</p>

## APRA

- 137 APRA is established under the APRA Act. APRA is the prudential regulator of the Australian financial services industry, including life insurers and superannuation funds. APRA jointly administers the Life Insurance Act and the SIS Act with ASIC.
- 138 Prudential supervision by APRA, that includes a licensing regime, aims to ensure that life insurers are financially sound, appropriately capitalised and have sound risk management so as to ensure that obligations to beneficiaries such as policyholders are met.

## ASIC

- 139 ASIC's regulatory framework as set out in Table 3 includes a licensing regime, disclosure requirements and consumer protection for advice, marketing and disclosure, and the requirement for parties to an insurance contract to act towards each other with the utmost good faith.

- 140 A life insurer is generally required to hold an AFS licence to cover the financial services it provides under the Corporations Act: see s911A(1).
- Note: For the definition of a ‘financial service’ under s766A of the Corporations Act, see ‘Key terms’.
- 141 ‘Handling insurance claims’ is specifically excluded from the definition of a financial service in the Corporations Act: see s766A(2)(b) and reg 7.1.33(1)–(2) of the Corporations Regulations. This means that ASIC’s powers under the Corporations Act generally do not apply to claims handling.
- 142 These limitations restrict ASIC’s capacity to take action for conduct such as:
- (a) an insurer relying on the terms of the contract to deny a claim (even where the exclusion clause relied on may be outdated or restrictive); or
  - (b) unnecessary or extensive delays in handling claims.
- 143 Amendments to the Insurance Contracts Act, which were implemented in June 2013, extended ASIC’s capacity to take action in relation to claims handling where an insurer has failed to act in accordance with the duty of utmost good faith provisions.
- 144 The effect of the amendments is that we can, if it is in the public interest to do so, either:
- (a) bring an action against the insurer on behalf of an insured person or third-party beneficiary in relation to a breach; or
  - (b) take over and continue, on behalf of the insured person or third-party beneficiary, an action brought against the insurer by that person or third-party beneficiary in relation to a breach.
- 145 However, these courses of action are subject to the following limitations:
- (a) we need to form a view that the conduct of the insurer breaches the duty of utmost good faith (noting that there is very little case law on the application of this duty);
  - (b) we need to be satisfied that taking action is in the public interest; and
  - (c) where these two requirements are met, our options are to either commence a court action for an individual transaction or to take action against the licence (i.e. we are not able to take other action).
- 146 Commencing court action for individual transactions may not be an effective regulatory tool to deal with systemic issues, and in many circumstances FOS or the SCT may be best placed to pursue these transactions so that ASIC can pursue underlying systemic conduct. As such, we generally refer individual disputes to the appropriate EDR scheme (e.g. FOS or the SCT). This applies not only to life insurance but to complaints from other sectors of the financial services industry.

- 147 AFS licence holders must be a member of an EDR scheme under the Corporations Act: see s912A(1)(g) and 912A(2). ASIC approved the terms of reference for FOS. The SCT is not an EDR scheme as defined by the Corporations Act, but rather, has been established as a statutory tribunal to deal with complaints from members about superannuation trustees and group policy life insurers.
- 148 FOS reports identified systemic issues to ASIC. The SCT has a statutory breach reporting responsibility to ASIC under which it is required to report any breaches to us that it identifies in carrying out its roles.

## Life Insurance Code of Practice

- 149 In contrast to other financial services sectors (e.g. banking and general insurance), for many years there has not been a self-regulatory code of practice for the life insurance industry. This makes it difficult to confirm minimum industry standards.

Note: In the 1990s, APRA's predecessor, the Insurance and Superannuation Commission (ISC) issued a *Code of Practice for Advising, Selling and Complaints Handling in the Life Insurance Industry* (1995). However, this Code was imposed on life insurers and reflected a different industry structure and regulatory landscape to that operating today.

- 150 In 2015 the Trowbridge Report recommended that a Life Insurance Code of Practice be developed, modelled on the General Insurance Code of Practice: Policy Recommendation 6. The Government's reform package for life insurance advice included a proposal that a life insurance code of practice be developed by the Financial Services Council (FSC) by 1 July 2016.

Note: See John Trowbridge, *Review of retail life insurance advice*, 26 March 2015.

- 151 The industry has been developing in consultation with ASIC and other stakeholders an inaugural Life Insurance Code of Practice (Code). All life insurance companies which are members of the FSC will be required to be compliant with the Code by 1 July 2017. We expect that the industry will continue to enhance the minimum standards set out in the Code in 2017.

Note: Superannuation fund trustees who are members of the FSC will not be bound by the Code unless they enter into a formal agreement with the FSC and the Life Code Compliance Committee under s2.1(b).

- 152 The Code aims to commit life insurers to minimum standards on (relevantly):
- (a) the currency and appropriateness of medical definitions, with reviews of definitions to occur at least every three years and updated where necessary;

- (b) claims timeframes (in relation to the notification of a claim, ongoing progress of a claim, and claims decisions), with the requirement to comply with set timeframes unless unexpected circumstances exist;
- (c) the evidence required for claims;
- (d) surveillances in relation to claims, including the need for a reasonable basis to conduct a surveillance, standards related to privacy and discretion, and the conduct of investigators;
- (e) sales practices and advertising;
- (f) policy changes, cancellation rights and termination of policies (including communication during the term of a policy); and
- (g) internal complaints and disputes processes.

153 On the whole, the Code supports the further work insurers should undertake to address the issues we have raised in our review. However, there are some specific areas where the Code could improve claims handling standards by more comprehensively addressing the issues we have raised.

154 Specifically, these issues include:

- (a) setting out more prescriptive criteria about ‘unexpected circumstances’ that may affect claims timeframes and monitoring trends in insurers’ use of the ‘unexpected circumstances’ exemption;
- (b) negotiating insurers’ arrangements with reinsurers and third parties to ensure compliance with the Code in relation to timeframes in order to minimise the risk of the occurrence of unexpected circumstances;
- (c) developing specific and prescriptive conduct standards for surveillance by third parties (e.g. investigators);

Note: See [Regulatory Guide 96](#) *Debt collection guideline: For collectors and creditors* (RG 96), issued by ASIC and the Australian Competition and Consumer Commission, which helps to set standards for debt collection in line with the Australian Consumer Law and privacy legislation, as an indication of how guidance or standards can be developed to apply to a particular activity where there is a risk of breaching consumer protection or privacy laws.

- (d) in relation to surveillance, providing documented reasons for carrying out surveillance to the policyholder, and restricting or prohibiting the use of surveillance for mental health claims (see paragraphs 207–214); and
- (e) exploring further more specific staff training obligations about dealing with claimants with mental health issues generally.

155 In addition, we are keen to work with the industry and APRA to enable provision of consistent claims data, on an ongoing basis to promote consistency and transparency of key data: see Section E.



- 156 The effectiveness of the minimum standards in the Code will be enhanced by superannuation trustees agreeing to adopt them in so far as they apply to claims handling by trustees of claims lodged under group policies. We support steps taken by industry to broaden the application of the standards to cover group insurance.
- 157 RG 183 sets out our guidance on the features of an effective industry code of practice. A better practice industry code should enhance services offered to policyholders while ensuring that subscribers comply with the provisions of the code, and that there are appropriate remedies and sanctions for non-compliance. While in practice, FOS will take into account the standards in an industry code when resolving a consumer dispute, we encourage industry to enhance the Code in light of the standards set out in RG 183, and the findings of this report, with the goal of making a formal application to us for approval of the Code.

## Other jurisdictions

- 158 Appendix 1 of this report summarises the regulation of life insurance and the claims handling requirements and standards in other jurisdictions. There are some areas where approaches differ significantly internationally.

- 159 In summary:

- (a) In the United Kingdom, there is standard wording for the minimum definitions that must be used within critical illness (or trauma) policy definitions but companies may enhance the definitions to cover more than the minimum requirement.
- (b) In the United Kingdom, insurers must also publicise their claim payout rates. This is done annually by the Association of British Insurers (ABI). This has required standardisation of definitions and aims to improve transparency for consumers and to help consumers understand why a small percentage of claims is not paid.

Note: See ABI, [\*Long term insurance statistics—Protection and long-term care \(3b\)\*](#), 2016.

- (c) Some jurisdictions have more prescriptive guidelines on what policyholders need to disclose in life insurance applications (this can be prescribed by legislation and/or other information and guidance).
- (d) In some jurisdictions (e.g. Canada), it is a requirement for life insurance policies to contain a definitions page.

## Recent policy development in life insurance

- 160 Over recent years, there has been a regulatory focus on identifying issues relating to life insurance remuneration and the quality of advice provided to consumers.

### Financial System Inquiry

- 161 On 7 December 2014, the Government released the final report of the Financial System Inquiry (FSI report) with recommendations to reposition Australia's financial system to best meet its evolving needs and support its economic growth over the next decade. A number of recommendations in the FSI report relate to life insurance.

Note: See Commonwealth of Australia, 2014, [Financial System Inquiry: Final report](#), November 2014.

- 162 These recommendations include reforms to remuneration arrangements, such as a staged reduction in upfront commission with a maximum ongoing commission (which is now being implemented), and recommendations for unclaimed money and the rationalisation of life insurance legacy products.

### Scrutiny of financial advice

- 163 On 2 March 2016, the Senate referred the following additional matters to the Economics References Committee as part of the 'Scrutiny of Financial Advice' inquiry:

- (a) the need for further reform and improved oversight of the life insurance industry;
- (b) whether entities are engaging in unethical practices to avoid meeting claims;
- (c) whether a life insurance industry code of practice is required; and
- (d) the role of ASIC in reform and oversight of the industry.

Note 1: On 4 September 2014, the Senate referred an inquiry to the Senate Economics References Committee, on the implications of financial advice reforms: see Parliament of Australia, [Scrutiny of Financial Advice](#).

Note 2: In our submission to this inquiry, we highlighted the long-standing concerns about problematic advice and misalignment of incentives for sales of life insurance by independent advisers, including 'churning'. See *Senate inquiry into the scrutiny of financial advice—Submission by the Australian Securities and Investments Commission*, December 2014, p. 46.

164

This inquiry has now lapsed and a separate inquiry [into the life insurance industry](#) was announced on 14 September 2016. The following matters were referred to the Parliamentary Joint Committee on Corporations and Financial Services for inquiry and report by 30 June 2017:

- (a) the need for further reform and improved oversight of the life insurance industry;
- (b) the assessment of relative benefits and risks to consumers of the different elements of the life insurance market, being direct insurance, group insurance and retail advised insurance;
- (c) whether entities are engaging in unethical practices to avoid meeting claims;
- (d) the sales practices of life insurers and brokers, including the use of approved product lists;
- (e) the effectiveness of internal dispute resolution in life insurance;
- (f) the roles of ASIC and APRA in reform and oversight of the industry; and
- (g) any related matters.

Note: See Commonwealth of Australia, [Inquiry into the life insurance industry](#), September 2016.

## C Detailed findings: Declined claims

### Key points

Our review found that declined claim rates varied:

- by insurer, ranging from 3% to 16% for all insurers, across all products and distribution channels; and
- by product and distribution channel, up to 37% for one insurer's product and up to 29% for one insurer's distribution channel.

Across the industry, these rates were higher for:

- TPD cover (averaging 16%) and trauma cover (averaging 14%); and
- non-advised (12%) compared to retail (7%) and group insurance (8%).

There was also a correlation between dispute rates and declined claim rates, with higher rates of disputes in the areas where claims were declined.

Policy definitions, particularly for trauma policies, varied between insurers—some of these variations were subtle, while others were more significant.

Some definitions were potentially out of date and/or not comprehensive enough to cover every possible scenario, meaning that insurers either declined claims, or paid them on an ex-gratia basis.

### Declined claim rates

- 165 As part of our review, we analysed declined claim rates and grounds for declined claims (based on the dispute data) to assess industry trends and also to identify any significant variations in terms of insurers, product types and distribution channels.
- 166 Our findings indicated that:
- some insurers had substantially higher than average declined claims rates and a substantially higher than proportionate share of disputes about claims;
  - declined claim rates were highest for TPD cover followed by trauma cover; and
  - declined claim rates were highest for policies distributed directly (i.e. on a non-advised basis).
- 167 By type of cover, declined claim rates across the industry for 2013–15 varied as follows:
- life*—industry average 4% (ranging from 1% to 13% among insurers);

- (b) *trauma*—industry average 14% (ranging from 6% to 31% among insurers);
- (c) *TPD*—industry average 16% (ranging from 7% to 37% among insurers); and
- (d) *income protection*—industry average 7% (ranging from 3% to 16% among insurers).

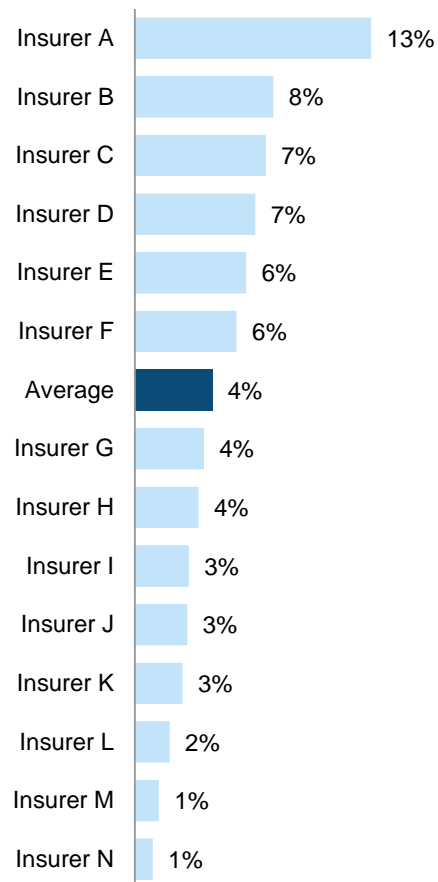
Note: ASIC is the source of all data in this report, unless otherwise specified. All ranges for claim outcome rates (e.g. maximum, minimum) disregard rates for insurers below certain thresholds (e.g. those with total claims over 2013-15 less than average minus one standard deviation or 20 total claims). Thresholds vary depending on circumstances. Due to rounding, percentages may not always appear to add up to 100%.

168 Figure 6–Figure 9 show the differences in rates between insurers, and also the incidences of insurers who had above average declined claim rates for particular types of cover.

Note 1: Insurers may calculate their own acceptance and declined claim rates by excluding withdrawn rates and yet to be determined claims from their calculations. However, we have included these categories in our calculations.

Note 2: Additionally, the definitions that insurers use for decline rates can vary (for example, they may or may not include claims declined for eligibility purposes or those that involve fraud).

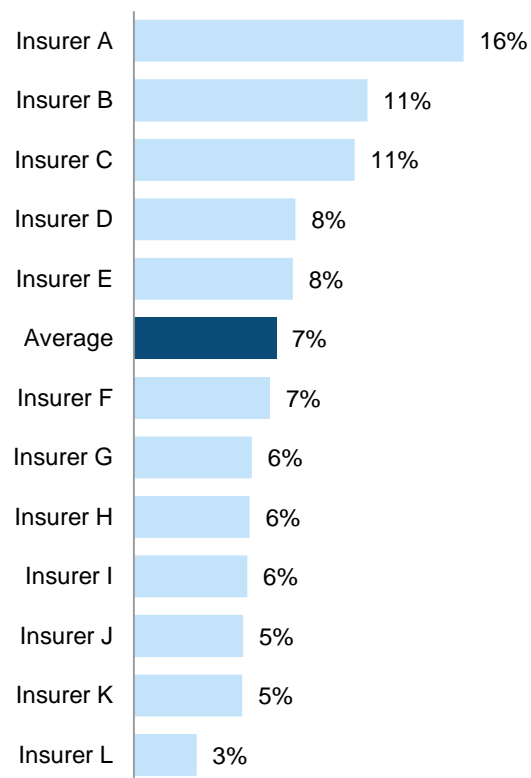
Note 3: Insurers A to N are not the same throughout this report, and have been randomly assigned letters to ensure anonymity. As noted earlier, we have not identified insurers in the findings in this report because conclusions cannot be drawn from the rates and incidences of declined claims alone, rather, the purpose of these statistics is to inform us about the insurers we need to target for further work.

**Figure 6: Declined claim rates—Life cover (2013–15)**

Note 1: See Table 14 in Appendix 2 for the complete data in this figure (accessible version).

Note 2: One insurer was excluded due to small population for cover type (i.e. total number of claims for 2013–15, less than 20).

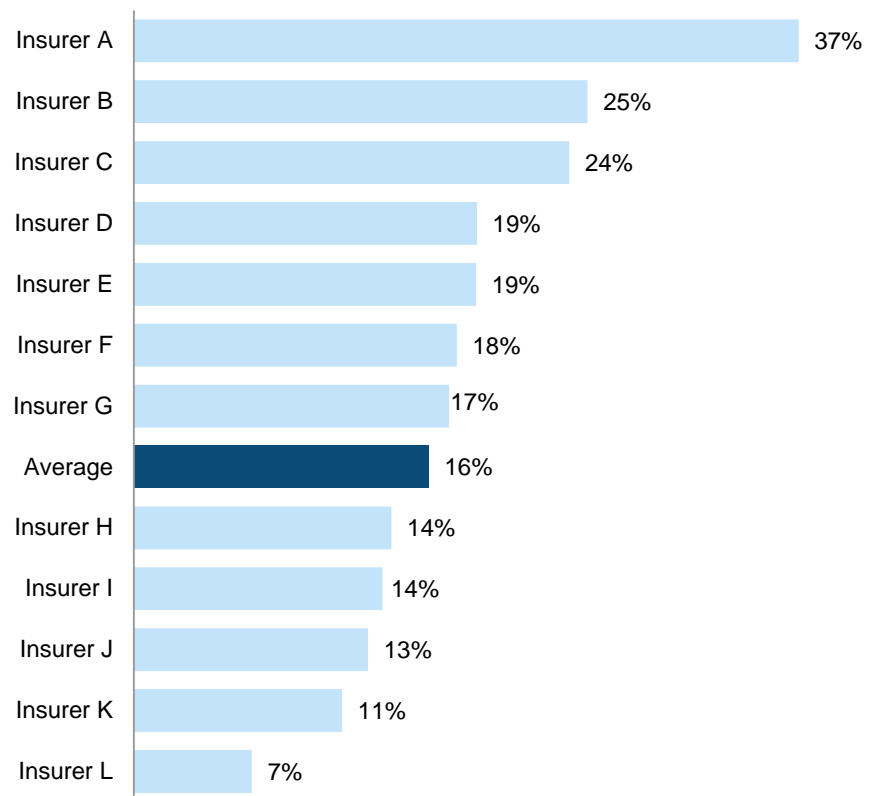
Source: Section 912C data and ASIC calculations.

**Figure 7: Declined claim rates—Income protection cover (2013–15)**

Note 1: See Table 15 in Appendix 2 for the complete data in this figure (accessible version).

Note 2: Three insurers were excluded due to no claims reported for cover type.

Source: Section 912C data and ASIC calculations

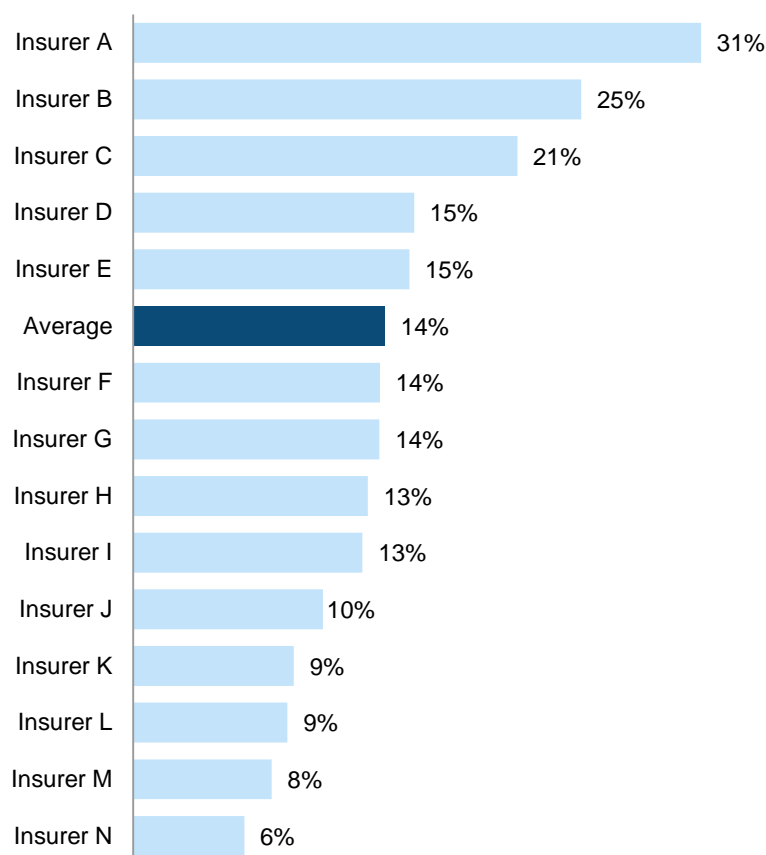
**Figure 8: Declined claim rates—TPD cover (2013–15)**

Note 1: See Table 16 in Appendix 2 for the complete data in this figure (accessible version).

