ASIC
Australian Securities & Investments Commission

REPORT 361

Consumer credit insurance policies: Consumers' claims experiences

July 2013

About this report

This report was commissioned by ASIC and produced by Susan Bell Research.

It sets out the results of research into consumers' experiences with consumer credit insurance (CCI) policies.

Consumer credit insurance policies: Consumers' claims experiences

Australian Securities and Investments Commission
July 2013

Susan Bell Research
Phone 02 9451 1234 Fax 02 9451 1122 Web www.sbresearch.com.au
1 Cullen St Forestville NSW 2087

Susan Bell Research is a division of Les Bell & Associates ABN 44 350 636 020

Susan Bell Research

Susan Bell Research is a market and social research agency, based in Sydney. We are Australian-owned and managed, AS/NZS ISO 20252 *Market and social research* certified and a member of the Association of Market and Social Research Organisations (AMSRO). Our research teams are members of the Australian Market and Social Research Society (AMSRS) and therefore bound by the AMSRS Code of Professional Behaviour. Susan Bell is a Fellow of the AMSRS.

Acknowledgements

Susan Bell Research and ASIC would like to thank the nine insurers who helped Susan Bell Research find a sample of consumers for this research by writing to their customers and inviting them to participate in this research. They would also like to thank the Insurance Council of Australia and the Financial Services Council for their role in assisting to facilitate this work with insurers.

They would also like to thank the consumers who kindly gave up their time to share their personal stories.

Contents

Executive summary

Background

Consumer credit insurance (CCI) policies provide cover to consumers if they cannot meet their credit repayments because they are made redundant, or are unable to work because they have an accident or fall ill. CCI policies also typically provide cover to consumers in the event of death. CCI policies are available on different types of credit products, including mortgages, personal loans and credit cards.

In 2011, ASIC released Report 256 *Consumer credit insurance: A review of sales practices by authorised deposit-taking institutions* (REP 256). This report identified concerns about how CCI is sold and made a number of recommendations to improve sales practices. REP 256 also raised concerns about the proportion of CCI claims that were denied.

Following REP 256, ASIC commissioned Susan Bell Research to conduct research to understand the experiences of consumers who had claimed on their credit card CCI policy. With the assistance of nine insurers who helped to find a sample of consumers for this research, Susan Bell Research conducted over fifty individual in-depth interviews with consumers who had recently claimed on such policies. This report describes the experiences of those consumers.

Overview of the findings

Consumers who had claimed on CCI policies for their credit card had originally believed that CCI was a relatively simple policy which would help them cover their monthly credit card repayments if they were unable to work. Consumers expected that these repayments would start quickly after their claim was lodged.

For some consumers, this was exactly what happened. They lodged a claim which was assessed quickly, and if it was successful, received a benefit payment. These consumers were highly satisfied with their claim experience, and generally relieved and grateful that they had this cover.

However for other consumers, the policy did not meet their expectations, and they were dissatisfied – and in some cases angry – about their CCI experience.

While it may be expected that consumers whose claims were denied would be dissatisfied, the problem was broader than this. These consumers were not only dissatisfied with the outcome of their claim, but they were also upset that they had not been made aware of important exclusions when they were offered the CCI policy which would, in some cases, have made it difficult for them to ever claim on their CCI policy.

Other consumers whose claim was accepted were also dissatisfied with aspects of their experience because of the way their claim was administered, particularly because of delays assessing their claim, and problems with how their benefit was paid.

Overall, this study showed that the process of claiming on a CCI policy can be stressful and costly for consumers who are already experiencing significant events in their life like the loss of a job or illness.

To explain the different consumers' experiences, the report traces the typical consumer's journey from initially acquiring the policy, through the claims process and decision, and where relevant, through the complaints process as well.

Key findings

Acquiring the policy

Most consumers interviewed for this report acquired their CCI policy when it was offered to them by their financial institution (usually a bank) who sold them their credit card. They were offered the CCI policy on the phone, face to face, or when applying for a credit card online.

Consumers generally admitted to having only a shallow knowledge of the policy at the time they took it out. Most said they were informed in very general terms about the kind of events which could trigger a claim – as in it will provide cover 'if you can't work'. However, some had forgotten about their policy, or never knew they had it, and so had even less product knowledge.[1]

Most consumers did not recall that they were asked any questions about eligibility when they acquired their policy. Some therefore assumed that if the policy was offered to them, they must be eligible to claim on it. However, some consumers (usually those with more experience and knowledge of insurance) took a proactive approach and sought further information by asking questions of the staff member they were speaking to or reading information provided to them about the CCI policy. When it came to making a claim these consumers were more likely to have their claim accepted.

The claims process

Claim events

The main focus of the study was to interview consumers who claimed on their CCI policy because they had to stop work (temporarily or permanently). A small number of consumers claimed on other features of the policy and we have summarised the findings from these interviews in the section **Claims on other CCI policy features**.

Consumers who made a claim on their CCI policy because they had to stop work claimed because:

- they were retrenched,
- they became too ill to work, or
- they were injured in an accident, which prevented them from working.

It was evident that most of the consumers were experiencing very difficult times, financially and emotionally, when they claimed on their CCI policy. Consumers had moved from paid employment to a much more limited income (usually from Centrelink) and reported the stresses of their debts growing. Some consumers were also dealing with serious illnesses and injuries and/or coming to terms with the fact that they would never work again.

Making a claim

When it came to making a claim on a CCI policy, most consumers in this study did not know how to go about it. While the insurer who issues the CCI policy is responsible for handling claims, most consumers initially contacted the financial institution that sold them their credit card (and CCI policy). Many then had to take a second step, to contact the insurer.

A few consumers claimed immediately after their claim event happened – that is just after they were made redundant, became ill or had an accident. However, for most there was a delay between the

[1] As discussed later in this report, these consumers typically learned that they had an existing CCI policy when they had a discussion with their financial institution about difficulties they were experiencing meeting their credit card repayments.

claim event and lodging the claim. For example, one consumer claimed 12 months after stopping work. While some of the reasons for this delay were of a practical nature, because they were in hospital for example, some people had simply forgotten they had a CCI policy, or did not know they had it.

The payment a consumer receives (if their claim is successful) is based on the credit card balance at the time the claim event happened. Therefore delays in lodging a claim had significant consequences for some consumers, when their credit card debt escalated after they stopped work, but was not ultimately covered by their claim.

Documentation required when lodging a claim

The claim assessment process for some consumers was smooth and easy and took only a couple of weeks to complete. However, for other consumers, claims took several months to assess often because the consumer was asked to supply what they perceived to be a large amount of documentation including medical and employment certificates. Generally, the consumers who were required to supply the most information had suffered the most serious problems and were unlikely to ever return to work.

Accepted claims

Consumers whose claims were accepted were generally very relieved; they believed that they had benefited from the policy. When the claim was paid as a lump sum, the process was especially smooth and relatively easy for consumers to manage.

However, some consumers whose claims were accepted experienced problems:

- When the claim was paid over several months, some consumers felt that the ongoing documentation and evidence some insurers required them to provide was unexpectedly burdensome.
- Some insurers did not pay the benefit amount by the monthly repayment due date on the credit card. Some consumers said that this caused them to receive demands from their financial institution chasing the debt. Some incurred late fees.
- Some consumers did not receive the full benefit payment they expected. Several consumers said that it was not clear how their benefit payment was calculated.

Denied claims

In this study, consumers' claims were denied because:

- they had a pre-existing medical condition,
- they were a contract worker or had been in casual employment, which were excluded by their policy,
- they had not met required waiting periods, and
- their age rendered them ineligible.

People whose claims were denied because they were ineligible were surprised to discover the existence of eligibility criteria that they had not expected. Some consumers had been ineligible to claim on a feature of the policy since they took the policy out. Some became ineligible to claim on a feature of the CCI policy during the life of the policy because, for example, their work status changed, or because they reached the upper age limit of the policy.

Consumers were generally shocked and distressed when they discovered that their claim was denied. Many clearly recalled that their initial conversation about making the claim with the financial institution or insurer was positive – there was no suggestion that their claim could be denied.

Many of these consumers felt that they had been "let down" by the financial institution that had sold them their CCI policy. Further, they felt they would not have spent time and money collecting the required documentation for their claim (e.g. medical certificates) if they had known there was a reasonable chance their claim would be denied. Indeed some consumers were worse off financially because they had claimed, due to the money they had spent providing evidence to support their claim.

Complaints

This research also looked at whether consumers who were dissatisfied with any aspects of the claims process made a complaint – to the financial institution or insurer. We found that consumers made a range of different claims-related complaints with varying levels of success.

The most common complaint made by consumers was in relation to the outcome of a denied claim. Only a small portion of these complaints were found to be in the consumer's favour and the decision overturned. Although the insurer is responsible for the claim decision, most consumers made their complaint about a denied claim to the financial institution who sold them their policy. In these circumstances the research found that the financial institutions seemed to take the view that complaints made after a claim were the responsibility of the insurer, even where consumers made it clear that they were not happy they had been sold the policy.

Some consumers complained about how long it took to process their claim. For the most part, these complaints seemed to be effective, in that the claim was decided soon after. However, for those consumers who complained that their benefit payment was being made too late, these consumers typically did not have their complaint resolved, as the insurer usually insisted that they had followed the appropriate process and little more could be done. This did not help consumers who were being "hassled" by their financial institution because their credit card monthly payment was late.

Based on the experiences of consumers we interviewed, making an initial complaint – and then escalating it – appeared to be at times a prolonged and stressful process for consumers, some of whom were in poor health.

Actions that may assist consumers' CCI claims experiences

This research has identified a number of actions that may assist consumers' CCI claims experiences. This includes actions financial institutions and insurers could take to improve consumers' claims experiences, as well as looking at what consumers could do themselves to ensure that they have a satisfactory claims experience.

ASIC's past work – REP 256

To the extent that this research has looked at consumers' experiences in relation to how they were sold their CCI policy, action has been taken by authorised deposit taking institutions (ADI) that sell CCI and participated in ASIC's earlier review (REP 256). All of the institutions involved in ASIC's past review agreed to adopt and implement the recommendations set out in REP 256 to improve CCI sales practices.[2]

It is likely that most of the consumers interviewed for this research had been sold their CCI policy by an ADI that was involved in ASIC's past review and therefore acquired the policy before these recommendations had been implemented.

[2] A copy of the recommendations can be found in Table 2 of REP 256, available from www.asic.gov.au.

Table 1. Actions by financial institutions and insurers that may assist consumers' CCI claims experiences

Stage in process	Actions by financial institutions and insurers
Information provided pre-sale	Consumers should be provided with prominent, timely and sufficient information to make an informed decision about whether or not to purchase a CCI policy.[3]
	Sales processes should be tailored to reflect a wide-ranging audience (including consumers who are not familiar with CCI policies).
Information provided after the sale	Consumers should be provided with information on a regular basis to remind them that they have a CCI policy and help them to decide whether they are still eligible to be covered by the policy.[4]
Claim lodgement	When a consumer makes a claim they should be presented with realistic expectations about the claims process and outcome.
Claim assessment	Assessment procedures should take into consideration the individual circumstances of consumers making a claim (including giving consideration to the amount of documentation required to evidence a claim).
Claim decision	The outcome of a claim should always be communicated to consumers in plain language that allows them to clearly understand how the decision was reached.
Benefit payment	Consumers would benefit from: - a clear explanation of how the benefit payment was calculated, and - improved coordination between the insurer and financial institution to ensure that the consumer always receives the benefit payment before their credit card repayment due date.
Complaint	If a consumer expresses negative feedback about the outcome of their claim (or any other aspect of the claims process), the financial institution or insurer should engage constructively with them, including: - identifying the root cause of their dissatisfaction, and - informing them of their right to make a complaint and the most relevant entity to make the complaint to.

