Lawyers for the People

AUSTRALIAN LAWYERS ALLIANCE

# DISCUSSION PAPER:

# CLAIMS HANDLING

## Submission to the Insurance in Superannuation Working Group

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Lawyers for the People

AUSTRALIAN LAWYERS ALLIANCE

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## Who we are

The Australian Lawyers Alliance (ALA) is a national association of lawyers, academics and other professionals dedicated to protecting and promoting justice, freedom and the rights of the individual.

We estimate that our 1,500 members represent up to 200,000 people each year in Australia. We promote access to justice and equality before the law for all individuals regardless of their wealth, position, gender, age, race or religious belief.

The ALA started in 1994 as the Australian Plaintiff Lawyers Association, when a small group of personal injury lawyers decided to pool their knowledge and resources to secure better outcomes for their clients – victims of negligence. While maintaining our plaintiff common law focus, our advocacy has since expanded to criminal and administrative law, in line with our dedication to justice, freedom and rights.

The ALA is represented in every state and territory in Australia. More information about us is available on our website.[1]

[1] www.lawyersalliance.com.au.

## Introduction

1. The Australian Lawyers Alliance (ALA) welcomes the opportunity to have input into the issues raised by the Insurance in Superannuation Working Group's (ISWG's) Discussion Paper: *Claims Handling.* This submission makes comments on the consultation questions B.1, B.2, B.3 and B.4 and C.

## Proposed ALA Draft Code of Practice

2. The ALA has previously prepared a comprehensive draft Code of Practice covering both life insurers and superannuation funds relevant to group life claims. This draft has been used in submissions to government and the Financial Services Council (FSC) on similar topics to those canvassed in the ISWG Discussion Paper: *Claims Handling*. A copy of the draft Code is at **Appendix A**. We would urge the ISWG to adopt this draft or similar provisions in any Code it may recommend. In particular, clauses 8 to 14 are relevant to the current discussion paper.

## B.1 Claims-handling principles

3. Most people with death and/or disability insurance cover have obtained their insurance cover automatically through an employment superannuation fund.

4. Given the involvement of superannuation funds both in providing this much-needed insurance cover, and also the assessment and administration of claims, the ALA welcomes the development of an Industry Code to guide superannuation funds in the principles to be applied when handling insurance claims.

5. It is noted that the ISWG has provided six suggested principles which could be included in an Industry Code. This submission makes comments that seek to refine those principles. In addition to those six suggested principles, the ALA recommends that the principles in the Industry Code should align with the trustees' duties under

the *Superannuation (Industry Supervision) Act 1993* (Cth) (SIS Act) and the insurer's obligations under the *Insurance Contracts Act 1984* (Cth). If the principles in the Industry Code conflict or do not align with already existing statutory obligations, it may lead to unnecessary confusion and possible infringements. It is thus essential that the two are consistent.

6. Aside from the principles that may be covered under an Industry Code, it is essential that there is broad acceptance and sign-up to the Code by superannuation trustees and insurers on an industry-wide basis. Regrettably, that is not the case with the current Life Insurance Code of Practice (Life Code).

7. The current Life Code will come into effect from 1 July 2017. The Life Code is binding upon members of the FSC, but not on non-members. There are a number of large life insurance companies who are not presently members of the FSC. They include Onepath Life, QInsure and CommInsure. Those companies will not be bound by the Life Code, yet they offer insurance cover to many thousands of consumers. Therefore, those consumers remain unprotected. Such a gap should not arise with the Industry Code, if its protections are to be adequate.

## Role of superannuation funds in claims-handling

8. One further significant failing of the Life Code is that it fails to bind superannuation trustees to a basic level of claims-handling standards. This ignores the often significant role that superannuation funds play in the claims assessment process.

9. There has been significant discussion in the industry and the media of various failings of the life insurance industry to do with claims assessment and meeting the expectations of members.

10. Superannuation funds have a significant role to play in the assessment of life insurance claims. The actual role adopted by any particular fund can vary greatly

depending on the internal arrangements of that fund. Some superannuation funds outsource significant parts of the claims administration to the insurer or alternatively to an administration or claims management company. Other superannuation funds are more hands-on.

11. Noting the many different ways in which superannuation fund trustees manage their claims processes, it is important to ensure that there is a basic minimum standard that applies to superannuation fund trustees and insurers. Equally, it is crucial that superannuation fund trustees and insurers are obliged to impose those minimum service standards upon those whom they might engage to assist in the claims process, including claims administration companies and surveillance companies (and their agents, where applicable).

12. It is noted that the ALA has previously provided a submission to the Senate Standing Committee on Economics dated 7 March 2017. We do not wish to repeat that submission in its entirety, but would refer you to paragraphs 36-52 of it.[2]

13. The ALA is aware of many occasions in which trustees promote the fact that they have a duty to act in the member's best interest and that the trustee can advocate on behalf of a member in relation to a claim. It is important to emphasise that this is not an accurate representation of the role of a trustee.

14. A trustee is a fiduciary and has a duty to act in the members' best interest – that is, the *collective* members, not any individual member. The interests of the individual member and the collective membership can be in conflict: the collective membership pays for an insurance payout to an individual member, so the collective membership could be seen to have an interest in denying claims, while an individual

[2] Copy available online at https://www.lawyersalliance.com.au/documents/item/812.

member has an interest in the claim being accepted. A trustee is in a fiduciary role, which must be distinguished from the role that a true advocate plays.

15. Superannuation funds and insurers already operate in a context where duties and obligations to act towards members in good faith, and with due regard to their interests, exist. Despite these clear statutory obligations, it is all too common to hear of poor outcomes for claimants, either in relation to rejections or delays in the assessment of their claims.