Note 2: Three insurers were excluded due to small population for cover type (i.e. total number of claims for 2013–15, less than 20).

Source: Section 912C data and ASIC calculations.



**Figure 9: Declined claim rates—Trauma cover (2013–15)**

Note 1: See Table 17 in Appendix 2 for the complete data in this figure (accessible version).

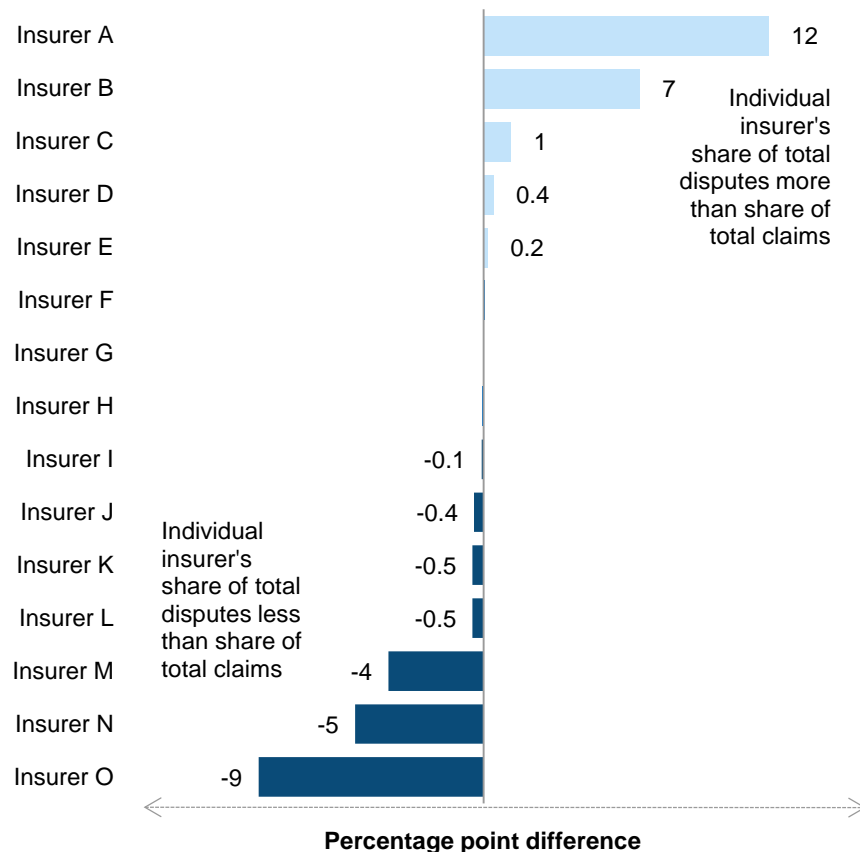
Note 2: One insurer was excluded due to small population for cover type (i.e. total number of claims for 2013–15, less than 20).

Source: Section 912C data and ASIC calculations.

- 169 Some insurers had above average declined claims rates for more than one type of cover. Specifically, nine insurers had higher than average declined claim rates across two or three types of cover, with three insurers having substantially higher rates across two areas.
- 170 However, some insurers also had above average declined claims rates in one area, and substantially lower than average declined claims rates in other areas. This indicates that high rates may be linked to cover types rather than a systemic issue within the insurer.
- 171 Our analysis also confirmed that there is a correlation between insurers' share of claims and their share of disputes (derived from the dispute data), with insurers with high proportions of total claims also having higher proportions of disputes: see Figure 10.
- 172 For some insurers, however, their share of complaints was substantially disproportionate to the share of claims. Based on the dispute data, the insurer with the highest proportion of total disputes had a share of disputes 12 percentage points higher than their share of claims in the market. Another

insurer had a share of disputes 7 percentage points higher than their share of claims.

**Figure 10: Share of disputes less share of claims, by insurer (2013–15)**



Note: See Table 18 in Appendix 2 for the complete data in this figure (accessible version).

Source: ASIC and external third parties, ASIC calculations

173 We also found that, across the industry, there is a 2% likelihood that a claims-related issue will be dealt with through the insurer's IDR process and a 0.9% chance that a dispute will be considered by FOS or the SCT. Generally, these disputes relate primarily to a declined claim or an alleged delay in a claims assessment.

Note: Based on published FOS data, life insurance disputes are 1.5 to 6 times less likely than general insurance disputes to be referred to FOS, on a per policyholder basis: see FOS, [Comparative tables 2014–2015](#), Final report).

174 For some insurers, the number of disputes for claims was substantially higher. For example, for one insurer, a claims-related issue was twice as likely to be dealt with through the insurer's IDR process, compared to the industry average. This could, however, be attributed to greater policyholder awareness of this insurer's IDR process rather than an increased number of concerns.

175 Our analysis also showed that retail policy claims were proportionally more likely to be the subject of a dispute than claims for non-advised or group insurance, even though claims for retail policies were the most likely to be approved in the first instance. These findings may be explained by the assistance that financial advisers provide during the claims process as part of their ongoing relationship with the policyholder.

176 We also examined the outcomes of claims considered by IDR and EDR (comprising both FOS and the SCT). After the dispute resolution process, claims acceptance rates (across the industry) were 24% for both IDR and EDR. Declined claim rates (i.e. affirming the original decision) were 46% for IDR and 30% for EDR.

### **Ex-gratia payments**

177 Our review also examined the incidences of ex-gratia payments by insurers, which also varied across the industry. The data indicated that insurers were more likely to make ex-gratia payments where claims decisions were referred to EDR schemes or a court, probably in order to resolve the dispute.

178 Ex-gratia payment rates varied across the industry in the following ranges:

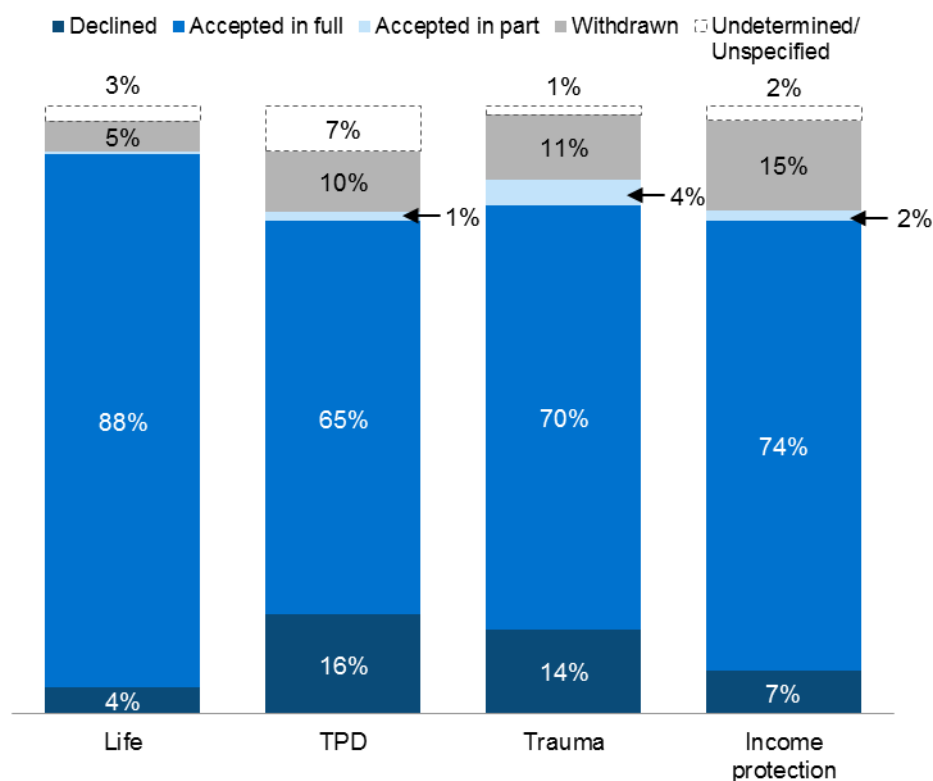
- (a) 0% to 1% of all claims;
- (b) 0% to 14% of claims decisions (average 2%) considered by insurers' IDR schemes;
- (c) 0% to 43% of all claims decisions (average 10%) considered by EDR schemes; and
- (d) 51% of all claims that became the subject of litigation brought by the policyholder against the insurer.

179 We identified some circumstances in which ex-gratia payments were made—for example, where:

- (a) medical or policy definitions were not satisfied;
- (b) an event occurred outside the policy (e.g. one case where cancer was diagnosed three days after the cancellation of the policy); and
- (c) payments were made because incorrect information was provided at the point of sale.

### **Claims experience by types of cover**

180 Across the products in our review, claims experience differed, with TPD having the highest proportion of declined claims (industry average of 16%), and life having the lowest (industry average of 4%).

**Figure 11: Claims outcome rates, by cover type (2013–15)**

Note 1: See Table 19 in Appendix 2 for the complete data in this figure (accessible version).

Note 2: Terminal illness and other cover types were excluded.

Source: ASIC

181 While the claims data we reviewed did not specify the medical condition or event that led to the claim, some insurers provided this information to us in other documents. For example, one insurer advised us that since 2012, their declined claim rate for heart attacks (within trauma cover) was around 17% of total claims. For severe rheumatoid arthritis, the rate was 37%.

182 While insurers are interested in minimising their claims experience by engaging in certain claims practices, it is important that these practices do not translate into unfair claims outcomes for consumers.

183 Some practices observed included:

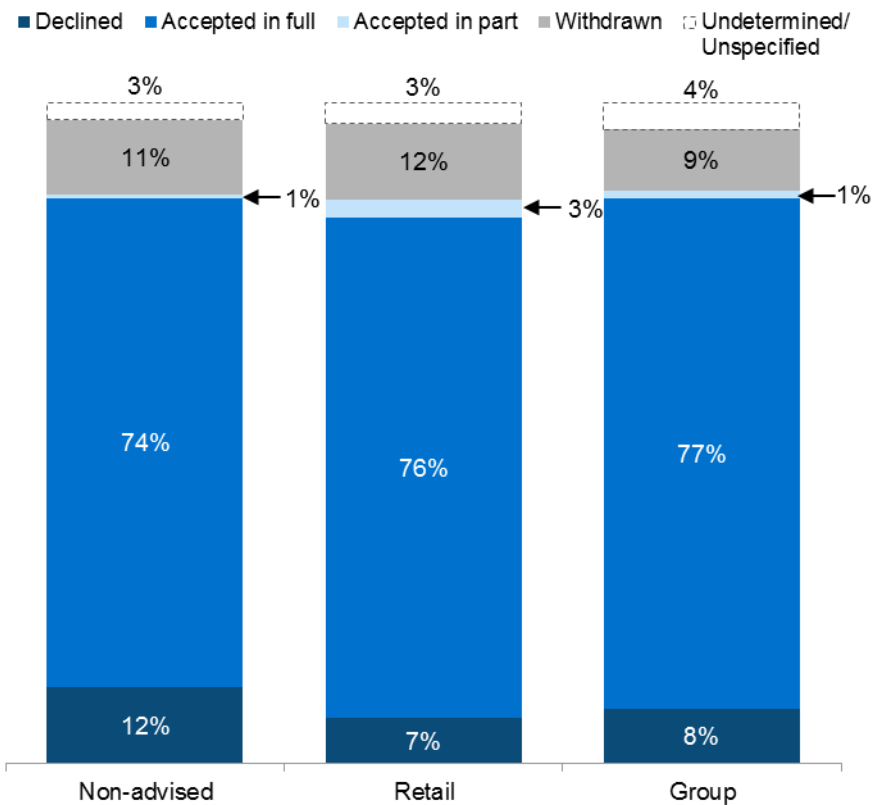
- (a) for income protection claims, engaging in early intervention to help claimants return to work sooner;
- (b) for TPD claims, tightening terms and conditions, including circumstances where higher levels of cover may be obtained without full underwriting (particularly in group cover), reducing the size of lump sum TPD benefits, replacing lump sum benefits with income replacement benefits, and using more restrictive TPD definitions; and

- (c) implementing strategies to reduce the propensity to claim, including ongoing underwriting and discounts for demonstrating positive lifestyles.

Claim experience by distribution channel

184 The insurers’ data we reviewed indicated that average declined claim rates were highest across the industry (for all products) for non-advised policies (12%), compared to group insurance (8%), and retail policies (7%).

Figure 12: Claims outcome rates, by distribution channel (2013–15)

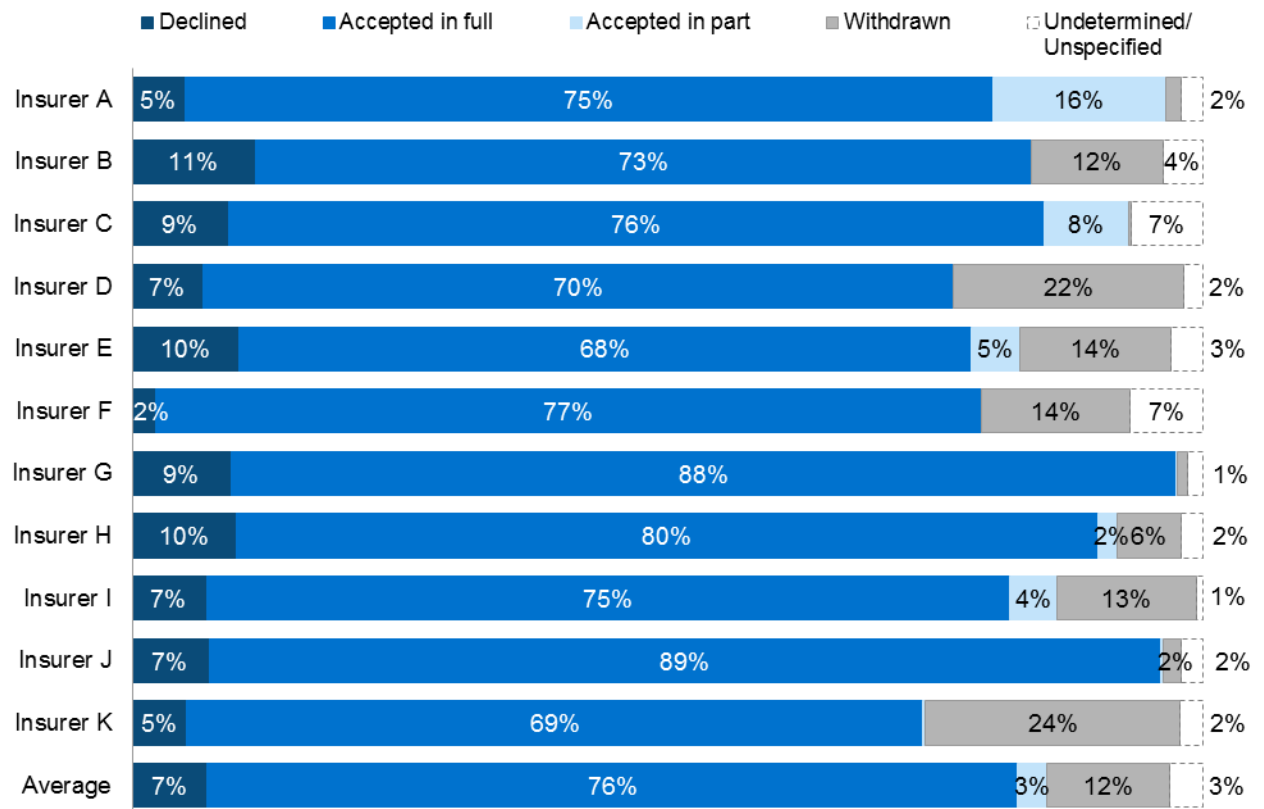


Note: See Table 20 in Appendix 2 for the complete data in this figure (accessible version).  
Source: ASIC

Retail policies

185 Claims on retail policies showed comparatively high acceptance rates. This result is consistent across the industry, with some insurers operating with almost 90% full claim acceptance rates and most insurers having less than 10% declined claim rates.

186 Some of these insurers had relatively high numbers of ‘withdrawn’ claims, with two insurers having more than 20% of retail policy claims withdrawn.

**Figure 13: Claims outcome rates—Retail policies, by insurer (2013–15)**

Note: See Table 21 in Appendix 2 for the complete data in this figure (accessible version).

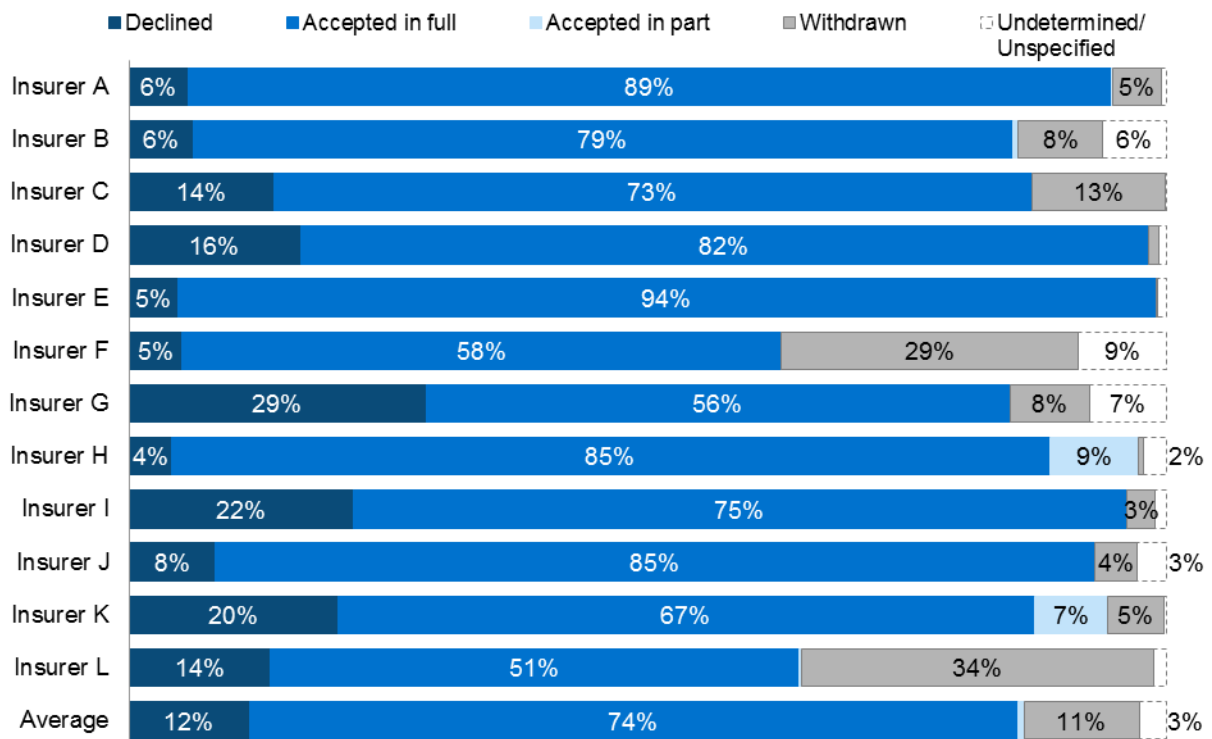
Source: ASIC

### Non-advised policies

187 For non-advised policies, claim acceptance rates were on average slightly lower than those of retail policies (74% for non-advised compared with 76% for retail). Of note, almost 30% of claims received by one insurer were declined. Two other insurers also had relatively high declined claim rates compared to the average.

188 Two insurers had high withdrawn claim rates of 34% and 29%.

**Figure 14: Claims outcome rates—Non-advised policies, by insurer (2013–15)**



Note: See Table 22 in Appendix 2 for the complete data in this figure (accessible version).

