FINANCIAL SERVICES COUNCIL

Life Insurance Code of Practice

Consultation draft | 18 August 2021

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The Life Insurance Code of Practice

Subscribers to the Code make 10 key promises

The 10 promises are:

1. We will be honest, fair, respectful, transparent and timely when we communicate with you, and we will use plain language where possible.
2. We will ensure our staff and Authorised Representatives use appropriate sales and retention practices.
3. We will offer extra support if you have trouble with the process of buying insurance or claiming.
4. If we find that an inappropriate sale has occurred, we will talk to you about fixing it, such as by issuing a refund or replacement policy.
5. When you make a claim, we will explain the process and keep you informed about our progress assessing it.
6. We will decide on your claim within the Code's timeframes. But if we cannot, we will explain why and tell you how to make a formal Complaint.
7. If we decline your claim, we will explain why in writing and let you know what to do if you disagree.
8. We will restrict the use of investigators and Surveillance to preserve your legitimate right to privacy.
9. The independent Life Code Compliance Committee (Life CCC) will monitor our compliance with the Code.
10. We will be accountable for Code requirements, and the Life CCC can sanction us.

1 This Code of Practice

Aims of the Code

The Code protects life insurance customers

1.1 The Financial Services Council (FSC) has voluntarily developed the Code to protect you, the customer. We are bound by the Code and its goal is to ensure that we:

a) deliver a high standard of customer service throughout your relationship with us
b) continuously improve the services we offer you
c) communicate with you in plain language where possible
d) seek to increase consumer trust and confidence in the life insurance industry as a whole.

1.2 The Code also outlines our obligations during the life insurance process, including when:

a) you buy a policy, make a claim or deal with us
b) we deal with claims, Complaints and requests for information, or help you if you experience financial hardship or need extra support.

1.3 We will make sure you know about the Code by including details on our Website, and telling you how you can access the Code when we receive your claim or Complaint. The FSC also promotes the Code to customers through its members, and we will work with the FSC to do this.

1.4 This version of the Code will take effect no later than [TBA] and replaces the previous version. It applies to all interactions we have with you – including about an existing claim or Complaint – from that date or the date we are bound by the Code, whichever is later. But it does not apply to interactions we had with you before we were bound by this version of the Code.

1.5 The Code does not limit your rights under any existing laws and regulations. We acknowledge that a contract of insurance is based on the principle of utmost good faith which requires both us and you to act honestly and fairly towards each other, and for us to have due regard for your interests.

Seven key principles apply to products and services under the Code

1.6 Seven principles apply to the products and services the Code covers. These inform the key promises in the next section:

a) clarity
c) transparency
d) fairness
e) respect
f) honesty
g) timeliness, and
h) plain language.

Scope of the Code

The Code applies to Australian life insurance

1.7 The Code covers Life Insurance Policies issued in Australia, including policies commonly called:
- a) term life or death and terminal illness insurance
- b) total and permanent disability (TPD) insurance
- c) trauma or critical illness insurance
- d) disability insurance
- e) income protection or salary continuance insurance
- f) business expenses insurance
- g) Funeral Insurance and funeral expenses insurance, and
- h) consumer credit insurance (CCI), if issued by a life insurer.

Other insurances and circumstances are not covered

1.8 The Code does not cover:
- a) whole-of-life and endowment insurance products
- b) products issued by general insurers
- c) health insurance products issued by health insurers, or
- d) annuities and investment life products, as defined in sections 9(1)(c), (d), (f) and (g) of *the Life Insurance Act 1995* (the Act).

1.9 It also does not cover other products issued by an entity that is not:
- a) registered as a life insurance company with the Australian Prudential Regulation Authority (APRA) under the Act, or
- b) authorised to issue Life Insurance Policies under the Act.

1.10 The Code does not apply to the following entities, unless they have adopted it:
- a) superannuation fund trustees
- b) financial advice companies or financial advisers, or
- c) other industry participants.

1.11 Sections of the Code that do not apply to certain parties will be clearly stated.

Insurers and third parties

Insurers will follow the Code

1.12 The FSC Website lists the organisations that subscribe to the Code and any brands they use (see www.fsc.org.au/policy/life-insurance/code-of-practice). The FSC works with the Life CCC, regulators and stakeholders to encourage all life insurers, Reinsurers and relevant industry bodies in Australia to adopt it.

1.13 The Code binds:
- a) FSC members who are registered life insurance companies issuing Life Insurance Policies
- b) other FSC members who are authorised to issue Life Insurance Policies, and
- c) any other industry entity that formally agrees with the FSC and Life CCC to adopt the Code.

1.14 The Code also sets responsibilities for the Life CCC, which monitors and enforces our compliance with the Code.

1.15 As we have adopted the Code, we will ensure that our staff and Authorised Representatives comply with it when they are acting for us. Certain standards also apply to Distributors and these can be found at clauses 2.11 and 2.19.

1.16 FSC members who are Reinsurers are bound by the principles in clause 1.6. They will comply with the Code if they:

a) comply with these principles, and
b) help us meet our commitments under the Code.

1.17 Before we enter an agreement with a Reinsurer who is not an FSC member and has not formally adopted the Code, we will take reasonable steps to satisfy Ourselves that they will:

a) comply with the principles in clause 1.6, and
b) help us meet our commitments under the Code.

Independent Service Providers will meet Code conditions

1.18 We may use Independent Service Providers to help us underwrite and administer policies, and manage claims. If we do, any service agreements we enter or renew after we are bound by the Code will meet the Code's standards relevant to the services they provide.

1.19 This means we will require providers to:

a) follow the principles in section 1.6 when dealing with you and us
b) get our approval before subcontracting their services
c) tell us if you make a Complaint about their services, such as an application for cover or a claim they are involved in, and
d) keep your information confidential, and only use that information for the purpose of the service they are providing.

1.20 If the provider is a medical assessor or examiner, we will require them to comply with the Australian Medical Association's Ethical Guidelines on Independent Medical Assessments, or an equivalent international guideline for providers overseas.

1.21 If you make a Complaint about an Independent Service Provider, we will follow our internal Complaints process unless we are satisfied they have a comparable process of an equivalent standard.

1.22 We will only enter contracts with providers who:

a) reasonably satisfy us of their expertise, experience, qualifications and integrity, and
b) hold any required federal, state, territory or industry licences.

1.23 Our contracts with them will refer to the relevant state or territory Expert Witness Code of Conduct.

1.24 We will seek impartial and objective medical reports from treating doctors, allied health professionals or Independent Service Providers and we will take all details in the report into account.

2 Policy design, advertising and sales standards

Policies we design will be clear, easy to understand and up to date

2.1 We will design products which:
  a) are designed to meet a genuine need of consumers in the target market, and
  b) are likely to be consistent with the likely objectives, financial situation and needs of consumers for whom the product is designed (known as the target market).

2.2 We will periodically review the target market so that policies are distributed to the relevant class of consumers who have a genuine need for the policy in light of its design.

2.3 When we design and introduce new Life Insurance Policies, we will:
  a) use plain language in our sales and policy information where possible
  b) consumer-test the plain language information required in clauses 3.5 and 3.8 which deals with policy documentation and yearly statements, and
  c) provide clear information to help customers make informed decisions, especially for policies that are available for new customers to buy without a financial adviser, planner or Group Policy Owner, and
  d) ensure products are designed with a view to meet a genuine need of consumers in the target market, and which are likely to be consistent with the likely objectives, financial situation and needs of consumers of the target market.

Updating Medical Definitions

2.4 For policies available to new customers where benefits are payable after a defined medical event, we will review all medical definitions at least every 3 years, with help from relevant medical specialists.

2.5 We will update these medical definitions if needed and tell you when we do.

2.6 When we design and introduce new policies that depend on the amount you earn when you make a claim, where we increase your benefit each year to match inflation, we will link the increase to an index that broadly reflects wage growth in Australia.

2.7 We will tell you that you can opt out of these increases.

2.8 Clauses 2.5–2.7 do not apply to cover under a Group Policy.

Advertising and sales practices

Advertising will meet certain standards

2.9 When we advertise and market our Life Insurance Policies, we will ensure that:
  a) our advertising will be clear and not misleading
  b) any images we use do not detract from or reduce the prominence of any statements
  c) any price or Premium we refer to is consistent with what members of the campaign's target audience will likely pay
  d) any specific circumstances a benefit depends on are clear
  e) any phrases like 'free' or 'guaranteed' are not likely to mislead
  f) short-term incentives that are not part of the policy, such as gift cards or reward points, do not encourage customers to buy the policy solely for these incentives
  g) we comply with the relevant laws, ASIC regulations and guidance on advertising financial products and services, and on unsolicited sales, and

h) any information in our advertising campaign is consistent with the product design and the target audience for whom the product has been designed to meet their genuine consumer needs and the disclosures in any corresponding Product Disclosure Statement.

Staff and Authorised Representatives will follow good sales practices

2.10 We will have clearly documented sales rules to ensure our salespeople and Authorised Representatives sell our policies appropriately and do not use unacceptable practices such as Pressure Selling.

2.11 We may use a Distributor to sell our policies. If we do, we will take reasonable steps to ensure that they do not use Pressure Selling.