16. Given this, an Industry Code that simply places duties on trustees and insurers without making them binding and enforceable, is unlikely to significantly improve the claims experience for members.

## Industry Code Compliance Committee

17. The best way to ensure consumer confidence in claims assessment is to ensure that the Industry Code is binding on superannuation funds and insurers and is enforceable. The ALA believes the best model for enforcing the Code is to establish an Industry Code Compliance Committee (ICCC), which is properly resourced and has the capacity to conduct audits where necessary. The Code should also be registered with ASIC and have regulatory oversight from ASIC.

18. The ICCC should include representatives from both the industry and consumer organisations, to ensure that it has legitimacy in resolving disputes.

19. As has previously been stated by the ALA, disputes invariably involve a claimant who is the victim of poor claims-handling practices. Therefore, where the ICCC identifies a failure by an insurer, the ICCC should have powers to intervene and provide assistance to the claimant which may include, for example, a requirement that the insurer take a particular step within a timeframe, which may include making a decision.

20. It is also essential that the ICCC's powers are clear and publicised, so that consumers can understand its role and whether they need to direct a complaint to the ICCC or instead to an external dispute resolution scheme or other body.

## B.2 Standard timeframes for superannuation fund claims

21. The ALA recommends that the timeframes for lodgement, assessment, decision-making and payment of claims through superannuation found in **Appendix B** be incorporated into the Industry Code and be enforceable.

22. The purpose of devising timeframes is to provide a timely, accountable and transparent claims processing regime that facilitates prompt determination within an agreed time period. This will ensure that claimants know what to expect, and will have a benchmark to which they can hold insurers accountable if unreasonable delays arise.

23. The ALA would suggest that monitoring, enforcement and sanctions be introduced for breaches of the timeframes proposed in the Discussion Paper in the form of penalties, adopting the FSC Life Code standards, and providing access to an external complaints process for claimants.

24. Timeframes ought to apply to all claims through superannuation, including the payment of insured benefits (TPD, Trauma, Death, Income or Salary Continuance) and early release of account balances on financial hardship or compassionate grounds.

## Advice to claimants and evidence-gathering

25. Superannuation call centres should not discourage members from making a claim when taking initial inquiries.

26. In circumstances where the fund is not providing personalised advice, no judgement should be made as to the prospects or otherwise of a claim on the first call.

27. The fund should be obligated to send a claim form package in response to every single query or request to claim, leaving it up to a member to decide whether to complete and lodge a claim. Where appropriate, claimants should be supported in completing this documentation.

28. The fund should be obligated to recommend that the member obtain independent advice, as this is the only true way a claimant can be properly advised, and avoids the inherent conflict of interest that the fund has between the interests of the membership as a whole and the interests of the individual member.

29. The fund should advise members of all insurance policy benefits to ensure that they are aware of all available benefits. It should be mandatory for the fund to issue a letter or email confirming all potential insurance available in response to any query or request to claim.

30. Wherever possible, the fund and insurer need to be mindful of the additional cost to the member in obtaining evidence to support their claim. For example, in an income protection claim, if a member's medical condition is stable and unlikely to change within three months, then it should be adequate for progress statements to be provided on a quarterly basis to minimise costs and inconvenience.

31. The current FSC Life Code guidelines in respect of medical examinations and investigation interviews ought to be adopted in any Industry Code developed by the ISWG.

32. The proposed timeframes encourage trustees of funds to be proactive in assessing and administering the claims process from the notification of a claim, as opposed to waiting to react to any determination or decision from the insurer first.

33. This proactive assessment process gives credibility to the trustees reaching an independent determination of the claim.

34. Claimants need to be informed as to what the trustees' processes are once an insurer's decision is made.

35. If there is a claims review process, it needs to be transparent. If a formal meeting is to occur, then the claimant should be advised when the trustees will meet and assess the claim.

36. The advice about the process needs to be given promptly and, where the claim is rejected, within no more than 14 days post-rejection of a claim by the insurer.

37. Where there is a disagreement between the trustees and the insurer, the claimant must be advised of the nature of the disagreement within seven days of the determination having been made.

38. Involving the claimant in that process will enhance the trustee's credibility, which can give members confidence that the decision on their insurance claim is truly being made in their best interests.

## B.3 Enhancing communications throughout the claims journey

39. The ALA supports the development of minimum communication standards for superannuation funds. The quality of the communication, however, also depends on what information is being shared between the fund and its insurer. It follows that any communication standards need to apply to both the fund and the insurer.

40. The standards ought to be mandatory, but much thought must be given to enforcement of the standards. Mandatory guidelines without any strong method of enforcement are useless. For this reason, any such standards must be capable of

enforcement by an ICCC which is properly resourced and has the capacity to conduct audits where necessary. The Industry Code should also be registered with ASIC and have regulatory oversight from ASIC.

41. Communication starts before the claim is brought. The availability of clear and easy-to-understand information about insurance coverage through superannuation is essential. Summarised product disclosure statement documents and insurance guides are general in nature and may tend to mislead an individual claimant who does not fit within the classic profile of members making claims. Therefore not only must general summaries of coverage be readily available to members, but also detailed documents and information. This would include, at the least, the actual insurance policy terms and conditions, claim forms, claim requirements, insurance claims philosophies and other policy and procedural documents that detail how claims are conducted and assessed.

42. The ALA submits that this information should not be filtered by the fund or its insurer but should be readily available via websites or member portals. Taking the insurance policy as an example, funds are notoriously bad at identifying the correct policy which applies in anything other than the most straightforward claim. Often terms of the policies require consideration of prior versions or amendments made to the policy. Having this information freely available will enable a member to obtain advice and make an early informed decision about their prospects of making a successful claim. The ALA further believes that making this information available will help to avoid the lodgement of a proportion of claims that have no prospect of success.