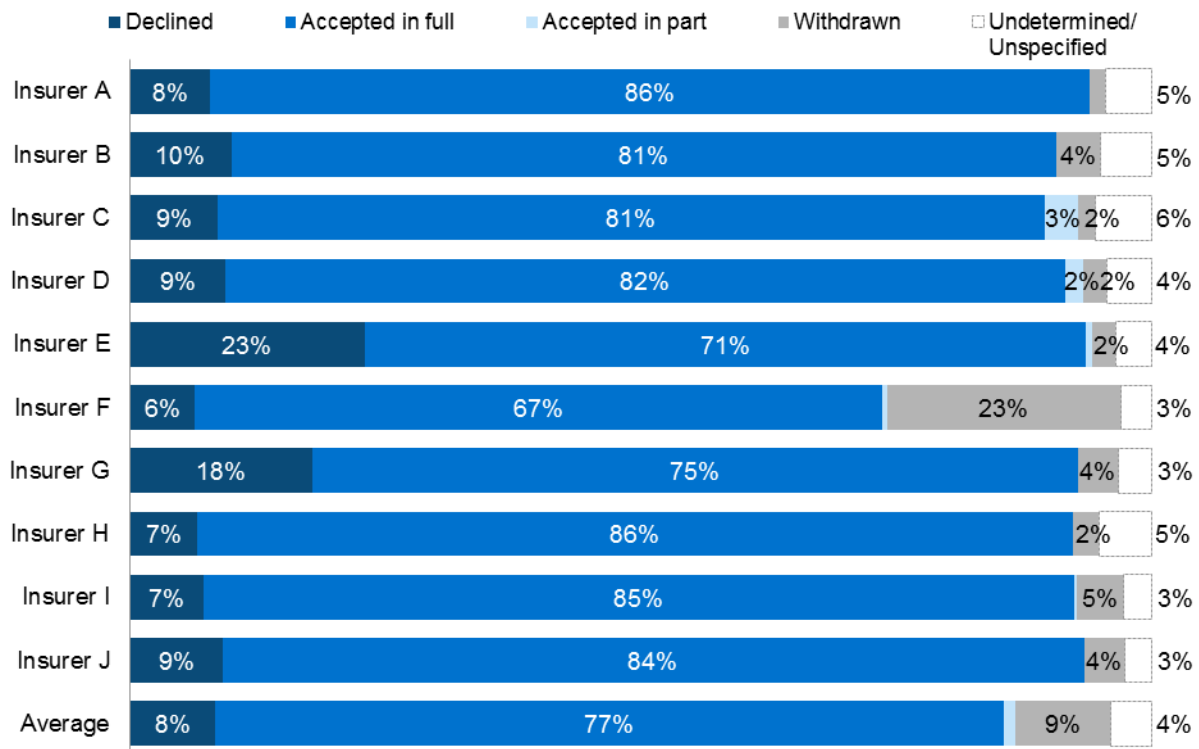
Source: ASIC

### Group policies

189 For group policies, average claim acceptance rates (77%) were similar to  
retail policies (76%). Two insurers had declined claim rates of 18% and 23%  
respectively, with all other insurers' declined claim rates being 10% or less.

190 Additionally, for one insurer, the rate of withdrawn claims was 23%.

**Figure 15: Claims outcome rates—Group insurance, by insurer (2013–15)**



Note: See Table 23 in Appendix 2 for the complete data in this figure (accessible version).

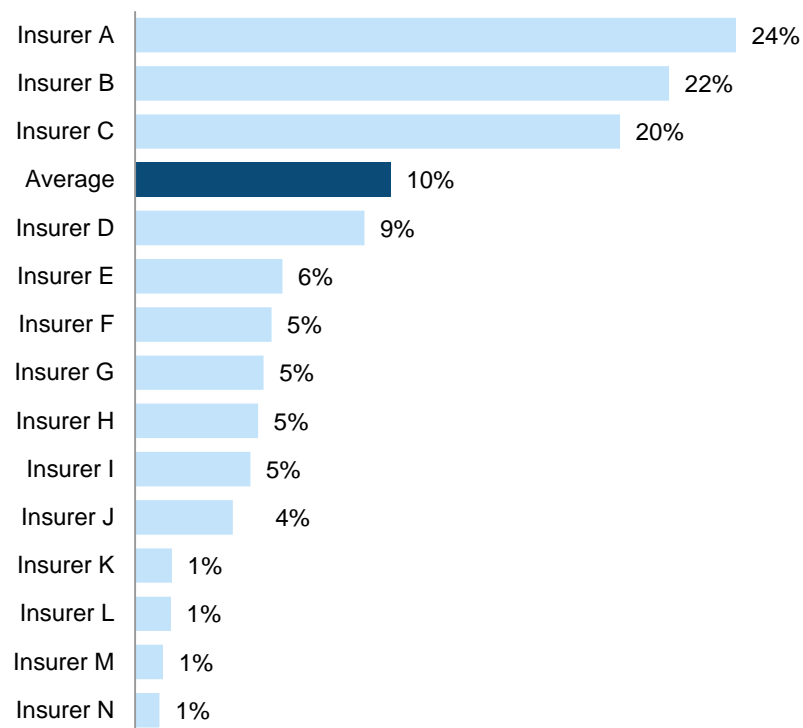
Source: ASIC



### Withdrawn claims

- 191 ‘Withdrawn’ claims are claims that are notified to the insurer but, for various reasons, do not proceed to an acceptance or decline decision.
- 192 Our review showed relatively high withdrawn claim rates for three insurers (across all distribution channels), with rates of 20% or more: see Figure 16.
- 193 As indicated in Figure 13–Figure 15, there were also trends among insurers in withdrawn claim rates for particular distribution channels.

**Figure 16: Withdrawn claim rates (2013–15)**



Note: See Table 24 in Appendix 2 for the complete data in this figure (accessible version).

Source: ASIC

- 194 A further analysis of these rates showed that these particular insurers had even higher withdrawn claim rates for some types of cover. For example, for TPD cover, one insurer’s withdrawn claim rate was 33% and for income protection another insurer’s was 30%. For one insurer, the trauma cover withdrawn claim rate was 26%.
- 195 While we obtained information from insurers about the number of withdrawn claims, the reasons for withdrawals were not apparent from insurers’ data or the dispute data. Further, there is not necessarily a consistent interpretation between insurers about the definition of a ‘withdrawn’ claim, and when a claim is considered to be ‘withdrawn’.

- 196 Understanding the reasons why claims are withdrawn and monitoring the rates at which they are withdrawn will provide a better understanding of claims experience and procedures. We will explore this issue as part of our further work, with a focus on the insurers with high withdrawn claim rates.
- 197 We will also explore insurers' interpretations of when a claim is 'withdrawn' as part of our data review work: see paragraphs 43–44.
- 198 As outlined in [Report 245](#) *Review of general insurance claims handling and internal dispute resolution procedures* (REP 245) at paragraph 16, we think it is important to understand the circumstances in which claims are withdrawn, to ensure that policyholders are making properly informed decisions that operate in their best interests.

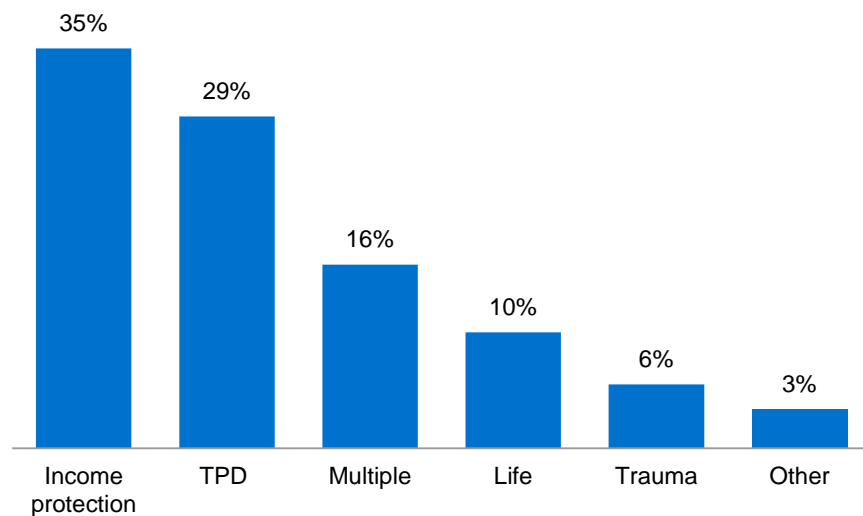
#### Further work: Declined claims

ASIC will:

- undertake targeted surveillance work to examine the reasons for insurers with substantially higher than average declined claim rates (and withdrawn claim rates), and consider regulatory options where these reasons cannot be justified;
- undertake further reviews across the industry on TPD claims files and systems, focusing on claims procedural issues (such as timeframes and evidence) and also any additional findings from our targeted surveillance work; and
- work with APRA, the insurance industry and stakeholders to establish a consistent public reporting regime for claims data and claims outcomes, including claims handling timeframes and dispute levels across all policy types. It is expected that data will be made available on an industry and individual insurer basis. This will help ASIC and APRA to monitor claims trends and identify any potential issues of concern from changes in data.

## Reasons for declined claims

- 199 We reviewed 5,438 disputes using information from EDR schemes and consumer and legal advocates, reports of misconduct made to ASIC, and also the selected insurers' internal reports. Of the disputes, 63% related to claims. An additional 9% of all disputes related to policy definitions, most of which also related to claims.
- 200 Income protection was the cover type most commonly disputed, representing 35% of all disputes, followed by TPD at 29% and life at 16%, then trauma at 6% of all disputes: see Figure 17.

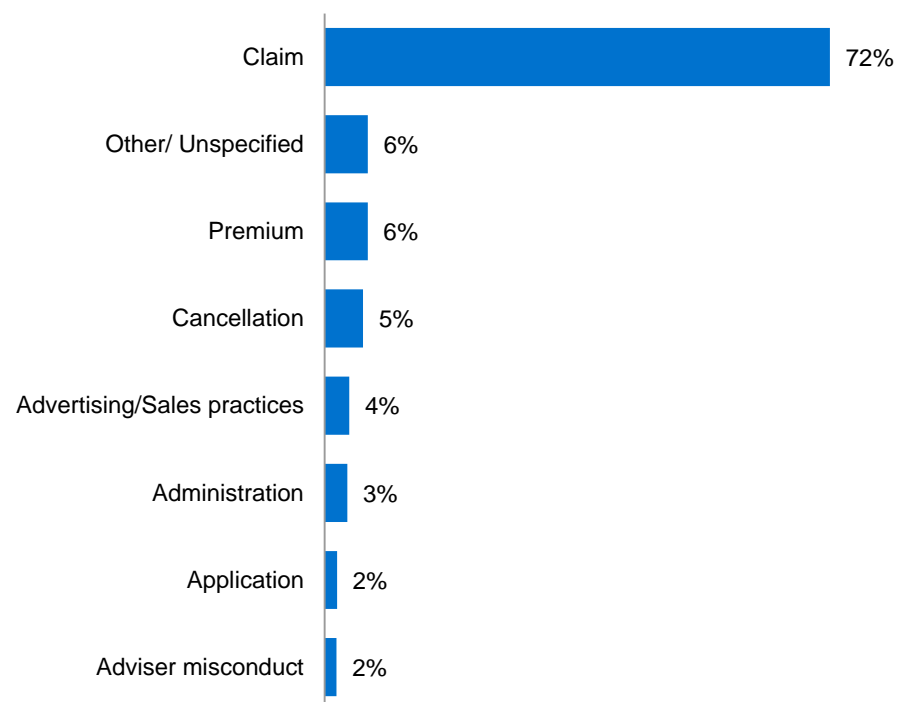
**Figure 17: Disputes by cover type (2013–end March 2016)**

Note 1: See Table 25 in Appendix 2 for the complete data in this figure (accessible version).

Note 2: Data includes all disputes between 1 January 2013 and 29 March 2016, including insurers outside the scope of our review.

Source: ASIC and external third parties

201 Most disputes (72%) were claims-related, although there were also disputes about other areas such as premiums and cancellations: see Figure 18.

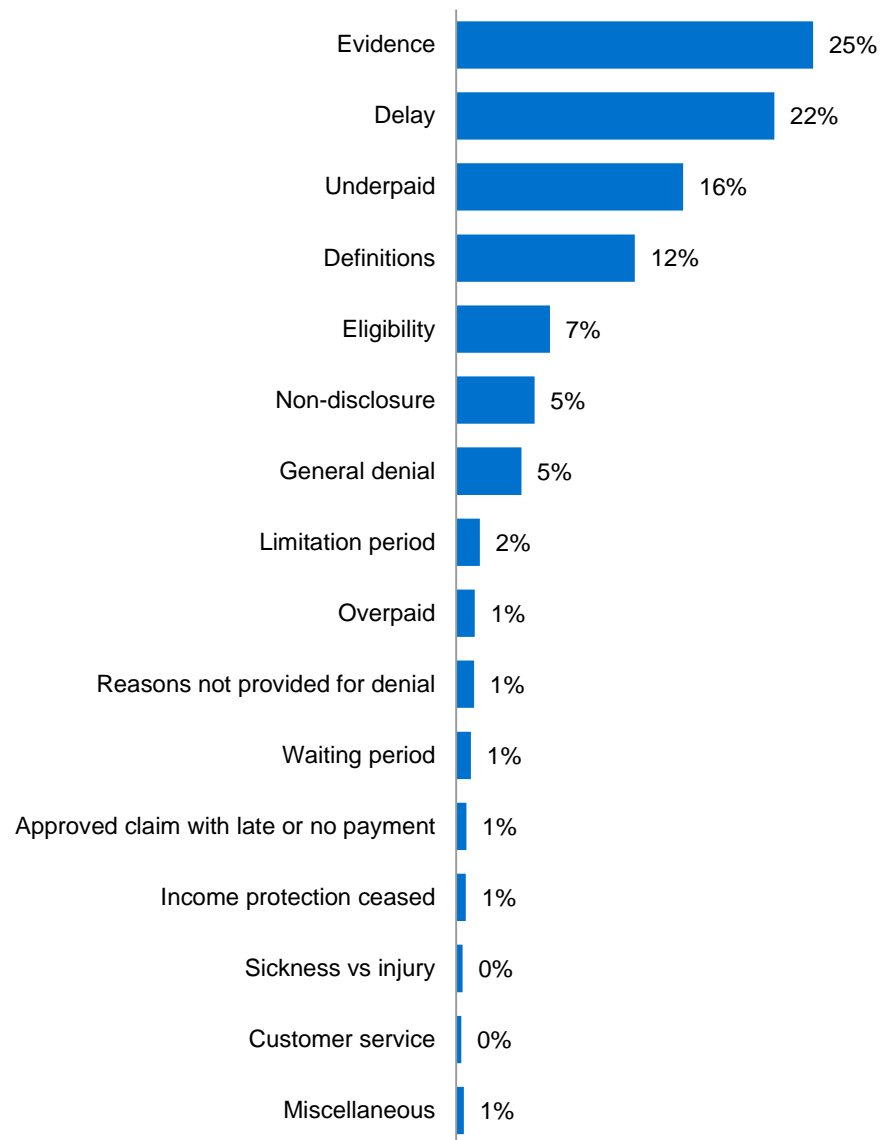
**Figure 18: Disputes by issue (2013–end March 2016)**

Note: See Table 26 in Appendix 2 for the complete data in this figure (accessible version).

Source: ASIC and external third parties

202 Figure 21 provides a breakdown of the disputes about claims. From the data we analysed, the largest proportion of disputes about claims related to evidence that the policyholder was required to provide to the insurer to assess their claim (25%), followed by delay (22%), and policyholders being underpaid for a claim (16%).

**Figure 19: Breakdown of disputes under ‘Claim’ category (2013–end March 2016)**



Note: See Table 27 in Appendix 2 for the complete data in this figure (accessible version).

Source: ASIC and external third parties

203 Approximately 32% of all disputes about claims (including disputes about policy definitions) were specifically about declined claims (in addition, some of the disputes about evidence and delay also related to claims that were ultimately declined).

- 204 Of these disputes:
- (a) 9% identified concerns with the application of policy definitions, with the majority relating to TPD, pre-existing conditions, cancer and heart attack (see paragraphs 215–286 for a further discussion of policy definitions);
  - (b) 5% related to the insurer alleging that the policyholder had not disclosed all the relevant information to the insurer before the contract was entered into (see s29(3) of the Insurance Contracts Act and related amendments);
  - (c) 5% related to general (or other) reasons the claim was declined (e.g. policies not operating as policyholders expected them to or administrative challenges accessing the correct documents for older policies); and
  - (d) 2% were for other reasons (e.g. waiting period not served).
- 205 In addition to these disputes, 7% of all disputes about claims related to a customer's eligibility under the policy to make a claim and this issue usually arose as a result of the claim being declined. See paragraphs 342–347 for a further discussion on the restrictions on a policyholder's eligibility to claim.
- 206 Case study 1 and Case study 2 provide examples of reasons a claim may be declined. They also highlight the inherent complexity of life insurance claims.

Note: All case studies used are based on real claim disputes, where the initial decision by the insurer was to decline the claim. These have been selected to highlight particular issues in relation to claims outcomes and procedures, and are not intended to convey that they represent systemic issues across the industry. Details in the case studies have been excluded or altered to avoid identification of the policyholders involved. We will also be following up these specific case studies with the relevant insurer in each case, to determine their responses to the broader issues raised.

#### Case study 1: Interpretation of insurance application form questions

The policyholder was diagnosed with lymphoma and attempted to claim under their trauma policy. The insurer rejected the claim on the grounds of non-disclosure of a pre-existing condition.

Before the policyholder applied for the policy, they had a non-cancerous lesion removed. The lesion was not growing, but was a lesion of dry skin due to sun damage. The application form asked whether the policyholder had ever had skin cancer, lesions, non-cancerous growths, moles or cysts. The policyholder answered 'no' to the question on the form. The policyholder spoke to their doctor who also stated that had they been asked the question in the same way they would have answered 'no'.

The policyholder raised the matter with EDR and it was resolved with the claim paid in full.

**Case study 2: Impact of superannuation fund changing insurer**

The consumer had been a member of the superannuation fund for a number of years. They suffered from depression and heart issues following a heart attack. The member returned to work a few months after the heart attack on light duties and ceased employment a few months later. They claimed a disability pension from Centrelink.

At approximately the same time that the member returned to work, new insurance arrangements took effect and the default insurance cover increased. The fund's trustee and the insurer argued that the member was not eligible to be covered by the new insurance arrangement as the member was not 'actively employed' and was suffering a pre-existing condition at the time the new default insurance arrangements commenced.

The dispute was raised with EDR and was resolved by settlement.

**Mental health claims**

207 We reviewed the number and nature of claim disputes relating to mental health conditions.

208 Our analysis of the dispute data indicated the following trends and potential concerns in this area:

- (a) The proportion of disputes about evidence required for mental health claims was substantially higher than the proportion of disputes about evidence for all claims (51% of all disputes about mental health claims compared to 25% of all claims-related disputes).
- (b) The proportion of disputes about a claim being declined for non-disclosure was also substantially higher for mental health claims than the proportion of disputes about non-disclosure across all claims (15% of all disputes about mental health claims compared to 5% of all claims-related disputes).
- (c) Other common issues for disputes about mental health claims included delays in assessing claims, pre-existing condition definitions, general declined claims and the application of exclusions for suicide.

Note: Around 6.4% or 300 complaints we reviewed related to mental health conditions experienced by the policyholder. Nearly all of these disputes (85%) were claims related.

209 These findings confirm the need for industry standards in this area to protect policyholders.

**Evidence**

210 From our review of the dispute data, it is clear that policyholders with a mental health condition face a challenging burden to establish that their condition entitles them to make a valid claim. The evidence for this includes the need for policyholders to attend psychiatric assessments, complete

activity diaries, submit regular progress claim forms, provide medical reports and attend interviews with private investigators, as well being the subject of surveillance.

- 211 Approximately 5% of the disputes we reviewed about evidence involved an allegation by the policyholder that their insurer had engaged in investigation and surveillance practices that they believed to be unfair or unreasonable, or even exacerbated their condition, as demonstrated by Case study 3.

### Case study 3: Impact of claims surveillance on a mentally ill policyholder

The policyholder was injured and received income protection for a few years. The policyholder was followed and photographed to the extent that they felt under great pressure and life was becoming very difficult. The policyholder suffered from a mental health condition and, from the policyholder's perspective, felt the insurer was using this to their advantage.

The matter was resolved by settlement after the policyholder contacted the EDR scheme.

- 212 Although we recognise that insurers need to use fraud management systems to ensure that only genuine claims are accepted (see paragraph 320), the vulnerability of claimants with a mental health condition must be considered as a part of these systems, as should the probative value of a surveillance for these types of claims.

### Non-disclosure

- 213 From our review, we found that 15% of the disputes that related to a claim for a mental health condition related to non-disclosure. Although these complaints depend on the specific facts of each case, three potentially concerning issues emerged from the dispute data:
- (a) An insurer may investigate a lengthy period of the policyholder's mental health history, as part of assessing whether there was a pre-existing condition. The complaints we reviewed revealed that insurers had examined policyholders' medical history as far back as seven, 16 or 20 years. In addition, we saw an example where an insurer considered a 'pre-existing condition' to include a matter as simple as a comment to a GP (e.g. the 'baby blues' after childbirth) or a visit to a counsellor (in the absence of any diagnosis), which then resulted in an unrelated mental health related claim being declined many years later.
  - (b) We saw some instances where insurers avoided policies for non-disclosure of a mental health condition even though the mental health condition did not cause or contribute to the claim. For example, a cancer claim was rejected and the policy was voided due to an undisclosed history of depression: see Case study 4.

- (c) Because of a combination of the issues in subparagraphs (a) and (b), policyholders may be reluctant to seek help for mental health conditions (even if they are ultimately not diagnosed with any mental health condition, or they receive help that enables them to recover and have not relapsed) if they are aware of the impact it may have on their ability to access life insurance cover (and at what price).

214 Case study 4 provides an example of some of these concerns.

#### Case study 4: Failure to disclose depression leads to declined cancer claim

A policyholder made an income protection claim after being diagnosed with cervical cancer and receiving both radiotherapy and chemotherapy treatment. They were very ill and could not work.