Table 2. Actions by consumers that may assist their CCI claim experience

Stage in process	Actions by consumers
Before purchasing	The decision to purchase CCI should not be rushed (it doesn't need to be made on the spot). Consumers should take the time to carefully consider whether a CCI policy is right for their circumstances and read policy documentation provided to them. Things to consider: - What events will CCI cover me for? - How much will CCI likely cost me? - Am I eligible to hold the CCI policy? Is my type of employment covered by the policy? - Do I have a pre-existing condition that would exclude me from making a claim? - What waiting periods apply? - Who is the insurer of the policy?

[3] Recommendation 1 of REP 256 provides a detailed list of information that ASIC considers should be disclosed to consumers at the time of sale: see Table 2 of REP 256.

[4] Recommendation 8 of REP 256 provides a similar expectation in relation to ongoing information provided to consumers who hold a CCI policy: see Table 2 of REP 256.

Stage in process	Actions by consumers
After purchasing	If a consumer changes their mind about taking out CCI they can get a full refund if they cancel their policy within the cooling off period – cooling off periods vary between policies and a consumer should check their Product Disclosure Statement for details.
	Consumers should regularly assess whether their CCI policy still meets their circumstances. Things to consider: - How much have I been paying for CCI? (Check your credit card statement) - Do I still meet the eligibility criteria? (If your employment situation has changed, this will be very important to check). - Does CCI still meet my needs?
Making a claim	Consumers should check their Product Disclosure Statement for the correct contact details to make a claim (this may also be available online) and make a claim promptly.
Complain	If a consumer is dissatisfied with any aspects of the claim process they can complain. For further information visit ASIC's MoneySmart website: www.moneysmart.gov.au.
Financial difficulties	If a consumer is experiencing difficulties meeting their repayments on their credit card they should talk to their financial institution as soon as they can and discuss options such as making a request for assistance. For further information visit ASIC's MoneySmart website: www.moneysmart.gov.au.

About CCI

What is CCI?

CCI policies for credit cards are sold by financial institutions – typically banks – and other institutions that issue credit cards. When taken out on credit cards, a CCI policy covers consumers if they cannot meet their credit card repayments because, for example, they are made redundant, or are unable to work because they had an accident or fell ill. CCI policies also typically provide cover to consumers in the event of death.

If a claim is successful, the insurer pays a benefit amount to the credit card issuer (usually the financial institution who sold the consumer their CCI policy). This could be an amount that meets a consumer's minimum credit card repayment or the whole outstanding balance (for events such as permanent disablement and death).

CCI policies may have additional features covering the items a consumer purchases on their credit card. For example, some CCI policies covered in this report provided consumers with a 'price protection' or 'merchandise protection' feature.

CCI policies are issued by insurers and provide cover that is generally a mix between general insurance and life insurance components.

These policies are typically offered to consumers when they first take out their credit card. In some cases, the policy is packaged with their credit card. Usually, the consumer pays a monthly premium for their policy, the payment of which is automatically debited from their credit card.

CCI claims

According to the General Insurance Code of Practice overview[5] for the 2011–2012 financial year:

- there were 983,648 CCI policies sold in Australia (including new business and renewals), and
- 27,388 claims were made and 3,171 of these claims were denied (11.6%).

In REP 256 ASIC reviewed the sales practices of 15 ADIs that sell CCI. ASIC found that for the institutions who participated in their review, they had sold over 600,000 policies during the year reviewed. About one in six (15.9%) of all claims received by these institutions were unsuccessful, with one institution rejecting almost half of all claims in a one-year period. ASIC also found that CCI sold with credit cards had a higher average claims denied rate (21.2%) than CCI sold with other credit products.

In their report, ASIC expressed concern about the proportion of claims that were denied and has since started a second phase of surveillance with a focus on how CCI claims and complaints are handled.

To obtain information generated directly from consumers, ASIC decided to commission consumer-based research with consumers who have claimed on their credit card CCI policy.

[5] Financial Ombudsman Service, *General Insurance Code of Practice: Overview of the year 2011/2012*, May 2013.

About this research

Research objectives

The overall purpose of this research was to understand the experience of consumers who make a claim on their credit card CCI policy. Specifically, ASIC was interested in understanding whether current claim processes for credit card CCI policies are transparent for consumers and deliver, in their view, appropriate outcomes. The research was designed to answer a number of questions about consumers' claims experiences, as outlined in the table below.

Table 3. Research objectives

Issue	Questions the research was designed to answer
Consumers' understanding of the policy	- How consumers acquired their policy - What consumers understood about the policy coverage at the point of sale, including exclusions that applied to their policy - How much consumers had paid in premiums for their policy
Consumers' claims experiences	- The point at which consumers initiated a claim – and if delayed, the causes and the consequences of delaying a claim - The process that consumers used to make their claim and how efficient this process was – including the information and documentation the insurer required them to provide to support their claim - The length of time the claims process took - Whether consumers understood why their claim was accepted in full, in part or denied - Whether the consumers accepted the decision – and if not, why not - What differences existed between those whose claim was accepted and those whose claim was denied
Consumers' complaint experiences	- The process that consumers used to complain about their claim and how efficient this process was for consumers - The types of issues that consumers complained about - Whether consumers received information about the insurer's or the financial institution's complaint(s) procedure - Why some consumers chose to complain when others did not - The experiences the consumers had when they complained - The result of any complaints

Research design and method

The best way for Susan Bell Research to meet ASIC's research objectives was to design a research study which allowed the research team to listen to consumers' own stories about their experiences with the CCI claims process. A qualitative research method, through individual in-depth interviews, was the ideal way to listen to these stories.

Due to the difficulties in finding consumers who could meet a relatively narrow set of criteria (i.e. those who have a credit card CCI policy and have made a claim on that policy), ASIC requested the assistance of insurers who issue credit card CCI policies to assist Susan Bell Research to find a representative sample of consumers for this research.

To do this, ASIC approached nine insurers who reflect the majority of the market. Each of these insurers wrote to a sample of their customers who had claimed on their CCI policy during the period

1 March 2012 to 31 August 2102. In these letters, the insurers invited consumers to opt in to the research project by registering with Susan Bell Research by phone or online. Susan Bell Research then selected consumers to interview from this list ensuring that all the insurers were represented appropriately, based on sales data that had been previously collected by ASIC. Interviews were conducted in the period November 2012 to February 2013.

The main focus of this research was on the experiences of consumers who had claimed on their CCI policy because they had stopped working either temporarily or permanently. The interview process identified six consumers who had claimed on other features of their CCI policy. We decided to include these respondents as an additional sub-sample, and have reported them separately, in the section **Claims on other CCI policy features**.

For more detailed information about the research method and limitations that apply, see the Appendix.

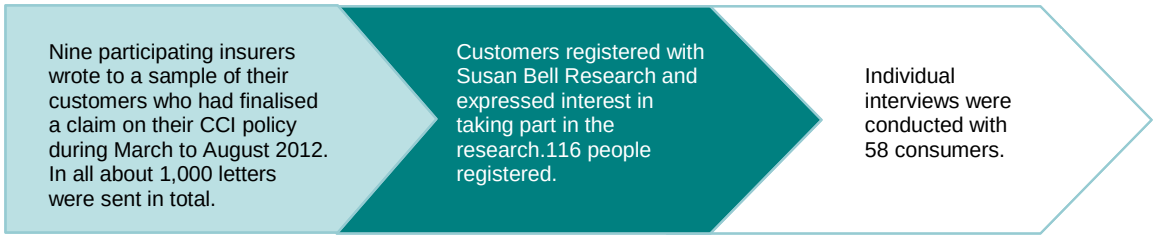
The sample

Susan Bell Research conducted 58 in-depth interviews with consumers who had claimed on a CCI policy sold in relation to a credit card, of whom 52 had claimed because they stopped work and six had claimed for other reasons. For the 52 consumers who had claimed because they stopped work, the breakdown of the consumer sample was:

- 32 consumers had their claim accepted, and
- 20 consumers had their claim denied.

The following diagram summarises the research process.

Figure 1. Summary of the sample selection process



To minimise the risk that only satisfied, or only dissatisfied, consumers opted in to the survey, participating insurers wrote to a designated number of consumers whose claim was accepted and a designated number of consumers whose claim was denied.

The sample of consumers and how they acquired their CCI policy are not intended to be representative of the market generally and should not be seen in this light. In fact, we will never know exactly how representative the sample is, because there is no validating data to confirm it. This means that we cannot describe how prevalent a particular attitude or behaviour is, though this does not invalidate the relevance of the experiences that people have shared with us.

So as not to interfere with internal dispute resolution (IDR) and external dispute resolution (EDR) complaints processes, the insurers were required to exclude anyone they could clearly identify as having an ongoing or non-resolved complaint. When selecting people to interview, Susan Bell Research also excluded any consumers where it was evident that their claim had not in fact been finalised, or where there was an unresolved complaint.[6]

[6] One consumer in this survey had lodged a complaint with the Financial Ombudsman Service (FOS). The consumer had not heard from FOS in over six months and no longer considered the complaint to be ongoing.

Detailed findings

The main focus of this report is on the experiences of consumers who claimed on their CCI policy because they had stopped working. This first part of the report describes the experiences of these consumers.

We start the report by describing how consumers who claimed on their CCI policy had originally acquired the policy, and how much they knew about the policy at that time.

A. Acquiring the CCI policy

Findings at a glance

Many of the consumers interviewed for this report acquired their CCI policy when it was offered to them by their financial institution (usually a bank) on the phone, face to face, or when applying for their credit card online. This was a quick process, with consumers being motivated to take out the policy for emotional reassurance. However, some have no recollection of this offer, believing that the policy was provided automatically. A few believed that it was mandatory to take it out.

At the time of acquiring the CCI policy, these consumers typically had a shallow knowledge of the policy – believing it would cover them when they stopped working, regardless of their circumstances or eligibility.

Some consumers informed themselves at this point by asking questions or reading information provided to them by the financial institution or online. However, other consumers lacked this knowledge and tended to take the brief description of the product provided during the sales process at face value, assuming that they would be eligible to claim on their CCI policy because they were paying for it.

How consumers came to have a CCI policy

CCI policies for credit cards are usually sold to consumers at the time they take out a credit card or shortly after. Many of the consumers interviewed could recall the financial institution offering them their CCI policy:

- in the branch of the financial institution when they originally took out the credit card
- when the consumer contacted the financial institution to activate their credit card
- in response to telemarketing. Some consumers responded to a telemarketing phone call, promoting the policy

  "It wasn't much longer after I got the credit card and had it for a few months and had transferred money onto the card, so it was full pretty quickly and then I got a call." (to offer the CCI policy). (Claim denied)
- in a store. Some acquired the policy when they were offered a credit card to help them pay for an expensive item such as furniture or white goods.

A few consumers had applied for their credit card online and ticked the box that asked if they wanted the insurance.

In most cases the decision to purchase CCI was an easy and quick decision for consumers to make.

> *"I didn't really look into it. It sounded good on the day."* (Claim accepted)

Some consumers told us that although they recalled purchasing their CCI policy, they had understood the policy was provided to them automatically by the financial institution on what they described as an 'opt-out' basis.

> *"Nowadays, it's just an automatic process."* (Claim denied)

Some consumers said that they received letters from the financial institution who was issuing them their credit card informing them of the CCI policy's existence, which explained that they had the right to opt out.

> *"The letter was framed as if, if you don't contact us back, we are going to assume you want it."* (Claim accepted)

A couple of people told us they believed that the policy was mandatory to take out. *"They did not offer me a choice."* (Claim accepted)

> *"One of the conditions was that we also took out the credit card insurance at the same time."* (Claim accepted)

A few consumers had no recollection of being offered the policy, so they did not actually discover they had the policy until after they stopped work and contacted their financial institution because of financial problems they were having paying their credit card debt.

Motivation to acquire the CCI policy

> *"It's a tick the box thing. I remember ticking the box for 'protection'."* (Claim accepted)

Consumers were motivated to take out the policy because they believed it was the *"right" or the "sensible"* thing to do. Some consumers were worried about repaying their credit card debt if they were unable to work or if they died.

