What is 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 by the life insurance industry through the Financial Services Council to:

1. Promote high standards of service to consumers
2. Provide a benchmark of consistency within the industry
3. Establish a framework for professional behavior and responsibilities

Designed to protect you, the consumer.

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.

It also sets out timeframes for insurers to respond to claims, complaints and requests for information from customers.

The Code covers many aspects of a customer’s relationship with their insurer, from buying insurance to making a claim, to providing options to those experiencing financial hardship or requiring additional support.

The Code is binding on life insurance companies; in its first iteration it is not intended to put obligations on financial advisers or planners or superannuation trustees. A list of the companies bound by the Code can be found on the FSC website.

The Code is monitored by an independent committee, to ensure effective compliance by life insurers. Insurers can be sanctioned if they do not correct breaches of the Code.

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 by our staff and our authorised representatives to ensure sales 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 making a decision on your claim.
6. We will make a decision on your claim within the timeframes defined in the Code, and if we cannot meet these timeframes you can access our complaints process.
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 restrict the use of investigators and surveillance, to ensure your legitimate right to privacy.
9. The independent Code Compliance Committee will monitor our compliance with the Code.
10. If we do not correct Code breaches, sanctions can be imposed on us.
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1. Introduction and objectives

1.1 The Life Insurance Code of Practice (Code) is binding on us. The Code commits us to uphold the standards set out in the Code when providing products and services covered by the Code.

1.2 If we fail to meet our commitments under the Code, the Life Code Compliance Committee (Life CCC) may impose sanctions on us, as set out in section 13 of the Code.

1.3 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 explained in section 13.16 of the Code.

1.4 The objectives of the Code are:
   a) to commit us to high standards of customer service throughout your relationship with us;
   b) to seek continuous improvement within the life insurance industry;
   c) to communicate with our customers in plain language where possible; and
   d) to increase trust and confidence in the life insurance industry.

1.5 The principles that apply to our products and services that are covered by the Code are:
   a) clarity and transparency;
   b) fairness and respect;
   c) honesty;
   d) timeliness; and
   e) communications in plain language.

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

1.7 Words with special meanings are in bold and can be found in the Definitions section at the end of the Code.

2. Scope of the Code

Who does the Code apply to?

2.1 The Code applies to:

   a) registered life insurance companies issuing Life Insurance Policies that are covered under membership of the FSC, and
   b) any other industry participant, including a non-FSC member, which adopts the Code by entering into a formal agreement with the FSC and the Life CCC to be bound by the Code.

You can find a list of the entities that are bound by the Code on the FSC website.
2.2 The Code does not apply to:
   a) superannuation fund trustees;
   b) financial advice companies or financial advisers; or
   c) other industry participants,
   unless they have adopted the Code in accordance with section 2.1(b).

2.3 Where your financial adviser or the financial advice company through which your financial adviser provides advice to you is a related party to us, they are not bound by the Code unless they have adopted the Code in accordance with section 2.1(b). Your financial adviser or financial planner who recommends one of our Life Insurance Policies has obligations under the law and their own industry codes of conduct.

2.4 “We”, “us” and “our” mean the entity that is bound by the Code. Where we are referred to in the Code, this refers to the entities described in section 2.1 acting individually and independently, and not collectively.

2.5 We will ensure our staff and any person or entity authorised by us to provide financial services on our behalf under our Australian Financial Services licence (Authorised Representatives) comply with the Code when they are acting on our behalf.

2.6 “You” and “your” mean a person or entity who:
   a) owns a Life Insurance Policy (called the Policy-owner); or
   b) is covered by a Life Insurance Policy (called the Life Insured); or
   c) who is entitled to benefits in the event of a claim (called the Third Party Beneficiary).
   Particular sections of the Code do not apply to all of the above parties where stated.

2.7 FSC members in their capacity as Reinsurers are bound by the Code, and will meet their commitments under the Code by complying with the principles in sections 1.5 and 1.6 and assisting us to meet our commitments under the Code.

When does the Code apply from?

2.8 The Code commences on 1 October 2016, and we have a transition period until 30 June 2017 to be bound by the Code. We must notify the FSC and the Life CCC of the date on which we transition to the Code.

2.9 The Code applies to all interactions we have with you from the date we are bound by the Code, including any interactions relating to an existing claim or Complaint.¹

What policies are covered by the Code?

2.10 The Code covers Life Insurance Policies issued in the Australian market as defined in the Definitions section of the Code. This includes insurance policies that are commonly referred to as:

¹The Code does not apply to interactions we have with you before we are bound by the Code, for example, if you buy a Life Insurance Policy from us before we are bound by the Code, the provisions in section 5 “When you buy insurance” do not apply to that purchase. For applications, claims or Complaints that already exist on the date we are bound by the Code, if the Code requires us to do something within a specified timeframe, that timeframe begins on the date we are bound by the Code.
a) term life insurance/death and terminal illness;
b) total and permanent disability (TPD);
c) trauma/critical illness insurance;
d) disability insurance;
e) funeral insurance;
f) income protection/salary continuance;
g) business expense cover; and
h) consumer credit insurance (CCI) issued by a life insurer.