The insurer had been paying monthly benefits but then informed the policyholder that it had cancelled their policy as they did not disclose that they had experienced depression several years ago.

The insurer claimed that, had the policyholder disclosed their depression from several years ago when they applied for the policy, they would not have offered them insurance cover under any circumstances.

The policyholder observed that the non-disclosure was innocent and that they had never been depressed enough to require medication or time off work.

The matter was resolved by settlement between the parties after the policyholder went to EDR.

#### Further work: Reasons for declined claims

ASIC will undertake targeted surveillance work to examine the reasons for substantially higher numbers of disputes for particular insurers than their share of claims, focusing on the areas of evidence and delay which had the highest numbers of disputes.

## Policy definitions

215 In our review, we looked at policy definitions for medical conditions in trauma products, and the definitions of TPD and pre-existing conditions in PDSs and in policy documents provided to group (superannuation) policy members to identify any systemic issues (e.g. insurers relying on outdated definitions and/or not paying claims in the ‘spirit’ of the policy based on a technicality in a definition).

216 Our findings indicated that:

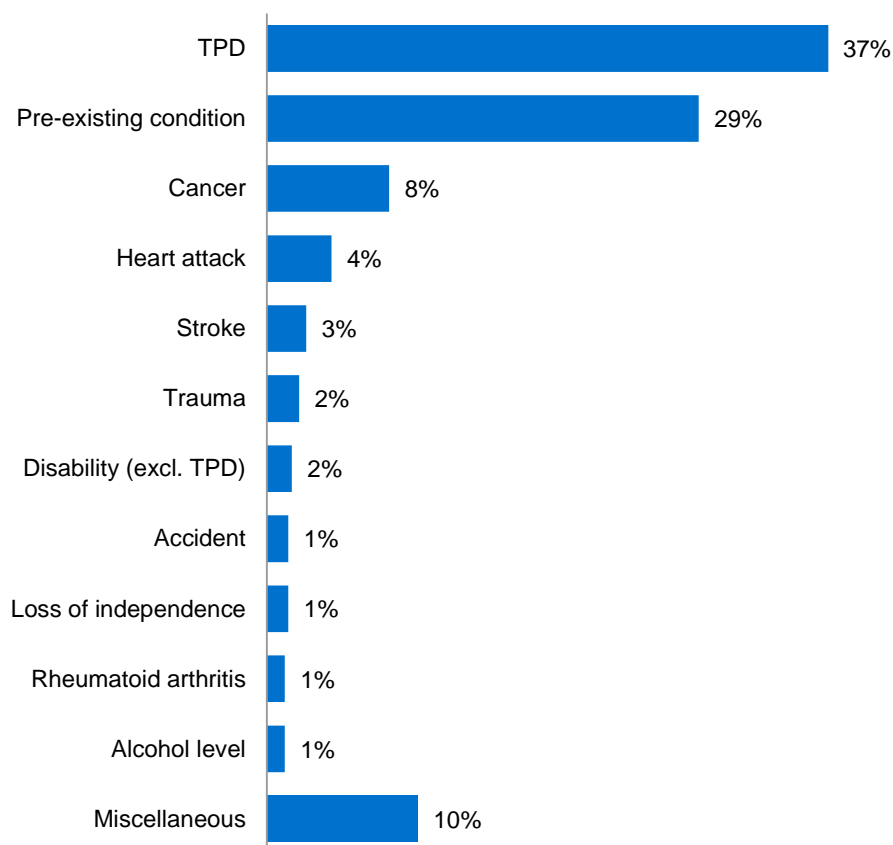
- (a) disputes about policy definitions accounted for 9% of all life insurance disputes;



- (b) most disputes related to definitions for TPD and pre-existing conditions;
- (c) definitions for different medical conditions varied across the industry, with even subtle variations significantly affecting the extent of cover provided; and
- (d) some insurers had not paid claims based on a ‘technicality’ or the application of a potentially out-of-date definition, while other insurers had paid claims on an ex-gratia basis, despite the policy definition not being met, as the payment was in the ‘spirit’ or intent of the policy.

217 Even though disputes about policy definitions were relatively low as a proportion of all disputes (9%), the rates of declined claims were higher for TPD and trauma policies, which typically contain technical definitions.

**Figure 20: Breakdown of disputes relating to ‘Definitions’ under ‘Claim’ category (2013–end March 2016)**



Note 1: See Table 28 in Appendix 2 for the complete data in this figure (accessible version).

Note 2: Data includes all disputes between 1 January 2013 and 29 March 2016, including insurers outside the scope of our review. ‘Miscellaneous’ includes categories with less than five disputes relating to policy definitions.

Sources: ASIC and external third parties

- 218 Across the industry, we also found that for some insurers, disputes about policy definitions were disproportionate to their share of claims. For example, one insurer had four times the number of disputes about definitions relative to their share of claims. Another insurer had double the share of disputes about definitions relative to their share of claims.
- 219 With this background, as part of our review, we reviewed a number of life insurance policy definitions to compare their scope and also their interpretation by insurers during the claims process.
- 220 Our observations on the variations between the definitions are set out in Table 4.

**Table 4: Review of policy definitions—Summary of observations**

Definition	Observations from our review of the definition
<b>Heart attack</b>	<p>The policies used a variety of definitions that included various diagnostic tests to determine the severity of the heart attack.</p> <p>Some policies included troponin as a diagnostic test.</p> <p>While all policies allowed for secondary tests, some policies stated that the insurer would consider appropriate and medically recognised tests if technological advancements had superseded the test set out in the policy.</p> <p>One insurer had a share of heart attack definition disputes that was six times its share of claims. Two other insurers also had higher than proportionate heart attack disputes based on their share of claims.</p>
<b>Severe rheumatoid arthritis</b>	<p>10 of the 11 policies prescribed the type of medical specialist who could diagnose the condition.</p> <p>The policy definitions required the diagnosis of severe rheumatoid arthritis to meet the criteria for the onset of the conditions, symptoms and other criteria (e.g. morning stiffness and rheumatoid nodules). Two definitions referred to the 'failure' of treatment regimes.</p>
<b>Multiple sclerosis</b>	<p>The policies referred to both the type of medical specialist who could diagnose the condition and the diagnostic criteria.</p>
<b>Stroke</b>	<p>The definitions referred to onset timeframes, the type of medical specialist who was required to confirm the diagnosis and a series of diagnostic tests.</p>
<b>Cancer</b>	<p>Cancer is a complex condition and therefore there is great complexity in the definition of specific cancers and cancer generally.</p> <p>Insurers require the cancer to be characterised with 'uncontrolled' or 'unlimited growth' and 'spread of malignant cells' and the 'invasion' of tissue.</p> <p>The definitions include various medical and/or histological classifications.</p> <p>One insurer had a level of cancer definition disputes that was four times its share of claims. Another insurer had a level of cancer definition disputes that was almost three times its share of claims.</p>

Definition	Observations from our review of the definition
<b>TPD</b>	<p>The definitions varied across policies, and within policies, in length and scope. As part of the definitions, the policyholder:</p> <ul style="list-style-type: none"> <li>• was required to meet a threshold level of disablement (e.g. 'unlikely to be able to work again');</li> <li>• had their ability to return to work tested against different types of work (e.g. either their usual job for 'own occupation' or any job at all for 'any occupation', while some insurers required policyholders to have been working for a certain number of hours a week for a particular period;</li> <li>• needed to have not been at work for at least three months or six months, depending on the policy;</li> <li>• needed to be able to show that they were unable to perform certain activities unaided, known as 'loss of independent existence' or 'activities of daily living'; and</li> <li>• was required to take steps to manage their care, such as attending regular appointments.</li> </ul> <p>Some policies contained exclusions (e.g. disablement caused by alcohol or drug abuse).</p> <p>Our review of the case studies indicated that consumers are not necessarily aware that meeting Centrelink tests for a disability payment or a worker's compensation test for disablement will not automatically mean that the policyholder qualifies for TPD, because the tests are different.</p> <p>One insurer had a level of TPD definition disputes that was approximately four times its share of claims. Another insurer had a level of TPD definition disputes that was just over double its share of claims.</p>
<b>Pre-existing conditions exclusions</b>	<p>The definitions varied greatly across policies in both their requirements and their location in the policy. Generally, for non-advised policies, there were 'blanket' exclusions for all pre-existing conditions.</p> <p>The definitions did not always require a pre-existing condition to be diagnosed, but generally concerned the existence of symptoms which either led the policyholder (or a reasonable prudent policyholder) to seek medical assistance or treatment.</p> <p>Only one policy limited a pre-existing condition to a particular time period before the inception of the policy; this policy excluded a number of default pre-existing conditions that may have emerged at any time.</p> <p>In the dispute data, some policyholders did not disclose a pre-existing condition before the policy was issued. This was for a number of reasons, including that they were not formally diagnosed with a condition or they believed they were cured.</p> <p>Policyholders and insurers, and their doctors, can disagree about whether the condition leading to the claim was related to a pre-existing condition.</p> <p>One insurer had a level of disputes about pre-existing condition definitions that was nearly four times its share of claims.</p>
<b>General</b>	<p>The definitions of all events vary in length and scope.</p> <p>The difference in definitions for the same event can be very confusing and make it difficult, if not impossible for policyholders to compare products.</p> <p>Insurers may choose to make ex-gratia payments to policyholders where the event falls outside the policy definition. However, the insurer is not required to do so.</p>

- 221 Our review showed that policy definitions are not always consistent between insurers, and they may have different thresholds or medical criteria for policyholders to meet. We also found that these definitions are often complex and likely to be difficult, or impossible, for policyholders to understand what they are covered for (or more crucially, what they are not covered for).
- 222 We also considered the exhaustive nature of policy definitions. Some examples demonstrated that not every potential circumstance or event can be contemplated by a policy definition: see Case studies 6, 7 and 8.
- 223 Our review highlighted examples of claims outcomes based on the application of technical definitions, where policyholders' claims may be declined by insurers based on a 'technicality'. Conversely, our review also highlighted examples where insurers paid claims 'in good faith' or in the 'spirit' of the policy despite the technical definition not being satisfied.
- 224 We are concerned that this approach presents a high degree of uncertainty for policyholders in a situation where the success or otherwise of a claim will have a significant impact on the policyholder's financial situation. Policyholders should not have to rely on insurers' purported 'good faith' or 'good will' to have their claim paid; rather, this should be a matter that is clearly set out in a policy; and one which the consumer understands at the time they start cover under the policy.
- 225 Some insurers and industry experts we consulted indicated that medical conditions for some conditions in policies being currently sold may be out of date and not in line with current medical practices or standards.
- 226 Insurers may not have updated these definitions for various reasons, including not taking steps to assess whether that they are out-of-date, taking the approach that they are 'market consistent' or because they have 'the technical support of reinsurers', or the reinsurer has not approved the update.
- 227 For older policies, the lack of updates is also likely to be due to the operation of s9A of the Life Insurance Act, which provides that life insurers cannot alter policies (including increasing premiums) unless the alteration improves the policy's benefits and is agreed to by the policyholder. As updating the definition would generally require a repricing of the policy, this can generally not be done automatically by the insurer. Changing some older definitions may actually be to the detriment of the policyholder, where the older definition covers a broader range of events
- 228 These reasons do not justify the sale, marketing and promotion of products that contain out-of-date definitions. Superannuation trustees and financial advisers should also carefully consider this issue when reviewing policies offered to members or recommending policies to clients.

- 229 The documents that insurers have provided to us indicate that many insurers review the medical definitions at set intervals, as well as in response to changes in the competitive environment and feedback from claims and customer experience. These reviews include input from actuaries, reinsurers and medical experts, and superannuation trustees (where relevant).
- 230 As part of insurers' independent reviews, we have asked them to review product design processes, including the currency of policy definitions. In response, some insurers have recently changed certain definitions (e.g. the definition of heart attack now including references to new diagnosis tools) and updated definitions for severe rheumatoid arthritis. The new Code developed by industry also addresses this issue by requiring insurers to review definitions at least every three years.
- 231 Medical advancements can also have an impact on definitions. For example, not all defined events may actually be medically (or financially) traumatic due to:
- (a) medical treatment; or
  - (b) medical advancements in the diagnosis of events which may not have been previously detected because of minimal trauma, or lack of trauma, to the policyholder (e.g. mild heart attacks) and/or the increase in the number of diagnoses.
- 232 The consequence of definitions covering events which are not 'traumatic' means that policyholders may be eligible to receive payment despite sustaining minimal or no loss. As such, some insurers are considering whether policies should better focus on the loss suffered and the expected impact on the policyholder, rather than the satisfaction of a technical definition. This may also address the issue of policyholders suffering obviously traumatic events, but the technical policy definition not being fulfilled.
- 233 For TPD definitions, we understand that the recent approach has been a 'tightening' of the definition, so that the threshold for a successful claim is significantly higher. For example, while the policies we reviewed mostly referred to a policyholder being 'unlikely' to ever work again, an increasing number of policies now require that the policyholder is 'unable' to work again, with further requirements added for reasonable rehabilitation and re-skilling. Some of the industry experts expressed the view that this undermines the main purpose of TPD, which is payment to cover the inability of people to work again.
- 234 For pre-existing conditions definitions, policyholders may not know how much disclosure is required, and we are also concerned about allegations that insurers are 'fishing' for information about pre-existing conditions at claim time, particularly their consideration of historical medical records that do not relate to the policyholder's condition that led to the claim.

## Our review of definitions

235 For this review, we reviewed policy definitions for the following conditions:

- (a) heart attack;
- (b) severe rheumatoid arthritis;
- (c) multiple sclerosis;
- (d) stroke; and
- (e) cancer;

236 We also reviewed the definitions for TPD and pre-existing medical conditions (typically used in non-advised policies).

### Heart attack

237 Seven of the PDSs we reviewed included trauma or critical illness cover. All of these policies contained a definition of ‘heart attack’.

238 The definitions we reviewed indicate that a policyholder will generally receive a lump sum payment when they have a heart attack that is of the defined level of severity. However, the ‘defined level of severity’ varied, as did the tests and diagnostic criteria used to determine whether the definition was met.

239 We are also aware of allegations that the use of ‘troponin’ as a criterion to assess the severity of heart attacks may not be in line with current medical practice.

Note: In general, when a person suffers a cardiac injury such as a heart attack, troponin is released into the bloodstream. Troponin continues to be released until the injury is stopped or reversed and thereafter the troponin level will decrease. To test the level of troponin in the bloodstream, a blood sample is taken and antibodies are introduced to the sample. The level of troponin is not measured directly; rather, a measurement is taken of the signal emitted by the antibodies due to the presence of troponin.

240 Clinically, troponin testing is used to diagnose whether a heart attack has occurred. It is generally not used to test the severity of a heart attack. In contrast, an insurance policy may not intend to cover all heart attacks and instead may rely on troponin testing as one way of assessing whether a heart attack meets a defined level of severity.

Note: There is scientific debate about whether troponin levels are linked with heart attack severity. Furthermore, there are a number of factors that can affect the level of troponin measured (apart from any relationship that may exist with heart attack severity) including when the test is administered after the injury, the particular test that is used and the patient’s relative heart mass.

241 Four of the policies we reviewed used ‘troponin’ as a diagnostic criterion and Troponin I, Troponin T and cardiac enzyme CK-MB were generally referred to together. Some policies required the enzymes to be at a certain

level (i.e. levels of ‘Troponin I greater than 2.0µg/L’ (micrograms per litre)). Other policies referred to these three tests, or more broadly ‘cardiac biomarkers’ where ‘at least one level [is] above the 99<sup>th</sup> percentile of the upper reference limit.’

242 All of the policies allowed for a secondary set of criteria if the first tests could not be satisfied or were inconclusive and one policy stated that it ‘may’ allow for alternative criteria. Four policies stated that ‘appropriate and medically recognised tests will be considered’ if there are new technological advancements that supersede the prescribed tests. Some policies referred to ‘troponin or equivalent’. It is unclear if this would allow for a different test to be used.

243 Our review of dispute data and information provided by insurers has illustrated the potential detrimental outcomes for policyholders when technical (and exhaustive) definitions are applied to insured events, and specifically heart attacks. One of these examples also highlights the risk of mistakes being made when applying technical definitions: see Case study 5.

#### Case study 5: Incorrect troponin conversion

A policyholder’s critical illness claim was declined on the basis that their Troponin Level I did not reach the level required to satisfy the definition of heart attack under the policy. The insurer’s chief medical officer (CMO) reviewed the medical reports and confirmed that the troponin had not reached the level required. The CMO was required to convert a nanogram (ng/L) reading (which the policyholder’s medical records reported on) to a microgram (µg/L) reading.

The policyholder disputed this. The policyholder’s medical reports confirmed the troponin level was above the level required. After review of the CMO advice and medical reports, it was found that the conversion was done incorrectly, and the correct microgram conversion met the definition of heart attack under the policy.

The claim was paid during the insurer’s IDR process.

#### Case study 6: Unexpected accident fell outside the ‘heart attack’ definition

A metal object accidentally lodged in the policyholder’s heart leading to cardiac arrest and requiring open heart surgery. This did not meet the policy trauma definition as, under the policy, only heart conditions related to congenital conditions and/or out of hospital cardiac arrests caused by arrhythmia were covered.

The matter was raised with EDR and the insurer made a goodwill payment outside of the policy terms and conditions.

- 244 While the data from insurers generally did not include the subject matter of the claims, one insurer's information indicated that the declined claim rate for heart attack claims was 17% (of a total of 432 claims).
- 245 We reviewed 18 disputes about the policy definition for 'heart attack' (4% of all definition-related disputes).
- 246 Our analysis of the dispute data in light of insurers' claims numbers by share of claims indicated that for three insurers, the number of disputes about 'heart attack' specifically was adversely disproportionate to their share of claims. For example, one insurer's share of heart attack definition disputes was six times their share of claims.

### **Severe rheumatoid arthritis**

- 247 We reviewed 11 policy definitions for 'severe rheumatoid arthritis': six individual risk policies issued by different insurers (all trauma cover) and five group insurance policies (involving three insurers). All were contained within the definition of TPD as a TPD trigger event.
- 248 For a diagnosis of severe rheumatoid arthritis, 10 of the policy definitions required it to be by a 'rheumatologist' or 'appropriate consultant medical specialist', whereas one required 'appropriate radiology and blood tests'.
- 249 Nine of the policy definitions required the diagnosis for severe rheumatoid arthritis to meet criteria for the onset of the condition (e.g. at least a six-week history involving three or more joint areas), symptoms (e.g. 'typical rheumatoid joint deformity'), and at least two other criteria such as morning stiffness and rheumatoid nodules.
- 250 One definition required other diagnostic criteria (including symptoms of swelling in at least 20 joint or four large joints and failure of treatment and drug therapy), and the other definition required 'appropriate radiology and blood tests' and failure of all treatment regimens.
- 251 Our research found that for severe rheumatoid arthritis, advancements in medication have led to improved outcomes for sufferers—particularly in minimising the appearance of 'joint deformity' and 'rheumatoid nodules'. However, anecdotal evidence plus information from the dispute data suggests that, even with medication, sufferers may still be affected by pain and be unable to complete at least some tasks they were previously able to do.
- 252 While we did not collect data from insurers about the subject matter of claims, we note that one insurer (in the past year) had declined 37% of claims for severe rheumatoid arthritis (out of a total of 73 claims). This high declined claim rate suggests that policyholders may be suffering from this condition, but not meeting the policy definition or criteria.



- 253 In the dispute data we reviewed, there were five disputes about the policy definition of severe rheumatoid arthritis. Three insurers were involved.
- 254 Some of the insurers we spoke to stated that they recognised that their policy definitions for this condition were out of date, particularly due to a failure to take into account the effect of advances in treatment. These insurers indicated that they would be updating their definitions and, in some cases, reviewing all previous declined claims in the past two to five years.

#### Case study 7: Consumer expectation gap—Rheumatoid arthritis (nodules and bone erosions)

The policyholder was diagnosed with severe rheumatoid arthritis. However, their claim was declined on the basis that they did not have rheumatoid nodules or bone erosions. However, the policyholder and their doctor stated with the form of rheumatoid arthritis the policyholder had, sufferers do not get rheumatoid nodules and rarely show bone erosions.

The policyholder discontinued the matter after it was raised with EDR.

We will follow up with the insurer with respect to the outcome of the policyholder's claim.

#### Case study 8: Consumer expectation gap—Rheumatoid arthritis (joint deformity)

The policyholder suffered from severe rheumatoid arthritis, which led to pain and swelling in all their joints. A specialist confirmed the diagnosis and prescribed methotrexate to control the progression and prevent irreversible joint deformity. However, the claim was declined on the basis that the policyholder did not meet the definition, as there was no joint deformity.

The dispute was resolved by settlement after the policyholder raised it with EDR.

