

Consultation Draft

Life Insurance Code of Practice

Introduction

FSC is pleased to invite feedback as part of the current review of the Life Insurance Code of Practice Consultation Draft (this Consultation Draft Code).

This Consultation Draft Code has been through an extensive redrafting process for clarity and consistency. None of this redrafting is intended to change the policy intent. To help people navigate the Consultation Draft Code, we have highlighted areas where the content is new or where the policy intent has changed.

Responding to this Consultation

Please send your feedback to FSC at policy@fsc.org.au by the closing date of 12 January 2019. Your feedback can be on any aspect of the Consultation Draft Code, but in particular FSC would welcome feedback on the following areas.

Chapter 1

1. Funeral Insurance – section 3.6

- The Consultation Draft Code has significantly more protections for people taking out funeral insurance than the current Code. Do these go far enough and, if not, what further protections are needed?
- Should the Code include age limits below which funeral insurance should never be available?
- Should funeral insurance only be available with level premiums?

2. People with a mental health condition

- The Consultation Draft Code aims to give greater support to people with a mental health condition. However, it does not offer a single solution that would resolve every challenge facing the community in mental health. Rather, it proposes a number of measures, each aiming to make some improvement. Taken together, we hope the following proposals go some way to address community concerns in this area.
 - Health information consent form – by favouring GP Reports over clinical notes, we hope people will have more confidence to get the treatment they need, even before they apply for life insurance – in development in consultation with RACGP.
 - By making it clearer in underwriting questions what needs to be disclosed – section 5.3A.
 - Taking account of individual circumstances, including the history and severity of the mental health condition, before deciding on the application for cover – section 5.3D.
 - Treating people with a mental health condition as vulnerable – section 7.1.
 - Not checking disclosures at claim time without reasonable grounds – section 8.5A.
 - Other than fraud, ensuring customers are no better or worse off after a mistake – section 8.8A.

3. Sales – section 4

- The Consultation Draft Code introduces additional protections to ensure that people are not pressured into taking out life insurance they do not want. Do these go far enough and, if not, what further protections are needed?
- The Consultation Draft Code has a placeholder for cold calling (at section 4.3A), which is already subject to legal restrictions – see section 992A of the Corporations Act 2001 (Cth) commonly known as the “anti-hawking provisions”. What further restrictions, if any, should apply to outbound unsolicited calls?

4. Moratorium on Genetics Tests in Life Insurance (the Moratorium) – Appendix 4

- Including the Moratorium in the Code would introduce independent oversight and governance through the Life Code Compliance Committee.
- It proposes that Australians would be able take out life insurance without disclosing an adverse genetic test result, up to amounts very closely aligned to those in Germany (€300,000) and Switzerland (CHF 400,000).
- It would treat people with all genetic conditions equally and run from 1 July 2019 to 30 June 2024, with a review in 2022.

Chapter 2

Chapter 2 mirrors the Insurance in Superannuation Voluntary Code of Practice which has already been through a consultation process. It is essential that Chapter 2 continues mirror this. However, the following sections of Chapter 2 are new, and we therefore welcome feedback from external stakeholders on these specific sections as follows:

- Section 12.1: to make Chapter 2 binding on superannuation trustees.
- Section 12.5: Chapter 2 binding date.
- Section 13.9: If our legal advice requires us to amend Chapter 2 to be compatible with the Duties of Trustees.
- Sections 13.22 to 13.24*: In particular, we would welcome feedback on these sections. If the “Protecting Your Super” package becomes Law, in certain circumstances it would require superannuation trustees to cancel a member’s insurance without their consent. Do these provisions to notify affected members go far enough and, if not, what more could be done to notify the member?

*Please note: If the “Protecting Your Super” package does not become Law, these sections would revert to the corresponding sections in the Insurance in Superannuation Voluntary Code of Practice.

FINANCIAL SERVICES COUNCIL
LIFE INSURANCE CODE OF PRACTICE

What is the Life Insurance Code of Practice?

The Life Insurance Code of Practice (the Code) is the life insurance industry's commitment to mandatory customer service standards.

It has been voluntarily developed through the Financial Services Council (FSC) to:

1. Ensure that you receive a high standard of customer service in all your dealings with us.
2. Seek continuous improvement in the service we offer you.
3. Give you confidence that you can trust the life insurance industry.

The Code is designed to protect you, the customer.

What does the Life Insurance Code of Practice cover?

The Code sets out the life insurance industry's key commitments and obligations to customers on standards of practice, disclosure and principles of conduct for their life insurance services, such as being open, fair and honest.

The Code has three separate self-contained Chapters:

- Chapter 1 – obligations your life insurance company has to you
- Chapter 2 – obligations your superannuation trustee has to you if your life insurance is in superannuation
- Chapter 3 – Code governance, sanctions and definitions

Life insurance companies and superannuation trustees perform different roles in the provision of life insurance and are subject to different laws including legislation and regulations. This is why there are separate, stand-alone chapters covering the specific functions that life insurance companies and superannuation trustees perform in the provision of life insurance and insured superannuation benefits (Chapters 1 and 2 respectively).

There is a final Chapter (Chapter 3) which sets out the governance provisions, monitoring and sanctions that apply to both life insurance companies and superannuation trustees, as well as some definitions that are used in various parts of the Code. This Chapter includes the roles and responsibilities of the Life Code Compliance Committee (Life CCC) which is an independent body responsible for the monitoring and enforcement of the Code.

Which Chapters apply to my life insurance?

Chapters 1 and 3 apply to all life insurance. If your life insurance is through your superannuation, then Chapter 2 also applies.

The Code sets out timeframes for dealing with claims, complaints and requests for information. It also covers many aspects of dealing with life insurance either directly with your insurance company or through your superannuation trustee, from getting covered initially to making a claim, to providing options to those experiencing financial hardship or requiring additional support.

A list of the organisations bound by the Code can be found on the FSC website at

<https://fsc.org.au/policy/life-insurance/code-of-practice/>

Key Code Promises

1. We will be honest, fair, respectful, transparent, timely, and where possible we will use plain language in our communications with you.
2. We will monitor sales and retention practices by our staff and our authorised representatives to ensure that these are appropriate.
3. If we discover that an inappropriate sale has occurred, we will discuss a remedy with you, such as a refund or a replacement policy.
4. We will provide additional support if you have difficulty with the process of buying insurance or making a claim.
5. When you make a claim, we will explain the claim process to you and keep you informed about our progress in assessing your claim.
6. We will decide on your claim within the timeframes in the Code and, if we cannot meet these timeframes, we will explain why and tell you how to make a formal complaint.
7. If we deny your claim, we will explain the reasons in writing and let you know the next steps if you disagree with our decision.
8. We will ensure that the use of investigators and surveillance is relevant, reasonable, and in line with your legitimate right to privacy.
9. The independent Life CCC will monitor our compliance with the Code.
10. We will be accountable to the commitments in the Code, and we can be sanctioned by the Life CCC if we do not apply reasonable corrective measures in response to a Code breach.

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Chapter 1 – obligations your life insurance company has to you

1 Chapter 1, Introduction and objectives

1.1 Chapter 1 of the Life Insurance Code of Practice (Chapter 1) is binding on **us** as:

- a) Members of the **FSC** that are registered life insurance companies issuing Life Insurance Policies or any other member of the **FSC** taken to be authorised to issue **Life Insurance Policies**.
- b) Any other industry participant, including a non-FSC member, who enters a formal agreement with the FSC and the Life CCC to adopt Chapter 1.

You can find a list of Chapter 1 **Code** subscribers, and where applicable the brands they use, on the **FSC** website at www.fsc.org.au.

1.2 Unless they have adopted the **Code** as set out in section 1.1(b), Chapter 1 of the **Code** does not apply to:

- a) Superannuation fund trustees¹
- b) Financial advice companies or financial advisers²
- c) Other industry participants

1.3 Chapter 1 commits **us** to upholding the standards in Chapters 1 and 3 when **we** provide products and services that Chapter 1 covers.

1.4 If **we** fail to meet the standards in the Chapter 1 of the **Code**, the Life Code Compliance Committee (**Life CCC**) may impose sanctions on **us**, as set out in section 26 of Chapter 3.

1.5 In accordance with **FSC** Standard No. 1, the **FSC** Board has the discretion to carry out disciplinary action if **we** do not correct a **Code** breach, as set out in section 25.17 of Chapter 3.

1.6 The objectives of Chapter 1 are to:

- a) Commit us to high standards of customer service throughout your relationship with us.
- b) Seek continuous improvement in the life insurance industry.
- c) Increase trust and confidence in the life insurance industry.

1.7 The principles that apply to **our** products and services that are covered by Chapter 1 are:

- a) Clarity
- b) Transparency
- c) Fairness

¹ If a superannuation trustee is an FSC member then it will be bound by Chapter 2 and 3 of this Code.

² **Your** financial adviser or financial planner who recommends one of **our Life Insurance Policies** does not have obligations under the Code unless they have adopted it, but they do have obligations under the law and their own industry codes of conduct.

- d) Respect
- e) Honesty
- f) Timeliness
- g) Plain language

1.8 **We** acknowledge that insurance is based on the principle of utmost good faith. This requires both **us** and **you** to act honestly and fairly towards each other and for **us** to have due regard for **your** interests.

1.9 Words in **bold** have a special meaning which **you** can find in the Definitions section at the end of Chapter 3.

2 Scope of Chapter 1 of the Code

2.1 “**We**”, “**us**” and “**our**” mean the entity bound by Chapter 1. Where the **Code** refers to **us**, this means the entities in section 1.1 acting individually and independently, and not collectively.

2.2 **We** will ensure **our** staff and any person or entity **we** authorise to provide financial services on **our** behalf under **our** Australian Financial Services licence (**Authorised Representatives**) comply with Chapter 1 when they are acting for **us**.

2.3 “**You**” and “**your**” mean a person or entity who in relation to a **Life Insurance Policy** with **us**:

- a) Applies for the policy (**Applicant**)
- b) Owns the policy (**Policy-owner**)
- c) The policy insures (**Life Insured**)
- d) Is entitled to benefits from a claim (**Third Party Beneficiary**)

Particular sections of Chapter 1 do not apply to all the above parties where stated.

2.4 **FSC** members in their capacity as **Reinsurers** are bound by Chapter 1 and will meet their commitments under Chapter 1 by complying with the principles in sections 1.7 and 1.8 and assisting **us** to meet **our** commitments under Chapter 1.

2.4A Before **we** enter into an agreement with a reinsurer who is not a member of the FSC and has not entered into an agreement to adopt the Code under 1.1b) above, **we** will take reasonable steps so that **we** are satisfied that the **reinsurer** will comply with the principles in sections 1.7 and 1.8 and will assist **us** to meet **our** commitments in Chapter 1.

When does Chapter 1 apply from?

2.5 This version of the **Code** replaces any previous version with effect from 1 July 2019.

2.6 Chapter 1 applies to all interactions **we** have with **you** from 1 July 2019 or, if later, the date **we** are bound by Chapter 1, including any interactions relating to an existing claim or **Complaint**. This version of Chapter 1 does not apply to interactions **we** had with **you** before **we** were bound by Chapter 1 of the **Code**.

Types of insurance covered by Chapter 1

2.7 Chapter 1 covers **Life Insurance Policies** issued in the Australian market, including policies that are commonly referred to as:

- a) Term life insurance/death and terminal illness
- b) Total and permanent disability insurance (TPD)
- c) Trauma/critical illness insurance
- d) Disability insurance
- e) Funeral insurance (including funeral expenses insurance)
- f) Income protection/salary continuance
- g) Business expense cover
- h) Consumer credit insurance (CCI) issued by a life insurer

2.8 Chapter 1 does not cover:

- a) Annuities and investment life products,³ except any component considered as a **Life Insurance Policy**
- b) Whole-of-life and endowment insurance products
- c) Insurance products issued by general insurers (including but not limited to cover for death by sickness or accident)
- d) Health insurance products issued by health insurers
- e) Other products issued by an entity that is not registered as a life insurance company with the Australian Prudential Regulation Authority (APRA) under the Life Insurance Act 1995⁴ or is not authorised under that Act to issue Life Insurance Policies

Insurance products issued by general insurers or health insurers may be subject to other codes of practice.

Communicating with you under Chapter 1

2.9 **We** will have complied with a requirement to communicate with **you** under Chapter 1 if **we** communicate to any one of the **Applicant, Policy-owner, Life Insured, Third Party Beneficiary** or **Representative**, as appropriate to **your** circumstances and subject to privacy and confidentiality requirements.

2.10 Where an employer or superannuation fund trustee owns the **Life Insurance Policy**, some of **our** interactions will be with them and they will communicate with **you** as appropriate.

Legal status of Chapter 1

2.11 Chapter 1 does not limit **your** rights under any existing laws and regulations.

2.12 **You** can:

- a) Make a **Complaint** to **us** if **you** are unhappy with any aspect of **your** experience with **us**.

³ Sections 9(1)(c), (d), (f) and (g), Life Insurance Act 1995.

⁴ Such as pre-paid funeral plans issued by funeral directors and discretionary mutual products that may provide benefits similar to those described in section 2.10.

- b) Report possible **Code** breaches to the **Life CCC**, which it can investigate at its discretion.
- 2.12A Examples in Chapter 1 of the Code are for illustrative purposes only. They are not standards and do not create any obligations on us.
- 2.13 Chapter 1 does not create legal or other rights between us and any person or entity other than the **FSC**.
- 2.14 **External dispute resolution** bodies, if permitted to do so, may consider whether we have complied with the standards in Chapter 1 when determining a dispute.
- 2.15 Where there is any conflict or inconsistency between Chapter 1 and any law or regulation, that law or regulation prevails.
- 2.16 Where Chapter 1 has standards that are higher than the law, we will comply with both the law and Chapter 1.
- 2.17 We may agree service standards with a **Group Policy-owner** in relation to a **Group Policy** that are higher than Chapter 1 standards, in which case the higher service standards apply.
- 2.18 Chapter 1 does not apply if you commence proceedings in any court or tribunal (with the exception of **External Dispute Resolution** bodies).

3 Policy design and disclosure

- 3.1 When we design and introduce new **Life Insurance Policies** we will do the following:
- a) Define suitable customers for the product.
 - b) Include benefits intended to cover genuine risks that generally affect the relevant customers.
 - c) Use plain language in our sales and policy information, and consumer-test the plain language information required in sections 3.4 and 6.3.
 - d) Ensure that information about our policies is clear and informative, particularly for policies that are available for new customers to buy without a financial adviser, planner or **Group Policy-owner** so that they can make an informed decision about whether the policy is suitable.
 - e) Regularly review, and re-design where necessary, our policies that are available for new customers to buy to ensure they remain suitable for the customers we designed them for.
- 3.2 For policies that are available for new customers to buy, at least every three years we will review, and update if necessary, any medical definitions for benefits payable after a defined medical event to ensure they remain current. We will do this in consultation with relevant medical specialists. We will tell you when we update any medical definitions in your **Life Insurance Policy**.⁵

⁵ This does not apply to cover under a **Group Policy**.

- 3.3 Where a **Group Policy-owner** owns **your Life Insurance Policy**, they may make changes to the benefit design and structure for all members covered by the insurance. The **Group Policy-owner** will tell **you** about these changes.
- 3.4 When **you** buy a **Life Insurance Policy**, **you** will receive the following information in plain language:⁶
- a) The types of cover **we** insure **you** for.
 - b) How much **we** insure **you** for, if **your** cover is for a fixed amount.
 - c) How much **your** cover costs (the **premiums**).
 - d) The cooling-off period (the period when **you** can change **your** mind about buying the policy and get a full refund of the **premiums you** have paid).
 - e) Specific events **you** are not insured for (exclusions and/or limitations).
 - f) For benefits payable following a defined medical event, a general description of the circumstances where benefits are payable, and specifically whether benefits are payable on diagnosis of a medical condition or whether additional criteria need be met.
 - g) Any waiting periods that apply before **you** can access benefits.
 - h) A description of how the **premiums you** pay might change, for example whether regular **premiums** are stepped or level.

Example 1. Comparing stepped and level premiums

Level premiums are almost always more expensive than stepped premiums when your policy starts, but you should expect stepped premiums to become more expensive than level premiums in the longer term.

Stepped premiums go up every year as you get older, as they are based on your age each year. Level premiums are based on your age when your cover starts.

Both level and stepped premiums will increase if we increase our premium rates generally, or if your insurance cover increases, including yearly increases linked to inflation.

- i) The effect, if any, a claim would have on other lump sum or income benefits.
- j) **Our** claims and **Complaints** processes.

Exclusion clauses in our standard terms and conditions

- 3.5 If **we** offer a **Life Insurance Policy** with a clause which means **you** are not covered in certain situations (for example, a **pre-existing condition exclusion clause** which excludes cover for all medical conditions **you** had before **your** policy started) **we will use plain language to explain how the clause works and when it applies.**

Example 2. Description of a pre-existing condition exclusion clause

⁶ This does not apply to cover under a **Group Policy**.

A life insurer offering cover over the telephone explains their pre-existing condition exclusion clause before starting the application process.

It explains that: “We only pay claims for illnesses or disabilities that happen after the start of your policy. This means that we will not pay a claim if it results from any illness or disability you knew, or reasonably ought to have known, you had before your policy started. We may check your health records to make this assessment if you make a claim.”

Variations to our standard terms and conditions

3.5A If **we** ask **you** questions about **your** health and personal circumstances or ask **you** for medical evidence (such as a blood test) when **you** apply for the policy:

- a) On the basis of **your** disclosure or information about **your** health **we** receive, **we** may not offer **you** insurance or may offer it with changes to **our** standard terms, for example, with a higher premium or excluding cover due to **your** circumstances or medical history (an **Individually Agreed Special Term or Exclusion**). If **we** do this, **we** will ask **you** to agree to the changes. If **you** take out the policy, **we** will take this as **your** agreement to the changes.
- b) **We** will not apply a **pre-existing condition exclusion clause** in relation to any condition **you** fully and accurately disclose, unless **we** agree this with **you** and confirm it **in writing** when **your** policy is issued.

Funeral Insurance

3.6 If **we** offer a **Funeral Insurance Policy**, **we** will do the following:

- a) Give **you** at least 30 days from the date the first (full) **premium** is paid to change **your** mind about buying the policy and get a full **premium** refund (the cooling-off period).
- b) If cover is provided from the start of the policy with no, or only a notional, **premium** being payable for longer than a month, **we** will:
 - i. Tell **you** before the policy starts what the full premium will be, or is estimated to be, after the initial period with no, or only a notional, **premium**
 - ii. Give **you** between 10 and 20 **business days'** notice of when **we** will collect the first **premium**, and
 - iii. Remind **you** about the cooling off period, which will apply from when the policy starts until at least 30 days after **your** first full premium is paid.
- c) Allow **you** to choose level premiums. If stepped premiums are offered, to include an illustration about how future premiums might be expected to increase and a warning about future affordability in the light of how **your** future income might change, for example, after **you** retire or need age care, and what will happen if **you** allow the policy to be cancelled.