2.11 The Code does not cover:

a) annuities and investment life products, 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; and 
e) other products that can be issued by someone who does not need to be registered as a life insurance company with the Australian Prudential Regulation Authority (APRA) under the Life Insurance Act 1995.3

Insurance products issued by general insurers or health insurers may be subject to similar codes of practice that may be available to you.

Communicating with you under the Code

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

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

Legal status of Code

2.14 The Code operates alongside and is subject to existing laws and regulations and in no way limits your rights under such laws and regulations.

2.15 You can:

a) access our Complaints process set out in section 9 of the Code, if you are unhappy with any aspect of your experience with us, or
b) report any concerns about possible Code breaches to the Life CCC, which it can investigate at its discretion.

2Sections 9(1)(c), (d), (f) and (g), Life Insurance Act 1995.
3Such 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.
2.16 The Code is not intended to create legal or other rights between us and any person or entity other than the FSC.

2.17 The Financial Ombudsman Service (FOS) and the Superannuation Complaints Tribunal (SCT) may consider whether we have complied with the standards of the Code when determining a dispute before it.

2.18 Where there is any conflict or inconsistency between the Code and any law or regulation, that law or regulation prevails.

2.19 Where the Code imposes standards on us that are higher than the law, we will comply with both the law and the Code.

2.20 We may agree service standards with a Group Policy-owner in relation to a Group Policy that are higher than the Code standards, in which case the higher service standards apply.

2.21 The Code does not apply once you commence proceedings in any court, tribunal or external alternative dispute resolution process [with the exception of FOS and the SCT].
3. Policy design and disclosure

3.1 When we design and introduce new Life Insurance Policies after we have adopted the Code, we will:

a) define suitable customers for the product;

b) include benefits intended to cover genuine risks that generally affect the relevant customers;

c) incorporate plain language into our sales and policy information, and consumer-test the plain language information required in sections 3.4 and 6.3;

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

e) regularly review our on-sale products to ensure they remain generally suitable for the relevant customers. We will re-design our on-sale products where necessary.

3.2 The medical definitions in our on-sale policies for benefits that are payable after a defined medical event will be reviewed at least every three years and updated where necessary to ensure the definitions remain current. This will be done in consultation with relevant medical specialists. When medical definitions in your Life Insurance Policy are updated by us as a result of this, we will let you know.6

3.3 Where your Life Insurance Policy is owned by a Group Policy-owner, they may agree changes to the benefit design and structure for all members covered by the insurance, and the Group Policy-owner will inform you of these changes.

3.4 When you buy a Life Insurance Policy, you will be provided with documentation that clearly explains the following key information in plain language:5

a) the types of cover you are insured for;

b) how much you are insured for, if there is a fixed amount assigned to your cover;

c) how much your cover costs;

d) the cooling-off period;

e) specific events you are not covered for (exclusions);

f) for key medical definitions in cover where a benefit is payable for a defined medical event, a general description of circumstances in which benefits would be paid, and specifically whether or not benefits are payable on diagnosis or require a certain degree of severity in order to be payable;

g) any waiting periods that apply before you can access benefits;

h) a description of how the price you pay is structured, for instance whether the cover has stepped or level premiums or a single premium;

i) information about the impact a claim could have on other benefits or income if it is relevant to your policy; and

j) information about our claims and Complaints process.

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

5This does not apply to cover under a Group Policy.
Where a Life Insurance Policy has an exclusion clause for a pre-existing medical condition:

a) we will provide you or the Group Policy-owner with details of how the exclusion works and when the exclusion applies and the potential implications of this in plain language; and

b) if we ask you for medical information during the application process and you fully and accurately disclose a medical condition to us, we will not apply a pre-existing exclusion clause in relation to that condition unless we agree this with you and confirm it in writing when your policy is issued. On the basis of your disclosure, we may not offer you insurance or may offer it on alternative terms.

If we offer a Funeral Insurance Policy, we will:

a) provide a minimum period of 30 days within which you can cancel the policy and get a full refund (the cooling-off period);

b) ensure that we have options available if you suffer financial hardship in accordance with section 6.6. These will include allowing your premium to remain unpaid for at least 60 days before we cancel your policy or allowing you to stop paying your premium for a fixed period, during which time you will not be eligible to make a claim; and

c) provide you with a key facts sheet that explains in plain language:
   i. the benefits you will be entitled to and when you will be entitled to them;
   ii. whether the premium structure is level or stepped and an illustration of the impact of this structure on your future payments;
   iii. any pre-existing medical condition exclusions and how they apply;
   iv. any period during which your policy pays out only if you suffer an accident and not illness;
   v. whether the total amount of premiums payable under the policy has the potential to exceed the benefit amount;
   vi. what happens if you cancel the insurance after the cooling-off period, including whether premiums paid are refunded;
   vii. what happens if you stop paying your premium including whether premiums paid are refunded; and
   viii. how your beneficiaries can make a claim in the event of your death.

