ASIC
Australian Securities & Investments Commission

TPD insurance: Progress made but gaps remain

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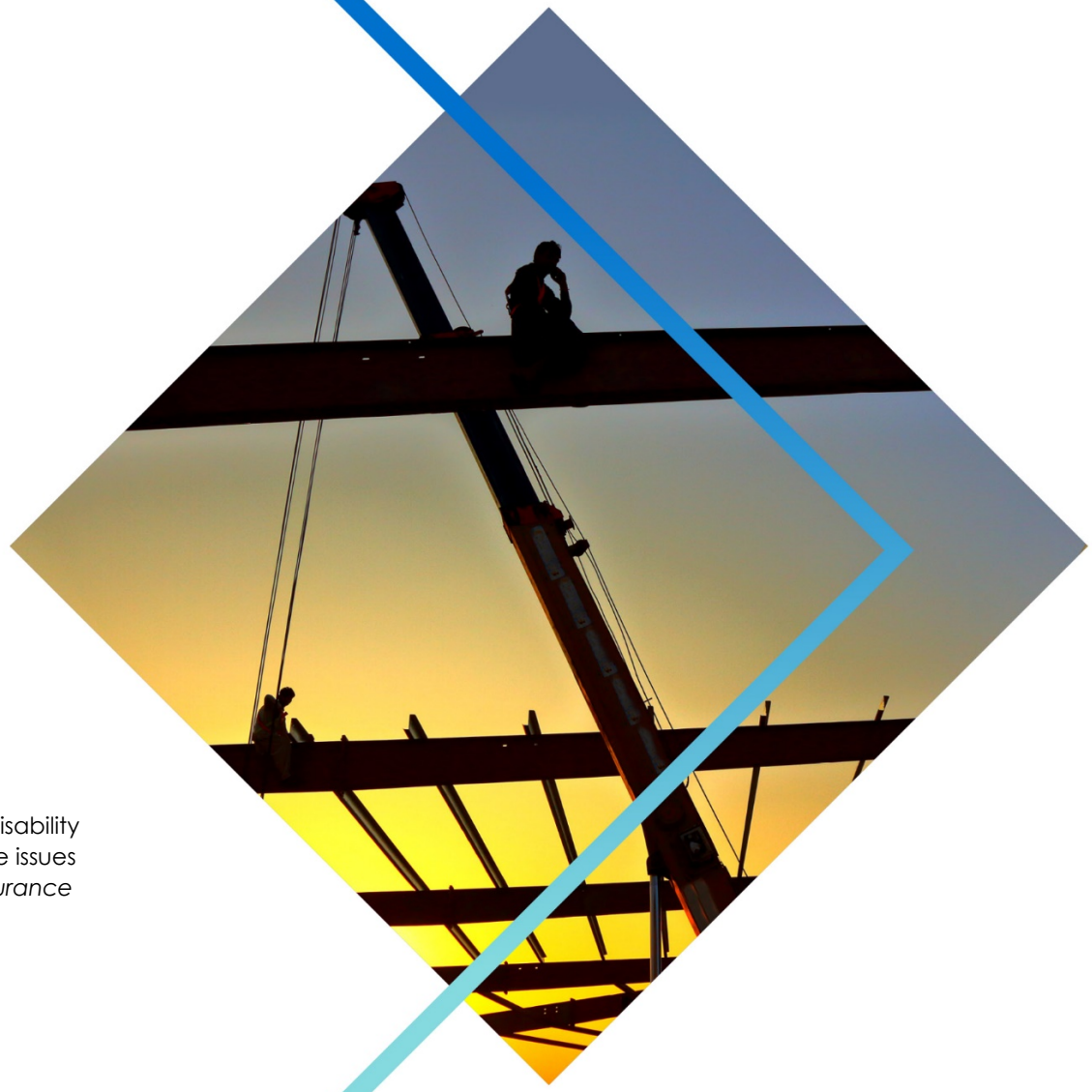

About this report

This report provides an update on ASIC's work on total and permanent disability (TPD) insurance. It focuses on how insurers in particular are addressing the issues identified in ASIC's Report 633 *Holes in the safety net: A review of TPD insurance claims*.

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ASIC's work on TPD insurance

Total and permanent disability (TPD) insurance typically provides a lump sum benefit if the insured person is injured or ill and unable to work again. Most Australians hold TPD insurance through their superannuation fund where it is commonly bundled with death cover.

ASIC's 2016 review of life insurance claims, Report 498 *Life insurance claims: An industry review* (REP 498), identified several concerns with TPD insurance, including above-average declined claim rates, high rates of withdrawn claims and poor claims-processing times.

ASIC undertook a detailed review of TPD, and in October 2019 released Report 633 *Holes in the safety net: A review of TPD insurance claims* (REP 633). The report identified four industry-wide issues:

- poor consumer outcomes from the 'activities of daily living' (ADL) disability test
- frictions in the claims handling process, contributing to withdrawn claims
- consumer harm arising from life insurers ('insurers') having inadequate data to monitor product performance and consumer outcomes
- higher-than-predicted declined claim rates for claims with certain features.

REP 633 set out ASIC's expectations of insurers *and* superannuation trustees ('trustees') in addressing the industry-wide issues: see REP 633, Table 3.

ASIC also undertook further work on the quality of data and analysis for TPD insurance in superannuation. In December 2020, we released Report 675 *Default insurance in superannuation: Member value for money* (REP 675) which revealed shortcomings with trustees' data and analysis in relation to a range of insurance offerings.

What we did

In May 2020, we wrote to nine insurers (see Table 1) to examine steps taken and progress made to address the industry-wide issues identified in REP 633. In particular, we asked insurers to report back to us on:

- their progress in conducting their own reviews of the industry-wide issues identified in REP 633
- the findings from their own reviews
- their changes, or intended changes, in response to both ASIC's findings and their own.

In June 2021, we re-engaged insurers to check their further progress and the currency of information previously provided to us.

Table 1: Participating insurers

Insurer	Full name
AIA	AIA Australia Limited (including The Colonial Mutual Life Assurance Society Limited)
AMP	AMP Life Limited and The National Mutual Life Association of Australasia Limited – part of Resolution Life Group
Hannover	Hannover Life Re of Australasia Limited
MetLife	MetLife Insurance Limited
MLCL	MLC Limited – part of the Nippon Life Insurance Group
QInsure	QInsure Limited
TAL	TAL Life Limited (including Asteron Life & Superannuation Limited – previously Suncorp Life & Superannuation Limited)
Westpac	Westpac Life Insurance Services Limited
Zurich	Zurich Australia Limited (including OnePath Life Limited)

This report – At a glance

In REP 633, we said that we would consider reporting publicly on the changes made by insurers during 2020 and 2021.

This report provides an update on insurers' progress to address the issues identified in REP 633. It highlights our key findings based on the responses made by insurers. It also identifies work that still needs to be done by insurers and trustees to improve restrictive TPD definitions, essential data capture and claims handling practices.