2.12 Our sales rules will include:
a) what information we or our Authorised Representatives will give you about the policy's Premium, features, benefits, exclusions, limits and cooling-off period
b) how to identify if you are unlikely to ever be eligible to claim a policy's benefits and, if so, not sell you the policy
c) when they must stop selling if you indicate you do not want a Life Insurance Policy, and
d) how to keep records that you agreed to buy the policy.

2.13 We will monitor our staff's compliance with these rules through:
a) quality assurance measures such as call monitoring, mystery shopping and post-sale customer surveys
b) analysis of and reports on key data, such as sales results, lapses, declined claims and Complaints.

2.14 We will agree with our Authorised Representatives their sales approach, staff training requirements, and monitoring and reporting framework so we are satisfied that their staff and businesses meet:
a) their agreed commitments
b) our sales rules, and
c) the Code's requirements.

2.15 We will also monitor our Authorised Representatives' conduct through arrangements such as:
a) mystery shopping
b) independent audits, and
c) analysis of key data, such as sales results, lapses, declined claims and Complaints.

Insurers will provide appropriate sales training

2.16 Our staff and the staff of our Authorised Representatives who sell our policies will receive ongoing role-appropriate training, as Well as extra training to correct any shortcomings we find.

2.17 The training will cover:
a) The customer perspective
b) our Life Insurance Policies and the characteristics of customers in the target audience
c) acceptable and unacceptable sales practices
d) the legal duties owed to customers that they have when they provide personal advice, and
e) the Code's relevant standards.

2.18 We will ensure our salespeople's remuneration is consistent with good customer outcomes and complies with relevant laws. This includes having compliance performance measures in

any staff sales incentive programs, with consequences for unacceptable sales practices, such as Pressure Selling or inappropriately using deferred Premiums or cooling-off periods.

2.19 If we use a Distributor, we will ensure that their processes and procedures are consistent with good customer outcomes and the Code's relevant obligations that apply to the activities we have contracted them to do.

Insurers will investigate concerns about sales practices

2.20 We will investigate any concerns raised or identified about the sales practices of our employees, any Authorised Representative or any Distributor.

2.21 If we find out that any of our employees, Authorised Representatives or Distributors have made an inappropriate sale, we will talk to you about fixing it and we will fix the issue by:

a) cancelling your policy
b) refunding your Premiums
c) paying you interest on the refunded Premiums
d) adjusting your cover or arranging for more suitable cover
e) correcting information
f) honouring a claim
g) another measure appropriate to the circumstances, and/or
h) saying sorry.

2.22 If we find out that any of our employees, Authorised Representatives or Distributors have made an inappropriate sale, we will also correct the practice, including where appropriate with further education and training.

2.23 Where we contact you about an inappropriate sale and how we will fix it, we will consider the method you prefer where practical, in line with clause 3.1.

2.24 If you tell us you are not satisfied with the remedy we propose, we will review it and tell you:

a) that you can ask us to review any remedy we propose
b) how to make a Complaint.

Insurers will have rules for direct sales

2.25 A direct sale occurs when a consumer contacts us to buy a Life Insurance. Where these sales are made verbally or face to face, we will have sales rules that state we will:

a) periodically, as appropriate, ask if you understand the information the salesperson has given you
b) allow you time to ask questions
c) give you information to help you decide how much cover you want
d) tell you at the start of the application process that you are now applying to buy a Life Insurance Policy, and ask for your explicit agreement to proceed
e) not sell you the policy or take your payment details if you ask for time to think about the policy before applying, and offer to set up a call or meeting to discuss it later, and
f) that sales staff should never take advantage of vulnerable customers and when to stop selling.

2.26 If you are not eligible for the policy and we offer a different policy instead, we will give you details about it including the PDS and offer to set up a call or meeting to discuss it later.

Funeral Insurance will be clearly explained

2.27 If we offer you a Funeral Insurance Policy, we will clearly explain in plain language:

a) that it is an insurance policy not a savings plan, and what this means
b) the benefits you are entitled to
c) how your beneficiaries can claim these benefits when you die

d) any pre-existing medical condition exclusions and how they apply
e) any period during which your policy only pays out if you die in an accident
f) that you can cancel at any time and what happens if you do so after the cooling-off period, including if we will refund Premiums
g) level and stepped Premiums, and an illustration of how they might go up if stepped
h) that the total Premiums you pay could be more than the benefits we pay, if applicable, and
i) what happens if you stop paying your Premiums, including if we refund them.

2.28 If you purchase a Funeral Insurance Policy from us, we will let you choose level or stepped Premiums if stepped Premiums are offered. Along with the key facts sheet, we will explain:

a) If you purchase a Policy with stepped Premiums, how stepped Premiums may increase, along with a warning about future affordability if your income changes, such as when you retire or enter aged care, and
b) what will happen if you allow the policy to be cancelled.

2.29 Some Funeral Insurance Policies require little or no Premium to be paid initially. In these cases, we will:

a) tell you before the policy starts what the first full Premium is or we estimate it will be
b) give you 10 to 20 Business Days' notice of when we will collect the first full Premium
c) not collect the first full Premium until we provide such notice, and
d) provide you with a 30–calendar day cooling-off period from the day you pay your first full Premium

Insurers will clearly explain consumer credit insurance (CCI)

In some cases, you may purchase a CCI Life Insurance Policy together with a credit product. If you do, unless there is an exemption we will not offer or sell to you the CCI Life Insurance Policy until 4 days after you have purchased the credit product. This is known as the 'deferred sales period' which is required by law in certain instances.

We can still provide you with factual information about CCI for you to consider during the deferred sales period.

2.30 Before you buy CCI with us or through our Authorised Representative or Distributor, we or They will give you clear information to help you make an informed decision. This will include:

a) the cost, as Well as any interest you will pay on the Premium
b) the monetary limits on the key benefits payable
c) the period you would be insured for, and
d) the date your insurance ends, if different from the date the underlying credit product ends.

2.31 We will only sell you CCI if you give us your explicit consent to do so. If we do, we will allow you to change your mind and get a full refund within 30 days in line with Clause 4.33.

2.32 If the CCI Life Insurance Policy is an add-on to a loan and you can pay the Premium through the loan, we will give you at least 1 non-financed payment option, such as a monthly direct debit.

2.33 If the CCI Life Insurance Policy is an add-on to a loan and the Premium is paid through the loan, we will tell you that you will pay interest on the Premium, and your initial loan repayments will be shown with and without the Premium to compare.

2.34 Clauses 2.32 and 2.33 do not include CCI that protects a credit card, line of credit facility or overdraft where the Premium is charged regularly to that card, credit facility or overdraft. In these cases, the information we give you in clause 2.30 may not include the cost or any interest you will pay on the Premium.

3 Communicating with you

Documents and notices

Communication will vary based on policy type and owner

If your application requires an Underwriting decision, we will send all communications about the Underwriting decision to the Policy Owner.

3.1 We will use the method you prefer where practical, unless the Code specifies that we will communicate with you in writing. We will comply with this requirement if we communicate with the Applicant, Policy Owner, Group Policy Owner, Life Insured, Third Party Beneficiary or Representative. This may be:

a) verbal, such as face to face or by phone, or
b) in writing, such as by mail, email, text message or any other way the law or a regulation allows.

3.2 If you are not the Policy Owner, we will not share your personal information with the Policy Owner without your consent, in line with privacy and confidentiality requirements.

3.3 If an employer or superannuation fund trustee owns the Life Insurance Policy, we will sometimes interact with them as appropriate. They will communicate with you as needed.

Insurers will provide policy information and notices in writing

3.4 Before you apply for a new Life Insurance Policy, you can read the PDS online or ask us to send you a copy. But if you ask us for a PDS we did not prepare, we will refer you to the relevant party – such as a superannuation If fund trustee or other Group Policy Owner – for a copy.

3.5 After you buy a Life Insurance Policy (but not a Group Policy), we will give you documentation including information about:

a) the types of risks we insure you for
b) how much you are insured for, if there is a fixed amount assigned to your cover, and the Premium you will pay
c) a description of how the price you pay is structured or how premiums could change, for instance whether the cover has stepped or level premiums or a single premium
d) the cooling-off period of 30 days
e) any exclusions or waiting periods that apply
f) the impact a claim could have on other benefits or income if it is relevant to your policy
g) our claims and Complaints processes
h) if benefits are payable after a defined medical event, and
i) whether benefits are payable when a medical condition is diagnosed or after you meet extra criteria.

3.6 Once you own a policy, we will send the Policy Owner a copy of your policy documents if you ask us to. But we will first meet any legal requirements for releasing them.

3.7 If we automatically upgrade your policy, we will tell the Policy Owner about any key changes, unless your policy is a Group Policy.

3.8 Before each policy anniversary, we will send the Policy Owner a notice in writing outlining:

a) what and how much we insure you for
b) an explanation for any increase in your Premiums
c) how to claim
d) the risks of cancelling and replacing your policy, and

e) how to contact us if you want to change the policy or are having trouble paying your Premium.

3.9 We will also remind you in the notice in writing, if applicable, at least once a year how the maximum you can claim depends on how much you earn at the time of claim.

3.10 Clauses 3.8 and 3.9 do not apply to CCI or Group Policies. For a CCI policy, the notice in writing we send before each policy anniversary will show:
a) the period of cover
b) the types of cover, and
c) our contact details for questions or claims.

Insurers will tell you if they cannot provide information

3.11 We will tell you if we cannot meet a deadline in the Code for giving you information because we are waiting for a third party to let us release it This will not be a Code breach if we tell you before the deadline.

