ASIC
Australian Securities & Investments Commission

# Roadblocks and roundabouts: A review of car insurance claim investigations

**Report 621 | July 2019**

# Contents



# About this report

ASIC reviewed how general insurers investigate comprehensive car insurance claims where fraud is suspected. We found that insurers are investigating some claims in ways that are causing significant consumer harm, eroding trust in insurance and without fair process.

Fraud is a real and serious issue and insurers need to investigate, identify and deny fraudulent claims. But our data shows that of all the claims that insurers decided to investigate, only 4% were declined for fraud, and only 10% were declined for some other reason. Over 70% of the claims that insurers investigated were paid.

Consumers expect a fair process to be followed when a claim is investigated. Consumers in our research whose claims were investigated and eventually paid felt angry, frustrated, confused, overwhelmed and helpless during investigations. Some consumers experienced difficulty contacting their insurer, hostile interviews, onerous information requests and inadequate support.

ASIC has been engaging with the Insurance Council of Australia (ICA) to improve industry standards, which has led to a proposal by the ICA for additional standards in the General Insurance Code of Practice (Code). We found that further improvements are necessary.

Our review considered aggregated data on 1.6 million claims from September 2016 to September 2017, consumer research with 52 consumers whose claims were both investigated *and* paid, and a review of insurers' investigation policies and procedures. The insurers we reviewed are Allianz Australia Insurance Limited (Allianz), Auto & General Services Pty Ltd (A&G), Insurance Australia Group Limited (IAG), AAI Limited (Suncorp), and Youi Pty Ltd (Youi).

**Note:** All claimant stories in this report are from consumers whose claims were investigated and paid. Case study names have been changed to protect consumer privacy.

# Insurance claim investigations at a glance

## This report highlights that:

**Insurers are not always treating consumers fairly when they investigate claims**
Insurers investigated some claims in ways that were inappropriate and harmful to consumers. This can undermine the community's trust in insurance.

**Changes to the industry code are necessary**
While some improvements to the General Insurance Code of Practice (Code) have been proposed, more improvements should be made to raise standards to ensure that claims investigation practices are appropriate and reflect a fair process.

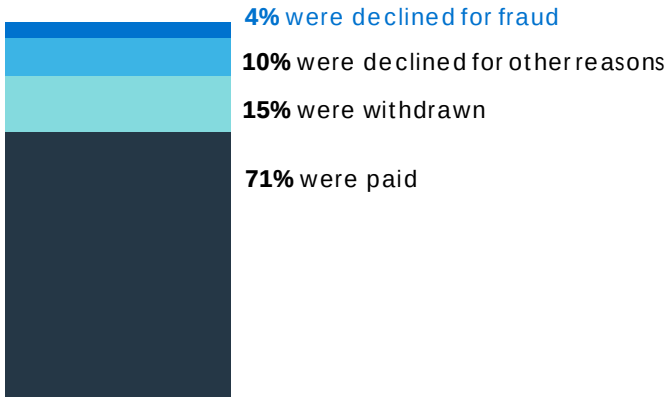
**ASIC will take action against poor conduct**
With significant civil penalties now available for breaches of the duty of utmost good faith, we will take court action against insurers who break the law.

This report forms part of ASIC's response to recommendations made by the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry (Royal Commission). We are also preparing for the use of enhanced penalties and supporting legislative reforms including reforms to make claims handling a financial service under the *Corporations Act 2001* (Corporations Act).

## Investigations targeted mostly valid claims

Out of 1.6 million claims, insurers flagged 4.85% of claims as suspicious and investigated 1.1% of claims. ASIC collected data on these 17,587 investigated claims. Of these investigated claims, 71% were paid. Only 4% were declined for fraud, and 10% for other reasons. 15% were withdrawn.

**Figure 1: Outcome of investigated claims (1.1% of all claims)**




**Note:** 0.6% of investigated claims were still undetermined when this data was collected. These claims have been omitted.

Our review also identified limitations in insurers' ability to provide timely and accurate data on the claims that they flagged or investigated for suspected fraud. Insurers must ensure that they have adequate resources to collect and understand data on conduct risks and consumer outcomes for investigated claims.