Example 3. Example wording for funeral insurance with stepped premiums

A life insurer offering funeral insurance over the telephone explains the importance of being able to afford the premiums over the intended life of the policy.

After it has explained how premiums might increase, it explains that: “This is an insurance policy, not a savings plan. If you can't afford to keep up the premiums or want to cancel your policy, you won't get a refund of any of the premiums you have paid. We encourage you to consider carefully whether you can afford the policy over the long term.”

- d) Not knowingly promote the policy to people under age 40.
- e) For people under age 40, as part of the sales process tell you that the appropriateness of funeral insurance depends on a number of factors such as health, lifestyle, age and financial objectives.
- f) In general marketing campaigns, explain the characteristics (such as the ages) of the people **we** designed the policy for.
- g) Design funeral insurance products to suit the target market, which includes designing a policy structure which is appropriate for the target market and supports affordability over the life of the policy.

Example 4. Example of funeral insurance product design

A funeral insurance provider offers funeral insurance policies to people over age 40, including retired people. In the design of the policy structure, the funeral insurance provider has regard to the typical income of people in retirement in assessing and designing the affordability over the life of the policy.

- h) Ensure that **we** have options available if **you** suffer financial hardship in accordance with section 6.6 including:
 - i. Allowing **your premium** to remain unpaid for at least 60 days before **we** cancel **your** policy.
 - ii. Allowing **you** to stop paying your **premium** for a fixed period, during which time **you** will not be eligible to make a claim.
- i) Provide **you** with a key facts sheet that explains the following in plain language:
 - i. That it is an insurance policy, not a savings plan.
 - ii. The benefits **you** will be entitled to and when **you** will be entitled to them.
 - iii. Whether the **premiums** are level or stepped, and an illustration of how **your future premiums** might increase.
 - iv. Any **pre-existing medical condition exclusions** and how they apply.
 - v. Any period during which **your** policy only pays out if **you** die as a result of an accident.
 - vi. Whether the total amount of **premiums you** pay could be more than the benefit amount **we** pay.
 - vii. That **you can cancel the insurance at any time**, and what happens if **you** cancel after the cooling-off period, including whether **premiums** paid are refunded.
 - viii. What happens if **you** stop paying **your premiums**, including whether **premiums** paid are refunded.
 - ix. How **your** beneficiaries can claim the benefits when **you** die.

Cover restricted to events caused by an accident

3.6A If we offer stand-alone cover for death or other benefits payable only if caused by an accident, we will:

- a) Document the characteristics of people in the target market, and why those people need the product.
- b) Not knowingly promote the product to people not in the target market.
- c) Give you at least 30 days from the date the first (full) premium is paid to change your mind about buying the policy and get a full premium refund (the cooling-off period).

Insurance where the amount you can claim depends on your earnings

3.6B If we design insurance⁷ (such as some types of income protection) where the amount you can claim depends on your earnings at the time you make a claim, we will:

- a) Design our application process so that we ask you for details about your current earnings, so that you do not take out more cover than your earnings would allow you to claim.
- b) If we increase your benefits yearly in line with inflation, we link the increases to an index that broadly reflects wage growth in Australia and allow you to opt out of the yearly increases if you choose to do so.
- c) Remind you at least yearly:
 - i. How much you are insured for.
 - ii. How the maximum you can claim depends on your earnings at the time of your claim.
 - iii. Tell you how to contact us if you want to change the amount you are insured for.

Product disclosure statements

3.7 A Product Disclosure Statement (PDS) will be available online for you to read before you apply for a new Life Insurance Policy. If you ask us for a PDS that we did not prepare (for example, if a superannuation fund trustee or other Group Policy-owner prepared it), we will refer you to the relevant party for a copy and we will encourage them to make these available online.

4 Sales practices and advertising

4.1 When we advertise and market our Life Insurance Policies, we will:

- a) Be clear and not misleading.
- b) Consider the target audience for the advertisement or marketing communication and whether it provides adequate information for that audience.
- c) Ensure statements in advertisements or marketing communications are consistent with the features of the relevant policy and the disclosures in any corresponding PDS.

⁷ This does not apply to group policies.

- d) Ensure that any images used do not contradict, detract from or reduce the prominence of any statements used.
- e) If price or **premium** are referred to, ensure that these are consistent with the price or **premium** likely to be offered to the target audience for the advertisement or marketing communication.
- f) Be clear about any specific circumstances a benefit depends on.
- g) Ensure any phrases such as “free” or “guaranteed” are not likely to mislead.
- h) Ensure that short-term customer incentives that are not part of the **life insurance policy** (such as gift cards or reward points) do not encourage customers to take out the policy solely for the incentive, rather than primarily for the features and benefits of the cover.
- i) Comply with the Australian Securities and Investments Commission’s (ASIC’s) guidance for advertising financial products and services⁸ and guidance regarding unsolicited sales.⁹

4.2 **Our** staff and the staff of **our Authorised Representatives** who sell **our** policies will receive appropriate initial and ongoing training, and any additional training needed to correct any identified shortcomings. **The training will be customer centric,** and will cover the following:

- a) **Our life insurance policies** and the characteristics of suitable customers for them.
- b) Acceptable and unacceptable sales practices.
- c) The best interests duty of financial advisers when providing personal advice.
- d) The relevant standards in Chapter 1.

4.2A **We** will ensure that **our** sales staff’s remuneration is consistent with good customer outcomes and complies with relevant law. This includes having compliance performance measures in any sales staff incentive programs with consequences for unacceptable sales practices, such as pressure selling or inappropriate use of deferred **premiums** or cooling off periods.

4.2B If **we** use a distributor to sell **our** policies that is not **our** staff or **our Authorised Representative**, **we** will take reasonable steps so that **we** are satisfied that the distributor maintains processes and procedures that are consistent with good customer outcomes and the obligations in the **Code**.

4.3 **We** will have clearly documented sales rules to ensure sales staff and **Authorised Representatives** **we** employ conduct sales appropriately and prevent pressure selling or other unacceptable sales practices. **Pressure selling means the use of techniques to coerce a customer into taking out a policy they do not wish to buy.** These rules will include:

- a) How to identify if someone is unlikely ever to be eligible to claim the benefits under a policy **and, if applicable, not sell you the policy.**
- b) When **our** staff must stop selling if **you** indicate **you** do not want a **Life Insurance Policy**.

Example 5. When a person says they do not want a policy

⁸ ASIC Regulatory Guide 234: Advertising financial products and services (including credit): Good practice guidance, as issued in November 2012.

⁹ ASIC Regulatory Guide 38: The hawking provisions, as issued on 1 May 2005. See also, Section 992A, Corporations Act 2001.

A life insurance company has documented sales rules that require sales staff to end a sales meeting or telephone call if the person clearly expresses the view more than once that they do not want to take out an insurance policy.

During a sales call, a consumer says that they do not need life insurance. In following the rules, the sales person asks politely for permission to ask some questions about the need for life insurance. They repeat that they do not want life insurance, so the sales person politely ends the call.

- c) How to record and keep adequate evidence that **you** consented to buy the **Life Insurance Policy**.
- d) The minimum information that must be disclosed to **you** about the **premium**, features, benefits, exclusions, limits and cooling-off period of the **Life Insurance Policy**.

Direct sales of Life Insurance

4.3A For direct sales of life insurance (that is, sales to consumers by our sales staff or Authorised Representatives), **we** will have documented sales rules which will include the following:

- a) [Placeholder: outbound calling]
- b) During the sale, periodically check that **you** have understood the information the sales person has given **you** and allow time for **you** to ask questions.
- c) Help **you** reach **your** own conclusion about how much cover **you** want, and the level of premium **you** can afford.

Example 6. Helping you decide how much cover to take out

A life insurance company trains its sales staff to help customers decide on the amount of cover they should take out by:

1. Explaining the range of cover that is available.
2. Asking the customer if they have a view about how much cover they should choose and, if so, prepare a quote for that amount.
3. If not, asking the customer how much they could regularly afford on life insurance to protect their family, and using that amount to prepare a quote.

- d) That sales staff should never take advantage of vulnerable customers and when to stop selling.

Example 7. Identifying vulnerable customers

A life insurance company has documented sales rules on how sales staff can identify vulnerable customers. For example, where the person:

1. Discloses that they have a vulnerability.
2. Appears to be having language difficulties.

3. Is having difficulty answering basic questions, even after the question is repeated.
4. Appears to be confused or under the influence of alcohol or drugs.
5. The person is, or becomes, distracted by something going on around them.

e) At the start of the application process, tell **you** that **you** are now applying to buy a **life insurance policy** and ask for **your** explicit consent to proceed.

Example 8. Being clear about when the application process starts

A life insurance company requires its direct sales staff to ask for explicit consent to start the process of completing an application for life insurance.

To do this, a sales person asks: “The next step will be for me to ask you questions to complete an application to take out the life insurance policy we discussed. Are you happy to go ahead with that?”

f) If **you** are not eligible for the policy **we** originally proposed, if **we** propose an alternative type of policy, **we** will give **you** details of the alternative (including the PDS) at the time and offer to arrange a future call or meeting to discuss it if you wish.

g) If **you** say that **you** want time to think about the policy or whether it is suitable for **you** before applying to buy it, not sell **you** the policy or take **your** payment details and offer to arrange a future call or meeting to discuss it.

4.4 **We** will monitor **our** staff’s compliance with **our** sales rules through a framework which includes:

- a) Quality assurance measures for reviewing sales and compliance with the obligations in section 4 of the **Code**, such as call monitoring, mystery shopping and post-sale customer surveys.
- b) Analysis and reporting on key data, such as sales results, lapses, declined claims and **Complaints**.

4.5 With **our** **Authorised Representatives**:

- a) **We** will agree with them their sales approach, staff training requirements and their monitoring and reporting framework, to satisfy **us** that their staff and businesses are meeting their agreed commitments, **our** sales rules, and the requirements of the Chapter 1.
- b) **We** will have monitoring arrangements in place to oversee their conduct, such as mystery shopping, independent audits and analysis of key data such as sales results, lapses, declined claims and **Complaints**.

4.6 **We** will make it clear to anyone distributing **our** policies that pressure selling is not permitted.

Consumer credit insurance

4.7 If **you** apply for consumer credit insurance (**CCI**) either with **us** directly, or through our **Authorised Representative** or another distributor, **we** will take all reasonable steps so that **we** are satisfied that the product is offered in a way that complies with sections 4.7 a) to 4.11 below.

a) Before **you** buy **CCI**, **you** will receive clear information to help **you** make an informed decision — including (to the extent **we** can):

- i. The cost of the **CCI**, including any interest **you** will pay on the **premium**.
- ii. How long **you** would be insured for.
- iii. The monetary limits on the key benefits payable under the insurance.
- iv. The date **your** insurance ends, if that date is different to the date on which the underlying credit product ends.

b) **You** must have given **your** explicit consent to buy **CCI**.

c) The **CCI** will have a minimum cooling-off period of 30 days.

4.8 If the **CCI** Life Insurance Policy is an add-on to a loan:¹⁰

a) If the option of paying the **premium** through the loan is offered, then at least one non-financed **premium** option, such as a monthly direct debit, will also be offered.

b) If the **premium** is fully funded by the loan, **you** will be told that **you** will pay interest on the premium, and **your** loan repayments will be shown with and without the **premium** for comparison.

4.9 We will send you a written notice each year before the anniversary of your **CCI** which will show:

a) the period of cover;

b) the types of cover; and

c) contact details if **you** have any questions or need to make a claim.

Separation of application process for **CCI** and credit products in digital channels

4.10 If **you** apply for **CCI** through a digital channel:

a) The digital application process for **CCI** will not start until **you** have completed¹¹ the digital application for a credit product, such as a credit card or loan.

b) It will be clear that taking out **CCI** has no bearing on whether or not the credit product is approved.

c) As **you** navigate through the digital experience, to help **you** understand **CCI** there will be clear disclosures, for example by:

- i. Using filtering questions to alert **you** to key policy exclusions such as age, residency and employment status, and if **you** are not eligible to claim under significant parts of the **CCI** policy, not offering it.

¹⁰ For clarity, this does not include **CCI** protecting a credit card or line of credit facility/overdraft where the **premium** is charged regularly to the credit card or line of credit facility/overdraft.

¹¹ For clarity, the digital application process for **CCI** may start once you have submitted your on-line application for the credit product, which may be during the approval process for the credit product.

- ii. Disclosing the circumstances in which a payout will be made and the amount of the payout.
- iii. Disclosing any incentives **you** might receive from taking out the **CCI** product and their effect.
- iv. Before **you** complete the purchase, if the premium is calculated by reference to an associated financial product, an explanation of how it is calculated, and show **you** an example. Otherwise, **we** must tell **you** the cost of the **CCI**.
- v. Telling **you** how the premium is to be paid.

Deferred sales period for CCI linked to credit cards and personal loans arranged over the telephone or face to face

- 4.11 Where **CCI** is available to cover credit cards and personal loans arranged over the telephone or face to face:
- a) The **CCI** will not be offered until at least four days after you have applied for the credit card or personal loan. This is known as the 'deferred sales period'.
 - b) You may be given factual information about **CCI** for you to consider during the deferred sales period.

Replacement policies

- 4.12 When **you** tell our sales staff or our **Authorised Representative** that **you** are replacing an existing **Life Insurance Policy**, they will tell **you** that **you** should not cancel any existing cover until **your** new application is accepted. They will also explain the general risks of replacing an existing policy, including the loss of any accrued benefits, the possibility of waiting periods to start again, and the implications of any errors or omissions in **your** new application (even where unintentional).

Investigating your concerns

- 4.13 **We** will investigate concerns raised or identified about the sales practices of **our** staff and **our Authorised Representatives**. If **we** find that **your Life Insurance Policy** was sold inappropriately:
- a) **We** will contact **you** to arrange an appropriate remedy, which depending on the circumstances may include:
 - i. Cancelling **your** policy
 - ii. Refunding the **premiums you** paid
 - iii. Paying **you** interest on the refunded **premiums**
 - iv. Adjusting the cover or arranging for more suitable cover
 - v. Correcting incorrect information
 - vi. Honouring a claim
 - b) If **you** tell **us** that **you** are not satisfied with the remedy **we** propose, **we** will review it and tell **you** how to make a **Complaint**.
 - c) **We** will correct the sales practice issues including through further education and training.

5 When you buy insurance

- 5.1 This section only applies where **your** application requires an underwriting decision.
- 5.2 The Law requires **us** to send all communications about **your** policy to the **Policy-owner**. If **you** are not the **Policy-owner**, **we** will not tell the **Policy-owner** about **your** personal health information without **your** consent.

Example 9. Respecting your privacy

A person applies for a policy to insure someone else. The person to be insured discloses details of a health condition. The life insurer decides that it can only offer insurance with an exclusion for the disclosed condition.

Knowing this fact would make it obvious that the insured person has that health condition. Accordingly, the insurer makes sure that the insured person has given their consent before telling the applicant. The applicant can then agree to the exclusion so the policy can proceed.

Use of family history in underwriting

5.2A If **we** ask **you** about any history of illness in **your** family, **we** will only ask **you** about and require **you** to disclose information about your relatives:

- a) That **you** are aware of.
- b) Who are **your** first-degree blood relatives (that is, only **your** parents, children, brothers and sisters).
- c) Without telling **us** the relative's name or date of birth.
- d) The illness **your** relative had and their age at diagnosis or death.

5.2B When **we** assess an application for insurance from **you**, **we** will not use any information about **your** family history that a person **you** are related to gave **us** about themselves, for example, when they took out a policy with **us**.

Use of genetic tests in underwriting

5.2C **We** will comply with The Moratorium on Genetic Testing and Life Insurance. The terms are set out in Appendix 4 of the **Code** and on the FSC website at www.fsc.org.au.

Questions in our application process

- 5.3 At the start of the application process, before asking **you** any underwriting questions, **we** will explain **your** duty of disclosure and the consequences of any errors or omissions in the information **you** give **us** when **you** answer **our** questions.
- 5.3A **We** will ensure that the questions we ask:

- a) Are in plain language where possible, are easy to understand and are not ambiguous, noting that **we** expect **you** to have a reasonable understanding of **your** health, lifestyle and financial situation.

Example 10. Being clear about what needs to be disclosed

In its application form, a life insurer asks a series of questions about mental health conditions to help applicants understand what needs to be disclosed. One of these asks whether applicants have had a mental health condition that has resulted in taking any time off work or being prescribed medication for the condition.

- b) Help **you** understand what **we** expect **you** to disclose to meet **your** duty of disclosure.
- c) Ask only about factual matters that do not require you to make unreasonable judgements or have specialist knowledge.

5.3B If **we** ask **you** questions verbally, either face to face or on the phone, **we** will do so carefully to help **you** understand what **we** are asking **you**. **We** will:

- a) Repeat a question as many times as **you** reasonably need to ensure **you** understand it.
- b) Allow **you** enough time to answer questions carefully so **you** can be confident **your** answers are not hurried.

5.3C **You** can ask **us** to send **you** a copy of **your** answers **we** used to assess **your** application for insurance.

5.3D If **we** ask **you** questions about **your** health to assess **your** application for a policy and **you** tell **us** about a mental health condition **you** have, or have had in the past, **we** will take into account the individual circumstances, such as the history and severity of the mental health condition, in making **our** decision about whether to insure **you** and, if so, the terms **we** offer **you**.

Example 11. Assessing your individual circumstances

When applying for TPD insurance, the applicant tells the life insurance company that they had a week off work 2 years ago following the loss of a family member. They consulted their doctor and were not diagnosed with a mental health condition. As they have had no recurrence and the normal grief cycle has passed, the life insurance company insures them at standard premium rates with no exclusion.

5.4 Where the information **we** received from **you** is all **we** need to make **our** decision on **your** application, **we** will tell **you** **our** decision within five **business days**.

Using information about your health

5.5 **We** may need information or reports from a third party (for example, **your** doctor) to assess **your** application. To access information about **your** health, **we** will ask for **your** consent as

part of **our** application process using the consent wording agreed between the FSC and the Royal Australian College of General Practitioners (RACGP) contained in Appendix 2 of the **Code** and on the FSC and RACGP websites. **We** will tell **you** each time **we** use **your** consent. Where possible **we** will do this by phone or electronic means (SMS, email or similar) to ensure that **you** receive notifications promptly to keep **you** informed.

