Cause for complaint: Complaints handling in general insurance

Report 802 | December 2024

About this report

In 2024, ASIC reviewed 11 general insurers to understand how they are supporting customers who make a complaint. Our review focused on how general insurers are complying with select enforceable obligations in Regulatory Guide 271 *Internal dispute resolution* (RG 271). While our review focused on general insurers, the findings in this report are relevant for all financial firms that must comply with RG 271. This report outlines the key findings from our review.

Contents

Overview 2
Snapshot: ASIC's review of general insurance complaints 7
Insurers failed to identify complaints 8
Insurers had significant blind spots 10
Insurers didn't always communicate well 12
Appendix: Methodology 15
Key terms, related information and accessible version of figures 16

About ASIC regulatory documents

In administering legislation ASIC issues the following types of regulatory documents: consultation papers, regulatory guides, information sheets and reports.

Disclaimer

This report does not constitute legal advice. We encourage you to seek your own professional advice to find out how the Corporations Act and other applicable laws apply to you, as it is your responsibility to determine your obligations. Examples in this report are purely for illustration; they are not exhaustive and are not intended to impose or imply particular rules or requirements.

Overview

Insurers have given their customers serious cause for complaint in recent years. Some customers have:

› had their insurance claims poorly handled while struggling to recover from the devastating impacts of major natural disasters

› been misled by their insurers about pricing discounts

› been sold products of little or no value, and

› suffered because of harmful sales practices, including pressure selling and unfair retention practices.

This is reflected in the volume of general insurance complaints to the Australian Financial Complaints Authority (AFCA). General insurance complaints lodged with AFCA increased by 50% in FY 2022–23. While this was due in part to major flood events in 2022, many of these complaints could have been solved by insurers through their internal dispute resolution (IDR) processes before they were escalated to AFCA.

Fair, timely and effective IDR processes that provide a genuine opportunity for redress are a key consumer protection and can produce beneficial outcomes for both consumers and firms. A positive complaints management culture is imperative to achieve these outcomes— one that takes a proactive approach in identifying a 'complaint', and that does not compound or further delay the recovery of customers and businesses from distressing events.

Strong complaints management processes can also enable firms to identify systemic and emerging issues that need to be addressed and reduce future remediation costs.

What we reviewed

We reviewed the practices of 11 general insurers that provide products such as home and contents and car insurance to understand how they support their customers through the complaints process and comply with their regulatory obligations.

In our review we:

- assessed insurers' policies, procedures and internal reporting
- analysed over 1.4 million complaints and assessed more than 36.9 million data points, and
- conducted meetings with more than 60 staff.

Our review covered the period between 1 January 2022 (1 January 2023 for data) and 27 March 2024.

Note: See the Appendix for details of our methodology and a list of the insurers we reviewed.

The regulatory framework for complaints

Broadly, the *Corporations Act 2001* (Corporations Act) requires financial firms (including general insurers) to deal with complaints by complying with IDR standards set by ASIC through the enforceable obligations in Regulatory Guide 271 *Internal dispute resolution* (RG 271).

These obligations cover the following topics, among other things:

- **Complaints identification and recording**: Insurers must deal with expressions of dissatisfaction that fall within the definition of 'complaints' in RG 271 under their IDR process. The IDR process must also comply with RG 271, which includes taking a proactive approach to the identification and recording of complaints (RG 271.28). Insurers must also record all complaints they receive (RG 271.179).
- **Content of written communications**: Insurers are required to provide a written IDR response that contains certain minimum content including the final outcome, the right to escalate to AFCA and AFCA's contact details. If an insurer rejects a complaint in part or in full, additional content requirements apply to ensure the reasons for the decision are clearly set out, including identifying and addressing the issues raised by the complainant and setting out the findings and the information relied upon (RG 271.53–RG 271.54, RG 271.112).
- **Timeframes**: Generally, a written IDR response must be provided to a complainant no more than 30 calendar days after receiving the complaint (RG 271.56, RG 271.163).
- **Delays in responding to complaints**: A written IDR response need not be provided within 30 days if resolution of the complaint is complex or there are circumstances beyond the insurer's control. Where this threshold criteria is met, the insurer must issue a letter (known as a 'delay notification') that sets out the reasons for the delay, the complainant's right to escalate to AFCA and AFCA's details (RG 271.64–RG 271.66, RG 271.112).
- **Implementation of complaint outcomes**: Financial firms must ensure that complaint resolution outcomes (such as refunds or compensation payments) are implemented in a timely manner following the resolution of the complaint (RG 261.165).