### Multiple sclerosis

- 255 We reviewed 12 policy definitions for 'multiple sclerosis' across the industry, comprising seven individual risk policies issued by different insurers (all trauma cover), and five group insurance policies (involving three insurers). All definitions were within the definition of TPD as a TPD trigger event.
- 256 The definitions varied in length and scope. One definition simply required an 'unequivocal diagnosis' that was 'confirmed by a consultant neurologist.' Six of the policies required the policyholder to have 'more than one episode of defined neurological deficit.' Two other policies required the additional aspect of 'more than one episode of well-defined neurological deficit with persisting neurological abnormalities'.
- 257 In the disputes we reviewed, there was only one dispute about the policy definition of 'multiple sclerosis'.

## Stroke

- 258 We reviewed eight policy definitions for ‘stroke’ (all trauma cover), and found that they significantly differed in threshold requirements.
- 259 For example, in half of those reviewed, the definition of ‘stroke’ required:
- (a) the onset to be greater than 24 hours; or
  - (b) a neurologist to confirm diagnosis; and
  - (c) clinical evidence—computed tomography (CT) scan, angiogram, magnetic resonance imaging (MRI) or ‘other reliable’ or ‘similar scanning’ techniques.
- 260 For others, the threshold was less prescriptive in that the requirement to meet the definition was neuro-imaging evidence or, in another case, a diagnosis by two neurologists.
- 261 The disputes we reviewed in this area indicated that a history of common conditions such as headaches may be grounds for insurers declining a claim on the basis that a stroke was caused by a pre-existing condition. The disputes also indicated that insurers may decline claims based on one aspect of clinical evidence, despite the effect of the stroke on the policyholder and other clinical evidence supporting the diagnosis.

### Case study 9: Consumer expectation gap—What is a stroke depends on the diagnostic test used

The policyholder had a stroke and was asked to provide evidence of a particular diagnostic test to the insurer. A small percentage of the time, strokes are not able to be detected using this diagnostic test. The policyholder provided other information from their hospital.

The stroke significantly impacted the policyholder's life. However, the claim was declined under the policy's trauma cover on the basis that there was no evidence of the stroke on that particular diagnostic test.

The dispute was resolved by settlement after the policyholder raised it with EDR.

- 262 In the disputes we reviewed, there were 11 disputes about the policy definition of ‘stroke’ (3% of all definition-related disputes). This involved seven insurers with one insurer the subject of five of these disputes.

## Cancer

- 263 A review of the 13 definitions for specific cancers and ‘cancer’ highlights the complexity of the condition and the requirements to meet the definition. In most cases, the definition stated that specific tumours are included. Where some excluded specific cancers, they included them under a specific definition (e.g. ‘prostate cancer’). All these definitions were contained in

individual risk policies, as part of trauma cover, with some policies containing multiple definitions for different types of cancer.

- 264 Generally, insurers required the cancer to be characterised with ‘uncontrolled’ or ‘unlimited growth’ and ‘spread of malignant cells’ and the ‘invasion’ of tissue. Furthermore, the definitions also included various medical and histological classifications. One insurer also required pathology tests to confirm the cancer.

Note: This characterisation may present difficulties in terms of applying the definition in a constant manner. The words used are not qualitative and appear ambiguous, which may result in different interpretation and different outcomes.

- 265 The following case studies give examples of claims declined on the basis of policy definitions for cancer.

#### Case study 10: Outdated requirement for pathology test

The policyholder was diagnosed with liver cancer by CT scan. However, the claim was declined because the definition of cancer in the policy stated that the cancer must be ‘confirmed by pathology results’. The policyholder’s doctors contacted the insurer to explain that pathology tests are no longer used by the medical profession to diagnose or confirm liver cancer. The policyholder’s doctors determined that a liver biopsy (a pathology test) would be life threatening and unreasonable in the circumstances, given the severity of the policyholder’s illness.

The dispute was resolved by settlement after the policyholder raised it with EDR.

#### Case study 11: Consumer expectation gap—Severity of cancer matters

The policyholder notified the insurer that they were diagnosed with cancer and it was removed. After asking a number of questions, the insurer advised the policyholder that they did not consider their condition would be covered since the cancer was removed and there was ‘no destruction of normal tissue’.

Some years later, the policyholder again enquired about this matter. The insurer informed them that the decision or advice initially provided might have been incorrect. The insurer looked into the matter and settled the claim over the phone for the amount insured at the time of the diagnosis. The policyholder raised the matter of interest on that amount considering the initial incorrect decision or advice and was referred to the insurer’s IDR process. The matter of interest payable was questioned given the initial record of the phone conversation could not be found and no claim was lodged.

The policyholder raised the matter with EDR and the dispute was resolved with the claim being paid.

- 266 Based on the dispute data, 34 disputes related to policy definitions of cancer (8% of all disputes about policy definitions).
- 267 Our analysis of the dispute data indicated that, for two insurers, their share of disputes specifically about the definition of ‘cancer’ was adversely disproportionate to their share of claims. For example, one insurer had nearly four times the share of cancer definition disputes relative to their share of claims. Another insurer had almost three times the share of cancer definition disputes relative to their share of claims.

### TPD

- 268 We reviewed the definition of TPD in eight retail and non-advised policies, and seven group life policies (involving five life insurers).
- 269 TPD benefits are designed to provide long-term financial compensation to policyholders if they are unlikely (or unable) to be able to return to work or their previous occupation (depending on the policy). The range of eligibility requirements across each of the elements of the definition indicates the challenge for policyholders to understand the value of the policy they are selecting, as well as the difficulties encountered at claim time in establishing eligibility to claim.
- 270 Table 5 sets out the elements of the definition we reviewed.

**Table 5: Variations in the definition of TPD**

Element	Explanation
<b>Threshold disablement</b>	To meet the definition of TPD, the disablement required was variously expressed as the policyholder being ‘unlikely to ever work’, ‘unlikely ever again to be engaged in any occupation’, ‘unlikely ever to be able to work again’ or ‘likely to be so disabled for life’. The policies also generally deemed some events automatically TPD (e.g. loss of both hands or feet or a combination of these events).
<b>Own occupation versus any occupation</b>	<p>In the policies we reviewed, there was some variation in the definition of ‘occupation’ between insurers in assessing the return to occupation capacity for policyholders (and also some policies where the policyholder could elect the level of cover). That is, whether the policyholder is fit to return to their own occupation or ‘any’ occupation. The latter test is harder to meet.</p> <p>Note: Since recent changes to the SIS Act, only definitions for ‘any occupation’ can be used in group policies (‘own occupation’ cover is prohibited for any new cover issued to a member after 1 July 2014: see reg 1.03C of the SIS Regulations). Since 1 July 2014, insurance cover offered inside superannuation funds must have wording that aligns with SIS Act conditions of release (see reg 4.07D of the SIS Regulations).</p>
<b>Waiting periods</b>	Generally, a claimant must be wholly out of work for a continuous period of at least three consecutive months before they are eligible to claim under a TPD policy. One insurer required a six month continuous absence from work as a pre-requisite. In contrast, three other insurers specified that certain conditions (e.g. severe rheumatoid arthritis and major head trauma) would automatically be deemed to be TPD without any waiting period.

Element	Explanation
<b>Pre-existing work provisions</b>	Some insurers required the policyholder to have been engaged in 12 consecutive months work before the TPD event as a condition of eligibility. At least one required the policyholder to be engaged in full-time gainful occupation immediately before the event. However, others had a lower threshold of minimum hours of work.
<b>Loss of independent existence and activities of daily living</b>	This aspect of the definition refers to the policyholder's ability to perform a specified number of activities of daily living (e.g. bathing/showering, eating and drinking, using a toilet, and dressing and undressing). Generally, a policyholder will be considered TPD if they cannot perform two or three of these activities. This generally applies to TPD policies with 'any' occupation provisions.
<b>Ongoing care</b>	Some policies had 'ongoing care requirements' for a policyholder to meet the definition of TPD. For example, some required the policyholder to have regular appointments and follow the advice and care of a specialist, and take steps to avoid further illness or injury. Others specified 'regular care of a medical practitioner'. One required the policyholder to have undergone rehabilitation for the illness or injury.
<b>Exclusions</b>	Some of the policies we reviewed contained exclusions, such as if the disablement is caused directly by alcohol or drug abuse, self-harm (including attempted suicide), or pre-existing conditions: see paragraphs 276–286.

- 271 The variations between the policy definitions may be confusing for policyholders and not enable simple comparison. For example, the impact of 'any occupation' clauses (as opposed to 'own occupation' clauses) is crucial in terms of outcomes for policyholders. A policyholder with the benefit of an 'own occupation' clause may fall within the definition of TPD if they cannot perform their own occupation.
- 272 However, the same policyholder with an 'any occupation' clause will only fall within the definition of TPD if they cannot work in any job, and meet one of the elements in Table 5 as well (e.g. be unable to perform two or three activities of daily living) to be deemed TPD. Similarly, a clause that states that a policyholder needs to be 'unable' to work again is significantly different to a clause that states that they need to be 'unlikely' to work again
- 273 The details of TPD-related claims disputes we have examined illustrate the complexity of these claims and the various criteria that a policyholder needs to meet to fall within the definition of TPD. The case studies also confirm that if a policyholder is deemed unable to work due to their disability by Centrelink or has been paid workers' compensation due to the same illness or injury, this does not mean they are eligible to make a TPD claim because the tests and criteria are different.

### Case study 12: Consumer expectation gap—Centrelink disability vs TPD definition

The policyholder had various medical conditions. Their Centrelink job capacity report stated that the policyholder had 'no work capacity and this is not likely to improve over the next two years' and 'medical conditions are the only reason that they were unable to participate in job search usually required by Centrelink'. The policyholder was placed on a disability support pension and advised to make a TPD claim with their life insurer.

However, the life insurer declined the claim. Two years later, Centrelink job capacity reports continued to indicate the policyholder's incapacity to work, with no further assessments required to remain on the disability support pension. The TPD claim was declined again.

The dispute was resolved by settlement after the policyholder raised it with EDR.

### Case study 13: Consumer expectation gap—'Own' occupation vs 'any' occupation

The policyholder was a 'blue collar' worker who was also illiterate. They suffered an injury rendering them unable to do any physical work. However, their TPD claim was declined on the basis that they could be retrained in another occupation (e.g. a TAFE teacher). The policyholder indicated that they would be unable to afford to train in another occupation to the level required, and had only ever done physical work.

The policyholder raised the matter with EDR and the dispute was resolved with the claim paid in full.

274 For disputes that we reviewed, there were 156 disputes about TPD policy definitions (37% of all definition-related disputes).

275 Our analysis of the dispute data in light of claims on insurers by share of claims indicated that for two insurers, the number of disputes in relation to 'TPD' specifically was adversely disproportionate to their share of claims. For example, one insurer had approximately four times the share of TPD-definition disputes relative to their share of claims. Another insurer had double the number of TPD definition disputes relative to their share of claims.

### Pre-existing conditions

276 Life insurance policies often contain provisions that exclude pre-existing conditions, meaning that an insurer can deny a policyholder's claim if it is related to a condition that existed before the policy was entered into (or sometimes within a specified period of time).

277 An insurer can choose to offer cover to a policyholder when pre-existing conditions are disclosed. If a formal underwriting process is conducted

before the cover is in effect, the insurer may decide to offer the cover without the exclusion for the disclosed medical condition.

278 As noted earlier, s21 of the Insurance Contracts Act places a legal obligation on the policyholder to disclose all matters they know, or a reasonable person in the circumstances of the policyholder would be expected to know, is material to the insurer's decision to accept the insurance.

279 However, under s47 of the Insurance Contracts Act an insurer cannot rely on a pre-existing exclusion provision where:

- (a) the policyholder was not aware of the pre-existing condition; and
- (b) a reasonable person in the policyholder's position would not be expected to be aware of the pre-existing condition.

280 Our review of policies revealed that, in terms of a policyholder's knowledge or expected knowledge of a pre-existing condition, insurers' definitions differed. For example, some policies referred to:

- (a) injuries or illnesses the policyholder 'was diagnosed with, had any symptoms of, or was treated for' prior to the policy inception;
- (b) health conditions for which the policyholder 'need[ed] to consult a medical practitioner or other health professional'; or
- (c) conditions where 'symptoms exist which would cause an ordinarily prudent person to seek diagnosis, care or treatment, or that medical advice or treatment has been recommended by or received from a Medical Practitioner'.

281 Insurers also varied in the time period of these exclusions (e.g. whether they required conditions suffered since birth to be disclosed, or only those experienced within the past five years).

282 In the dispute data we received, there were 120 disputes about the definition of pre-existing conditions (29% of all definition-related disputes).

283 Our analysis of the dispute data in light of insurers' disputes by share of claims indicated that for three insurers, their share of disputes about pre-existing conditions definitions specifically was adversely disproportionate to their share of claims. For example, one insurer had nearly four times the share of pre-existing condition definition disputes relative to their share of claims.

284 Our review of the dispute data indicates that many disputes about pre-existing definitions arise because policyholders may not disclose all conditions that they have ever suffered from, including in the distant past. Further, policyholders may not disclose conditions that they have not been formally diagnosed with or conditions for which they believe they have been cured.

285 The dispute data also indicates that there can be disagreement between policyholders and insurers about whether the condition leading to the claim was related to a pre-existing condition. When these disagreements occur, there can also be conflicting medical evidence: see paragraph 297.

#### Case study 14: What is a pre-existing condition?

The policyholder was in an accident with a truck while riding their motorbike and their back was injured. The insurer denied the policyholder's income protection claim in full on the grounds that they had a pre-existing condition. A doctor had reported that the policyholder had a defect in their back which may have been there from birth and contributed to their spinal issues. The policyholder was unaware that they had any defect in their back. They did not suffer any pain before the accident and maintained that if there had been no accident, their back would have operated as it had before. The policyholder's surgeon was also not of the view that there was a pre-existing condition.

The policyholder raised the matter with EDR and the dispute was resolved with the claim paid in full.

286 Media reports and discussion with industry experts referred to an alleged practice of insurers obtaining access to policyholders' personal Medicare billing data dating back to the early 1980s to identify pre-existing conditions that the individual failed to disclose, enabling insurers to deny the claim.

#### Further work for insurers: Policy definitions

Given the concerns identified, we expect insurers to:

- review the currency and appropriateness of policy definitions; and
- examine advertising and representations that insurers, and trustees, make about the scope of cover to ensure that this is aligned with the definitions and cover provided, and report any discrepancies to us.

We will conduct a follow-up review of the currency and appropriateness of policy definitions, after insurers' first three-yearly review stipulated in the Code (late 2019). We will consider options (including the need for law reform) if there are still concerns about the currency and appropriateness of policy definitions.



## D Detailed findings: Claims handling and sales practices

### Key points

Most disputes we reviewed related to claims procedures (e.g. the evidence required to be provided for a claim to be assessed) and delays in claims assessments.

Insurers' procedures generally required significant amounts of information and supporting evidence for a claim to be assessed. The timeframes for claims assessments were also generally likely to be lengthy, due to the number of steps involved.

Insurers' claims systems (including staff) varied significantly, with some systems including incentives and performance measurements for claims staff and management.

## Claims procedures

### Overview of insurers' procedures

287 We asked insurers to provide us with an overview of their claims procedures. This showed that claims procedures are broadly similar between insurers, but have some variations depending on policy type and distribution channel.

288 Typically, claims are initiated by the policyholder (or family member) contacting the insurer, or a superannuation fund member contacting the superannuation fund trustee in the case of group policies offering insurance inside superannuation, and notifying them of an intention to make a claim. On receiving notification, insurers open a claim on their systems and conduct an initial assessment of the claim.

289 Most insurers contact the claimant within a certain timeframe and provide a claim form and further information; some insurers have formal protocols for keeping in regular contact with the claimant.

Note: The Code states that insurers should contact the claimant within 10 days of being notified of the claim. Our analysis indicates that most insurers already do this. The Code also requires insurers to keep the claimant informed about the status of the claim at least once every 20 business days, and to respond to requests for information within 10 business days.

290 The next step is an assessment of whether there is sufficient information and, if not, to request that information. The exact content required differs depending on the policy type and the insurer, but usually includes evidence to substantiate the claim such as medical records and financial information. The insurer may also seek information from external sources or for the

claimant to attend an independent medical examination. For more information about evidence, see Section C.

291 Many insurers also have arrangements for investigations to be undertaken if it is deemed necessary (e.g. as a result of the evidence triggering ‘red flags’). This can involve interviews with the claimant as well as surveillance of the claimant. For more information about insurers’ investigation and surveillance processes, see Section C.

292 Once the assessor has enough information the claim is assessed. Sometimes the claim is referred to the reinsurer for assessment, particularly if the claim is above a certain threshold.

Note: The Code includes timeframes for claims handling, including notifying the claimant within 12 months if a decision has not been made so that they can access the complaints process about the delay.

293 If the claim is denied, some insurers provide a formal mechanism for the claim to be reviewed (which is in addition to the required IDR procedures).

Note: The Code states that insurers should give reasons in writing for the decision and inform claimants that they have the right to copies of the documents and information relied upon and the right to request a review of the decision.

294 Some insurers also have systems in place to monitor individual high-value claims and claims attracting potential media attention at board or board committee level.

295 In relation to claims processes, we also noted that not all insurers appear to have documented controls to monitor claims trends and individual claims outcomes on an ongoing basis. Even for the insurers that do have these processes, we are aware of at least one insurer who is unable to comply with them due to staff resourcing issues.

## Procedural issues

### Evidence

296 The dispute data we reviewed showed that the largest proportion of disputes about claims related to evidence that the policyholder was required to provide to the insurer to assess their claim (25% of all disputes about claims). Given these statistics and the case studies we reviewed, there is a need for industry to review standards in this area.

297 Media reports and some of the industry experts we spoke to referred to an alleged practice of insurers ‘cherry picking’ doctors’ reports, so that where there are conflicting medical opinions about a claim, an insurer may choose the opinion more favourable to them (and therefore less favourable to the policyholder).

298 The dispute data we reviewed indicated some examples of this, although we did not find evidence that it was systemic or widespread.

#### Case study 15: Policyholder's doctor vs insurer's doctor

The policyholder sustained a head injury in an accident that rendered them unable to work, and they made a TPD claim. Their GP, neurosurgeon and pain management specialist certified that they were unable to work and had perfect health before the accident, with their injuries from the accident making them TPD. However, the insurer's doctor determined that the injuries from the accident did not cause the TPD. Their claim was declined on this basis.

The dispute was resolved by settlement after the policyholder raised it with EDR.

299 Other examples of evidence-related dispute issues we reviewed included:

- (a) the amount of evidence a policyholder must submit in support of a claim, such as the need to:
  - (i) obtain numerous and regular medical opinions; and
  - (ii) complete daily activity diaries, and the level of detail required (particularly by policyholders who may be incapacitated);
- (b) whether historical medical records were reliable evidence of a pre-existing condition (see also paragraphs 276–286);
- (c) whether evidence of a policyholder's ability to perform certain activities meant that their medical condition did not exist or was minimised; and
- (d) disputes about the level or type of surveillance practices used by insurers (see paragraphs 320–324).

300 Case study 16 and Case study 17 demonstrate some of these issues.

#### Case study 16: Difficult evidence requirements

The policyholder had a stand-alone trauma policy and was diagnosed with breast cancer, which required them to have a double mastectomy and chemotherapy. They had no history of cancer (although had a family history which they disclosed before taking out the policy). The policyholder made a claim (together with submitting supporting documents) at the time of their diagnosis. Their claim had still not been paid six months later.

The policyholder felt that they could not remember all the medical events that had happened in their lifetime and that the insurer was asking for a large volume of medical records. Responding to these requests was very time consuming, as these were not documents they had readily available.

The policyholder discontinued the claim after the matter was raised with EDR.

We will follow up with the insurer about the outcome of the policyholder's claim.

**Case study 17: Evidence requirements for seriously ill policyholder**

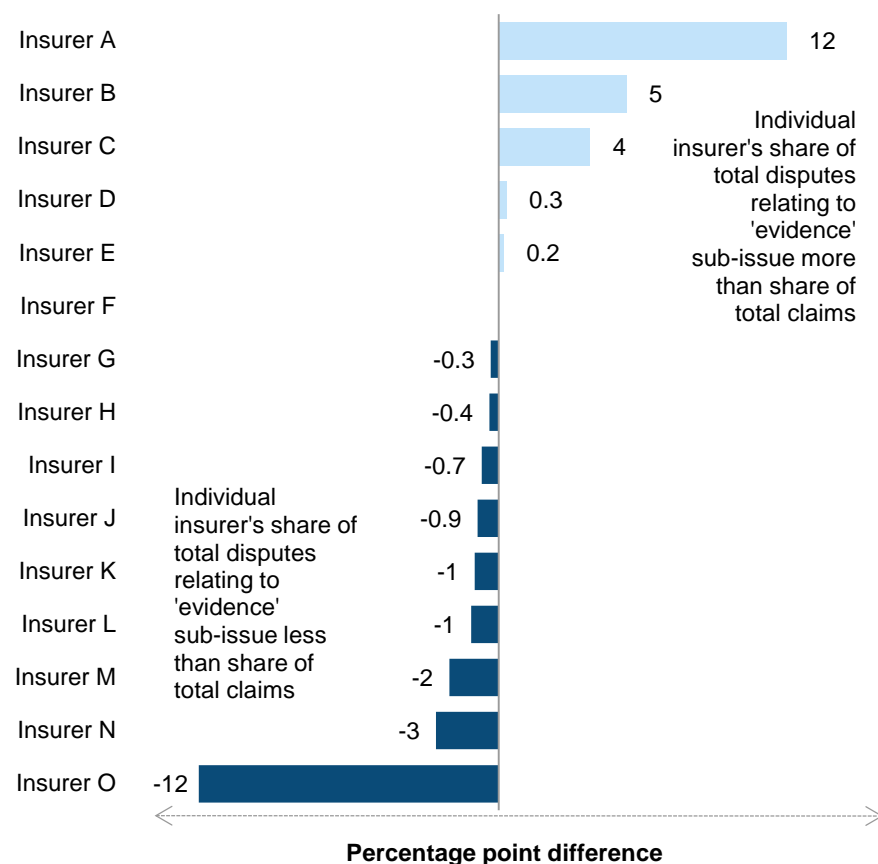
The policyholder was badly burnt in a bushfire while a volunteer in the bushfire brigade. Their income protection claim was initially paid but ceased after additional information that was required was not provided. The information was not provided by the policyholder because they were seriously injured and their recovery time was significant and they were physically unable to gather the information.