- 5.6 **We** may also ask for additional information to assess **your** application, such as a medical examination by an **Independent Service Provider** **we** choose.¹² **If we ask you to have a medical examination, if you ask us, where possible we will allow you to choose the gender of the examiner.** **We** will explain why **we** need any additional information **we** ask for. If **you** disagree that **we** need the additional information, **we** will review our request. If **you** are not satisfied with **our** review, **we** will tell **you** how to make a **Complaint**.
- 5.7 If **we** ask **you** to attend an assessment by an **Independent Service Provider**, **we** will meet the cost of the appointment (excluding missed appointment fees), reasonable travel costs **we** agree in advance, and the production of any reports.
- 5.8 If **we** ask **you** to attend an assessment by an **Independent Service Provider**, **we** will ask them to give **us** their report within ten **business days**. If **we** ask for any reports from **Independent Service Providers** that do not require **you** to attend an assessment, **we** will ask them to give **us** their report within four weeks of **our** request. If the **Independent Service Provider** fails to meet these timeframes, **we** will tell **you** and keep **you** informed of **our** progress in obtaining the report.
- 5.9 **We** will request the information **we** need as early as possible and will avoid multiple information requests where possible.
- 5.10 If **we** find out during the application process about any errors or omissions in the application or the information **we** have asked for, **we** will address these promptly. **We** may require additional information to implement corrections.
- 5.11 If **we** issue temporary insurance while **we** are undertaking the underwriting process, **we** will let **you** know that this insurance is only temporary, what it does and does not cover, and when it will cease.
- 5.12 **We** will tell **you** **our** decision about whether to accept **your** application and, if so, on what terms within five **business days** after **we** have all the information **we** reasonably need and have completed all reasonable enquiries relating to **your** application.¹³
- 5.13 After considering **your** application, **we** may not be able to offer **you** any insurance, or **we** might offer **you** insurance on alternative terms, such as:
- a) A higher **premium**
 - b) Excluding specific events, activities or medical conditions from the cover provided
 - c) A longer waiting period before **you** can access benefits

¹² Standards for **Independent Service Providers** are contained in section 10 including particular requirements for medical assessors/examiners at section 10.5.

¹³ Including enquiries to one or more **Reinsurers** **we** deem necessary.

- d) A shorter benefit period or term of the insurance cover
- e) Applying other specific terms or conditions to the **Life Insurance Policy**
- f) An alternative policy
- g) A lower benefit amount

5.14 If **we** do not offer **you** any insurance, or if **we** offer **you** insurance on alternative terms, **we** will tell **you** (or **your** doctor, where appropriate¹⁴) in plain language:

- a) The reasons for **our** decision.

Example 12. Explaining the reasons for our decisions

In an application for life insurance, the applicant discloses that they have a history of high blood pressure and cholesterol, and that they recently saw a doctor about chest pain. The life insurance company decides not to offer life insurance on any terms until the cause of the chest pain has been fully investigated and the cause found. It explains that the reason for the decision is due to the undiagnosed chest pain, and the high blood pressure and cholesterol test results.

- b) If **we** offer **you** insurance with a higher **premium**, revised terms, or with an **Individually Agreed Special Term or Exclusion**, whether **you** can ask **us** to review the terms, and if so, under what circumstances and how to do so.

Example 13. Explaining when you can ask us to review an exclusion

When applying for an income protection policy, the applicant tells the life insurance company they had 2 weeks off work 2 years ago for an injury to the left shoulder. The injury was treated at the time, but they continue to have shoulder pain. The life insurance company offers insurance at standard premium rates but with an exclusion for conditions related to the left shoulder.

It explains that the reason for the exclusion is that the continuing shoulder pain. It also explains that they can ask to have the exclusion reviewed at any time if the circumstances have materially improved.

- c) That **you** have the right to the information about **you** that we have relied on to make **our** decision, and if **you** ask **us** **we** will give this to **you** (or **your** doctor, where appropriate) within ten **business days**, in accordance with the Access to Information section in Chapter 3 of the **Code**.
- d) That if **you** disagree with **our** decision, or if **you** think that the information **we** have relied on to make our decision is incorrect or out of date, **you** can tell **us** and **we** will review **our** decision. If **you** are not satisfied with **our** review **we** will tell **you** how to make a **Complaint**.

¹⁴ In some circumstances, **we** might find out information about **you** that could be significant to **your** health or that **you** may not be aware of. In these circumstances, it might be appropriate for **your** treating doctor to explain the implications to **you**.

- 5.14A **If we offer you insurance with revised terms, such as a higher premium or with an Individually Agreed Special Term or Exclusion, we will tell you what the revised terms are so that you can decide whether to buy the policy. If you do then buy the policy, we will take this as your agreement to the revised terms.**
- 5.15 **Our** underwriters will be appropriately skilled and trained. They will not make underwriting decisions for **us** until they have demonstrated technical competency and an understanding of all relevant law, the requirements of Chapter 1 and relevant **FSC** Standards and Guidance. They will have access to professional advice and support during the assessment process where required, in the relevant disciplines (for example, medical specialists and accountants).
- 5.16 **We** will comply with all relevant **FSC** Standards and Guidance Notes¹⁵ during the assessment process.
- 5.17 **Our** decisions on applications for insurance will comply with the requirements of anti-discrimination law. **Our** decisions will be evidence-based, involving relevant sources of information where this is available, and having regard to any other relevant factors where no actuarial or statistical data is available and cannot reasonably be obtained. **We** will regularly review **our** underwriting decision-making processes to ensure **we** are not relying on out-of-date or irrelevant sources of information.
- 5.18 **We** will monitor **our** underwriters to ensure the questions asked and the decisions made are consistent, evidence-based and compliant with legislation and regulation.
- 5.19 Where **we** allow **you** to apply for insurance via electronic underwriting, **we** will regularly review and monitor this to ensure the questions asked and the decisions made are consistent, compliant with legislation and regulation and **we** believe are necessary for **us** to assess **your** application based on information, analysis and evidence available to **us**. Where a decision about **your** application has been made solely via an electronic method and **you** have questions or concerns about the outcome, **you** can ask **us** to review the decision.
- 5.20 **When you apply for life insurance (or make changes to your life insurance) we will rely on the information you give us in making our decision about whether to accept your application and, if so, what terms we offer you. We encourage you to do this carefully so that you can rely on your cover at claim time.**
- If we later find that there was an error or omission in what you told us, for example because you tell us or we find out while we are assessing your claim, we first need to decide whether the error or omission would have changed our decision about your life insurance that we previously made. Before we do this, we may ask for further information:**
- a) **From you.**

¹⁵ As at 1 October 2016, Standard No. 11 - Genetic Testing Policy, Standard No. 16 - Family Medical History Policy, Standard No. 21 - Mental Health Education Program and Training, Guidance Note No. 15 - Underwriting Guidelines for Mental Health Conditions and Guidance Note No. 32 – HIV/AIDS Underwriting Guidelines.

- b) With **you** consent, from other parties such as **you** doctor, accountant or financial adviser.

If the error or omission does not affect the decision **we** made regarding your application, **your** policy will continue unchanged and the error or omission will not affect the terms and conditions of **your** policy, and therefore any claim **you** make.

If the error or omission changed the decision **we** would have otherwise made about **your** life insurance, **we** will then consider what action the law allows **us** to take¹⁶. This may include changing the terms of **your** insurance, changing the amount **you** are insured for or cancelling¹⁷ **your** insurance as if it never existed.

Before deciding what action to take, **we** will let **you** review the relevant information **we** have about **you** and give **you** an opportunity to explain the error or omission.

In the interests of fairness, **we** will consider **your** explanation before **we** reach **our** decision. Unless you acted fraudulently, **we** will try to change **your** life insurance to the same terms, if any, that **we** would have offered had the error or omission not occurred. In doing this, **we** will aim to make **you** no better or worse off than other customers who fully and accurately disclosed their personal circumstances.

Once **we** have made our decision, **we** will:

- a) Tell **you** **our** decision.
- b) Explain the reasons for it.
- c) Explain the implications for **your Life Insurance Policy**.
- d) Explain how to have **our** decision reviewed if **you** disagree with it.
- e) Tell **you** how **you** can make a **Complaint**.

6 Policy changes and cancellation rights

6.1 This section 6 does not apply to cover under a **Group Policy**, as the **Group Policy-owner** is responsible for communication with **you** and policy changes.

6.2 For the rest of this section “**you**” means the **Policy-owner** only.

Communication during the term of your policy

¹⁶ The decisions the law allows **us** to make are:

- (a) Cancel **your** insurance from its start as if it never existed, and no claim will be payable (if **your Life Insurance Policy** or particular cover is older than three years **we** can only do this if **you** acted fraudulently);
- (b) If **your Life Insurance Policy** or part of **your** cover started after 28 June 2014, change the terms of **your Life Insurance Policy**, such as charging a higher premium or excluding claims arising from a particular medical condition or injury; or
- (c) Change the amount that **you** are insured for.

¹⁷ Cancelling means avoiding **your** policy.

6.3 **We** will send **you** a **written** statement each year before **your Life Insurance Policy**¹⁸ anniversary covering:

- a) The types and amounts of cover **we** insure **you** for.
- b) An explanation for any increase in **your premiums**.
- c) The risks of cancelling and replacing **your Life Insurance Policy**.
- d) How to contact **us** to discuss options if **you** want to change the terms of **your Life Insurance Policy** or are having difficulty meeting **your premium**.
- e) What to do in the event of a claim.

6.4 If **your Life Insurance Policy** has an automatic upgrade of benefits and we pass an automatic upgrade on to **you**, **we** will tell **you** about the relevant changes to the key information detailed above at section 3.4.

Life Insurance Policy changes and financial hardship

6.5 If **you** tell **us** that **you** want to change the terms of **your Life Insurance Policy**, or that **you** are having trouble paying **your premiums**, **we** will tell **you** what options are available, such as:

- a) Changing **your** benefits or the amount **we** insure **you** for.
- b) Stopping **your premium** for a short period. **You** would not be able to make a claim for any event that occurs or condition that is diagnosed or first becomes apparent during this period, but **your Life Insurance Policy** would not be cancelled, in accordance with **our** hardship procedures.
- c) **Making a claim if you are experiencing financial hardship due to an illness or injury your policy covers.**

6.6 In cases where **you** tell **us** that **you** are experiencing financial hardship, **we** may ask **you** to give **us** reasonable evidence, such as:

- a) For Centrelink clients, **your** Centrelink statements.
- b) Financial documents such as bank statements.
- c) A statement showing the termination of employment.

Cancellation rights

6.6A **We will not try to coerce you into keeping a policy you no longer want.** If **you** tell **us** that **you** can no longer afford it, if possible, **we** will offer to discuss ways that **you** can reduce **your premium** to an amount **you** tell **us** that **you** can afford.

6.7 **You** may be entitled to a **premium** refund when **you** cancel **your Life Insurance Policy**, in accordance with the terms of **your Life Insurance Policy**. If **you** cancel **your Life Insurance Policy**, **we** will send **you** any money **we** owe **you** within 15 **business days**. If **your** cover is in

¹⁸ This section 6.3 does not apply to **CCI**, as the requirements for the annual notice for **CCI** are contained in section 4.7.

superannuation **we** will make the refund to **your** chosen superannuation fund or, if **you** have not made a choice, as set out in **our PDS**.

- 6.8 If **we** cancel **your Life Insurance Policy** due to unpaid **premiums**, **you** can ask **us** to consider reinstating it, subject to its terms. Reinstatements are at **our** discretion, and **we** may ask for additional information (such as medical or financial information) to make **our** assessment.

7 Supporting vulnerable consumers

- 7.1 **We** recognise that some groups may have unique needs when accessing insurance, making an inquiry, claiming on their insurance, making a **Complaint** or communicating with **us**. These groups might include older people, people with a disability, **people experiencing family violence, people with a mental health condition**, people from non-English speaking backgrounds and indigenous people. Where **we** identify that a person requires additional support, **we** will take reasonable measures to ensure that **we** provide it.
- 7.2 **We** will have processes in place to train **our** staff to help identify and engage appropriately with consumers who are having particular difficulty with the process of buying insurance, making an inquiry, making a claim or making a **Complaint**, or who may not be capable of making an informed decision, and to refer these consumers for appropriate additional support where required.¹⁹ **We** will take into account someone's capability when making decisions that affect them.
- 7.3 **We** acknowledge that **we** will not always be able to identify when someone requires additional support when they apply for insurance. If **we** later become aware that **we** or **our Authorised Representative** sold **you** a **Life Insurance Policy** and **you** were not given the additional support **you** needed to make an informed decision, **we** will investigate this. If **we** find the **Life Insurance Policy** was sold inappropriately, **we** will remedy this in accordance with section 4.9. If the person who recommended **our Life Insurance Policy** (for example, **your** financial adviser) is not **our** staff or **our Authorised Representative**, **we** will tell **you** how **you** can address the matter.
- 7.4 **We** recognise that some groups of people (for example, people from indigenous communities, people new to Australia, people who are homeless, or those from non-English speaking backgrounds) may require support in meeting identification requirements. **We will take reasonable measures to assist and a flexible approach to verification and identification in line with AUSTRAC²⁰ guidance, while still meeting our obligations under the law.**
- 7.5 **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 take this into account in **our** underwriting and claims processes.

¹⁹ This is in addition to the requirements of FSC Standard 21: Mental Health Education Program and Training.

²⁰ Australian Transaction Reports and Analysis Centre.

8 When you make a claim

- 8.1 If **your** claim is covered by a **Group Policy**, **we** may be required to provide the communications referred to below to the **Group Policy-owner** (for example, the superannuation fund trustee which owns **your Life Insurance Policy**) in accordance with section 2.13. The **Group Policy-owner** will then communicate with **you** and assist with **your** claim. When **you** make a claim, **we** and/or the **Group Policy-owner** will let **you** know who will be in contact with **you**.

When you make a claim

- 8.2 **We will not discourage you from making a claim.**
- 8.2A When **you** make a claim, **we will make you aware of all the available benefits under the Life Insurance Policy you are claiming on.**
- 8.3 **Within five business days of your claim being received, we will explain to you your cover, the claim process, and if any waiting period applies before we pay any benefits. We will give you contact details that you can use to get information about your claim.**
- 8.4 **Until we make our initial assessment²¹ about your claim, we will keep you informed about the progress at least every 20 business days unless otherwise agreed with you, the Group Policy-owner, or other representative acting on your behalf. We will respond to your requests for information about your claim within ten business days.**

What we need to assess your claim

- 8.5 **We will get your consent for us to collect the information about you (for example, about your finances, your job or your health) on each occasion that you make a new claim and, if you ask us, explain why we need it.** If **you** disagree about whether **we** need any particular information, **we** will review **our** request. If **you** are not satisfied with the outcome of **our** review, **we** will explain the implications and tell **you** how **you** can make a **Complaint**.
- 8.5A **We will respect your privacy by only asking for information we need to assess the eligibility of your claim. We can fully investigate the history of any condition you are claiming for when we assess your claim. We will only seek to assess the accuracy of the information you gave us about conditions that are not related to your claim when you applied for the cover if we have reasonable grounds for doing so. If you ask us, we will explain to you what those reasonable grounds are. If you disagree that the grounds are reasonable, we will review them. If you are not satisfied with the outcome of our review, we will explain the implications and tell you how you can make a Complaint.**
- 8.6 **We might ask you for the information, ask you to have an assessment, or ask for information from other sources (for example, your accountant, doctor or other health professional).**
- 8.6A **If we need to collect medical information about you from your doctor, we will ask for your consent using the wording agreed between the FSC and the Royal Australian College of**

²¹ **Our** initial assessment will be complete if **we** either start the procedural fairness process or reach a decision.

General Practitioners (RACGP) as set out in Appendix 2 of the **Code**. **You** can also see a copy on the FSC website and the RACGP website.

8.6B Wherever possible **we** will avoid multiple information requests. If **we** have asked **you** to consent to **us** asking for information from a number of sources, **we** will tell **you** each time **we** use **your** consent. Wherever possible **we** will do this by phone or electronic means (SMS, email or similar) to keep **you** informed.

8.7 **We** will ask for the information **we** need as soon as possible, including from **you** and third parties, and also referrals to **our** reinsurers, so that **we** can assess **your** claim as quickly as **we** can.

8.8 If **we** ask for a report from an **Independent Service Provider**, **we** will ask them to give it to **us** within four weeks from either the date of **our** request or of **your** appointment if **you** need to attend one. If the **Independent Service Provider** fails to meet this timeframe, **we** will tell **you** and keep **you** informed of **our** progress in obtaining the report.

8.8A When **you** apply for life insurance (or make changes to **your** life insurance) **we** will rely on the information **you** give **us** in making **our** decision about whether to accept **your** application and, if so, what terms **we** offer **you**. **We** encourage **you** to do this carefully so that **you** can rely on **your** cover at claim time.

If **we** later find that there was an error or omission in what **you** told **us**, for example because **you** tell **us** or **we** find out while **we** are assessing **your** claim, **we** first need to decide whether the error or omission would have changed **our** decision about **your** life insurance that **we** previously made. Before **we** do this, **we** may ask for further information:

- a) From **you**.
- b) With **your** consent, from other parties such as **your** doctor, accountant or financial adviser.

If the error or omission does not affect the decision **we** made regarding your application, **your** policy will continue unchanged and the error or omission will not affect the terms and conditions of **your** policy, and therefore any claim **you** make.

If the error or omission changed the decision **we** would have otherwise made about **your** life insurance, **we** will then consider what action the law allows **us** to take²². This may include changing the terms of **your** insurance, changing the amount **you** are insured for or cancelling²³ **your** insurance as if it never existed.

²² The only decisions the current law allows **us** to make are:

- (a) Cancel **your** insurance from its start as if it never existed, and no claim will be payable (if **your** Life Insurance Policy or particular cover is older than three years **we** can only do this if **you** acted fraudulently); or
- (b) If **your** Life Insurance Policy or part of **your** cover started after 28 June 2014, change the terms of **your** Life Insurance Policy, such as charging a higher premium or excluding claims arising from a particular medical condition or injury; or
- (c) Change the amount that **you** are insured for.

²³ Cancelling means avoiding **your** policy.

Before deciding what action to take, **we** will let **you** review the relevant information **we** have about **you** and give **you** an opportunity to explain the error or omission.

In the interests of fairness, **we** will consider **your** explanation before **we** reach **our** decision. Unless you acted fraudulently, **we** will try to change **your** life insurance to the same terms, if any, that **we** would have offered had the error or omission not occurred. In doing this, **we** will aim make **you** no better or worse off than other customers who fully and accurately disclosed their personal details.