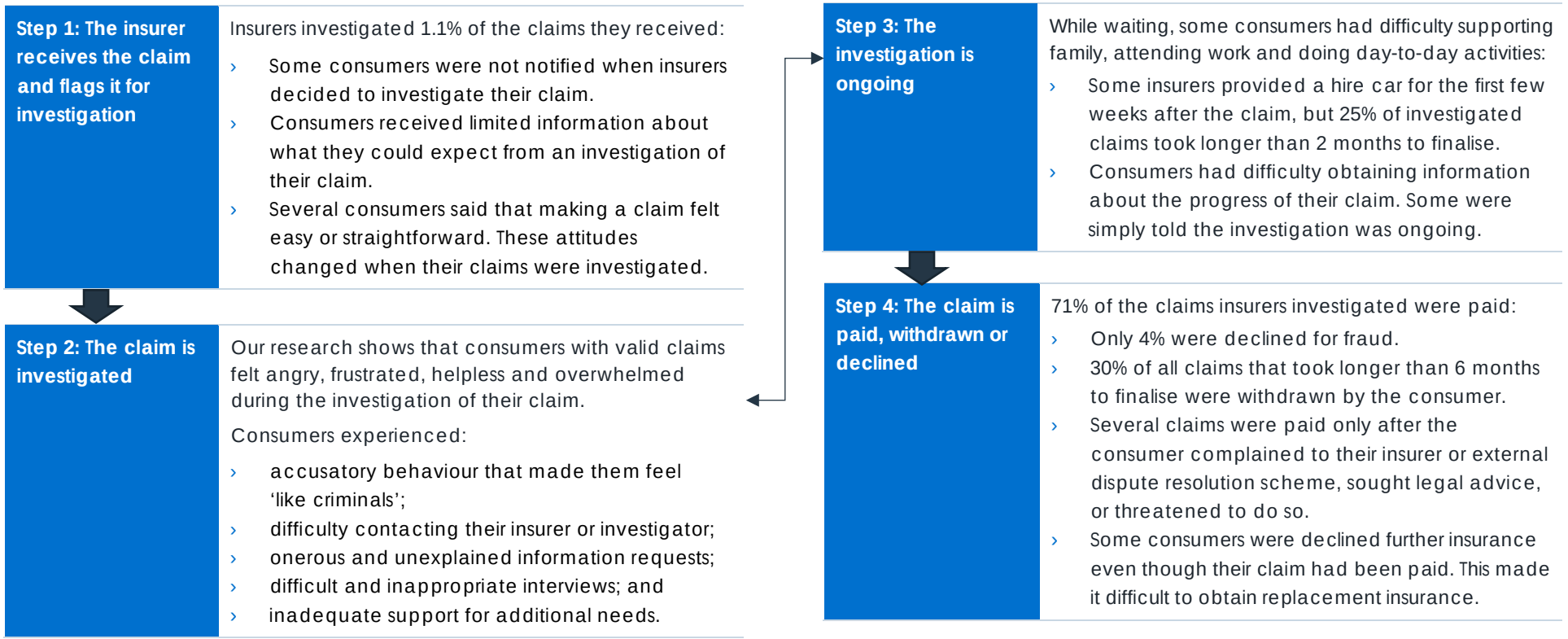
## How insurers investigated some claims

Fraud is a real and serious issue. It is important for insurers to identify, investigate, decline and deter fraudulent claims. Fraudulent claims increase the cost of insurance for other consumers. But our review found that insurers investigated claims in ways that can harm consumers, most of whom had lodged valid claims: see Figure 2.

Our data indicates that the vast majority of investigated claims are paid, which highlights the need for insurers to reconsider the process they use to select claims for investigation.

**Note:** See General Insurance Code Governance Committee (CGC), *Investigation of claims and outsourced services* (May 2017) (PDF, 432 KB).

**Figure 2: Effect of the investigation process on consumers**



# Consumer detriment

## Inappropriate practices harm consumers

Consumers can face significant detriment while waiting for their claim to be finalised. Consumers often relied on their insurer to pay their claim so that they could replace a stolen or damaged car. Some consumers reported difficulty in accommodating the needs of their family, attending work and engaging in day-to-day activities while they waited.

**Dan's story**

Dan waited nine months for his insurer to investigate and finalise his claim. He was left without a car throughout this period. Because he worked night shifts, his wife had to use her car to drive him to work at 4:45 pm and pick him up at 1–3 am, while also using the car to transport their four children between home and school.

