



**Submission by the
Financial Rights Legal Centre**

The Insurance in Superannuation Working Group

Claims Handling Discussion Paper, April 2017

May 2017

About the Financial Rights Legal Centre

The Financial Rights Legal Centre is a community legal centre that specialises in helping consumer's understand and enforce their financial rights, especially low income and otherwise marginalised or vulnerable consumers. We provide free and independent financial counselling, legal advice and representation to individuals about a broad range of financial issues. Financial Rights operates the National Debt Helpline, which helps NSW consumers experiencing financial difficulties. We also operate the Insurance Law Service which provides advice nationally to consumers about insurance claims and debts to insurance companies. Financial Rights took over 25,000 calls for advice or assistance during the 2015/2016 financial year.

Financial Rights also conducts research and collects data from our extensive contact with consumers and the legal consumer protection framework to lobby for changes to law and industry practice for the benefit of consumers. We also provide extensive web-based resources, other education resources, workshops, presentations and media comment.

This submission is an example of how CLCs utilise the expertise gained from their client work and help give voice to their clients' experiences to contribute to improving laws and legal processes and prevent some problems from arising altogether.

For Financial Rights Legal Centre submissions and publications go to www.financialrights.org.au/submission/ or www.financialrights.org.au/publication/

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National Debt Helpline 1800 007 007
Insurance Law Service 1300 663 464
Aboriginal Advice Service 1800 808 488

Monday – Friday 9.30am-4.30pm

Introduction

Thank you for the opportunity to comment on insurance claims handling in superannuation. The Financial Rights Legal Centre has provided comment or answers to only those questions where it feels it is able to provide input.

Financial Rights provided over 1000 case studies via our Insurance Law Service (ILS) relating to poor claims handling cases for aggregate use in the recent Australian Securities and Investment Commission (ASIC) Report 498 centring on life insurance claims handling between January 2013 and March 2016. 16 per cent of the data provided to ASIC involved Group Insurance. We provided cases that involved:

- claims handling delays
- hardship caused by delays
- unreasonable requests for information
- piecemeal evidence gathering tactics
- issues with surveillance
- alleged discrimination
- issues with doctor/forum shopping
- mis-selling arising from bad advice or commissions
- no PDS available

We therefore have significant experience in hearing from consumers faced with difficulties in the claims handling process in the group insurance space. We have included case studies in our submission, drawn from the past few years and from our current casework, to elucidate on some of the common problems.

B.1. Claims Handling Principles

1. Do you agree that an industry Code should be developed to guide superannuation funds in the principles to be applied when handling claims?

Yes.

A Life Insurance Code of Practice was developed and introduced in 2016 following a series of scandals. The FSC took the appropriate step to introduce the Code which includes significant claims handling commitments. The Life Insurance Code however only covers insurer's interactions with the policyholders. It cannot impose obligations on Superannuation Trustees, which leaves a significant gap.

A Superannuation Code of Practice must be developed as a priority to fill this gap and ensure consumers who hold insurance via their superannuation are in no way disadvantaged simply

because they have accessed life insurance via their superannuation rather than having a direct relationship with the insurer.

The superannuation industry is lagging significantly behind the rest of the sector in terms of commitments to meet minimum or best practice claims handling standards. It is critical that a consumer facing Code of Practice is introduced – sooner rather than later. At a minimum this should be at the same time as the launch of the next iteration of the Life Insurance Code of Practice – expected to be reviewed March 2018, 18 months after its launch.

We note too that ASIC has stated that:

The effectiveness of the minimum standards in the [Life Insurance] Code will be enhanced by superannuation trustees agreeing to adopt them in so far as they apply to claims handling by trustees of claims lodged under group policies. We support steps taken by industry to broaden the application of the standards to cover group insurance.¹

The role of Codes of Practice

Industry codes are a set of enforceable rules that set the standard for expected conduct by signatories to that code. An industry code is therefore first and foremost about self-regulating an industry's own conduct. A Code is also fundamentally about addressing consumer issues, concerns and problems with industry practice through the imposition of self-regulating obligations and commitments to raising the standards of industry behavior.