Example 14. Where a higher premium would have applied

In an application for life insurance, a customer fails to disclose a health-related matter which, if known to the insurer, would have resulted in the insurer charging a higher premium. The life insurer finds the missing information when they make an otherwise valid claim.

As they did not withhold the information fraudulently, the life insurer works out the amount of cover they would have had if the omission had not occurred, based on the premium paid, and pays that amount.

Example 15. Where an exclusion would have applied

In an application for life insurance, a customer fails to disclose a health condition which, if known to the insurer, would have resulted in the life insurer excluding cover for that condition. The life insurer finds the missing information when they make an otherwise valid claim.

As they did not withhold the information fraudulently, the life insurer adds an exclusion to the policy relating to the undisclosed condition, and then assesses whether the exclusion applies to the claim. If the exclusion does apply, no claim is payable for the excluded condition and the policy can continue in force with the exclusion. If it does not, the life insurer pays the claim.

Example 16. Where the life insurer would not have offered any cover at all

In an application for life insurance, a customer fails to disclose a health-related matter which, if known to the insurer, would have resulted in the insurer declining the application and not offering any cover at all. The life insurer finds the missing information when they make an otherwise valid claim.

As the life insurer would not have offered any cover at all, even though they did not act fraudulently, the life insurer avoids the policy (cancels the policy from commencement). The life insurer does not pay the claim, even if the claim is for an unrelated condition. Had the omission not occurred, the customer would not have had a policy at all, and

would therefore not have paid any premiums. Accordingly, the life insurer refunds all the premiums paid since the policy started.

Once **we** have made our decision, **we** will:

- a) Tell **you** our decision.
- b) Explain the reasons for it.
- c) Explain the implications for **your Life Insurance Policy**.
- d) Explain how to have **our** decision reviewed if **you** disagree with it.
- e) Tell **you** how **you** can make a **Complaint**.

8.9 For income-related claims (such as income protection or business expense cover):²⁴

- a) **We** may need information on an ongoing basis to review **your** entitlement to benefits or to calculate the amount of **your** benefit payments. This can include financial as well as medical information.
- b) **We** will not ask **you** for a statement from **your** doctor more frequently than reasonably necessary to assess **your** condition, so that **we** can determine your ongoing entitlement to benefits. **We** may ask for information from **your** doctor every six months, even if **your** condition is stable.
- c) **We** will not request a medical statement from **your** doctor for the sole reason of processing **your** regular benefit payment.
- d) **We** will only request financial information in circumstances where **we** need it to assess **your** entitlement to benefits or to calculate the amount of **your** benefits.

8.10 If **we** ask **you** to have an independent medical examination:²⁵

- a) **We** will pay for the appointment (excluding any missed appointment fees), the production of any reports, and any extraordinary travel costs we agree in advance.
- b) **You** can ask **us** to give **you** a list of doctors that **you** can choose from to carry out **your** medical examination (note that **your** chosen doctor's availability might cause delays). **You** can ask **us** to include at least one doctor of each gender, and **we** will do this wherever it is practical.
- c) **We** will avoid asking for more than one examination from the same type of specialist within six months where possible. If **we** do need more than one (such as where the claim is for a terminal illness or where superannuation legislation requires it), **we** will explain the reasons.
- d) **You** can ask **us** for a copy of the report which **we** will send to **you**, or to **your** doctor if **we** think that is more appropriate.

²⁴ An income-related claim is a claim for an ongoing benefit that **we** pay to **you** when **you** are unable to work due to being ill or injured.

²⁵ Standards for independent medical examiners are contained in section 10.5.

8.11 If **we** ask **you** to be interviewed to establish some factual information about **your** circumstances.²⁶

- a) **We will check our records before we engage an interviewer to see if we already know that you are likely to need a support person or an interviewer/interpreter who speaks your preferred language.**
- b) The interviewer will tell **you** who they are, that they are acting for **us**, the reason for contacting **you**, **your** right to have a **Representative** or other support person present, **and will give you a privacy collection notice**, before **you** give a statement.
- c) **The interviewer will explain why the investigation is taking place, how long it is expected to take, and what areas it will cover.**
- d) **The interviewer will give you an information sheet explaining the interview process and your rights, including that we will give you a transcript of the interview, and how to make a complaint if you wish to do so.**
- e) Interviews will be conducted respectfully and take a **maximum time of 90 minutes**, unless **you** agree to an extension.
- f) **A further interview will be arranged if it is reasonably needed, but not within 24 hours of the first interview unless you agree that it can be sooner.**
- g) If **you** ask **us** to communicate through a **Representative**, **we** will tell the interviewer to contact **your Representative** before contacting **you** to arrange the interview.
- h) **You** can have someone attend the interview with **you**. Additionally, if **you** need an interpreter, **we** will arrange this at **our** cost.
- i) **The interviewer will end the interview immediately if it becomes apparent that you need an interpreter or a support person that you do not have.**
- j) If the interview relates to a claim involving a mental health condition, or if **you** have limited English, or known cognitive decline or impairment, **we** will only use an interviewer that **we** are satisfied has appropriate training and experience to carry out the interview.
- k) **We will offer you a 5-minute break at least every 30 minutes.** **You** can ask for further breaks during the interview if **you** need them, and **you** can end the interview early.
- l) If **you** ask **us**, **we** will arrange an interviewer of a specific gender if one is reasonably available.
- m) **You** can choose to be interviewed somewhere other than **your** home, at a location acceptable to both parties, unless interviewing **you** at **your** home is essential to establishing whether **you** are eligible to claim.²⁷ If it is essential, **we** will explain why.
- n) **If the interview is to be recorded, you will be told before the interview starts.**
- o) **We** will give **you** a transcript of the interview and, if the interview was recorded, **you** can ask **us** for a copy of the recording.
- p) **If you withdraw your claim after an interview, a different person will contact you on our behalf to discuss the reasons for your decision and ask if you would like to restart your claim.**

²⁶ This section 8.11 does not apply to independent medical examinations, which are covered in section 8.10, or interviews conducted by an allied health professional.

²⁷ For example, where **your** claim relates to a total and permanent disablement cover with an “Activities of Daily Living” definition.

- 8.12 If **we** have reason to believe that there are inconsistencies in the information **we** have about **your** claim, **we** will try to reconcile these without using **surveillance**. If **we** cannot do that:
- a) **We** will document the inconsistencies before any surveillance starts.
 - b) A senior claims manager will review each request for **surveillance** before it starts and, only if they are satisfied that **surveillance** is necessary and justified, approve the request.
 - c) **Surveillance** will not be conducted in any court or other judicial facility, in any medical or health facility, in any bathroom, changing room, lactation room or inside **your** home.
 - d) **Our surveillance** investigator will not intentionally film **family members, neighbours, friends, acquaintances or work colleagues** in the company of the subject of the enquiry. If this cannot be avoided, these people will be pixelated or blurred in any video recording before **we** give it to any external party such as a court or **External Dispute Resolution** body.
 - e) **Our surveillance** investigator will not communicate with neighbours or work colleagues in ways which might directly or indirectly reveal that surveillance is being, will be or has been conducted.
 - f) **We** will stop the **surveillance** if **we** receive evidence from an independent medical practitioner that it is having a negative impact on **your** health.
- 8.13 If **we** become aware of any errors in the information **we** have about **your** claim, **we** will address these promptly. **We** may need additional information to correct the error.

Claims decisions and benefit payments

- 8.14 **We** will make every effort to meet the timeframes in Chapter 1. However, factors outside **our** control (**Unexpected Circumstances**) can affect timeframes for assessing claims. Examples of these include the time taken by a superannuation trustee to review **our** decision or fulfil its legal obligations, or the time **you** or **your** treating doctor takes to provide information. **We** will not have breached the **Code** if we cannot meet a deadline due to **Unexpected Circumstances**. **We**, or the **Group Policy-owner**, will tell **you** why there is a delay and keep **you** informed of progress.
- 8.14A If **we** close **your** claim because information we need, such as from **you** or **your** doctor, remains outstanding, **you** can ask **us** to reopen the assessment of **your** claim at any time. Any applicable timeframes in Chapter 1 will restart from when **we** reopen your claim.
- 8.15 Once **we** have completed all reasonable enquiries²⁸ and have all the information **we** reasonably need to assess **your** claim, including **your** response to the information **we** are basing **our** decision on if **we** have given this to **you**, **we** will tell **you** **our** decision within ten **business days**.
- 8.16 For income-related claims, unless **Unexpected Circumstances** apply, **we** will contact **you** with the outcome of **our** initial assessment²⁹ within two months either of **your** claim being received or, if later, of the end of **your** waiting period. Where **Unexpected Circumstances** apply, **we**

²⁸ Including any enquiries to **Reinsurers**.

²⁹ **Our** initial assessment will be complete if **we** either start the procedural fairness process or reach a decision.

will make **our** decision within 12 months of **your** claim being **received** or, if later, within 2 months of the end the waiting period. **We** will let **you** know the reasons for the delay, and if **you** disagree **we** will review this. If **we** have not made a decision after this extended period, **we** will give **you** details of **our Complaints** process.

- 8.17 For all claims other than income-related claims, unless **Unexpected Circumstances** apply, **we** will contact **you** with the outcome of **our** initial assessment³⁰ within six months of **your** claim being **received** or, if later, of the end of any waiting period. Depending on **your** policy and the benefit **you** are claiming, **our** decision may be to require **you** to undertake a period of rehabilitation or retraining, or it may be a final decision on whether or not **we** agree that **we** will pay **your** claim. Where **Unexpected Circumstances** apply, **we** will make **our** decision within 12 months of **your** claim being **received** or, if later, within 2 months of the end the waiting period. **We** will let **you** know the reasons for the delay, and if **you** disagree **we** will review this. If **we** have not made a decision after this extended period, **we** will give **you** details of **our Complaints** process.
- 8.17A For death claims, after **we** have made **our** final decision, **we** may be unable to pay the benefits until the representatives of **your** estate confirm that they have obtained probate or letters of administration.
- 8.18 If **we** accept **your** claim and it includes a lump sum payment of at least \$50,000, **we** will suggest **you** seek financial advice to help manage **your** claim payment. For an income-related claim, if **we** offer to finalise your claim by paying **you** a lump sum instead of ongoing payments, **we** will suggest that **you** seek financial and legal advice before accepting **our** offer.
- 8.19 If **we** decline **your** claim **we** will let **you** know in writing:
- a) The reasons for **our** decision.
 - b) That **you** can ask **us** for copies of the documents and information **we** relied on, which **we** will then give **you** (or **your** doctor, where appropriate) within ten **business days**, in accordance with the Access to Information section in Chapter 3 of the **Code**.
 - c) That if **you** disagree with **our** decision, **you** can ask **us** to review it or give **us** additional information to consider.
 - d) Details of **our Complaints** process.

Training and remuneration

- 8.20 **Our** claims assessors will be appropriately skilled and trained to make objective decisions. They will not make claims decisions on **our** behalf until they have demonstrated technical competency and an understanding of all relevant law, the **Code** and relevant **FSC** Standards and Guidance. We will ensure that the remuneration of **our** claims assessors, including their entitlements to any bonuses, is consistent with the principles set out in section 1.7 of the **Code**, and is not based on financial targets for declined claims or deferrals of decisions.

Foundation Medical Trauma/Critical Illness Cover Definitions

³⁰ **Our** initial assessment will be complete if **we** either start the procedural fairness process or reach a decision.

- 8.20A The **Foundation** Medical Trauma/Critical Illness Cover Definitions in the **Code** Appendix 1 apply to the first \$2 million of trauma/critical illness cover where **we** issued **your Life Insurance Policy** or group trauma/critical illness scheme on or after 1 July 2017. They do not apply to other benefits such as trauma/critical illness cover either reinstated after a claim or where the amount payable varies according to the severity of the condition, or to payments for benefits included with Income Protection or Total Permanent Disability (TPD).
- 8.20B Where **your** trauma/critical illness cover includes cancer, a heart attack or a stroke and **you** make a claim, **we** will assess **your** claim against:
- a) the applicable definition in **our** PDS/Policy Document linked to the full benefit amount; and
 - b) if different, the corresponding Foundation Medical Trauma/Critical Illness Cover Definition in **the Code** Appendix 1 that is current at the time of the insured event;
- so that **you** get the better of the two definitions.

Income-related benefits

- 8.21 Where **you** are receiving an income-related benefit:
- a) **We will pay you by the due date or, if later, within 5 business days of receiving all the information we reasonably need and have completed all reasonable enquiries for the corresponding period.**
 - b) **We will not stop or withhold your benefit payments during a non-disclosure or misrepresentation investigation (in accordance with section 8.8A) unless we reasonably believe that we have evidence that will lead to your claim being declined, or your Life Insurance Policy being cancelled or avoided³¹.**
 - c) **If your benefit payment will be delayed, we will tell you in advance and explain why.**
- 8.22 **Your policy may state that your income-related claim payments will only continue after a period of time if additional or different requirements are met. We will give you at least three months' notice of this and explain to you what is changing and any additional information we need to assess your eligibility after the change takes effect. We will try to assess your continuing eligibility before the change takes effect so that your benefit payments are not interrupted if you continue to be eligible.**
- 8.23 If **your** income-related claim payments are coming to an end, **we** will tell **you** when **we** will make the last payment:
- a) At least 30 days before the last payment if **your** benefit period is expiring.
 - b) As soon as possible if **we** have received information that causes **us** to stop all future payments.

³¹ This standard does not apply to policies owned by a superannuation fund trustee as access to superannuation benefits is limited by law.

How we support you when you make a claim

- 8.24 **We** acknowledge that claims time is difficult for **our** customers and that the circumstances of each customer is different. **We** will treat you individually and with empathy, compassion and respect.
- 8.25 If **you** tell **us** that **you** are having difficulty providing the information **we** ask for to assess **your** claim, **we** will work with **you** to find a solution. This will include trying to collect the information on **your** behalf.

Helping you on the road to recovery

- 8.26 For income-related claims **we** consider relevant **we** will aim to:
- Identify ways **we** can support **your** recovery at the early stage of **your** claim.
 - Collaborate with **your** doctor, other healthcare providers and/or **your** employer to improve **your** health.
 - Ensure **you** have a primary contact person for the duration of **your** claim.
 - Promote best-practice rehabilitation and return to work programs if **you** are injured or ill.

Example 17. Getting back to wellness

A customer is receiving monthly payments from an income protection policy as they are unable to work due to a serious mental health condition. They live on their own and feel lonely as they no longer have work colleagues to engage with. To support their wellbeing, in addition to the monthly payments, in collaboration with the treating doctor the life insurance company may in its discretion pay for them to become a member of a local support group to reduce their sense of isolation.

Urgent financial need

- 8.27 While **we** are assessing **your** claim, **you** can ask **us** for help if **you** are in urgent financial need of the benefits **you** are covered for under **your Life Insurance Policy**,³² as a result of the condition that has caused the claim.
- 8.28 **We** will only ask **you** for evidence we reasonably need to assess your request, such as:
- For Centrelink clients, **your** Centrelink statements
 - Financial documents such as bank statements
- 8.29 **We** will tell **you our** decision within five **business days** of receiving this evidence. If **you** disagree with **our** decision, **we** will review it.

³² This standard does not apply to policies owned by a superannuation fund trustee as access to superannuation benefits is limited by law. However, **you** should contact the trustee directly as they may have other means of assisting **you** with financial hardship.

- 8.30 If **we** accept **your** request, **we** will confirm the arrangement **in writing**. The help **we** offer might be to:
- a) Prioritise **our** assessment of **your** claim and reaching **our** decision.
 - b) Advance part of **your** claim payment to help alleviate **your** immediate hardship.

9 Complaints and disputes

- 9.1 **You** can make a **Complaint** to **us** about any aspect of **your Life Insurance Policy**, claim, or customer experience with **us**, or with one of **our Authorised Representatives** or **Independent Service Providers**.
- 9.2 If **you** tell **us** that **you** have a concern about someone recommending **our Life Insurance Policies** who is not **our Authorised Representative**, **we** will tell **you** how **you** can have the matter addressed.
- 9.3 **We** will make information about **your** right to make a **Complaint** and how to make a **Complaint** available on **our** website and in **our** relevant communications.
- 9.4 **Your Complaint** will be handled by someone different from the person or people whose decision or conduct is the subject of the **Complaint**.
- 9.5 **We** will tell **you** of the name and contact details of the person assigned to liaise with **you** in relation to **your Complaint**.
- 9.6 **We** will only ask for and rely on information relevant to **our** investigation into **your Complaint** and **our** response.
- 9.7 If **we** become aware of errors or omissions in the handling of **your Complaint**, **we** will address these promptly.
- 9.8 **We** will keep **you** regularly informed about the progress of **our** investigation. **We** will update **you** at least every 20 business days unless **we** agree a different arrangement with **you**. If there is a delay in the assessment of **your** complaint, **we** will let **you** know.
- 9.9 If **we** resolve **your Complaint** within five **business days** of receiving it, **and you confirm that you are satisfied**, the processes described in sections 9.10 to 9.13 below do not apply, provided that:
- a) **your Complaint** is not about hardship, a declined insurance claim,³³ or the value of an insurance claim; and

³³ For the purposes of this section only, in accordance with ASIC Regulatory Guide 165, “declined insurance claim” means **you** have made a claim on an insurance policy, and:

- a. **we** have declined or not accepted the claim; or
- b. **we** have not determined the claim within 10 **business days** of receiving all the information necessary to do so.

- b) **you** have not asked for a response **in writing**.

Where your Complaint is about a Life Insurance Policy owned by a superannuation fund trustee

- 9.10 The law requires superannuation fund trustees to give **you** a final response to **your Complaint in writing** within 90 calendar days³⁴ of receiving it. **Where possible, within 45 calendar days we** will either tell **you**, or the superannuation fund trustee so that they can tell **you**:
- a) **Our** final response to **your** complaint and the reasons for it.
 - b) That **you** can ask **us** for a copy of the documents and information **we** relied on in assessing **your Complaint**. If **you** ask for these, **we** will send them to **you** (or to **your** doctor, where appropriate) within ten **business days**, in accordance with the Access to Information section of Chapter 3.
 - c) That **you** may have the right to take **your Complaint** to an **External Dispute Resolution** body if **you** are not satisfied with **our** decision, how to contact them, and any time limit for doing so.
- 9.11 If the superannuation fund trustee does not respond to **your Complaint** within 90 calendar days of receiving it, **you** can ask them to explain (in writing) the reasons for the delay. **You** have the right to take **your Complaint** to an **External Dispute Resolution** body if **you** are not satisfied.