I was without a vehicle, you know, and at the time I was using that vehicle for work, so I don't have $40,000 to go out and replace [it with] another one.

**Joe**, who lives in a regional town

I had to take [my] wife wherever she wanted to go, like if I had to do something myself for the day, [my] wife couldn't move out of the house. It's stressful for her.

**Larry**, a pensioner

Claiming on insurance is a particularly stressful and vulnerable time for consumers. Harmful practices can exacerbate these stresses.

With some policies, insurers offered consumers a hire car for a fixed period while their claim was considered. But investigated claims often took longer to finalise, so some consumers had to return these cars after the fixed period and continue waiting for their claim to be decided.

Delays also have harmful effects on consumers. The Code promises that insurers will decide a claim within four months, unless 'exceptional circumstances' apply. Exceptional circumstances include where an insurer suspects fraud. When exceptional circumstances apply, a decision will be made within 12 months.

To reduce the risk of consumer harm, we consider that all claims, including investigated claims, should be decided within four months. For some insurers, this did not occur for a significant number of claims: see Table 1.

**Table 1: Number and percentage of investigated and paid claims that took more than four months to resolve**

| Insurer | Percentage of claims | Number of claims |
|---|---|---|
| A&G | 21% | 36 |
| Allianz | 4% | 133 |
| IAG | 10% | 397 |
| Suncorp | 2% | 107 |
| Youi | 1% | 6 |

Our data indicates that as a claim takes longer to resolve, more consumers are likely to withdraw their claim: see Table 2.

**Table 2: Number and percentage of investigated claims that were withdrawn, by duration**

| Duration of claim process | Percentage of claims | Number of claims |
|---|---|---|
| Less than 30 days | 10% | 1,154 |
| 31–240 days | 21% | 1,261 |
| More than 240 days | 25% | 159 |
| More than 360 days | 36% | 57 |

There may be a number of factors driving withdrawn claims. Some withdrawn claims could be fraudulent, but we are concerned that others could have been legitimate and withdrawn due to the investigation process.

Many consumers who persevered through an investigation said they did so because they could not financially afford to withdraw their claim. Other consumers said they continued fighting because they felt they were 'entitled' to a payout on their claim.

> There was no way I was going to lose. I felt like it was me against the insurance company in the end, and I was going to take it as far as I could.

> So, at this point, I was probably in the top five as angry as I've ever been…in my entire life.

**Carlos**, whose SUV was stolen

## Inappropriate practices can erode trust in insurance

The insurers in our review advertised 'a quick and easy claim process' or a promise to 'be there for you when you need us most'. While lodging a claim can be easy, we found that insurers are largely failing to deliver on these promises for the claims that they investigate.

Our research indicates that many consumers felt disempowered and helpless at every stage of the claims process. Claim investigations were not something that consumers thought about when buying insurance. However, many consumers became frustrated, angry and confused with the ways in which their insurer had investigated their claim.

> You pay good money to have these people go in to bat for you, you see their ads, [and instead] to feel threatened by [the insurer] supposed to protect you against these sorts of things happening in your life, I think that's incredibly unfair.

**Sam**

Insurers relied on partial, indirect or vague references to claim investigations in their Product Disclosure Statements (PDSs) —for example, a statement that consumers may need to 'atten[d] an interview', or that consumers may need to 'provid[e] all information and assistance necessary to process any claims'. These references understated the magnitude of effort that insurers required from some consumers to comply with an investigation.

Our research suggests that the harmful investigation practices outlined in this report have affected how some consumers perceived their insurers.

> I don't trust them. … They don't deliver what they promise.

**Balto**

# Harmful investigation practices

## Consumers feeling like criminals

Our research indicates that consumers overwhelmingly reported that they felt they were treated like criminals by their insurer or investigator. Consumers reported the following behaviour by investigators:

- conducting interviews at the consumer's home like a police interrogation, by introducing themselves as former police officers, requiring the consumer to sit opposite them, and requiring family members to sit in different rooms during the interview;
- challenging the consumer's answers—for example, by questioning why the consumer would behave in the way they described, challenging their relationship status, and in another instance by responding to a consumer's explanation by saying 'I don't think that's what happened';
- using a tone of voice that implied, suggested or presumed that the consumer was lying or at fault for the car accident or theft;
- asking the same questions repeatedly during an interview to seek to obtain an inconsistent response;
- making overt suggestions about the claim—for example, in one instance suggesting that the consumer knew the person who stole his car and that they were conspiring together; and
- suggesting that the consumers had said something during the interview that they had not, to examine whether the consumer would notice and object to the suggestion.