Any product disclosure statement (PDS) that we have prepared for a Life Insurance Policy will be made available online for you to view prior to making an application for a new Life Insurance Policy. If you ask us for a PDS that has not been prepared by us (for example, if it was prepared by a superannuation fund trustee or other Group Policy-owner), we will refer you to the relevant party for a copy and we will encourage those that we work with 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;
   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) make clear if a benefit depends on a certain set of circumstances;
   g) ensure any use of phrases such as “free” or “guaranteed” are not likely to mislead; and
   h) comply with the Australian Securities and Investments Commission (ASIC)’s guidance for advertising financial products and services6 and guidance regarding unsolicited sales.7

4.2 Our staff and the staff of our Authorised Representatives who sell our policies will:
   a) receive appropriate training initially and on an ongoing basis covering our policies, suitable customers for our policies, acceptable and unacceptable sales practices, the best interests duty of financial advisers when providing personal advice, and the requirements of the Code; and
   b) receive additional remedial training as needed to correct any identified performance shortcomings.

4.3 We will have clearly documented sales rules to ensure our staff conduct sales appropriately and prevent pressure selling or other unacceptable sales practices. These will include:
   a) how to identify if someone is unlikely to ever be eligible to claim the benefits under a policy;
   b) having clear rules on when our staff must stop selling if you indicate you do not want a Life Insurance Policy being offered or if it becomes clear that you will be unlikely to ever be eligible to claim the benefits under the policy;
   c) how to record and keep adequate evidence that you have genuinely consented to purchase 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; and
   e) compliance performance measures included in our staff incentive programs including consequences if we identify they have engaged in pressure selling, incentivisation of financial advisers contrary to law or other unacceptable sales practices.

6ASIC Regulatory Guide 234: Advertising financial products and services (including credit): Good practice guidance, as issued in November 2012.
7ASIC Regulatory Guide 38: The hawking provisions, as issued on 1 May 2005. See also, Section 992A, Corporations Act 2001.
4.4 We will have a framework in place to monitor our staff’s compliance with our sales rules, including:
   a) quality assurance measures for reviewing sales such as call monitoring, mystery shopping and post-sale call surveys; and
   b) analysis and reporting on key data, such as sales results, lapses, claim declines 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 Code; and
   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, claim declines and Complaints.

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

4.7 If you apply for a consumer credit insurance (CCI) Life Insurance Policy as an add-on to another financial product, either with us directly or through our Authorised Representative, we will:
   a) require you to provide consent to purchase the Life Insurance Policy;
   b) provide the following information prior to purchase:
      i. a clear statement that the purchase of the Life Insurance Policy is optional;
      ii. a clear question asking if you consent to the purchase of the Life Insurance Policy; and
      iii. a clear explanation of the eligibility criteria for the Life Insurance Policy, the main exclusions that apply and the cooling-off period;
   c) inform you how the premiums will be structured;
   d) if the CCI Life Insurance Policy is an add-on to a loan:8
      i. if the option of paying the premium through the loan is offered, then at least one non-financed payment option such as a monthly direct debit will also be offered; and
      ii. if the premium is fully funded by the loan, you will be informed that you will pay interest on the premium, and your loan repayments will be quoted with and without the premium for comparison;
   e) obtain adequate evidence that you have consented to purchase the Life Insurance Policy;
   f) have a minimum cooling-off period of 30 days; and
   g) provide you with an annual notice in writing each year prior to the anniversary of your Life Insurance Policy. The annual notice will include:
      i. the period of cover;
      ii. the types of cover; and
      iii. contact details if you have any questions or need to make a claim.

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8For 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.
4.8 When you tell our sales staff 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, and 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 non-disclosure on your new application (even where unintentional).

4.9 We will investigate concerns raised or identified with the sales practices of our staff and our Authorised Representatives. If as a result we identify that one of our Life Insurance Policies has been sold inappropriately:

a) we will contact you to discuss an appropriate remedy. 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; or
   vi. honouring a claim;

b) if you are not satisfied with our proposed remedy, we will review this and tell you how to make a Complaint; and

c) we will correct any identified 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 We are legally required to send all communications about your policy to the Policy-owner. However, where the Policy-owner is different from the Life Insured, we will not communicate personal medical information about a Life Insured to a Policy-owner unless the Life Insured has given consent for this.

5.3 At the start of the application process, before asking you any underwriting questions, we will explain the duty of disclosure and the consequences of not disclosing all relevant information and answering all questions honestly and completely.

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

5.5 We may also require direct discussions with a third party (for example, your doctor), or ask for information or reports from them, to further assist in our assessment of your application.

5.6 We may also require additional information to assess the application such as a medical examination by an Independent Service Provider who is selected by us. We will only engage an Independent Service Provider where we believe this to be relevant and reasonable for the assessment of your application, and we will provide you with our reasons for requiring the additional information. If you disagree with the relevance of any assessment,
we will review the need for this, and if you are not satisfied with our review we will tell you how to make a Complaint.

