Life Insurance Draft Code of Practice
Submission on Draft Code
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About Slater and Gordon

Slater and Gordon is a leading international consumer law firm employing 1,330 people in 61 locations across Australia and 3,310 people across 25 locations in the United Kingdom. Slater and Gordon's mission is to give people easier access to world class legal services. The firm provides specialist legal and complementary services in a broad range of areas.

Slater and Gordon's superannuation and insurance practice operates out of eight offices in four states, and runs and wins hundreds of disability insurance claims every year, for clients from right across the country.

1. SUMMARY

Life insurance has a number of serious systemic problems. The most important problems are:-

a. long delays in the approval or rejection of claims
b. unfair treatment of claimants while their claims are assessed, including problems with communication, surveillance and interrogations.
c. irregular payment of income protection insurance payments, including people being cut off their regular payments on the basis that 'further investigations' are required
d. churning - meaning unnecessary changes from one insurer to another - which can cause problems with pre-existing conditions and disclosure
e. useless, mis-sold and overpriced policies
f. commissions and the conflicts of interest they create

This Code of Practice is a good opportunity to fix many of these problems. Unfortunately, the Code in its current form does little to fix these problems. It is full of loopholes, exceptions, and carve-outs, and short on hard obligations for insurers.

Unless significant changes are made to the Code, life insurance customers cannot rely on it to deliver them fairness.

2. EXISTING PROBLEMS IN LIFE INSURANCE

Delay

Slater and Gordon analysed hundreds of disability insurance claims (mostly total and permanent disability "TPD", and income protection "IP" claims) which we won for our clients in the 2015 Financial Year. We found that only around half of all claims were approved within six months of being lodged. Many claims took more than a year, and some took more than two years.

People claiming TPD and IP benefits are very unlikely to be working and many of them will have no income. That leads to severe financial hardship. TPD and IP benefits are intended to help relieve that problem, but because of the gross delays, the intended relief does not come soon enough. People lose their homes, and often suffer mental illness as a result of the problems caused by delays.

The claims process

Many claimants find the claims process confusing, frustrating, confrontational and even traumatic. There are a number of problems:-

a. Insurers demanding face-to-face or telephone interrogation of claimants, often by ex-police or private investigators
b. Insurers demanding to deal directly with a claimant's treating doctors
c. Covert surveillance of claimants, even where the claimed condition is a psychiatric injury and therefore not visible on film
d. Examinations by so-called 'Independent Medical Examiners', who are in fact paid for by the insurer and therefore not independent
e. Case managers giving meaningless updates on the progress of the claim (the most commonly heard example being 'It is under review')
f. Information and documents being requested on 'the drip-feed' – that is, one after the other, with a decision constantly being delayed until the most recently requested information is received.

g. Insurers refusing to speak with a claimant's chosen representative (whether a financial counsellor, lawyer or union official), and instead and unexpectedly contacting claimants direct

Irregular payment of Income Protection, including unjustified cutting-off of payments
Income protection is a periodic benefit, usually paid monthly. We often see cases where our clients are not paid their monthly payment on time. Delays of a few days or weeks are common, and can cause serious financial hardship.

Another problem is being cut off IP payments while 'further investigations' take place. This is what happens:-

a. a person has their IP claim approved and goes on payments
b. they continue to provide updated medical certificates showing that they are entitled to ongoing IP benefits
c. the insurer cuts off payments, sometimes without any explanation
d. eventually, the insurer says that they need further information, and either request that information themselves or ask the claimant to provide it
e. until that information is received, no IP payments are made
f. financial hardship, stress, and mental illness often follow for the person cut off their IP payments
g. when the information is received by the insurer, they may ask for further information still and refuse to reinstate payments, or they may belatedly back-pay the IP benefits, or they may reject the claim.

The effect of this is that people are cut off their IP payments even though the insurer has not made a decision to reject their claim.

Churning
Churning is the process where customers are moved from one insurer to another, for little or no benefit to the customer, but sometimes significant benefit to the insurance salesperson in the form of commissions.

Moving to a new insurer exposes the customer to risks:-

a. some policies do not cover pre-existing conditions. Any condition which first occurred after the old policy commenced, but before the new (churned) policy, may be a pre-existing condition under the new policy. The effect is that the new policy may not cover the person for the conditions which the customer is most likely to claim on.
b. new policies may require a health questionnaire to be completed. That exposes a customer to the risk that the new insurer may complain that a full medical history was not disclosed, which may justify the cancellation of the policy. With non-underwritten cover (that is, cover obtained without any medical questionnaire) as is common with superannuation-based insurance, there is no risk of cancellation for non-disclosure. If the new insurance does come with disclosure obligations, the risk of losing that cover can be significant.