**Balto's story**

Three members from Balto's family had recently passed away. Balto took time off work to manage stress from these deaths. During his interview, the investigator repeatedly mentioned the fact that Balto had not been working to suggest he was experiencing financial difficulty and destroyed his car to receive an insurance payout.

[I felt] depression, stressed, and frustrated to a point because I felt it should have been fairly straightforward.

**Balto**

While consumers understood that insurers may need to verify some claims, these behaviours can be unprofessional and inconsistent with the neutrality that consumers expect from an investigator. Consumers reported feeling significantly insulted and distressed because they were being honest with their insurer. In some instances, this exacerbated emotional stresses from the loss of their car or other issues in their lives.

[I'm] now trying to heal from it … and trying to forget about it because it caused me a lot of distress, I mean, someone who doesn't even know me… trying to make me out to be a liar.

**Stephen**

A few consumers said their investigator was neutral and respectful, and these consumers were more likely to be satisfied with their claim.

## Keeping consumers in the dark about their claim

### Initial contact

Our review of standard communications from insurers at the start of an investigation indicates that most insurers did not give consumers written information about what they could expect. In ASIC's view, consumers should be informed in writing of:

- the purpose and possible duration of the investigation;
- the volume and types of documents they may be required to produce during an investigation, the duration and number of interviews they may need to attend, and other steps they may be required to take; and
- how these requests are relevant to the investigation.

Four out of five insurers in their initial notification did not clearly explain to consumers that the claim would be investigated. Instead, many consumers were only vaguely informed that they were required to supply further information to 'process' or 'finalise' their claim.

Some insurers did not inform consumers at the start of an investigation that they could complain about the conduct of the investigation. Consumers are less likely to know about their right to complain when this information is presented only in the PDS or on a website.

Despite the limited initial communication by insurers, some investigators subsequently communicated early, openly and honestly with consumers. This reduced consumer dissatisfaction.

Table 3 sets out a comparison of the initial written information provided by insurers. Youi had procedures to notify consumers about some aspects of the investigation by telephone but did not provide written information to consumers.

**Table 3: Initial written information that insurers gave to consumers**

| Information provided | Allianz | A&G | IAG | Suncorp | Youi |
|---|---|---|---|---|---|
| Notification that the claim will be investigated | Partly | No | Yes | Partly | No |
| An overview of the investigation process | No | No | Yes | No | No |
| The person investigating the claim and their contact details | Partly | Partly | Partly | Partly | No |
| What the investigation may involve | No | Yes | Yes | Partly | No |
| How the consumer can make a complaint | No | No | Yes | No | No |

**Note:** See the Appendix for an overview of the methodology for this table.

### Ongoing communication with consumers

Our research indicates that some consumers experienced excessive difficulty contacting their insurer. Consumers reported needing to phone their insurer or investigator multiple times to connect to someone, receiving calls at inappropriate times, and re-explaining their claim to a different representative each time they called.

Some consumers who asked for an update on their claim reported being told each time that their claim was 'still being considered'.

> It was like waiting as if you've just been forgotten.
>
> **Chantelle**

**Joe's story**

As the investigation dragged on, Joe's insurer was increasingly difficult to contact. The claims manager failed to return phone calls and went on holiday without transferring her responsibilities. Joe contacted the insurer every Friday but was consistently passed between insurer and investigator. After four months, he threatened legal action and his claim was finally processed.

## Difficult interviews and information requests

### Information requests

Our research identified instances where consumers believed they had been subjected to unnecessary or unreasonable information requests from their investigator.

> I had to get the [record] of all my phone calls and beside each phone call and each text [I was told to write down] the nature of the phone call.
>
> **Anna**

Consumers were frequently required to produce an onerous volume of documents, including but not limited to: criminal record checks, social media histories, birth certificates, telephone and text message records, financial statements for each of their bank and loan accounts and information about family members and friends. One insurer required some consumers to provide telephone records with an annotated explanation for each call. These requests could be exhausting, unnecessary, and in some instances difficult to afford.