5.7 Where we require you to attend an assessment by an Independent Service Provider, we will meet the cost of the appointment (excluding missed appointment fees), extraordinary travel costs agreed in advance, and production of any reports.

5.8 If we ask you to attend an assessment with an Independent Service Provider, we will ask them to provide their report on the assessment within ten business days. If we request any other reports from Independent Service Providers that do not require you to attend an assessment, we will ask for the report to be provided to us no later than four weeks after the date of request. If the Independent Service Provider fails to meet these timeframes, we will inform you of this, 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 become aware during the application process of any errors or mistakes in the application or the information we have asked for, we will address these promptly. 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 Once we have all the information we reasonably need and have completed all reasonable enquiries relating to the application,10 we will let you know our decision about whether to accept the application and on what terms within five business days.

5.13 After considering the application, we may only be able to offer insurance on alternative terms based on your personal circumstances, such as:

a) an additional 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 Life Insurance Policy; or
f) an alternative policy.

There may also be circumstances in which we are unable to offer any insurance cover.

5.14 If we do not offer any insurance cover, or if we offer on alternative terms, we will let you know (or your doctor, where appropriate):

a) the reasons for our decision;
b) that you have the right to the information about you that we have relied on to make our decision, and if you request we will provide this to you (or your doctor, where appropriate) within ten business days, in accordance with the Access to Information section of the Code; and

10Including referral to one or more Reinsurers where necessary.
c) 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 discuss this with us and we will review our decision, and if you are not satisfied with our review we will tell you how to make a Complaint.

5.15 Our underwriters will be appropriately skilled and trained. They will not make underwriting decisions on our behalf until they have demonstrated technical competency and an understanding of all relevant law, the requirements of the Code 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 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 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 contact us to review the decision.

5.20 Should we become aware after the cover is issued that information you provided in your application for insurance was incorrect or incomplete at the time the Life Insurance Policy was issued:

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 we make any decision such as changing the terms or cancelling your cover; and

b) once we have made a decision, we will advise you of our decision and any actions we will be taking, and the process to have this reviewed or make a Complaint if you disagree with our decision.

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

6.3 We will provide you with an annual notice in writing each year prior to the anniversary of your Life Insurance Policy. The annual notice will include:
   a) the types of cover you are insured for and how much you are insured for;
   b) an explanation for any increase in your premiums in accordance with the terms of your Life Insurance Policy;
   c) information about the risks of cancelling and replacing an existing Life Insurance Policy;
   d) information about 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 payments; and
   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 notify you of the relevant changes to the key information detailed above at section 3.4.

Life Insurance Policy changes and financial hardship

6.5 If you wish to change the terms of your Life Insurance Policy, or if you are having trouble meeting your premium payments, we will tell you about the options that may be available to you, such as:
   a) changing your benefit structure or how much you are insured for;
   b) reducing your benefits and/or removing or altering benefit options in order to reduce your premium; or
   c) stopping your payments 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.

6.6 If you ask us to consider an arrangement on the basis of financial hardship, you may be required to provide reasonable evidence of your hardship, such as:
   a) for Centrelink clients, your Centrelink statements;
   b) financial documents including bank statements; or
   c) a statement of termination from your employment.

Cancellation rights

6.7 You may be entitled to a 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, any money we owe you will be reimbursed to you within 15 business days.

6.8 If your Life Insurance Policy is cancelled due to non-payment of premiums, you may contact us if you wish us to consider reinstatement of your policy. Reinstatement will be subject to the terms of your Life Insurance Policy and is at our discretion, and may require additional questions and assessment.

This section 6.3 does not apply to CCI, as the requirements for the annual notice for CCI are contained in section 4.7.
7. Consumers requiring additional support

7.1 We recognise that some groups may have unique needs, such as older persons, consumers with a disability, people from non-English speaking backgrounds and Indigenous people, when accessing insurance, making an inquiry, claiming on their insurance, making a Complaint and communicating with us. Where we identify that a customer requires additional support, we will take reasonable measures to ensure that we provide additional support.

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. We will take into account someone’s capability when making decisions that impact them.

7.3 We acknowledge that we will not always be able to identify when someone requires additional support at the time of their insurance application. If we later become aware that we or our Authorised Representative has sold a Life Insurance Policy to a customer who was not provided with the additional support they needed to make an informed decision, we will investigate this and if 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 have the matter addressed.

7.4 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 when buying insurance or making a claim or Complaint. We will undertake reasonable measures to assist those consumers and still meet our obligations under the law.

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

13This is in addition to the requirements of FSC Standard 21: Mental Health Education Program and Training.
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 When you make a claim we will consider all of the features of the Life Insurance Policy to which your claim relates in order to ensure you are claiming for all available benefits under your Life Insurance Policy. We will not discourage you from making a claim.

8.3 Within ten business days of being notified about your claim, we will explain to you your cover and the claim process, including why we request certain information from you and any waiting period before payments will be made. We will give you contact details that you can use to get information about your claim.