> *"I felt safer."* (Claim accepted)

> *"I have a terror of getting into debt that I can't repay."* (Claim accepted)

> *"I didn't really know about the specifics of it and I didn't read about it. I decided it was worthwhile to do cover insurance, I was thinking if I died anyone in my family wouldn't have to pay it – so I just thought that more than anything."* (Claim accepted)

Some consumers acquired the policy when they were consolidating several credit cards into one, buying an expensive piece of furniture, or taking out a credit card for the first time. It made them feel more comfortable about taking on debt. They feared that they were getting into more credit card debt than they were used to. Some had been working in a fairly volatile work environment, where they could anticipate that they might be retrenched.

> *"I knew the job I had was heading down a bad path."* (Claim accepted)

Talking about 'motivation' presumes that consumers were seeking some form of benefit from the product. While that was certainly true in some cases, it does not explain why some consumers took the policy out. Some took it out but did not actually expect to use it.

> *"You never expect this is going to happen to you."* (Claim accepted)

> *"I made some assumptions; I assumed I would never need it."* (Claim denied)

Information provided at acquisition

What information did consumers receive about the policy?

The type and extent of information provided to consumers depended on where they first learned about the CCI policy. A few consumers reported having detailed conversations about the features of the CCI policy when the policy was offered to them over the phone.

> *"They went through the whole process of explaining exactly how the policy works and the terms and conditions."* (Claim accepted)

A few consumers reported a similar conversation within a bank branch, for example *"the lady (at the branch) showed it to me. I scanned it. I was happy with it."* (Claim accepted)

> *"The lady went through the whole sort of thing with me."* (Claim accepted)

However, others felt that the purchase process worked against them undertaking a detailed assessment of the policy features.

> *"When you sign up you don't get the time to read the fine print."* (Claim denied)

> *"The big bank manager says 'Initial this. Sign here' and you expect that everything falls into place."* (Claim denied)

One woman took out her policy over the phone. She felt that she received a mixed message from the person who sold her the policy. On the one hand she was clearly told *"it's up to you to go through the booklet and suss out the finer points."* On the other hand, she felt swayed by the implied promise and certainty that: *"you will have your credit card minimum repayment repaid until you could resume your work."* (Claim accepted)

Some had no recollection of receiving any information, though they acknowledged they may simply have forgotten.

Some consumers who took part in this study were not fluent speakers of English as it was not their first language; they had difficulties both speaking and understanding English. One woman whose first language was English was actually illiterate. Others described problems that they had reading and understanding financial terminology. There is therefore a strong likelihood that some of these consumers misunderstood what they were told or read – or they did not communicate effectively with the person who sold them their CCI policy.

After signing up to the policy, some consumers could clearly recollect receiving policy documentation later in the mail. However, only a small number read that information at that time. The consumers felt that once they had the policy there was no need to read up on it – once the decision was made to take out the policy, they stopped thinking about it.

> *"The policy was done and dusted. We agreed to it on the phone. Later they sent me a booklet. I didn't have the opportunity to read it before I agreed."* (Claim denied)

Eligibility criteria and exclusions

When offered the CCI policy in person or on the phone, consumers told us that they were not asked any questions about their potential eligibility before, during or after they purchased the policy. They were apparently not asked if they were self-employed, working casually or on a contract, or had pre-existing illnesses or injuries. All of these factors potentially limit eligibility to claim, depending on the policy.

"The manager gave me the idea to have a credit card. He said (because you have the policy) you are safe." (Claim denied)

The impression given by many respondents in this study was that the staff they dealt with did not know about the policy's eligibility criteria.

"I had an appointment at the branch. The girl should have said 'do you have a pre-existing condition?'" (Claim denied)

"Well when I did the sign up for the credit card and when I spoke to operators at (the financial institution), they told me about the great insurance policy that if you became unemployed or broke your arm, for whatever reason it would cover your wages. Or if you had issues with your employment the insurance would kick in. No fine print, nothing like that. So basically I agreed it to on the phone. A few weeks later I had something arrive in the mail which I put away in the drawer." (Claim denied)

One man offered this advice to consumers considering a CCI policy: *"Be very very careful what they tell you over the phone."* (Claim denied)

Some consumers believed that the responsibility to provide consumers with eligibility information rested clearly with the provider of the policy (be that the financial institution or insurer) when the policy was taken out.

"They should tell you upfront." (Claim denied)

"It is their job to tell me about the fine print, when they sell me it, not my job to know it." (Claim denied)

They felt that the financial institution should have known the questions to ask them.

"You need the bank to ask questions before you put it on my card." (Claim denied)

Some people became ineligible to claim after they had taken out their policy, although they did not realise this at the time. For example, one woman had a permanent job when she took out the policy. Later on she became a contractor, which made her ineligible to claim on certain features of that policy. Consumers did not expect to check their policy documentation when their circumstances changed.

Consumers who informed themselves about the policy

"They explained it after I asked what it entailed." (Claim accepted)

The extent to which consumers informed themselves at the time they were acquiring the policy seems to have had a significant impact on the outcome of their claim, so it is important to explore why some people informed themselves, and others did not.

Just under half of the consumers we interviewed told us that they did seek further information, by asking questions, or reading the policy information. All of the consumers who informed themselves in some way later had their claim accepted. *"I asked a couple of questions and then made a decision from there."* (Claim accepted)

First, those who read the policy or asked questions were typically:

- educated to the tertiary level

"I am educated enough to make an educated decision whether it is worthwhile." (Claim accepted)

"I did a lot of reading of that stuff. I think it (comes about) from Uni." (Claim accepted)

- worked in occupations – such as nursing, optometry, or IT management – where they were familiar with contracts and policies

  "I work with contracts. I do understand there is fine print and conditions to it." (Claim accepted)
- were generally careful or meticulous, saying they had been *"brought up"* that way
- had claimed on a similar policy before.

Second, those who proactively sought information spoke English as their first language.

Consumers who did not inform themselves about the policy

In contrast, those who did not appear to have informed themselves about the CCI policy proactively seemed to have had different life experiences from those who did. They specifically seemed to have had little (if any) exposure to contracts or similar types of insurance policies. Consumers also told us these reasons for not doing more to learn about the CCI policy:

- some admitted to literacy problems, saying "*it's like talking to a brick wall with me,"* (Claim denied) or *"I am slow to understand because I don't know the big words"* (Claim denied)
- some were not fluent in English
- others were busy. "*Who goes home and reads that? We are all time poor"* (Claim denied)
- some also seemed to expect the documentation to be long and complex

  "It's like reading foreign policy. You go 'what?' You know this is English but you don't know how to put it together to make it meaningful." (Claim accepted)

Consumers who did not read or ask questions took the policy at face value.

> *"I was just happy to have some sort of cover."* (Claim accepted)

Some consumers now feel that not asking any questions was a mistake. As one man said "*People should ask the bank about the insurance policy and what it covers and what its features are and what their rights are and what their obligations are. Ask for it in writing."* (Claim accepted)

One consumer gave the following piece of advice: *"Contact the people offering it to you. I would make up a list of worst-case scenario questions."* (Claim accepted)

The importance of product understanding at acquisition

Overall, this section has shown that consumers who took part in this study made the decision to acquire the CCI policy very quickly – and some have no recollection of doing even that. Consumers were generally not well informed about terms and conditions that applied to the policy they acquired. Some took this on face value, while others made further inquiries.

Those who took the product on face value believed it was the responsibility of the financial institution or insurer to inform them about the product – as some said, they would have never known the right questions to ask. On the other hand, those who made an effort to inform themselves about the CCI policy they were purchasing were much more likely to go on to have a successful claim. In short, the better informed a consumer was, the more likely the CCI policy would benefit them when they experienced an adverse event and make a claim.

This section has explored how consumers acquired their policy. Next, we describe how much they paid for it.

B. Paying for the CCI policy

Findings at a glance

The consumers interviewed had typically paid between $20 and $80 a month for their CCI policy.

Many of the consumers had their CCI policy for one or two years, though some said they had the policy for much longer than that.

How much did these consumers pay for their CCI policy?

With the exception of those who were not aware they had a CCI policy, all other consumers understood that they were paying a premium for the policy and that their premium was a percentage of the balance.[7] The percentages quoted to us were between 0.5% and 1% of the balance, though many were unsure as to the exact percentage.

> *"I said 'how much is it? They said 'it is only 1%', so if you only spend $2600, it is $26.' So I said 'look, for 1%, I'll take it'."* (Claim denied)

> *"It's a percentage of the balance, it's variable. It's not a lot."* (Claim accepted)

Many of the consumers in this study had been paying between $20 to $80 a month for their cover, with some paying more than that. The highest reported amount was $120 per month.

One consumer in this study paid no premium because he always paid off his balance before the date his credit card statement was issued on, and therefore his card usually had a nil balance. As far as he was concerned, this was "free insurance".

Most reported that they paid very little attention to the premiums they were being charged, to the extent that many had forgotten that they had the policy at all. To some extent this shows that consumers may not read their credit card statement very closely. However, others pointed out that they had seen the policy mentioned on their statement but at the time had simply thought it was some form of fee.

Many had taken out the policy in the last one or two years. Some policies however had been in place for over five years and their premium had varied a lot over that time. Before claiming, no one had calculated the total amount they had paid in premiums.

[7] Typically premiums for credit card CCI policies are calculated using the following method: $X per $100 of the outstanding credit card balance (the $X amount varies but is usually less than $1). For example if the premium was calculated at 70 cents per $100 of the outstanding balance, and the consumer had a $5,000 outstanding balance, their premium would be $35. Some premiums may also be calculated based on a set percentage of the outstanding balance.

C. The event that triggered the claim

Findings at a glance

The event that led to consumers making a claim varied from being made redundant to suffering a serious illness where the consumer could not work again. Some of the consumers interviewed very quickly found themselves struggling financially and emotionally.

The 'claim event'

Consumers we interviewed who had stopped work made a claim on their CCI policy because:

- they had become too ill to work, with – for example – a heart attack, cancer, chronic fatigue, or depression,
- they had an accident, such as a fall or a car accident, resulting in injuries such as a fractured hip or shoulder or back problem which prevented them from working, and
- they were 'laid off' by their employer or retrenched.

The claim events varied in severity. Nevertheless, what most of these consumers shared was the loss of a regular income.

Impact of the 'claim event' on consumers

The financial impact

Most of the consumers in this survey reported a significant change to their financial situation, as they no longer could rely on a wage or salary to pay regular living expenses.

Some consumers who took part in this study were in a relationship with someone in the workforce and they reported being able to obtain some financial assistance from their partner. Others, though, had been the sole breadwinner for their family, or were single and therefore it was more difficult for these consumers to find financial assistance quickly.

As one woman who had to stop work because of a breakdown, said *"I was single. I had been salary sacrificing which meant that I had no savings, then all of a sudden I hear 'you will not be paid tomorrow'."* (Claim accepted)

After stopping work consumers' only income was generally from Centrelink, although some had sick pay or annual leave payments before they made their claim. The change from a work-based income to reliance on Centrelink meant that for many their financial obligations now exceeded their income.

One man had earned $1,200 a week before his illness, and his wife added $700 a week to their income. They were living in a rented house nearby to both of their places of work for $500 a week. When he lost his job, the couple could not afford to stay in this house as they now only had $700 per week coming in – so they moved somewhere outside the city. It was cheaper, but inconvenient for his wife's commute to her work and for him to find work. (Claim denied)

Difficulty paying the credit card debt and other expenses

Some consumers recognised immediately that they were struggling to pay the minimum due on their credit card.

"After I got out of hospital, I told (the financial institution) 'I have a bit of a problem paying my bills'." (Claim accepted)

Others only told their financial institution later on. They used their credit card after they had stopped work, as they had no other income – sometimes to the point of reaching their credit card limit.