**Kathy and Dan's story**

The investigator requested personal details, a police report number, criminal record checks, bank account statements, loan statements, telephone records (in a specific format) and a list of every person Kathy and Dan had contacted over a specific time period, including their full names and addresses. Kathy's friends and family were not happy that their personal details had to be supplied for an investigation.

During Dan's interview, the investigator also asked to examine his mobile phone but did not explain why. Kathy and Dan couldn't immediately afford to pay for the criminal record checks. This further delayed their claim.

Some consumers reported feeling uneasy about requests to hand over detailed information about their personal lives to an investigator. This unease was heightened because some investigators did not explain why this information would be necessary or relevant to substantiating the circumstances of their claim.

> If you required all this information, you should set it out in the initial claim point… I mean my driving history, what the hell has that got to do with a stolen vehicle?
>
> **Ben**

### Fishing for a reason to decline the claim

The limited communication to consumers, together with the scale and perceived irrelevance of these information requests, led some consumers to believe that their investigator was 'fishing' for a reason to decline it.

[The investigator] really wanted to, I think, find a loophole or something, find a gap in my story and all that, so he asked for a lot of things.

**Stephen**

Investigators can identify other reasons to decline a claim besides fraud—for example, if an exclusion under the policy is identified. Our research also identified instances where consumers recalled being told that their claim would be declined if they failed to comply with an information request, on the basis that this would breach their contractual duty of utmost good faith to their insurer.

### Difficult and unscheduled interviews

Some investigators chose to interview consumers in their home, which can make it difficult for consumers to end an interview if they feel uncomfortable. Consumers did not report that they were given an opportunity to choose from a list of possible interview locations.

A&G, Suncorp and IAG also did not set specific limits on the possible duration of interviews. As a result, some consumers could be subjected to interviews that were long, exhausting and held at inappropriate times. Our research identified phone interviews that were conducted without prior notice, which can place inappropriate pressure on consumers and made it difficult for them to comply.

**Robert's story**

Robert and his wife were interviewed at their home for over three hours. This included interviews with Robert alone, with his wife alone, and with Robert and his wife together.

**Kevin's story**

The investigator interviewed Kevin over the telephone for about an hour on each of six separate occasions. Interviews sometimes covered information already mentioned at previous interviews.

The investigator also arrived at the house of Kevin's sister, without notice, to interview her in the morning while she was preparing her four children for school. Kevin's sister was shocked and confused, but she complied with the interview.

## Inadequate support for some consumers

Our research highlights that insurers needed to do more for some consumers. Consumers who had limited English literacy did not recall being offered an interpreter, and a Torres Strait Islander was interrupted against his wishes during 'Sorry business', a traditional mourning period with several ceremonial and cultural obligations.

**Stephen's story**

An investigation was taking place while Stephen, a Torres Strait Islander, was grieving the recent death of his father. Stephen asked the investigator to respect his culture by not contacting him at specific times.

Despite this, the investigator later called Stephen during the traditional mourning period, which caused him significant emotional distress in front of his family.

## Complaining to get a resolution

Nearly one out of every five consumers in our research reported that their claim had been resolved only after they had threatened to or did complain to an insurer, complain through an external dispute resolution scheme or seek legal advice about their claim.

Our research suggests some consumers thought that their insurer might only have taken action on their claim after a complaint had been made. This can undermine consumer trust in the claims process and can create a risk that consumers who are less willing to confront their insurer about a problem could be treated differently.

**Carlos' story**

Carlos' insurer refused to continue paying for a hire car beyond two weeks while his insurer continued to assess his claim.

Carlos complained to the insurer. Shortly after, he was reimbursed for a cleaning fee, the excess on his claim was waived, a hire car was approved for an additional week, and his insurer committed to inspect his vehicle as soon as possible.

## Punishing innocent consumers

Some of the consumers in our research reported that their insurer had declined to provide them with further insurance after their claim had been investigated and paid.

Consumers who are declined insurance from one insurer can find it difficult to obtain insurance cover from other insurers. Consumers must disclose that insurance has been declined when applying for new insurance, which can increase premiums or lead those insurers to decline their application.

**Sam's story**

Sam's claim was investigated and paid. He later received a letter stating that his insurer would no longer insure him and that he would be denied the option to renew his policy.