43. As discussed above, it is inappropriate for superannuation trustees to make decisions for members about how and when a claim should be lodged when they are not in a position to independently advise and advocate for that member. Allowing the members ready access to information and independent advice as early as possible will greatly reduce the number of rejected claims generally.

44. The first call where a member enquires about or intimates an intention to claim is a crucial communication point. The ALA understands that many members in that first call are either told that they cannot claim or that their claim will not succeed. Some are actively discouraged from claiming. There should be no advice given in that first call about a member's prospects of their proposed claim being successful or not. All members should be encouraged to claim if they think they might be eligible for benefits. Telling members that they cannot claim in circumstances where the superannuation fund is neither an independent adviser nor an advocate is poor practice and is not acting in the member's best interests. It is for this reason that having freely available, clear and comprehensive policy information available is so important.

45. It is also clear from the material available on industry representative websites and the funds' own websites that members are being actively encouraged not to use a lawyer or independent adviser in the claims process.[3] This is not acting in the individual member's best interest. For reasons already articulated, the fund is in a hopelessly conflicted position with respect to advising members on anything other than the very basic requirements of what is necessary to claim. The fund cannot be an independent adviser or advocate and is not equipped to act in an individual member's best interest.

46. Financial advisers, insurance brokers and other professionals are capable of providing independent assistance. Only lawyers, however, are qualified to provide legal advice. There can be no disputing that advice about whether a member is covered by a policy and how the policy ought to be interpreted in an individual member's own circumstances is legal advice which can only be provided by legally qualified practitioners who are licensed to practice and held to high professional standards. Disability claims are conducted within the sphere of contract law,

[3] See, for example, http://www.superguru.com.au/manage-your-super/insurance-in-super/making-a-claim and http://www.bussq.com.au/insurance/make-a-claim/forget-the-lawyers-claim-direct-and-save.

insurance law, corporations law and the law of equity and trusts. To suggest that these claims are always easy or straightforward is simply untrue. As such, funds should be required to encourage members to obtain independent legal advice.

47. The claimant's access to documents generated by their claim is an area where further minimum standards are required. Medical reports obtained about the claimant should be provided to the claimant as soon as they are received and not as part of a last-minute procedural fairness process. The claimant should be given the ability to review and respond to reports being written about them to ensure that any inaccuracies in reports are corrected before they are used for any purpose. The ability to comment on and put into context medical and vocational opinions about them is a fundamental right of a claimant. Privacy laws require that these documents be made available to claimants. There are exceptions, of course, such as in cases of suspected fraud, but they are exceptions. The general rule should be that reports are provided to the claimant throughout the course of their claim as they come to hand.

48. Obligations in relation to procedural fairness require clarification generally. There are consistent problems with procedural fairness provided by superannuation funds and sometimes even their insurers. Procedural fairness principles are not satisfied merely by the provision of a copy of a bundle of documents at the end of a claims-assessment process. Procedural fairness requires that in an appropriate case the proposed decision-maker articulate which parts of the evidence they have seen which they consider to be adverse to the claim and what possible conclusions they are drawing from that evidence. This is so the claimant can respond and clarify their position on those issues, and if necessary seek further evidence.

## B.4 Claims-handling governance

49. A complaint lodged with a superannuation fund by a consumer is supposed to be resolved within three months. It is our experience that this timeframe is frequently not met, and a complaint can be delayed far in excess of what is reasonable, and with few consequences for the superannuation fund or insurer. This inequity has contributed to the already significant backlog of the Superannuation Complaints Tribunal, causing further significant delays which create poor consumer outcomes, even where the claim is accepted. It is therefore important to ensure that the Industry Code includes specific obligations to ensure that a complaint/review is dealt with fairly, efficiently and with independence from the original decision-maker, and must be resolved within enforceable timeframes.

50. An area of significant concern is delays in claims and in review decisions. That is particularly so where, for example, the benefit being claimed is an income protection benefit, which is designed to provide income in the short term. The entire design and purpose of income protection insurance can be undermined if an insurer takes too long to assess the claim.

51. Accordingly, while there will be legitimate reasons why certain claims take a longer time than others, the ALA believes an important part of good claims-handling governance is to ensure that there are not systemic delays in assessment of claims. To that end, the ALA believes that there should be accurate collection of data relating to average claim timeframes and average timeframes to resolve complaints. The data should be reported to the ICCC on an annual basis to enable the ICCC to conduct an audit or make further enquiries, if necessary.

52. The ALA otherwise understands that superannuation funds and insurers often have significantly different operating procedures, and it is unnecessary to be prescriptive as to the structure of the governance framework, so long as minimum standards are being met.

## C Further considerations

53. The ALA supports the reporting and publication of claims data by funds. The data should be as transparent as possible. The ALA understands that data such as decline rates can adversely affect a fund's brand and the way in which data is collected is critical. Where a particular fund has a unique characteristic such as the type of members or industry it supports that might affect the data, the fund ought to be able to also publish explanations as to these nuances with the data.

54. The minimum types of data collected should include claims:

    a. enquiries;

    b. lodged;

    c. accepted;

    d. declined by insurer;

    e. declined by trustee;

    f. accepted after internal review by trustee and insurer; and

    g. accepted after external review by trustee and insurer.

55. The ALA supports the current exemption of insurance claims-handling from being categorised as a financial service. Claims-handling is an assessment and decision-making process and should not require the giving of advice by the insurer or superannuation fund to a consumer. If, however, superannuation funds insist on acting as quasi-advocates and advisers for their members bringing claims, then removing the exemption is more likely to be appropriate.