Where your Complaint is about a Life Insurance Policy that is not owned by a superannuation fund trustee

- 9.12 Where possible, **we** will give **you our** final decision on **your Complaint in writing** within 45 calendar days. **We** will tell **you**:
- a) **Our** final decision and the reasons for it.
 - b) That **you** can ask us for a copy of the documents and information **we** relied on in assessing **your Complaint**. If **you** ask for these, **we** will send them to **you** (or to **your** doctor, where appropriate) within ten **business days**, in accordance with the Access to Information section of Chapter 3.
 - c) That **you** may have the right to take **your Complaint** to an **External Dispute Resolution** body if **you** are not satisfied with **our** decision, how to contact them, and any time limit for doing so.
- 9.13 If **we** are unable to respond to **your Complaint** within 45 calendar days, before the end of the 45 calendar days **we** will tell **you**:
- a) Why there is a delay.
 - b) That **you** may have the right to take **your Complaint** to an **External Dispute Resolution** body if **you** are not satisfied with **our** explanation, how to contact them, and any time limit for doing so.

External Dispute Resolution

³⁴ This timeframe is prescribed by section 19, Superannuation (Resolution of Complaints) Act 1993.

- 9.14 **You** can have **your** complaint reviewed by an **External Dispute Resolution** body if it is within their Terms of Reference. **You** may seek independent legal advice and access any other External Dispute Resolution options that may be available to **you** or of which **we** are a member.
- 9.15 If **our** final decision does not resolve **your Complaint** to **your** satisfaction, or if **we** do not resolve **your Complaint** within the timeframes required above, **you** may refer **your Complaint** to an **External Dispute Resolution** body.
- 9.16 **Determinations** made by an **External Dispute Resolution** body are binding on **us** by law or in accordance with their Terms of Reference.

10 Standards for third parties dealing with underwriting or claims

- 10.1 **We** may use **Independent Service Providers** to assist with underwriting and the management of claims. This includes but is not limited to independent medical assessors, accountants, investigators, rehabilitation providers and claims management services.
- 10.2 This section applies to agreements with **Independent Service Providers** that **we** enter into or that are renewed after **we** are bound by Chapter 1, which must reflect the standards of Chapter 1 as they relate to the **Independent Service Provider's** services.
- 10.3 **We** will require **Independent Service Providers** to act with honesty, fairness, respect, transparency and timeliness towards **you** and **us**, and to obtain **our** approval for subcontracting their services.
- 10.4 **We** will only enter into contracts with **Independent Service Providers** who reasonably satisfy **us** of their expertise, experience, qualifications and integrity, and who hold any required Federal, State, Territory or industry licensing. **Our** contracts will include reference to the relevant States' and Territories' Expert Witness Code of Conduct.
- 10.5 Where **we** engage an **Independent Service Provider** who 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.
- 10.6 **We** will only rely on reports from treating doctors, allied health professionals and **Independent Service Providers** in relation to **your** application for insurance or claim that **we** are satisfied are impartial and objective. **We** will take into account all the details in a report.
- 10.7 **We** will require **Independent Service Providers** to comply with the Privacy Act 1988 and maintain confidentiality of **your** information, and only use that information for the purpose of the service they are providing.
- 10.8 **We** will require that **Independent Service Providers** involved in **your** application for insurance or claim must tell **us** if **you** make a **Complaint** about their services. If so, **we** will handle the

Complaint in line with **our** internal **Complaints** process unless **we** are satisfied they have their own complaints handling process of at least an equivalent standard.

Standards for investigators

- 10.9 **We** may engage an investigator to assist **us** with **your** claim. If **we** engage an investigator, in addition to the above obligations, **we** will require that the investigator:
- a) Is a licensed private investigator that complies with any relevant State and Territory legislation.
 - b) Does not use illegal means to carry out the investigation or induce someone to perform a task or activity that they would not have performed without the involvement of the investigator.
 - c) Only collects information relevant to its investigation.
 - d) Does not make any threat or promise or offer any inducement to any person when conducting the investigation.
 - e) Upholds the **Code** standards relating to interviews (section 8.11) and surveillance (section 8.12).
 - f) Keeps a record of all investigation activities in accordance with the Privacy Act 1988.

Chapter 2 – obligations your superannuation trustee has to you if your life insurance is in superannuation

11 Chapter 2, introduction and objectives

Introduction

- 11.1 Chapter 2 of the Life Insurance Code of Practice (Chapter 2) contains standards that **we**, as superannuation trustees, will uphold when providing insurance benefits to **you**.
- 11.2 **“We”** are superannuation fund trustees that have adopted Chapter 2.
- 11.3 **“You”** are members of **our** fund who are insured through cover that **we** arrange and, in the event of **your** death, **your** beneficiaries. This includes **Automatic Insurance Members** and members who have chosen specific cover.
- 11.4 **We** will ensure that **you** are aware of **your** rights under Chapter 2, by making the **Code** available to **you** on our website, and explaining **our Code** commitments in relevant communications and marketing materials.
- 11.5 Definitions for important terms are in bold and can be found at the end of Chapter 3.

Objectives

- 11.6 The overarching objective of Chapter 2 is to improve the insurance in superannuation offered to **you**, and the processes by which **we** provide insurance benefits to **you**.
- 11.7 In carrying out **our** commitments under Chapter 2, **we** will be:
- a) transparent
 - b) fair
 - c) respectful
 - d) honest
 - e) timely.
- 11.8 Insurance offered on an automatic basis in superannuation must be appropriate and affordable, and must not inappropriately erode retirement income.
- 11.9 **Our** communications to **you** will be clear, timely and in plain language, to assist **your** understanding of the role of insurance in superannuation and the details of **your** insurance cover.
- 11.10 **We** will play a visible role in the claims process, and ensure **you** receive regular updates as well as a decision on **your** claim in a reasonable timeframe.

12 Scope of Chapter 2 of the Code

Who does Chapter 2 apply to?

12.1 Chapter 2 applies to:

- a) Members of the FSC that are superannuation fund trustees who hold Life Insurance Policies covering their members.
- b) Any other industry participant, including a non-FSC member, which enters a formal agreement with the FSC and the Life CCC to adopt Chapter 2.

You can find a list of Chapter 2 Code subscribers, and where applicable the brands they use, on the FSC website at www.fsc.org.au.

12.2 We will ensure our staff and our Service Providers comply with Chapter 2 when they are acting on our behalf.

What products are covered by Chapter 2?

12.3 Chapter 2 covers life insurance products held by superannuation funds. These are commonly referred to as:

- a) death cover, which pays on the death of an insured member, or if they are diagnosed as terminally ill with a life expectancy less than a specified period (generally 12 or 24 months)
- b) total and permanent disability (TPD) cover, which pays if an insured member becomes disabled and is unable or unlikely to ever work again, or unable or unlikely to look after themselves ever again
- c) income protection cover, which pays a replacement income if an insured member becomes unable to work due to illness or injury. Depending on the policy, payments may continue up to a specified age if the disability is ongoing or permanent, or may be payable for a specified maximum period.

12.4 Chapter 2 does not cover insurance products held outside superannuation funds, including health insurance products issued by health insurers.

When does Chapter 2 apply from?

12.5 Chapter 2 starts on 1 July 2019. By then we must notify the FSC and the Life CCC of the date on which we will transition to adopt Chapter 2.

We will comply with Chapter 2 as early as we can, but not later than 30 June 2021. For applications for insurance, claims or complaints that already exist on the date we transition to Chapter 2, if Chapter 2 commits us to do something within a specified timeframe, that timeframe begins on our date of transition.

Our relationship with insurers

12.6 We will work closely with our insurers who issue the cover that applies to you, to ensure you have a consistent end-to-end experience.

12.7 Life insurers who are members of the Financial Services Council are bound by service standards, set out in Chapter 1 of the Code. Any contract that we enter into with an insurer will require both parties to comply with the chapter of the Code to which they subscribe.

Legal status of Chapter 2

- 12.8 Chapter 2 operates alongside and is subject to existing laws and regulations. Where there is any conflict or inconsistency between Chapter 2 and any law or regulation, that law or regulation prevails.
- 12.9 **We** have a legal requirement to perform **our** duties and exercise **our** powers in the best interests of **our** beneficiaries. **We** will comply with **our** commitments in Chapter 2 to the extent that they are in the best interests of beneficiaries and consistent with **our** other legal duties. However, **we** cannot comply with anything in Chapter 2 that limits our ability to comply with **our** statutory and general law duties, and **our** trust deed. This may require **us** to alter **our Code** commitments, which **we** will publish in **our** annual Code compliance report. **We** will use **our** discretion when making decisions about the insurance benefits that **we** provide.
- 12.10 Chapter 2 does not limit **your** rights under any law or regulation.
- 12.11 Chapter 2 does not apply if you start proceedings in any court, tribunal or external alternative dispute resolution process (with the exception of the **External Dispute Resolution** organisation that is relevant to your complaint).

13 Appropriate and affordable cover

- 13.1 For the purposes of sections 13.2 to 13.16, “**you**” refers to **Automatic Insurance Members** only.

Benefit design

- 13.2 Insurance in superannuation is often provided automatically. **We** will design insurance benefits for our **Automatic Insurance Members** with the objectives that they are appropriate and affordable for **our** membership.
- 13.3 **We** will publish **our** insurance strategy on **our** website. This will include an explanation of how **we** have designed **our** automatic insurance cover, to help **Automatic Insurance Members** decide whether the automatic insurance cover is appropriate for them.
- 13.4 If a benefit design is determined by a party other than **us**, for example a sponsoring employer, **we** will review the design to ensure it is appropriate and affordable.
- 13.5 When **we** design insurance benefits for our **Automatic Insurance Members**, **we** will assess **our** members’ likely insurance needs, including considering the following characteristics of **our** membership where **we** know them and believe them to be relevant:
- a) age distribution
 - b) gender
 - c) industry and occupation
 - d) work status (for example, full-time, part-time, contract, casual)
 - e) salary
 - f) employer contribution levels

- g) claims history
 - h) insurability outside automatic arrangements
 - i) member feedback based on member research and attitudes to insurance.
- 13.6 **We** will assess the appropriateness of **our** benefit design, including types and levels of automatic insurance cover, for **our** membership generally, and for the particular categories of members described below at 13.10 to 13.12.
- 13.7 As well as determining the insurance needs of **our Automatic Insurance Members**, **we** will design cover that is affordable and does not inappropriately erode the retirement income of **our Automatic Insurance Members**. **We** will specifically consider the impact on the segments of members described below at 13.10 to 13.12.
- 13.8 **We** will adjust cover levels or other factors impacting cost such as terms and conditions or definitions (subject to legislative, regulatory and **Code** constraints) so that **we** are satisfied that **our** automatic insurance cover is affordable.

Option 1

13.9 **We** will uphold this clause (section 13.9) on an “if not, why not basis” when providing insurance benefits to **you**. As part of determining affordability when **we** design insurance benefits for **our Automatic Insurance Members**, premiums for this benefit design will be set at a level that does not exceed 1% of an estimated level of salary for our membership generally, and/or for segments within the membership, subject to 1.1c) below.

We will document and publish:

- a) **our** basis for determining an affordable level of cover within the 1% of salary limit(s) for **our** membership generally and/or for segments within the membership
- b) the measures of salary and timeframes **we** have used to apply the 1% of salary limit for **our** membership, including the specific measures **we** have used for insurance provided to **our** younger members
- c) the rationale for instances in which cover has been provided to **Automatic Insurance Members** with premiums that exceed 1% due to the identification of particular circumstances relating to the membership generally and/or segments within the membership.

Option 2

13.9 To allow **our** members to decide whether their cover is affordable for them, when **we** design insurance benefits for our **Automatic Insurance Members**, **we** will estimate the cost of the premiums as a percentage of an estimated level of salary for our membership generally, and/or for segments within the membership, and publish this on **our** website.

We will also document and publish on our website:

- a) **our** basis for estimating the percentage cost for **our** membership generally, and/or for segments within the membership

- b) the measures of salary and timeframes **we** have used to estimate the cost for **our** membership, including the specific measures **we** have used for insurance provided to our younger members
- c) the rationale for instances where **we** have provided cover to **Automatic Insurance Members** and the cost exceeds 1% of the estimated level of salary for **our** membership generally, and/or for segments within the membership.

Categories of our membership

- 13.10 For members with low or infrequent contributions, when designing benefits **we** will consider:
- a) the characteristics of these members, which may include people who have taken leave for substantial lengths of time and members who are casual or part-time workers
 - b) the impact of premiums on members who have low or infrequent contributions
 - c) fair treatment, taking into account whether there is any cross-subsidisation between different groups of members, for example members at different ages.
- 13.11 For members nearing retirement, when designing benefits **we** will consider:
- a) appropriate types of cover given they will generally have higher superannuation balances, which may reduce the amount of cover needed
 - b) the impact of high premiums associated with their higher likelihood of claiming
 - c) the greater emphasis members at these ages typically place on building savings for retirement as opposed to life insurance protection.
- 13.12 **We** will not automatically include **you** in a division of **our** fund that is higher risk than the membership generally due to smoker status or occupation (where such a designation exists) without relevant evidence.

Reviews and changes to benefit design

- 13.13 **We** will review and update as necessary the benefits **we** offer and the policy details at each insurance contract renewal (and our review will occur no later than every 3 years), to ensure they remain appropriate and affordable for the categories of members described in sections 13.10 to 13.12 above.
- 13.14 **We** will assess the premiums for **our Automatic Insurance Members** at each policy renewal (and no later than every 3 years) to ensure premiums remain affordable and consistent with section 13.8 above.
- 13.15 If **we** decide to change any of the benefits offered (including the definition of the benefits) as part of **your** cover, **we** will provide **you** with details of the changes and any options available to **you** to change or cancel the new cover.
- 13.16 If the impact on **your** cover or premiums is material,³⁵ **we** will let you know in writing at least 30 days before the changes take effect.

³⁵ In line with the requirements of section 1017B of the *Corporations Act 2001*.

Cancelling your insurance cover

- 13.17 **You** can cancel or reduce the insurance cover which **we** arrange for **you** at any time, and the associated premiums will no longer be deducted from **your** superannuation account. **You** can cancel part of **your** cover and keep some of it, provided this is permitted under **our** fund rules and the insurance policy. **We** will make the process straight-forward. **You** can cancel or reduce **your** cover in the following ways, subject to appropriate member identification: ³⁶
- a) via **our** website, the insurer's website or **our** digital application
 - b) over the phone
 - c) **in writing** by email or post.
- 13.18 **We** will include clear instructions on how to cancel or reduce **your** insurance cover in **your** welcome pack, **our** disclosure information, **your** annual statement, and on **our** website. If **you** request a cancellation form, **we** will send it to **you** within 5 **business days**.
- 13.19 As part of the cancellation process, **we** will tell **you** that:
- a) **you** will not be able to make a claim for insurance benefits for events or conditions that arise after **your** cover has ended
 - b) **we** will no longer deduct insurance premiums from **your** account
 - c) **your** ability to restart **your** cover may be subject to health assessment and acceptance by the insurer, and **you** may not be able to get cover
 - d) if **you** are replacing **your** cover with alternative cover, **you** should not cancel until the replacement cover is in place
 - e) **you** can get independent financial advice to help **you** to make a decision on cancellation.
- 13.20 **We** will confirm that **you** have cancelled **your** insurance cover and the date on which **your** cover will stop in writing.
- 13.21 If **you** cancel within 14 calendar days of **us** telling **you** that **we** have provided **you** with automatic insurance cover or that **we** have increased **your** level of automatic insurance cover, any premium **we** have deducted from **your** account for that insurance cover will be waived or refunded back to the cover start date or the start of the increased cover (as applicable). No cover will then apply for that period.

Communicating with you if we are required to cancel your automatic insurance cover

- 13.22 In cases where the law requires **us** to cancel **your** automatic insurance cover, for example if **your** account becomes inactive because **we** have not received contributions for 13 months, or if **your** account balance falls below \$6,000, **we** will tell **you** that:
- a) **your** automatic insurance cover will cease, and give **you** at least 30 days' notice
 - b) **you** will not be able to make a claim for insurance benefits for events or conditions that arise after **your** cover has ended
 - c) **we** will no longer deduct any insurance premiums from **your** account

³⁶ The cancellation standards in the Code do not apply to members of a defined benefit fund, in which the value of the retirement benefit is defined by the fund rules, or where the insurance arrangement with an employer does not allow for member cancellation.

- d) **your** ability to restart **your** cover after it has ceased may be subject to health assessment and acceptance by the insurer, and **you** may not be able to get cover
- e) **you** can ask **us** not to cancel it
- f) **you** can get independent financial advice to help **you** make a decision on cancellation
- g) **your** insurance cover has been cancelled when it has ended.

13.23 If **you** tell us that **you** want to keep **your** automatic insurance cover, **we** will record this and continue deducting insurance premiums from your account, provided that your account balance is enough to meet the cost of each premium. **We** will tell **you** that **you** will no longer be an **Automatic Insurance Member**, but that **you** will still receive any updates **we** make to **our** automatic insurance cover.

Reinstatement of cover

13.24 **We** will explain **our** process and the circumstances for members to apply to restart cover **after it has been cancelled**, when **we** confirm that the cover has ended.³⁷

Duplicate insurance cover

13.25 When **you** become a member of **our** fund, **we** will ask **your** permission to help **you** to determine whether **you** have any other insurance cover in a superannuation fund. The purpose of this is to ensure **you** do not unintentionally pay premiums for multiple insurance covers, or for any cover on which **you** may be unable to claim. If we identify that **you** have other insurance cover, **we** will let **you** know.

14 Helping members to make informed decisions

How we will provide you with information

- 14.1 **We** will help **you** to make better informed decisions by giving **you** appropriate and easy-to-understand information when **we** provide **you** with cover and on an ongoing basis.
- 14.2 **We** will seek to understand the characteristics of **our** members, so that **we** can tailor **our** communications.
- 14.3 **We** will use plain language in **our** insurance communications, and will limit the use of jargon and acronyms. If acronyms or jargon are used, plain language definitions will be provided. **We** will ensure that the wording of key insurance concepts has been consumer tested for comprehension.
- 14.4 **We** will regularly review the insurance communications that **we** provide to ensure they are appropriate and consistent.

³⁷ This process may differ between trustees and may involve a health assessment.