We will provide each insurer detailed feedback on their responses, including areas where we consider improvement is required. Those insurers that have not delivered the necessary changes need to act now to help ensure ongoing compliance with the law and good consumer outcomes. Many of our findings apply more broadly to other life insurance products as well as TPD cover.

This report does not focus in detail on steps taken by trustees in response to REP 633 and REP 675. Trustees are responsible for arranging group insurance on behalf of their members. Trustees should address our findings in REP 633, including working with insurers to do so. We will continue to monitor and engage with trustees in relation to whether improvements are being made.

This report is a timely reminder for insurers and trustees about taking steps to meet the new design and distribution obligations from 5 October 2021, which apply to Choice superannuation products (including any attached insurance cover). ASIC's interpretation of these obligations is set out in Regulatory Guide 274 *Product design and distribution obligations* (RG 274).

Insurers and trustees should use complaints data better to identify and respond to potential systemic issues in their businesses relevant to TPD insurance to comply with updated internal dispute resolution requirements from 5 October 2021: see Regulatory Guide 271 *Internal dispute resolution* (RG 271).

COVID-19 pandemic

During this review, we considered the demands on insurers due to the COVID-19 pandemic. The pandemic created broad challenges and insurers' normal business activities were affected to varying degrees.

ASIC recognises that the ability of insurers to consider and respond to REP 633, and our follow-up review, was affected. We took steps to mitigate any regulatory burden and gave insurers more time to respond to our inquiries. All nine insurers provided timely responses during challenging times.

We limited the extent of our inquiries by excluding requests for claims data. Instead, we sought qualitative information from insurers that, while valuable, contains a degree of variability and subjectivity that makes strict comparison between insurers less precise. For this reason, we have identified the insurers included in the review in Table 1 but have not named them in relation to specific findings in this report.

ASIC's completion of this report was delayed due to the need to prioritise COVID-19 projects in 2020.

Summary of key findings

Most insurers have completed self-assessments against REP 633, some committing further

- ✓ Eight insurers have completed their reviews of each industry-wide issue identified in REP 633. The remaining insurer is in the final stages.
- ✓ Insurers conducted reviews of claims handling practices swiftly.
- ✓ Some insurers have committed to future reviews across issues, and some to specific annual reviews (e.g. value of insurance measures) and bi-annual reviews (e.g. withdrawn claims).
- ✓ Insurers have made changes, or plans, to address consumer harms identified in REP 633 – particularly in relation to the use of restrictive TPD definitions and onerous claims handling practices.
- ✗ While insurers are improving their claims data, data capability remains an area in need of significant enhancement.

Insurers have started work on TPD definitions, particularly for insurance within superannuation

- ✓ All insurers have started discussions with trustees about restrictive TPD definitions to improve consumer outcomes.
- ✓ Most insurers have provided options to their trustee clients for changing the ADL definition in group policies.
- ✓ There is a trend to broaden the eligibility criteria to assess consumers under an 'any' or 'own' occupation definition, rather than an ADL or 'activities of daily working' (ADW) definition, which should help lead to fewer consumers being funnelled into restrictive definitions.
- ✓ There is a trend to include mental health criteria in TPD definitions, which should produce fairer outcomes for consumers with mental health claims.
- ✓ Most insurers have developed measures to better assess the value that TPD products offer to consumers.
- ✗ Some insurers identified challenges in collecting these value measures for group policies.

Insurers have improved some claims handling practices, lowering many hurdles

- ✓ Most insurers have enhanced their written and verbal communication practices with consumers.
- ✓ Most insurers have created new or improved staff guidelines to improve claims handover between claim managers.
- ✓ There is a shift to minimal or infrequent use of physical surveillance – all insurers have guidelines or protocols to help ensure it is used appropriately.
- ✓ Some insurers have implemented or enhanced controls for requesting medical information and investigating potential non-disclosure.
- ✓ Most insurers now offer consumers at least two ways to lodge claims (e.g. paper form, online form and 'tele-claim').
- ✗ However, not all insurers automatically provide a copy of the claim details to consumers after tele-claim lodgement.
- ✗ Most insurers do not record the timing of withdrawn claims relative to a particular claim event – information which would help monitor 'pain points'.
- ✗ Although all insurers record reasons for withdrawn claims – and industry is taking steps to get more consistent reporting of reasons – some do not use this data to identify or respond to potential 'pain points' in the claims process.

Insurers found shortcomings in their data capabilities, particularly in the use of data

- ✓ All insurers have undertaken work to identify shortcomings in their data capabilities – reviewing existing data capabilities against ASIC's expectations for capture, storage and retrieval of data.
- ✗ Over 100 data gaps emerged from insurers' data gap analyses, confirming what we found in REP 633: insurers still lack the data needed to monitor consumer outcomes and harm.
- ✗ Insurers hold data but need to enhance their systems to improve the way data is stored and used – data captured by insurers is often inconsistent or not in a searchable or reportable format, limiting its usability.
- ✗ Most data gaps relate to key claim events, and this deficiency means insurers lack insight into key frictions within the claims handling process.
- ✓ For the most part, insurers have undertaken work to strengthen their data capabilities and close the majority of data gaps – some insurers are more advanced in this area than others.
- ✗ Insurers face challenges in addressing gaps in claims and membership data in group insurance.

Future areas of ASIC focus for insurers and trustees are set out on pages 7 and 8.

ASIC's key messages

Most insurers have conducted reviews to identify areas for improvement, and have started to make appreciable **changes** in response to ASIC's findings and their own, to lift industry standards.

Insurers need to **act on gaps identified** by the findings of their reviews and continue to implement changes to drive better outcomes for consumers. Insurers need to **uplift their data capability** because poor data capability creates key conduct, compliance and governance risks, which can lead to financial risk.

Trustees also need to enhance their data capability for **insurance in superannuation**. As noted in REP 675, trustees need to consider how they can collect and analyse data to monitor and review member outcomes across all forms of insurance they offer to their members. Trustees also need to consider trade-offs between the different value measures when designing insurance for their members. **Trustees** will need to work **collaboratively** with **insurers** to lift industry standards.

Insurers and trustees need to **act now** to meet the requirements of new insurance law reforms that cover:

- **design and distribution obligations**, from 5 October 2021
- **claims handling and settling services**, from 1 January 2022 for insurers and from 1 January 2021 for trustees – licensees will need to act efficiently, honestly and fairly.

Next steps for insurers

At a minimum, insurers should complete their existing reviews, meet their commitments to undertake future reviews, and make the necessary enhancements to address ASIC's findings and their own.

Changes to restrictive definitions

What insurers should do
Insurers should continue to review TPD policies that include restrictive definitions and consider removing them or appropriately redesigning the product. Insurers need to consider product design now to comply with the design and distribution obligations from 5 October 2021. These steps will include working with trustees in relation to group cover.
Insurers should continue to improve the design of their products to meet consumer needs – including products that are fit for purpose in meeting mental health needs – and ensure they monitor the effects of any product changes on consumer outcomes and value to consumers.
What ASIC will do
Where appropriate, ASIC will use our enhanced regulatory powers, including in relation to design and distribution obligations, from 5 October 2021, to drive better outcomes for consumers covered by life insurance.