We note that the Life Insurance Code of Practice includes objectives (subsection 1.4) and includes a set of “Key Code Promises”. The General Insurance Code of Practice too includes a series of Code objectives at subsection 2.1.

Claims handling principles should be articulated in the Code via objectives, key promises and real solid commitments using with strict, effective bright line rules that extend the industry beyond their current legal obligations.

Recommendations

Claims handling principles should be articulated in the Superannuation Code via objectives, key promises and real solid commitments using with strict, effective bright line rules that extend the industry beyond their current legal obligations.

¹ ASIC Report 498: Life Insurance claims: An Industry review, <http://download.asic.gov.au/media/4042220/rep498-published-12-october-2016a.pdf>, para 156, p 41.

3. Are there any other principles that you believe should be incorporated into the Code?

“Claims Philosophy”

Financial Rights notes that a “claims philosophy” is referred to a number of times in the proposed principles. We do not understand what individual claims philosophies are in the context of an industry Code, and how this would assist a consumer. The Code should enunciate commitments that all superannuation funds will meet as a minimum that extend the industry beyond their current legal obligations.

Recommendations

The Superannuation Code should enunciate commitments that all superannuation funds will meet as a minimum that extend the industry beyond their current legal obligations, and should not defer to individual claims philosophies.

Monitoring claims activity and time frames

Financial Rights notes that one of the principles articulated in the discussion paper is that:

Each superannuation fund should be aware of and monitor claims activity and durations through the entire claims journey and should not wait for the insurer’s decision prior to commencing their involvement in the claim.

While Financial Rights supports this we feel it should be bolstered to ensure that a superannuation fund is more active or proactive in this regard.

Rather than simply not waiting for the insurer, Superannuation funds should commit to actively ensuring that they are up to date with where the Insurer is in the process and actively engage with an Insurer where there are delays. The timeframes that life insurers have committed to under the Life Insurance Code of Practice such as the commitment to 12 months to make a decision is an *absolute maximum*, not a guide. The superannuation fund needs to work with the insurer to find out as soon as possible whether a life insurer will be relying on, for example an exceptional circumstance.

Case study – Holly’s story – Delays and lack of advocacy

For many years, Holly has held a TPD policy with \$60,000 cover with an Insurer through her Superannuation Fund. In 2007 Holly applied for an additional \$200,000 TPD cover.

In 2010 Holly ceased work because of generalised osteoarthritis, anxiety and depression. Holly made a claim on her TPD in November 2014. In July 2015 the Insurer wrote to her to

say they will pay out the \$60,000 from the original plan but that they will not pay on the second 2007 TPD. The Insurer claimed that Holly did not disclose at that time that she had anxiety depression.

Holly had been asked in 2007 whether she

“received any medical advice or undergone any medical treatment, investigation or an operation, ... for ...depression or mental disorder (including but not limited to stress, anxiety, chronic tiredness or fatigue, panic attacks, post traumatic stress, behavioural or nervous disorder?)”

Holly had answered no but she had been on anti-depressants since the death of her child some time prior to 2007. Holly however had never sought to hide this. She had interpreted depression as not being able to cope. She did not put herself in that category as she had been caring for her family and working. She thought she was run down and not getting enough sleep. There is no dispute that this was an innocent misrepresentation (ie not fraudulent).

The Insurer then sought further info from her regarding her entitlement to the additional amount of \$200,000 pending her response. Holly responded within 28 days.

It is now March 2017, almost two years later and the Superannuation Fund wrote to saying

“the Trustee has still not made a decision on this claim. We are currently obtaining legal advice on the options for the Trustee to continue to pursue this claim on with our insurer, Comminsure.”

In the end the Insurer has accepted that Holly meets the definition of TPD (on terms of original policy) and have said that had they known about the depression, a mental health exclusion would have been applied. However Holly meets the definition of TPD on the basis of her osteoarthritis alone.

The Insurer has therefore been considering the same issue for over two years and Financial Rights sees no evidence that the Superannuation fund has been advocating sufficiently on Holly’s behalf, if at all.