- 14.5 **We** will publish a Key Facts Sheet for our automatic insurance cover based on a standard industry format on our website as set out in Appendix 3 of the **Code**.
- 14.6 The purpose of the Key Facts Sheet is to provide high-level, fund-specific insurance information, to help **you** to understand **your** cover better and to compare cover across different superannuation funds.
- 14.7 **We** will also provide **you** with clearly identifiable insurance-specific information in a welcome pack when **we** provide **you** with automatic insurance cover. This may be provided as part of a broader welcome pack about **our** superannuation fund.
- 14.8 The purpose of the insurance information in **our** welcome pack is to give **you** greater awareness and better information about the insurance cover that **you** receive automatically from **us**.
- 14.9 The insurance information in **our** welcome pack will contain the following:
- a) a copy of the Key Facts Sheet
 - b) how much **you** are insured for
 - c) the **premiums you** will pay
 - d) any other information specific to **you** that is not included in the general information on the Key Facts Sheet
 - e) that **you** should consider whether **you** hold cover elsewhere, either within another fund or outside superannuation, and the impacts of holding multiple insurance covers
 - f) a link to the **Code**
 - g) a link to the product disclosure statement and other relevant insurance information on **our** website.
- 14.10 **We** will make the following information easily accessible on **our** website, and provide **you** with hard copies upon request:
- a) the Key Facts Sheet
 - b) the product disclosure statement for **our** automatic insurance cover
 - c) information about the benefits and costs of insurance in superannuation
 - d) information on how to cancel **your** insurance and the consequences of cancelling
 - e) how to make a claim
 - f) how to make a complaint.

Explaining our definitions

- 14.11 **We** will clearly explain on **our** website and in **our** product disclosure statement **our** intention in providing total and permanent disability and income protection cover, and how the definitions that **we** use will be applied in practice.
- 14.12 **We** will agree on the interpretation and application of **our** definitions with **our** insurers to ensure a consistent approach.
- 14.13 **We** will undertake a regular review to ensure the interpretation and application of **our** definitions are consistent with any changes in **our** policy terms, and **our** insurers' approach.

14.14 **We** will use the following standard headings that are relevant to **our** total and permanent disability cover:

- a) Total and permanent disability – [unable/unlikely] to do a suited occupation ever again
- b) Total and permanent disability – [unable/unlikely] to do your own occupation ever again
- c) Total and permanent disability – [unable/unlikely] to look after yourself ever again
- d) Total and permanent disability – [unable/unlikely] to do basic activities associated with work ever again
- e) Total and permanent disability – permanent loss of intellectual capacity
- f) Total and permanent disability – loss of limbs and/or sight
- g) Total and permanent disability – suffering a specifically defined medical condition and permanently unable to work because of it
- h) Total and permanent disability – significant impairment to your whole body.

14.15 If the total and permanent disability definition that **we** use has more requirements than those listed above, **we** will ensure they are described in similar plain language terms to the descriptions above.

14.16 If the total and permanent disability definition that **we** use is different from the standard definition which allows superannuation benefits to be released under legislation,³⁸ **we** will explain the differences in plain language.

Communication during the term of your cover³⁹

14.17 **We** will provide **you** with an annual statement which includes the following information:

- a) the types of cover **you** hold and how much **you** are insured for
- b) **your** current premium
- c) an explanation for any change in **your** premiums
- d) the policy's standard exclusions and benefit limitation terms that may impact **your** entitlement to insurance benefits
- e) if **we** have not received any eligible contributions in the previous year, or if **your** eligible contributions are less than \$1,800 for the previous year, a warning that **your** premiums may be inappropriately eroding **your** account balance
- f) information about how to contact **us** to discuss options if **you** want to change the terms of **your** cover
- g) how **you** can increase, decrease or cancel **your** cover based on **your** individual needs;
- h) information about the **Code**
- i) what to do in the event of a claim.

14.18 **We** will contact **you** about **your** insurance cover if **we** become aware that:

- a) a change in **your** employment arrangements may impact **your** cover
- b) **your** contributions have stopped (in line with section 13.22)
- c) **you** are no longer covered due to the terms of the policy.

³⁸ *Superannuation Industry (Supervision) Act 1993*.

³⁹ For defined benefits members, the requirements for communication during the term of the cover will be tailored as appropriate to the insurance arrangements in place.

- 14.19 The purpose of the communications during the term of **your** cover is to prompt **you** to evaluate the appropriateness of **your** cover, and ensure that **you** are kept informed of **your** options to change, review or cancel **your** cover.
- 14.20 **We** will promote any digital tools that **we** provide, to help **you** to monitor **your** account and **your** contributions, the cost of insurance and the impact on **your** balance.

Lost members

- 14.21 **We** will use **our** best efforts to keep **our** members' contact details current, so that **we** can provide the communications required by the **Code**.
- 14.22 If **we** cannot contact **you** as we do not have **your** current contact details, **we** may be required to report to the Australian Taxation Office that **you** are a lost member.
- 14.23 **We** will not be in breach of the **Code** if **we** are unable to provide **you** with any of the communications required by the **Code**.

15 Supporting vulnerable consumers

- 15.1 **We** recognise that some people may have unique needs, such as older persons, people with mental health conditions, people with a disability, people from non-English speaking backgrounds, people with low levels of literacy, people in financial distress, and Indigenous Australians, when accessing insurance, making an enquiry, claiming on their cover, making a complaint and communicating with **us**.
- 15.2 **We** will have internal policies in place to help **our** staff to identify vulnerable consumers and to take practical steps to better assist members who may need further support. This may include referral to people or services with specialist training and experience to appropriately engage with and support them.
- 15.3 Where **you** tell **us** that **you** require support or assistance from **us**, **we** will provide support or assistance to the best of our ability. **We** will ask for **your** permission to keep a record of the support or assistance **you** require.

Providing information

- 15.4 **We** recognise that some groups of consumers (for example, people from Indigenous communities or those from non-English speaking backgrounds) may require support in meeting identification requirements. **We** will take reasonable measures to assist and a flexible approach to verification and identification in line with AUSTRAC⁴⁰ guidance, while still meeting **our** obligations under the law.
- 15.5 **We** recognise that people living in remote and regional communities may have trouble meeting their obligations to provide **us** with documents and to take part in assessments in the

⁴⁰ Australian Transaction Reports and Analysis Centre.

timeframes **we** set. **We** will take this into account when going through the underwriting and claims processes.

- 15.6 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** and the insurer to find a solution. This may include endeavours to collect the information on **your** behalf, with **your** permission.

Interpreting services

- 15.7 **We** will provide access to an interpreter at **your** request, or where **we** need an interpreter to communicate effectively with **you**. **We** may use an interpreter who is a member of **our** staff, or an external interpreter.
- 15.8 **We** will record **your** interpreting needs and plan ahead to meet these needs. Where an interpreter is offered but declined, this will also be recorded.
- 15.9 **We** will provide a direct link on **our** website to information on interpreting services and any other relevant information for non-English speakers, including any insurance information that **we** have translated into other languages.

Guardianship

- 15.10 Where **you** are under the care of a State-appointed guardian or administrator or the holder of **your** enduring power of attorney, any communications **we** provide will be sent directly to **your** guardian, administrator or attorney, and **we** may only accept payment instructions from them.

Release of funds

- 15.11 If **we** allow **our** members to receive early release of some of the money in their account on the basis of severe financial hardship or compassionate grounds, **we** will clearly explain the process on our website. If **we** do not allow this, **we** will explain the reasons for this on **our** website.
- 15.12 If **we** grant **you** release of **your** superannuation account balance (for example, due to a terminal illness), **we** will let **you** know the impact on any insurance cover **you** still have at the time and that **you** can choose to leave enough funds in **your** account to pay the premiums for your cover.

16 When you make a claim

Principles for claims handling

- 16.1 **We** acknowledge that claim time can be difficult. **We** will treat you with compassion and respect. **We** will make the claims process as straight-forward as possible for **you**.
- 16.2 **We** will help **you** identify any cover held within **our** fund under which **you** may be entitled to claim. **We** will not discourage **you** from making a claim.

- 16.3 **We** will oversee the claims process, and help **you** to navigate the process.
- 16.4 **We** will be responsible for overseeing the conduct of the insurer and any Service Provider **we** engage in the claims process, in line with the standards in Section 21 of the **Code**. **We** will proactively engage with other parties in the claims process, such as any representative that **you** engage, to minimise delays and remove unnecessary duplication from the process.
- 16.5 **We** will put in place appropriate governance arrangements for **our** claims handling.
- 16.6 **We** will publish **our** claims philosophy on **our** website, and **we** will assess the claims philosophies of **our** insurers to ensure they align with **our** own philosophy.

The claims process

- 16.7 The claims process incorporates a number of steps, and there are roles for **us**, for the insurer and for **you**. **You** may be required to provide relevant documents and attend assessments.
- 16.8 Chapter 1 of this **Code** places responsibilities on insurers to determine claims within specific timeframes. **We** will work together to ensure a consistent and efficient process for **you**.
- 16.9 **You** will be given contact details for the primary contact during the claim process.
- 16.10 **We** will have complied with the requirements to communicate with **you** in this section even if the communications are provided to **you** by the insurer or a Service Provider.
- 16.11 **We** may take responsibility for a step in the claim process that is not covered below, such as arranging an independent medical examination or an interview with **you**. In these cases, we will comply with the relevant standards in Chapter 1 of the **Code**.

Making a claim

- 16.12 If **you** tell us that **you** wish to make a claim, **we** will help **you** provide the information for **your** claim, or direct **you** to the appropriate forms or information online or email these to **you** by the next business day. If **you** require hard copy forms, **we** will send these within 5 business days.
- 16.13 If **we** receive a completed claim from **you**,⁴¹ within 5 business days **we** will:
- a) acknowledge receipt of the claim
 - b) assess whether **you** have provided all of the necessary information and documentation
 - c) carry out an initial eligibility assessment to assess whether **you** have insurance cover based on the information available
 - d) provide **you** with a summary of the claim process (if this has not already been provided to **you** when **you** tell **us** **you** wish to make a claim)
 - e) either provide the claim to the insurer, or tell **you** that **you** are not eligible to make a claim based on the information available (in line with section 16.16 below).

⁴¹ A completed claim requires lodgement of claim forms with **us**, or provision of requested claim information via telephone.

- 16.14 If a claim is made via telephone, a written record or call recording will be kept and can be sent to **you** on request.
- 16.15 The summary of the claim process that **we** will give **you** will include:
- a) an explanation of the terms of **your** cover, including the policy's standard exclusions and limitations
 - b) the steps involved in the claim process and a reasonable expectation of the end-to-end timeframe for the assessment of the claim, taking into account the timeframes in Chapter 1 of the **Code** and **our** review of the insurer's decision
 - c) **our** role and duties and the role and duties of the insurer
 - d) who will be **your** primary contact and contact details **you** can use to get information about **your** claim
 - e) whether **you** may be required to attend ongoing assessments
 - f) how payments will be made if the claim is accepted
 - g) that there may be financial or tax implications and **you** may wish to get independent advice
 - h) the impact on the amount of the claim of receiving income from other sources including Centrelink and workers' compensation if offsets are applied
 - i) how **we** will review the insurer's decision.
- 16.16 If **we** assess that **you** are not eligible to make a claim, **we** will:
- a) explain this in writing
 - b) give **you** the opportunity to provide more information so that **we** can review **your** eligibility
 - c) tell **you** that if **you** are not satisfied with **our** decision, **you** can make a complaint and **we** will explain **our** complaints process.

While a claim is being assessed

- 16.17 If **you** have a query about **your** claim while it is being assessed, **we** will respond:
- a) with an acknowledgment by the next **business day**
 - b) with a full response within 10 **business days**.
- 16.18 **You** will receive progress updates at least every 20 business days (unless a different timetable is agreed with **you**). If there are any issues delaying assessment of **your** claim, we will let **you** know what these are.
- 16.19 **We** will oversee the progress of the claim to minimise delays and intervene if **we** become aware that the insurer is not complying with the timeframes provided in Chapter 1 of the Code.
- 16.20 If the insurer tells **us** that it cannot make a decision on **your** claim in the timeframes provided in Chapter 1 of the Code because information which is necessary for assessment has not been provided, **we** will tell **you** the revised timeframes. If **your** medical condition has not yet stabilised to allow a decision to be made, **we** will tell **you** that **your** claim will be progressed further when more information is available.

16.21 If **we** become aware of any errors or mistakes in the claim or in the information requested, these will be addressed promptly. **We** may request more information to correct errors or mistakes.

Review of insurer's decision

16.22 Once the insurer has made its decision on your claim, if the insurer informs **us** that it intends to make a payment to **us**,⁴² **we** will carry out a review within 5 **business days** to assess whether **you** have met the requirements for the money to be released from **your** superannuation account. **We** will also have oversight processes in place to confirm that the insurer is paying the correct amount, either to **us** or directly to **you**.

16.23 If **we** identify as part of our review that there are differences between the requirements for **your** insurance claim to be paid and the legal requirements for the release of funds from **your** superannuation account, **we** will clearly explain the differences in plain language.

16.24 If the insurer informs **us** that it has decided not to pay the claim, **we** will carry out a review within 15 **business days**. As part of **our** review, **we** will determine whether the insurer has provided **you** with the below, and **we** will provide **you** with any of the below that **you** have not yet received:

- a) an explanation in plain language to enable **you** to understand the reasons for the insurer's view
- b) an outline of the evidence relied upon in forming that view
- c) a list of all documents obtained by the insurer and **us** during the assessment, and an opportunity to receive any documents on request
- d) an opportunity to make further representations and submissions or provide further information about **your** claim.

16.25 Wherever possible, when **we** review the insurer's decision **we** will use information already collected during the claim assessment process, rather than asking **you** to provide information again, or to attend any further assessments. If **we** believe there is not enough information to make a properly informed decision, **we** will let **you** know. **We** will request any further information or assessments **we** need as early as possible and will avoid multiple information requests where possible.

16.26 **We** will only ask for and rely on information and assessments that are relevant to the claim and policy, and **you** can ask us to give you an explanation of the relevance of the information requested. If **you** disagree with the relevance of any requested information, the request will be reviewed. If **you** are not satisfied with the outcome of the review, **we** will tell **you** how to make a complaint.

16.27 If **we** obtain new information or assessments, or **you** make further representations and submissions or provide further information, **we** will have another 15 **business days** to review the new information.

⁴² This does not refer to payments that the insurer makes to you directly (such as with some income protection payments).

- 16.28 If **our** review results in **us** querying the insurer's decision, **we** will tell the insurer within 5 **business days** of completing **our** review. If **we** believe the claim has a reasonable prospect of success, **we** will advocate on **your** behalf. **We** will keep **you** informed as the claim proceeds.
- 16.29 In exceptional cases, the timeframes for **our** review in this section may not be appropriate. In these cases, **we** will tell **you** that **we** need more time, and will clearly communicate **our** revised expected timeframes until **our** review is complete. **We** will tell **you** how to make a complaint if **you** are not satisfied.

Claim decision

- 16.30 If the claim is approved and paid to **us** by the insurer, **we** will confirm this with **you** as soon as **we** have carried out **our** assessment of whether **you** have met the requirements for the money to be released from **your** superannuation account. Within 5 **business days** of confirmation being given, **we** will release the claim money to you,⁴³ provided that:
- a) valid identification, and payment instructions and other necessary documents have been received from **you**
 - b) we have confirmed that the legal requirements for release of funds from **your** superannuation account have been satisfied
 - c) for death benefit claims, **we** have contacted all potential beneficiaries where relevant and given them the opportunity to provide submissions in support of their claim to be paid a benefit.⁴⁴
- 16.31 If **your** claim is declined, **we** will tell **you** within 5 **business days** of completion of **our** review:
- a) the reasons for the decision in writing in plain language
 - b) that **you** can request copies of the documents and information relied on in line with the standards in section 22
 - c) how **you** can make a complaint if **you** are not satisfied with the decision.

Income protection claims

- 16.32 For income protection claims, **we** will support the insurer to:
- a) seek to identify ways to support **your** recovery as quickly as possible
 - b) collaborate with **your** doctor, other healthcare providers and employer to maximise the health outcomes
 - c) promote best-practice rehabilitation and injury management where these are consistent with the terms of the policy.
- 16.33 Where **you** are receiving ongoing income protection payments, **we** will have oversight processes in place to determine whether the information **you** are required to provide is reasonable, and ensure **you** and **your** doctor are providing the required information, to assist **you** to receive timely payments. **We** will also have processes in place to oversee **our** insurer's

⁴³ For income protection claims, the insurer may make the payments to you directly.

⁴⁴ The distribution of death benefits under a regulated superannuation fund is generally at our discretion, applied in line with the terms of our trust deed and subject to the *Superannuation Industry (Supervision) Act 1993*.

decisions about continuing or stopping income protection payments, and we will raise any concerns that **we** have with the insurer regarding a decision to stop payments.

- 16.34 If **we** become aware that **you** have made claims against more than one income protection policy, **we** will suggest that **you** take independent advice about how the off-setting arrangements operate, and the factors **you** may want to consider to determine the best financial outcome from **your** multiple policies. **You** may be entitled to a premium refund in line with section 20.1 below.
- 16.35 If **we** identify that any of **your** claim payments are going to be offset or reduced by income **you** are receiving from other sources including Centrelink and workers' compensation, **we** will let **you** know.

17 Premium adjustments

- 17.1 If **we** receive money or other material benefits (other than claims payments for members and any related costs) directly or indirectly from an insurer or reinsurer, **we** will publish details of the arrangement on **our** website. These arrangements are sometimes referred to as premium adjustment mechanisms.⁴⁵
- 17.2 Any premium adjustment payments **we** receive from an insurer will be passed onto **our** insured members through adjustments to future premiums charged to members, including for insurance administration.
- 17.3 Any premium adjustment payment made to **us** by an insurer or any deficit incurred will be allocated to our insurance reserve, governed by a board-approved insurance reserving policy.
- 17.4 **Our** annual report, product disclosure statement and relevant insurance documentation will include information about **our** premium adjustment arrangements and policy and the members to which it applies.
- 17.5 **We** will report details of any premium adjustment payments made to and from **our** insurance reserve, and what the payments from the reserve have been used for.

18 Promoting our insurance cover

- 18.1 When **we** promote the insurance cover that **we** offer, **we** will:
- a) be clear and upfront and not misleading
 - b) consider the target audience for the communication and whether it provides adequate information for that audience
 - c) ensure that statements in communications are consistent with the features of the relevant policy and the disclosures in any corresponding product disclosure statement

⁴⁵ For the avoidance of doubt, where premiums cover both insurance risk and an investment component (known as participating policies), these are not considered to be premium adjustment mechanisms.