Claims handling practices

What insurers should do
Insurers should continue to identify and remove frictions in the claims handling process.
Insurers will need to comply with new claims handling obligations from 1 January 2022, including to act efficiently, honestly and fairly.
What ASIC will do
ASIC is reviewing the use of physical surveillance and non-disclosure investigations in income protection claims, and will act if we find evidence of practices in breach of the law including the duty of utmost good faith.
ASIC will consider targeted surveillance of insurers if they do not address the consumer harms highlighted in this report.
ASIC will continue to analyse claims data to identify outliers or trends which indicate potential consumer harm, and will act if we see problems in claims data such as lengthy claims handling timeframes or high rates of claim-related disputes.

Poor data and data usability

What insurers should do
Insurers should continue to invest in systems to capture, store and retrieve data, especially in relation to key claim events (e.g. independent medical examinations (IMEs)) and policy-level data.
Insurers need to maintain searchable and reportable data to proactively identify trends and manage consumer harm. They should view data collection as a continuous improvement exercise and have a detailed plan and timetable to strengthen their data capability.
Insurers should use data to drive a consumer-centric approach to designing, marketing and distributing sustainable products. This aligns with APRA's expectations.
What ASIC will do
ASIC will follow up insurers that failed to provide a level of confidence about their investment in data and systems to address consumer harm and close data gaps.
ASIC and APRA will work together on refining our data collection on life insurance, targeting standardised, granular information for early identification of trends and emerging risks.

Next steps for trustees

Although this report is focused on findings from our work with insurers, trustees have a key role to play in making improvements to consumer outcomes in relation to TPD insurance. Trustees should address our findings in REP 633 and REP 675. We will continue to engage with trustees about their progress towards better monitoring of member outcomes in insurance in superannuation.

Changes to restrictive definitions

What trustees should do

Trustees should continue to review whether their insurance strategies and offerings are meeting members' needs and providing value for money: see REP 675.

Trustees should proactively consider how they can refine the design and pricing of default insurance (including terms and conditions), working closely with insurers. Trustees are often better placed than insurers to collect member data, such as demographic and work characteristics, which are needed to evaluate the effects of eligibility criteria and the effect of restrictive definitions on different member cohorts.

What ASIC will do

Where appropriate, ASIC will use our regulatory powers to drive better outcomes for consumers covered by life insurance provided through superannuation. These include our enhanced powers under the *Financial Sector Reform (Hayne Royal Commission Response) Act 2020* as well as the design and distribution obligations that will apply to Choice superannuation products from 5 October 2021.

Claims handling practices

What trustees should do

In providing a superannuation trustee service, from 1 January 2021 trustees need to act efficiently, honestly and fairly, including when handling and settling insurance claims.

Trustees need to do everything that is reasonable to pursue a member's insurance claim, if the claim has a reasonable prospect of success: see s52(7)(d) of the *Superannuation Industry (Supervision) Act 1993* (SIS Act).

In light of these obligations, trustees should proactively address hurdles that members face when making a claim – trustees are better placed than insurers to see the members' entire journey from obtaining cover to claim decision.

What ASIC will do

ASIC will use its enhanced regulatory oversight of consumer protection in superannuation to ensure trustees are meeting their obligations when handling members' insurance claims.

Poor data and data usability

What trustees should do

Trustees should collect and analyse data to monitor and review outcomes to better meet their regulatory obligations, including to promote the best interests of their members. This includes analysing outcomes for members on the default insurance settings: see REP 675.

Trustees should consider embedding detailed data-sharing arrangements in service level agreements with insurers so they can access the data required to monitor member outcomes, and insurers can access data to manage consumer harm (e.g. pre-lodgement information on claims): see REP 675.

What ASIC will do

ASIC will continue to engage with trustees to better understand progress towards improving data quality and monitoring member outcomes. We will do this in light of the new regulatory obligations on trustees.

ASIC will also continue to work closely with APRA to drive data uplift by trustees.

Changes to restrictive definitions

Claims assessed under the ADL eligibility test generally result in poor consumer outcomes. The design of TPD eligibility criteria results in some cohorts of consumers being automatically funnelled into ADL-only cover when it may not meet their needs.

Some of Australia's largest insurers are removing or modifying ADL definitions for insurance in superannuation

All insurers in our review undertook a review of their in-force retail and group TPD policies that include restrictive definitions

In their reviews, insurers prioritised group policies, where there is greater potential for poor consumer outcomes, as most TPD cover is provided through superannuation to fund members by default and without financial advice.

The most prevalent restrictive definition is ADL, with eight insurers using this restrictive definition in the group distribution channel and eight insurers using this restrictive definition in the retail distribution channel.

Most insurers have shown a willingness to explore alternative TPD definitions in the group distribution channel to improve consumer outcomes.

All insurers have started discussions with trustees about restrictive TPD definitions

Discussion with trustees is important because generally an insurer cannot unilaterally remove or vary a definition in an existing group insurance policy.

Trustees are responsible for providing insurance cover to their members. They need to work with their insurer to obtain cover that meets their members' needs at an affordable and sustainable price, having regard to the effect on the fund as a whole and fairness between members.

Eight insurers have provided options to their trustee clients for changing the ADL definition

Five insurers have provided options for removing the ADL definition. Two insurers have provided options for replacing the ADL definition with an ADW definition. Two insurers have provided options for creating a new definition to replace the ADL definition.

Note 1: One insurer does not use an ADL definition. Some insurers have provided multiple options to their trustee clients.

Note 2: ASIC's inquiries of insurers as part of this review excluded requests for claims data and quantitative information from insurers. As a result, the total number of group policies containing an ADL definition subject to an option for change is unknown.

Some changes that have been adopted by trustees are listed on page 11. Generally, trustees will consider such options when renewing their group policies (generally every three years).

There is a trend to broaden the eligibility criteria in TPD definitions

Broadening the eligibility criteria should lead to fairer outcomes by allowing more consumers to access the general or 'any occupation' TPD definition, with fewer consumers being funnelled into restrictive definitions. In considering a change to the insurance cover, trustees must balance breadth of cover with the cost of the insurance product.

Three insurers have modified eligibility criteria to allow consumers to be assessed against an 'any occupation' definition, rather than an ADL or ADW definition

One insurer expanded the eligibility criteria for a consumer to be assessed under an 'any occupation' definition to include having worked at least one day in the six-month or 12-month period (as applicable) before the disablement, regardless of employment type (e.g. full-time, part-time, casual).

Two insurers have broadened the eligibility criteria (e.g. a longer unemployment period before a restrictive definition applies) offered to trustee clients – one insurer has given the option to extend the period of unemployment up to 24 months, and the other insurer has given the option to extend the period up to 16 months.

Including mental health criteria in TPD definitions helps achieve fairer outcomes for consumers with mental health issues.

There is a trend to include mental health criteria in TPD definitions

Industry reports indicate that 25% of TPD claims paid in 2019 were for mental health conditions and it is expected that mental health claims will increase as a result of COVID-19.