Financial Rights notes that later, the discussion paper states:

“Where activities required as part of the assessment of a claim are outside the control of the superannuation fund (for example, where the insurer is seeking information from third parties such as medical providers), the superannuation fund will apply oversight to the timeliness of the claims assessment activities, to ensure that delays are not exacerbated due to a lack of focus or escalation.”

“The superannuation fund will also oversee the activities required of the insurer to monitor whether the insurer is adhering to its obligation under the FSC Life Insurance Code of Practice, and escalate this with the insurer where potential breaches are identified”

The Code should therefore articulate the principal that the superannuation fund will actively and regularly engage with a life insurer on behalf of their member. This should be reflected in actual commitments in the Code that will guide and in part dictate the development of service level agreements with life insurers. Superannuation funds should commit to monitor compliance with time lines etc by the life insurer and escalate code breaches on behalf of their members when they occur.

Recommendation

The Superannuation Code should articulate the principal that superannuation funds will actively and regularly engage with a life insurer on behalf of their member.

Superannuation funds should commit to monitor compliance with time lines etc by the life insurer and escalate Code breaches on behalf of their members when they occur.

No worse off

As articulated above, there is currently a gap of coverage in industry-led minimum claims handling standards for those consumers who have accessed life insurance product via their superannuation fund rather than directly.

For example, the commitments made by Life Insurance Code of Practice subscribers on surveillance are strong, well over due and an improved level of protection for life insurance consumers than was previously the case. However given superannuation funds are not covered by the obligations of the code there is a potential for regulatory arbitrage to take place where superannuation funds undertake surveillance that does not meet the commitments made under the Life Insurance Code of Practice.

It is therefore important that a leading principle moving into the development of this Code and to be articulated in this Code is that that no consumer is left worse off because they accessed a life insurance product via their superannuation fund rather than directly. In other words, the Code should articulate a commitment to ensure that the claims handling section (and all other sections) work symbiotically with the Life Insurance Code of Practice to ensure a consistency in consumer experience, where possible.

Recommendation

The Superannuation Code should articulate a commitment to ensure that the claims handling section (and all other sections) work symbiotically with the Life Insurance Code of Practice to ensure a consistency in consumer experience, where possible

Complaints handling

The Code should include a principle that all superannuation funds maintain an effective and clear internal dispute resolution (IDR) service for consumers with complaints about claims handling or any other complaints about the consumer's interaction with the Superannuation fund.

Currently there is significant confusion as to where a consumer can go and what to do when they have a complaint.

For example, Australian Super has a "Tell us about a problem" on their website² It states that:

If you don't receive a response to your complaint within 90 days, or are not satisfied with the response provided after going through AustralianSuper's internal dispute resolution process, you have the option of contacting the Superannuation Complaints Tribunal. The Tribunal may be contacted at:

...

You may be eligible to take your complaint to the Financial Ombudsman Service if you don't receive a response to your complaint within 45 days or are not satisfied with the response provided after going through AustralianSuper's internal dispute resolution process.

This is extremely confusing for a consumer. Under what circumstances does a consumer approach FOS or the SCT, on reading the above? A lot of time is wasted because of this confusion particularly when a consumer innocently applies to the incorrect forum. Similar confusion can be seen on other superannuation fund websites such Media Super or Cbus just to name two others.³

Other funds do not have a complaints process available online at all.⁴

² <https://www.australiansuper.com/about-us/contact-us/tell-us-about-a-problem.aspx>

³ <https://www.mediasuper.com.au/about-need-help/complaints-procedure>
<https://www.cbussuper.com.au/support/complaints>

⁴ For example: www.myfuturesuper.com.au simply has a general inquiry line and refers to complaints with respect to privacy but no complaints details.

Further both General Insurance Code of Practice and the Life Insurance Code of Practice include commitments regarding complaints processes. The ability to make a complaint at any time is an important part of the claims handling process. This should be articulated in the Code.