3.12 If we decide not to disclose information you ask us for, we will:
a) do so reasonably
b) give you a list of the items we have not disclosed
c) give you details of our Complaints process, and
d) explain our reasoning, for example where privacy laws allow us to withhold it.

Insurers will tell you about errors, omissions or inconsistencies when they impact you

3.13 If we find that we have made an error, omission or inconsistency that impacts you, we will tell you within 10 Business Days how we will address it. We may need extra information to address it. These timeframes will not apply if the error is identified as part of a broader remediation program affecting multiple customers.

Communicating certain medical or health information

3.14 Some information about your health may be better communicated to you by your doctor. If so we will provide this information to your doctor.

4 Buying a Life Insurance Policy

Section 4 sets out what information we may require from you, such as about your health and family medical history. It is vital that you do this carefully, in line with your duty to take reasonable care. It also describes who can make the underwriting decision and what we will tell you about it.

Duty to take reasonable care

Giving you information about your duty

4.1 When you start your application for a Life Insurance Policy, we will explain:
  a) that you have a duty to take reasonable care not to make a misrepresentation when you answer our questions, and
  b) the possible consequences of not taking reasonable care.

4.2 We will ensure that you are not required to have specialist knowledge to answer our questions, but we do expect you to have a good understanding of your health, lifestyle and financial situation. We will ensure that the questions we ask are in plain language where possible.

4.3 If we ask you questions face to face or on the phone, we will:
  a) do so carefully, to help you understand what we are asking you to help you meet your duty to take reasonable care not to make a misrepresentation
  b) repeat a question as many times as you reasonably ask us to,
  c) give you time to ask questions, and
  d) ask if you have understood.

4.4 We will give you a record or summary of the answers we use to assess your application no later than 10 Business Days of the cover starting.

When you apply for Life Insurance cover, you have a legal duty in relation to the information you provide to the life insurer.

If you do not comply with your duty, the Insurance Contracts Act may allow us to vary or avoid your life insurance cover. Our options may include:

- charging a higher premium, changing the amount we insure you for, or applying an exclusion, or
- avoiding your cover, which means cancelling it as if it never existed.

Insurers will give consumers a chance to explain

4.5 Before we make a decision to vary or avoid your cover pursuant to the Insurance Contracts Act, we will send you a 'Show Cause' letter that:
  a) includes copies of any information that may be relevant to our decision
  b) explains any remedies and the impact our decision may have on your cover under the Life Insurance Policy, and
  c) gives you a chance to explain and provide any further information or documents you would like us to consider.

4.6 In line with the Code's fairness principle, we will consider any response you provide to the Show Cause letter before we make our decision.

Insurers will confirm variations or avoidances in writing

4.7 If we decide to vary or avoid your cover, we will then write to the Policy Owner to:

a) explain our decision and reasoning, including each variation or avoidance being applied
b) confirm what impact our decision has on your cover under the Life Insurance Policy
c) tell you that you can ask us for copies of the information about you that we relied on, that we will give these to you within 10 Business Days, subject to any legal requirements,
d) tell you that you can ask us to review our decision, and
e) tell you how to make a Complaint.

Underwriting decisions

Insurers can seek more information about a consumer's health

4.8 We will only ask for information about your health that we reasonably need to assess your application, such as by asking:

a) you about your health
b) a third party, such as your doctor, for a report, or
c) you to undergo a medical exam from an Independent Service Provider we choose.

4.9 If the information you give us is enough to make our decision, we will let the Policy Owner know the outcome within 5 Business Days of receiving the information.

4.10 Clause 1.20 outlines the standards that independent medical assessors or examiners will meet. While we will choose the provider referred to at clause 4.8, we will tell you that you can choose the gender of the examiner where this is possible.

4.11 If we ask you to have a medical exam with an Independent Service Provider, we will pay for:

a) the appointment, but not any fees if you miss it without a good reason,
b) any reports, and
c) any reasonable travel costs and out of pocket costs we agree in advance.

4.12 We will ask the Independent Service Provider to give us their report within 10 Business Days of your appointment.

4.13 If we ask an Independent Service Provider for a report that does not require you to attend an assessment, we will ask them to send it within 20 Business Days of our request.

4.14 If the Independent Service Provider does not meet the deadlines in clauses 4.12 and 4.13, we will tell the Policy Owner and periodically update you on our progress getting the report.

4.15 We will ask for any extra information to assess your application as early as possible and try to avoid multiple requests. We will also explain why we need it and that you can ask us to review our request. If you are unhappy with the outcome of our review, we will treat this as a Complaint.

Insurers will ask consumers for consent

4.16 We will ask for your consent to access any information about your health using the wording that the FSC and the Royal Australian College of General Practitioners agreed. You can find this wording on the FSC Website at www.fsc.org.au.

4.17 We will tell you each time we use this consent. We will contact you by phone, SMS, email or similar when possible, unless you tell us you have a different preference.

Mental health, family medical history and genetics

4.18 If you tell us about a diagnosed mental health condition or symptoms of a mental health condition you have or have had, we will:

a) allow you the opportunity to provide information about the history, severity or type of condition before making our decision about whether to insure you and, if so, the terms we offer you, and
b) take into account your circumstances such as the history, severity or type of condition, when deciding whether we can offer you cover. If we do not offer you cover, or we offer you alternative terms, we will explain to you why in line with clause 4.26.

4.19 If we ask you about any family history of illness, we will only ask you to tell us about:

a) the family history that you know about
b) your first-degree blood relatives (parents, children and siblings), without giving their names or dates of birth, and
c) their illness and age at diagnosis and/or death.

4.20 When we assess your application, we will not consider any family medical information about your family that relatives have given us about themselves, for example when they took out their own policies with us.

4.21 If you have had a genetic test, we will comply with the Moratorium on genetic tests at Appendix A:. It explains what we can ask you about the results and how we can use that information.

Underwriters will have appropriate skills

4.22 We will ensure our underwriters have the appropriate skills and training, including for mental health where applicable. They will not make decisions for us until they have shown technical competency and an understanding of all relevant laws, Code requirements, and FSC standards and guidance.

4.23 While assessing an application, our underwriters will have access to professional advice and support in relevant disciplines – such as from medical specialists and accountants – if needed.

Offering insurance

Insurers will explain the terms of any offer, including alternative terms

4.24 We will tell you if we accept your application and, if so, on what terms within 5 Business Days of:

a) receiving all the information we reasonably need, and
b) completing all reasonable enquiries, including to any Reinsurer.

4.25 If we issue temporary insurance during the Underwriting process, we will let you know what it does and does not cover, and when it will end.

4.26 If we offer you alternative terms, we will explain in plain language:

a) the alternative terms
b) that if you agree to buy the policy, we will take this as your agreement to the alternative terms
c) that you can ask us to review any alternative terms we offer now or in the future if circumstances change, and how to do so, and
d) the elements in clause 4.29.

Insurers will explain the general risks of replacing an existing policy

4.27 If you are applying for a Life Insurance Policy with us and you tell us that you are replacing an existing Life Insurance Policy, we will tell you that you shouldn't cancel any existing cover until we accept your application.

4.28 We will also explain the general risks of replacing an existing Life Insurance Policy, including, where relevant, the:
a) loss of any accrued benefits
b) possibility of waiting periods starting again, and
c) implications of any errors or omissions in your new application.

Insurers will share information they relied on to make decisions

4.29 If we do not offer you insurance, we will explain to you in plain language:
a) the reasons for our decision
b) that you can ask us for the information about you that we relied on to make this decision
c) that you can contact us if you think the information we relied on is incorrect or out of date
d) that you can ask us to review our decision or give us extra information to consider, and
e) our Complaints process.

4.30 We may sometimes learn information about you that could be significant to your health or that you may not know about. If this is the case, we may give the information in clause 4.29 to your treating doctor to explain to you.

4.31 If you ask us for the information about you that we relied on in clause 4.29, we will give it to you or your doctor within 10 Business Days. But clauses 3.11 and 3.12 apply.

Policy cancellations

Customers can cancel policies they do not want

4.32 We will tell the Policy Owner that they have at least 30 calendar days from the day they buy the policy to change their mind and get a full refund, unless the duration of cover is designed to be 3 months or less, in which case we will provide a refund in line with the terms of the policy. This is the cooling-off period.

4.33 In line with the policy terms, we may owe the Policy Owner a refund when they cancel the policy. If so, we will send them any money we owe within 15 Business Days.

4.34 We will not pressure you to keep a policy you no longer want.

4.35 If we cancel a policy because the Policy Owner has not paid the Premiums, we will let them know if there is an option to reinstate the policy. If this reinstatement is at our discretion, we may ask for extra information.

4.36 Clauses 4.32–4.35 do not apply to cover under a Group Policy, as the Group Policy Owner is responsible for communication about changes.

5 Claims

Communication during a claim

Insurers will work with you throughout the claims process

5.1 We acknowledge that claims time is difficult for you and that each situation is unique. We will treat you with empathy, compassion and respect throughout the claims process.

5.2 We will not discourage you from making a claim.

5.3 If you tell us that you are having trouble providing the information we need, we will work with you to try to find a solution. This may mean that we try to collect it for you.