56. The ALA sees little merit in an industry-funded claims assistance service. This is what the superannuation funds are meant to be doing anyway. To abdicate this process

to an external service undermines the fund's statutory obligations to assist members to pursue claims where there is a reasonable prospect of success.[4]

57. It is noted that the feedback questions in this section do not seek feedback on the comments contained in the Discussion Paper about the involvement of law firms in claims. The assumption that a member is 'unnecessarily' paying fees to pursue a claims process is flawed. Members are receiving a valuable service from independent skilled professionals who are entitled to be paid a fair fee for their work. Members can seek assistance for reasons other than the complexity or otherwise of the claim. Members are injured or ill and most commonly experiencing the lowest point of their lives. They need independent advice and advocacy, not general summarised advice, poor quality assistance and lengthy delays from superannuation funds and their insurers, which are currently all too common. Access to independent legal advice is a fundamental right and we reiterate our previous comments in relation to the legal nature of the advice required regarding these claims and that only qualified lawyers can provide that advice.

58. The ALA would welcome the opportunity to meet with the ISWG regarding this issue to more fully expand on our feedback in this regard.

## Recommendations

The ALA makes the following recommendations:

- Any Industry Code must be consistent with relevant legislation, including the SIS Act and the *Insurance Contracts Act 1984*;

[4] It is important to distinguish the statutory obligation to assist members, by providing claims forms and reviewing insurers' assessment decisions, and the independent assistance or legal advice which are most appropriately provided by an independent lawyer.

- Broad acceptance of the Industry Code should be encouraged, so that all members of superannuation funds are covered;
- There should be a basic minimum standard of claims management that applies to superannuation fund trustees and insurers;
- An adequately resourced ICCC should be established with representatives from both industry and consumer groups. The role and powers of this Committee should be clearly publicised;
- Standard, enforceable timeframes should be included in the Industry Code in line with Appendix A;
- Superannuation funds should ensure that members are not advised that potential claims would have no prospect of success. Members should have access to all relevant policy documents, be informed of all available policy benefits, be sent a claims pack and encouraged to obtain independent legal advice;
- Fund processes should be transparent, and ensure that claimants are informed of the progress of their claims at timely intervals;
- Clear, regular communication and access to relevant documents should be required under the Industry Code;
- Superannuation funds should refrain from discouraging claimants from claiming. Instead, they should provide members with information about the right to seek independent advice;
- Medical reports obtained about the claimant should be provided to the claimant as soon as they are received. Claimants should be able to review and respond to reports being written about them to ensure that inaccuracies in the reports are corrected before they are used for any purpose;

- The Industry Code should contain specific obligations to ensure that a complaint or request for review is dealt with fairly, efficiently and with independence from the original decision-maker, and must be resolved within enforceable timeframes;
- The ICCC should collect data to provide an accurate picture of average claim times and the average time taken to resolve complaints, and requests for review. Minimum data to be collected should be stipulated; and
- No industry-funded claims assistance service should be implemented, as this would undermine funds' statutory obligations to members.

## Appendix A

# Superannuation Disability Claims Code of Practice

**Proposal / Foreword**

The Superannuation Disability Claims Code of Practice **(the Code)** provides a unique opportunity to include claimants and their representatives in a joint partnership with the superannuation industry to improve the disability claim making process.

The aim of this **Code** is to establish a best practice guide that will raise industry standards, encourage cooperation, more informed relationships and promote community confidence. The **Code** covers superannuation total and permanent disability (TPD), income protection, salary continuance, terminal illness, death and other claims **(Claims)** and will acknowledge that claimants are often facing financial, psychological and physical challenges when making such claims.

This comprehensive set of rules will be developed in conjunction with all industry stakeholders, including funds, insurers, lawyer advocates and other claims service providers. It will be different to most codes of practice that are limited to the conduct of the relevant industry members and will require all signatories to work cooperatively in the interests of claimants.

The **Code** would be non-binding, although it could be subject to **ASIC** endorsement or approval in the future and it will apply to all superannuation funds - retail, industry, corporate and public sector funds.

The **Code** will be written in plain English and designed to complement and extend legislative requirements. It will place obligations on all parties to work cooperatively, to avoid obstructionist and time delaying conduct and to take into account claimants experiencing hardship and financial difficulty.

The **Code** aims to set out clear processes for making claims including procedures for: communicating with claimants, the exchange of information and documentation, obtaining expert reports, timeframes for decision making, paying benefits and for dealing with complaints.

The **Code** will respect a claimant's right to seek legal help but will provide obligations on claimant lawyers to minimise adversarial or legalistic conduct. It will require active and genuine participation in the claims and internal complaints process before action is taken in the Superannuation Complaints Tribunal or courts.

The task of overseeing that the **Code** continues to meet its objectives and is effectively monitored and enforced will be undertaken by the Code Compliance Committee (**the CCC***).* The **CCC** will comprise an independent chair, a consumer representative, lawyer representative, and a superannuation and insurer representative.

The **Code** will be a living document, improvements should be made as and when required and it should undergo a mandatory three year review.

The hope is that this **Code** will raise standards and complement the legislative requirements that already set out how superannuation funds and their insurers deal with members and their lawyer representatives when making a disability claim.

**CONTENTS**

## 1. DEFINITIONS

**1.1.** **ASIC** – Australian Securities and Investment Commission

**1.2.** **Claim/s –** under this Code of Practice **Claim or Claims** refers to claims for total and permanent disability benefits, income protection, salary continuance, terminal illness, death and other claims that may arise under a member's superannuation fund entitlements.