"Because I wasn't working, I was so much in debt." (Claim accepted)

The amount owed on the credit card at the time they stopped work varied from consumer to consumer. In many cases, the total amount owed was around $2,000 to $3,000, although several owed over $10,000. The highest debt recorded for this study was $18,000.

For some, this was their first ever credit card. In fact only a small number of consumers in the study had more than one credit card at the time of the interview. Some had only recently rolled the balance from other cards into one card, usually because it had lower interest.

Some of our sample told us that due to their difficulties they had been granted some form of financial hardship assistance on their outstanding credit debts by their financial institution. Often this discussion was with the same institution that sold them their credit card and they remembered (or were reminded) that they had a CCI policy during the conversation about hardship.

"I had to apply … for hardship because I was unemployed, and they told me 'you have this great policy, you're so lucky.' To be honest I'd forgotten. They said 'your income will be protected and payments will be made'." (Claim denied)

"I was panicking over the repayments and called them and the lady said 'don't you realise you have insurance?'" (Claim accepted)

Many in the sample had to stop work because of illnesses like heart disease or cancer, or because of serious injuries from accidents. Those who had an accident or illness often incurred ancillary costs – for example the cost of travelling to hospitals and doctors – on top of their normal expenses.

The emotional impact

Those with serious injuries and illnesses were physically and mentally fragile and easily fatigued. One woman described her mental state in these terms:

"When you have a breakdown, you can't keep things straight in your head." (Claim accepted)

It was also a highly emotional time. One man with stomach cancer described it this way:

"I definitely was not in the right state of mind – going in and out of hospital, and telling my wife and family what was going on was really really hard for me as well." (Claim accepted)

Some had been told that they would never work again which was a significant cause of worry for them.

"I have worked all my life; I didn't want to quit work. No one wants to employ you when you are in your fifties when you have a heart condition." (Claim accepted)

Some who had been retrenched were looking for work. Several of these people had become depressed and stressed during that time.

"You don't feel you are part of anything. You can really lose your way." (Claim accepted)

This section has described the event that caused the claim and the impact of loss of income for these consumers. Many also experienced physical pain or emotional distress because of the claim event.

The next section looks at experience of consumers in making a claim.

D. Making a claim

Findings at a glance

Some consumers claimed immediately after their diagnosis, accident or loss. Others did not make a claim until they were struggling financially.

Most initiated the claim by contacting the financial institution who had provided them with their credit card, who told them to contact the insurer.

In some cases, the consumer completed a simple form and received a decision from the insurer in a couple of weeks. Others however had to supply proof of the cause of their inability to work, which for some meant filling in several forms and supplying multiple medical certificates – this whole process took up to six months in some cases.

Some consumers with low levels of literacy struggled to understand the forms.

Lodging the claim

Most consumers interviewed did not know how to make a claim on their CCI policy.

> *"I wasn't satisfied with … the lack of knowledge on my part on how to do it and not knowing how to deal with the bank."* (Claim accepted)

Making contact

Although the insurer who issues the CCI policy is responsible for handling claims, most consumers in this study contacted the financial institution that sold them the credit card first, by phone or, if a bank, some visited a branch. That they contacted the financial institution at the first instance is further evidence that the consumers generally lacked product understanding.

In almost all cases, the financial institution then told the consumer to contact their insurer.

Some found this process puzzling. They had not seen reference to the insurer's brand name on their statement, for example: *"It just says (bank brand name) cover."* (Claim denied)

It was also onerous for some people in ill-health to have to search out how to claim.

> *"When I first rang up (the financial institution) to say that I had a new claim etcetera, I was sort of passed from one person to the next, to the next, and then back to the original person, and she was horrified that I'd been sent back to her. She basically said 'well look, the insurance side of it is now handled by, I can't think of the name of the company now, she said 'I'll give you their direct number', and I'm thinking 'well why didn't she do that in the first place?'"* (Claim accepted)

There were only two cases where consumers reported that the financial institution contacted the insurer on their behalf – one in a bank branch and the other over the phone.

> *"I rang (the financial institution). They were fine. They said they would get in contact with (the insurer). They looked at my policy number and everything and they confirmed that (the insurer) were doing this."* (Claim accepted)

In a very small number of cases, the consumer contacted the insurer first. One consumer downloaded the claim form from a website without having any conversation with the financial institution or the insurer.

Conversations before claiming

Many consumers had a conversation with someone at the financial institution or the insurer (or both) before submitting their claim. This conversation appeared to play a pivotal role in setting the consumers' expectations of the claim process. In particular, most of the consumers who had their claim denied were shocked because this possibility had never been raised before.

It was often financial institution staff who initially prompted the consumer to put in a claim. According to the consumers we spoke to, some of these staff were later surprised to discover that the consumer was ineligible.

> *"I applied to (the financial institution) for hardship and they told me 'oh you have this great policy, you're lucky' … then several weeks later I got a letter saying I don't meet the criteria … I rang (the financial institution) letting them know and they were pretty shocked to know it wouldn't go through."* (Claim denied)

Some consumers reported that the financial institution's attitude towards their CCI policy was overly positive – that anyone who had a policy would be eligible to successfully claim.

> *"Don't feel bad about it, you know that's why you have taken out this policy."* (Claim accepted)

In nearly all of the reported conversations eligibility criteria was not discussed at any great length. Some people who had their claim denied due to their ineligibility said that it would have helped a lot if they had been informed of the eligibility criteria during this initial conversation.

For example, one man who contacted the insurer to make a claim said the staff *"were very helpful"* at the time. He completed the forms they sent him, then they denied his claim. He said *"it would have saved a lot of trouble"* if they had alerted him to the policy exclusions when he first rang. As he said *"All the certificates were just a waste of time."* (Claim denied)

Unusually, one woman was advised very early on in the process that she would be ineligible: *"I went to the bank. I was hysterical at the time – I'd lost my job. They put me on to the insurance company on the phone. They said to me 'it will be declined because it was a contract job'."* (Claim denied)

When consumers made their claim

Timing of claims

The benefit a consumer receives (if their claim is successful) is based on their credit card balance at the time the claim event occurred. Therefore, the timing of the claim is important. Some consumers we spoke to had already reached their credit card limit by the time they stopped work. However some of those who had not reached their credit card limit continued to use their credit card after stopping work, because they now had no income and had medical or other expenses. The premium for their CCI policy was also being paid by their credit card, as was interest. Therefore, for some of these consumers it appeared to be easy for the balance on their credit card to continue to grow.

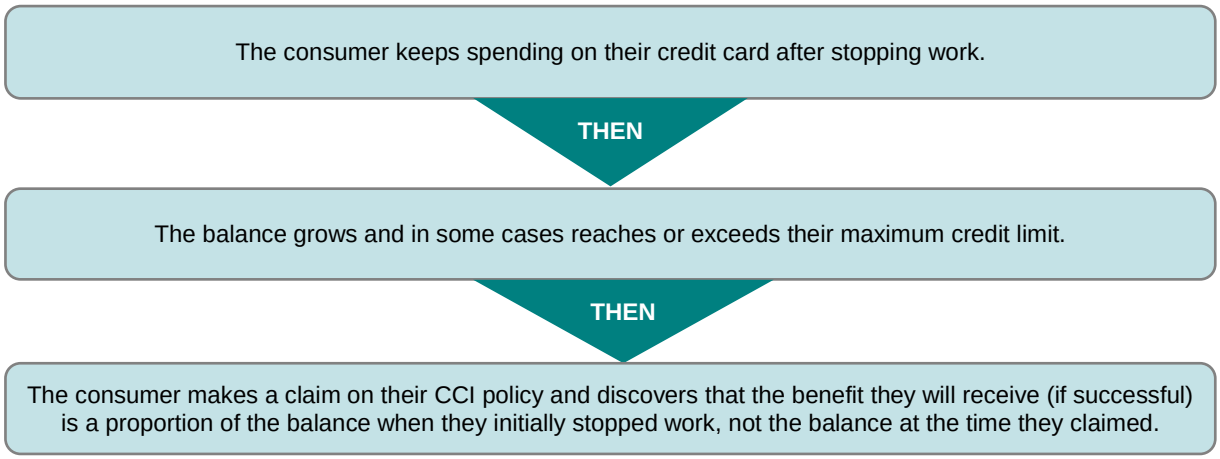
The consequence of delaying a claim is that as a consumer's credit card debt grows, the benefit amount does not increase proportionately. Consistent with their generally low level of understanding of their policy, most consumers in this situation had not understood this until they claimed.

One consumer did not lodge a claim until 12 months after he stopped work. Some others delayed making a claim for about six months, during which time their credit card balances grew. These

consumers reached a point of realisation that they could not pay even the minimum repayment amount.

How this happens is summarised in the diagram below.

Figure 2. The consequences of delaying the claim



Reasons for delayed claims

There were several reasons why some people did not make a claim straightaway:

- Some were in hospital.
- Some consumers had lost their job or were disabled had to prove they were registered with Centrelink. In some cases there was a delay in the person receiving Centrelink assistance, either because of the circumstances with which they had left work, or queries about whether they had other sources of income at that time.
- Several had forgotten that they had a policy – or did not even know they had it. Some suddenly remembered it or were reminded by a relative or friend, while others were reminded (or informed that they had it) by staff at the financial institution when the consumer contacted them worried about their inability to repay.

Because some people forgot they had a CCI policy, one person suggested that the financial institution or insurance provider should provide a reminder every year, on the policy anniversary.

> *"If there is a way to let people know, maybe when they renew every year, the benefits that they get."* (Claim accepted)

A small number of consumers did claim immediately after they stopped working. These consumers were able to claim immediately because they:

- remembered they had a CCI policy,
- realised immediately that they would struggle to pay their credit card debt, and
- had no other income (such as sick pay) and were therefore eligible for Centrelink assistance, if they were claiming for involuntary redundancy.

Documentation and forms to support the claim

Evidence required to support the claim

The table below summarises the evidence that most consumers were asked for to support their claim. The simplest experiences were for those who had lost their job through redundancy who were asked to supply their redundancy notice (or similar) and a number from Centrelink.

Table 4. Evidence required to support claims

	Job loss / redundancy	Illness or accident
Documents/evidence required by all insurers:	Certificate from Centrelink	Certificate from a doctor
Documents/evidence required by some insurers:	Severance letter from the employer / redundancy notice Past payslips	MRI, X-Rays, and letters from treating specialists Letter from the employer confirming absence from paid work

Different insurers have different requirements and there appeared to be no 'standard' in relation to document requests across insurers. For example, one man who stopped work on medical grounds, claimed on two different credit card CCI policies. On one of his two credit cards, he was able to claim over the phone, in a call that took half an hour. The insurer requested the necessary information from his employer on his behalf. He completed no forms. This was not the case with his second card, for which he spent three months supplying medical and other evidence before his claim was accepted.

Some consumers also had to supply previous pay slips or letters from their employer. Some insurers required that people who were off work from accidents or illnesses supply not just their medical certificates but also written proof from their employer, a process which they found *"embarrassing"*. This was also a burden on the employer. Some questioned why this was necessary saying *"It's not like I lied; I had the doctor's proof."* (Claim accepted). One man could no longer find his former employer as it had *"gone bust".*

Some had to provide specialist reports on their health. The latter proved to be hard to provide if the person had stopped work some time ago and made their claim much later. One person no longer lived near their doctor of that time, which also made things difficult.

Consumers with certain illnesses or injuries were required to supply a lot more proof which they regarded as onerous. For example, one person was asked three times for information about her medical condition.

> *"I had to fill in forms and get doctor's certificates. It just went on and on, the paperwork that I had to fill out they want all the doctor's past reports … and I don't know why. I am ill with pneumonia; I don't know what they want past reports for."* (Claim accepted)

In general, the people who received repeated requests for proof to support their initial claim:

- had some kind of pre-existing condition, or had had a similar accident before and/or
- were judged by their doctor to be unable ever to return to work.