Note: See Financial Services Council (FSC), *Detailed data reveals top causes of claim for the industry*, media release, 29 July 2020 and Actuaries Institute, *Life insurance implications of coronavirus (COVID-19)*, 5 May 2020.

Five insurers have developed definitions to include specific criteria to assess claims for mental health conditions

Three insurers have developed ADW definitions to incorporate psychology-based criteria into function-based definitions, to better respond to mental health conditions. Two insurers are including psychology-based criteria in new alternative TPD definitions.

Case studies: Including mental health criteria in TPD definitions

One insurer has developed what it describes as a 'best practice' ADW definition by including mental health criteria, reducing the number of activities a consumer must be unable to perform in order to claim, and rewording descriptions for comprehensibility and objectivity.

One insurer has developed three options, one of which is to replace the ADL definition with an ADW definition that includes psychology-based criteria. This insurer found that some product design elements did not respond to the challenge of determining the permanence or severity of the mental health condition on a consumer's capacity, where an assessment of 'total' incapacity is required – particularly for young consumers.

Several trustees have made positive changes to insurance arrangements

Generally, trustees will not change the terms and conditions of a group policy before policy renewal or expiry of the guaranteed rate period.

However, since REP 633, several trustees have worked with insurers to make positive changes to new or existing arrangements, for example by:

- removing the ADW definition
- adopting a new ADW definition (incorporating mental illness)
- removing the ADL definition and/or the minimum average hour requirement
- adopting a new 'education, training or experience' definition to replace the ADL definition
- amending the 'everyday work activities' (EWA) definition to increase the consecutive period of unemployment before the EWA definition applies, from six months to 16 months.

Insurers and trustees should start improving TPD definitions as early as possible before renewing insurance arrangements, and consider mid-term amendments where possible.

Further research into the use of restrictive terms

In December 2020, ASIC released REP 675 which shared insights from our work on metrics for measuring the value for money that members receive from default insurance offered through superannuation.

In that review, we consulted 11 trustees (covering about 40% of superannuation accounts with insurance as at 30 June 2019) and used data on the design and pricing of default insurance obtained from public sources (covering 82% of MySuper accounts at 30 June 2020).

Some trustees have conducted their own reviews of policy definitions when their group insurance arrangements came up for renewal.

In December 2020, Choice published work undertaken by Super Consumers Australia, which consulted 20 trustees to determine their commitments to remove restrictive terms in their TPD insurance – building on ASIC's findings in REP 633.

Design and distribution obligations

With effect from 5 October 2021, the new design and distribution obligation regime aims to ensure that firms (insurers and trustees where relevant) design and distribute financial products specifically to meet consumers' needs. Issuers and distributors need to take a consumer-centric approach and implement effective product governance arrangements to ensure that financial products are designed for, targeted at and sold to the right consumers. This change should result in better outcomes for consumers – so products that meet the needs of consumers and provide real value are designed and distributed.

ASIC's guidance on the obligations for issuers and distributors, including designing fit-for-purpose products and information about making a target market determination, is in RG 274.

Trustees will need to ensure that insurance arrangements are considered when identifying the target market for a Choice superannuation product. Where trustees have the same insurance offerings across their Choice and MySuper (default) products, insurance design considerations may flow through to MySuper products.

Most insurers have developed measures to better assess the value TPD products offer

In REP 633 (Table 14) we said insurers should develop and collect data on measures to assess the value of products to consumers or groups of consumers. These measures need to be collected at the level of granularity required to allow the value of each limb of the TPD definition (e.g. 'ADL' and 'any occupation' limbs) to be assessed.

Six insurers have developed and implemented a range of measures to assess the value of products for consumers

The most common product value measures across distribution channels (group or retail) were customer experience, complaints, claims outcomes, claims loss ratios and lapse rates: see Table 2.

Insurers' methods of assessing customer experience vary considerably, making this a less robust measure compared to the quantitative measures. For example, one insurer uses a formal survey at the conclusion of a claim; another considers the average claims processing time.

Table 2: Most common product value measures (no. of insurers)

Product value measures	Group	Retail
Customer experience	5	6
Complaints	4	5
Claims outcomes	5	5
Claims loss ratios	6	4
Lapse rates	1	3

One insurer has developed a framework with key metrics for determining ongoing consumer value outcomes.

Another insurer has introduced a pilot dashboard to proactively track metrics and assess insight into consumer outcomes, and to inform decisions on the end-to-end product proposition, from underwriting eligibility and definitions through to claims processes and ongoing consumer engagement. This insurer will include industry standard definitions of value measures for different groups of consumers (e.g. age and employment characteristics) once these have been developed.

Three insurers said they will work with the FSC to develop industry standard consumer value measures for TPD; two of the three do not have value measures in place.

Some insurers identified challenges in collecting value measures

Most insurers identified data gaps in value measures for each limb of the TPD definition, when conducting a data gap analysis against ASIC's expectations for data needed to manage consumer harm: see REP 633, Table 14.

For example, some insurers reported data gaps in relation to consumers' employment status and premiums paid, as well as data gaps in automation around capturing the lower limbs of the TPD definition. This highlights deficiencies in insurers' **understanding of the product**.

Note: See 'Poor insurer data and data usability' for more information about data gaps.

Most insurers have committed to addressing the need for better value measures, largely by collecting claims information in a sufficiently granular manner to identify the TPD definition used. However, some insurers identified challenges in collecting these value measures for group policies.

One insurer said that product value cannot be easily or usefully assessed for the different limbs of the TPD definition until trustees are able to identify which members paying premiums are unemployed and which are casually employed. This insurer suggested that an industry solution could be for trustees to use data from Government sources (e.g. Australian Taxation Office or Centrelink) to identify which members are unemployed and casually employed.

As discussed in REP 675, trustees are required to monitor insurance outcomes and the value they deliver to members.

Most insurers have committed to improving communication with consumers about eligibility

Most insurers recognised a need to improve communication with consumers and have committed to helping trustees in their communication with members about their insurance cover.

One emerging communication strategy in superannuation is to align eligibility criteria (e.g. hours worked) with events that trigger Protecting Your Super (PYS) notification obligations. Trustees can leverage this communication to inform consumers that their cover has changed from an 'own' or 'any occupation' definition to an ADL or ADW definition.

> '[We] believe PYS provides a clear engagement point for customers to elect to maintain their cover and understand the terms that apply to that cover …'
>
> Insurer | Response to ASIC's inquiries

While insurers have improved consumer communications, they should continue to work with their trustee clients to ensure fund members understand the type of TPD cover they will be eligible for in various circumstances.

We encourage industry to make better and simpler product design a priority, including standardising terms where possible, which in turn will simplify communication with consumers.

Case studies: Improving communications with consumers

One insurer has developed sample wording to share with trustee clients for use as a starting point when they communicate with members or employees. The wording explains that a change will occur in the TPD definition that will apply to the member, with options to vary the text depending on the various TPD thresholds that might apply before a more restrictive definition applies.