When things go wrong, complaints are an opportunity to re-set the course and get back on track. We expect all insurers to listen to their customers and identify, record and handle all complaints in line with their obligations.

What we found

Failure to identify complaints

Of most concern, **insurers are not identifying and recording all complaints**. Insurers are required to proactively identify any expression of dissatisfaction that meets the definition of 'complaint' in RG 271, and deal with those complaints under their IDR process. Overall, insurers failed to identify 1 in 6 customer complaints, denying customers the important consumer protections of the IDR framework.

Failure to identify systemic issues

Nearly 50% of insurers in our review did not identify a single systemic issue. From 1.4 million insurer complaints, only 85 systemic issues were identified by insurers. Conversely, from only about 16,000 external dispute resolution (EDR) complaints, AFCA identified 11 systemic issues. For some insurers, AFCA identified more systemic issues from a much smaller cohort of complaints escalated to AFCA than the insurer did from a far broader suite of complaints the insurer received. Early identification and resolution of systemic issues by insurers is critical to minimise adverse customer outcomes and should be prioritised by insurers as an area for improvement.

System constraints and data

Insurers had immature systems for handling complaints and reporting on complaints. Almost all insurers' IDR systems failed to record when complaint outcomes (e.g. payment of compensation) were actually provided to customers. As a result, insurers had no visibility of how long complainants were waiting before receiving an outcome from the IDR process. Improvements are required for insurers to consistently, and accurately, capture key data points, fully integrate their systems and overcome design limitations to give their staff and customers a positive customer-centric experience.

Communication failures

While every insurer was non-compliant with one or more of their IDR obligations under RG 271, there were significant variations in the level of non-compliance. Every customer should be entitled to access fully developed and compliant IDR processes, irrespective of which insurer they choose. The variations we observed deny customers that right.

Communication was a key area where we saw variability in compliance:

- **IDR response content requirements for rejected complaints were not met.** Insurers are required to provide certain minimum content in IDR responses, particularly where a complaint has been rejected. 1 in 8 IDR responses for rejected complaints failed to meet mandatory content requirements. 10 of the 11 insurers did not comply with the requirements, with the proportion of non-compliant IDR responses for rejected complaints ranging from 3% to 35%.
- **Delay notification content requirements were not met.** Insurers are required to inform complainants of the reason for the delay and their right to escalate to AFCA. 1 in 5 delay notifications failed to meet mandatory content requirements. 9 of the 11 insurers did not comply with the requirements, and once again, the extent of non-compliance varied between insurers. The proportion of non-compliant delay notifications ranged from 7% to 75%.
- **Delay notifications were not provided within required timeframes** (i.e. within 30 calendar days). All insurers failed to provide delay notifications within required timeframes. The proportion of delay notifications that were provided late exceeded 33% for nine insurers, with the worst performing insurer failing to meet the timeframes over 90% of the time.

Delays in communicating complaint outcomes, particularly for insured events such as floods, delay customers' recovery and may contribute to, and prolong, customer distress. It is critical that insurers take these obligations seriously.

Importance of a positive complaints management culture

While we identified a number of root causes contributing to the failures observed in this review — such as deficiencies in systems and processes, staff training and resourcing — it was clear that **a key driver for the most serious issues was an absence of a positive complaints management culture.**

A culture that understands the value of identifying and addressing complaints — in terms of the insurer's relationship with its customers and the insurer's own risk management — is crucial to achieve proactive identification of complaints and systemic issues: see RG 271.127.

One insurer that compared favourably to others in the review displayed a far more positive complaints management culture, having commenced a major program of work to improve its complaints management processes in 2021.

In contrast, some insurers have been slow to enhance components of their IDR process — for example, only recently upgrading or starting to upgrade their systems. These enhancements could have occurred in earnest over three years ago when the obligations commenced.

Some insurers in the review showed that they are working towards a more positive complaints management culture through the introduction of complaints transformation programs. Insurers must measure the impact of these programs to ensure they lead to genuine and lasting improvements.

Lessons for insurers: Where to from here?

The extent to which insurers are not meeting the threshold requirement of identifying complaints is unacceptable given the IDR obligations commenced over three years ago.