5.4 If you make an income-related claim because you are ill or injured and cannot work, if we consider it appropriate, we will:

a) ensure you have an assigned claims assessor throughout the claims process
b) identify and act upon ways to support your recovery early on
c) identify and act upon ways to encourage best practice rehabilitation and return to work programs, and
d) work with your doctor, other healthcare providers and your employer to improve your health.

Insurers will keep in regular contact about claims

5.5 Within 10 Business Days of the Claim Received Date, we will tell you:

a) how you can access the Code, in line with clause 1.3
b) about your cover and any waiting periods that may apply
c) about all of the relevant benefits under the Life Insurance Policy you are claiming on, and
d) about the claims process and who to contact for more information.

5.6 We will update you on your claim's progress at least every 20 Business Days, unless you, the Group Policy Owner or your Representative agrees to a different timeframe. We will do this until:

a) we have made a decision, or
b) started the Show Cause or Procedural Fairness process.

5.7 If you ask us for information about your claim at any point, we will respond within 10 Business Days.

5.8 If your benefit period for income-related payments is expiring, we will tell you at least 3 months before your last payment is due to be made. If you are no longer eligible for payments, we will tell you as soon as possible.

5.9 If there is a change in the definition under which you are being assessed after a stated period of time, we will also:

a) give you at least 3 months' notice, and
b) try to do the assessment before the change takes effect so your income is not disrupted if you are still eligible.

5.10 If the benefit you are insured for is going to reduce (except for where offsets or partial payments reduce your benefits), we will give you at least 3 months' notice.

5.11 If you make a claim that is covered by a Group Policy, we may be required to communicate with the Group Policy Owner. If the trustee asks us to communicate with them, we will agree

with them the relevant communications to send them. We or they will let you know who will contact you and help with your claim.

Required information

Insurers will ask you to provide information or agree to it being collected

5.12 Every time you make a new claim, we will ask for your consent for us to collect information about you, such as about your finances, job or health. We may ask you to consent to us requesting information from more than 1 source. We will tell you each time we use your consent by phone, SMS, email or similar when possible, to ensure you know quickly. If you do not agree that we need some of this information, we will review our request.

5.13 We will ask for the information we reasonably need from you and third parties as soon as possible and will avoid multiple information requests over time where possible.

5.14 When we assess your claim, we will respect your privacy by only asking for information we reasonably need to make our assessment. We can fully investigate the history of any condition you are claiming for. We will only try to verify the information you gave us when you applied for cover about conditions that are not related to your claim if we have reasonable grounds. We will explain those grounds and how you can make a Complaint.

5.15 If you tell us that you do not agree that the grounds are reasonable, we will review them. We will tell you the outcome of our review and how you can make a Complaint.

5.16 From time to time, we may use information that is available online about you. If we do this, we will do so within the relevant laws and regulations and only rely on information that is in the public domain.

5.17 For income-related claims, such as for income protection or business expense cover, we:

a) may need medical and financial information regularly to assess if you are entitled to ongoing benefits or calculate your benefit payments
b) will not ask you for a statement from your doctor more often than we reasonably need to assess your condition
c) will not ask your doctor for a statement solely to process your regular benefit payment,
d) will only request financial information if we need it to assess if you are entitled to benefits or calculate the amount, and
e) may ask your doctor for information every 6 months, even if your condition is stable.

Medical exams

5.18 If we ask you to have an independent medical examination we will tell you that you can ask us:

a) for a list of doctors to choose from, and
b) to include at least 1 doctor of each gender on the list where practical.

5.19 Clause 1.20 outlines the standards that independent medical examiners will meet.

5.20 If the doctor you choose has limited availability, we will tell you that this may delay your claim.

5.21 If we ask you to have a medical examination, we will pay for:

a) the appointment, but not if you miss it unless we are satisfied you had a good reason for missing it,
b) any reports, and
c) any reasonable travel and out of pocket costs we agree in advance.

5.22 We will avoid asking for more than 1 examination from the same type of specialist within 6 months, where possible. But if we do, such as for a claim for terminal illness or where superannuation law requires, we will tell you why.

5.23 We will ask the doctor to give us a report within 20 Business Days after our request or your appointment, if you need to attend one. You can ask us for a copy, and we will send it to you or to your doctor if we think that is more appropriate. If the doctor fails to meet this timeframe we will inform you of this and keep you informed of our progress in obtaining the report.

Interviews

5.24 If we ask you to be interviewed (not an independent medical examination) to establish some facts, we will check our records before we hire an interviewer to see if you need one who speaks your preferred language, or a support person or interpreter to attend. If you do need an interpreter, we will pay for it.

5.25 We will arrange an interviewer that:

a) is a certain gender, if you ask and one is reasonably available
b) we are satisfied has the appropriate training and experience to discuss a claim involving a mental health condition, if relevant
c) can help if you have limited English, or
d) can help if you have known cognitive decline or impairment.

5.26 We will tell the interviewer to contact your Representative before arranging the interview with you if you have asked us to communicate with your Representative.

5.27 You can ask us to be interviewed at a place we both agree to outside your home, unless interviewing you at your home is essential to establishing your entitlement to a benefit. If it is, we will explain why.

5.28 Before the interview, you will receive a key information sheet that explains the process and your rights, including:

a) that we will provide a record of the interview,
b) that you can have a Representative or support person with you,
c) how to make a Complaint, and
d) Whether the interview will be recorded. If you ask us, we will give you a copy.

5.29 At the start of the interview, the interviewer will:

a) tell you who they are, what the interview is for, how long it should take and what it will cover, and
b) explain that they are acting for us.

5.30 We will ensure that all interviews are conducted respectfully and take no more than 90 minutes, unless you agree to an extension.

5.31 We will offer you a 5 minute break at least every 30 minutes during the interview, and you can ask for more breaks or to end the interview early.

5.32 The interviewer will end the interview right away if it becomes clear that you need a support person or interpreter and do not have one.

5.33 We will arrange another interview if we reasonably need it, but not within 24 hours of the first one unless you agree.

5.34 If you withdraw your claim after an interview, a different person will contact you to discuss your reasons and ask if you would like to restart your claim.

Restricting the use of surveillance

5.35 If we have reason to believe that the information we have about your claim is inconsistent with other information available to us, we will try to resolve those inconsistencies without using Surveillance by an investigator.

5.36 If Surveillance is justified, we will document the inconsistencies and ask a senior member of our team to review and approve it.

5.37 If approved, we may appoint an investigator to help us with your claim. If we do, we will require that they:

a) are a licensed private investigator
b) comply with relevant state or territory laws, and clauses 1.19 and 1.22
c) only collect information that is relevant to the assessment of your claim
d) uphold the Code's standards for interviews (clauses 5.24–5.34) and Surveillance (clauses 5.35–5.38)
e) keep a record of all investigation activities in line with the *Privacy Act 1988*, and
f) do not use illegal methods, threaten anyone, make any promise or offer, or cause anyone to do anything they wouldn't have done otherwise during the surveillance.

5.38 If we appoint an investigator, we will direct them:

a) not to conduct Surveillance in any court or judicial facility, medical or health facility, bathroom, changing or lactation room, or inside your home
b) not to intentionally film your family members, neighbours, friends, acquaintances or colleagues with you
c) if filming them cannot be avoided, to pixelate or blur any video they appear in before giving it to any external party such as a court or External Dispute Resolution Body
d) not to communicate with those people in ways that might reveal the Surveillance, and
e) to stop the Surveillance if we receive evidence from a doctor or psychologist that it is negatively affecting your health, including your mental health.

Claim decisions

Training and remuneration for claims assessors

5.39 We will ensure our claims assessors have the appropriate skills and training to make objective decisions. They will not make decisions for us until they have shown technical competency and an understanding of all relevant laws, Code requirements, and FSC standards and guidance.

5.40 We will ensure our claims assessors' remuneration, including their entitlement to any bonuses:

a) is consistent with the principles set out in clause 1.6, and
b) is not directly based on financial targets for claims outcomes.

Timeframes apply for handling claims

We complete our assessment of your claim by:

- making a decision on your claim, or
- issuing a Show Cause or Procedural Fairness letter.

Making a decision on your claim may include:

- admitting, closing or declining your claim, or
- making an initial decision for income-related benefits.

5.41 If your claim is for income-related benefits, unless there are or have been Circumstances Beyond Our Control, we will complete our assessment of your claim within 2 months of:

a) the Claim Received Date, or
b) if later, the end of the waiting period your policy specifies.

5.42 If your claim is for a lump sum benefit, unless there are or have been Circumstances Beyond Our Control, we will complete our assessment of your claim within 6 months of:

a) the Claim Received Date, or
b) if later, the end of any waiting period your policy specifies.

5.43 Once we receive all the information we reasonably need to complete our assessment – including your response to the Procedural Fairness or Show Cause letter, if relevant – and have taken all steps to finalise our decision, we will:

a) tell you our decision within 5 Business Days, and
b) confirm our decision in writing within 10 Business Days of telling you, if we have not already done so at a) above.

5.44 Depending on your policy and the benefit you are claiming, we may tell you that you may be required to do rehabilitation or retraining before we can make a decision on the claim.

5.45 If we accept a death claim, we will tell you that we may be unable to pay the benefits until your estate's Representatives confirm that they have obtained probate or letters of administration.

5.46 If we need a medical or financial report to assess your claim, we will ask the provider to give us their report within 20 Business Days of our request or the appointment, if relevant. If they do not meet this deadline, we will tell you and update you on our progress getting the report, in line with clause 3.11.