One insurer has developed a range of options depending on the trustee's preferred member engagement model: for example, leveraging PYS notification obligations to enable members to make an active decision to maintain their cover and understand the terms that apply to that cover, rather than a passive default option. This insurer is consumer testing these options to inform its recommendations to trustees about product complexity, consumer understanding and communication requirements.

Frictions in the claims handling process

The processes of lodging and assessing TPD claims can present many hurdles to consumers at a time when they are likely to be experiencing vulnerability. Improving these processes by removing or reducing frictions can help prevent additional harm to claimants under stress.

All insurers reviewed aspects of their claims handling practices, some more broadly than others

All insurers undertook at least one review of practices for claims handling and/or withdrawn claims

Insurers gave varying levels of detail to show their progress against the expectations in REP 633. Most insurers made an effort to identify frictions for consumers caused by their processes, and to improve their practices accordingly. Some insurers committed to future reviews to continue to identify areas for improvement.

Trends in TPD claims

On 20 April 2021, APRA released its life insurance claims and disputes statistics for the 12 months to 31 December 2020. Certain metrics specific to **TPD claims** show the following trends:

- The **claims admittance rate** (as a percentage of claims finalised) has increased since REP 633 for the group channel (89%) but declined for retail advised (81%) and direct (67%) channels. REP 633 identified concerns about the poor admittance rates for TPD claims assessed under the ADL test (60% declined) – the APRA data is not collected to this level of granularity.

Trends in TPD claims (cont.)

- The average rate of **claims withdrawn** (as a percentage of claims received) is 5%. However this data does not capture claims withdrawn between 'claim notified' and 'claim received' (see APRA Reporting Standard LRS 750.0 *Claims and disputes* for these terms) and is not directly comparable to the claims withdrawn rate of 12.5% reported in REP 633.
- The average **claim processing duration** (the period of time from when a claim is reported to when it is finalised) is 5.4 months. TPD has the longest average claims processing duration of all life insurance products, which reflects the complexity of the product. Concerningly, nearly 30% of claims still take longer than six months to finalise.
- Rates of **claim-related disputes** remain high relative to other products (except disability income insurance) and a few insurers have much higher dispute rates than the average.

Insurers should continue to streamline processes for lodging claims and lower hurdles for consumers

Most insurers offer at least two methods for consumers to lodge claims

We asked insurers about all the methods they provide to consumers to lodge a claim (e.g. paper form, online form, tele-claim): see Figure 1.

We found that the claim lodgement method varied depending on the distribution channel (retail or group). In some instances, consumers in the group channel may not have access to all methods, depending on the arrangements between the insurer and trustee.

Figure 1: Claim lodgement methods for at least one distribution channel

3 insurers offer three claim lodgement methods	**6** insurers offer two claim lodgement methods	**1** insurer offers only 'paper form' lodgement to consumers

Note 1: The one insurer said that the 'paper form' can be completed and returned by post or email. This is distinct from other methods of lodgement that are truly digital or online.

Note 2: The numbers in Figure 1 account for two responses from one insurer, due to an acquisition.

Trustees' levels of involvement in the claims process vary. For group insurance, insurers need to work with trustees to further lower hurdles for consumers.

A broader choice of lodgement methods makes it easier for consumers to lodge a claim.

Not all insurers automatically provide a copy of the claim details to their consumers after tele-claim lodgement

We asked insurers if they give the consumer a copy of their claim details (to check for accuracy and completeness) and, where they do, if they give the copy automatically or only on request: see Figure 2. Insurers' responses revealed that the tele-claim lodgement process varied depending on the distribution channel (retail or group).

Figure 2: Tele-claim lodgement process for at least one distribution channel

5 insurers offer tele-claim lodgement	**3** of those insurers automatically provide a copy of the claim	**2** of the five insurers provide a copy of the claim on request

Note 1: Two insurers are investigating whether they can automatically provide a copy.

Automatically giving consumers a written record after they lodge a tele-claim lets them promptly correct any errors and gives them an easily accessible copy of their claim details.

Some insurers have made changes to claim forms to reduce length, but some still ask for more information than is needed

Five insurers require a completed TPD claim form to start processing the claim. Three insurers have made positive changes to the format and/or content of their TPD claim forms. This is particularly important where an insurer requires a completed form to start assessing the claim.

Case studies: Changes to claim forms

One insurer condensed and simplified questions and focused on collecting TPD-specific information, halving the original claim form.

One insurer has developed tailored forms for TPD claims, as well as more consumer-focused, condition-specific forms. It is working with trustee clients to simplify group claim forms.

Further changes to claim forms are expected in response to FSC Standard No 26 *Consent for accessing health information*. FSC members were required to have adopted this Standard no later than 1 July 2021.

Insurers need to focus on both the length *and* content of the claim form to lower hurdles for consumers. It is important that insurers ask for only the minimum essential information they need to start assessing the claim, particularly when an insurer requires a completed claim form to start the assessment.

Insurers should continue to improve assessment processes and use data to identify frictions

Two insurers record the timing of withdrawn claims relative to a particular claim event

Withdrawn claims can be an indicator of consumer 'pain points' in the claims process. We asked insurers the categories they use when recording the *timing* of a withdrawn claim following a particular event or activity in the claim journey, and how they use the data.

- While all insurers record particular claim events such as a request for information or a request to attend an IME, only two record the timing of withdrawn claims relative to a particular event or activity.
- Another insurer reports to management on withdrawn claims, including when the claim was withdrawn, but not relative to a claim event.
- Another insurer obtained an external review of a subset of claims and complaints data to better understand whether any frictions were causing consumers to withdraw their claim. The review found no significant indication of such frictions in the claims processes.
- Some insurers can only manually review withdrawn claim reasons relative to other key claim events.

By not routinely recording this data, insurers miss the opportunity to proactively target, identify and respond to potential indicators of 'pain points' in the claims process that may be contributing to withdrawn claims.

Case studies: Capturing and using timing of withdrawal

Two insurers have developed, and another two are developing, their capability to capture and analyse the timing of withdrawn claims to identify any causal links to specific claim assessment events.

All insurers record reasons for withdrawn claims, but some do not use this data to identify or respond to potential 'pain points'

We asked insurers the categories they use when recording the *reasons* for a withdrawn claim, and how they use the data.

- All insurers record reasons for withdrawn claims.
- One insurer has 12 categories of reasons, one being that the consumer 'feels the process is too difficult'.
- Some insurers do not use the data to identify claims handling frictions or trends in withdrawn claims.

By continuing to develop their data capabilities, insurers are likely to make better use of the data they collect. There is little to no value in monitoring the reasons for, and timing of, claim withdrawal if no further use is made of this information.

Case studies: Using reasons for withdrawal

Four insurers use information about the reasons for withdrawal to better analyse withdrawn claims. Another four plan to use this information; one plans to use the categories of withdrawal to monitor and respond to any trends identified, including those occurring before a claim proceeds to 'claim received'.