Further, the extent to which insurers are failing to identify systemic issues from valuable complaints data to prevent future customer harm highlights concerning failures in governance and is equally unacceptable. Insurers need to do more and focus on getting the basics right — to ensure that their customers are supported.

The variability between insurers in complying with basic communication obligations must be addressed. Action is needed across the board, but particularly by poorer performing insurers, to ensure that **all** customers receive timely and accurate communications.

It is encouraging to see that, as noted above, several insurers have programs of work underway to improve their approach to complaints handling, some of which were commenced or expanded in response to this review. However, the effective implementation of these programs needs to be prioritised.

Insurers and Australian financial service licensees more generally should use the information in this report to assess their own IDR process, looking at their compliance with regulatory obligations and how complaints can be used to drive improvements for all customers.

We expect insurers to take active steps to address areas they identify as needing improvement. Going forward, insurers need to be vigilant in ensuring that they have the systems, processes, resources and capabilities necessary to effectively implement regulatory reforms and comply with their ongoing regulatory obligations.

At a minimum insurers should:

- ✓ Take immediate steps to comply with their regulatory obligations
- ✓ Ensure all customer complaints are identified and acknowledged
- ✓ Identify systemic issues to improve customer outcomes
- ✓ Invest in and improve systems, data, policies and procedures
- ✓ Prioritise the adoption of a positive complaints management culture

Further ASIC work

ASIC will provide individual written feedback to insurers that were part of this review. We will ask them to prepare an action plan outlining how they intend to respond to the issues identified and follow up to ensure they have taken those actions.

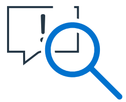
We are considering further regulatory action in relation to some of the issues identified in this review.

More generally, we will continue to work with the insurance sector to drive behavioural change, particularly in complying with regulatory obligations and treating customers efficiently, honestly and fairly.

ASIC's review of general insurance complaints

We collected complaints data from 11 general insurers, representing about 86% of the general insurance market by premium.

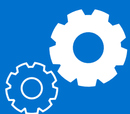
Key findings



Insurers failed to identify 1 in 6 customer complaints.

Insurers identified only 85 systemic issues from over 1.4 million complaints, yet AFCA found 11 systemic issues from approximately 16,000 EDR complaints.

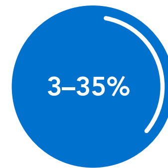
Nearly 50% of insurers did not identify a single systemic issue.



Insurers had **immature systems** for handling complaints and reporting on complaints.

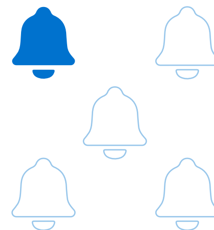
Every insurer failed to comply with one or more of their mandatory IDR obligations with significant variations in the level of non-compliance.

Communication was a key area where we saw variability in compliance:



Non-compliance

1 in 8 IDR responses for rejected complaints did not meet mandatory content requirements. The extent of non-compliance between insurers ranged from 3% to 35%.



1 in 5 delay notifications failed to meet mandatory content requirements. The extent of non-compliance between insurers ranged from 7% to 75%.

0%

All insurers failed to provide delay notifications within required timeframes. The extent of non-compliance varied between insurers.

Top complaints by product or service

Home building insurance

Car insurance

Home contents insurance

Top complaints by issue

Other service-related issues

Premiums

Delay in claims handling

Top complaints by outcome

No remedy (apology or explanation only)

Service-based remedy

Monetary remedy

Insurers failed to identify complaints

Identification of customer complaints is critical to ensuring that customers receive the benefits of the protections of the IDR framework. We assessed how insurers defined, identified and recorded complaints.

Missed complaints are a missed opportunity to make things right for individual customers and identify systemic or emerging issues. All insurers must make it a priority to recognise and record all customer complaints.

Insurers are missing many complaints

Insurers failed to identify complaints for 1 in 6 customers, missing 18% of complaints across the insurers we reviewed. Worryingly, one insurer missed nearly 50% of complaints, and three insurers missed between 30–40% of their customers' complaints.

Note: See the Appendix for details of our methodology and data analysis.

Poorer practice: Failure to identify complaints

One of the poorest performing insurers in this area failed to identify 40% of complaints. The insurer has a long history of poor complaint identification, with their complaints management capture and response practices not matching the firm's policy and procedures. The insurer has commenced a program to address this and other failures.