8.4 Prior to making a decision on your claim, we will keep you informed about the progress of your claim at least every 20 business days unless otherwise agreed with you or the Group Policy-owner. We will respond to your requests for information about your claim within ten business days.

What we require to assess your claim

8.5 We will only ask for and rely on information and assessments that are relevant to your claim and policy, and we will explain why we are requesting these. This can include, for example, financial, occupational and medical information. If you disagree with the relevance of any information, we will review the request, and if you are not satisfied with our review we will tell you how you can make a Complaint.

8.6 Where we require information from other sources, such as your doctor, accountant or another health professional, we may ask you for a general authority to obtain information about you from them. We will only use a general authority to obtain information that we reasonably believe is relevant to your claim. You can instead authorise us to request particular information from particular sources. However, this may cause delays in the assessment of your claim or mean that we are unable to assess your claim, and we may require further authorities before we can progress the assessment of your claim.

8.7 We will request the information we need as early as possible and will avoid multiple information requests where possible.

8.8 If we request a report from an Independent Service Provider, we will ask for the report to be provided to us no later than four weeks after the date of request or the date of your appointment (if you are required to attend one). If the Independent Service Provider fails to meet this timeframe, we will inform you of this, and keep you informed of our progress in obtaining the report.
8.9  For income-related claims [such as income protection or business expense cover]:

a)  information may need to be provided on an ongoing basis in order to review your entitlement to benefits or to calculate your payments. This can include financial as well as medical information;

b)  we will not require you to get ongoing statements from your doctor more frequently than reasonably necessary to assess your condition, so that we can determine your ongoing entitlement to benefits. For monitoring purposes, we may seek 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 payment;

d)  we will only request financial information in circumstances where it is required to assess your eligibility to claim or to calculate your entitlement;

e)  if you disagree with the relevance of any requested information, we will review this; and

f)  if your payment is going to be delayed, we will notify you prior to this and let you know the reasons for the delay.

8.10  Where we require you to attend an independent medical examination:

a)  we will meet the cost of the appointment [excluding missed appointment fees], production of any reports and extraordinary travel costs agreed in advance;

b)  you can request copies of your independent medical examination reports, which we will send to you, or your doctor where appropriate.

c)  we will avoid requesting more than one independent medical examination from the same type of specialist within six months where possible. If we do require more than one (such as where the claim is for a terminal illness or where superannuation legislation requires this), we will let you know the reasons for this; and

d)  if you request, you can choose from a list of doctors we nominate for your independent medical examination, although this may cause delays to your claim depending on your chosen doctor’s availability.

8.11  Where we require interviews to be carried out:

a)  the interviewer will tell you who they are, that they are acting on our behalf, their reason for contacting you, and your right to have a Representative or other support person present, before statements are taken;

b)  if you have requested that we communicate through a Representative, we will let the interviewer know to advise the Representative before contacting you;

c)  you can choose to have someone attend the interview with you. If you require an interpreter, we will arrange this at our cost;

d)  if the interview relates to a claim involving mental illness, we will only use an interviewer that we are satisfied has appropriate training or experience to carry out the interview;

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.

Standards for independent medical examiners are contained in section 10.5.

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.
e) if the interview is to be recorded, you will be advised before the interview starts and you may request a copy of the recording;

f) interviews will be conducted respectfully and take a maximum time of two hours, unless you agree to an extension. A further interview will be organised if it is reasonably required;

g) you can request breaks during the interview if you require;

h) if you request, we will arrange an interviewer of the same sex if one can reasonably be arranged;

i) 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;17 and

j) a transcript of the interview (or copy of the recorded interview if requested) will be provided to you for confirmation.

8.12 Where we require surveillance to be carried out:

a) alternative methods of verifying information will be sought prior to arranging surveillance;

b) surveillance will only be arranged where we reasonably believe prior to carrying out the surveillance that your claim appears to be inconsistent with information available to us, and our reasons for this will be documented;

c) requests for surveillance must be internally reviewed and approved by a senior claims manager;

d) surveillance will not be conducted in any court or other judicial facility, in any medical or health facility, in any bathroom, change room, lactation room or inside your house;

e) our investigator will not intentionally film people in the company of the subject of the enquiry, and where this cannot be avoided, any footage of people in the company of the subject of the enquiry will be pixelated or blurred before being provided by us to any external party such as a court or external dispute resolution body;

f) we will discontinue surveillance where there is evidence from an independent medical examiner that it is negatively impacting your recovery; and

g) surveillance investigators 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.

8.13 If we become aware of any errors or mistakes in your claim or the information we have asked for, we will address these promptly. We may require additional information to implement corrections.

Claims decisions and benefit payments

8.14 All efforts will be made to meet the timelines required by the Code. However, timeframes for making claims decisions can be affected by factors outside our control [Unexpected Circumstances]. Examples of this include the time taken by a superannuation trustee to review our decision or fulfil its legal obligations, or the time taken by you or your treating doctor to provide information. Where we cannot comply with a deadline required by the Code due to a delay that is out of our control, we will not have breached the Code. If there are external impacts on timeframes, we will inform you of this and we or the Group Policy-owner will keep you informed of progress.