> *"I thought 'what is this?' I took out a simple policy."* (Claim accepted)

Gathering documents to support a claim was very difficult for some people who were too ill to travel. One man was not allowed to drive, because his accident occurred when he had *"blacked out"* when driving. He lived four hours away from the hospital that was treating him. Indeed, many of those who could not work because of serious illnesses like heart failure were not allowed to drive.

This meant that the people who were required to supply the most information tended to be those who were likely to be the worst off, such as people who had serious accidents and were unlikely to return to work.

> *"It was a nightmare when you are not very well."* (Claim accepted)

How evidence was sent to the insurer

A few consumers were allowed to email their forms directly to a case officer at the insurer. This method of communication was very useful for one man in particular, as he could not walk to his own letterbox, let alone to somewhere to post any forms. It should be noted, however, that the ability to email forms and documentation would not have helped everyone in this study as some consumers did not have a computer/internet connection.

The rest of the consumers were required to photocopy and mail their forms to their insurer, which was particularly difficult for people living in remote areas. People who were too ill or injured to work found it very difficult to travel and to organise the photocopies needed to complete the paperwork.

Difficulty with the forms

A few consumers found that completing the forms was difficult.

> *"I phoned up a few times about the forms. I didn't understand. You can't answer 'not applicable', They ask you about things you can't answer, because it's not relevant to you."* (Claim accepted)

The process was also difficult for some people with low levels of literacy especially if English was not their first language.

> *"The forms were difficult. I had to read them a few times before I understood them."* (Claim accepted)

> *"The forms are very long, you even have to put what you do at work, how many hours you stand, and all sorts of stuff on that, it's a really long form. Even the one that goes to the doctor is quite long because I had to send my daughter back to pick it up so it is quite a lot of work to do."* (Claim accepted)

Some were also reluctant to ask their doctor to complete more than one form.

> *"Doctors like to do doctoring, you can't go back to the doctor's, everyone wants a letter."* (Claim accepted)

The cost to supply the evidence

Consumers generally reported that each visit to the doctor cost about $50. Photocopying and mailing costs were also reported to be quite high. The paperwork barriers caused a couple of consumers to wonder whether it was financially worth their while to make a claim, given the amount of money they had to spend to prove the claim.

> *"You have to get a doctor's certificate as well, which costs $50, so every time … you had to go to the doctors and get $50 so really $50 is being taken out of the interest they are paying … so I did question that with them."* (Claim accepted)

Consumers who supplied documentation over several months, and later had their claim rejected, were generally distressed that they had to endure what was to them a costly and arduous experience, for "*nothing*".

Speed of assessment

The time taken for claims to be accepted or denied varied enormously, from two weeks to six months. There were two main reasons why some claims took longer to process:

- Lost paperwork. We heard from two consumers that their insurer reported not receiving their original claim form. So they had to start again. A couple of consumers reported that the insurer originally sent the wrong form.
- The amount of documentation required to support the claim. As described below, some consumers spent months providing evidence for their claim.

As these consumers were struggling to pay their credit card repayments, the length of time taken to assess their claim had a significant financial and emotional impact for some. In particular, most financial institutions continued to require consumers to pay their minimum monthly repayment during this time, even after consumers had initiated the claim.

Several consumers in this situation told us that their financial institution wrote to them and phoned them demanding that they pay their minimum balance while they were waiting for their claim to be assessed. These consumers tried to explain to the financial institution that they were claiming on the policy, to no avail.

> *"The bank kept ringing for their payments. I kept telling them 'I am waiting on the insurance.' You don't know where you are. Just give me an answer."* (Claim accepted)

While waiting for their claim to be assessed some consumers continued to use their card, so their debt increased. If the consumer did not meet their minimum repayment during the assessment period, some had to pay late fees – again increasing their debt. Therefore, the longer the claim took to assess, the more difficulties the consumer was likely to experience.

Some consumers had their credit card cancelled by their financial institution during the claim assessment process because they had not kept up with repayments. In most cases, the credit card was later reinstated – but this process created additional stress for consumers.

One man found his six week wait very difficult because he and his family were trying to find money to pay bills as he had just been released from hospital and *"everyone was still dealing with the trauma of the accident."* (Claim accepted)

Product understanding improves during the claim process

This section has again shown how important it is that consumers understand their CCI policy and what it entails. Consumers' lack of product knowledge can again be seen here, as these consumers could not accurately identify the organisation that had issued their cover.

Some consumers also discovered during this process that the product was not as simple as they had thought. In some cases, the process of lodging the claim was arduous, expensive and stressful, which was not what consumers were expecting.

So far we have made few references to the differences between successful (accepted) or unsuccessful (denied) claims. As we explore consumers' claims experiences in more detail, these differences and some of the problems that consumers experienced become important. The next section describes the experiences of consumers whose claim was accepted.

E. Accepted claims

Findings at a glance

Consumers whose claim was accepted were generally very relieved. They reported that the money helped them significantly.

There were a few consumers who were unclear about how their benefit amount was calculated and thought that they possibly had not received the full benefit amount.

Once their claim was accepted, some consumers experienced a smooth benefit period in which all the required payments were made on time and without error.

However, several consumers suffered poor experiences because of a lack of coordination between the financial institution and the insurer – especially when the insurer made a payment later than the consumer's repayment date on their credit card.

The benefit paid

Thirty two consumers had their claim accepted. This included a small number whose claim was initially rejected (for further information, see section **G. Making a complaint**).

The table below summarises the accepted claims in terms of the reason for the claim and how the claim payment was made to consumers – whether it paid the consumer's outstanding balance on their credit card in one payment or whether it was paid on a monthly basis to cover consumers' repayments on their credit card.

Table 5. Accepted claims

Reason for claim	Paid monthly or lump sum	Number of consumers
Illness	Monthly repayments	10
Illness	Lump sum payment	2
Accident	Monthly repayments	6
Accident	Lump sum payment	6
Unemployed	Monthly repayments	7
Unemployed	Lump sum (or one monthly repayment – unclear)	1

Some of those who were paid a percentage were off work for long enough for the whole balance to be paid in the end.

By and large most of the consumers whose claim was accepted were happy and relieved with the outcome of their claim. Consumers whose whole balance was paid were particularly pleased.

> *"You can imagine how wonderful that was."* (Claim accepted)

Having a claim paid as a lump sum can be very helpful for consumers as can be seen from the following comparison between the experiences of two consumers from two different insurers.

Table 6. Benefit paid as a lump sum or as a monthly payment

	Different ways to pay the benefit
Example 1:	A young woman had a serious head injury for which she was off work for 11 months. Her claim was paid in full, about a month after she submitted the claim, as a lump sum. She described this as *"the best day of my life"*. Apart from the original documentation, she did not have to supply any other evidence of her injury after she claimed. (Claim accepted)
Example 2:	A woman diagnosed with macular degeneration had to close her business because she could no longer see. Her doctor described this as a permanent injury which would prevent her from working again. Her claim was paid as six separate payments over about 10 months. For each payment she was required to provide a new medical certificate, which she described as *"sending some one back through the trauma by making them go back to the doctor every six weeks."* (Claim accepted)

Some people claimed on two policies (for two different credit cards) for the same event. In one case, one insurer paid in full, while the second insurer paid monthly repayments to cover their minimum balance for the three months it took for him to return to work.

Overall, though, most consumers whose claims were paid were very pleased with the outcome.

> *"It made a huge difference. It was a load off my mind. A big relief."* (Claim accepted)

> *"It came at a time when I didn't know where the money was going to come from."* (Claim accepted)

> *"It wasn't a huge amount of money. It just meant that I didn't have to worry about it."* (Claim accepted)

Many of these consumers reported that their customer service encounters went very smoothly. As one said *"I have nothing but high praise for the people I dealt with. They were really good. They were understanding."* (Claim accepted)

A lower benefit payment than expected

Some consumers did not receive as much money as they expected, though it is hard to know whether this was a decision by the insurer to pay only a 'part payment', or whether their expectations were incorrect – as they themselves did not understand why they had received the amount they received.

One man received $3,000 when he was expecting $5,000: *"I have no idea at all what the policy covers*." (Claim accepted) Another had a credit card debt of $4,500 and received one payment only of $700 and was told that there will be no more payments. He was still unemployed and says *"It would have been better if I understood how they paid out."* (Claim accepted)

One consumer believed that their claim had been denied because they had a pre-existing injury, but they were allowed a payment of $298 *"for disability."* (Claim accepted)

Some people submitted claims for the same event to two different insurers, because they had cards from different providers and achieved a different outcome. For example, one had a claim paid in full by one insurer and in part by another, and again this was puzzling. *"I owed $13,000 on one credit card and they gave me $700. I owed $1,400 on another card and they gave me $1,700."* (Claim accepted)

Those who did not think they received the full benefit amount were generally not happy with the outcome. One advised others*: "Don't rely on it. Don't think they will give you enough to get you through more than a month or two … Look very carefully into how much they pay you … be very careful."* (Claim accepted)

Evidence needed during the benefit period

In order to get to the acceptance stage of their claim, consumers generally had to provide a lot of paperwork, but for many the paperwork did not stop there. Consumers needed to continue to provide insurers with evidence that they were unable to work – in the case of an accident or illness claim – or evidence that they were looking for work for claims relating to job loss.

Consumers had different stories to tell about the amount of documentation required of them to prove their claims, as outlined in Table 7.

Table 7. Continuing requests for documentation

	Job loss / redundancy	Illness or accident
Documents required by all insurers:	Proof of Centrelink assistance	At least one further medical certificate
Documents required by some insurers:	Evidence of job seeking Letters from the employer	Medical certificates every month or two months

Those with short term illnesses or who returned to work quickly needed to supply less information to the insurer. Some with longer term illnesses or injuries had to resupply medical certificates every month, or every two months.

While most consumers did not recall being overly happy with the amount of documentation they were required to provide during the period their benefit was being paid, two consumers who had their claim accepted with the same insurer were relatively positive about their experience:

- One consumer had a long term illness and was only required to provide proof of the illness after six months.
- The other consumer was told after a few months that she no longer had to supply proof each month and instead the insurer paid her a lump sum.

  "They covered me for everything on the card, so they said it was easier for them to pay it out rather than (make) payments every month, because it appeared that I would still be disabled for a while." (Claim accepted)

Some consumers formally complained about the amount of documentation required. It added considerably to their financial stress and distress. Each visit to the doctor for a certificate cost money plus transportation costs. The cost of travel was especially significant for people in remote areas.

> *"They assess it every 30 days, so every 30 days you have to fill out paperwork again so it is a very difficult process to get this amount of money, which is peanuts."* (Claim accepted)

> *"If you are claiming for two to three months, then your credit card payment is $110 or whatever. Then you have to take off the $50 to get a medical certificate, so it doesn't seem right, because you are paying quite a bit for your insurance."* (Claim accepted)

One woman said that while she would advise other people to take out a CCI policy, she would also advise them to ask questions about the need for these ongoing medical certificates "*because people don't realise they have to pay this on top of their insurance."* (Claim accepted)

Problems after the claim was accepted

Once a claim was accepted, the rest of the process sometimes went smoothly, especially if the claim period was short. However, several consumers whose claim was accepted told us of poor coordination between the financial institution and the insurer – as one man said, "*the right hand not talking to the left hand".* (Claim accepted)

Timing of the payment

Several consumers interviewed experienced problems when their financial institution "*demanded*" that they pay their credit card monthly repayment amount by a certain due date, but the insurer paid the benefit amount on a different date. This resulted in the consumer receiving demands from the financial institution and in some cases incurring late fees. One consumer even paid the monthly repayment so as to avoid incurring a late fee.