5.47 Before we close your claim because we need outstanding information, such as from you or your doctor, we will follow up with you at least twice using different methods of communication.

5.48 If we close or decline your claim, you or the Policy Owner can ask us to reopen or reassess it. If you do, we will treat it as a new claim with a new Claim Received Date, and the timeframes under the Code will restart once the claim is reopened.

5.49 If we decline your claim, we will tell you in writing:

a) our reasons and a summary of the information about your claim that we relied on
b) that You can ask us for copies of the documents about your claim that we relied on, which we will send to you, or to your doctor if we think that is more appropriate. We will send these copies within 10 Business Days in line with privacy provisions,
c) that You can ask us to review our decision, or give us extra information to consider, and
d) about our Complaints process.

Circumstances Beyond Our Control may affect our claims timeframes

5.50 Circumstances Beyond Our Control can affect our timeframes for assessing claims. If they mean we cannot meet a claims timeframe, we will not have breached the Code. Where we identify that there are Circumstances Beyond Our Control we, or the Group Policy Owner, will:

a) let you know what they are in writing
b) tell you about our Complaints process, and
c) update you on your claim's progress at least every 20 Business Days, unless we have agreed to a different timeframe in line with clause 5.6.

5.51 If we believe the Circumstances Beyond Our Control will likely continue for more than 12 months after the Claim Received Date, before the end of the 12 months timeframe we will:

a) refer your claim to a senior member of our team or review committee to review the circumstances
b) let you know the outcome of our review in writing, and
c) tell you about our Complaints process.

Insurers may suggest independent advice for some benefits and payments

5.52 For a claim that is not income related, if we accept it and the amount is at least $50,000, we will provide information to help you obtain independent financial advice to help manage your payment, unless the recipient is a superannuation trustee.

5.53 If we accept an income-related claim and offer you a lump sum settlement instead of future income payments we will suggest that you get independent financial advice before you make a decision. But we will not do this for lump sum payments that do not require you to make a decision, such as make advance payments.

Paying you promptly

5.54 For any income-related benefit we owe you, we will:
a) pay you by the later of the due date or within 5 Business Days of when we have completed all reasonable enquiries, have all the information we reasonably need to assess your claim, and have taken all the steps we need, or
b) tell you that your payment will be late within 5 Business Days of us finding out.

5.55 We will also not stop or withhold any income-related benefit payment during a non-disclosure or misrepresentation investigation, unless we reasonably believe we have evidence that will lead to your claim being declined or your policy being cancelled or avoided.

Specific definitions apply to medical trauma and critical illness claims

5.56 The definitions in the ‘Medical definitions’ section apply to the first $2 million of trauma or critical illness cover for Life Insurance Policies we issued or group schemes that started on or after 1 July 2017. But they do not apply:
a) to such cover that we reinstate after a claim
b) where the amount we pay varies based on how severe the condition is, or
c) to benefits included with income protection or TPD.

5.57 Where your trauma/critical illness cover includes cancer, a heart attack or a stroke (but not the exclusions listed in the ‘Medical definitions’ section) and you make a claim, we will assess your claim against these 2 definitions so that you get the better of the following 2 definitions:
a) the applicable definition in our PDS/policy document linked to the full benefit amount
b) if different, the definition in the ‘Medical definitions’ section that is current at the time of the insured event.

6 Supporting customers experiencing vulnerability and financial hardship

Vulnerable people

A range of circumstances can cause vulnerability

6.1 We recognise that some customers may experience vulnerability due to age, disability, injury, a mental health condition, physical health condition, language barriers, literacy barriers, cultural background, remote location, Aboriginal or Torres Strait Islander status, family violence or financial distress. We are committed to taking extra care to support vulnerable customers.

6.2 We will treat you with empathy, compassion and respect.

6.3 We will ask for your permission to keep a record of the support or assistance you require.

6.4 We understand that some customers' may also have unique needs which makes them vulnerable because of their circumstances and this makes it harder to access our products and services.

6.5 We will have a publicly available policy on our website about how we will support you if you are affected by family violence.

6.6 We will arrange relevant training for our employees who are likely to be involved in communications requiring an interpreter.

6.7 On our website there will be an easy-to find link to:
a) information on interpreting services
b) teletypewriter services (TTYs)
c) any information on our products that we have translated into other languages, and
d) any other relevant information for people with language barriers.

Vulnerable people can ask for help

6.8 If you tell us or we identify that you need extra support to access our services due to vulnerability, we will work with you and find a suitable, sensitive and compassionate option where possible. We will do this as early as practical.

6.9 We encourage you to tell us about your vulnerability and if you need extra support, we can arrange support or help to access our services. Otherwise we may not find out about it.

6.10 We will protect your right to privacy.

6.11 If you tell us that you need extra support from someone else or if we identify that you need extra support – such as a lawyer, consumer representative, interpreter or friend – we will recognise this and allow it in all reasonable ways. We will make sure our processes are flexible enough to recognise the authority of your support person where possible.

6.12 If you need support to meet verification and identification requirements, we will take reasonable steps to support you, especially if you are from an Aboriginal or Torres Strait Islander community or a non-English speaking background. Our approach will be flexible in line with AUSTRAC guidance, while still meeting our legal obligations.

6.13 We will have internal policies and role-appropriate training to help our employees:
a) identify and understand if you are vulnerable
b) consider your unique needs or vulnerability
c) decide how we may be able to help you engage with us and to what extent, and

d) engage with you with empathy, compassion and respect.

6.14 We recognise that people living in remote and regional communities may have trouble meeting the timeframes we set to give us documents or to take part in assessments. We will consider this in our Underwriting and claims processes.

Financial hardship

Customers experiencing financial hardship

6.15 If you tell us you are having trouble paying or can no longer afford your Premium due to financial hardship, we will tell you about available options. Some of these options may include:

a) changing your, benefits or the amount we insure you for to reduce your premium
b) asking for urgent benefits due to an illness or injury your policy covers, in line with clauses 6.18–6.21, or
c) not collecting your Premium for a short time, noting that you may not be able to claim for anything that happens, is diagnosed or becomes apparent during this time.

6.16 We will let you know what help we can offer based on reasonable evidence we ask you to give us. We will only ask for evidence we reasonably need to assess your request for extra support due to financial hardship. This could include:

a) your Centrelink statements if you are a Centrelink client
b) your bank statements or other financial documents, or
c) a statement showing your employment ended.

6.17 Clauses 6.15 and 6.16 do not apply to cover under a Group Policy, as the Group Policy Owner is responsible for changes.

Customers can ask for help when making a claim

6.18 If you need help with the claim process, in understanding what is required of you, completing claim forms or providing requested claim information, we will work with you to find a solution. This may include endeavours to collect the information on your behalf, with your permission.

6.19 If you tell us that you urgently need the benefits of your Life Insurance Policy due to a condition that your policy covers, we will assess your request for urgent access to your benefits. We may ask you for evidence of this urgent need.

6.20 We will let you know what help we can offer you within 5 Business Days of receiving all the evidence we need. We will let you know that you can ask us to review our decision and give you details about our Complaints Process. If you disagree with our decision, we will review it.

6.21 If we accept your request, we will confirm any help we offer in writing. This might be:

a) prioritising your claim assessment and our decision, or
b) advancing part of your claim payment.

6.22 Where you have cover under a Group Policy, we will tell you who to contact about your urgent need for benefits. The law limits access to superannuation benefits.

7 Complaints

Making a Complaint

7.1 We will not discourage you from making a Complaint.

7.2 If you make a Complaint to us, we will tell you how you can access the Code, in line with clause 1.3 and acknowledge your Complaint within 24 hours (or 1 Business day) of receiving it, or as soon as practicable.

Customers can make a complaint

7.3 If you tell us that you have a concern about us and someone who is not our Authorised Representative, we will tell you how to have the matter addressed.

7.4 We will give you the name and contact details of the person assigned to or dealing with your Complaint.

7.5 The person assigned to your Complaint will not be the person or people whose decision or conduct is the subject of your Complaint.

7.6 We will only ask for and rely on information relevant to our investigation into your Complaint and our response.

Complaints about declined or closed claims

7.7 If you make a Complaint about a declined or closed claim or the value of a claim, our final response will include the final outcome of your complaint, including if we will reconsider or reopen your claim, or if we maintain or overturn the decision. We will then close your Complaint.

7.8 If the outcome of your Complaint is that we will reconsider or reopen your claim, we will also confirm the name and contact details of the claims assessor assigned to liaise with you.

Handling your Complaint

Insurers will respond directly to some Complaints

7.9 We will only close your Complaint within 5 Business Days of receiving it, if we have:
a) resolved your Complaint to your satisfaction, or
b) give you an explanation and/or apology where we cannot take further action to reasonably address the complaint.

7.10 If we do this, clauses 7.12–7.18 below do not apply, as long as:
a) your Complaint is not about hardship, a declined insurance claim, the value of an insurance claim or a superannuation trustee’s decision, and
b) you have not asked for a response in writing.

7.11 We will provide a written response to your Complaint, even if we resolve your Complaint within 5 Business Days, if:
a) your Complaint is about hardship, a declined insurance claim, the value of an insurance claim or a superannuation trustee’s decision, or
b) you have asked for a response in writing.