Missed complaints can cause consumer harm. Insurers should recognise that every customer expressing dissatisfaction in a way that meets the definition of 'complaint' in RG 271 has a right to seek redress through the IDR process. Insurers should be open to receiving complaints and demonstrate a commitment to their customers to resolve the complaint in accordance with their complaints processes.

Where customer complaints are missed, customers are denied their right to access an insurer's IDR process and there is a genuine risk that the customer may not receive the full outcome to which they may be entitled.

Even where some customers lodging 'missed' complaints received an outcome outside of the IDR framework (e.g. an apology from the person taking the call), the customer lost the opportunity to seek a fairer outcome with the benefit of processes afforded to customers under their insurer's IDR framework. Processes that could result in a fairer outcome include the disclosure of reasons for not providing the remedy sought and the ability to escalate the complaint to AFCA.

Our data shows that customers who are given the benefit of their insurer's IDR process often receive beneficial outcomes. For example, for claims-related complaints approximately:

- 10,000 complainants received a monetary remedy, comprising over $30.5 million in total
- 66,000 complainants received a service-based remedy, and
- 92,000 complainants received some remedy compared to 86,000 that received no remedy or an apology.

Between 1 January 2023 to 27 March 2024 insurers provided financial compensation as part of the IDR process totalling approximately $87.2 million. This includes compensation for claim related complaints.

Missed complaints highlight other failures

Customers had to complain multiple times to multiple staff members over long periods. We were disappointed to see examples where some insurers failed to handle customers' concerns as a complaint, requiring customers to repeatedly raise their concerns with their insurer, often over long time periods, to receive an outcome.

Case study: Missed complaint – missed opportunity

In one case we reviewed, an insurer failed to update a payment arrangement from annual to monthly as agreed with the customer. The insurer then debited the annual, rather than monthly, premium from the customer's bank account.

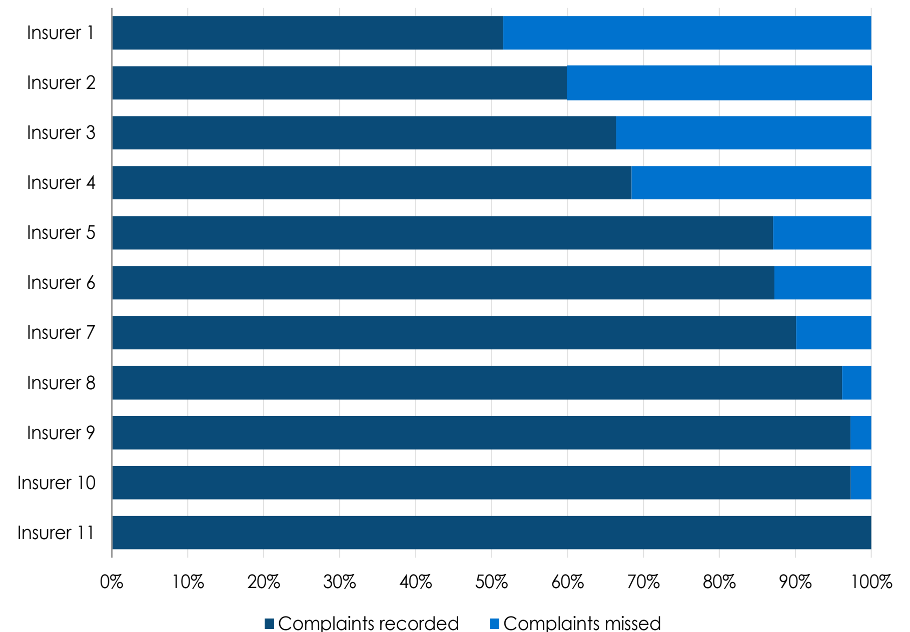
After this error was brought to the insurer's attention, the insurer promised that an emergency refund would be issued the same day. This did not occur.

The increasingly distressed and frustrated customer had to complain to multiple people over several days to receive the refund and be put back into the position they should have been in but for the insurer's mistake.

All insurers should treat complainants with respect, be helpful and adopt a user-friendly approach to complaints management that demonstrates a real commitment to resolving complaints through action.

Missed complaints were underpinned by several, often interrelated, failure points. These included staff and system errors, process challenges and lack of consistent or fulsome quality assurance activities.

Figure 1: Missed complaints (as a proportion of all complaints)



Note: See Table 1 for the data shown in this figure (accessible version). This table is ordered by proportion of missed complaints and does not reflect the alphabetical list of insurers.