Most insurers use the FSC's reasons for withdrawal

Since REP 633, the FSC has added a set of defined categories of reasons for withdrawn claims to its recurrent data collection from insurers.

- Six insurers have aligned their categories with those developed by the FSC.
- One intends to conduct a compliance review of the new reporting process, including contacting consumers to understand why they withdrew their claim.
- Another insurer intends to implement the FSC's categories.

ASIC sees value in insurers having a consistent approach to categorising reasons for withdrawn claims. We urge insurers to continue to work together towards consistent reporting of reasons.

All insurers record when supporting material (e.g. a medical report) is requested, and some have improved controls for such requests

All insurers record when they request additional information from a consumer. However, this data is mostly used ad hoc rather than to monitor and prevent frictions such as excessive requests for information.

Three insurers have made improvements to their controls around requests for medical information, with a view to avoiding unnecessary or intrusive requests.

Case studies: Changes to controls for information requests

One insurer now offers medical case conferences as an alternative means to collect information from consumers (and their medical professionals) to reduce follow-up requests, and has guidelines for contact between its Chief Medical Officer (CMO) and treating doctors.

Changes to controls for information requests (cont.)

Another insurer has increased controls to ensure that where more than one IME request is made per claimed medical condition, the decision to request a subsequent IME is first reviewed and approved by the CMO and the Head of Claims.

One insurer has strengthened controls to prevent unnecessary repeated requests for IMEs from the same type of specialist within a six-month period. This insurer has also implemented controls to ensure management approval is obtained where such requests are deemed necessary.

Use of physical surveillance appears to be minimal or infrequent for TPD claims. Three insurers told us about their controls on physical surveillance in TPD claims involving mental health conditions

We asked insurers about the circumstances in which they use physical surveillance, and the extent to which it is used, for TPD claims involving **mental health** conditions.

- Two insurers outlined when they may use physical surveillance for a mental health claim: one requires approval from the Head of Claims and the General Manager; the other prohibits use unless 'defending litigated matters'.
- One insurer committed to improving controls and will require approval from the CMO and a claims review panel.

At a minimum, all insurers have guidelines or protocols in place to help ensure appropriate use of physical surveillance (though these are not specifically linked to mental health claims). For example, all insurers require at least a second sign-off from a senior claims consultant or team manager and most require sign-off from a department head or above.

We consider that physical surveillance would rarely, if ever, provide evidence of a consumer's mental health status and may exacerbate an existing mental illness.

It is critical that insurers have stringent controls in place if they are going to undertake physical surveillance in any claims involving mental health conditions.

ASIC is currently reviewing the use of, and controls around, physical surveillance in income protection claims.

Only one insurer still uses daily activity diaries as a TPD claims assessment tool

We asked insurers about their use of daily activity diaries, and the extent to which they are used, as a claims assessment tool. Eight insurers categorically stated that they do not use activity diaries in TPD claims.

> 'Daily activity diaries are used in minimal circumstances and used as a tool to assist claimant[s], treating doctors and ourselves to better appreciate what the insured's daily activities are and capacity …'
>
> Insurer | Response to ASIC's inquiries

Significant consumer harm can result from daily activity diaries. If an insurer decides there is a valid reason to use a diary as a claims assessment tool, they should consider and prioritise the health and wellbeing of the consumer.

Some insurers have made changes to communication practices

We asked insurers about any changes to their communication with consumers to be more transparent, informative and proactive. Five insurers had made enhancements to their communication practices, such as improving staff training programs to encourage a person-centred approach, improving standard letter templates and enhancing the tracking and reportability of communication with consumers.

Most insurers have improved their policies and guidelines for assessing claims

We asked insurers about any changes to their claims handover procedures for staff handling TPD claims: see Figure 3. Most insurers had implemented new or enhanced guidelines to improve the consumer experience when a claim is reassigned to a new manager.

Figure 3: Changes to claims handover guidelines

5	insurers implemented new claims handover guidelines	**2**	insurers enhanced existing claims handover guidelines

Although we did not ask about changes to policies relating to claimants' disclosure of pre-existing conditions, four insurers reported changes made to improve processes around non-disclosure inquiries: see Figure 4.

Figure 4: Changes to inquiries for unrelated non-disclosures

3	insurers updated their non-disclosure policies	**1**	insurer developed a new non-disclosure policy

Following recent changes to the law, ASIC is doing further work on insurers' investigations of non-disclosure by claimants, focused on income protection claims.

Poor insurer data and data usability

Insurers need good-quality data to manage the risk of consumer harm. Without it, insurers may rely on less targeted, reactive methods (e.g. consumer feedback) to identify key friction points in claims handling, staff conduct issues, or the value of products. Good-quality data enables more targeted, proactive supervision and monitoring processes.

All insurers have shown a commitment to identify the shortcomings in their data capabilities

All insurers undertook at least one review of their data capability, together with a data gap analysis

In their reviews (see Figure 5), insurers conducted a data gap analysis – that is, a review of their existing capabilities to capture, store and retrieve data against ASIC's expectations in REP 633, Table 14.

Some insurers committed to future reviews to continue to identify areas for improvement.

Figure 5: Data gap analysis

9	insurers found data gaps	**114**	data gaps (not all unique) emerged from insurers' analysis

Note: These are not unique data gaps; they include similar data gaps across insurers. Some subjective judgement has been applied to insurers' responses to arrive at this total number.

Over 100 data gaps emerged from insurers' data gap analyses.

All insurers identified data gaps and gave varying insights into how they intend to close gaps, including working with trustees.

All insurers have given a commitment and, for the most part, timeframes to address the vast majority of data gaps they identified.

Some insurers conducted a deeper dive, beyond the data gap analysis, to determine what may be required to lift data capabilities to improve insight into, and outcomes for, consumers.

Case study: Extensive review

One insurer conducted an extensive review of teams and systems spanning several areas of the business. It considered ASIC's expectations against its products, sales, claims, underwriting, new business, policy administration, complaints and retentions. This shows an intent to understand existing limitations and improve data capability.

Insurers' reviews confirm what ASIC found in REP 633: insurers still lack the data needed to monitor consumer outcomes and harm. At best, they hold data but are constrained by the way it is stored, and limited in how they can use it to improve consumer outcomes.

Data gaps indicate insurers lack insight into key frictions within the claims handling process

We categorised all insurers' data gaps (see Figure 5) by the type of data needed to manage consumer harm and ranked them by the number of gaps: see Table 3.

Table 3: Main types and number of data gaps (114 in total)

Type of data gap	No. gaps
Key claim events	39
Group data from trustees and intermediaries	19
Claims experience of consumers assessed under TPD definition	12
Value measures for each TPD definition	11
Involvement of advisers in claims process	9
Data for analysis at a policy level	6
Data for analysis of withdrawn claims	6
Involvement of reinsurers	5
Primary and secondary cause(s) of claims	4
Data for behavioural analysis of claims staff	3

Note 1: Each individual data gap has been categorised into only one type of data gap.