7.12 We will give you our final written response to your Complaint in writing within 30 calendar days, unless clause 7.14 applies. Our final response will include:

a) the action taken to resolve the complaint or the reasons for our decision
b) identifying and addressing the issues raised in the Complaint with a summary of the information relied on
c) that you can ask us for a copy of documents and information relied on in assessing your Complaint, and
d) that you have the right to take your Complaint to an External Dispute Resolution Body if you are not satisfied with our decision, along with how to contact them and any time limit for doing so.

7.13 If you ask for the documents and information relevant to your Complaint that we relied on, we will send them to you within 10 Business Days, in line with clauses 3.11 and 3.12.

7.14 We may not be able to respond within 30 calendar days if the Complaint is complex and/or there are circumstances that are beyond our control causing a delay. If we cannot respond to your Complaint within 30 calendar days, before this time is up we will tell you:
a) why there is a delay,
b) keep you regularly updated about progress, and
c) that you may have the right to take your Complaint to an External Dispute Resolution Body if you are not satisfied with our explanation, along with how to contact them and any time limit for doing so.

Superannuation fund trustees will respond to other Complaints

7.15 If you make a Complaint about a Life Insurance Policy a superannuation fund trustee owns, you can complain to us or to the trustee.

7.16 The trustee must give you a final written response to your Complaint within 45 calendar days of us or them receiving the Complaint. This will include:
a) the action taken to resolve the complaint or the reasons for their decision
b) identifying and addressing the issues raised in the Complaint with a summary of the information relied on
c) that you can ask for a copy of documents and information relied on in assessing your Complaint
d) that you have the right to take your Complaint to an External Dispute Resolution Body if you are not satisfied with their decision.

7.17 If they do not respond within 45 calendar days, we will tell you that you can ask them to explain the delay in writing.

7.18 We will give You our final decision in writing or give it to the superannuation fund trustee so that they can give it to you. This will include everything from clause 7.12.

8 Code governance

The FSC and the Life CCC

The Financial Services Council develops the Code

8.1 The FSC develops this Code. It will:

a) consult with the Life CCC, External Dispute Resolution Bodies, consumer and industry representatives, regulators and other stakeholders about the content, and

b) commission formal independent reviews as needed starting in 2024, and at least every 3 years after that.

The Life Code Compliance Committee monitors governance

8.2 The FSC also developed the Life CCC charter, which sets out the Life CCC's functions and powers. The Life CCC is made up of:

a) an independent chair

b) a consumer representative, and

c) an industry representative.

8.3 The Life CCC will regularly report to the FSC's Life Board Committee on industry issues and Code compliance. It may recommend:

a) improvements to the Code to address weaknesses or non-compliance, and

b) that the Life Board Committee review the Code if it could better meet its goals.

8.4 The Life CCC also publishes an annual report with consolidated, de-identified analysis on compliance.

8.5 The Life CCC may outsource its functions to an appropriate body, but not its powers to sanction.

Breaches and sanctions

Entities will comply with both the law and the Code

8.6 The Code only creates legal or other rights between the entities bound by it and the FSC. It does not create rights for any other parties, except where it identifies enforceable provisions. The enforceable provisions of the Code are: [Placeholder to identify ECPs]

8.7 If there is a conflict or inconsistency between the Code and any law or regulation, the law or regulation prevails. But where the Code has higher standards than the law, entities will comply with both the law and the Code.

8.8 Life insurance companies may agree with a Group Policy Owner to service standards that are higher than the Code standards.

8.9 Only the enforceable provisions apply to proceedings in a court or tribunal. But External Dispute Resolution Bodies, if allowed, may consider if the entities bound by it have met their obligations in the Code when they Determine disputes.

Insurers will ensure compliance with the Code

8.10 Any organisation bound by the Code (see clause 1.12) will meet Code standards for all products and services it provides. We will:

a) have appropriate systems and processes to enable compliance

b) report to the Life CCC yearly about our compliance, and
c) have a governance process to report to our Board of Directors or executive management about our compliance.

8.11 We will be in breach of the Code if our staff or our Authorised Representatives do not comply with the Code.

8.12 If We find a Significant Breach in our organisation, we will report it to the Life CCC within 30 Business Days of discovering it. But we will not do this if we have already reported (or will report) a Significant Breach to the relevant regulator, and they know the matter may also involve a Code breach. If so, the relevant regulatory timeframes will apply.

8.13 Anyone – including you and External Dispute Resolution Bodies – can report an alleged Code breach to the Life CCC. The Life CCC may then:
a) tell us about the allegation and give us a chance to respond
b) investigate as it sees fit
c) decide if there was a Code breach
d) decide if we should deal with the allegation through our internal Complaints process, and refer you to us if so
e) agree with us to any fair and reasonable corrective actions we will take and the relevant timeframes (considering any related actions that a regulatory body has imposed), and
f) monitor our actions and decide if they are effective and on time.

8.14 The Life CCC may also impose sanctions, in line with clauses 8.17–8.20.

8.15 We will cooperate with the Life CCC's reviews of our compliance with the Code, investigations of alleged Code breaches and reasonable requests at any time. For any Code breach they find, we will also take fair and reasonable corrective actions in agreed timeframes. But any corrective actions that a regulatory body imposes on us will take precedence.

8.16 In line with FSC Standard No. 1, the FSC Board can discipline us if we do not correct a Code breach. This includes if we do not comply with a Life CCC sanction, which is regarded as a breach of an FSC Standard.

The Life CCC can sanction insurers

8.17 If the Life CCC finds a Significant Breach or if we cannot agree on corrective actions, it will:
a) tell our Chief Executive Officer (CEO) in writing
b) give us 15 Business Days to respond
c) consider our response before making a final decision and imposing any sanctions, and
d) tell our CEO and the FSC its decision in writing.

8.18 The Life CCC's decisions are binding on us.

8.19 When deciding any sanctions, the Life CCC will consider:
a) the Code's principles and goals
b) if the sanction is appropriate, and
c) any related actions that a regulatory body has imposed on us.

8.20 A sanction may mean giving a formal warning or requiring us to:
a) take steps to fix the Code breach in a set timeframe, considering any related actions that a regulatory body has imposed on us
b) audit our Code compliance
c) put out corrective advertising
d) write to customers affected by the Code breach, and
e) publish our non-compliance on our Website and the FSC Website.

9 Definitions

General definitions

These acronyms appear throughout the Code

Acronym	Meaning
APRA	Australian Prudential Regulation Authority
ASIC	Australian Securities and Investments Commission
CCI	Consumer Credit Insurance
FSC	Financial Services Council Limited
Life CCC	Life Code Compliance Committee
PDS	Product Disclosure Statement
TPD	Total and Permanent Disability

These definitions apply to the Code (but not to Appendix A: Moratorium on Genetic Tests in Life Insurance)

Term	Meaning
Applicant	A person who applies for a Life Insurance Policy with us to become a Policy Owner or Life Insured.
AFS license	Australian Financial Services licence
Authorised Representative	Person, company or other entity we authorise to provide financial services on our behalf under our AFS licence, in line with the *Corporations Act 2001*. It does not include a person, company or entity that is an Authorised Representative of any other holder of an AFS license, including a holder of an AFS license that is a related company to us.
Business Day	Monday to Friday, except public holidays.
Circumstances Beyond Our Control	Any of the following: a) We have not received reports, records, evidence or information we reasonably requested from you, your Representative, the Policy Owner, the Group Policy Owner, an Independent Service Provider, your doctor, a government agency, or another person or entity (but not a Reinsurer). b) You, your Representative, the Policy Owner or the Group Policy Owner have not responded to our reasonable enquiries or requests for documents in a reasonable timeframe. c) There are difficulties communicating with you, your Representative or the Policy Owner about the claim. d) You are or will be undergoing rehabilitation, retraining or further treatment, which may impact our ability to form a view on your claim. e) You, your Representative, the Policy Owner or the Group Policy Owner have asked for a delay or extension to part of the claims process.

Term	Meaning
	f) We reasonably suspect there was non-disclosure or misrepresentation before the cover or policy started that we believe may impact your claim, and we need further investigation, evidence and/or information. g) We reasonably suspect that your claim is fraudulent and need further investigation, evidence and/or information.
Claim Received Date	The date a life insurer records it has received the first piece of information, but not necessarily all information, to allow it to commence the assessment of a claim.
Code	This Life Insurance Code of Practice.
Complaint	An expression of dissatisfaction made to or about an organisation about its products, services, staff or handling of a Complaint, where a response or resolution is: a) explicitly or implicitly expected, or b) legally required.
Determine	When an External Dispute Resolution Body makes a final decision.
Distributor	A person or entity we appoint to distribute our policies on our behalf, excluding independent financial advisors and platform operators.
External Dispute Resolution Body	An external organisation that is relevant to your Complaint, which may include the Australian Financial Complaints Authority or a Complaints handling process that legislation mandates.
Funeral Insurance Policy	A Life Insurance Policy which is issued for the purpose primarily to cover funeral, burial or cremation expenses for the Life Insured or their family members.
Group Policy	A Life Insurance Policy owned by an employer, superannuation fund trustee, or another person or entity that: a) covers a group of eligible Life Insured, and b) includes any extra cover purchased at the request of the Life Insured.
Independent Service Provider	A person or entity we enter an agreement with to help with Underwriting, administration or claims management, such as a/an: a) independent medical assessor b) allied health professional c) rehabilitation provider d) accountant e) investigator, or f) claims management service. A Reinsurer is not an Independent Service Provider.