The dispute was raised with EDR but was discontinued as the policyholder failed to respond.

We will follow up with the insurer about the outcome of the policyholder's claim.

301 Some insurers had substantially more disputes about evidence than others: see Figure 21. These same insurers also had the highest rates of disputes about delay: see Figure 22. This indicates that there may be potential broad deficiencies across these particular insurers' claims processes.

**Figure 21: Share of 'evidence-related' disputes less share of claims (2013–15)**



Note 1: See Table 29 in Appendix 2 for the complete data in this figure (accessible version).

Note 2: Percentage point differences do not take into account original proportion of total claims.

Sources: ASIC and external third parties, ASIC calculations

- 302 We also looked at issues relating to evidence for claims that may affect Indigenous policyholders. Consumer advocates, particularly in remote areas, have reported difficulty obtaining medical certification for TPD claims because medical services are under-resourced and do not have the time to complete lengthy claims forms.
- 303 Case study describes the experience of an Indigenous policyholder and the required evidence for a claim.

#### Case study 18: Evidence requirements—Identity documents

On a recent trip to a remote community with a superannuation fund, ASIC's Indigenous Outreach Program provided assistance to an Indigenous policyholder with a TPD claim. Inconsistencies in the policyholder's name and birth date had meant the claim process with the insurer had stalled. Their birth certificate incorrectly recorded their birthday as 1 January, which is a commonly recorded birthdate for remote communities if the exact date is unknown. In this case, the policyholder's driver's licence had a different date selected by the policyholder based on the month they were actually born.

After ASIC informed the superannuation fund of the identification issues experienced by Indigenous consumers, the fund and the insurer accepted an alternative identification measure.

Ultimately, the insurer paid the TPD claim.

#### Waiting periods

- 304 Certain cover types include waiting periods, which must be completed before a claim can be assessed. Generally, waiting periods apply to TPD and income protection claims, noting that eligible life and trauma claims are usually payable immediately after the event has occurred.
- 305 Generally, TPD waiting periods range from three to six months. Income protection waiting periods usually vary from between two to three months.
- 306 For TPD claims, some insurers told us that for certain types of injury or disease (specifically, where there are obviously no prospects of improvement) a waiting period of six months may be excessive.

#### Complicated and lengthy claim forms

- 307 Claim forms may be lengthy and complicated. For example, one claim form we reviewed had 26 pages for the claimant to fill out, and 11 pages for their doctor(s).
- 308 We recognise that claim forms need to be comprehensive enough to capture the relevant information needed by the claims assessor to make a timely decision. However, insurers should consider whether all the information

required of the policyholder is relevant, as easy as possible to complete and is not itself the cause of delays.

### Timeframes and delays

309 Based on our review of dispute data and documents provided by insurers, we found that the overall timeframes for life insurance claims are dependent on:

- (a) whether there are waiting periods;
- (b) the cover that the claim relates to;
- (c) the complexity of the policyholder's claim;
- (d) the ability of the policyholder (or their beneficiaries) to provide all the required information to the insurer in a timely manner;
- (e) the ability of the insurer to manage and assess the claim;
- (f) the reliance on any third-party information;
- (g) whether there are any aspects of the claim, including suspected fraud, that the insurer has decided to investigate; and
- (h) for group insurance, the ability of the trustee to manage and assess the claim.

310 Table 6 sets out the timeframes for one insurer as an example.

**Table 6: Example of one insurer's claim timeframes**

Cover type	Average time taken from claim notification to closure (months)
TPD	21
Trauma	5
Life	7
Income protection	3

Source: Insurer

311 In the dispute data we reviewed, disputes about delays in the claims handling process, whether real or perceived, were the second largest source of claims disputes (22% of all claims-related disputes).

312 As outlined in paragraphs 287–295, there are many steps in the claims assessment process, which vary depending on the complexity of the claim and the evidence required. For example, a claim under a group insurance policy is likely to involve the insurer, the trustee and the administrator. Policyholders are unlikely to be aware of these steps, and we found that insurers are also unlikely to communicate to policyholders the expected timeframe for the assessment of claims.

- 313 This lack of information may be contributing to the number of disputes in this area. This is an area for industry focus, particularly with new standards being established under the Code.

Note 1: Currently, while many insurers commit to contacting a policyholder within a certain timeframe once a claim is lodged, most insurers do not provide policyholders with formal information or formal service guarantees in relation to timeframes for their claims. Only one insurer had a service standard of paying claims (which are approved) within 48 hours once all claims requirements were received by the insurer. However, this insurer gave no indication about the likely timeframe of the claims process where all of the 'claims requirements' would have been received.

Note 2: The Code sets out some minimum standards in relation to claims timeframes: see paragraph 318.

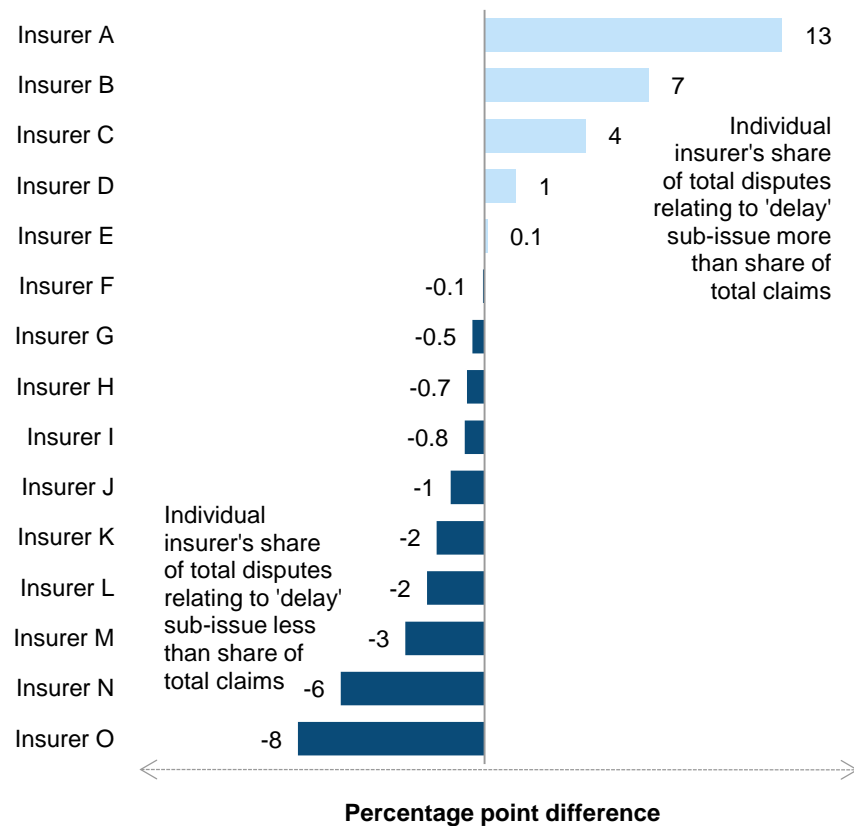
- 314 The dispute data we reviewed indicated that for some claims, there may be a significant length of time between a policyholder lodging a claim and the claim being determined. In some cases, lengthy claims timeframes may have a significant impact on policyholders, particularly those who were dependent on income that is no longer available due to the insured event.
- 315 These policyholders may find themselves in a position of hardship, and may need to rely on savings or social security payments until the claim is approved. This could lead to significant stress for the policyholder, at a time of existing distress from the claim event.
- 316 The dispute data indicated various reasons for delays, including insurers' requests for evidence increasing the time to make a decision, and poor claims management practices (e.g. lost documents and change in claims personnel).

#### Case study 19: Claim delayed due to poor claims management

The policyholder made a TPD claim after being diagnosed with severe depression. At the time of the complaint they had had been unable to work for the last two years and had relied on Centrelink and had been drawing down on their superannuation. The claim was supported by the claimant's doctors and psychologist. The original case manager left and the new case manager had to start the assessment again, requesting new copies of all documentation including the original TPD claim (one year after original submission). The policyholder felt that this all added to their debilitating depression and high anxiety.

The dispute was raised with the EDR and was resolved by the insurer.

- 317 The dispute data shows that some insurers have substantially more disputes about claims timeframes than others: see Figure 22. These same insurers also had the highest rates of disputes about evidence: see Figure 21. This points to potential deficiencies across their whole claims processes.

**Figure 22: Share of 'delay-related' disputes less share of claims (2013–15)**

Note 1: See Table 30 in Appendix 2 for the complete data in this figure (accessible version).

Note 2: Percentage point differences do not take into account original proportion of total claims.

Sources: ASIC and external third parties, ASIC calculations

318

The Code includes standards for timeframes for claims to be determined:

- (a) two months from the end of the waiting period for income protection claims, or within 12 months if 'unexpected circumstances' apply; and
- (b) six months from the claim for life or TPD cover, or no timeframe if 'unexpected circumstances' apply.

Note 1: See s8.14–17 of the Code and s15 for the definition of 'unexpected circumstances' (which includes matters such as delays by third parties).

Note 2: The Code also includes standards for the following:

- (a) when a policyholder notifies insurer of a claim, the insurer will explain the cover and claims process within 10 business days (s8.3);
- (b) the policyholder is to be kept informed of the progress of claim every 20 business days (s8.4);
- (c) independent service providers (e.g. doctors) will be asked to provide any requested reports within 4 weeks of date of request (s8.8), and the policyholder is to be kept informed of failure to meet this timeframe; and
- (d) claims decisions will be communicated within 10 business days, after all 'reasonable enquiries' are completed, including referral to reinsurers where required (s8.15).



- 319 Our review suggests that insurers will have to significantly improve their claims handling to meet these timeframes, especially for TPD. It also remains to be seen when and how often ‘unexpected circumstances’ will apply.

### **Fraud risk management, including surveillance**

- 320 Any claims assessment process includes steps to ensure that claims are genuine. ASIC and APRA both require life insurers to have adequate risk management systems, which would include managing fraudulent insurance claims. APRA has outlined its expectations in relation to standards on fraud risk management.

Note: See ASIC, Section D of [Regulatory Guide 104 Licensing: Meeting the general obligations](#) (RG 104) and APRA, [Prudential Standard CPS 220 Risk management](#), [Prudential Practice Guide CPG 220 Risk management](#), and [Prudential Practice Guide SPG 223 Fraud risk management](#).

- 321 A claim may be considered to be fraudulent by an insurer if it:
- (a) exaggerates an otherwise legitimate claim;
  - (b) includes deliberately misleading information in support of a claim; or
  - (c) involves the deliberate fabrication of a claim.

Note: See Insurance Council of Australia, [Understanding insurance](#), 1 August 2016.

- 322 Insurers need to address the risk of fraud, including by the use of surveillance practices where appropriate. However, these practices should take into account the following good practice guidelines:
- (a) *Comply with legal and regulatory requirements*—This includes State and Territory surveillance legislation, the ASIC Act, *Privacy Act 1988* and *Disability Discrimination Act 1992* and State and Territory anti-discrimination legislation.
  - (b) *Be effective in detecting fraud*—For example, it is questionable that physical surveillance practices would always be effective for mental health claims, bearing in mind that everyday activities are often part of a treatment plan.
  - (c) *Be efficient*—Specifically, where the initial period of investigation does not result in evidence of fraud, the insurer should be able to provide a reasonable justification to any extension to investigations. When a claim is investigated, there is an almost inevitable increase to the time required to assess the claim.
  - (d) *Avoid or minimise detriment to the claimant*—The adverse effect that investigations may have on a claimant’s health, particularly those with mental health conditions, has been highlighted by consumer groups and

the media. At least one insurer has publicly stated that it no longer uses surveillance in the assessment of claims related to mental illness.

Note: 'As a result, we now no longer use surveillance in the assessment of claims related to mental illness': see Metlife media release, [Response to the ABC's Four Corners episode, 'Insult to injury'](#), 1 August 2016.

- (e) *Include processes for monitoring and enforcing professional and acceptable standards of conduct on its investigators*—Insurers should have in place processes to monitor the conduct of their investigators and enforce the required standards.

Note 1: The Code includes provisions about surveillances, including the need for a reasonable basis and the need to comply with standards about privacy and discretion (s8.12).

Note 2: The Code also includes a section on the expected conduct of investigators (s10.9). It may be appropriate for a specific code of practice for investigators to be developed and for insurers to only use investigators that have agreed to adhere to appropriate standards of conduct.

- 323 Some of the insurers we spoke to provided data about claims that result in surveillance being used, with figures ranging from 1% to 5% of all claims. These insurers indicated that TPD and income protection claims are more likely to lead to an investigation, as they require an assessment of the effects of an illness on a continuing or long-term basis.
- 324 Unreasonable investigation or surveillance represented a very small proportion of all disputes we reviewed (only 1% of all disputes). While some of the dispute information indicated that there were apparently justifiable reasons for the surveillance, this was questionable for others.

#### Further work for insurers: Claims procedures

We expect insurers to:

- ensure claims timeframes are consistent with industry good practice;
- consider the scope of the definition of 'unexpected circumstances' in the Code and how its use will be monitored and reported;
- ensure that expected claims timeframes are adequately communicated to policyholders; and
- consider whether their processes adequately justify fraud risk mitigation (including surveillance, particularly for mental health claims) and include monitoring the conduct of fraud risk investigators.

## Claims staff and systems

325 Our review of insurers' claims systems, including staffing and technological systems, found that:

- (a) insurers' systems varied significantly; and
- (b) conflicts of interest in remuneration could be an issue for insurers with incentives and performance measures for staff based on declined claim rates.

### Systems

326 Some insurers stated that their investment in systems and processes had fallen behind the requirements of the business. For example, the following issues were reported to us:

- (a) manual processes that are antiquated and do not readily allow reporting;
- (b) systems that are too highly dependent on key staff;
- (c) paper-based files;
- (d) policy administration systems that do not support customer service; and
- (e) poor data quality.

327 Our observation is that the lack of investment in these systems has significantly limited some insurers' ability to enhance claims management practices and gain insights into portfolio experience.

328 Insurers' processes and systems should also allow insurers to maintain accurate and complete databases of insured files, old policy wordings and disclosure materials.

### Staffing

329 Consistent with ASIC and APRA licensing requirements, life insurers are required to have available adequate resources (including financial, technological and human resources) to provide the financial services covered by the licence, and also to carry out supervisory arrangements.

### Suitably trained staff

330 As part of this obligation, insurers should ensure that they have an adequate number of suitably trained staff along with suitable workflow systems and databases, to enable staff to deliver timely and accurate claims decisions. Further, claims should be allocated to the claims staff with the right skills.

Note: The Code includes references to training: see, for example, s8.20.

331 A number of insurers we spoke to reported that it could be difficult to recruit claims staff with the appropriate skills and experience, noting that a background in workers compensation or compulsory third party insurance is not necessarily adequate to assess complex life insurance claims. These skills shortages have also affected some insurers' ability to internally audit claims decisions.

### **Conflicts of interest in remuneration**

332 Our review indicated that two insurers provided performance benefits to staff based on a number of differently weighted criteria. This approach is referred to by many employers as a 'balanced scorecard' approach.

333 One of the weighted criteria for claims staff was a measurement of the 'decline rate' of the claims they assess (which may account for up to 15% of the 'balanced scorecard'). We consider that this is a potential conflict of interest that could have a detrimental effect on genuine claims, because the inclusion of this criterion is in conflict with a claim assessor's responsibility to assess each claim on its merit.

Note: The Code states that remuneration and entitlements to bonuses will not be based on claims decisions or deferrals of decisions: see s8.20.

### **Conduct risk**

334 Conduct risk refers to the risk of inappropriate, unethical or unlawful behaviour on the part of a company's management or employees. Such conduct can be caused by deliberate actions or may be inadvertent and caused by inadequacies in practices, frameworks or education programs.

335 Conduct risk can have significant ramifications for a company, its shareholders, clients, customers, counterparties and the life insurance industry as a whole. Both ASIC and APRA have an ongoing interest in insurers being able to manage conduct risk. The design of and adherence to policies and procedures in conjunction with claims handling systems and resources are central to managing conduct risk linked to claims handling.

336 Improved systems and reporting can better and more quickly identify changes in behaviour or claims statistics. This also allows the insurer to better manage its own risks, including compliance and conduct risks, as well as potentially assisting with ensuring that an insurer's culture is consistent and in line with the intended cultural settings.

337 Inappropriately designed remuneration structures can also drive poor behaviour and culture. Specifically, we consider that conflicts of interest in remuneration negatively impact the culture of an organisation and may increase the probability of conduct risk materialising in the insurer, and detrimentally affect claims handling and bona fide claims: see paragraphs 332–333.

## Superannuation trustees

- 338 A number of particular issues apply in relation to insurance cover made available to superannuation fund members via a group insurance policy issued by a life insurer to the fund trustee which are integral to the claims handling process.
- 339 We are aware of situations where trustees are not as involved as they should be in the claims process, with fund members instead corresponding directly with the insurer. However, some trustees appear to be aware of issues in claims handling and the reputational risk this presents. For example, one trustee we have spoken with made a decision to have insurance matters handled in the trustee office rather than by the fund administrator.

### Further work for insurers: Claims staff and systems

ASIC will work with APRA, the insurance industry and stakeholders to establish a consistent public reporting regime for claims data and claims outcomes, including claims handling timeframes and dispute levels across all policy types. This will help ASIC and APRA to monitor claims trends and identify any potential issues of concern from changes in data.

We expect insurers to:

- invest in systems and staff to meet future needs; and
- ensure that incentives and performance measurements for claims handling staff and their management are not in conflict with their obligation to assess each claim on its merit.

## Sales practices and eligibility

- 340 Our review found that problematic sales practices may lead to poor claims outcomes.
- 341 In particular, the files we reviewed indicated that:
- (a) claims may be declined based on policy exclusions (e.g. pre-existing conditions) and/or policy criteria (e.g. citizenship and work hours), which means the product may not have been suitable for the policyholder's needs and/or they would never have been eligible to make a claim; and
  - (b) policyholders may take out a policy without understanding the extent or limits of the cover at the point of sale and/or may have been misled about the cover under the policy.
- 342 Despite holding insurance cover and paying premiums, some policyholders may be ineligible to make a claim, either under the whole policy or specific parts of the policy.

- 343 For example, the policyholder may:
- (a) have a pre-existing condition for which cover is excluded;
  - (b) be in an excluded category of employment (e.g. work on a casual basis or have recently been made redundant) for income protection cover;
  - (c) not be an Australian citizen or resident (a prerequisite for some policies); or
  - (d) have lost their cover without realising it (e.g. they were not at work on the day that the group cover commenced for their superannuation fund—an eligibility requirement).
- 344 Further, eligibility for cover may change over time. For example, where a superannuation fund member's account balance falls below a designated amount, or their employment arrangements change, a fund member may lose cover. Some superannuation trustees contact their members in advance of these events to give time to take action if insurance cover is still required.
- 345 The dispute data we reviewed showed that disputes about a policyholder's eligibility to claim under a policy made up 5% of all disputes and 7% of all claims-related disputes.
- 346 Case study 20 gives an example of one of these disputes.

#### Case study 20: Residency and claims eligibility

The insurer declined to pay a life insurance claim to the policyholder's estate on the basis that the policyholder was not a permanent resident of Australia. The family were strongly of the view that there was no fraud by the policyholder and if they had known about this requirement they would have taken out a life insurance policy in their country of citizenship.

The policyholder raised the matter with EDR and it was resolved with the claim paid in full.

- 347 Some disputes about eligibility resulted in the insurer making an ex-gratia payment to the policyholder, possibly in recognition that the policyholder had been paying premiums and understood they were covered.
- 348 This issue is closely related to sales practices, in that problematic sales practices may have led to a policyholder purchasing a policy where they are ineligible to make a successful claim, due to policy exclusions.
- 349 Consumers may also purchase a policy without understanding the extent or limits of coverage and/or may have been misled about coverage or price.