17For example, where your claim relates to a total and permanent disablement cover with an “Activities of Daily Living” definition.
Once we have all the information we reasonably need and have completed all reasonable enquiries\(^\text{18}\) to assess your claim, including your response to the evidence we are basing our decision on if we have presented this to you, we will let you know our decision on your claim within ten business days.

For income-related claims, we will let you know our initial decision no later than two months after we are notified of your claim or two months after the end of your waiting period (whichever is later), unless Unexpected Circumstances apply. Where Unexpected Circumstances apply, our decision will be made no later than 12 months after we are notified of your claim. We will let you know the reasons for the delay, and if you disagree we will review this. If we cannot make a decision within 12 months, we will give you details of our Complaints process.

For all claims other than income-related claims, we will let you know our decision no later than six months after we are notified of your claim or six months after the end of any waiting period, unless Unexpected Circumstances apply. Depending on your policy, our decision may be a requirement that you undertake a period of rehabilitation or retraining, or it may be a final decision on your benefits. Where Unexpected Circumstances apply, our decision will be made no later than 12 months after we are notified of your claim. We will let you know the reasons for the delay, and if you disagree we will review this. If we cannot make a decision within 12 months, we will give you details of our Complaints process.

If we accept your claim and it includes a lump sum payment, we will suggest you seek financial advice to help manage your claim payment. For an income-related claim, if we offer to pay you a lump sum instead of ongoing payments in order to finalise your claim, we will suggest that you seek financial and legal advice before accepting our offer.

If we decline your claim we will let you know in writing:

a) the reasons for our decision;

b) that you have the right to copies of the documents and information we have relied on, and if you request we will provide you (or your doctor, where appropriate) with copies within ten business days, in accordance with the Access to Information section of the Code; and

c) that you have the right to request a review if you disagree with our decision, and we will give you details of our Complaints process.

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. Remuneration and entitlements to bonuses will not be based on declined claims or deferrals of decisions.

**Income-related benefits**

Where you are receiving an income-related benefit, we will not stop payments during a non-disclosure investigation [in accordance with section 5.20] unless we reasonably believe that we have evidence that will lead to your claim being declined or your Life Insurance Policy being cancelled or avoided.\(^\text{19}\)

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\(^{18}\)Including referral to one or more Reinsurers where necessary.

\(^{19}\)This standard does not apply to policies owned by a superannuation fund trustee as access to superannuation benefits is limited by law.
8.22 **Your** policy may state that **your** income-related claim payments will continue after a period of time only 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.

8.23 If **we** identify that **your** income-related claim payments are coming to an end, **we** will contact **you** to confirm when the last payment is to be made, either:

a) at least 30 days in advance of the last payment if **your** benefit period is expiring; or

b) as soon as possible if **we** have received information that has caused **us** to cease all future payments.

**How we support you when you make a claim**

8.24 **We** acknowledge that claims time is difficult for **our** customers, and that empathy is required in **our** claims management. **We** will treat **you** with compassion and respect.

8.25 If **you** tell **us** that **you** are having difficulty providing requested claim information **we** will work with **you** to find a solution. This will include endeavours to collect the information on **your** behalf.

8.26 For income-related claims **we** will:

a) seek to identify ways **we** can support **your** recovery at the early stage of **your** claim;

b) seek to collaborate with **your** doctor, other healthcare providers and **your** employer in ways which will optimise **your** health outcome;

c) ensure **you** have a primary contact person for the duration of **your** claim; and

d) if injured or ill, **we** will promote best-practice rehabilitation and injury management.

**Urgent financial need**

8.27 While **we** are assessing **your** claim, **you** can tell **us** if **you** are in urgent financial need of the benefits **you** are covered for under **your** Life Insurance Policy, as a result of the condition that has caused the claim.

8.28 **We** will ask **you** to provide documentation to support this, but will only ask for information that is reasonably necessary to assess **your** request, such as:

a) for Centrelink clients, **your** Centrelink statements; or

b) financial documents including bank statements.

8.29 If **you** reasonably demonstrate to **us** that **you** are in urgent financial need, **we** will:

a) prioritise the assessment and decision in relation to **your** claim; and/or

b) make an advance payment to assist in alleviating **your** immediate hardship.

8.30 **We** will notify **you** about **our** decision within five business days of receipt of the documentation **we** have reasonably requested from **you**. If **you** disagree with **our** decision, **we** will review this. If **we** accept **your** request, **we** will confirm the arrangement in writing.

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20This 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.
9. Complaints and disputes

9.1 You are entitled to 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 our process for handling Complaints available on our website and in our relevant communications.

9.4 Your Complaint will be handled by someone different from the person or persons whose decision or conduct is the subject of the Complaint.

9.5 We will notify 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 the investigation into your Complaint and our response to your Complaint.