Term	Meaning
Life Insurance Policy	Any of the following issued in the Australian market, but not a contract of reinsurance: a) An insurance contract that provides for the payment of money on the death of a person or on the happening of a contingency dependent on the ending or continuation of human life (Section 9(1)(a), *Life Insurance Act 1995*). b) An insurance contract that is subject to payment of Premiums for a term dependent on the ending or continuation of human life (Section 9(1)(b). c) A continuous disability policy (Section 9(1)(e). d) Another insurance contract, if we carry on life insurance business (other than annuity business) by issuing or undertaking liability under such a contract due to a declaration by APRA under section 12A of the *Life Insurance Act 1995*.
Life Insured	A person insured under a Life Insurance Policy covered by this Code, whether or not they are a party to the policy. A Third Party Beneficiary is not a Life Insured.
Plain Language	A communication is in plain language if its wording, structure and design are so clear that the intended audience can easily find what they need, understand what they find and use that information. Plain language can include technical terms where these words are the most relevant or precise.
Policy Owner	Any person, company or entity that owns a Life Insurance Policy covered by this Code, including joint Policy Owners. A Third Party Beneficiary is not a Policy Owner.
Premium	The amount you pay, or another person or entity pays for your insurance cover.
Pressure Selling	Using certain techniques to pressure, compel or otherwise encourage someone to buy a policy they do not want.
Procedural Fairness	When we write to you with our preliminary view on your claim and give you a chance to respond before we make our decision.
Procedural Fairness letter	A letter we write to you with our preliminary view on your claim and which states you have a chance to respond before we make a decision.
Reinsurer	An entity that provides insurance to issuers of Life Insurance Policies (known as reinsurance). A Reinsurer does not have a contract of insurance with you.
Representative	Someone you choose or who is authorised to communicate with us on your behalf, such as a: a) lawyer or person with power of attorney b) financial adviser or planner c) Group Policy Owner d) interpreter, or e) family member or guardian.

Term	Meaning
Show Cause letter	A letter we will send you before we make a decision to vary or avoid your cover, that: a) includes copies of any information that may be relevant to our decision, b) explains any remedies and the impact our decision may have on your cover under the Life Insurance Policy, and c) gives you a chance to explain and provide any further information or documents you would like us to consider.
Significant Breach	Any Code breach that we or the Life CCC reasonably determine to be significant by referring to the: a) number and frequency of previous similar breaches b) actual or potential financial loss it causes c) impact it has on our ability to provide our services, or d) extent to which it suggests that our arrangements to ensure compliance with Code obligations are inadequate.
Surveillance	When an investigator watches or films your activities in public.
Third Party Beneficiary	Any person or entity who is entitled to benefits from a claim but is not a Life Insured or Policy Owner. This may include someone: a) a Life Insurance Policy covered by the Code specifies or refers to, by name or otherwise, as someone who may receive the benefit of the insurance, or b) seeking the benefits of the insurance.
Underwriting	The process we use to decide whether to offer you insurance and the terms that should apply to that insurance when you apply for cover. Underwriting requires medical and other personal information from you, which we will consider.
We, us, our	A life insurance provider that is bound by the Code. This includes its Authorised Representatives. 'Us' means the Code subscribers acting individually and independently, not collectively.
You, your	Means, as the context may require: a) the Applicant, Life Insured or Policy Owner b) a person authorised to act on your behalf, such as a named Representative, adviser, parent, guardian or a person with power of attorney, or c) a Third Party Beneficiary, if relevant.

Medical definitions

Three medical terms have specific definitions

Term	Meaning
Cancer, excluding certain early stage cancers	Cancer means any malignant tumour diagnosed with histological confirmation and characterised by: the uncontrolled growth of malignant cells; and invasion and destruction of normal tissue beyond the basement membrane. The term malignant tumour includes leukaemia, sarcoma and lymphoma.

Term	Meaning
	The following are not covered: • All tumours which are histologically classified as any of the following: a) pre-malignant; b) non-invasive; c) high-grade dysplasia; d) borderline or low malignant potential. • Carcinoma in situ except carcinoma in situ of the breast where a total mastectomy with full removal of the breast has been undertaken and was considered by treating doctors to be the appropriate and necessary treatment. • All cancers of the prostate unless: a) histologically classified as having a Gleason score of 7 or above; or b) having progressed to at least clinical stage T2bN0M0 on the TNM clinical staging system; or c) where a total prostatectomy has been undertaken where the procedure was specifically to arrest the spread of malignancy and was considered by treating doctors to be the appropriate and necessary treatment. • All cancers of the thyroid unless: a) having progressed to at least TNM classification T2N0M0; or b) where a total thyroidectomy has been undertaken and was considered by treating doctors to be the appropriate and necessary treatment. • All cancers of the bladder unless having progressed to at least TNM classification T1N0M0. • Cutaneous lymphoma confined to the skin. • Chronic lymphocytic leukaemia unless having progressed to at least Rai stage I. • All non-melanoma skin cancers unless having spread to the bone, lymph node, or an other distant organ. • All melanoma skin cancers unless having progressed to at least TNM classification T2bN0M0.
Heart attack, with evidence of severe heart muscle damage	Heart attack means the death of a portion of the heart muscle as a result of inadequate blood supply, where the diagnosis is supported by the detection of a rise and/or fall of cardiac biomarker values with at least one value above the 99th percentile upper reference limit (URL) and with at least three of the following: a) Symptoms of ischaemia. c) New significant ST-segment–T wave (ST–T) ECG changes or new left bundle branch block (LBBB). d) Development of new pathological Q waves in the ECG. e) Imaging evidence of new regional wall motion abnormality present at least six weeks after the event. If the tests specified in a) to d) above are inconclusive or unable to be met, then the definition will be met if at least three months after the event the insured's left ventricular ejection fraction is less than 50 per cent. The following are not covered: a) A rise in biological markers as a result of an elective percutaneous procedure for coronary artery disease. b) Other acute coronary syndromes including but not limited to angina pectoris.
Stroke in the brain resulting	Stroke means death of brain tissue caused by one of the following: a) Ischaemic infarction of brain tissue.

Term	Meaning
in specified permanent impairment	b) Intracranial haemorrhage (cerebral, intraventricular or subarachnoid). The diagnosis must be supported by both of the following: a) Evidence of permanent neurological deficit with persisting symptoms confirmed by a specialist physician as a definite result of the stroke at least six weeks after the event. b) Findings on MRI, CT, or other reliable imaging evidence consistent with the diagnosis of a new stroke. The following are not covered: • Transient ischaemic attacks. • Brain damage due to an accident, injury, infection, or non-vasculitic inflammatory disease. • Vascular disease affecting the eye or optic nerve. • Ischaemic disorders of the vestibular system. • Strokes caused by or related to illicit drug use or substance abuse. • Migraine. • Hypoxic events. Words within the stroke definition that have special meaning *“Permanent neurological deficit with persisting symptoms”* means dysfunction in the nervous system that is present on clinical examination and expected to last throughout the insured person's life. It includes outcomes such as: numbness, hypertonicity, hemiplegia, monoplegia, hemiparesis, monoparesis, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, coma and objectively documented significant loss of cognitive function. The following do not constitute “permanent neurological deficit with persisting symptoms”: • An abnormality seen on brain or other scans without definite related clinical symptoms. • Neurological signs occurring without symptomatic abnormality, such as brisk reflexes without other symptoms. • Symptoms of psychological or psychiatric origin.

Appendix A: Moratorium on Genetic Tests in Life Insurance

A.1 This Moratorium

Life insurance should not dissuade people from Genetic Testing

a) Genetic Testing has the potential to play an important role in informing people about their health and enabling them to manage their health risks through preventative actions and personalised medicine.

b) It is important that public concerns about the use of Genetic Test results in life insurance do not dissuade people from taking Genetic Tests or taking part in genetic research.

c) The objective of the Moratorium on Genetic Tests in Life Insurance (the Moratorium) is to ensure people can access a level of life insurance without being asked about the result of a previously taken Genetic Test.

d) The Moratorium covers an Applicant for individually underwritten life insurance (including individually underwritten life insurance in group insurance) with an FSC member.

e) The Moratorium starts for applications received on or after 1 July 2019 and applies until 30 June 2024.