I tried to get insurance after that with other providers and the cost was just way out of my reach … or others would just say that I was uninsurable because I had been denied insurance by another business.

So, to this day I've still not been able to obtain insurance … it's like I'm uninsurable and it's super frustrating because it's actually led to me not buying a new car for five years. I'm still driving that same car because I'm scared [of driving a new one uninsured].

**Sam**

# Investigating claims fairly

## Consumers expect better

Our research found that while some investigations were conducted appropriately, many others were inconsistent without a fair process for consumers and undermined trust in insurance.

Insurers have a legitimate need to investigate and decline fraudulent claims. But the harmful investigation practices that we identified are inconsistent with a fair process for investigating claims.

ASIC supports reforms recommended by the Royal Commission to strengthen penalties and legal accountability for claims handling conduct. This includes reforms to make claims handling a financial service under the Corporations Act so that civil penalties will apply when insurers do not handle claims honestly and fairly.

### Enforcement action

ASIC is ready to pursue new civil penalties that came into effect on 12 March 2019. These penalties will apply when general insurers breach their duty of utmost good faith to the consumers they insure.

On page 13, we set out better practice standards that are consistent with an approach that treats consumers fairly, reasonably and in line with community expectations. We expect insurers to implement these standards immediately.

ASIC is working to identify particular breaches of the law to take court action against insurers that break these laws. As part of this process, we will consider whether insurers acted consistently with our better practice standards in this report.

## Industry self-regulation

ASIC has been actively liaising with the Insurance Council of Australia (ICA) to help raise standards in the Code. In March 2018, we held a workshop with ICA members, which led to proposals by the ICA in its review of the Code (ICA review) to incorporate additional standards in the Code for claim investigations.

**Note:** See ICA, *Review of the general insurance code of practice* (June 2018).

However, our findings demonstrate that further improvements are necessary to ensure a fair process for investigating claims. Insurers should also reconsider how claims are selected for investigation. The ICA should prioritise this work to ensure that the Code provides adequate consumer protection.

There are other limits to self-regulation under the Code. For example, insurers are not liable to pay pecuniary penalties if they breach the Code.

The Royal Commission recommended reform to provide for enforceable provisions in the Code. ASIC will support implementation of the Government response to Royal Commission recommendations.

While the General Insurance Code Governance Committee (CGC) investigates breaches of the Code, the Code only provides for public reporting on a consolidated industry-wide basis. We consider that these mechanisms should be further considered to provide adequate assurance that insurers are accountable for their conduct in relation to the Code.

## Our expectations for insurers' claim investigations

We expect insurers to implement these better practice standards immediately. Some of these standards were proposed for inclusion in the Code, but industry should take urgent steps to implement these standards given the uncertainty about the commencement of an updated Code.

### Safeguards for consumers

| What we expect | Already proposed for Code |
|---|---|
| Insurers should regularly review fraud investigation indicators to ensure that they are relevant and do not discriminate against particular types of consumers. |  Partly |
| Insurers must actively identify and penalise poor behaviour by investigators. |  Yes |
| When an investigation starts, insurers should give written information about the purpose, scope, and expected timeframe of the investigation, what it may involve, and how the consumer can complain. |  Yes |
| Before investigating a claim, insurers should consider if an interpreter or support person should be offered. |  Partly |
| Interviews should be immediately suspended until appropriate support is available if a need is identified. |  Yes |
| Insurers must adequately collect and evaluate data on conduct risks and outcomes for investigated claims. |  No |

### Fair and efficient interviews

| What we expect | Already proposed for Code |
|---|---|
| Consumers should not be interviewed excessively. This means they should be:<br>› advised of the expected duration of the interview before it begins;<br>› given a break every 30 minutes during an interview; and<br>› interviewed for no longer than 90 minutes in any one sitting, and no longer than 4 hours in total, unless the insurer has given written approval with reasons why this would be justified. |  Partly |
| Consumers should be asked to participate in an interview only if it has been scheduled in advance for a time that is suitable for the consumer. |  No |
| Insurers should offer consumers several possible convenient interview locations, in addition to their home, and allow the consumer to choose a reasonable location. |  No |
| Interview transcripts should be provided to consumers by default. |  Partly |