We also note that it is a legislative requirement under s. 19 of the *Superannuation (Resolution of Complaints) Act 1993* to provide a response within 90 days of receipt of a complaint. We believe that a total of three months to deal with a complaint is completely unreasonable and has a severe impact upon policyholders suffering financial hardship, injury and/or illness.

To use the example of Australian Super's "Tell us about a problem" website page again, it states that:

We will investigate your complaint and while it is a legislative requirement that we provide you with a response within 90 days of receipt of your complaint, we want to address your concerns as quickly as possible.

This Code provides the opportunity to improve this service and we recommend that the industry commit to a shorter timeframe – a time frame in line with the industry standard of 45 days.

Recommendations

Superannuation fund trustees should commit to the same 45 day time limit for resolving complaints as Life Insurers have committed to under the Life Insurance Code of Practice.

B.2. Standard time frames for superannuation

3. What do you consider to be the appropriate time frames for superannuation?

Never ending claims handling

One of the biggest issues faced by consumers is the fact that there are no timeframes around how long a claim takes.

Financial Rights provides the following case studies that demonstrate the nightmares that consumers face when working with superannuation funds.

Case study – Lisa’s story – Delays - C138474

Lisa was diagnosed with stage 4 melanoma. She realised she had benefits in her superannuation, and so made a claim. When she contacted the ILS the claim was with the superannuation fund. It had been 5 months. She never hears from the superannuation fund. She follows up with them, and she is often asked to re-send documents she has already sent in. She has received further news from her treating doctors that her prognosis is getting worse. She is seeking advice from Financial Rights about what are the expected time frames. We explain to her that there are no timeframes currently, that the Life Insurance Code of Practice is implementing a time frame of 6 months for claims like hers with insurers, however, the start of 6 months commences from when the superannuation fund makes the claim with the insurer. It is not clear whether her claim is with the fund or the insurer. No one is talking to her.

Case study – Bianca’s story – Delays - C132535

Bianca lodged a claim for income protection in late October 2014. In February 2016 when she spoke to the ILS the claim had still not been approved or declined. Bianca put a second claim in around June 2015 and that too hadn’t been decided. She told the ILS by email “I would be extremely happy if the outcomes of my cases were determined. But at least I think it's fair after 15 months to know how much longer until a decision will be made!!!!!!” All she has been told is that her case was still being reviewed. They're not asking her for anything. She says the case manager at her superannuation fund has been lovely to her, but they keep saying that they are waiting on the Insurer.

Case study – Heather’s story – Delays - C138474

Heather's husband passed away 3 months ago. He was on income protection during his last few months. On his passing, Heather made a claim for his death benefits. She does not understand the delay. The insurer states they are waiting for the superannuation fund, and the superannuation fund says they are waiting for the insurer. She is not sure whether it is due to any issues around the payment of benefits to the nominees or whether they are questioning the claim itself. They keep passing her off to other departments and she does not get a straight answer. She has a mortgage to pay, and this is distressing. They treated him poorly when he was sick, they kept asking for medical statements even though he was dying and they knew it. She just wants to know how long she has to wait for a decision.

Case study – Doreen’s story – Delay - C127532

(Email to the ILS)

As part of my insurance arranged by my superannuation fund I had Temporary and Total Permanent Disability Insurance with [Insurer]. At the end of 2011 I had a breast cancer. During the most of 2012 I was undergoing chemo and other cancer treatments. I was unable to work and for a period of 2 years [Insurer] was paying me a Temporary Disability allowance according to the insurance PDS. Because all my doctors classified me as unable to perform my before cancer duties I lodged a claim with [Insurer] for the TPD. After almost 18 months and providing to [Insurer] a number of medical reports, sometimes even two from this same doctor I do not have any concluding answer. I have impression that they are trying to avoid my questions about the status of my claim. I do not have from them either "yes" or "not" answer regarding my claim. Please advise: is there any time limit to process TPD claim on insurance company side (so far no resolution after almost 18 months).

Issuing of claims forms at the request of the person claiming

Issuing of claim forms should be a basic task that is easily implemented. Financial Rights cannot understand why a super fund should be provided with a whole week to implement a basic task like this. This Code should be about extending superannuation funds performance. We believe 2 or 3 days is more than reasonable.