9.7 If we become aware of errors and mistakes in the handling of your Complaint, we will address these promptly.

9.8 We will make an arrangement with you for keeping you regularly informed about the progress of your Complaint.

9.9 If we resolve your Complaint to your satisfaction by the end of the fifth business day after your Complaint was received by us, and:

a) your Complaint does not relate to hardship, a declined insurance claim, or the value of an insurance claim; and

b) you have not requested a response in writing,

the processes described below in sections 9.10 to 9.13 do not apply.

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

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

a) our final decision in relation to your Complaint and the reasons for that decision;

b) that you have the right to copies of the documents and information we relied on in assessing your Complaint, and if you request we will provide you (or your doctor, where appropriate) with copies within ten business days, in accordance with the Access to Information section of the Code;

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

d) contact details for the SCT.

21For 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.

22This timeframe is prescribed by section 19, Superannuation (Resolution of Complaints) Act 1993.
9.11 If the superannuation fund trustee does not respond to your Complaint within 90 calendar days of receiving your Complaint, you can request written reasons from them for the delay. You have the right to take your Complaint to the SCT 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 provide a final response to your Complaint in writing within 45 calendar days. We will tell you:

a) our final decision in relation to your Complaint and the reasons for that decision;

b) that you have the right to copies of the documents and information we relied on in assessing your Complaint, and if you request we will provide you (or your doctor, where appropriate) with copies within ten business days, in accordance with the Access to Information section of the Code;

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

d) contact details for FOS.

9.13 If we are unable to respond to your Complaint within 45 calendar days, we will inform you of the reasons for the delay before the end of the 45 calendar days, and inform you of your right to take your Complaint to FOS if you are not satisfied, along with contact details for FOS.

External Dispute Resolution

9.14 FOS is available to customers and third parties who fall within the FOS Terms of Reference. The SCT is available to customers and third parties whose complaints are covered by the Superannuation (Resolution of Complaints) Act 1993. 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 FOS or the SCT as appropriate.

9.16 External dispute resolution Determinations made by FOS are binding on us in accordance with the FOS Terms of Reference. Determinations made by the SCT are binding on us and the superannuation fund trustee in accordance with the Superannuation (Resolution of Complaints) Act 1993.
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, including but 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 the Code, which must reflect the standards of the Code 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.

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. All details in a report will be taken into account.

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 an Independent Service Provider involved in your application for insurance or claim must notify us if you make a Complaint about their services, and we will handle the Complaint in accordance with our internal Complaints process unless we are satisfied they have their own complaints handling process of 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:

a) surveillance can only be carried out by a licensed private investigator and they must comply with any relevant State and Territory legislation;

b) the investigator does not use 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) the investigator only collects information relevant to its investigation;

d) the investigator does not make any threat or promise or offer any inducement to any person when conducting an investigation on our behalf;

e) the investigator acts in accordance with the standards relating to interviews and surveillance in sections 8.11 and 8.12; and

f) records of all investigation activities are kept in accordance with the requirements of the Privacy Act 1988.

11. Information and education

11.1 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.

11.2 The FSC is responsible for the promotion of the Code to consumers and to industry participants that have not yet adopted the Code. We will work with the FSC to promote the Code.

11.3 The FSC will work with the Life CCC, relevant regulators and stakeholders to encourage all life insurers and other industry participants that carry on business in Australia to adopt the Code.

11.4 The FSC may develop guidance documents from time to time which are not enforceable but assist us in interpreting and meeting our obligations under the Code.

11.5 We will work with the FSC on the promotion and education of life insurance, financial literacy and the life insurance industry.
12. Code governance

Role of FSC

12.1 The FSC is responsible for the development of the Code, including the Charter of the Life CCC.

12.2 The FSC is responsible for commissioning formal independent reviews of the Code as appropriate, no less than every three years. The Life CCC may recommend to the FSC Life Board Committee that the Code be reviewed, if the Life CCC believes the application of the Code is not meeting its objectives.

12.3 In addition to formal independent reviews of the Code, the FSC will consult with the Life CCC, FOS, SCT, consumer and industry representatives, relevant regulators and other stakeholders to develop the Code on an ongoing basis.

Role of Life Code Compliance Committee

12.4 The Life CCC is the body responsible for monitoring and enforcing our compliance with the Code.

12.5 The Life CCC is made up of:
   a) a consumer representative;
   b) an industry representative; and
   c) an independent chair.

12.6 The Life CCC’s functions and powers are set out in its Charter.

12.7 The Life CCC is responsible for providing regular reports to the FSC’s Life Board Committee, 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.

12.8 The Life CCC may outsource its functions to an appropriate body, with the exception of its powers to sanction.
13. Monitoring, enforcement and sanctions

13.1 Anyone can report alleged breaches of the Code to the Life CCC. If the Life CCC determines that your allegation is better dealt with through our internal Complaints process, it will refer you to us to make a Complaint.

13.2 FOS may report possible Code breaches to the Life CCC.

Our Responsibility

13.3 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; and
   c) have a governance process in place to report on our compliance with the Code to our Board of Directors or executive management.