> *"The bank would still expect you to pay the $99 which was the minimum repayment even though the $328 had gone in as a repayment (but on the wrong date). If you defaulted, you got the late fee."* (Claim accepted)

> *"I kept having to contact different people and ring (the financial institution) to ask questions about payments or stuff like that and they were like 'oh, we don't look after it', but … (the insurer) were actually paying a certain amount each month but there was never any coordination with when (the financial institution) wanted me to pay my credit card."* (Claim accepted)

The problem was compounded by the fact that some consumers did not understand that the insurer and the financial institution were separate departments or organisations.

> *"I was a bit confused. They were from (the insurer) but it was a (bank) credit card, and I think they said they were calling on behalf of them but at the time I didn't realise it was a separate, which caused some dramas when I was trying to deal with them – having to contact different people and ring (the bank) to ask questions and payments*." (Claim accepted)

Two consumers reported that they understood their insurer paid the claim amount on a set number of days after receiving the completed forms for their claim (e.g. four days and two weeks). Another consumer said it varied – it could take *"between seven to 21 days"* to process. Another consumer told us that the insurer paid the claim on the anniversary of the policy – or possibly the anniversary of the claim, though they may have been mistaken.

Some insurers did not communicate to consumers about how long they would receive a payment for, so some consumers did not know when to start making their own repayments. One financial institution cancelled a consumer's credit card after the insurer paid only one payment – the consumer was expecting a payment during the second month and therefore did not make their own repayment and their card was cancelled along with their policy. (Claim accepted)

Where a case officer had been assigned to a consumer's claim this usually helped those who experienced the administrative problems we described earlier.

> *"I generally talked to the same person and that person was very open with what they were doing and whether they got my forms."* (Claim accepted)

The importance of coordination between insurer and financial institution

There is no doubt that some consumers whose claim was accepted were very satisfied. They were relieved and pleased to receive a lump sum payment or monthly repayment at a time when they really needed some financial assistance. The process, for these satisfied consumers, was speedy and smooth.

However, some suffered stress and financial problems during the time they received their benefit, because of poor coordination between the insurer and financial institution. Consumers had been led to believe that the insurance would cover their minimum monthly repayment on the date it was due. However, several found that the insurer had their own timeframe for paying the benefit, which did not appear to have been conveyed to the financial institution.

Most consumers had made their claims because they were already in a position where they were struggling to meet their credit card repayments. Many were ill and suffering from some form of physical or mental incapacity. Receiving phone calls and letters from their financial institution demanding that they pay their minimum balance when it was supposed to have been paid from their insurance benefit was unnecessarily stressful.

The next section of the report describes why some claims where denied and the impact that had on those consumers.

F. Denied claims

Findings at a glance

Some consumers' claims were denied because they had been ineligible to claim on certain aspects of their policy since they first took it out. Others became ineligible after they took out the policy because their work or circumstances changed.

Most consumers were shocked when their claims were denied. They felt surprise, emotional distress and financial strain.

To some extent, making a claim added to their financial problems because of the expenses incurred in the process.

Why claims were denied

This section explores the reasons why for 20 of the consumers interviewed their CCI claims were denied.[8] Table 9 in the Appendix outlines the reasons why each of these claims were denied.

Three consumers could not in fact tell us the exact reason why their claim was denied. Two of these consumers could provide us with some details of why they thought their claim had been denied, although it was an incomplete or unclear response. One consumer could not provide us with any reason – this consumer spoke English as a second language and had not understood what he had been told in relation to why his claim was denied.

Denied claims: unemployment

Ten consumers who had lost their job and made a claim on their CCI policy had their claim denied – for varied reasons. In some cases it was because their employment status made them ineligible to claim (CCI policies typically exclude contract workers, seasonal workers and sometimes the self-employed) or they did not meet standard waiting periods that applied to their CCI policy. Also, CCI policies generally only cover consumers when their unemployment is involuntary – as a few consumers in this survey discovered when their claim was denied because their employer claimed that they had left their job voluntarily.

Some of the consumers whose claims were denied due to their employment status had worked in that capacity since they took out their CCI policy. For example, one consumer worked in the public service on a contract, another was a contract cleaner. In all of these cases, the consumer had not understood that they were not – and had never been – eligible to claim on certain features of their CCI policy.

[8] Another three people had their claim denied, and then accepted. We have categorised these as 'accepted' claims.

Denied claims: accidents and illnesses

Ten consumers who made a claim because they could no longer work due to an accident or illness had their claim denied. The reason for most of these claims being denied was due to an exclusion where consumers generally could not claim for an injury or illness they had before the commencement date of their CCI policy, typically known as a 'pre-existing condition'.

Therefore, most of the denied claims made on the basis of an accident involved injuring the same part of the body to a previous injury. In at least two cases consumers told us that they had not in fact injured the same part of their body but a 'similar' part of their body and the insurer still found this to be a pre-existing condition. For example, one woman had previously injured her back, but her claim related to injuring a different part of her back.

One consumer had her claim denied because she had visited a doctor for her ongoing chronic fatigue in the previous months before making her claim.

These consumers told us that they would not have taken out the policy if they had known that there was a pre-existing condition exclusion, because it was very likely that they would be excluded. In particular, we interviewed a blind person who tried to claim on their CCI policy.

> *"It really wasn't explained to us at all about the pre-existing condition, because we wouldn't have done it."* (Claim denied)

Reaction to the denial of the claim

The shock when the claim was denied

The consumers we spoke to were surprised – and often shocked – when their claim was denied. Some consumers said they were *"gut wrenched"* and spoke to us about their distress.

One woman said that *"You would have seen me in foetal position on my lounge room floor"* when she first learned of the decision.

One of the reasons for this strong emotional reaction was that the denial of the claim left the consumer with no way to pay their credit card debt.

> *"It added to my stress levels. I thought I was insured. I had to find another solution to my problems."* (Claim denied)

After the initial surprise came anger and a sense of being *"deceived"* that they had paid premiums for no purpose. *"It shatters you. You don't sleep. You have been throwing money away for something that is not there, that you think is there."* (Claim denied)

> *"I thought it was disgusting."* (Claim denied)

The customer service received by people whose claims were denied seemed to have varied enormously, possibly because some of these consumers responded to the denial of the claim with anger and frustration, and were at the same time unaware of policy exclusions.

Some consumers reported that customer service staff were impatient with them when they struggled to understand what had happened. One said that that staff "*confused me by saying 'I didn't know what I was saying'".* (Claim denied)

The financial implications of a denied claim

Consumers whose claims were denied specifically mentioned the time and money they had spent submitting their claim – the costs of doctor's visits, phone calls and photocopying mentioned earlier.

One man, who lived in a remote area and called the insurer from his mobile phone, was put on hold several times, and was asked to return calls to voicemail. He said this had cost him too much when he was unemployed and already in debt.

The longer-term financial consequences for some of these consumers whose claim was denied have been quite severe. They have a credit card debt and no way to pay it, and only an income from Centrelink to cover medical and living expenses.

Most have cancelled their credit card. Some have now been declared bankrupt, and no longer have access to credit.

> *"In the last four months I have gone through hardship anyway, and you have to cut up the card, so the insurance stopped automatically."* (Claim denied)

Dissatisfaction with CCI policy

To summarise, consumers were generally surprised and shocked when their claim was denied. Many of these consumers felt they had been *"let down"* by the financial institution who sold them their policy. The overriding theme here was that consumers had believed that paying the premium for their policy made them eligible to make a claim on their policy.

> *"I am paying $20 for an insurance premium on a credit card. If they are going to take that money off me, then I want to make a claim on them."* (Claim denied)

> *"At the end of the day you can honestly say that you paid for a product that you didn't get."* (Claim denied)

When they found out that they were ineligible to make a claim on their policy some consumers believed that they should have their premium returned. These consumers were not aware that their policy had exclusions that would impact them. They say they weren't told, and they did not know what to ask.

One woman was six months off her 65th birthday when she took out the policy. She became ineligible to claim when she turned 65. She was unaware of the age exclusion.

> *"There was no thought in my mind that I wouldn't be covered."* (Claim denied)

It is clear that some consumers' understanding of their policy was inadequate. They did not know the policy had exclusions and eligibility criteria, and were shocked and distressed to discover why their claim was denied.

This report highlights the issue of responsibility. To what extent should the consumers have informed themselves? Conversely, to what extent should the financial institutions and insurers have been more transparent in explaining how the policy worked?

We observed that consumers who did make some effort to inform themselves when they took out the policy were generally educated to the tertiary level and had prior exposure to contracts and insurance policies. In contrast, those who did not ask questions about eligibility criteria, and did not read the policy material did not know that they needed to do so. They assumed they would be able to claim on the policy because the policy had been offered to them. This lead to the situation where some of the people least able to afford the premium and the cost of evidencing the claim had their claim denied.

Consumers who are unhappy with any aspect of the claim process could make a complaint to the relevant organisation. The next section of the report examines what happened when some people decided to complain.

G. Making a complaint

Findings at a glance

Consumers made a range of different claims-related complaints to the financial institutions and insurers.

Some consumers complained about how long it took to process their claim. For the most part, these complaints seemed to be effective, in that the claim was decided soon after.

Some consumers complained about problems with the payment of benefits. These complaints were typically neither resolved nor escalated.

Some consumers complained that their claim was denied. In three cases, the complaint decision was found to be in the consumer's favour and the insurer accepted their claim.

Making the initial complaint – and then escalating it – appeared to be a prolonged and stressful process for the consumer. People with very little income, who may be suffering from ill health were understandably reluctant to pursue a process which they believed showed little sign of succeeding.

How and why consumers complained

In all, 19 consumers interviewed for this report made a complaint[9] at some point during the claim process. Consumer complaints about CCI claims fell into three categories:

1. Complaints about the process of assessing the claim.
2. Complaints about the denial of a claim.
3. Complaints about the process of paying the benefit.

We asked all consumers whether they were aware that they could complain. Nearly all consumers told us that they were informed about how to complain if they wanted to.

Complaints about the process of assessing a claim

Four of the consumers interviewed complained to the insurer during the assessment phase because of issues they were experiencing in processing their claim. Three of these consumers complained because they did not know why it was taking the insurer so long to assess their claim.

These consumers wanted to end the uncertainty of their outstanding claim. They had difficulties paying their credit card debt and wanted to know if they needed to find other ways to pay their debt should their claim be unsuccessful. These three consumers had their complaints successfully resolved – although in two cases the consumer had to complain more than once.

[9] Regulatory Guide 165 *Licensing: Internal and external dispute resolution* (RG 165) defines a 'complaint' as *"An expression of dissatisfaction made to an organisation, related to its products or services, or the complaints handling process itself, where a response or resolution is explicitly or implicitly expected."* (RG 165.79)

One consumer made a complaint about the amount of 'paperwork' he had to complete and gather to support his claim. This complaint was not resolved in the consumer's favour as the insurer insisted that he must provide the documentation that had been initially requested. He chose not to gather more information and his claim was denied.

Complaints about the outcome – denied claims

Successful complaints

Three consumers made a complaint about their claim being denied and had the decision overturned in their favour, as the table below summarises.

Table 8. Complaints about the outcome: successful

Reason for the claim	Summary of the complaint	Method of complaint	Outcome
Accident	The consumer's claim was denied on the basis that the consumer had a pre-existing injury. The consumer was able to show that the original Product Disclosure Statement (PDS) did not specifically exclude their condition. The consumer also raised issues in relation to inadequate disclosure at the time the policy was sold to them.	The consumer wrote to the insurer to inform them that the policy had not specifically excluded their condition when they took it out.	The claim was accepted. The insurer wrote to the consumer apologising for the error.
Accident	The claim was denied because the insurer said the consumer had a zero balance. The consumer was able to show that the balance on the statement prior to their accident was not zero.	The consumer phoned the insurer and asked for someone else to assess the claim.	The original claim was cancelled and a second claim for the same event was accepted. The insurer wrote to the consumer apologising for the error.
Illness	The consumer returned to work on limited duties after being told by the insurer that the benefit payments would continue. The insurer wrote to the consumer to inform them that they were not eligible to claim as they had returned to work.	The consumer wrote to the insurer pointing out that the PDS on the website did not support their interpretation.	The consumer began to receive payments.