**1.3.** **Claimant/s –** includes the claimant's representative

**1.4.** **CCC** - Code Compliance Committee

**1.5.** **Code** - Superannuation Disability Claims Code of Practice

**1.6.** **SIS Act -** *Superannuation (Industry) Supervision Act* 1993 (Cth)

**1.7.** **SIS Regulations -** *Superannuation (Industry) Supervision Regulations* 1994

**1.8.** **We** – includes all signatories to this Code of Practice.

## 2. INTRODUCTION

**2.1.** **We** have entered into this voluntary **Code** with the Code Compliance Committee

**2.2.** This **Code** commits us to uphold certain standards when providing services related to the making of a disability **Claim** under a superannuation fund.

**2.3.** **We** recognise our relationships with **Claimants** and their best interests at this time are the foundations of our business and the purpose behind this **Code**.

**2.4.** **We** acknowledge that **Claimants** may be undergoing physical, financial and / or emotional hardship and that our primary goal is to work together to expedite the **Claim** making process and ensure it is user friendly.

**2.5.** The terms of this **Code** require us to be open, fair and honest in our dealings with other industry stakeholders and **Claimants.**

**2.6.** This **Code** aims to work with the statutory obligations covering our conduct and in no way limits claimant and stakeholder rights. This **Code** also deals with issues not dealt with in legislation.

**2.7.** The **Code** terms provide that signatories will have additional avenues to raise concerns about how **Claims** are being managed in accordance with the process set out in section 10.3 of this **Code**.

**2.8.** By agreeing to this **Code**, **we** enter into a contract with the **CCC** to abide by this Code.

**2.9.** This Code does not create legal or other rights between us and any person or entity other than the **CCC**.

**2.10.** Important terms, which have a special meaning, are identified in bold and can be found in the Definitions section at the end of this **Code**.

## 3. OBJECTIVES

The Objectives of this **Code** aim to commit all signatories to high standards of service, specifically with regard to:

**3.1.** Processing **Claims** quickly, efficiently and in a user friendly manner;

**3.2.** Providing reasonable and relevant information and documentation upon request;

**3.3.** Communicating clearly and simply;

**3.4.** Strict compliance with complaints process as set out in the **SIS Act**;

**3.5.** Providing a fair, effective and independent complaints dispute resolution mechanism;

**3.6.** Recognizing that **Claimants** have a right to access legal help to assist them through the claims process;

**3.7.** Promoting better, more cooperative relations between superannuation funds, insurers, claimant lawyers and other claimant advocates;

**3.8.** Promoting continuous improvement of the superannuation **Claims** process through ongoing communication, education and training between superannuation funds and their members, insurers, claimant lawyers and other claimant advocates;

The objectives of this **Code** will be pursued having regard to the law, and acknowledging that the superannuation industry has an obligation in contract to act in the utmost good faith toward its claimant members.

## 4. APPLICATION

**4.1.** This **Code** takes effect on_____.

**4.2.** This **Code** applies to all industry participants who have adopted it and includes:

(a) superannuation funds;

(b) superannuation fund insurers;

(c) lawyers acting on behalf of claimants;

(d) lawyers acting on behalf of Funds/insurers;

(e) other claimant advocates.

**4.3.** This **Code** covers all superannuation funds including retail, industry, corporate and public sector funds.

**4.4.** Where there is any conflict or inconsistency between this **Code** and any Commonwealth, State or Territory law, that law prevails.

**4.5.** Where this **Code** imposes an obligation in addition to obligations applying under a law, the **Code** should be complied with except where doing so would lead to a breach of a law.

## 5. THE CLAIMS PROCESS

**5.1.** **We** will conduct **Claims**-handling in an honest, fair, transparent and timely manner, in accordance with this section.

**Representation**

**5.2.** Funds / Insurers can engage representatives to assist with assessment of disability claims.

**5.3.** **Claimants** can engage legal help or other advocate services to assist them in making a claim.

**5.4.** Funds / Insurers agree to the confidentiality obligations set out in the *Privacy Act* 1988 (Cth).

**5.5.** Funds / Insurers agree to inform **Claimants** of their right to seek legal help.

**Making a claim**

**5.6.** **Claimants** are entitled to ask the superannuation fund for details of any benefit they might be entitled to before making a **Claim**. Funds / Insurers agree to respond promptly to any request, made by the **Claimant**, or with the **Claimant's** authority, for details of their entitlement.

**5.7.** Funds / Insurers will provide individual benefit details and the relevant insurance policy within 10 days of a written request being made.

**Documentation**

**5.8.** **We** agree to use the standard forms prescribed by this **Code**, including:

- Member claim forms;
- Employer statements;
- Medical reports;
- HIC, Centrelink, PBS, ATO and worker's compensation authorities;
- Medical attendance statements reasonably relevant to the claim;
- Permanent incapacity certificates consistent with Regulation 1.03 of the **SIS Regulations**
    - Benefit nomination forms
    - Benefit payment forms

**5.9.** **We** agree to comply with the directions provided for in the benefit nomination forms and benefit payment forms.

**5.10.** **We** agree to the fair and reasonable exchange of all documentation relied upon in establishing and/or assessing the claim.

**Communication**

**5.11.** **We** agree to engage in respectful and cooperative communication at all times.

**5.12.** Funds / Insurers agree that all communication will be directed to a **Claimant'**s representative where **Claimants** have given notice and authority for this requirement.

**5.13.** Where phone messages are left, **we** agree to respond within a 24 hour period.

**5.14.** Where there is a change in the **Claim** operator, **we** commit to informing all other relevant parties to the **Claim** of the new operator and contact details within 5 working days.