13.4 If we identify a Significant Breach of the Code within our organisation, within ten business days of becoming aware of the breach we will report it to the Life CCC unless:
   a) the breach relates to a matter that has been reported to a regulator; and
   b) the regulator has been informed that the matter may also involve a breach of the Code.

13.5 We will be in breach of the Code if our staff or our Authorised Representatives fail to comply with the Code.

13.6 We will cooperate with the Life CCC in its:
   a) review of our compliance with the Code;
   b) investigations of any alleged Code breach; and
   c) reasonable requests of us when it carries out its functions.

13.7 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

13.8 The Life CCC will:
   a) receive allegations about breaches of the Code;
   b) notify us of any alleged Code breaches by us and provide an opportunity for us to respond;
   c) use its discretion to investigate alleged breaches in accordance with the Code;
   d) determine whether a breach has occurred;
   e) agree with us any fair and reasonable corrective measures to be implemented by us and the relevant timeframes, taking into account any corrective measures related to the breach imposed on us by any regulatory body; and
   f) monitor the implementation of any corrective measures by us and determine if they have been implemented effectively and within the agreed timeframe.
13.9 The Life CCC will publish an annual report containing consolidated, de-identified analysis on Code compliance.

Sanctions

13.10 If the Life CCC considers we have failed to correct a Code breach in accordance with section 13.8, or if we cannot agree on corrective measures, it will:

a) notify our Chief Executive Officer in writing; and
b) provide an opportunity for us to respond within 15 business days.

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

13.12 The Life CCC will notify 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.

13.13 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; and

d) whether the breach is a Significant Breach.

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

a) a requirement that particular rectification steps be taken by us within a specified timeframe, taking into account any rectification related to the breach imposed on us by any regulatory body;
b) a formal warning;
c) a requirement that a Code compliance audit be undertaken;
d) a requirement that we undertake corrective advertising or write directly to the customers impacted by the breach; and/or

e) publication of our non-compliance on our website and on the FSC website.

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

13.16 Where we do not comply with a sanction imposed on us by the Life CCC, this is 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.
14. Access to information

14.1 We will abide by the principles of the Privacy Act 1988 and any other legal obligations when we collect, store, use and disclose personal information about you.

14.2 Subject to section 14.5, you can access the information about you that we have relied on in assessing your application for insurance cover, your claim or your Complaint.

14.3 Subject to section 14.5, you can also access the reports from Independent Service Providers that we have relied on in assessing your application for insurance cover or your claim.

14.4 If we cannot comply with a timeframe for providing information to you required by the Code due to the fact that we are waiting for permission from a third party to release information to you, we will advise you of this before the end of the timeframe, and this will not constitute a Code breach.

14.5 In special circumstances, we may decline to provide access to or disclose information to you, such as:
   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 by us to your doctor;
   c) where the release of the information may be prejudicial to us in relation to a dispute about your insurance cover or your claim, or in relation to your Complaint; or
   d) where we reasonably believe that the information is commercial-in-confidence.

14.6 If we decline to provide access to or disclose information to you:
   a) we will not do so unreasonably;
   b) we will give you a schedule of the documents we have declined to provide and give you reasons for doing so; and
   c) we will provide details of our Complaints process.

14.7 If you request any of your Life Insurance Policy documentation from us, we will provide this to you promptly and in an electronic form if you request, subject to any process for releasing policy documentation that we are required to carry out by law.
15. Definitions

APRA means the Australian Prudential Regulation Authority.

ASIC means the Australian Securities and Investments Commission.

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.

business days are Monday to Friday excluding public holidays.

CCI means consumer credit insurance.


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 a FOS Ombudsman or by the SCT.

FOS means the Financial Ombudsman Service.

FSC means the Financial Services Council Limited.

Funeral Insurance Policy means a 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-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.

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

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

Life Insurance Policy means:

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); or

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, issued in the Australian market and excluding a contract of reinsurance.

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.

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

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

Life Insurance Policy means:

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); or

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, issued in the Australian market and excluding a contract of reinsurance.
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 seeking to own or owning a Life Insurance Policy covered by the Code, including joint Policy-owners, but excludes a Third Party Beneficiary.

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.

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 to communicate with us on your behalf, such as a lawyer, financial adviser, financial planner, Group Policy-owner, interpreter, or family member.

SCT means the Superannuation Complaints Tribunal.

Significant Breach means a 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; or

d) the actual or potential financial loss caused by the breach.

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 means:

a) your claim has been notified to us 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 (including a Reinsurer);

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) 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.

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 a Life Insured, Policy-owner, or a Third Party Beneficiary, as relevant to a particular section of the Code.
Minimum standard Trauma/Critical Illness Definitions

8.20A The **minimum standard medical definitions** in the Code 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 **minimum standard medical definition** in the Code that is current at the time of the insured event;

so that you get the better of the two definitions.

Add the following in Chapter 15 - Definitions...

**minimum standard medical definition** means:

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 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.