- d) ensure that any images used do not contradict, detract from or reduce the prominence of any statements used
 - e) if prices or premiums are referred to, ensure that these are consistent with the prices or premiums likely to be offered to the target audience for the communication
 - f) make clear if a benefit depends on a certain set of circumstances
 - g) ensure that any use of phrases such as "free" or "guaranteed" are not likely to mislead
 - h) comply with the Australian Securities and Investments Commission (ASIC)'s guidance for advertising financial products and services and guidance regarding unsolicited sales.
- 18.2 If **we** enter into an agreement or renew an agreement (no later than two years after **we** adopt the **Code**) with a financial adviser or dealer group to distribute the products **we** offer, including any insurance cover available via those products, the agreement will require the adviser to comply with the requirements of this section of the **Code**.
- 18.3 When **we** promote insurance cover additional to our automatic insurance cover, **we** will only target any promotion to the segments of **our** membership for whom **we** have identified the cover is likely to be appropriate, affordable and of value.
- 18.4 **We** will investigate any concerns raised or identified with the practices of **our** staff and the financial advisers that **we** engage. If as a result **we** identify that cover has been promoted or recommended inappropriately:
- a) **we** will contact you to discuss an appropriate remedy, in consultation with the insurer. Appropriate remedies will vary depending on the circumstances, and may include:
 - i. cancelling the cover
 - ii. arranging a refund of premiums paid
 - iii. payment of interest on the refunded premium
 - iv. adjusting the cover or arranging for more suitable cover
 - v. correcting incorrect information
 - b) if **you** are not satisfied with **our** proposed remedy, **we** will review this and tell **you** how to make a complaint
 - c) **we** will correct any identified conduct issues, including through further education and training.

19 Changes to cover

- 19.1 If **we** provide a calculator or other tool to help **you** to determine the level of insurance **you** need, **we** will make it clear that any insurance cover **you** request may be subject to assessment and approval by **us** and the insurer.
- 19.2 **We** will include clear instructions on how **you** can change **your** cover in **our** welcome pack, **our** disclosure information, **your** annual statement, and on **our** website.
- 19.3 **We** will let **you** know the consequences of any changes **you** request.
- 19.4 If **you** tell us that **you** want to reduce **your** cover or make any other changes that do not require the approval of the insurer, **we** will confirm **your** changes and the date on which **your** cover has changed in writing within 5 **business days** of receiving **your** instructions.

- 19.5 If **you** tell us that **you** want to increase **your** cover, replace cover **you** have in another fund, or make any other changes that **we** determine will require assessment and approval by the insurer, **we** will explain the process to **you** within 5 **business days**. **You** will be given contact details for the primary contact during the application process.
- 19.6 **We** will have oversight processes in place to monitor the decisions of **our** insurers, as part of **our** duty to act in **our** members' best interests.
- 19.7 **We** may take responsibility for a step in the application process, such as arranging an independent medical examination. In these cases, **we** will comply with the relevant standards in Chapter 1 of the **Code**.
- 19.8 **We** will have complied with the requirements to communicate with **you** in this section even if the communications are provided to **you** by the insurer or a Service Provider.
- 19.9 At the start of the application process, before asking **you** any health-related questions, **we** will explain the duty of disclosure (information **you** need to tell **us**) and the consequences of not disclosing all relevant information and answering all questions honestly and completely.
- 19.10 If **you** tell **us** that **you** are replacing existing insurance cover that **you** hold elsewhere, **we** will tell **you**:
- a) that **you** should not cancel any existing cover until **your** new application is accepted
 - b) the general risks of replacing existing cover, including the loss of any accrued benefits, the possibility of waiting periods to start again (if applicable), and the implications of any non-disclosure on an application for cover (even where unintentional)
 - c) that once **your** new cover is accepted, if **you** do not cancel your previous cover, **you** may be unable to claim on multiple insurance covers (depending on the terms of **your** policies).
- 19.11 **We** will provide **you** with information about any change in **your** premiums and general information about the impact of insurance premiums on retirement savings.
- 19.12 If cover is offered on alternative terms based on **your** personal circumstances, such as:
- a) a higher premium
 - b) the exclusion of specific events, activities or medical conditions that are not covered
 - c) alterations to any waiting periods that apply before benefits can be accessed
 - d) alterations to the benefit period that applies, including the term of the insurance cover
 - e) any other specific terms or conditions that may be applicable to the policy,
- we** will make it clear to **you** what alternative terms are being offered.
- 19.13 If insurance cover is not offered, or is offered on alternative terms, we will let **you** know (or **your** doctor, where appropriate):
- a) the reasons for the decision
 - b) that **you** can request copies of the documents and information relied on in line with the standards in section 22
 - c) if **you** disagree with the decision, or if **you** think that the information relied on to make the decision is incorrect or out of date, **you** can discuss this with **us** and **we** will review the

decision, and if **you** are not satisfied with the review **we** will tell **you** how to make a complaint.

19.14 Should **we** become aware after the cover is issued that information relied on for **your** application for insurance was incorrect or incomplete at the time the cover was issued, **we** will notify the insurer, and:

- a) if **we** consider the information to be important for **your** cover, **we** will ask **you** to provide an explanation, including giving **you** an opportunity to review any relevant documents about **you**, before any decision is made such as changing the terms or cancelling **your** cover
- b) once a decision has been made, **we** will advise **you** of the decision and any actions to be taken, and the process to have this reviewed or make a complaint if **you** disagree with the decision.

Transfer between divisions in our fund

19.15 There are circumstances in which **we** will transfer you between different divisions of **our** fund. For example, if **you** leave an employer, **you** may be automatically transferred from the employer's plan to a different division. This may change the type and/or the terms of the insurance cover **you** receive from **us**.

19.16 If **you** have been transferred to another division which changes the type or terms of the cover **you** receive from **us**, **we** will contact **you** to explain the changes and **your** options for changing or cancelling this cover.

19.17 **We** may also transfer a group of members to a different division, for example if **your** employer restructures its insurance. If this occurs, **we** will let **you** know in writing 30 calendar days before the transfer. **We** will confirm to **you** any changes to **your** insurance cover and **your** options for changing or cancelling this cover.

20 Refunds

20.1 If at claim time **we** identify that **you** have multiple automatic insurance covers in superannuation and **your** benefit is offset or not able to be claimed on because **you** have claimed on another benefit under another similar policy, which means that no payment is made to **you** under the cover **you** hold with **us**, **we** will give **you** the option of a refund of **your** premiums into **your** account for the duration of the overlap of covers, to a maximum of 6 years, and **we** will then cancel **your** cover.

20.2 If **we** identify that **you** were not eligible to claim against **your** automatic insurance cover for any event from the start of the cover, **we** will refund **your** premiums to **your** account for the period **you** were ineligible.⁴⁶

⁴⁶ Refunds will not be provided if **you** have an illness or injury that means **you** are not covered due to a limited cover or pre-existing condition exclusion or limitation, because **you** may still be eligible for cover for any new or other illnesses or injuries.

20.3 If **you** make a claim that is accepted, and **your** cover ceases under the terms of the policy on the date **you** became eligible to claim, **we** will refund **your** premiums to **your** superannuation account back to the date **you** became eligible to claim.

21 Staff and Service Providers

21.1 **We** will ensure **our** staff have the appropriate education and training to provide their services competently and to deal with **you** professionally, initially and on an ongoing basis. This will include training on their responsibilities under the **Code**. **We** will only allow **our** staff to provide services that match their expertise.

21.2 **We** will have processes in place to train **our** staff to help identify and engage appropriately with vulnerable consumers, to carry out any internal protocols **we** put in place, and to refer these consumers for appropriate support where required. Specific training regarding engaging appropriately with members who have mental health conditions will be provided.

21.3 **Our** claims handling staff who make initial eligibility assessments and review claim decisions made by insurers will be appropriately skilled and trained to make objective decisions. They will not make decisions on **our** behalf until they have demonstrated technical competency and an understanding of all relevant law and the requirements of the **Code**. Performance measures, remuneration and entitlements to bonuses will not be based on declined claims or deferrals of decisions.

21.4 **We** will monitor the performance of **our** staff and provide appropriate education and training to correct any identified performance shortcomings.

21.5 In addition to an insurer, we may engage another party to provide a service to **you** on **our** behalf; for example, a claims management service or a fund administrator. When **we** enter into an agreement, or renew an agreement (no later than two years after **we** adopt the **Code**) with a Service Provider, the agreement will require them to comply with the relevant standards of the **Code**.

21.6 **We** will review **our** agreements with Service Providers no later than every 3 years.

21.7 **We** will require Service Providers to act with honesty, fairness, respect, transparency and timeliness towards **you** and **us**.

21.8 **We** will only enter into agreements with Service Providers who reasonably satisfy **us** of their expertise, experience, qualifications and integrity, and who hold any required licensing.

21.9 **We** will require Service Providers to comply with the Privacy Act 1988 and maintain confidentiality of **your** information, and only use that information for the purpose of the service they are providing.

21.10 **We** will monitor the activities of any Service Providers that **we** engage to ensure that they are complying with the relevant standards of the **Code**. This can include requiring regular

reporting, putting in place quality assurance measures, and analysing data such as claim decisions and complaints.

- 21.11 **We** will require any Service Providers that **we** engage to notify **us** if **you** make a complaint to them about their services, and **we** will handle the complaint in line with **our** complaints process.

22 Making enquiries and complaints

How to make an enquiry

- 22.1 If **you** have a question about **your** cover, **your** premiums, any communication **we** have sent **you** or a decision that has been made regarding **your** cover, **you** can make an enquiry to **us**. **We** will provide **you** with information without requiring **you** to make an insurance claim.

- 22.2 **You** can also access the following information (in an electronic format if preferred) upon request:

- a) details of **your** cover
- b) **our** insurance contract with **our** insurer (sometimes called the policy document)
- c) the product disclosure statement relevant to **your** cover
- d) **our** trust deed
- e) any personal information **we** hold about **you**
- f) information relied on to decide **your** claim or complaint.

- 22.3 **We** will respond to your enquiry:

- a) with an acknowledgment by the next **business day**
- b) with a full response within 10 **business days**.

- 22.4 If **we** cannot comply with a timeframe for providing information required by the **Code**, for example because we are waiting for permission from a third party to release the information, **we** will tell **you** why before the end of the timeframe, and this will not constitute a **Code** breach.

- 22.5 In some circumstances, information may not be able to be provided, for one of the following reasons:

- a) where information is protected from disclosure by law, including the *Privacy Act 1988*
- b) where **we** reasonably determine that the information should be provided directly to **your** doctor
- c) where the release of the information may be prejudicial in relation to a dispute about insurance cover, a claim, or a complaint
- d) where **we** reasonably believe that the information is commercial-in-confidence.

- 22.6 If information is not provided:

- a) **we** will act reasonably
- b) **we** will give **you** a schedule of the documents not provided and the reasons for doing so

c) **we** will tell **you** how **you** can make a complaint if **you** are not satisfied.

22.7 If **you** are not satisfied with **our** response to **your** enquiry, **you** can make a complaint.

How to make a complaint

22.8 **You** can make a complaint to **us** about any of **our** decisions or conduct, or the decisions or conduct of a Service Provider. If **you** make a complaint to **us** about a decision or conduct of **our** insurer, **we** will ask the insurer for a response and **we** will review this as part of **our** complaints process.

22.9 **We** will make information about **your** right to make a complaint and **our** process for handling complaints available on **our** website and in **our** relevant communications to **you**.

22.10 **Your** complaint will be handled by someone different from the person or persons whose decision or conduct is the subject of the complaint.

22.11 **We** will notify **you** of the name and contact details of the person assigned to liaise with **you** about **your** complaint, and an overview of the process and timeframe.

22.12 **We** will only ask for and rely on information relevant to the investigation of **your** complaint and **our** response to **your** complaint.

22.13 If **we** become aware of errors and mistakes in the handling of **your** complaint, **we** will address these promptly.

22.14 **You** will receive progress updates at least every 20 **business days** (unless a different timetable is agreed with **you**). If there are any issues delaying assessment of **your** complaint, **we** will let **you** know.

22.15 **We** will provide a final response to **your** complaint in writing within 45 calendar days of receiving **your** complaint. In exceptional cases, **we** will need more time to investigate and respond to **your** complaint. In these cases, **we** will tell **you** that **we** need more time, and will clearly communicate **our** revised expected timeframe, which will not exceed 90 calendar days.

22.16 If **we** do not respond to **your** complaint within 90 calendar days, **we** will give **you** written reasons for the delay before the end of the 90-day period, and **we** will let **you** know that **you** can take **your** complaint to **External Dispute Resolution**.

22.17 In **our** response to **your** complaint, **we** will explain:

- a) **our** decision on **your** complaint and the reasons for that decision
- b) that **you** can request copies of the documents and information relied on in line with the standards of this section
- c) that **you** have the right to take **your** complaint to **External Dispute Resolution** if **you** are not satisfied with **our** decision and the timeframe within which **you** must take **your** complaint to **External Dispute Resolution**
- d) contact details for the relevant **External Dispute Resolution** organisation.

22.18 A summary of the complaints **we** handle will be regularly reported to our Board.

External determination of complaints

- 22.19 If **you** make a complaint to **us** and **our** final decision does not resolve **your** complaint to **your** satisfaction, or if **we** do not resolve your complaint within 90 calendar days, **you** may refer **your** complaint to **External Dispute Resolution**.
- 22.20 **You** may seek independent legal advice and access any other dispute resolution options that may be available to **you** or of which **we** are a member.

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Chapter 3 – Code Governance, Sanctions and Definitions

23 Information and education

- 23.1 We will make our customers aware of the Code, which will include providing information about the Code on our websites and in our relevant marketing documents.
- 23.2 The FSC is responsible for the promotion of the Code to consumers through its members and to industry participants that have not yet adopted it. We will work with the FSC to promote the Code.
- 23.3 The FSC will work with the Life CCC, relevant regulators and stakeholders to encourage all life insurers, reinsurers and other relevant life insurance industry in Australia to adopt the Code.
- 23.4 The FSC may develop guidance documents from time to time. These are not enforceable but may help us interpret and meet the standards in the Code.
- 23.5 We will work with the FSC on the promotion and education of life insurance, financial literacy and the life insurance industry.

24 Code governance

Role of FSC

- 24.1 The FSC is responsible for developing the Code, including the Charter of the Life CCC.
- 24.2 The FSC will commission formal independent reviews of the Code as appropriate. The first independent review will be in 2022, and not less than every three years thereafter. The Life CCC may recommend to the FSC Life Board Committee and/or the Superannuation Board Committee as appropriate that the Code be reviewed, if the Life CCC believes the application of the Code could better meet its objectives.
- 24.3 In addition to formal independent reviews of the Code, the FSC will consult on an ongoing basis with the Life CCC, External Dispute Resolution bodies, consumer and industry representatives, relevant regulators and other stakeholders to develop the Code.

Role of Life Code Compliance Committee

- 24.4 The Life CCC is responsible for monitoring and enforcing our compliance with the Code.
- 24.5 The Life CCC is made up of:
- a) An independent chair
 - b) At least one consumer representative
 - c) The same number of industry representatives

- 24.6 The **Life CCC**'s functions and powers are set out in its Charter.
- 24.7 The **Life CCC** is responsible for providing regular reports to the **FSC**'s Life Board Committee and/or the Superannuation Board Committee as appropriate, with recommendations on any **Code** improvements and industry issues, including where non-compliance with any standards of **the Code** indicates an industry issue or highlights weaknesses in **the Code**.
- 24.8 The **Life CCC** may outsource its functions to an appropriate body, except for its powers to sanction.

25 Monitoring, enforcement and sanctions

- 25.1 Anyone can report alleged breaches of the **Code** to the **Life CCC**.
- 25.2 If the **Life CCC** decides that an allegation should be dealt with through **our** internal **Complaints** process, it will refer **you** to **us** to make a **Complaint**.
- 25.3 **External dispute resolution bodies** may report possible **Code** breaches to the **Life CCC**.

Our Responsibility

- 25.4 **We** will:
- a) Have appropriate systems and processes in place to enable compliance with **the Code**.
 - b) Prepare an annual return to the **Life CCC** on **our** compliance with **the Code**.
 - c) Have a governance process to report on **our** compliance with **the Code** to **our** Board of Directors or executive management.
- 25.5 If **we** identify a **Significant Breach** of **the Code** within **our** organisation, **we** will report it to the **Life CCC** within ten **business days** of becoming aware of it, unless both the following apply:
- a) The breach relates to a matter that has been reported to the relevant regulator.
 - b) The regulator has been informed that the matter may also involve a **Code** breach.
- 25.6 **We** will be in breach of **the Code** if **our** staff or **our** **Authorised Representatives** fail to comply with **the Code**.
- 25.7 **We** will cooperate with the **Life CCC** in its:
- a) Review of **our** compliance with **the Code**.
 - b) Investigation of any alleged **Code** breach.
 - c) Reasonable requests of **us** when it carries out its functions.
- 25.8 **We** will apply fair and reasonable corrective measures within set timeframes, as agreed with the **Life CCC**, in response to a **Code** breach. For the avoidance of doubt, any corrective measures related to the breach agreed with **us** or imposed on **us** by any regulatory body will take precedence.

Life CCC Responsibility

25.9 The **Life CCC** will:

- a) Receive allegations about breaches of **the Code**.
- b) Tell **us** about any alleged **Code** breaches by **us** and give **us** an opportunity to respond.
- c) Use its discretion to investigate alleged **Code** breaches.
- d) Determine whether a **Code** breach has occurred.
- e) Agree with **us** any fair and reasonable corrective measures **we** must implement and the relevant timeframes, taking into account any corrective measures related to the breach imposed on **us** by any regulatory body.
- f) Monitor **our** implementation of any agreed corrective measures and determine if they have been implemented effectively and within the agreed timeframe.

25.10 The **Life CCC** will publish an annual report containing consolidated, de-identified analysis on **Code** compliance.

Sanctions

25.11 If the **Life CCC** considers **we** have failed to correct a **Code** breach in accordance with section 25.8, or if **we** cannot agree on corrective measures, it will:

- a) Inform **our** Chief Executive Officer **in writing**.
- b) Provide an opportunity for **us** to respond within 15 **business days**.

25.12 The **Life CCC** will consider any response by **us** before making a final determination and imposing any sanctions.

25.13 The **Life CCC** will inform **our** Chief Executive Officer and the **FSC in writing** of its decision regarding any failure to correct a **Code** breach and any sanctions to be imposed.

25.14 When determining any sanctions to be imposed, the **Life CCC** will consider:

- a) The principles and objectives of **the Code**.
- b) The appropriateness of the sanction.
- c) Any measures related to the breach imposed on **us** by any regulatory body.
- d) Whether the breach is a **Significant Breach**.

25.15 The **Life CCC** may at its discretion impose one or more of the following sanctions:

- a) Require **us** to take particular rectification steps within a specified timeframe, taking into account any rectification related to the breach imposed on **us** by any regulatory body.
- b) Give **us** a formal warning.
- c) Require **us** to undertake a **Code** compliance audit.
- d) Require **us** to undertake corrective advertising or write directly to the customers affected by the **Code** breach.
- e) Require publication of **our** non-compliance on **our** website and/or on the **FSC** website.