Useless, mis-sold and overpriced policies
We have had the opportunity to read in draft the joint submission by the Consumer Action Law Centre ('CALC') and Financial Rights Legal Centre ('FRLC'). We refer to the observations in that submission on sales practices and problem products, and funeral insurance and Consumer Credit Insurance in particular. We agree with the comments on those problems set out in that submission.

3. RECOMMENDED CHANGES TO THE DRAFT CODE

We suggest the following changes to the Draft Code.

1.4 Objectives of the code

The objectives are too narrow. Further objectives should be added

e. to ensure that customers are sold only insurance appropriate to their needs
f. to ensure that the interests only of customers and beneficiaries are taken into account in advice to buy or replace insurance
g. to ensure that customers are sold only insurance that has a price that fairly reflects the risk covered and potential benefits
h. to ensure that claims are assessed quickly and efficiently so that benefits are paid to clients as soon as possible
i. to avoid causing stress, confusion and inconvenience to claimants
j. to ensure that decisions on claims are fair

1.5 Principles that apply to our products

Further principle should be added

f. value for money

2.1 Who is bound by the Code - Superannuation-based insurance

Most Australians who have life insurance get it through their superannuation fund. The protections and benefits provided by the Code should be fully available to those people.

Clause 2.1 provides that superannuation fund trustees are not bound by the Code.

The Code should be amended to require that any new or revised life insurance policy provided to a superannuation fund include a term requiring the superannuation fund to conduct itself in such a way as to ensure that the Code is complied with. Clause 2.1 should be amended by removing the footnote and including the following new provision:-

c) any superannuation fund trustee which enters into a new or revised ***Life Insurance Policy*** *after the commencement of this code.*

A new clause 2.7 should be added:-

2.7 Any new or revised ***Life Insurance Policy*** *to which a superannuation fund trustee is a party, entered into after the commencement of this* ***Code,*** *shall include a term requiring the superannuation fund trustee to conduct itself in such a way as to ensure that the Code is complied with.*

The terms of the Code are incorporated into all new and revised contracts by new clause 2.15, set out below.

2.4 Authorised representatives
The protection does not go far enough. Authorised representatives should be required to agree to be bound by the Code as a condition of their appointment or continuation as authorised representatives.

2.5 Financial Advisors
The protection does not go far enough, and demonstrates the limitations of self-regulation. Many of the problems in the life insurance industry are the result of conduct of financial advisers and insurance brokers. Many of them will have no formal relationship with life insurers or the FSC. It is not a good outcome for some, but not all participants in the life insurance industry to be covered by the Code. It should be a condition of any financial services licence covering life insurance that the licence holder agree to be bound by the Code.

2.6 Reinsurers
The protection does not go far enough. 'Assistance' may not be sufficient for the requirement of the Code to be met. Reinsurers should be required to conduct themselves so that their conduct does not cause insurers to be in breach of the code. The provision should be redrafted, as follows:-

> ***FSC*** *members in their capacity as* ***Reinsurers*** *are bound by the* ***Code****, and will meet their commitments under the* ***Code*** *by complying with the principles at sections 1.5 and 1.6 and ~~assisting~~ acting in such a way as to ensure that* ***we*** ~~***us*** *to*~~ *meet* ***our*** *commitments under the* ***Code****.*

2.11 and 2.12 Communications
These clauses deal with communications with claimants. They are problematic. There is an existing problem with insurers and their agents contacting claimants directly, even in cases where the claimant has given clear instructions for their insurer to deal with their appointed representatives. This often causes distress and confusion, deprives a claimant of the benefit of the expert assistance they have sought, and restores the insurer to a position where it enjoys an advantage in expertise and therefore power.

There is also an existing problem, particularly with employer-owned policies, with employers, insurers and their agents all refusing to provide information (including a copy of the policy) to beneficiaries.