Note 2: APRA set out its expectations about data collection for individual disability income insurance in its letter of 2 May 2019 to all life insurers and friendly societies. In part, APRA recognised the need for these entities to make appropriate investments to improve the quality, quantity and timeliness of this data.

The greatest number of data gaps relates to key claim events (39). All insurers identified this gap, which is not surprising given the broad range of data this might cover. This gap suggests that insurers lack insight into key friction points and an **understanding of the claims handling process**.

Group data from trustees and intermediaries had the second largest number of gaps (19). All insurers identified this gap, highlighting the need for improved access to pre-lodgement information from trustees and intermediaries.

The third largest number of data gaps related to the claims experience of consumers assessed under each TPD definition (12). This gap suggests that insurers lack an **understanding of the consumer experience**.

> **Lack of insight into key frictions within the claims handling process is not necessarily confined to TPD insurance claims; the findings about data gaps likely apply to other life insurance products too.**

Lack of searchable data fields prevents insurers using data

A common theme from insurers' data gap analyses is that captured data is not stored in a consistent, searchable or reportable format.

Case study: A need for enhanced systems

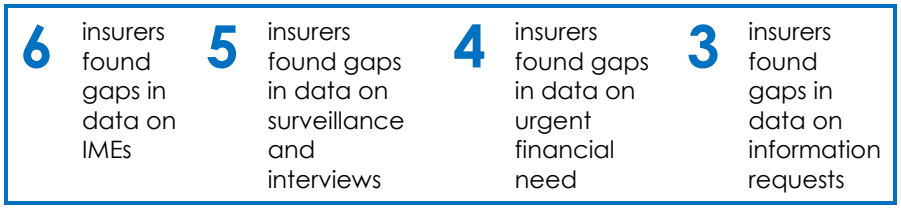
One insurer captures data about rehabilitation, IMEs, surveillance, requests for information, and third-party involvement. This insurer acknowledged the data is not in an easily reportable format and that its systems need enhancing to make better use of such data.

> **Data that is not readily available, such as unstructured data entered in a free text field which requires manual review to be of any use, should raise concerns for insurers.**
>
> **The lack of searchable and reportable data inhibits insurers' ability to identify trends and proactively manage potential consumer harm.**

A closer look at data gaps for key claim events

The lack of searchable and reportable data produced a significant number of data gaps related to key claim events: see Figure 6.

Figure 6: Data gaps relating to key claim events



As at July 2020, six insurers had found gaps in IME-related data – for example, capturing dates of every IME request and attendance, and recording such data in a searchable format rather than 'free text' fields.

Now, four of the six insurers record both IME request and attendance dates in a searchable format, and another insurer records the IME request date but not attendance.

> 'Events during the claims management process are not consistently recorded in an easily accessible format. This information is often stored so that follow-up can be conducted (e.g. as a text field) rather than an easily searchable format.'

> 'Most data points in Table 14 [of REP 633] exist, but quality is questionable or they are not easy to retrieve (e.g. item exists as a 'note' in free-form text).'

Two insurers | Data gap analysis, response to ASIC's inquiries

All insurers have made at least some improvements to strengthen their data capabilities

Insurers have worked to strengthen their data capabilities and close most data gaps by a variety of methods. Some insurers are more advanced in this area than others.

Most insurers have improved their practices around poor data

Improvements made include implementing new strategies, plans and initiatives to improve data management, governance and reporting.

Such changes result from insurers identifying areas for improvement (going beyond an examination of data gaps) and committing to future changes.

Case studies: Improvements to data management and use

One insurer committed to a more structured and regular annual review of insurance value measures to continuously improve TPD consumer outcomes.

Another insurer introduced a triage forum that regularly reviews prioritisation of data work and data management practices. It also established a dedicated data and analytics team.

One insurer acknowledged that further opportunities exist to improve its ability to minimise consumer harm by improving controls, centralising data storage, and enhancing accountability for data management.

All insurers have invested in data resources and associated systems to address consumer harm

All insurers have made investments to improve their data capability to identify and respond to consumer harm. Four insurers have, to varying degrees, invested in staff resourcing dedicated to data and its management.

Case studies: Investments in data and systems

In October 2019, one insurer launched a claims system with greater automation and fewer manual tasks, streamlining the claims process.

In January 2021, another insurer implemented a new claims system across all life insurance products and channels, which is intended to include in searchable format the types of claims data listed in REP 633.

One insurer has plans for a 'comprehensive data services platform' aligned with ASIC's expectations – integrating, storing and retrieving high-quality data in a timely fashion for analysis to manage conduct risk and consumer harm.

All insurers gave a commitment to address most data gaps, while some insurers went further and made changes to close gaps

Most insurers have implemented initiatives to improve data management and made investments in data and systems overall (which go toward addressing data gaps), and some insurers have since made changes to target individual data gaps.

Data and system upgrades tend to be undertaken on a large scale and require substantial investment and time for implementation after review. However, insurers' data capability is an area long identified by both ASIC and APRA as needing significant improvement.

Case study: Changes to address data gaps

One insurer introduced a new claims system, with reporting to be developed, and gave a commitment to lift its data quality to enhance data consistency and ensure reporting is 'reliable, repeatable and responsive'.

This insurer's system captures in a searchable form:

- individual consumers' address, postcode and state
- primary and secondary causes of claims
- information to help identify consumers who may be in a sensitive state
- likely client matches, to help the overarching management of individual claims – for example, to identify if a consumer has a previous claim, has lodged a complaint, or been underwritten
- additional information on consumers' fund-related data.

Despite a general commitment to close their data gaps, some insurers are less advanced in their plans to do so. One insurer did not assess whether it can address all the data gaps but said it will address them 'where possible'. Another provided no details about how, or when, many of the data gaps would be addressed, instead saying actions are in 'preliminary stages'.

Insurers should view data collection as a continuous improvement exercise, and have a detailed plan and timetable to improve data capability. ASIC will follow up insurers that failed to provide a level of confidence about addressing identified data gaps.

Insurers face challenges in addressing gaps in claims and membership data in group insurance

Insurers are seeking to close gaps in group data from trustees and intermediaries

As noted in the discussion of Table 3, all insurers identified data gaps that relate to group data from trustees and intermediaries. Insurers' intentions to close gaps in group data varied: see Figure 7.

Figure 7: Intention to close gaps in group data

6	insurers are working, or intend to work, with trustees to close gaps in group data	**3**	insurers are less advanced in addressing gaps in group data

Some insurers described instances where they find it challenging to close data gaps in group insurance and, as a result, do not have measures in place to monitor and respond to trends.

More access to pre-lodgement information is needed

In REP 633, we said that insurers need access to enough pre-lodgement information about a claim to allow them to proactively and independently identify examples of potential consumer 'pain points'.

We found most insurers have limited visibility of group claims before claims are lodged. One said its operating model does not allow for involvement until a claim has reached 'claim received' status and that pre-lodgement is the responsibility of others (e.g. trustees). As the insurer does not receive claims information directly, it relies on the trustee (or fund member) to pass on the claim information.