However what would make this more effective is all superannuation funds committing to providing claims forms online. Superannuation funds should also commit to including Product Disclosure Statement (**PDS**) documents online as well. Financial Rights discusses the issue of the provision of PDSs further below under the communications section.

Recommendations

The issuing of claims forms at the request of the person claiming should be provided with a 2-3 day time frame. PDS documents should be automatically provided with a claims form when a claims form has been requested.

An initial eligibility assessment of the claim (eligibility to lodge a claim)

Financial Rights wishes to clarify that once an initial eligibility assessment has been made that the lodgement of the claim with the life insurer should be initiated immediately, or at the very least within the 10 business day period of this timeframe. There is ambiguity in the description of the process whereby an assessment could be made in favour of lodging a claim but lodgement not actually occurring until well after due to a variety of bureaucratic reasons.

Recommendations

The lodgement of a claim with a life insurer after a positive assessment for eligibility by the superannuation fund should be conducted within the 10 day timeframe provided for assessment eligibility.

4. Are there any other actions required by the superannuation fund that should have a time frame established?

Request for a Product Disclosure Statement

Financial Rights discusses the issue of the provision of PDSs further below under communications however suffice to say at this point that a timeframe should be placed around all requests for PDS – in addition to the issuing of a claims form. The timeframe should be the same as the timeframe for issuing a claims form and should be conducted at the same time (when a claims form has been requested).

Recommendations

The Superannuation Code of Practice should commit to providing a PDS within 2-3 days upon request of a member or beneficiary and should be provided automatically upon request for a claims form.

The Superannuation Code of Practice should commit to having all PDS documentation available online.

Relevant Documents

ILS solicitors are regularly contacted by policyholders with concerns over document requests. Many feel that their privacy may be breached with requests for particularly sensitive documents. Others do not see the documents' relevance to the facts at issue since this

relevance has not been spelled out to them by the insurer. A number of policyholders that Financial Rights speak to are overwhelmed by the extent of documents requested and overcome by the process of obtaining the documents. And most policyholders that Financial Rights speak to are not provided with any assurances that their information will be stored and dealt with in accordance with the National Privacy Principles.

With respect to privacy concerns callers can feel a genuine sense of violation when insurers seek certain documents and want to know whether they can refuse access to particularly sensitive material, such as material on relationship breakdowns, and personal health information.

Financial Rights notes that the General Insurance Code of Practice includes subsection 4 which states:

We will only ask for and rely on information and documents relevant to our decision in assessing an application for insurance.

The Life Insurance Code of Practice includes subsection 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.

An equivalent commitment should be included in the Superannuation Code of Practice.

Further the Life Insurance Code of Practice includes commitments relating to the general authorities. Subsection 8.6 states:

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.

Recommendations

The Superannuation Code of Practice should commit to

- only requesting relevant documents and explaining why they are requesting them. Where a member or beneficiary disagrees with the relevance the Code should commit superannuation funds to review the request and if the complainant is not satisfied with the review the superannuation will tell the complainant how to make a Complaint to the appropriate external dispute resolution service.

- dealing with all consumer documents in accordance with the National Privacy Principles.
 - only using a general authority to obtain information that a superannuation fund reasonably believes is relevant to the claim.
-

Piecemeal gathering of information

Financial Rights notes that the paper does not include any discussion on procedures with respect to the requesting of documents, either generally or in relation to timeframes.

In our experience many claims are delayed due to the piecemeal or drip feeding of requests for documents. Piecemeal gathering of evidence and subsequent loss or misplacement by insurers and superannuation funds are among the most common complaints our solicitors hear on the ILS. We have long held concerns that such delays are in fact unethical strategies used to drag out claims leading to consumers to tire out and disengage with their claims.