The provision should be redrafted as follows:-

> ***2.11*** *Where* ***you*** *have appointed a* ***Representative****,* ***we*** *will have complied with a requirement to communication to you under the* ***Code*** *only if* ***we*** *communicate with that* ***Representative****. In other cases,* ***we*** *will have complied with a requirement to communicate to* ***you*** *under the* ***Code*** *if* ***we*** *communicate to any one of the* ***Life Insured****,* ***Policy-owner****,* ***Third Party Beneficiary*** *or* ***Representative****, as appropriate to* ***your*** *circumstances and subject to privacy and confidentiality requirements.*
>
> ***2.12*** *Where* ***you*** *or your* ***Representative*** *request information from* ***us,*** *we will provide that information directly to you, even if you do not own the policy.*

Legal Status of the Code – 2.13 – 2.20
Enforceability is an existing serious problem with self-regulation in the industry. For example, despite the existence of FSC Guidance Note 11 (on Group Life Takeover Terms) and its predecessors, insurers take positions in litigation which are inconsistent with the Guidance Note, that is, each stating that the other is liable to pay.

The Code should be incorporated into insurance contracts.

Clauses 2.15 should be removed and replaced with the following:-

> *2.15 The **Code** will be incorporated into and form part of all **Life Insurance Policies** entered into or varied after the commencement of this **Code**.*

Clause 2.20, which deprives claimants of the protections of the Code in legal proceedings, renders the Code meaningless when it is most important, and should be removed.

3.1(d) Policy Design and Disclosure
This provision provides protections for people sold life insurance directly by insurers. The requirement for clear and informative language is just as important for group and financial-advisor sold policies. Beneficiaries of group policies and people with financial advisors still need to understand the policies they have the benefit of. The provision should be amended as follows:-

> *ensure that the policy information ~~for policies sold directly to individuals (with no financial adviser/planner or **Group Policy-owner**)~~ is clear and informative enough for a consumer to reasonably assess the suitability of the policy for them;*

3.5 Information provided on purchase
A clear explanation of when benefits will be paid is required. For example, some current TPD policies have a number of different TPD definitions that apply to different occupations (unskilled workers often get tougher definitions), modes of work (contractors and casuals often get tougher definitions), or hours of work (unemployed and part time workers often get tougher definitions). The following should be added to 3.5(a)

> *, including what needs to be established for a benefit to be paid, and where different tests for payment of a benefit apply in different circumstances, information about those tests and circumstances*

The exclusion for group policies in the footnote should be removed.

The following should be added

> *j) the projected cost of cover over the potential duration of the policy*
> *k) any commissions payable, including the dollar amount and payee*

3.6(b) Information about pre-existing condition exclusions

Exclusions in writing might still get lost in the fine print. The provision should be amended to state

> *b) if **you** disclose a medical condition to **us** when **you** apply for the policy , **we** will not apply a pre-existing exclusion clause in relation to that condition unless **we** <u>specify the condition prominently in writing and</u> agree this with **you in writing** when **your** policy is issued.7*

3.7 Funeral insurance

We refer to and adopt the CALC/FRLC submission on funeral insurance. We would add that we are not convinced that rules aimed at protecting prospective buyers of funeral insurance would be anti-competitive as seems to have been suggested.

3.8 Product Disclosure Statements

Replace ‘encourage’ with ‘require’

4.1 Advertising

We refer to the comments in the CALC/FRLC submission about existing problems with advertising of life insurance products.

4.3 Sales Philosophy

The provision does not go far enough, and should be amended as follows:-

> ***We** will have a clearly documented sales philosophy to ensure **our** staff conduct sales appropriately and avoid pressure selling or other unacceptable sales practices. This ~~should~~ <u>will</u> include:*
>
> *a) ~~having clear rules on when~~ **our** staff must ~~stop~~ <u>not</u> sell~~ing~~ if **you** indicate **you** do not want a **Life Insurance Policy** being offered or if it becomes clear that **you** will be unlikely to claim the benefit under the policy<u>, and must not otherwise engage in pressure selling</u>;*
>
> *b) how to record and keep adequate evidence that **you** have genuinely consented to purchase the **Life Insurance Policy**;*
>
> *c) guidance on the minimum information that must be disclosed to **you** about the premium, features, benefits, exclusions, limits and cooling-off period of the **Life Insurance Policy**;*
>
> *d) compliance performance metrics included in **our** staff incentive programs including consequences if **we** identify they have engaged in pressure selling or other unacceptable sales practices.*

4.4 Compliance with Sales Philosophy

Reporting should be made available to the Life CCC, FSC, ASIC and APRA. The provision should be amended as follows:-