**Case study 21: Sales representation about policy coverage**

The policyholder received a sales call from a life insurer and told the representative that they had a medical condition that made them uninsurable.

The sales representative assured the policyholder that they would be covered, after checking with others in the company. The policyholder felt the representative used forceful sales techniques and encouraged them to take out insurance to protect their family if something happened. A follow-up call from the company also reassured the policyholder that they were covered.

On that basis, the policyholder decided to continue the policy.

The policyholder later found out that their medical condition had progressed and no further treatments were available. They attempted to claim under the terminal illness benefit of the policy; however, they were declined due to a pre-existing medical condition.

The dispute was resolved by settlement after the policyholder raised it with EDR.

350 While the focus of our review was not on sales practices, the insurers' documents we reviewed indicated that there are issues in this area, particularly in terms of complaints from policyholders. As noted earlier, 4% of disputes related specifically to sales practices.

Note 1: We are committed to undertaking further work on life insurance sales practices, with a focus on non-advised sales given the projected growth in this area.

Note 2: Based on industry reports, non-advised sales of life insurance (e.g. through branches, call centres and mail-outs) are on the rise, with sales and in force premiums expected to substantially increase by 2024: see Plan for Life Actuaries and Researchers (Plan for Life), [Life insurance report](#), December 2014.

351 High lapse rates may also be an indicator of mis-selling of policies to consumers for whom the cover is not suitable or unaffordable. We will explore this issue as part of our further work on non-advised sales practices.

**Further work for ASIC and insurers: Sales practices**

ASIC will conduct a thematic industry review of life insurance sales practices, focusing on non-advised policy sales, and take enforcement action where necessary.

In advance of our review, we expect insurers to:

- consider ASIC's previous work on sales practices in other areas, and apply these principles to life insurance sales where appropriate (including the use of formal sales scripts, obtaining evidence of consent to purchase the policy, and ensuring that there is clear disclosure of the premium structure); and
- ensure that policy documents provided to policyholders (e.g. PDSs, application forms and claim forms) are clear and understandable.

## Other issues

### Role of reinsurers

- 352 Clearly reinsurers have an important role in life insurance policy pricing, policy definitions and claims handling. Reinsurers play an important role in:
- (a) helping insurers manage financial stability, capital support, and payment of individual large claims;
  - (b) product expertise, research and access to actuarial models; and
  - (c) resourcing and training assistance with underwriting and claims.

- 353 In very general terms, an insurer will either reinsure a particular risk, or some portion of all its underwritten risks for particular classes of insurance, with a reinsurer. Industry data indicates that for life insurance, around one third of premiums collected is used to pay for reinsurance.

Note: See APRA, QLIP June 2016.

- 354 We noted the following issues from our review of the role of reinsurers:
- (a) *Policy development*—Reinsurers can have a significant influence on product strategy, including updating policy definitions.
  - (b) *Claims management processes*—Reinsurers can significantly influence the administration and payment of claims, particularly large claims, ex-gratia payments and resolving disputes with policyholders.

- 355 In responding to the issues raised in this report, insurers should consider the role of reinsurers and how their support is required in order to improve claims handling standards. In seeking to respond fairly and reasonably to claims, insurers need to ensure that their reinsurance arrangements are aligned to their claims philosophy. We encourage reinsurers to consider the issues raised in this report and how they can support insurers to respond positively to the issues raised.

### Insurance offered through superannuation

- 356 Our review highlighted a number of issues relating to insurance offered through superannuation. As insurance in superannuation is an arrangement between the superannuation trustee and the insurer, members of the fund do not always have access to the underlying group policy. However the terms of the cover are disclosed to members in the fund's PDS.
- 357 Effective disclosure to members is critical given the default nature of insurance in superannuation.
- 358 There are particular issues in relation to definitions used in insurance in superannuation as noted in Table 5. Recent changes to the SIS Act affect the



definitions selected by superannuation trustees when choosing group cover for fund members. This means that only ‘any occupation’ definitions are permissible to be used in group insurance (‘own occupation’ cover is prohibited for any new cover issued to a member after 1 July 2014: see reg 1.03C of the SIS Regulations). Since 1 July 2014, insurance cover offered by superannuation funds must have wording that aligns with SIS Act conditions of release (see reg 4.07D of the SIS Regulations): see paragraphs 268–275.

- 359 Some group insurance policies are also including new conditions imposing exclusions for accidental injuries or illness, paying TPD benefits by instalments, and limits on the timeframe in which to lodge TPD claims.
- 360 In part, this may be because superannuation trustees are subject to a requirement under the SIS Act to ensure they only offer or acquire insurance if the cost of the insurance does not inappropriately erode the retirement income of beneficiaries. Exclusions and conditions may assist in reducing the cost of premiums for the fund members overall. Further, paying TPD benefits in instalments represents an attempt by the trustee to assist the member to return to the workforce.
- 361 Superannuation trustees generally change their insurance arrangements every three years. This can mean that fund members are not aware of the details of the current cover, and of any relevant changes to the claims process.
- 362 In general, we note the following issues in superannuation:
- (a) *Members unaware of cover*—In a compulsory superannuation system, members of a superannuation fund are often unaware that they have insurance cover through the fund, even less how to claim or that the cover may change or even cease in certain circumstances. Inconsistent information in disclosure as a result of administration and other issues (e.g. relying on data coming from employers) can exacerbate member confusion. In some instances, members may approach lawyers for assistance with the claims process, which can add cost.
- Note: Information about insurance in superannuation on ASIC’s [MoneySmart](#) website has recently been updated and is designed to encourage people to consider whether they need to approach a lawyer to make a claim in all cases.
- (b) *Multiple premiums*—Members may have multiple accounts with different (or the same) superannuation trustees, meaning that they pay multiple premiums but may only be able to claim once.
- Note: Intrafund consolidation is now permitted under s108A of the SIS Act.
- (c) *Reasons for decisions not provided*—Requirements to provide members with adequate written reasons for decision in a complaint situation are not always being met (either because no written reasons are provided, or because the information contained in the document is so limited), which hinders decision making by members about pursuing a complaint.

## E Further work and policy reform

### Summary of further work

- 363 Table 7 summarises the further work that ASIC will undertake in response to the issues raised in this report.
- 364 Table 8 summarises the work that insurers will need to do to address the issues that we have raised.

**Table 7: Summary of further work for ASIC**

Area	Description	Timeframe (work commencing)
<b>Declined claim rates</b>	We will undertake targeted surveillance work to examine the reasons for substantially higher than average decline rates and withdrawn claim rates for particular insurers, and consider regulatory options where these reasons cannot be justified.	Now
<b>Dispute rates</b>	We will undertake targeted surveillance work to examine the reasons for substantially higher numbers of disputes for particular insurers than their share of claims, focusing on the areas of evidence and delay which had the highest numbers of disputes.	Now
<b>TPD claims</b>	We will undertake further reviews across the industry on TPD claims files and systems, focusing on claims procedural issues (such as timeframes and evidence) and also any additional findings from our targeted surveillance work.	Mid 2017
<b>Data reporting</b>	<p>We will work with APRA, the insurance industry and stakeholders to establish a consistent public reporting regime for claims data and claims outcomes, including claims handling timeframes and dispute levels across all policy types. It is expected that data will be made available on an industry and individual insurer basis. This will help ASIC and APRA to monitor claims trends and identify any potential issues of concern from changes in data.</p> <p>Note: Similar ongoing data reporting is already undertaken by general insurers who subscribe to the General Insurance Code of Practice.</p>	Now
<b>Sales practices</b>	We will conduct a thematic industry review of life insurance sales practices, focusing on sales of non-advised policies, and take enforcement action where necessary.	Between now and January 2017
<b>Policy definitions</b>	We will conduct a follow-up review of the currency and appropriateness of policy definitions, after insurers' first three-yearly review stipulated in the Code (late 2019). We will consider options (including the need for law reform) if there are still concerns about the currency and appropriateness of policy definitions.	Late 2019

**Table 8: Summary of further work for insurers**

Area	Description	Timeframe
<b>Policy definitions and scope of cover</b>	<p>We expect insurers to:</p> <ul style="list-style-type: none"> <li>review the currency and appropriateness of policy definitions;</li> <li>consider the scope of the definition of 'unexpected circumstances' in the Code and how its use will be monitored and reported; and</li> <li>examine advertising and representations made about the scope of cover to ensure that this is aligned with the definitions and cover provided, and report any discrepancies to us.</li> </ul>	Immediately, and reviewed every three years and updated where necessary (in accordance with the Code)
<b>Claims handling</b>	<p>We expect insurers to:</p> <ul style="list-style-type: none"> <li>ensure claims timeframes are consistent with industry good practice;</li> <li>ensure that expected claims timeframes are adequately communicated to policyholders; and</li> <li>consider whether their processes adequately justify fraud risk mitigation (including surveillance, particularly for mental health claims) and include monitoring the conduct of fraud risk investigators.</li> </ul>	Immediately
<b>Sales practices and disclosure</b>	<p>We expect insurers to:</p> <ul style="list-style-type: none"> <li>consider ASIC's previous work on sales practices in other areas and apply these principles to life insurance sales where appropriate (including the use of formal sales scripts, obtaining evidence of consent to purchase the policy, and ensuring that there is clear disclosure of the premium structure); and</li> <li>ensure that policy documents provided to policyholders (e.g. PDSs, application forms and claim forms) are clear and understandable.</li> </ul>	Immediately

## Policy review

- 365 Our review has identified a number of areas where we consider insurers' claims handling practices are inadequate. Our ability to achieve improvements to these practices is constrained due to the limited power given to ASIC under the Corporations Act to regulate insurers in relation to claims handling.
- 366 We have identified several areas which are currently under review for possible reform where changes could usefully be made to augment ASIC's powers and enable effective regulatory intervention to improve outcomes for consumers. We have also identified a further area for review where we suggest reform could be made to improve the regulation of claims handling.

## Current policy reform initiatives

- 367 There are a number of policy reform initiatives already underway that may address some of the matters raised in this report.

### Penalties

- 368 A review of penalties is underway (noting that ASIC currently cannot seek penalties for breaches of the duty of utmost good faith in the Insurance Contracts Act). This process could consider changes that seek to deter poor conduct by life insurers through enhanced sanctions including by:
- (a) enabling ASIC to seek civil penalties where insurers have breached the duty of utmost good faith under the Insurance Contracts Act; and
  - (b) aligning penalties for breaches by directors of life insurance companies of their duties to policyholders with the civil and criminal penalties that apply to directors of managed investment schemes.

### Review of the Australian Consumer Law

- 369 This includes a review of whether the unfair contract terms in the ASIC Act should continue to be excluded from applying to insurance contracts (by operation of s15 of the Insurance Contracts Act).

### Upgrading policies' medical definitions

- 370 The FSI report included a recommendation that the Government should introduce a mechanism to facilitate the rationalisation of legacy products in the life insurance and managed investments sectors. The Government has recently accepted this recommendation, noting that rationalisation needs to be considered in the light of consumer, constitutional and fiscal issues (given that there are possible tax implications of facilitating the transition away from legacy products).
- 371 This process may also provide an opportunity to consider the effect of s9A of the Life Insurance Act, which provides that an insurer can only pass on the benefit of a change to a policy if they do not charge the consumer more as a result.
- 372 Currently the effect of s9A is that an insurer can provide increased benefits (e.g. through updating a definition) but cannot change the price to cover that increased risk. The insurer therefore can only pass on the cost of the increased benefits by asking existing insureds to upgrade to a new policy, which is a costly and inefficient way of achieving this outcome. Policy reform may allow upgrades of existing life insurance policies on a portfolio basis to more current definitions, where this is beneficial to policyholders, allowing any premium impact to be spread across the portfolio.

### External dispute resolution

- 373 In May 2016, the Government established a review of the EDR and complaints framework in the financial services sector. Relevant to consumer disputes about life insurance claims (inside and outside the superannuation environment), the panel conducting the review is tasked with making recommendations on the extent of gaps and overlaps between each of the bodies (including considering legislative limits on the matters each body can consider) and their impacts on the effectiveness, utility and comparability of outcomes for users. A final report will be provided to the Government in March 2017.
- 374 ASIC recommends consideration of the jurisdiction of EDR schemes over life insurance claims. In particular, we have highlighted the need to:
- (a) ensure better and more effective consideration of issues of fairness to supplement the existing jurisdiction; and
  - (b) give better access to consumers with complaints about delays in claims handling and ensure better remedies when these complaints are found in favour of the consumer.
- 375 ASIC will be raising these issues as part of the current review of the EDR and complaints framework in the financial services sector. The terms of reference for this review include considering the extent of gaps and overlaps between each of the dispute resolution bodies (including the legislative limits on the matters each body can consider) and their impacts on the effectiveness, utility and comparability of outcomes for users. A final report will be provided to the Government in March 2017. Insurance in superannuation.
- 376 In relation to life insurance cover provided through superannuation, the Productivity Commission is currently undertaking a study to develop criteria to assess the efficiency and competitiveness of the superannuation system. In the draft report released earlier this year, the Productivity Commission proposed that one system-level objective could be whether group insurance was meeting members' needs.

### Additional law reform proposal

- 377 The current exclusion in relation to the handling or settling of insurance claims in reg 7.1.33 (see paragraph 141) means that insurers are not subject to a number of broad standards of conduct that apply to other parts of their business (such as the sale of their policies).
- 378 The excluded obligations include requirements on the insurer:
- (a) to do all things necessary to ensure that it provides financial services efficiently, honestly and fairly;
  - (b) to have in place adequate arrangements for the management of conflicts of interest that may arise in the provision of financial services; and

- (c) to take reasonable steps to ensure that its representatives comply with the financial services laws.

379 While a breach of the duty of utmost good faith in the handling of a claim does activate ASIC's licensing powers, our capacity to take action for systemic conduct or seek broad improvements to current practices in relation to claims handling is limited. We would only be able to take enforcement action to seek redress for conduct in relation to specific individuals where the insurer had breached either the ASIC Act or the Insurance Contracts Act.

380 The limitations can be illustrated through two examples of conduct that are impacted by the exclusion:

- (a) incentives for claims handling staff and management, including whether they are in conflict with the insurer's obligation to assess each claim on its merit; and
- (b) surveillance practices by investigators, particularly for mental health claims.

381 The exclusion of claims handling from the definition of financial services in reg 7.1.33 limits ASIC's capacity to seek changes in insurer conduct from inappropriate incentives or the way an investigator operates. Our view is that removing the exemption in reg 7.1.33 would enhance our capacity to seek improvements in claims handling practices.

382 The next stage of our work will examine insurers' practices in more detail, which may identify further issues that could be addressed through law reform. Examples of the areas where possible changes may be identified include:

- (a) the relationship between sales practices, the failure by the consumer to provide full disclosure at the point of sales, and adverse claims outcomes;
- (b) whether there could be changes to sales practices, including disclosure, so that the way in which policies operated is better aligned with the consumer's expectations; and
- (c) whether the use of standard definitions (particularly for complex medical definitions used in trauma policies) would improve consumer outcomes.

## Appendix 1: Comparison with international jurisdictions

**Table 9: Approach to life insurance in other jurisdictions**

Jurisdiction	Regulatory regime	Common definitions	Disclosure	Mental health
United Kingdom	<p>Companies conducting life insurance business in the UK must be authorised under, and comply with, the provisions of the <i>Financial Services and Markets Act 2000</i> (FSMA) unless they are authorised elsewhere in the European Economic Area (EEA), in which case they may 'passport' into the UK. They must also be approved as suitable by the Financial Conduct Authority (FCA).</p> <p>Insurers are also required to publicise their claims rates annually, with a view to improving transparency for consumers.</p>	<p>The Association of British Insurers (ABI) is an industry body which released a 'Statement of Best Practice for Critical Illness cover' which sets out standard wording for critical illness definitions.</p>	<p>The <i>Consumer Insurance (Disclosure and Representations) Act 2012</i> (Consumer Insurance Act) came into force on 6th April 2013. It gives consumers in the UK more clarity on what information they need to disclose to their insurer when taking out insurance.</p>	<p>According to disability discrimination law under the <i>Equality Act 2010</i>, an insurance provider cannot refuse to cover a person or charge more for insurance on the basis of mental health problem, unless both the following are true:</p> <ul style="list-style-type: none"> <li>the insurer can provide objective, accurate and reliable evidence that the person is at a higher risk of making a claim; and</li> <li>the information the insurer used to assess the person's application was used in a reasonable way.</li> </ul>
Canada	<p>Life insurance companies that are federally incorporated under the <i>Insurance Companies Act</i> are prudentially regulated by the Office of the Superintendent of Financial Institutions (OSFI) to determine their financial soundness. Provincial regulators administer the licensing of all insurers operating within their jurisdictions as well as the marketing of insurance products. The provinces operate under the <i>Uniform Life Insurance Act</i> which is a uniformity of law, not a statute that governs the life insurance activities in those provinces.</p>	<p>The Canadian Council of Insurance Regulators (CCIR) working group developed a principle stating all policies should include a definition page. It was not considered appropriate to dictate where the definition page be included, but rather they must appear in a way that is clear, legible and easily understood by the policyholder.</p>	<p>The life insurance industry association, the Canadian Life and Health Insurance Association (CLHIA), has subsequently developed and implemented guidelines on consumer disclosure and insurance practices that have been endorsed by the industry.</p>	<p>CLHIA has also issued Guiding Principles to Support Good Mental Health in the Workplace, which note that in order to demonstrate leadership to support good mental health in Canada, based on the nature of their business, CLHIA member companies commit to adopting a mental health strategy that incorporates the five principles that establish the benchmarks for best practices in the industry.</p>

Jurisdiction	Regulatory regime	Common definitions	Disclosure	Mental health
New Zealand	Life insurance contracts are regulated under the common law, and a number of statutes dealing with general contractual requirements. Some specific provisions are included in the <i>Life Insurance Act 1908</i> . The <i>Insurance (Prudential Supervision) Act 2010</i> brought in requirements for all insurance companies to be licensed by the Reserve Bank of New Zealand. The <i>Financial Service Providers (Registration and Dispute Resolution) Amendment Act 2010</i> brought in a requirement that insurers be registered as financial service providers.		The primary dispute resolution scheme for the insurance industry, the Insurance & Financial Services Ombudsman, has published information sheets to provide guidance on common problems relating to disability insurance, pre-existing conditions and the duty of disclosure.	



## Appendix 2: Accessible versions of figures

383 This appendix is for people with visual or other impairments. It provides accessible versions of the figures included in this report.

384 We show the underlying data for each figure, where appropriate, or we may include a text description of the figure's key messages.

**Table 10: Dispute data by source (2013–end March 2016)**

Data source	FOS	SCT	FRLC	LA (NSW)	ASIC	PIAC
Percentage of total	43%	25%	16%	14%	2%	1%

Note: This is the data contained in Figure 1.

**Table 11: In-force annual premiums for risk products (2012–end March 2016)**

Risk product	2012	2013	2014	2015	2016 (to end March)
Individual lump sum	\$4934.98m	\$5424.52m	\$5874.12m	\$6271.28m	\$6609.38m
Individual income	\$1872.20m	\$2046.82m	\$2227.78m	\$2377.11m	\$2550.30m
Group	\$3570.17m	\$3952.99m	\$4914.10m	\$5855.48m	\$6258.72m

Note: This is the data contained in Figure 2.

**Table 12: New annual premiums for risk products (2012–end March 2016)**

Risk product	2012	2013	2014	2015	2016 (to end March)
Individual lump sum	\$1190.43m	\$1348.75m	\$1378.52m	\$1363.11m	\$1346.16m
Individual income	\$435.02m	\$469.82m	\$497.19m	\$489.22m	\$517.68m
Group	\$1049.76m	\$717.14m	\$1387.70m	\$1143.98m	\$952.42m

Note: This is the data contained in Figure 3.

**Table 13: No. of policies (non-advised and retail) and members (group) by distribution channel (2013–15)**

Channel	2013	2014	2015
Non-advised	3.6m	3.8m	3.9m
Retail	3.6m	3.7m	4.0m
Group	13.0m	13.4m	14.0m

Note: This is the data contained in Figure 5.

**Table 14: Declined claim rates—Life cover (2013–15)**

Insurer	A	B	C	D	E	F	Average	G	H	I	J	K	L	M	N
Rate	13%	8%	7%	7%	6%	6%	4%	4%	4%	3%	3%	3%	2%	1%	1%

Note: This is the data contained in Figure 6.

**Table 15: Declined claim rates—Income protection cover (2013–15)**

Insurer	A	B	C	D	E	Average	F	G	H	I	J	K	L
Rate	16%	11%	11%	8%	8%	7%	7%	6%	6%	6%	5%	5%	3%

Note: This is the data contained in Figure 7.

**Table 16: Declined claim rates—TPD cover (2013–15)**

Insurer	A	B	C	D	E	F	G	Average	H	I	J	K	L
Rate	37%	25%	24%	19%	19%	18%	17%	16%	14%	14%	13%	11%	7%

Note: This is the data contained in Figure 8.