Only one insurer has full visibility of group claims before lodgement. This insurer can track claims from 'claim notification' through its claims system with regular follow-up until the date of 'claim received' (see APRA Reporting Standard LRS 750.0 *Claims and disputes* for these terms). Two insurers have full visibility of those group claims where trustees use claims management systems provided by the insurer, but neither has visibility of the rest of their group arrangements.

Some insurers have made, or intend to make, process improvements to gain greater visibility of the whole claim.

Gaps in group data from trustees and intermediaries cannot be closed by insurers alone. However, the need for trustee and intermediary help does not remove the need for insurers to do more work too.

Case studies: Process improvements to close data gaps

One insurer improved the digitisation of the claims process to enable greater and earlier visibility of group claims being processed by the trustee. From time to time, this insurer receives data from trustees about consumer claims experiences with the trustee.

One insurer intends to engage with its trustee clients and implement a direct tele-claims notification model for them.

One insurer is working with trustees (and administrators) to receive quarterly reports about pre-lodgement information (e.g. number of times the member was contacted and the date the claim file was closed) to enable the insurer to monitor withdrawn claim inquiries.

Insurers have identified gaps in data on default cover

In REP 633, we said that insurers and trustees should collect and keep data on the number of members who change their default cover.

Most insurers identified data gaps for default cover. There seemed to be a consensus among insurers that group insurance data is the responsibility of, and more efficiently managed by, the trustee.

One insurer said it does not have access to member administration systems and cannot maintain data on all changes to default cover in real time. Instead of collecting the data, this insurer proposed to periodically ask trustees for a summary of member data.

In REP 675 we said that trustees need to be able to identify which of their members are on the default insurance settings to assess whether the default arrangements are delivering value for money, and to evaluate whether groups of members with different insurance arrangements are being treated fairly.

Trustees need to make progress in this area. They need the right data, as well as the systems and analysis, to track what is happening to their members. We will continue to engage with trustees across the industry.

Some insurers have shown a willingness to explore solutions and engage with trustees, where needed, to increase their data capabilities.

All insurers and trustees should start this engagement as it is clear that data gaps that relate to group data held by trustees and intermediaries cannot be addressed without co-operation.

Case studies: Working with trustees to close data gaps

One insurer considered that a 'data link' to enable insurers to query claim data held by trustees would not be feasible, since each trustee has different data architecture. Further, a real-time link is not necessary since the insurer becomes responsible for claims handling once the claim is lodged with them. Instead, this insurer proposed to close the gap by suitable handover processes at the time the claim is lodged.

Another insurer has extended its digital platform to its trustee clients to help their members manage claims. This gives consumers choice about how they interact with the insurer and lets them upload documents and seek clarification about any requests for further information. This may increase efficiency by providing the insurer with earlier visibility of claims.

APRA's work to drive data uplift by trustees

APRA's new Superannuation Reporting Standard SRS 251.0 *Insurance* will require trustees to report more granular data about insurance in superannuation, including TPD claims by assessment criteria.

APRA's objectives for data in Phase 1 of its Superannuation Data Transformation also highlight the need for access to high-quality consistent data to assess industry performance and the outcomes being delivered for superannuation members.

ASIC will continue to work closely with APRA to drive data uplift by trustees.

Key terms and related information

Key terms

ADL	Activities of daily living – a set of disability criteria (e.g. dressing, toileting, bathing, feeding) that are a sub-definition of TPD under many insurance policies
ADW	Activities of daily working – a set of disability criteria (e.g. seeing, communicating, walking, lifting) that are a sub-definition of TPD under many insurance policies
any occupation TPD definition	Where a benefit is paid if a person is unable to engage in gainful employment in any occupation for which the person is is reasonably qualified by education, training or experience (definitions can vary across insurance contracts)
Choice superannuation	A superannuation product that is not a MySuper product
declined claim rate	The percentage of claims declined by an insurer out of total claims received
EWA	Everyday working activities – a set of disability criteria comprising a sub-definition of TPD under many insurance policies (criteria includes seeing, communicating, walking, lifting, etc)
eligibility criteria	The criteria used to determine whether a claim will be assessed under a restrictive TPD definition or an any occupation/own occupation TPD definition (e.g. employment status, number of hours of work per week)
group policy	A life insurance policy issued to a third party (e.g. a superannuation trustee)that policyholders can access through their membership of the third party's fund
insurer	The company that issues the life insurance policy
life insurance policy	A life insurance contract as defined by s9 of the *Life Insurance Act 1995*, excluding investment or annuity-related contracts
MySuper superannuation	A default superannuation product provided under Pt 2C of the SIS Act
non-disclosure	When the consumer fails to comply with their duty of disclosure in s21 of the *Insurance Contracts Act 1984*
own occupation TPD definition	Where a benefit is paid if a person is unable to work again in their own occupation, that they worked in immediately before becoming totally and permanently disabled (definitions can vary across insurance contracts)
Protecting Your Super (PYS)	*Treasury Laws Amendment (Protecting Your Superannuation Package) Act 2019*
retail policy	A life insurance policy sold to policyholders who have received financial product advice
superannuation fund	Has the meaning given in s10(1) of the SIS Act
superannuation trustee service	A 'superannuation trustee service' means operating a registrable superannuation entity as a trustee and it covers all conduct associated with operating a superannuation fund, including claims handling.
TPD insurance (cover)	A type of life insurance that pays a lump sum if the consumer becomes totally and permanently disabled
trustee (superannuation)	A person or group of persons licensed by the Australian Prudential Regulation Authority under s29D of the SIS Act to operate a registrable superannuation entity (e.g. superannuation fund) (also known as an 'RSE licensee')

Related information

Headnotes

Activities of daily living test, ADL, claims handling, consumer harm, data resources, declined claims, group insurance, life insurance, mental illness, non-disclosure, restrictive definitions, retail channel, superannuation trustees, surveillance, total and permanent disability, TPD, withdrawn claims

ASIC documents

REP 498 *Life insurance claims: An industry review*

REP 633 *Holes in the safety net: A review of TPD insurance claims*

REP 675 *Default insurance in superannuation: Member value for money*

RG 271 *Internal dispute resolution*

RG 274 *Product design and distribution obligations*

Standards

APRA, SRS 251.0 *Insurance* (PDF 242 KB), August 2020

APRA, LRS 750.0 *Claims and disputes*, October 2018

FSC, Standard No 26 *Consent for accessing health information*, 21 June 2019

Other references

APRA, *APRA completes first phase of its Superannuation Data Transformation*, media release, 25 March 2021

APRA, *APRA urges life insurers and superannuation funds to address sustainability of insurance in superannuation*, 9 March 2021

APRA, *Letters issued to life insurers and friendly societies 2019*, 18 September 2019

APRA, *Life insurance claims and disputes statistics* (December 2020 edition), 20 April 2021

APRA, *Topic paper 6 – Insurance arrangements*, 28 August 2020

Choice, *Junk TPD insurance set to return in 2021*, 22 December 2020

FSC, *Detailed data reveals top causes of claim for the industry*, media release, 29 July 2020