These successful complaints have some common characteristics:

1. These consumers persisted with their complaints. None of these complaints were resolved at the initial conversation.

2. Each consumer was able to demonstrate the legitimacy of their complaint. They all had a reasonable understanding of the policy and had familiarised themselves with terms and conditions relevant to their circumstances. In each case, the consumer reviewed the PDS on the website, or the copy they had kept when they took out the policy. They were able to refer to it to support their complaint.

3. Two consumers initially expressed their complaint in writing. One of these consumers believed that the insurer took them more seriously because they were fortunate enough to be able to express themself in 'corporate' language. They also had some additional finances to help pay for phone calls and photocopying to support their claim.

Unsuccessful complaints

Eleven consumers complained about their denied claim and did not have the complaint resolved in their favour.

In general, these consumers complained about wanting to have the insurer's claim decision reversed. However, most of these claims had been denied because the consumer clearly fell within the exclusions of the CCI policy, therefore consumers were not able to refer to the PDS or other policy documentation to support the basis of their complaint (unlike the complaints that were successful). One consumer complained because they thought their insurer had misunderstood their employment situation but this didn't change the outcome.

Other consumers had had another purpose when making their complaint which was to have the premiums they had paid refunded:

> *"My complaint was that they sold it to me. My complaint was 'you told me the policy was this and it isn't' … I was jumping up and down talking 'ombudsman' and things like that."* (Claim denied)

In two cases the insurer did offer to return the premium. One was to a woman who became blind and was unaware that her condition made her ineligible.

Some consumers were not entirely clear about the outcome they wanted to achieve from their complaint. While they would have liked the decision to be reversed, they were also frustrated with the process and the fact that they had been sold the CCI policy in the first place.

The organisation the complaint was made to

There was little consistency in relation to who consumers complained to about a denied claim – some consumers complained to the financial institution who sold them their policy (including visiting the financial institution, usually a bank branch) and other consumers complained to the insurer. In two cases, consumers did not know who they had contacted – one consumer said that they had followed the 'IDR process', and the other consumer could not be sure.

Where consumers complained to the financial institution about the outcome of their complaint, the financial institution usually informed the consumer that the claim decision was not theirs, but the insurer's. No consumers reported that the financial institution responded to any general frustrations they expressed about why the policy was sold to them. When these consumers then complained directly to the insurer, the insurer generally refused to reconsider their decision. The fact that the consumer had been unaware of the eligibility criteria was not their concern and this left the consumer with nowhere else to go.

Complaints about the process of paying the benefit

Successful complaints

Turning now to claims that were accepted, six consumers complained to the financial institution or insurer about problems they experienced during the benefit payment period. The complaints were:

- that the benefit was paid after the credit card payment was due,
- that the insurer required too much paperwork from the consumer, and
- that a mistake had been made.

Three consumers had a successful outcome in relation to their complaint. This included one consumer who insisted that the insurer was expecting too much documentation from them such as regular medical certificates. They considered that this was unnecessary when their doctor had informed the

insurer that they would never be able to return to work. After raising this issue with the insurer several times, the matter was resolved and the consumer no longer had to provide the additional documentation.

The other two complaints related to the benefit payment. One consumer complained because the benefit amount was being paid into the wrong credit card account – while this complaint was resolved to the consumer's satisfaction, it took three months and repeated phone calls from the consumer to finalise.

Unsuccessful complaints

Three consumers had unsuccessful outcomes in relation to their complaints about problems they experienced during the benefit payment period. All three complaints related to the problem described earlier in this report – that the financial institution expected payment on a specific date and the insurer seemed to pay according to a different schedule.

Two consumers contacted their insurer and one consumer contacted their financial institution to resolve this problem. All of these complaints were made by phone and in many cases the consumers had to speak to several people about their problem. This became a trail of phone calls, to two different organisations, as the financial institution referred the consumer back to the insurer, and the insurer did the opposite.

> *"When a bill was sent to me from (the financial institution), I was thinking 'well, do I pay this?' … when I rung up the insurance company to say 'what is going on?' they said 'oh no we aren't anything to do with them, you have to talk to them'."* (Claim accepted)

Consumers who complained about this issue wanted to solve a very specific problem which was to have their payment made on time – as this of course was the purpose of taking out a CCI policy. These complaints were not resolved to the consumers' satisfaction because the problem persisted until the consumer returned to work or completed the benefit period.

Escalated complaints – EDR schemes

Consumers can escalate complaints which are not resolved to their satisfaction by lodging a complaint with an EDR scheme.

Only one person contacted an EDR scheme, the Financial Ombudsman Service (FOS), but so far this has been without success – it had been six months since the complaint to FOS was made, and the consumer does not consider it worthwhile to chase them up. The main reason for their complaint to FOS was that they felt the process they had been through was unjust and they wanted to *"expose"* the flaws in the industry.

> *"I didn't think I had a hope, but I am like a terrier or a pit bull. I did it because these kinds of things should be exposed."* (Claim denied)

One consumer threatened to complain to FOS, but in the end decided that the financial institution's offer to provide them with financial hardship assistance was sufficiently supportive.

Complaints that were not escalated

Most consumers chose not to escalate their complaint when it was not resolved to their satisfaction.

The consumers who complained about the timing of the payments saw it as an administrative bungle which needed to be corrected, rather than a complaint that could be escalated.

Some consumers who complained about the decision to deny their claim did not feel encouraged to pursue their complaint further.

> *"I just washed my hands of them and said 'enough is enough'."* (Claim denied)

One consumer did report that they pursued their complaint about a denied claim quite extensively. *"I put in a complaint … and they've said, 'we have taken this complaint very seriously, and we are taking it to the next step' and that person took it to the next person up to God."* (Claim denied) By December he was still waiting to hear back – after lodging the complaint in June.

The process left these consumers feeling worn out and sceptical that their complaint would be found in their favour. Also, some consumers simply could not afford to keep pursuing their complaint either financially (e.g. with long distance phone calls on mobile phones costing too much) emotionally, or both.

Claims on other CCI policy features

This section of the report describes the experiences of a small number of consumers who claimed on features of CCI policies which have nothing to do with stopping work. These features typically cover the merchandise a consumer purchases with their credit card and the 'claim event' is unrelated to consumers' life circumstances. For example, some consumers claimed on a 'price protection' feature of their CCI policy, whereby a product they purchased using their credit card was later promoted at a lower price, and they made a claim to be covered for the difference in price.

We identified six consumers in this report who claimed on these 'other' features. This included a consumer who claimed because they purchased an item which was later stolen, and other consumers who claimed because they found purchased goods at a cheaper price.

All six consumers had their claim accepted, although for one consumer their claim was initially denied but accepted when they complained.

In contrast to some of the experiences of people who claimed because they stopped work, the claim process for these consumers was quick and straightforward. The documentation required was relatively simple.

> *"They sent me a form. I filled it in and mailed it back."* (Claim accepted)

The claims were assessed within a few weeks. *"It took two weeks. It was smooth. It was easy. I didn't have to chase them."* (Claim accepted) Again this contrasts to the claims described earlier, some of which took several months to assess. There was much less urgency too, as the consumer wanted to receive the benefit but did not need it to live on.

The benefit paid varied but was usually a few hundred dollars, with which the consumer was happy. They generally knew what to expect, because they knew the price of the goods they were claiming on. Of course, this is considerably less than the benefits paid to some (but not all) consumers who claimed when they were unable to work.

These consumers faced none of the difficulties described earlier in this report including supplying evidence throughout the benefit period, as their claim was paid as a lump sum.

Overall, consumers who claimed on these 'other' features of their CCI policy reported generally positive or satisfactory experiences, because:

- they understood the policy,
- they were not in financial stress or physical or emotional pain when they made the claim,
- relatively little documentation had to be supplied, and
- the benefit payment was made quickly.

Appendix

A. Reasons why claims were denied

Table 9. Why consumers' claims were denied

No.	Reason claim was denied
Consumers made a claim due to an illness	
1	The consumer was unable to work because of complications from her pregnancy. She was found to be ineligible to make a claim because her employer said she resigned.
2	The consumer had a pre-existing condition (blindness).
3	It remains unclear as to why this consumer's claim was denied. The consumer thought it might be because they were only allowed to make a claim during the first 12 months of their CCI policy, and as they claimed one month after this period their claim was denied.
4	The consumer was found to be ineligible to make a claim because they had been treated by a doctor in the last six months.
5	The consumer had a zero credit card balance on the date given on their medical certificate, therefore they could not claim for any benefit amount and their claim was denied.
6	The consumer was over 65 when their claim event occurred and therefore outside the eligible age required to make a claim in relation to the policy they held.
Consumers made a claim due to an injury or accident	
7	The consumer had a pre-existing injury from several years ago and claimed in relation to a similar injury after treatments failed. Their claim was denied as the insurer found their injury to be pre-existing.
8	It remains unclear as to why this consumer's claim was denied. The consumer thought it might be because they claimed for temporary disablement but their claim was denied on the grounds that they did not meet the criteria for permanent disablement.
9	The consumer had a pre-existing injury and claimed in relation to injuring a similar part of their body. Their claim was denied as the insurer found their injury to be pre-existing.
10	The consumer had a pre-existing injury and claimed in relation to injuring a similar part of their body. Their claim was denied as the insurer found their injury to be pre-existing.
Consumers made a claim due to becoming involuntarily unemployed	
11	The consumer had not worked for the required length of time as required by their CCI policy terms and conditions before losing their job.
12	A qualifying or waiting period applied to the consumer's CCI policy and the consumer claimed within this period.
13	A qualifying or waiting period applied to the consumer's CCI policy and the consumer claimed within this period.
14	A qualifying or waiting period applied to the consumer's CCI policy and the consumer claimed within this period.
15	The consumer was ineligible to claim because they were a contractor – this type of employment was excluded from their CCI policy.

No.	Reason claim was denied
16	The consumer was ineligible to claim because they were a contractor – this type of employment was excluded from their CCI policy.
17	The consumer was ineligible to claim because they held a casual job – this type of employment was excluded from their CCI policy.
18	It remains unclear as to why this person's claim was denied. The consumer couldn't provide a reason.
19	The employer reported that the consumer resigned and was not made redundant, therefore their unemployment was not considered to be involuntary.
20	The employer reported that the consumer resigned and was not made redundant, therefore their unemployment was not considered to be involuntary.

B. Case studies

1. Claim accepted because the consumer had to stop work because he had an illness

This consumer originally acquired his CCI policy when it was offered to him by the financial institution because it “seemed like a good idea”.

He became ill, and it took him about a month after that to claim, because he was struggling to pay his credit card debt. It was the financial institution that reminded him he had CCI.

The financial institution was very responsive and explained what would happen, and sent his paperwork to the insurer for him. The insurer told him not to worry.

His claim was accepted and the benefit paid was about $600 a month for six months, up to the point when he returned to work.

2. Claim accepted and the consumer complained about the process

This consumer took out a credit card when he did a credit card ‘balance transfer’ taking advantage of a lower interest rate. He had several credit cards and at the time and he was about $16,000 in debt. He was prompted to take the CCI policy via a telemarketing call. He was a bit suspicious originally but asked questions “to make sure what they covered.” He had been concerned about job security – rightly as it turned out as he was retrenched some months later.

As he was aware of the policy when he lost his job, he claimed almost immediately. It then took about four weeks to get everything sorted.

He encountered problems once the claim was accepted because of poor coordination between the insurer and the financial institution. As he described it:”There was never a co-ordination with when the (financial institution) wanted me to make a payment on my credit card, so I was always getting overdue amounts and then a big lump sum would come in.”

He complained to the insurer when one of the payments took three weeks to be paid into his account, and he did receive an apology. While the apology was appreciated, what he really had wanted was to have the payments made at the time he needed them.