Case study – Rosita’s story – Delays - C128766

Rosita lodged a TPD claim through her superannuation fund in April 2014 due to a clot in her brain. Rosita provided all requested information throughout the claims process. The last time she had to provide requested docs was February 2015. It is now August 2015. Rosita’s case manager works part time and also has difficulty getting in touch with various specialists. Rosita has still not had a determination from her claim. She has tried to follow up many times with her case manager who works part time but does not get anywhere.

Rosita tried to ask for a new case manager who worked full time so her claim could be processed more quickly but was told no. Rosita is currently receiving monthly benefits from her temporary salary continuance but is experiencing financial hardship.

In September 2015 Rosita had not yet raised dispute. Her superannuation fund have written to her asking her to undergo an employability assessment. She thinks the whole process is a “sham”.

The Life Insurance Code of Practice has committed to the following subsection 8.7 with respect to piecemeal information gathering:

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

The equivalent commitment should be included in the Superannuation Code of Practice.

Recommendation

The Superannuation Code of Practice should commit to requesting the information needed as early as possible and avoiding multiple information requests over an extended period where possible.

Complaints and IDR

As argued above, Financial Rights note that it is a legislative requirement to provide a response within 90 days of receipt of a complaint. We believe that a total of three months to deal with a complaint is completely unreasonable and has a severe impact upon policyholders suffering financial hardship, injury and/or illness.

To use the example of Australian Super's "Tell us about a problem" website page again, it states that:

We will investigate your complaint and while it is a legislative requirement that we provide you with a response within 90 days of receipt of your complaint, we want to address your concerns as quickly as possible.

This Superannuation Code provides the opportunity to improve this service and we recommend that a shorter timeframe be committed to.

Financial Rights notes that the discussion paper states that:

*"It is recognised that, at any time, the person claiming may instigate a complaint with the superannuation fund at which time the legislated dispute resolution processes and timeframes will commence, **although future good practice guidance may encourage superannuation funds to respond to complaints more quickly than the ninety (90) day time frame currently prescribed within the Superannuation Industry (Supervision) Act 1993. (our emphasis).***

Future good practice guidance? Financial Rights does not accept that an improved complaints timeframe should be left to "future good practice guidance." Financial Rights expects this to be a part of this Code of Practice. As stated above, commitments to complaints processes are made under all Codes of Practice including the General Insurance and Life Insurance Codes of Practice. To leave this to "good practice guidance" is to not take seriously the need for improved complaints processes and timeframes now. A Code of Practice is a commitment to consumers that should build trust and improve confidence in the industry. Leaving such improvements to "good practice guidance" is unacceptable. A shorter complaints timeframe should be included in this Code of Practice.

Recommendations

The Superannuation Code of Practice should include timeframes with respect to complaints timeframes and that these should be improvements on the legislated requirement.

B.3. Enhancing communications throughout the claims journey

5. Do you agree with the development of minimum communication standards for superannuation funds?

Yes.

Again one of the key issues faced by consumers that we speak to is a distinct lack of knowledge of the claims process be it what is occurring with their claim; why a claim is taking so long; how long a claim should take or how long a part of the claims process should take; what rights they have and what they can do. However, superannuation funds do not even provide the most basic of information such as claims forms or PDS documentation.

Consumers are consistently left in the dark about their claim and what they can do about it. This leads to frustration, anger, annoyance, stress (something that is particularly bad for people claiming on their insurance for mental health or other related illnesses), a lack of confidence in the superannuation fund and can lead to constructive withdrawal of a claim where there is a legitimate claim to be made.

This Code should include minimum standards for superannuation funds which directly address the key issues faced by consumers.

Case study – Pria’s story – lack of clear communication- C117348

Pria lodged a income protection claim via her superannuation fund. She has been having problems being back paid for the previous 12 months. Pria says she has all the supporting Doctor's reports but she is confused as to what further information they need and why they haven't paid her.