### Investigating claims professionally

| What we expect | Already proposed for Code |
|---|---|
| Insurers should request information only if it is strictly relevant to the claim, avoid multiple requests, and clearly communicate why each item of information is necessary and relevant. |  No |
| Insurers and investigators should treat consumers respectfully, approach investigations with an open mind, and avoid acting in ways that are likely to intimidate or unduly pressure consumers. |  Partly |
| Face-to-face interviews should only occur if the information cannot be obtained in a less intrusive way. |  No |
| All claims, including investigated claims, should be decided within four months. |  No |
| Consumers whose claims are paid should not be declined further insurance unless compelling and exceptional reasons exist. |  No |

# Appendix: Methodology

## Selection of insurers for this review

We selected a cross-section of smaller and larger insurers, who account for 62% of written premiums in the general insurance market.

## Policies, practices and procedures

We obtained copies of each insurer's claim investigation procedures and communication templates. We also sent questionnaires to each insurer which focused on their practices and procedures as of 8 February 2018.

### Note on tables on pages 8 and 13

In these tables, 'Partly' indicates that the criteria was partly but not entirely satisfied.

For example, in Table 3 on page 8, four of five insurers informed consumers about the company that had been assigned to investigate a claim, but did not identify the person within that company who was investigating or their contact details.

## Data collection

We used our compulsory information gathering powers to obtain aggregated data on the number of claims lodged between September 2016 and September 2017, and the number of these claims that were investigated, subject to an IDR complaint, paid, declined and withdrawn within specified time periods.

Two insurers were required to resubmit data after ASIC identified errors. When ASIC conducted a final factual accuracy review, one insurer identified further errors in data that it had provided to ASIC. For a range of reasons, including materiality, this data has not been changed in this report and does not change the report's recommendations.

## Consumer research

We commissioned an independent research company, Heartward Strategic (Heartward), to interview consumers whose claim had been both investigated and paid. Heartward is a member of the Australian Market and Social Research Society.

To identify respondents, we used our compuslory information gathering powers to identify consumers. We contacted consumers by phone to obtain their consent to participate.

Consumers who consented were contacted by Heartward to confirm their consent and to arrange a time for them to participate.

Heartward interviewed 27 consumers for 90 minutes each and ran an online discussion forum with over 25 consumers for three days. The online discussion forum presented a set of questions to consumers each day.

Our research sample included respondents from each insurer and located in each state and territory except for the Northern Territory and Western Australia: see Table 4.

**Table 4: Overview of respondents**

| Insurer | In-depth interviews | Online forum |
|---|---|---|
| A&G | 4 | 4 |
| Allianz | 5 | 3 |
| IAG | 4 | 3 |
| Suncorp | 5 | 5 |
| Youi | 6 | 2 |

Qualitative research is intended to be rich and illustrative and it should not be used to draw conclusions about individual insurers or claims.

To protect consumer privacy and for ethical reasons, Heartward did not inform ASIC of the the insurer used by each respondent.

# Key terms and related information

## Key terms

| | |
|---|---|
| **A&G** | Auto & General Services Pty Ltd |
| **Allianz** | Allianz Australia Insurance Limited |
| **CGC** | General Insurance Code Governance Committee |
| **claim** | When a consumer seeks a payout for an insured event under the insurance policy |
| **claim investigation** | When an insurer makes further inquiries about the circumstances of a claim to decide it if should be paid |
| **Code** | The General Insurance Code of Practice, a voluntary industry code covering general insurers and administered by the ICA |
| **comprehensive car insurance** | Insurance which covers the loss of or damage to a car due to specified events |
| **Corporations Act** | *Corporations Act 2001*, including regulations made for the purposes of that Act |
| **general insurance** | Any insurance that is not life insurance |
| **Heartward** | Heartward Strategic, an independent research company that conducted the consumer research for ASIC |
| **IAG** | Insurance Australia Group Limited |
| **ICA** | The Insurance Council of Australia, an industry group of general insurers |
| **PDS** | Product Disclosure Statement (see s761 of the Corporations Act) |
| **Royal Commission** | Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry |
| **Suncorp** | AAI Limited |
| **Youi** | Youi Pty Ltd |

## Related information

### Headnotes

car insurance, claims, fair process, fraud, general insurance, insurers, investigations

### Legislation

Corporations Act

### Other documents

CGC, *Own motion inquiry on investigation of claims and outsourced services* (May 2017)

ICA, *Review of the General Insurance Code of Practice* (June 2018)