> ***We** will have a framework in place to monitor **our** staff’s compliance with **our** sales philosophy, including:*

a) quality assurance measures for reviewing sales such as call monitoring, mystery shopping and post-sale call surveys; and

*b) analysis and reporting to the Life CCC, FSC, ASIC and APRA on key data, such as sales results, lapses, claim declines and **Complaints**.*

4.5 Authorised Representatives Compliance and Reporting
This provision also requires reporting on monitoring results to the Life CCC, FSC, ASIC and APRA. The provision should be amended as follows:-

*With **our Authorised Representatives:***
*a) **we** will agree with them their sales approach, staff training requirements and their monitoring and reporting framework, to satisfy **us** that their staff and businesses are meeting their agreed commitments, **our** sales philosophy, and the requirements of the **Code**; and*

*b) **we** will have monitoring arrangements in place to oversee the conduct of our **Authorised Representatives** when they are acting on **our** behalf, such as mystery shopping, independent audits and analysis of key data such as sales results, lapses, claim declines and **Complaints**; and*
*c) we will report to the Life CCC, FSC, ASIC and APRA on key data, such as sales results, lapses, claim declines and **Complaints**.*

4.7 Policies as add-ons to other products
Again, we refer to and adopt the comments in the CALC/FRLC submission about add-on life insurance policies.

4.8 Advice on Risks of Replacement Cover
The risks to be explained to be expanded to by including the following words to the end of the provision

"*pre-existing condition exclusions, disclosure obligations and risks of avoidance for non-disclosure*"

5.2 Communications with beneficiaries
This communications regime is not appropriate in the context of underwritten cover. In such cases, the applicant will have supplied information to the insurer (possibly via a third party) and will have an expectation of getting cover. It is too risky to leave responsibility for communicating the outcome of the underwriting decision to the policy owner, particularly given that some policy owners will be unfamiliar with financial services (for example, employers, sports clubs and associations, and SMSF trustees).

The provision should be redrafted as follows:-

*Where the **Policy-owner** applying for cover is different from the **Life Insured, our** commitments below to communicate with **you** will be made to both **you** and the **policy owner**. However, **we** will not communicate medical information about a **Life Insured** to a **Policy-owner** unless **you** have given consent for this.*

5.3 Explanation of Duty of Disclosure
The obligation should extend to explaining the consequences of non-disclosure. The provision should be redrafted as follows:-

> *At the start of the application process, before asking **you** any underwriting questions, **we** will explain the duty of disclosure and the potential consequences of non-disclosure to **you**.*

5.10 Errors in an application for insurance
It is difficult to see what purpose this provision serves. If an insurer has information before it that demonstrates that information provided is in error, it can either resolve the issue prior to making a decision on the application or it cannot rely on the error after cover is granted (see s21(2)(c), s21(3) and s27 of the *Insurance Contracts Act*). If the provision is to remain, it should be amended as follows:-

> *If **we** become aware during the application process of any errors or mistakes in the application or the information **we** have asked for, **we** will address these promptly and in any case prior to cover commencing. ~~**We** may require additional information based on these errors or to implement corrections.~~*

The second sentence is superfluous and could be taken to suggest that an insurer's right to deal with manifest errors does not stop at the commencement of cover.

5.17 Anti-discrimination
There is an existing problem with insurers discriminating against people suffering mental illness. Given the increasing understanding of the widespread incidence of mental illness in the community, and of the ability of people who have suffered mental illness to recover and lead productive lives, insurers' underwriting practices (which often refuse any cover for people with a history of mental illness) are out of date and discriminatory. The provision should be amended, as follows:-

> ***Our** decisions on applications for insurance will comply with the requirements of anti-discrimination law. **Our** decisions will be evidence-based~~, involving relevant sources of information where this is available, and having regard to any other relevant factors where no data is available and cannot reasonably be obtained~~. **We** will regularly review **our** underwriting decision-making processes to ensure **we** are not relying on out-of-date or irrelevant sources of information.*

5.20 Non-disclosure
There is an existing problem where insurers make non-disclosure allegations without providing a complete set of the records they had prior to cover commencing, The provision needs to be amended to include a new (a):-

*a. **we** will first provide **you***
   i. a copy of all information provided or obtained during the application and underwriting process
   ii. all records of the underwriting process
   iii. a copy of the relevant part of any underwriting guide

   *and then **we** may;*

6.3(c) Communication during the term of the policy
See comments for 4.8 above.