A.2 Test results

Insurers can ask for test results in some circumstances

a) The overriding principle is that for all applications, regardless of the amount of Cover and any other clause in the Moratorium, we can ask you to disclose, and use as part of our Underwriting process, any diagnosis of a condition, even if the diagnosis resulted directly or indirectly from a Genetic Test.

b) For all applications, regardless of the amount of Cover, we will not ask or otherwise encourage you to:
   i. take a Genetic Test as part of your application and Underwriting process
   ii. disclose the result of a Genetic Test that was taken as part of a medical research study conducted by an accredited university or medical research institution where the test results have not been and will not be provided to you, or you have specifically asked not to receive them.

c) As part of the application process for the benefits listed below, we may only ask for or use the results of a Genetic Test if the total amount of Cover you would have – including both the Cover being applied for and any existing individual and group insurance Cover with all life insurers – is more than any of the following:
   i. $500,000 of lump sum death Cover
   ii. $500,000 of total permanent disability (TPD) Cover
   iii. $200,000 of trauma and/or critical illness Cover
   iv. $4,000 a month of any combination of income protection, salary continuance or business expenses Cover.

d) If your total amount of Cover exceeds any of the limits in clause A.2c), we may ask for and use the result of a previously taken Genetic Test or planned test when assessing the full amount of Cover being applied for across all types. A planned test means you have consented to a Genetic Test. We can do this provided that an evidence base shows that the test has relevance to the Cover applied for, in line with the Disability Discrimination Act.

e) We will take the following into account as part of our Underwriting assessment:
   i. a favourable Genetic Test result you choose to disclose, regardless of the amount of Cover, for example to show that you are not carrying a gene pattern associated with developing an illness that runs in your family
   ii. evidence based preventative treatment, or adherence to evidence based preventative measures, which reduce the possibility of developing an illness that runs in your family.

f) We will only ask for or use Genetic Test results as part of the process to decide the terms offered for Cover in line with clause A.2c). For example, this means that we will not ask for or use adverse Genetic Test results, even if the limits in clause A.2c) are exceeded due to an increase in Cover without Underwriting through automatic yearly increases in Cover.

g) We will ensure that Underwriting staff can consult a medical professional (such as a Chief Medical Officer) where a Genetic Test result is deemed to be relevant in the Underwriting assessment.

h) We will comply with privacy law regarding sensitive information in asking for, using and retaining Genetic Test results in our life insurance operations.

i) For the purposes of governance and compliance, and to inform the review in clause A.3a), we will record anonymous details of all Genetic Test results received as part of the Underwriting process, whether or not we asked for them, on the FSC database of Genetic Test results.

Undisclosed results might not breach duty of reasonable care

j) When assessing claims, we will not treat the Life Insured as having breached their duty to take reasonable care not to make a misrepresentation for not disclosing the results of a Genetic Test that we were not entitled to ask for or use as part of our Underwriting process in line with the Moratorium.

A.3 Moratorium governance

The Financial Services Council (FSC) will review this Moratorium

a) During 2022, the FSC will review the Moratorium in consultation with stakeholders with a view to extending the date, taking account of its objectives and:
   i. feedback from consumer groups and expert stakeholders
   ii. the appropriateness of the amounts of Cover in clause A.2c), taking into account any cross-subsidy between customers who have a genetic pre-disposition and those who do not
   iii. the rates of participation in genetic research
   iv. advances in the field of genomics and Genetic Testing
   v. impacts of the Moratorium on the sustainability of the life insurance industry.

b) The FSC will not reduce the term of, or otherwise change, the Moratorium outside this review process.

These definitions apply to the Moratorium

c) For the Moratorium, the following terms have the associated meaning:

Term	Meaning
Applicant	A person who applies for a Life Insurance Policy with us to become a Policy Owner or Life Insured.
Cover	Any type of life insurance, including: • lump sum death cover • total permanent disability (TPD) cover • trauma/critical illness cover • income protection, salary continuance or business expenses cover.
Genetic Test	A test that examines a person's chromosomes or DNA. It does not include any non-genetic medical tests (such as blood or urine tests for proteins, cholesterol, liver function or diabetes), even if they are to test for a condition that may have a genetic origin.
Underwriting	The process we use to decide whether to offer you insurance and the terms that should apply to that insurance when you apply for Cover.
We, Us, Our	A life insurance provider that is bound by the Code. 'Us' means the entities acting individually and independently, not collectively.
You, Your	The Applicant.

Appendix B - supporting customers experiencing a mental health condition

People with mental health conditions

This Appendix B sets out sections of the Code which we believe may be of particular interest to customers experiencing mental health conditions. In this Appendix B we also refer you to certain parts of the Code containing more detailed information which you may wish to read. **Please note that this Appendix B is not part of the Code.**

We will take extra care if you are vulnerable due to your mental health

1. We recognise that some customers may experience vulnerability due to a mental health condition. We are committed to taking extra care to support you. We will treat you with empathy, compassion and respect. See Clause 6.1 and 6.2 of the Code.

You can ask us for extra support

2. If you tell us or we identify that you need extra support to access our services due to a mental health condition, we will work with you and find a suitable, sensitive and compassionate option. We will do this as early as practical. See Clause 6.5 of the Code.
3. We encourage you to tell us about your mental health condition and if you need extra support, we can arrange support or help to access our services. Otherwise we may not find out about it. See Clause 6.6 of the Code.
4. If you tell us that you need extra support from someone else – such as a lawyer, consumer representative, interpreter or friend – we will recognise this and allow it in all reasonable ways. We will try to make sure our processes are flexible enough to recognise the authority of your support person. See Clause 6.8 of the Code.
5. If you need support to meet verification and identification requirements, we will take reasonable steps to support you. Our approach will be flexible in line with AUSTRAC guidance, while still meeting our legal obligations. See Clause 6.9 of the Code.
6. We will have internal policies and role-appropriate training to help our employees:
   a) identify and understand if you are vulnerable
   b) consider your unique needs or vulnerability
   c) decide how we may be able to help you engage with us and to what extent, and
   d) engage with you with empathy, compassion and respect. See Clause 6.10 of the Code.

Buying a Life Insurance Policy

7. When you apply for a Life Insurance Policy, if you tell us about a diagnosed mental health condition or symptoms of a mental health condition you have or have had, we will:
   a) allow you the opportunity to provide information about the history, severity or type of condition before making our decision about whether to insure you and, if so, the terms we offer you, and
   b) take into account your circumstances such as the history, severity or type of condition, when deciding whether we can offer you cover. If we do not offer you cover, or we offer you alternative terms, we will explain to you why in line with Clause 4.26. See Clause 4.18.
8. We will ensure our underwriters have the appropriate skills and training. They will not make decisions for us until they have shown technical competency and an understanding of all relevant laws, Code requirements, and FSC standards and guidance. See Clause 4.22 of the Code.

9. While assessing an application, our underwriters will have access to professional advice and support in relevant disciplines – such as from medical specialists and accountants – if needed. See Clause 4.23 of the Code.

Making a claim under a Life Insurance Policy

10. We acknowledge that claims time is difficult for you and that each situation is unique. We will treat you with empathy, compassion and respect throughout the claims process. See Clause 5.1 of the Code.
11. We will not discourage you from making a claim. See Clause 5.2 of the Code.
12. If you tell us that you are having trouble providing the information we need, we will work with you to try to find a solution. This may mean that we try to collect it for you. See Clause 5.3 of the Code.
13. If you make an income-related claim because you are ill or injured and cannot work, if we consider it appropriate, we will:
    a) ensure you have an assigned claims assessor throughout the claims process
    b) identify and act upon ways to support your recovery early on
    c) identify and act upon ways to encourage best practice rehabilitation and return to work programs, and
    d) work with your doctor, other healthcare providers and your employer to improve your health. See Clause 5.4 of the Code.
14. Within 10 Business Days of the Claim Received Date, we will tell you:
    a) how you can access the Code, in line with Clause 1.4
    b) about your cover and any waiting periods that may apply
    c) about all of the relevant benefits under the Life Insurance Policy you are claiming on, and
    d) about the claims process and who to contact for more information. See Clause 5.5 of the Code.

Claim interviews will follow set rules

15. If we ask you to be interviewed (not an independent medical examination) to establish some facts, we will check our records before we hire an interviewer to see if you need one who speaks your preferred language, or a support person or interpreter to attend. If you do need an interpreter, we will pay for it. See Clause 5.24 of the Code.
16. We will arrange an interviewer that:
    a) is a certain gender, if you ask and one is reasonably available
    b) we are satisfied has the appropriate training and experience to discuss a claim involving a mental health condition, if relevant
    c) can help if you have limited English, or can help if you have a known cognitive decline or impairment. See Clause 5.25 of the Code.
17. We will tell the interviewer to contact your Representative before arranging the interview with you if you have asked us to communicate with your Representative. See Clause 5.26 of the Code.

Restricting the use of surveillance

18. If we have reason to believe that the information we have about your claim is inconsistent with other information available to us, we will try to resolve those inconsistencies without using Surveillance by an investigator. See Clause 5.35 of the Code.
19. If Surveillance is justified, we will document the inconsistencies and ask a senior member of our team to review and approve it. See Clause 5.36 of the Code.

20. If approved, we may appoint an investigator to help us with your claim. If we do, we will require that they:
    a) are a licensed private investigator
    b) comply with relevant state or territory laws, and Clauses 1.20 and 1.23
    c) only collect information that is relevant to the assessment of your claim
    d) uphold the Code's standards for interviews (Clauses 5.25-5.33) and Surveillance (Clauses 5.34-5.36)
    e) keep a record of all investigation activities in line with the *Privacy Act 1988*, and
    f) do not use illegal methods, threaten anyone, make any promise or offer, or cause anyone to do anything they wouldn't have done otherwise during the Surveillance. See Clause 5.37 of the Code.

21. If we appoint an investigator, we will direct them:
    a) not to conduct Surveillance in any court or judicial facility, medical or health facility, bathroom, changing or lactation room, or inside your home
    b) not to intentionally film your family members, neighbours, friends, acquaintances or colleagues with you
    c) if filming them cannot be avoided, to pixelate or blur any video they appear in before giving it to any external party such as a court or External Dispute Resolution Body
    d) not to communicate with those people in ways that might reveal the Surveillance, and
    e) to stop the Surveillance if we receive evidence from a doctor or psychologist that it is negatively affecting your health, including your mental health. See Clause 5.38 of the Code.