**Table 17: Declined claim rates—Trauma cover (2013–15)**

Insurer	A	B	C	D	E	Average	F	G	H	I	J	K	L	M	N
Rate	31%	25%	21%	15%	15%	14%	14%	14%	13%	13%	10%	9%	9%	8%	6%

Note: This is the data contained in Figure 9.

**Table 18: Share of disputes less share of claims, by insurer (2013–15)**

Insurer	Percentage point difference
Insurer A	13
Insurer B	7
Insurer C	1
Insurer D	0.4
Insurer E	0.18
Insurer F	0.04
Insurer G	-0.01
Insurer H	-0.05
Insurer I	-0.1
Insurer J	-0.4

Insurer	Percentage point difference
Insurer K	-0.5
Insurer L	-0.5
Insurer M	-4
Insurer N	-5
Insurer O	-9

Note: This is the data contained in Figure 10.

**Table 19: Claims outcome rates, by cover type (2013–15)**

Cover type	Declined	Accepted in full	Accepted in part	Withdrawn	Undetermined/ unspecified
Life	4%	88%	0.3%	5%	3%
TPD	16%	65%	1%	10%	7%
Trauma	14%	70%	4%	11%	1%
Income protection	7%	74%	2%	15%	2%

Note: This is the data contained in Figure 11.

**Table 20: Claims outcome rates, by distribution channel (2013–15)**

Channel	Declined	Accepted in full	Accepted in part	Withdrawn	Undetermined/ unspecified
Non-advised	12%	74%	1%	11%	3%
Retail	7%	76%	3%	12%	3%
Group	8%	77%	1%	9%	4%

Note: This is the data contained in Figure 12.

**Table 21: Claims outcome rates—Retail policies, by insurer (2013–15)**

Insurer	Declined	Accepted in full	Accepted in part	Withdrawn	Undetermined/unspecified
Insurer A	5%	75%	16%	1%	2%
Insurer B	11%	73%	0%	12%	4%
Insurer C	9%	76%	8%	0%	7%
Insurer D	7%	70%	0%	22%	2%
Insurer E	10%	68%	5%	14%	3%

Insurer	Declined	Accepted in full	Accepted in part	Withdrawn	Undetermined/unspecified
Insurer F	2%	77%	0%	14%	7%
Insurer G	9%	88%	0%	1%	1%
Insurer H	10%	80%	2%	6%	2%
Insurer I	7%	75%	4%	13%	1%
Insurer J	7%	89%	0%	2%	2%
Insurer K	5%	69%	0%	24%	2%
<b>Average</b>	<b>7%</b>	<b>76%</b>	<b>3%</b>	<b>12%</b>	<b>3%</b>

Note: This is the data contained in Figure 13.

**Table 22: Claims outcome rates—Non-advised policies, by insurer (2013–15)**

Insurer	Declined	Accepted in full	Accepted in part	Withdrawn	Undetermined/unspecified
Insurer A	6%	89%	0%	5%	0.5%
Insurer B	6%	79%	1%	8%	6%
Insurer C	14%	73%	0%	13%	0%
Insurer D	16%	82%	0%	1%	1%
Insurer E	5%	94%	0%	0%	1%
Insurer F	5%	58%	0%	29%	9%
Insurer G	29%	56%	0%	8%	7%
Insurer H	4%	85%	9%	0.5%	2%
Insurer I	22%	75%	0%	3%	1%
Insurer J	8%	85%	0%	4%	3%
Insurer K	20%	67%	7%	5%	0%
Insurer L	14%	51%	0%	34%	1%
<b>Average</b>	<b>12%</b>	<b>74%</b>	<b>1%</b>	<b>11%</b>	<b>3%</b>

Note: This is the data contained in Figure 14.

**Table 23: Claims outcome rates—Group insurance, by insurer (2013–15)**

Insurer	Declined	Accepted in full	Accepted in part	Withdrawn	Undetermined/unspecified
Insurer A	8%	86%	0%	1%	5%
Insurer B	10%	81%	0%	4%	5%
Insurer C	9%	81%	3%	2%	6%
Insurer D	9%	82%	2%	2%	4%
Insurer E	23%	71%	1%	2%	4%
Insurer F	6%	67%	0.5%	23%	3%
Insurer G	18%	75%	0%	4%	3%
Insurer H	7%	86%	0%	2%	5%
Insurer I	7%	85%	0%	5%	3%
Insurer J	9%	84%	0%	4%	3%
<b>Average</b>	<b>8%</b>	<b>77%</b>	<b>1%</b>	<b>9%</b>	<b>4%</b>

Note: This is the data contained in Figure 15.

**Table 24: Withdrawn claim rates (2013–15)**

Insurer	A	B	C	Average	D	E	F	G	H	I	J	K	L	M	N
<b>Rate</b>	24%	22%	20%	<b>10%</b>	9%	6%	5%	5%	5%	5%	4%	1%	1%	1%	1%

Note: This is the data contained in Figure 16.

**Table 25: Disputes by cover type (2013–end March 2016)**

Cover type	Income protection	TPD	Multiple	Life	Trauma	Other
<b>Percentage of total</b>	35%	29%	16%	10%	6%	3%

Note: This is the data contained in Figure 17.

**Table 26: Disputes by issue (2013–end March 2016)**

Issue category	Percentage of total
Claim	72%
Other/unspecified	6%
Premium	6%
Cancellation	5%

Issue category	Percentage of total
Advertising/sales practices	4%
Administration	3%
Application	2%
Adviser misconduct	2%
Buyback	0%

Note: This is the data contained in Figure 18.

**Table 27: Breakdown of disputes in 'Claim' category (2013–end March 2016)**

'Claims' issue sub-category	Percentage of total
Evidence	25%
Delay	22%
Underpaid	16%
Definitions	12%
Eligibility	7%
Non-disclosure	5%
General denial	5%
Limitation period	2%
Overpaid	1%
Reasons not provided for denial	1%
Waiting period	1%
Approved claim with late or no payment	1%
Income protection ceased	1%
Sickness versus injury	0%
Customer service	0%
Miscellaneous	1%

Note: This is the data contained in Figure 19.

**Table 28: Breakdown of disputes relating to 'Definitions' under 'Claims' category (2013–end March 2016)**

Issue	Percentage of total
TPD	37%
Pre-existing condition	29%
Cancer	8%
Heart attack	4%
Stroke	3%
Trauma	2%
Disability (excluding TPD)	2%
Accident	1%
Loss of independence	1%
Rheumatoid arthritis	1%
Alcohol level	1%
Miscellaneous	10%

Note: This is the data contained in Figure 20. 'Miscellaneous' includes items individually totalling less than 5 disputes.

**Table 29: Share of 'evidence-related' disputes less share of claims, by insurer (2013–15)**

Insurer	Percentage point difference
Insurer A	12
Insurer B	5
Insurer C	4
Insurer D	0.3
Insurer E	0.2
Insurer F	0
Insurer G	-0.3
Insurer H	-0.4
Insurer I	-0.7
Insurer J	-0.9
Insurer K	-1

Insurer	Percentage point difference
Insurer L	-1
Insurer M	-2
Insurer N	-3
Insurer O	-12

Note: This is the data contained in Figure 21.

**Table 30: Share of 'delay-related' disputes less share of claims, by insurer (2013–15)**

Insurer	Percentage point difference
Insurer A	13
Insurer B	7
Insurer C	4
Insurer D	1
Insurer E	0.1
Insurer F	-0.1
Insurer G	-0.5
Insurer H	-0.7
Insurer I	-0.8
Insurer J	-1
Insurer K	-2
Insurer L	-2
Insurer M	-3
Insurer N	-6
Insurer O	-8

Note: This is the data contained in Figure 22.



## Key terms

Term	Meaning in this document
ABI	Association of British Insurers
advice	Financial product advice
advice provider	<p>A person to whom the obligations in Div 2 of Pt 7.7A of the Corporations Act apply when providing personal advice to a client. This is generally the individual who provides the personal advice. However, if there is no individual that provides the advice, which may be the case if advice is provided through a computer program, the obligations in Div 2 of Pt 7.7A apply to the legal person that provides the advice (e.g. a corporate licensee or authorised representative)</p> <p>Note: These obligations apply from 1 July 2013, unless a person elects to comply with Pt 7.7A before this date (from 1 July 2012).</p>
AFS licence	<p>An Australian financial services licence under s913B of the Corporations Act that authorises a person who carries on a financial services business to provide financial services</p> <p>Note: This is a definition contained in s761A.</p>
AFS licensee	<p>A person who holds an AFS licence under s913B of the Corporations Act</p> <p>Note: This is a definition contained in s761A.</p>
APRA	Australian Prudential Regulation Authority
ASIC	Australian Securities and Investments Commission
ASIC Act	<i>Australian Securities and Investments Commission Act 2001</i>
client	A retail client as defined in s761G of the Corporations Act and Div 2 of Pt 7.1 of Ch 7 of the Corporations Regulations
conflicted remuneration	<p>A benefit given to an AFS licensee, or a representative of an AFS licensee, who provides financial product advice to clients that, because of the nature of the benefit or the circumstances in which it is given:</p> <ul style="list-style-type: none"> <li>• could reasonably be expected to influence the choice of financial product recommended by the licensee or representative to clients; or</li> <li>• could reasonably be expected to influence the financial product advice given to clients by the licensee or representative.</li> </ul> <p>In addition, the benefit must not be excluded from being conflicted remuneration by the Corporations Act or Corporations Regulations</p>

Term	Meaning in this document
Corporations Act	<i>Corporations Act 2001</i> , including regulations made for the purposes of that Act
Corporations Regulations	Corporations Regulations 2001
Corporations legislation	Corporations Act and Corporations Regulations
declined claim rates	The proportion of total claims that are finalised by the insurer without paying a benefit to the claimant of any times (except for an ex-gratia payment).
dispute data	<p>Data on complaints about life insurance policies in the period 1 January 2013 and up to the end of March 2016 based on:</p> <ul style="list-style-type: none"> <li>• reports of misconduct lodged with ASIC; and</li> <li>• complaints made by policyholders to the following EDR schemes or consumer advocacy groups and provided to ASIC for the purpose of this review: <ul style="list-style-type: none"> <li>– Financial Rights Legal Centre Inc.</li> <li>– Legal Aid NSW</li> <li>– Public Interest Advocacy Centre Ltd</li> <li>– Financial Service Ombudsman Limited</li> <li>– Superannuation Complaints Tribunal</li> </ul> </li> </ul> <p>Note: As consumers may raise their dispute with any one or more of the above organisations, dispute data from these organisations may overlap.</p>
Code	The Life Insurance Code of Practice developed by the FSC, with a planned release date in October 2016
EDR data	Data on complaints made by policyholders about a life insurance policy to an EDR scheme such as FOS or the SCT, provided to ASIC for the purpose of ASIC's review
EDR scheme	An external dispute resolution scheme
endowment insurance	An insurance policy that pays a sum of money to the policyholder if they survive beyond a specified age or period of time. If the policyholder dies before the policy matures, the benefit will be paid to their beneficiaries. These policies may have an investment component (also known as an 'investment policy')
ex-gratia payment	A payment made on a goodwill basis
financial adviser	An advice provider

Term	Meaning in this document
financial product advice	<p>A recommendation or a statement of opinion, or a report of either of these things, that:</p> <ul style="list-style-type: none"> <li>• is intended to influence a person or persons in making a decision about a particular financial product or class of financial product, or an interest in a particular financial product or class of financial product; or</li> <li>• could reasonably be regarded as being intended to have such an influence.</li> </ul> <p>This does not include anything in an exempt document</p> <p>Note: This is a definition contained in s766B of the Corporations Act.</p>
financial service	Has the meaning given in Div 4 of Pt 7.1 of the Corporations Act
financial services laws	Has the meaning given in s761A
FSC	Financial Services Council
FSI	Financial System Inquiry
FSI report	<a href="#"><i>Financial System Inquiry: Final report</i></a> , November 2014
FOS	Financial Ombudsman Service Limited
general advice or general financial product advice	<p>Financial product advice that is not personal advice</p> <p>Note: This is a definition contained in s766B(4) of the Corporations Act.</p>
group insurance or group policies	Life insurance policies issued to a third party (e.g. a superannuation trustee) that policyholders can access through their membership of the fund
group risk	Includes both lump sum and income products
IDR procedures/process	The internal dispute resolution procedures/process that all insurers must have as AFS licensees and that must comply with standards and requirements made or approved by ASIC under RG 165
individual risk income	<p>Includes income protection cover</p> <p>Note: See <i>Plan for Life, Life insurance report</i>, March 2016</p>
individual risk lump sum	<p>Includes life cover, TPD cover, trauma–rider and trauma standalone cover</p> <p>Note: See <i>Plan for life, Life insurance industry report</i>, March 2016.</p>
in-force annual premiums	<p>Total of premiums in-force (current) at the point of time (i.e. this measures the annual premiums of current policies at the time)</p> <p>Note: See <i>Plan for life, Life insurance industry report</i>, March 2016.</p>

Term	Meaning in this document
insurance broker	<p>An AFS licensee who is authorised by ASIC to use the terms 'insurance broker' or 'life insurance broker'.</p> <p>This authorisation can only be granted to AFS licensees who provide a financial service relating to contracts of insurance, or contracts of life insurance, and in providing that service, act on behalf of the intending insured. The AFS licensee may also engage in other financial services.</p> <p>In the context of this report, this term only applies to entities that provide such a service in relation to life insurance</p> <p>Note: See s764A, 923B and 985A of the Corporations Act For the purpose of this authorisation, a contract of insurance includes a contract of life insurance.</p>
Insurance Contracts Act	<i>Insurance Contracts Act 1984</i>
insurer	The company that issues the life insurance policy
income protection cover	A life insurance policy that replaces the income lost if the policyholder is unable to work for a certain amount of time due to injury and or sickness
life annuity	An annuity pays the policyholder a guaranteed income for a defined period of time
life cover	A life insurance policy that pays a lump sum to the person nominated by the policyholder when the policyholder dies (also known as 'term life insurance' or 'death cover')
life insurance	An insurance policy that pays either a lump sum or income stream payment in the event of death, illness, disability. Life insurance policies can include cover for death, total and permanent disablement, trauma and income protection. These policies may be held or purchased inside or outside the superannuation environment
Life Insurance Act	<i>Life Insurance Act 1995</i>
life insurance policy	A life insurance contract as defined in s9 of the Life Insurance Act, excluding investment or annuity-related contracts
mechanical breakdown insurance	General insurance that typically covers the cost of repairing or replacing parts of the car due to mechanical failure after the manufacturer's or dealer's warranty has expired (often referred to as an 'extended warranty')
member	A member of a superannuation entity, and includes a prospective member

Term	Meaning in this document
mental illness	<p>A clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional and/or social abilities. The diagnosis of mental illness is generally made according to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders or the International Classification of Diseases</p> <p>Note: See the definition of 'mental illness' in Australia's <i>National Mental Health Policy 2008</i>.</p>
non-advised policies	Life insurance policies that are sold to consumers directly, without an intermediary such as an adviser or superannuation fund
personal advice	<p>Financial product advice given or directed to a person (including by electronic means) in circumstances where:</p> <ul style="list-style-type: none"> <li>the person giving the advice has considered one or more of the client's objectives, financial situation and needs; or</li> <li>a reasonable person might expect the person giving the advice to have considered one or more of these matters</li> </ul> <p>Note: This is a definition contained in s766B(3) of the Corporations Act.</p>
Plan for Life	Plan for Life Actuaries and Researchers
policyholder	The person who holds the life insurance policy (also known as the 'insured') or superannuation fund members (under group life insurance policies)
policy lapse	When a policy ceases due to non-payment or cancellation by the client
Product Disclosure Statement (PDS)	<p>A document that must be given to a retail client for the offer or issue of a financial product in accordance with Div 2 of Pt 7.9 of the Corporations Act</p> <p>Note: See s761A of the Corporations Act for the exact definition.</p>
QLIP June 2016	<a href="#">Quarterly life insurance performance—June 2016</a> (PDF 720 KB) APRA, 16 August 2016
reg 7.1.33 (for example)	A regulation of the Corporations Regulations (in this example numbered 7.1.33), unless otherwise specified
representative of an AFS licensee	<p>Means:</p> <ul style="list-style-type: none"> <li>an authorised representative of the licensee;</li> <li>an employee or director of the licensee;</li> <li>an employee or director of a related body corporate of the licensee; or</li> <li>any other person acting on behalf of the licensee</li> </ul> <p>Note: This is a definition contained in s910A of the Corporations Act.</p>

Term	Meaning in this document
retail policies	Life insurance policies that are sold to policyholders who have sought financial product advice
RG 175 (for example)	An ASIC regulatory guide (in this example numbered 175)
s961 (for example)	A section of the Corporations Act (in this example numbered 961), unless otherwise specified
SCT	Superannuation Complaints Tribunal
SIS Act	<i>Superannuation Industry (Supervision) Act 1993</i>
SIS Regulations	Superannuation Industry (Supervision) Regulations 1994
superannuation trustee	A person or group of person licenced by APRA under s29D of the SIS Act to operate a registrable superannuation entity (e.g. superannuation fund) (also known as an 'RSE licensee')
terminal illness cover	A component of life cover that pays the lump sum benefit to the policyholder when they are diagnosed with a terminal illness (a further payment is not made when the policyholder dies)
total and permanent disability (TPD) cover	A life insurance policy that pays a lump sum benefit if the policyholder becomes injured or ill or is unable to work again
trauma cover	A life insurance policy that pays a lump sum benefit if the policyholder is diagnosed with a specific an illness at a specific severity
tyre and rim insurance	General insurance that covers the cost of repairing or replacing damaged tyres and rims due to blowouts, punctures or other road damage
underwriting	The process used by an insurer to decide whether or not to accept a risk by entering into a contract of insurance, and, if the risk is accepted, the terms and conditions to be applied and the level of premium to be charged
whole-of-life insurance	Life insurance policies that pay a lump sum when the policyholder dies or reaches a certain age. The surplus profits of the insurer are distributed as bonuses or added to the value of the policy, which are also payable to the policyholder or their beneficiaries

## Related information

### Headnotes

claims handling, claims procedures, declined claims, dispute resolution, EDR, IDR, income protection, industry review, insurers, life insurance, policy definitions, total and permanent disability, TPD, trauma

### Regulatory guides

[RG 36](#) *Licensing: Financial product advice and dealing*

[RG 96](#) *Debt collection guideline: For collectors and creditors*

[RG 104](#) *Licensing: Meeting the general obligations*

[RG 165](#) *Licensing: Internal and external dispute resolution*

[RG 168](#) *Disclosure: Product Disclosure Statements (and other disclosure obligations)*

[RG 175](#) *Licensing: Financial product advisers—Conduct and disclosure*

[RG 183](#) *Approval of financial services sector codes of conduct*

### Legislation

ASIC Act, s12CA, 12CB, 12DA, 12DB

Australian Consumer Law

*Competition and Consumer Act 2010*

Corporations Act, Pts 7.7, 7.7A and 7.9; Sch 10D; s760A, 764A, 766A, 911A(1), 912A, 912C

Corporations Regulations, reg 7.1.33

*Disability Discrimination Act 1992*

Insurance Contracts Act, s13, 14, 14A, 15, 21, 29, 47

*Insurance Contracts Amendment Act 2013*

Life Insurance Act, Pt 10 (other than s206–210); s9, 9A, 16U, 17(1), 21, 180, 195

*Privacy Act 1988*

SIS Act, s52(7), 68AA, 101, 108A

SIS Regulations, reg 1.03C, 4.07D

Superannuation Guarantee (Administration) Regulations 1993, Sch 1

## Reports and submissions

[REP 245](#) *Review of general insurance claims handling and internal dispute resolution procedures*

[REP 413](#) *Review of retail life insurance advice*

[REP 471](#) *The sale of life insurance through car dealers: Taking consumers for a ride*

[REP 492](#) *A market that is failing consumers: The sale of add-on insurance through car dealers*

*Senate inquiry into the scrutiny of financial advice—Submission by the Australian Securities and Investments Commission*

## Other references

APRA, [CPG 220](#) *Risk management*

APRA, [CPS 220](#) *Risk management*

APRA, [Life insurance institution-level statistics](#)

APRA, [LPS 320](#) *Actuarial and related matters* (PDF 241 KB)

APRA, [QLIP June 2016](#) (PDF 720 KB)

APRA, [SPS 250](#) *Insurance in superannuation* (PDF 41 KB)

APRA, [SPG 223](#) *Fraud risk management*

Commonwealth of Australia, [Financial System Inquiry: Final report](#)

DEXX&R, [Life analysis report](#)

FOS, [Comparative tables 2014–2015](#), Final report

Insurance Council of Australia, *General Insurance Code of Practice*

Metlife, [Response to the ABC's Four Corners episode, 'Insult to injury'](#)

Plan for Life, [Life insurance report](#)

Productivity Commission, [How to assess the competitiveness and efficiency of the superannuation system](#) (PDF 2.64 MB)

Trowbridge, John, *Review of retail life insurance advice*