6.6 – 6.7 Cancellation rights
These provisions needs to be improved to ensure that

a. communications go to the life insured or beneficiary directly as well as to the policy owner
b. insurers will not treat a policy as having ended for failure to pay a premium when, at the time the premium was due or when the notice was sent, the policy owner, life-insured or beneficiary was seriously unwell, or unable to communicate with the insurer due to circumstances beyond their control.

8.3 When you make a claim
Many insurers and superannuation funds refuse to provide direct contact details for the claim assessor. This causes huge delays. It is not uncommon to be kept on hold for longer than half an hour before being transferred to the claims assessor, who often has their phone diverted to voicemail. The provision should be amended as follows:-

> *Within ten **business days** of being notified that **you** wish to make a claim, **we** will explain to **you your** cover and the claim process, including why **we** request certain information from **you** and any waiting period before payments will be made. **We** will give **you** contact details that **you** can use to get information about **your** claim, including a direct phone number and email address for your claim assessor.*

8.4 Updates during a claim
There is an existing problem with lots of time being soaked up with meaningless updates like 'it is under review'. The time frame for response to requests for updates should be five business days, not ten, and must include a record of what action has been taken since the last update was given. The provision should be amended as follows:-

> *Unless otherwise agreed with **you** or the **Group Policy-owner**, **we** will keep **you** informed about the progress of **your** claim at least every 20 **business days**. **We** will respond to **your** requests for information about **your** claim within ~~ten~~ **five business days**. **Our** response will include a record of what action has been since the last update was given.*

8.8 Third-party service providers
This provision needs to be amended to provide a solid remedy for delay. The insurer should be required to determine the claim in the absence of the report if it is not provided within 4 weeks. The provision should be amended, as follows:-

> *If **we** request a report from a **Third Party Service Provider, we** will ask for the report to be provided to **us** within four weeks of the date of request or the date of **your** appointment (if **you** are required to attend one). If the **Third***

Party Service Provider *fails to meet this timeframe,* ***we*** *will* ~~*inform* ***you*** *of this, and keep* ***you*** *informed of* ***our*** *progress in obtaining the report*~~ *proceed to determine the claim in the absence of the report.*

8.9(f) Delay in income protection claims
Irregular payments and delays are a serious problem with income benefits. This clause should be removed and replaced with the following:-

(f) Where you are receiving payments from us we will not delay a payment or cease paying you until such time as we have decided that you are no longer entitled to the benefit, and such decision will be communicated to you in writing no less than 30 days prior to the date your last payment is made.

8.10 Medical examinations
A doctor selected and paid by an insurer is not independent and will not be rendered independent by the signing of a statement. Rather than continuing to pretend these doctors are independent, they should be identified for what they are – insurer's medical examiners. The provision should begin with the following words to remedy the illusion of independence:-

A doctor or medical examiner retained or paid for by ***us*** *or by others acting on our instructions will be referred to as an 'insurer's medical examiner'.*

And then references to 'independent medical examiner' should be replaced with 'insurer's medical examiner'.

8.10(d) Medical Examinations
This does not resolve the problem of independence. An alternative provision which do a better job of solving the problem is

if ***you*** *request, instead of attending an insurer's medical examination* ***you*** *can seek to reach agreement with us about which doctor examines* ***you*** *and about the list of questions to be put to the doctor. If agreement is reached, instructions to the doctor will prominently state that the doctor has been retained jointly by* ***you*** *and* ***us*** *and you may at your discretion choose to contribute an amount of your choosing towards the costs of the assessment and report. If agreement cannot be reached,* ***we*** *may proceed with an insurer's medical examination.*

8.11 Interviews
There is an existing problem with insurers trying to take back from claimants control over how they make their cases. One way they do this is by replacing written claims with interrogations – usually described as 'interviews'. Interviews are particularly problematic for people suffering mental illness, people who have poor English, and people with poor education. There needs to be an explicit protection against compulsory interviews:-

We *will not require you to undergo and interview unless* ***we*** *are unable to obtain the information that we need in writing or by obtaining documentary evidence.*

8.11 Surveillance
Surveillance causes distress and can make mental illness worse. It is not appropriate except where dishonesty is suspected on reasonable grounds. Further protections need to be added:-