Insurers had significant blind spots

We reviewed whether insurers had adequate arrangements in place to support and monitor the implementation of complaint outcomes and identify systemic issues.

We observed significant inconsistencies in insurers' data and identified a lack of focus by insurers on identifying systemic issues to improve and drive better consumer outcomes.

We found that **most insurers' systems let them and their customers down**, compromising the ability of insurers to identify systemic issues, track complaint outcomes, and fully understand complaint drivers.

Customer complaints are a valuable data source of indicators for systemic issues within a financial firm. Identifying and addressing systemic issues helps to minimise the risk of customers experiencing repeatedly poor outcomes.

Insurers are failing to identify systemic issues

Many insurers had limited processes in place to identify systemic issues. Complaints data can provide useful insights into what is and is not working at an insurer's firm. Identifying and addressing systemic issues early not only benefits customers; managing systemic issues identified from complaints can also help to reduce downstream remediation and business costs.

From over 1.4 million complaints, only 85 systemic issues were identified by insurers (one systemic issue for about every 16,770 complaints). Conversely, from about 16,000 EDR complaints, AFCA identified 11 systemic issues (one systemic issue for about every 1,450 complaints).

Nearly 50% of the insurers in our review failed to identify a single systemic issue. Given a systemic issue is defined in RG 271 as a matter that affects, or has the potential to affect, more than one consumer, we would have expected to insurers to identify a higher number of systemic issues.

We saw three instances where AFCA identified more systemic issues than the insurer itself. This is despite AFCA having visibility over a much smaller subset of complaints (namely, only those escalated by the customer to AFCA) than the insurer.

Insurers should not be relying on third parties to identify systemic issues, in that their own staff should have a much better understanding of the operational pain points and have access to significantly more complaints data.

All insurers should be making a conscious effort to:

- flag potential systemic issues
- invoke actions to prevent and rectify actual systemic issues, and
- report on the handling of flagged systemic issues as part of complaints reporting.

Poorer practice: Failure to identify systemic issues

For one insurer, AFCA identified multiple systemic issues over a 15-month period despite the insurer not identifying one systemic issue in that period.

In one of these cases, AFCA initially identified a possible systemic issue and raised concerns with the insurer about dissuading the complainant from making a claim in a matter that was the subject of an AFCA determination. In response to AFCA's concerns, the insurer undertook a review and identified other instances where customers could have been dissuaded from making claims.

As a result, AFCA determined the issue was systemic and reported it to ASIC. The insurer then made undertakings to AFCA to put in place processes to prevent this conduct from occurring again. If AFCA had not identified this issue, there could have been a continued risk of the insurer's customers missing out on lodging a claim.

IDR systems are not fully developed

Almost all insurers failed to demonstrate that they kept their promises to their customers by implementing outcomes in a timely manner. Almost all insurers' IDR systems failed to record when complaint resolution outcomes were provided to customers, reducing the ability of insurers to monitor and take action on delays.

Insurers lacked robust controls to support the implementation of complaint outcomes. Several insurers did not have controls in place, such as tracking, system alerts and/or reporting, to allow them to monitor progress in implementing an outcome after resolution of a customer complaint (e.g. refund of fees), or whether it had been implemented at all. Where controls were in place, their effectiveness was likely to be limited due to poor complaints data collection.

Insurers failed to properly capture key data points for complaints management (if at all). Data is an important source of intelligence to assist with the monitoring of compliance with legislative requirements, such as design and distribution obligations, remediation and breach reporting obligations. Several insurers' systems could not capture more than one issue, product, service, or outcome for each complaint, reducing their ability to identify issues (including systemic issues), trends, key risks, and customer outcomes.

Some insurers did not have fully integrated systems (e.g. claims and complaints) or had design limitations in their complaints management systems. Constrained access to information can contribute to delays in complaints handling, and poor staff and customer experiences.

Insurers didn't always communicate well

We assessed how insurers communicated with their customers once a complaint had been identified, including the content of written communications and adherence to timeframes. We also assessed how insurers communicated when the complaint was delayed.

We found that, depending on the type of communication, there were significant variations in the level of compliance between insurers. The variation in performance and inconsistencies we saw was concerning, particularly as the IDR obligations are not new. Whether a customer receives written communication that, for example, allows them to easily understand the basis for an insurer's decision in a timely manner, should not come down to chance — every insurer needs to meet the minimum standards set out in RG 271.