25.16 The **Life CCC**'s decisions are binding on **us**.

25.17 If **we** do not comply with a sanction imposed on **us** by the **Life CCC**, this will be regarded as a breach of an **FSC** Standard. The **FSC** Board has the power to undertake disciplinary action in accordance with **FSC** Standard No. 1.

26 Access to information

26.1 **We** will comply with the Privacy Act 1988 and any other legal obligations when **we** collect, store, use and disclose personal information about **you**.

26.2 Subject to section 26.5, **you** can ask **us** for the information about **you** that **we** relied on in assessing **your** application for insurance cover, **your** claim or **your Complaint**.

26.3 Subject to section 26.5, **you** can also ask us for a copy of any reports from **Independent Service Providers** that **we** relied on in assessing **your** application for insurance cover or **your** claim.

26.4 If **we** cannot meet a timeframe in the **Code** for giving **you** information because **we** are waiting for permission from a third party to release it, **we** will tell **you** this before the end of the timeframe, and this will not be a **Code** breach.

26.5 In special circumstances, **we** may decide not to disclose information to **you**, such as where:

- a) The information is protected from disclosure by law, including the Privacy Act 1988.
- b) **We** reasonably decide that we should give the information directly to **your** doctor.
- c) **Your** treating health practitioner has advised **us** that it is not in **your** best interests.
- d) Releasing the information may be prejudicial to **us** in relation to a dispute about **your** insurance cover or **your** claim, or in relation to **your Complaint**, in line with privacy laws.
- e) **we** reasonably believe that the information is commercial-in-confidence.

26.6 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 given **you** and explain **our** reasons for withholding them.
- c) Give **you** details of **our Complaints** process.

26.7 If **you** ask **us** for a copy of **your Life Insurance Policy** documentation, **we** will send it to **you** promptly, and in an electronic form if **you** ask **us**, subject to any process for releasing policy documentation that **we** are required to carry out by law.

27 Definitions

APRA means the Australian Prudential Regulation Authority.

ASIC means the Australian Securities and Investments Commission.

Applicant means a person who applies for a **life insurance policy** with **us** to become a **policy owner** or a **life insured**.

Authorised Representative means a person, company or other entity authorised by **us** to provide financial services on **our** behalf under **our** Australian Financial Services licence, in accordance with the Corporations Act 2001. It does not include a person, company or entity that is an authorised representative of an Australian Financial Services licensee that is a related company to **us**.

Automatic Insurance Member means you are a superannuation fund member to whom we have provided insurance automatically. You are not regarded as an **Automatic Insurance Member** if:

- a) you have made an application for cover (including cover that is underwritten or the reinstatement of previous cover)
- b) you have varied the cover in any way, such as cancelling, fixing cover or changing the benefit or waiting period
- c) your insurance premiums are wholly paid for by your employer (whether through contributions to your superannuation account or otherwise) or not paid by deduction from your account
- d) you are a defined benefit member.

business days are Monday to Friday excluding public holidays.

CCI means consumer credit insurance.

Code means the Life Insurance Code of Practice.

Complaint means an expression of dissatisfaction made to **us**, related to **our** products or services, or **our Complaints** handling process itself, where a response or resolution is explicitly or implicitly expected.

Determination means a final determination made by an **External Dispute Resolution** body.

eligible contributions for measuring contributions inactivity consist of:

- a) **Superannuation Guarantee**
- b) additional employer contributions
- c) personal contributions (including a rollover and contributions made by a spouse).

They do not include government contributions, including co-contribution, super guarantee credits, or Low Income Super Tax Offset.

exceptional cases for the purposes of Chapter 2 means any of the following:

- a) the claim is lodged so late that there are significant difficulties obtaining information necessary for the claim assessment;
- b) **we**, as trustee, believe that a claim which has been declined by the insurer may have a reasonable prospect of success, but involves complex matters that require further consideration by **us**;
- c) despite reasonable follow up, reports from third parties have not been received
- d) the insurer has not provided information to **us** that **we** require to make a decision about a claim or complaint, which **we** have requested in line with our Code commitments;
- e) **you** or **your Representative** have not responded to **our** reasonable enquiries or requests for documents or information concerning **your** claim;

- f) there are difficulties in communicating with **you** in relation to the claim due to circumstances beyond **our** control;
- g) there is a delay in the claims process that **you** have requested; or
- h) the claim is fraudulent or **we** reasonably suspect fraud or non-disclosure that requires further investigation.

External Dispute Resolution means the external organisation that is relevant to your complaint, which may include the Australian Financial Complaints Authority, the Superannuation Complaints Tribunal, the Financial Ombudsman Service, or a complaints handling process mandated by legislation.

FSC means the Financial Services Council Limited.

Funeral Insurance Policy means a type of **Life Insurance Policy** where the primary purpose of all of the benefits is to meet the expenses of or that are incidental to the funeral, burial or cremation of the person covered under the policy or a member of their family.

Group Policy means a type of **Life Insurance Policy** owned by an employer, superannuation fund trustee or another person or entity, covering a group of **Lives Insured** or an individual **Life Insured** and includes additional cover purchased by **Lives Insured**.

Group Policy-owner means a **Policy-owner** of a **Group Policy**.

Independent Service Provider means someone **we** enter into an agreement with to assist with underwriting, administration or claims management, including but not limited to an independent medical assessor, an allied health professional, an accountant, an investigator, a rehabilitation provider or a claims management service. This excludes **Reinsurers**.

Individually Agreed Special Term or Exclusion means a variation to the policy terms, such as the addition of an exclusion clause for a specific condition, that **we** apply to **your** policy with **your** agreement which changes the standard terms **we** offer due to **your** individual circumstances or health history.

in writing or **written** means a communication conveyed by mail or via electronic means such as by email, facsimile or text message, or any other means permitted by legislation or regulation.

inappropriately erode means the erosion of retirement balances as a result of insurance premiums to the extent that the primary purpose of superannuation, to provide income in retirement to substitute or supplement the Age Pension, is not met.

Life CCC means the Life Code Compliance Committee as described in section 12.

Life Insurance Policy means any of the following issued in the Australian market, excluding a contract of reinsurance:

- a) A contract of insurance that provides for the payment of money on the death of a person or on the happening of a contingency dependent on the termination or continuance of human life (Section 9(1)(a), Life Insurance Act 1995).
- b) A contract of insurance that is subject to payment of **premiums** for a term dependent on the termination or continuance of human life (Section 9(1)(b), Life Insurance Act 1995).

- c) A continuous disability policy (Section 9(1)(e), Life Insurance Act 1995).
- d) Another contract of insurance, 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 means a person covered under a **Life Insurance Policy** covered by the **Code**, regardless of whether that person is a party to the **Life Insurance Policy** but excludes a **Third Party Beneficiary** (collectively referred to as **Lives Insured**).

PDS means product disclosure statement.

Policy-owner means a person, company or entity that owns a **Life Insurance Policy** covered by the **Code**, including joint **Policy-owners**, but excludes a **Third Party Beneficiary**.

Pre-existing condition exclusion clause means a standard clause in a **Life Insurance Policy** that excludes cover for any unspecified illnesses or disabilities **you** knew, or reasonably ought to have known, **you** had before **you** took out the policy.

Premium or **premiums** mean the amount **you** pay for **your** insurance cover or an amount paid by another person or entity for **your** insurance cover.

Received means the point in time where sufficient information (not necessarily all information) is received by the life insurer to allow it to commence the assessment of a claim. This may include completed claim forms with **your** completed consent form, or the provision of claim information and **your** consent by telephone.

Reinsurer means an entity that provides insurance to issuers of **Life Insurance Policies** (referred to as reinsurance). A **Reinsurer** does not have a contract of insurance with **you**.

Representative means someone **you** have nominated, or is authorised, to communicate with **us** on **your** behalf, such as a lawyer, financial adviser, financial planner, **Group Policy-owner**, interpreter, or family member.

Service Provider means another party that we engage to provide a service on our behalf; for example, a claims management service, a fund administrator, or a health information collection service. A life insurer in its capacity as an insurer is not a **Service Provider**.

Significant Breach means a **Code** breach that is reasonably determined by **us** to be significant by reference to:

- a) The number and frequency of similar previous breaches.
- b) The impact of the breach on **our** ability to provide **our** services.
- c) The extent to which the breach indicates that **our** arrangements to ensure compliance with **Code** obligations are inadequate.
- d) The actual or potential financial loss caused by the breach.

Surveillance means an investigator filming and/or observing a person undertaking activities in public.

Superannuation Guarantee means the compulsory superannuation contributions made by employers on behalf of their employees.

Third Party Beneficiary means a person or entity who is not a **Life Insured** or **Policy-owner** but is seeking to be or is specified or referred to in a **Life Insurance Policy** covered by the **Code**, whether by name or otherwise, as a person to whom the benefit of the insurance cover extends.

Unexpected Circumstances for the purposes of Chapter 1 means any of the following:

- a) **We received your** claim more than 12 months after the later of the date of disability or the end of your waiting period, and there are reasonable delays obtaining evidence necessary for the assessment of **your** claim from the intervening period.
- b) For a claim for total and permanent disability, **we** cannot reasonably satisfy ourselves on the basis of the information provided in the six months after the end of **your** waiting period that **your** condition meets the requirements of **your Life Insurance Policy**.
- c) **We** have not received reports, records or information reasonably requested from an **Independent Service Provider**, **your** doctor, a government agency or other person or entity **(but not including Reinsurers)**.
- d) The **Policy-owner** or **Group Policy-owner** has disputed or taken a protracted period to consider **our** decision.
- e) **You** or **your Representative** have not responded to **our** reasonable enquiries or requests for documents or information concerning **your** claim.
- f) There are difficulties in communicating with **you** in relation to the claim due to circumstances beyond **our** control.
- g) **You** or **your Representative** have asked for a delay or extension to part of the claims process.
- h) **We** reasonably suspect non-disclosure or misrepresentation that requires further investigation, or if your claim is fraudulent.

we, **us** and **our** mean the entity that is bound by the **Code**, and includes **our Authorised Representatives** but not an **authorised representative** of a company related to **us**.

you and **your** mean an **Applicant**, a **Life Insured**, a **Policy-owner**, a person with the authority to act on **your** behalf (such as a named representative, adviser, parent, guardian, or a person with a power of attorney), or a **Third Party Beneficiary**, as relevant to a particular section of the **Code**.

Appendix 1: **Foundation** Medical Trauma/Critical Illness Cover Definitions

a) **Cancer** – *excluding specified early stage cancers*

Cancer means any malignant tumour diagnosed with histological confirmation and characterised by:

- a) the uncontrolled growth of malignant cells; and
- b) invasion and destruction of normal tissue beyond the basement membrane.

The term malignant tumour includes leukaemia, sarcoma and lymphoma.

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.

b) **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.
- b) New significant ST-segment–T wave (ST–T) ECG changes or new left bundle branch block (LBBB).
- c) Development of new pathological Q waves in the ECG.
- d) 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 rise in biological markers as a result of an elective percutaneous procedure for coronary artery disease.
- Other acute coronary syndromes including but not limited to angina pectoris.

c) **Stroke** – *in the brain resulting in specified permanent impairment*

Stroke means death of brain tissue caused by one of the following:

- a) Ischaemic infarction of brain tissue.
- 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.

DRAFT

Appendix 2: Access to Health Information Consent Form

[Placeholder for Access to Health Information Consent Form when agreed with RACGP – also to go on the FSC and RACGP websites]

Appendix 3: Key Facts Sheet




XYZ Superannuation Fund

Insurance in Superannuation Key Facts Sheet


This fact sheet relates to our automatic insurance cover for [Fund] members




Insurance can give you peace of mind, as it provides financial support to protect what's important to you if you die or have to stop work due to illness or injury.



We provide you with insurance cover automatically when you join, and deduct fees from your super so you don't have to remember to pay for it.



Don't forget, if you or your employer stop making contributions, your **Insurance fees will continue to be deducted from your super balance.**




You can **cancel** or apply to **change** your automatic insurance cover at any time.

What automatic insurance cover is included?

	 Terminal Illness	 Death	 Total and Permanent Disability	 Income Protection
	Pays if you're medically certified as likely to die within 24 months.	Pays on death to your dependants, estate or legal representative.	Pays if you're <unable> <unlikely> to ever work again due to illness or injury.	Provides replacement income if you're temporarily unable to work due to illness or injury.
Automatic cover	yes	yes	yes	yes <small>(maximum benefit period of x years)</small>
Cover can start from age	14 - 60	14 - 60	14 - 55	14 - 55
Cover ends at age	75	75	65	65
Are pre-existing medical conditions covered?	yes	yes	yes	yes <small>provided you're in Active Employment*</small>
Is cover limited if employer contributions are not received?	yes	yes	yes	yes
	<small>--- contributions must be received within 120 days of starting work otherwise New Events Cover** may apply ---</small>			
Does work status at date of injury or illness affect cover?	no	no	yes	yes
Is cover provided if a claim has previously been paid under the same type of cover?	no	N/A	no	yes
Is there a waiting period before a claim can be made?	no	no	yes <small>x months</small>	yes <small>x days</small>

Other eligibility requirements

- **At Work**  when provided with cover
- Employer contribution received within x months
- Other

Active Employment** means an ability to perform or be capable of performing all the duties of your normal job on a full time basis on the date that cover starts. **New Events Cover* applies until In Active Employment for 2 consecutive months.

****New Events Cover** means that cover is only for claims arising from an illness which first became apparent, or an injury which occurs on or after your cover starts.

*****At Work** means an ability to perform or be capable of performing all the duties and hours of the occupation from which you earn your regular income.

What are your options?



Keep it

Keep the insurance cover you receive automatically.

Decide if the automatic cover meets your needs.

Review your cover when your circumstances or financial commitments change. For example, you change jobs, start a family, buy a property, divorce etc.



Cancel it

Cancel your insurance cover.

You will not be able to make a claim with us for an event that occurs after your cover is cancelled.

If you cancel your cover, insurance fees will stop being deducted from your account.

If you want cover later, you will have to apply and be assessed by our insurer.



Tailor it

Change the cover to meet your needs.

You can reduce your cover at any time.

You can also apply to increase your cover.

Frequently asked questions



What if I need to claim?

We can discuss the claim process and requirements with you, so that you know what to expect.

We will oversee the claims process and help you step through it.



Can I nominate beneficiaries?

You can nominate who will receive your super if you pass away.

Please contact us to receive a nomination form.



What if I change my super fund?

Before changing or consolidating super funds, make sure you can get the insurance cover you need, in your chosen fund.

Be careful if you have a medical condition or are over age 60, as this could affect your eligibility for new cover.

Circumstances that may affect your insurance cover

The following may change your insurance cover:

- Ceasing work with your employer
- No superannuation contributions received after x months
- Changing or combining your superannuation accounts
- A change in your working hours
- Not having worked for longer than x months
- You are on extended employer approved leave
- Your account balance falls below \$ xxxx

For further information, please refer to the product disclosure statement or call us.

Taking action is easy



Have you used our online insurance calculator? Check to see if your automatic insurance cover may meet your needs.
Visit xyz.com/calculator



Call us if you want to learn more.
2222 2222



Chat with our great team to learn more.
xyz.com/chat



Send us an email to learn more.
email@xyz.com

For more information on insurance in super visit the Australian Government website:
www.moneysmart.gov.au

Important information

Any advice in this document has been prepared without taking account of your objectives, financial situation or needs. Because of this, you should, before acting on any advice in this document, consider its appropriateness, having regard to your objectives, financial situation and needs. You should obtain the Product Disclosure Statement and the insurance guide, available at [insert website address], and consider it before making any decision about whether to acquire the superannuation product. The superannuation product is issued by [insert trustee name, ABN and AFSL number]. The information in this document is a high-level summary only and you should refer to the Product Disclosure Statement and the insurance guide.

Appendix 4: Moratorium on Genetic Tests in Life Insurance

1. 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 to reduce morbidity and mortality, and in some cases widen access to insurance through greater underwriting accuracy.
2. It is, however, important that public concerns about the application of genetic tests in life insurance do not dissuade people from taking genetic tests or taking part in genetic research.
3. The objective of The Moratorium on Genetic Tests in Life Insurance (The Moratorium) is to promote genetic inclusion by ensuring people can access a level of life insurance without being asked about the result of a previously taken genetic test.

Scope of The Moratorium

4. The Moratorium applies to people taking out or increasing individually underwritten life insurance (including group insurance) with a Financial Services Council (FSC) member.
5. The Moratorium starts on 1 July 2019 and applies until 30 June 2024.
6. For the purposes of The Moratorium, a genetic test means a test which examines a person's chromosomes or DNA. For the avoidance of doubt, it does not include any non-genetic medical tests (for example, blood or urine tests for cholesterol, liver function or diabetes), even if they are to test for a condition that may have a genetic origin.

Underwritten applications for life insurance

7. Life insurers will not ask applicants to take a genetic test as part of their application and underwriting process.
8. As part of the application process for the benefits listed below, life insurers may only ask for or use the results of a previously taken genetic test if the total amounts of cover for the applicant, including both the cover being applied for and any existing individual and group insurance cover with all life insurers in aggregate, is more than any of the following:
 - \$500,000 of lump sum death cover.
 - \$500,000 of total permanent disability cover (TPD).
 - \$200,000 of trauma or critical illness cover.
 - \$4,000 a month of income protection or salary continuance cover.

These limits are consistent with limits used in other international markets.

9. Where an applicant's total amount of cover exceeds one of the limits above, a life insurer may ask for and use the result of a previously taken, planned or considered genetic test when assessing the full amount of cover being applied for across all types.
10. Life insurers will take the following into account as part of their underwriting assessment:
 - A favourable genetic test result an applicant chooses to disclose, for example, to show that they are not carrying a gene pattern associated with developing an illness that runs in their family.
 - Preventative treatment, or adherence to preventative measures, which reduce the possibility of developing an illness that runs in the family.

11. For the purposes of governance and compliance, and to inform the review described in clause 13 below, life insurers will record anonymous details of all genetic test results received as part of the underwriting process, whether or not the life insurer asked for them, on the FSC database of genetic test results.

Claims assessments

12. When assessing claims, life insurers will not treat the insured person as having breached their duty of disclosure for not disclosing the results of a genetic test that the life insurer was not entitled to ask for or use at the time of the application for cover, in accordance with clause 8 of The Moratorium.

Review

13. During 2022, FSC will undertake a review of The Moratorium, taking account of its objectives and the following, with a view to extending the date:

- The rates of participation in genetic research.
- Advances in the field of genomics and genetic testing.
- Any adverse impacts of The Moratorium on the sustainability of the life insurance industry.

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