He was very pleased with the benefit he received – the insurer paid 15% of the balance each month, which after six months paid off the whole balance.

3. Claim denied because the consumer had a pre-existing illness

This consumer originally acquired the CCI policy when she went into the financial institution (in person) to get a credit card. She assumed that it was “automatic cover” which meant that anyone who had it “was covered”. The people at the financial institution did not ask her any questions and did not mention the existence of exclusions based on pre-existing conditions. In fact, she had ongoing chronic fatigue at the time.

Soon, she reached a point that she could no longer work due to her chronic fatigue – a decision she made herself because she was self-employed. She claimed on the policy when the amount owed on

her credit card was $8,000. Her claim was denied on the basis that she had visited a GP about her illness in the previous six months.

She was angry that she paid the premium. “It was $60 a month. I should try to claim that back.”

She was angry at the branch staff. “I had an appointment at the branch. The girl should have said “do you have a pre existing condition? … I have chronic fatigue and myalgia. If someone said I would not be covered if I claimed, I would never have taken it out.”

She was more annoyed about the financial institution than the insurer. “I am annoyed at the (financial institution). The insurer was doing it on the facts that they have in front of them.”

However, she was also annoyed because there was a lot of paperwork she had to complete for her claim, which was difficult given her illness. She did not complain about the outcome of her claim because she accepted that the exclusion was in the policy. She felt that complaining would only add to her troubles. “I have been stressed for health reasons. I didn’t pay this to get more stressed. I can only fight so many battles.”

She sought financial hardship assistance, which included the cancelling of her card, and therefore her CCI policy.

“It added to my stress levels. I thought I was insured. Then I had to find another solution to my problems. That was when I contacted the bank, to ask them what do I do? That was when I got onto hardship [assistance].”

She recently filed for bankruptcy because her debts had now escalated to $30,000.

She has kept this a secret from her family. Only her best friend knows. “I had to tell these little fibs about my life”. “I have hit rock bottom.”

4. Claim denied because the consumer had a pre-existing injury, they also made a complaint

This consumer consolidated various credit cards into one and also got a loan with the same financial institution at the same time. When he received the credit card he had to call the financial institution to activate the credit card and during the call he was offered CCI. He asked some questions. “I asked ‘does that cover wages and loss of wages if you get injured?’ and was told it did.” He also informed the financial institution that he was on work cover at the time and shortly due to have surgery on his shoulder but said he wasn’t “told anything other than the questions I asked”.

He had an accident one month after taking out the policy. The accident damaged his other shoulder, and he could no longer work in that job.

He made a claim on his insurance policy but made a mistake at first by claiming for the original injury. Then he had to re-submit the claim based on the recent accident. He had to supply information about the injury, the doctors he saw in hospital, the local GP and his medication. “They wanted to know everything.” He said he felt that he had to “jump through hoops like you train a dolphin.”

He received a letter five to six weeks later to tell him his claim was denied. He does not know why his claim was denied. It was not clear to him whether his shoulder injury was regarded as a pre-existing injury, or whether it had something to do with his work status, or the workers compensation payments.

He complained about the decision to deny his claim. He followed the dispute resolution process described in the pamphlet he was provided. “I put in a complaint … and they’ve said, ‘we have taken this complaint very seriously, and we are taking it to the next step’ and that that person took it to the next person up to God.” He was still waiting to hear back. “It fell on deaf ears basically.”

5. Claim denied and the consumer complained and the decision was over-turned

This consumer had a CCI policy for three to four years. The “interview” to take it out was over the phone. He was asked some questions about it when he took it out. He knew he was not eligible for an income protection policy because of his pre-existing back problem, so needed some kind of policy to protect himself – he thought this was it. One day at work he experienced a new set of back problems so severe that his employer has now told him that he will not be able to work in that job any more.

For him the policy had been “just a bit of protection in case something happened” as he and his wife usually paid off the card “immediately”. However, at the time he stopped work he had just put the cost of a new kitchen on to the card.

He submitted the claim forms in early Autumn 2012. He was then asked to complete more forms about what seemed to be his whole medical history, as he said, “ … right back from the cradle. I couldn’t believe it.” He was surprised at how extensive the questioning was, since to him this was just a “simple policy”.

His claim was denied. The denial letter said “the conditions that are causing your disability are progressive”. He acknowledges that he has a “progressive” injury but he said that he was never asked about this when he took out the policy. “I should have been told that I wouldn’t be covered for specific illnesses”. “Then I would have declined the insurance.”

He wrote a letter complaining about the decision on the basis that he was not asked questions about his health when he acquired the policy so the denial of the claim was unfair. He wrote: “These are not the questions that you people asked me.” He made a formal written complaint in which he stated that the claim had been judged on a different basis than the ‘spirit’ of the policy. He requested that they should honour the policy (i.e. pay his claim), or return his premium.

One of the reasons he complained was that he perceived that these policies are potentially unjust. From his experience, the staff promoting the policy “make it seem easy.” “They don’t say ‘you will be required to fill out a full medical history and we’ll go through it with a fine tooth comb’”. He feels he was “conned” when he took out the policy.

C. Research method in detail

The research was designed as a collection of case histories. The Susan Bell Research team interviewed 52 consumers who had claimed on a CCI policy on their credit card because they had to stop work, and six who claimed on others features of the policy.

Most consumers had acquired the CCI policy from a financial institution such as a bank. A few consumers acquired their CCI policy from a retailer, when they were taking out credit (in the form of a credit card) and were offered a CCI policy. All of these consumers had claimed through one of nine CCI insurers during the six-month period March–August 2012.

The research was conducted via in-depth interviews. Individual in-depth interviews are the ideal method for researchers to use when they want to listen to people describe their experiences in the kind of detail required to meet the objectives for this study. Consumers are usually in their own homes, so the interview takes place in a private and safe setting where they feel comfortable.

These interviews were conducted by phone with each interview taking about 30–60 minutes. Phone interviews enabled the research team to interview people across Australia, including people who live in remote or regional areas. These interviews were recorded and later transcribed when permission was given by the respondent. Otherwise detailed notes were taken.

CCI policies account for only two in every hundred insurance policies in Australia. Therefore, one key research challenge was to identify people to interview who have a CCI policy. ASIC suggested that Susan Bell Research ask insurers who issue CCI policies for credit cards to assist with the research process, by contacting a sample of consumers who had claimed and/or complained on their credit card CCI policies. Nine of the insurance companies responsible for issuing the policies agreed to take part. Each insurer wrote to a sample of their customers who had claimed in the last six months, using a template designed by Susan Bell Research. The letter asked customers to opt in to the research by registering by phone or online. Q and A Market Research managed the registration process.

Susan Bell Research specified how many letters each insurer should send, based on sales data collected by ASIC, and was able to ensure that the final sample of consumers broadly reflected market share. Susan Bell Research selected consumers to interview, ensuring that all the insurers were represented appropriately.

To minimise the risk that only satisfied, or only dissatisfied, consumers opted in to the survey, insurers wrote to a designated number of consumers whose claim was accepted and consumers whose claim was denied. The final sample of 58 interviews was structured accordingly. The insurers did not know which of their consumers we had interviewed.

In addition, there was a limited quota of people who had complained about their claim. So as not to interfere with the IDR/EDR process, the insurer was required to exclude anyone they could clearly identify as being in the middle of either an IDR or EDR process.

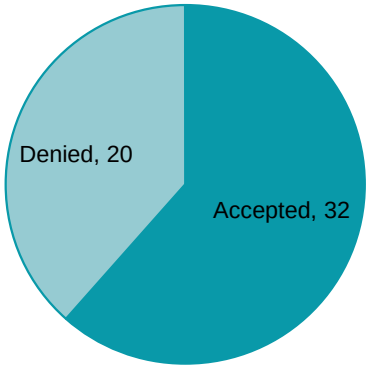
This was a highly efficient approach, because the researchers only needed to contact actual claimants and complainants for the policies of interest. The researchers can also be confident that everyone participated had claimed on a CCI policy in the designated period.

Consumers who had stopped work: sample structure

Outcome of claim

The sample included accepted and denied claims from each participating insurer. As the pie chart below shows, 32 of the consumers in this study had their claim accepted, 20 had the claim denied.

Figure 3. The number of consumers who stopped work, with accepted and denied claims

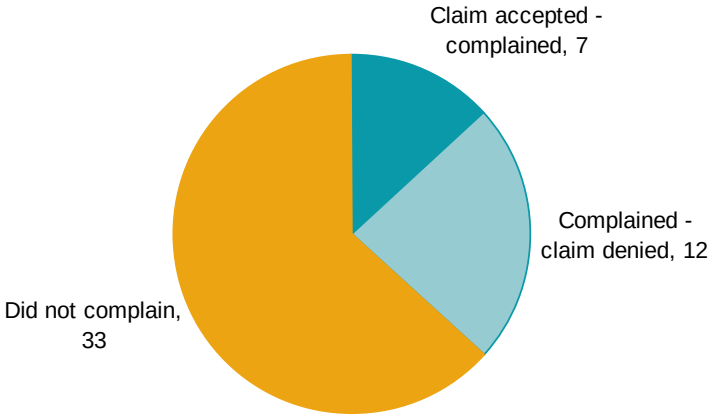


This included two people who claimed on two cards, were denied by one and accepted by one. Of the consumers whose claim was accepted, three consumers had their claim denied originally and then that decision was overturned when they complained.

Consumers who complained

It was important to include in the study some people who had complained[10] about their claim. We found that 19 of the 52 consumers interviewed made some form of complaint (from expressing dissatisfaction in a conversation with the financial institution/insurer to writing a formal letter). Of these, seven consumers whose claim was accepted complained and 12 consumers whose claim was denied complained. The remaining 33 consumers in this study did not complain.

Figure 4. The number of consumers who stopped work who complained



The characteristics of consumers in the sample

When we look at the kind of occupations of the consumers interviewed for this report we can see that consumers who hold CCI policies and claim on these policies can potentially come from all walks of life. Several consumers in the study had white collar occupations, such as IT, event management, or were public servants. Some were in trades such as plumbing while others were in a variety of other occupations – they were cleaners, delivery drivers or store packers, for example.

[10] RG 165 defines 'complaint' at RG 165.79.

Education and literacy levels varied. Some had tertiary qualifications, others did not. One person who took part told us that she was illiterate. English was not the first language for six consumers we interviewed.

In terms of work status, some had worked casually until they stopped work. Some were on contract and others were self-employed. The rest had had permanent full time jobs.

Most of the consumers who took part in this study had never made a CCI claim before. Thirty two consumers had only ever had this one CCI policy. Eight consumers had previous CCI policies but had not claimed on them.

Limitations of the method

The study was designed to highlight the experiences of people with different claims' experiences. The sample of consumers and how they acquired their CCI policy are not intended to be representative of the market generally, and should not be seen in this light.

When using the research results, be mindful of the following:

- **Sample size**. The sample for the study was small so caution should be exercised when attempting to generalise these findings to the overall population. It was, however, sufficient to meet the objectives of this study.
- **Poor recall**. In some of the interviews we discussed events which occurred some years ago. A few respondents were unable to recall the timing of these events accurately or in detail. Nevertheless, the claim itself had been paid in the March to August period so was relatively fresh in people's minds.
- **Hindsight bias**. People view the past subjectively when being interviewed after the fact, which may lead them to judge events differently now than they did in the past. Also, some people might think differently now because new information has come to light. This hindsight bias would affect people whose claim was accepted as much as it would those whose claim was denied.
- **Impression management**. People may have attempted to present themselves in a favourable light to the researcher and may have been unwilling to admit to some socially unacceptable behaviour.

Other details

The researchers who conducted the interviews were Susan Bell, Suzanne Burdon and Jane Gregory. All three are skilled and qualified researchers who are members of the AMSRS and are therefore bound by the industry's Code of Professional Behaviour.

The research was conducted in accordance with ISO 20252.