> *j) surveillance will only be arranged where **we** reasonably believe prior to carrying out the surveillance that **your** ~~claim appears to be inconsistent with~~ have been dishonest in the information you have made available to **us**, and **our** reasons for this will be documented;*
>
> *m) surveillance will not be conducted in cases where the condition claimed is a mental illness.*

8.13 – 16 Time limits
Delay is probably the biggest problem with life insurance claims at the moment. These protections do not go nearly far enough. Slater and Gordon's data on hundreds of TPD and IP claims approved in the 2015 financial year show that around half of all claims were accepted *later* than the 6 month time period set for TPD claims in 8.16. That suggests that either the industry must substantially improve its performance, or that it accepts that exceptional circumstances apply in about half of all cases. If the latter is the case, those circumstances could hardly be called 'exceptional'.

The current definition of 'exceptional circumstances' basically covers all of the usual claims management process, and needs a re-write to include only genuinely exceptional circumstances:-

> ***Exceptional Circumstances** means:*
>
> ~~*a) **your** claim has been notified to us more than three months after the later of the date of disability or the end of your waiting period, and there are reasonable delays obtaining evidence necessary for the assessment of **your** claim from the intervening period;*~~
>
> ~~*b) for a claim for total and permanent disability, **we** cannot reasonably satisfy ourselves on the basis of the information provided in the six months after the end of your waiting period that **your** condition meets the requirements of **your Life Insurance Policy**;*~~
>
> ~~*c) **we** have not received reports, records or information reasonably requested from a **Third Party Service Provider**, **your** doctor, a government agency or other person or entity (including a reinsurer);*~~
>
> ~~*d) the **Policy-owner** has disputed or taken a protracted period to consider **our** decision;*~~
>
> *e) where we cannot access information essential to the determination of the claim other than by **you** providing it, you have not responded to **our** reasonable enquiries or requests for documents or information concerning **your** claim;*
>
> *f) there are difficulties in communicating with **you** in relation to the claim due to circumstances beyond **our** control;*
>
> *g) there is a delay in the claims process that **you** have requested; or*
>
> *h) the claim is fraudulent or **we** reasonably suspect fraud.*

The Code also needs to set out the consequences of undue delay. If there are not exceptional circumstances (within the revised and more limited definition set out above), the claimant should be able to treat the claim as declined and access the full range of dispute resolution options.

8.13 Time limits
The provision needs to be amended to remove the 'get-out-of-jail-free card'. Examples of exceptional circumstances are superfluous, because it is a defined term.

> *8.13 All efforts will be made to meet the timelines required by the **Code**. However, timeframes for making claims decisions can be affected by factors outside **our** control (**Exceptional Circumstances**). ~~Examples of this include the time taken by the trustee to review **our** decision for policies held on your behalf by a superannuation trustee, and the time taken by **you** or **your** treating doctor to provide information. Where **we** cannot comply with a deadline required by the **Code** due to a delay that is out of **our** control, **we** will not have breached the **Code**.~~ If there are external impacts on timeframes, **we** will inform **you** of this and keep **you** informed of **our** progress.*

The Code also needs to set out the consequences of undue delay. If there are not exceptional circumstances (within the revised and more limited definition set out above), the claimant should be able to treat the claim as declined and access the full range of dispute resolution options.

The following should be added to the end of 8.13:-

> *Where **we** do not comply with a deadline required by the **Code**, **your** claim will be deemed to be declined. If **your** claim is deemed to be declined under this clause, **we** will still be obliged to make a formal decision on your claim.*

8.15 Time Limits for Income Protection Claims
This provision needs to be amended to reduce the initial time limit to 45 days from 2 months and to reduce the further time limit from twelve months to six months, as follows:-

> *For income-related claims, **we** will let **you** know **our** decision no later than ~~two months~~ forty-five days after the end of **your** waiting period, unless **Exceptional Circumstances** apply. Where **Exceptional Circumstances** apply, **our** decision will be made within ~~12~~ six months. **We** will let **you** know the reasons for the **Exceptional Circumstances**, and if **you** disagree **we** will review this.*

8.16 Time Limits for Lump Sum Claims
This provision needs to be amended to reduce the time limit from 6 months to three months, in accordance with court decisions stating that period should be sufficient for claims to be determined, as follows:-

> *For all claims other than income-related claims, **we** will let you know **our** decision no later than ~~six~~ three months after **we** are notified of **your** claim or*

*the end of any waiting period, unless **Exceptional Circumstances** apply. Where **Exceptional Circumstances** apply, **we** will keep you informed of our expected timetable. **We** will let **you** know the reasons for the **Exceptional Circumstances**, and if **you** disagree **we** will review this.*

8.21 Discontinuance of Income Protection Payments
This provision should be removed in light of the amendment to 8.9(f).

8.22(b) Discontinuance of Income Protection Payments
This provision should be removed in light of the amendment to 8.9(f).