**5.15.** Where an error or mistake in dealing with the **Claim** is identified **we** will immediately initiate action to correct it and to advise all other relevant parties of the error and correction.

**Time frames**

**5.16.** Funds / Insurers agree to assess **Claims** in a timely manner and to avoid excessive delays.

**5.17.** **Claim** forms will be provided within 10 working days of a request being made.

**5.18.** When a **Claim** is made Funds / Insurers agree to provide an initial estimate of the timetable and process for making a decision on the claim.

**5.19.** Funds / Insurers agree that **Claimants** will be informed of requests for medical reports and medico-legal examinations within 3 months of receipt of the claim.

**5.20.** Funds / Insurers will keep **Claimants** informed about the progress of the claim at least every 28 business days.

**5.21.** **We** will respond to routine requests made about the **Claim** within 10 business days.

**5.22.** Funds / Insurers agree that the time for assessing the level of disability is as stipulated in the relevant insurance policy and that it is unreasonable and unfair to wait a lengthy period to assess a **Claim**.

**5.23.** Funds / Insurers agree that a decision on a **Claim** will be made and notified to the **Claimant** within, whichever is the earliest of the following events:

- 60 days of receipt of all reasonably relevant information; or
- 60 days of the initial decision of the Insurer; or
- within 6 months of the initial **Claim**.

**5.24.** If it is not practical to assess a **Claim** in a reasonable period of time due, for example, to the complex nature of the **Claim,** parties can agree to a reasonable alternative timetable.

**5.25.** If a **Claim** is not assessed within a reasonable period of time after an internal complaint is lodged pursuant to the Internal Complaint Procedure in the **SIS Act** then the procedure in 7.2 can be followed.

**5.26.** If an agreement cannot be reached for an alternative timetable, and where the delay is excessive and causing hardship, **Claimants** can pursue a complaint through either the Internal Complaint Procedure in the **SIS Act**, or the Superannuation Complaints Tribunal or Courts.

**5.27.** Procedural fairness letters will be sent; including provision of all materials relied upon by the assessor. The letter will also include reasonable timelines for reply and final decision.

**Medical Examinations**

**5.28.** **We** agree that Funds / Insurers are entitled to obtain medical records and reports that are reasonably relevant and necessary to assess **Claims.**

**5.29.** Funds / Insurers will request medical reports or records as soon as reasonably possible and will adhere to the time frames as specified in section 5.19 of this **Code**.

**5.30.** When requesting medical reports Funds / Insurers will take into account:

- The nature of injuries / illnesses;
- The **Claimant**'s capacity to attend examinations
- Number of appointments
- The expertise of the doctors

**5.31.** **Claimants** will cooperate with requests to obtain medical reports and records that are reasonably relevant to the assessment of **Claims**.

**5.32.** Funds/ Insurers agree to avoid sending **Claimants** for unnecessarily repetitious medical examinations.

**5.33.** **We** agree that **we** will not engage in 'doctor shopping' for the purpose of sourcing favorable reports.

**5.34.** If Funds / Insurers engage a medical expert to provide a report which is necessary to assess the **Claim**, they will ask the medical expert to provide their report within 8 weeks of the date of examination. If the medical expert cannot meet or fails to meet this timeframe, The Fund / Insurer will inform the **Claimant** of this, and will keep the **Claimant** informed of progress in obtaining the report.

**5.35.** Where medical evidence reasonably establishes that attendance at further independent medical examinations or other assessments would be harmful to a **Claimant's** psychological or physical health Funds / Insurers agree to assess the **Claim** without reliance on additional examinations.

**5.36.** Where medical evidence reasonably establishes that no change is likely in the injury or illness that is the subject of an ongoing income protection or salary continuance claim, Funds / Insurers will consider all requests to extend the period for medical certificates to 3 or 6 monthly.

**Other assessments necessary to determine a claim**

**5.37.** **We** agree that an investigator may be appointed to interview a **Claimant** but where a **Claimant** is represented; the representative must be notified and can attend.

**5.38.** A diary may be required to be completed by the **Claimant** in the prescribed form but this will be limited to a period of one month.

**5.39.** **We** agree financial documents may be required e.g. tax returns, source documents, pay slips, group certificates and these will be provided in a timely manner.

**5.40.** **We** agree financial investigations may be conducted, including reasonable requests for access to **Claimants'** accountant's records.

**5.41.** **We** agree **we** may obtain our own forensic accounting and expert reports.

**5.42.** **We** will not undertake surveillance on **Claimants** that could reasonably be deemed invasive, excessive or unnecessary.

**Decisions**

**5.43.** **We** agree that decisions must be in writing.

**5.44.** Where a claim is rejected, Funds / Insurers agree to:

- Provide substantial reasons;
- Include relevant information and documentation;
- Inform of a right to lodge a Section 101 complaint and details of the complaints process;
- Inform the **Claimant** of their entitlement to seek legal help if not already represented, and any relevant time frames.

## 6. REHABILITATION AND RETURN TO WORK STANDARDS

**6.1.** **We** agree that where a relevant insurance policy requires a **Claimant** to undertake rehabilitation or engage in return to work programs the insurer agrees to adhere to the following standards:

**6.1.1** Decisions on what is reasonable rehabilitation will be made by Funds / Insurers only after:

- the **Claimant** is clearly notified of the proposed rehabilitation program including the program provider, duration, location and the basis for considering it is likely to result in medical improvement, and given a reasonable opportunity to provide submissions or evidence in response as to the proposed program's appropriateness.

- receiving the advice of treating medical practitioners as to the appropriateness of the proposed rehabilitation program.