Written notifications are inadequate

Insurers communicated poorly when they rejected complaints. Insurers did not include mandatory content in their IDR response that would have allowed the complainant to clearly understand the reason for the decision. 1 in 8 IDR responses for rejected complaints failed to meet mandatory content requirements. While 10 of the 11 insurers did not comply with the requirements, the level of non-compliance varied from insurer to insurer. There were material gaps, with the worst performer failing to meet the content requirements for 35% of their IDR responses for rejected complaints.

The failures were because the IDR responses did not address each of the issues raised by customers, or set out the insurer's findings and supporting information, and/or provide enough detail for the customer to understand the insurer's decision.

Case study: Rejected flood complaint

We reviewed a complaint lodged 6 months after the February 2022 flood event. The customer expressed concerns that they were given incorrect information by the insurer about their policy cover in circumstances where their house had been flooded.

The customer initially contacted the claims team and was referred to the policy team. During these exchanges, a complaint was escalated to the IDR team with a complaints specialist first contacting the customer 21 days after the complaint was raised.

It is clear from the IDR response that the insurer failed to identify, investigate, and address all of the issues the customer raised in the complaint. In particular, while the IDR response stated that the customer's circumstances were outside the policy's cover, it did not address the customer's concern that they were given incorrect information about their policy cover, and therefore could have potentially been left out of pocket.

Insurers communicated poorly when delays occurred. Almost all insurers failed to provide delay notifications that met the minimum content requirements in RG 271. In 1 in 5 cases, the notifications to their customers did not contain either the reasons for the insurer's delay, the customer's right to complain to AFCA, and/or AFCA's contact details. We observed several drivers underpinning these failures, such as poor templates, staff capability and errors, and sub-optimal processes.

Once again, we observed significant variability between the best and worst performers with the proportion of non-compliant delay notifications ranging from 7% to 75%.

In some cases, insurers sought to rely upon invalid reasons for extending the response timeframe. The IDR obligations only allow an extension of timeframe due to complaint complexity or circumstances beyond an insurer's control. We saw insurers try to extend response timeframes by citing inappropriate reasons such as public holidays, a complaint being allocated late, and staff leave arrangements. While we encourage insurers to communicate all delays, non-compliant reasons should not have the effect of extending response timeframes. We observed that poor templates, system designs, inadequate training, and resource constraints contributed to these failures.

Case study: Inadequate reasons for delay

A customer complained to their insurer about a declined home insurance claim. The insurer first acknowledged the complaint in writing 47 days after receiving it. A response was provided 5 days later (at day 52, nearly twice the mandatory response timeframe), subsequently overturning the insurer's denial of the claim.

The reason the insurer gave for the delay (that the 'dispute was not raised to my office until today') was inadequate and inappropriate. Due to this avoidable delay, the customer had to wait longer for their claim to be rightfully accepted.

Lack of timeliness is a common issue

Timeliness is a key performance measure of the effectiveness of a firm's IDR process. ASIC's research into consumers' experience of the IDR journey indicates that delays can create real barriers and damage the customer–insurer relationship. This is particularly salient in an environment where serious weather events are leaving customers' homes uninhabitable.

Insurers were not always timely. There was a noticeable difference in insurers' response timeframes. For example, one of the poorer performing insurers provided an IDR response within the 30 calendar-day period required by the IDR obligations for only 76% of complaints while better performers achieved 98.6% and 99.9%.

All insurers failed to provide customers with mandatory delay notifications within timeframes, leaving customers with no timely written record on the status of their complaint. While some customers may have received a verbal update and some insurers performed better than others, we still observed high rates of failure, with the worst performing insurer failing to meet the timeframes over 90% of the time.

Insurers' reasons for failing to provide mandatory notifications on time to their customers were avoidable. Examples included workflow challenges, lack of resourcing, system issues and poor-quality assurance measures.

Delays in resolving complaints, when combined with often lengthy claims processes, are likely to contribute to and exacerbate customers' trauma and stress. This may be further compounded if the customer is dissatisfied with the IDR outcome and makes a complaint to AFCA. Insurers should be doing all they can to resolve complaints in a timely manner.

There are other communication failures

Insurers' acknowledgment of complaints was inconsistent. Most insurers demonstrated that they could acknowledge complaints and do so within the suggested timeframes in RG 271. However, once again, insurer performance varied and customers received a different rate of acknowledgment depending on their insurer.