8.26 Rehabilitation
Rehabilitation must not delay determination of a claim or payment of benefits. There needs to be an explicit provision that none of these steps will delay determination of claims:-

> *As signatories to the Australian and New Zealand Consensus Statement for the Health Benefits of Good Work, for income-related claims **we** will take the following steps, unless any of them might result in a decision on **your** claim being delayed:*

9.10 Complaints about superannuation-based insurance decisions
By the time a claim has been rejected and complaint made, there is no good reason for response to a complaint to take longer than 90 days. There should be a time limit of 45 days for the insurer to respond to the trustee:-

> ~~*Where possible,*~~ ***we** will respond to the superannuation fund trustee within 45 days so that it can provide a final response to **your Complaint in writing** within 90 calendar days of the superannuation fund trustee receiving **your Complaint**. **You** will be informed of:*

9.10(c) Advice about dispute resolution schemes
The SCT is a jurisdiction characterised by gross delays and bad outcomes for complainants. Claimants should also be advised of their right to take their case to Court:-

> *that **you** may have the right to take **your Complaint** to Court or to the Superannuation Complaints Tribunal (**SCT**) if **you** are not satisfied with **our** decision and the timeframe within which **you** must take **your Complaint** to Court the **SCT**; and*

9.12 Advice about dispute resolution schemes
FOS is a jurisdiction that is often bureaucratic and has a patchy quality of decision making. Claimants should also be advised of their right to take their case to Court:-

> *c) **your** right to take **your Complaint** to Court or the Financial Ombudsman Service (**FOS**) if **you** are not satisfied with **our** decision, and the timeframe within which **you** must take **your Complaint** to Court or to **FOS**; and*

9.14 Advice about dispute resolution schemes

All dispute resolution options should be disclosed:-

> ***FOS*** *is available to customers and third parties who fall within the* ***FOS*** *Terms of Reference. The* ***SCT*** *is available to customers and third parties whose complaints are covered by the Superannuation (Resolution of Complaints) Act 1993. Court is available to all claimants.* ***You*** *may seek independent legal advice and access any other external dispute resolution options that may be available to* ***you.***

10 Third-party service providers

Delays caused by third party service providers are dealt with by removing them from the definition of 'exceptional circumstances'.

10.9 Standards for Investigators

Dishonesty by investigators is an existing problem in the industry. The provision should be removed and replaced with the following:-

> ***We*** *may engage an investigator to assist* ***us*** *with* ***your*** *claim. If* ***we*** *engage an investigator, in addition to the above obligations,* ***we*** *will require that:*
> *a) surveillance can only be carried out by a licensed private investigator and they must comply with any relevant State and Territory legislation;*
>
> *b) the investigator does not use dishonest, unethical or illegal means to carry out the investigation;*
>
> *c) conduct any form of pretext activity for the purposes of encouraging activity or behaviour that could be used to decline* ***your*** *claim;*
>
> *d) the investigator only collects information relevant to its investigation;*
>
> *e) the investigator acts in accordance with the standards relating to interviews and surveillance at 8.11; and*
> *f) records of all investigation activities are kept.*

14.5 Access to information

This provision is drafted to give the insurer too much discretion about when it may refuse to release information. 'Special circumstances', is not defined. Commercial-in-confidence is ill-defined and should not the basis for any claim that records cannot be provided. This provision should be amended as follows:-

> *~~In special circumstances,~~* ***we*** *may decline to provide access to or disclose information to* ***you****~~, such as~~ in the following circumstances only:*
> *a) where we are prevented from disclosing information ~~is protected from disclosure~~ by law, ~~including the Privacy Act 1988~~;*
>
> *b) where* ***we*** *reasonably determine that the information should be provided directly by* ***us*** *to* ***your*** *doctor;*
>
> *~~c) where the release of the information may be prejudicial to **us** in relation to a dispute about **your** insurance cover or **your** claim, or in relation to **your** **Complaint**; or~~*
>
> *~~d) where **we** reasonably believe that the information is commercial-in-confidence.~~*