**6.1.2** Decisions on what reasonable steps can be taken to attempt return to work will be made by Funds / Insurers only after:

- the **Claimant** is clearly notified of the proposed rehabilitation or return to work including the identity of the proposed employer, the return to work duties / tasks, the days and hours of work, the medical accommodations such as rest breaks and ergonomic considerations, and the basis for considering it is likely to result in sustained gainful employment, and given a reasonable opportunity to provide submissions or evidence in response as to the proposed program's appropriateness.

- receiving the advice of treating medical practitioners as to the appropriateness of the proposed return to work program.

**6.1.3** A qualified rehabilitation consultant is one who is recognised by a State or Commonwealth workers compensation authority as qualified to undertake rehabilitation in a State or Commonwealth workers compensation scheme and who is currently clinically practising as such.

**6.1.4** A Fund / Insurer will only require a **Claimant** to undergo rehabilitation with an independent fully qualified rehabilitation consultant.

**6.1.5** Any rehabilitation or return to work program will be conducted at the expense of the Fund / Insurer who will be liable for all costs involved in

the administering of rehabilitation, rehabilitation treatment or provision of advice about rehabilitation options.

**6.1.6** No decision to cease payment of benefits or to reject payment of benefits on rehabilitation or return to work grounds will be made by a Fund / Insurer until a period of 28 days has passed from when the Fund / Insurer provided the **Claimant** with written notice of its proposed decision in that regard along with copies of all medical evidence reasonably available to the Fund / Insurer.

**6.2.** In this clause the following terms have the meanings referred to:

**6.2.1** **Rehabilitation** means a process designed to—

(a) ensure the **Claimant**'s timely return to sustainable work; or

(b) maximise the **Claimant**'s independent functioning.

**Rehabilitation** includes—

(a) necessary and reasonable—

(i) suitable duties programs; or

(ii) services provided by a registered person; or

(iii) services approved by a Fund / Insurer; or

(b) the provision of necessary and reasonable aids or equipment to the worker.

**6.2.2** **Registered Person** means a doctor, dentist, physiotherapist, occupational therapist, psychologist, chiropractor, osteopath, podiatrist or speech pathologist or audiologist registered to practice as such in the jurisdiction in which they practice.

**6.2.3** **Suitable duties** means work duties for which the Claimant is suited having regard to the following matters—

(a) the nature of the **Claimant**'s incapacity and pre-injury employment;

(b) relevant medical information; in particular the views of the **Claimant**'s treating medical practitioner

(c) any rehabilitation and return to work plan for the **Claimant**;

(d) the provisions of any relevant employer's workplace rehabilitation policy and procedures;

(e) the **Claimant**'s age, education, skills and work experience;

(f) if duties are available at a location (the other location) other than the location in which the **Claimant** was injured—whether it is reasonable to expect the claimant to attend the other location;

(g) any other relevant matters.

## 7. COMPLAINTS AND DISPUTES

**7.1.** Complaints handling will be conducted in a fair, transparent and timely manner, in accordance with this section.

**7.2.** When a Section 101 complaint is made Funds/ Insurers will provide the following to the **Claimant** within 15 business days of the date of receipt of the complaint:

- Acknowledgment that the complaint has been received;
- The name and relevant contact details of the employee assigned to reviewing the complaint;
- Confirmation that a decision should be made within 90 days of receipt of the complaint.

**7.3.** Requests to the **Claimant** for further information or documentation can be made within 30 days of receipt of the complaint.

**7.4.** Complaints will be reviewed by an employee or employees with the appropriate experience, knowledge and authority, who is/are, to the extent it is practical, different from the person or persons who was/were involved in the initial decision.

**7.5.** If it is not possible to review the complaint within 90 days, an alternative time frame may be agreed between the parties. If an agreement on an alternative timetable cannot be reached the **Claimant** will retain the right to take their complaint to the Superannuation Complaints Tribunal or Court.

**7.6.** If a decision is not made within 90 days of receipt of the complaint, and no alternative time frame has been agreed, the claimant or their representative can lodge a review in the Superannuation Complaints Tribunal or file court proceedings.

**7.7.** The notification of a section 101 complaint decision will be in writing and will include:

- The reasons for the decision; and
- Notification of the right to lodge a complaint in the Superannuation Complaints Tribunal or file court proceedings, if the claimant is not satisfied with the decision, and the time frames for doing so.

**7.8.** For the resolution of other **Code** related disputes between signatories, other than those addressed in this section, see section 10.3 of this **Code**.

## 8. SUPERANNUATION COMPLAINTS TRIBUNAL AND COURT PROCEEDINGS

**8.1.** **We** agree that **we** will actively and genuinely participate in the **Claims** and section 101 complaints process before taking any action in the Superannuation Complaints Tribunal or filing court proceedings.

**8.2.** The **Claimant** agrees to only issue court proceedings in the following circumstances:

- At the expiry of 90 days where no decision has been made and no alternative timetables have been agreed to; and/or
- The **Claimant** has provided in writing notice of intention to issue proceedings in 5 business days; and/or
- Once the internal complaints process has been exhausted; and/or
- Where the **Claimant** believes the **Claim** has reasonable prospects of success; and/or
- Where it can be demonstrated that there have been excessive, unjustifiable delays in making a decision regarding the claim or communicating the same; and/or
- Where it is necessary to do so to avoid the expiry of any relevant limitation period.