For example, one insurer could only produce data to show acknowledgement for 60% of complaints, compared to other insurers in our review that acknowledged 98% of complaints. Two insurers struggled with timeframes, taking an average of 8 days and 4 days respectively to acknowledge their customers' complaints. This is well beyond the guidance in RG 271 of 24 hours.

Insurers made their complaints policies publicly available but some were not easily accessible or were confusing customers. Meeting the requirement of having and making a complaints policy publicly available is not difficult. While most insurers got this basic obligation right, some insurers did not make it easy for their customers to find policies or follow their complaints process.

For example, one insurer's public complaints policy was potentially misleading, in that customers may have believed they were required to go through all stages of the IDR process before they could escalate their complaint to AFCA. This is not consistent with creating a positive complaints management culture and may lead to customers being dissuaded or discouraged from making a complaint.

Appendix: Methodology

Scope of our review

We assessed insurers compliance between 1 January 2022 (1 January 2023 for data) and 27 March 2024 with select enforceable obligations in RG 271. The obligations related to complaint identification, content of written communications, response timeframes, delayed complaints, and implementation of complaint outcomes.

Under the Corporations Act, financial firms (including general insurers) must have in place a dispute resolution system that consists of:

- an IDR procedure that complies with standards and requirements made or approved by ASIC (as set out in RG 271), and
- membership of AFCA.

Note: Specific provisions in RG 271 are enforceable through the operation of *ASIC Corporations, Credit and Superannuation (Internal Dispute Resolution) Instrument 2020/98*.

What we did

We **reviewed relevant IDR policies, processes, procedures and guidance documents**, training materials, templates of key correspondence to customers, as well as copies of internal reports and reviews relating to the insurer's IDR function.

We analysed over **1.4 million complaints** and assessed over **36.9 million data points**. A proportion of data provided to us was defective. Where practicable, we have taken steps to verify the data and omitted a small number of records for the purposes of comparability.

We **met with each insurer** to clarify our understanding of their approaches to IDR and to seek further information where appropriate.

In relation to **missed complaints**, we asked insurers to undertake a self-assessment over a sample of contact centre records for a 4-day period. Based on a list of keywords provided to insurers, we asked them to identify the number of interactions that were complaints, and the number that were complaints but had not been recorded at the time as a complaint. The missed complaints figures in this report represent insurer responses to the self-assessment.

The 11 Insurers in our review

- AAI Limited
- Allianz Australia Insurance Limited
- Hallmark General Insurance Company Ltd
- The Hollard Insurance Company Pty Ltd
- Hollard Insurance Partners Limited
- Insurance Australia Limited
- Insurance Manufacturers of Australia Pty Limited
- QBE Insurance (Australia) Limited
- RAA Insurance Limited
- RACQ Insurance Limited
- Youi Pty Ltd

Key terms, related information and accessible version of figures

Key terms

AFCA	Australian Financial Complaints Authority
Corporations Act	*Corporations Act 2001*, including regulations made for the purposes of the Act
EDR	External dispute resolution
IDR	Internal dispute resolution processes (also referred to as 'complaints processes')
IDR obligations	The enforceable obligations set out in RG 271
RG 271 (for example)	An ASIC regulatory guide (in this example numbered 271)

Related information

Headnotes

complaints handling, delay notification, dispute resolution, IDR process, general insurance, outcomes

Legislation

ASIC Corporations, Credit and Superannuation (Internal Dispute Resolution) Instrument 2020/98

Corporations Act 2001

ASIC documents

RG 271 *Internal dispute resolution*

Accessible version of figures

Table 1: Missed complaints (as a proportion of all complaints)

Insurer	Complaints recorded	Complaints missed
Insurer 1	51.54%	48.46%
Insurer 2	60.00%	40.00%
Insurer 3	66.42%	33.58%
Insurer 4	68.44%	31.56%
Insurer 5	87.09%	12.91%
Insurer 6	87.25%	12.75%
Insurer 7	90.09%	9.91%
Insurer 8	96.15%	3.85%
Insurer 9	97.25%	2.75%
Insurer 10	97.30%	2.70%
Insurer 11	100.00%	0.00%

Note: This is the data shown in Figure 1. This table is ordered by proportion of missed complaints and does not reflect the alphabetical list of insurers.