## 9. URGENT FINANCIAL NEED BENEFIT

**9.1.** Where it can be reasonably demonstrated that a **Claimant** is in urgent financial need of the benefits they are entitled to under their superannuation fund, and where the **Claim** has reasonable prospects of success, Funds / Insurers will:

(a) fast-track the assessment and decision process of the claim; and/or

(b) make an advance payment on a without prejudice basis to assist in alleviating the immediate hardship within five business days of the **Claimant** demonstrating the urgent financial need.

## 10. INFORMATION AND EDUCATION

**10.1.** The **CCC** is the independent body responsible for the promotion of this **Code** to fund members and to industry participants that have not yet adopted this **Code**.

**10.2.** The **CCC** will work with stakeholders to encourage all superannuation funds, claimant legal practitioners and other industry participants in the superannuation disability claims area in Australia to adopt this **Code**.

**10.3.** The **CCC** may develop guidance documents from time to time, to assist us in meeting our obligations under this **Code**.

**10.4.** The **CCC** may include any recommendations on **Code** promotion in its reports to **ASIC.**

**10.5.** **We** will work with the **CCC** to promote this **Code**.

**10.6.** **We** will provide information about this **Code** on our websites and in our product information where **we** consider it appropriate to do so.

**10.7.** **We** will work with the **CCC** to provide general information to assist **Claimants** in accessing relevant information.

**10.8.** **We** will work with the **CCC** to initiate programs to promote better understanding of fund members' rights to disability benefits and **we** will support **CCC** initiatives aimed at education on superannuation disability claims.

**10.9.** Funds / Insurers will work to ensure employers and fund members understand their obligations to notify their superannuation funds when employment status changes.

**10.10.** The **CCC** may include any recommendations on education relevant to the operation of this **Code** in its annual reports to **ASIC**.

## 11. CODE OF GOVERNANCE

**11.1.** The **CCC** is the independent body responsible for monitoring and enforcing compliance with this **Code**.

**11.2.** The **CCC** is made up of:

(a) An independent chair;

(b) A consumer representative;

(c) A lawyer representative;

(d) A superannuation representative; and

(e) An insurer representative

**11.3.** **Code** related disputes between signatories, other than those dealt with in section 6 of this **Code,** may be assessed by the **CCC**.

**11.4.** All signatories to the **Code** will conduct internal audits of **Code** compliance with external reporting to the **CCC.**

**11.5.** The **CCC** will report annually to **ASIC** with recommendations on any **Code** improvements, **Code**-related issues and matters of importance.

**11.6.** The **CCC** will review the **Code** every two years and report findings of the review to **ASIC** and all signatories to the **Code**.

**11.7.** **Code** compliance results will be made public / published.

**11.8.** This **Code** will be subject to oversight by **ASIC.**

**11.9.** The **CCC** is responsible for commissioning formal independent reviews of this **Code** from time to time. The **CCC** may recommend that this **Code** be reviewed, if the **CCC** believes the application of this **Code** is not meeting the objectives outlined in section 3 of this **Code.**

**11.10.** In addition to formal independent reviews of this **Code,** the **CCC** will consult with the Superannuation Complaints Tribunal, Financial Ombudsman Service, **ASIC**, consumer and industry representatives, relevant regulators and other stakeholders to develop this **Code** on an ongoing basis.

# Appendix B

| | Step | Superannuation Fund | Insurer | |
|---|---|---|---|---|
| LODGEMENT | Call Centre – on receipt of initial enquiries from member should ensure they provide information of all life insurance policy benefits to ensure members are aware of available benefits | At time of enquiry plus email confirmation where possible confirming advice and brief details of all benefits available within 2 business days | | For claims other than income-related claims, it is expected that the majority of claims would have an end to cycle time within 7/8 months unless unexpected circumstances apply. For income-related claims, it is expected that the majority of claims would have an end to cycle time within 3 months, unless unexpected circumstances apply. |
| | Notification of a claim (where a member or the member's representative notifies the Fund of a claim – all claim forms, relevant authorities, relevant documents including Trust deed, insurance policy and confirmation of insured benefit amount be provided | Within 5 business days of the request by quickest means (email) of communication | | |
| | Provision of introductory claims information and details of claims officer assigned to the claim | | Within 10 business days of the insurer receiving the claim | |
| ASSESSMENT | On receipt of completed claim submission - independent proactive assessment of claim to commence (ability to serve claim on both Fund and Insurer direct) | Within 5 business days of receipt of claim submission | | Assessment of claims should take a maximum of 3 months days |
| | Medical Examination of claimant (if required) and/or<br>Investigation interviews | To be arranged within 21 business days<br><br>14 business days' notice to claimant | | |
| | Response to queries | Within 10 business days of the request | | |
| | Proactive communication of updates throughout assessment process | Within 20 business days of the last update | | |
| | Preliminary Claims decisions – any disparities to be fully disclosed to claimant | Within 10 business days of all necessary and relevant requirements being received | | |
| DECISION | Procedural fairness – if trustee or insurer looking to decline a claim, opportunity provide additional information– provide copies of all documents and information relied upon in making the decision if requested by claimant | Within 10 business days | | |
| | Review of the claimants' further submissions | Within 10 business days | | |
| | Decision to deny claim | Within 5 business days of the trustee/insurer confirming denial of claim | | |
| | Review of denied claim following formal request | 90 days in accordance with *Superannuation (Resolution of Complaints) Act 1993* | | |
| | Date of trustees convening to review submissions in response to denial of claim | Within 7 business days prior to review date | | |
| | Decision to accept or reject claim – provide all necessary settlement/payment documents if claim accepted | | | |
| PAYMENT | If claims approval – medical condition stable as certified by treating medical practitioner | Ongoing medical statements to be provided on 3 monthly basis | | |
| | Approved Benefit Payment | Within 7 business days of receipt of completed payment documentation | | |