Case study – Tina’s story – Frustrating communication - C115769

(Email to ILS in March 2014)

Hi there, I became ill Nov/Dec 2011, left work Feb 2012. I claimed on [Super Fund 1] insurance that I had been paying into. [Super Fund 1] claim went from March 2012 to Nov 2013. I found out I had income protection thru [Super Fund 2]. I applied in Dec 2013. I received paperwork from [Super Fund 1], filled it in thinking they would merge my old claim with new oneno after constantly contacting [Super Fund 1] for an answer, I was told that my claim was back with [Super Fund 2] Trustees awaiting review, I contacted [Super Fund 2] Trustees to be told that claim was still with [Super Fund 1]. I then contacted [Super Fund 1], my claim was waiting for [Super Fund 1] manager review. This week I contacted [Super Fund 1] for an answer, to be told that claim was again back with [Super Fund 2] Trustees awaiting review. I contacted [Super Fund 1] Trustees to be told that my claim has been cancelled as I never completed and returned paperwork to [Life Insurer]??? I had to contact [Insurer] to discuss. they have no record of any claim pertaining to my name? I'm very depressed at this treatment I've endured!!

Case study – Cecile’s story – Delay - C112058

Cecile lodged a claim for TPD for a debilitating ankle injury and subsequent arthritis after receiving income protection for 24 months. Cecile filled out all the paperwork, they have her GP's report and the Orthopaedic Surgeons reports too. Cecile claim has now been going for approximately 8 months. And every time she calls or emails all she gets told is that it is being assessed and they are waiting for more Doctors reports. Cecile feels that this is an excessive amount of time and they never contact her. She is the one making all the contact and getting no answers.

6. Should they be mandatory or good practice guidance?

This should be mandatory and a part of a consumer facing Code of Practice.

7. What additional/alternative communication should be required to improve the understanding of and confidence in the claims process for people claiming?

Additional to those articulated in the discussion paper, Financial Rights believes that superannuation funds needs to make a number of basic, practical, easily instituted commitments with respect to what and how they communicate with their members during the claims handling process as well as more generally about the nature of their coverage.

Provision of Product Disclosure Statements

One of the most complained about issues that Financial Rights solicitors hear on the ILS is the inability to access the Product Disclosure Statement of their insurance held via their superannuation fund.

Financial Rights notes that subsection 3.7 of the Life Insurance Code states:

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.

Financial Rights finds it absurd that PDSs for insurance products in superannuation are generally not available online. They are sometimes not even provided when they are directly requested with the superannuation fund.

Not having access to a PDS for the insurance product that a beneficiary member wishes to consider to make a claim on again causes frustration, annoyance, and anger. It contributes to significant delays for consumers many of whom are at their most vulnerable and needy. It feeds distrust and a lack of confidence in the superannuation fund. Fundamentally, a consumer will not know what definition or evidence is required of them in order to make a claim, which can also result in claims not being made or unnecessary claims being made.

The provision of a PDS, including both upon taking up a group insurance product and when wishing to make a claim, should be a bare minimum commitment by Trustees in any Code. To do otherwise would be unconscionable.

Recommendations

The Code of Practice should include a commitment to provide every member or beneficiary with the appropriate Product Disclosure Statement for their group insurance product. This should be in both soft copy and hard copy form.

Product Disclosure Statements should be provided to members or beneficiaries upon becoming a member or beneficiary (be it automatically or otherwise).

Product Disclosure Statements should be made available online for members or beneficiaries.

Communication through the term of the policy

Financial Rights notes that the Life Insurance Code of Practice includes a commitment to keeping policyholders informed during the term of a 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.

Financial Rights strongly believes the same information in the form of an annual statement or notice should be provided to group insurance members or beneficiaries.

Recommendations

The Code of Practice should include a provide an annual notice or statement in soft copy and hard copy form each year prior to the anniversary of your Life Insurance Policy

The annual notice or statement should 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) what to do in the event of a claim

Not Discouraging Claims

Financial Rights believes that a particular communication commitment that superannuation funds should make to a consumer is that they will not discourage lodging a claim. Financial Rights regularly hears from consumers who have been discouraged from making a claim – legitimate or otherwise.

Financial Rights notes that both the General Insurance Code of Practice and the Life Insurance Code of Practice include wording to this effect:

You are entitled to ask us if your insurance policy covers a particular loss before a claim is lodged. In answering, we will not discourage you from lodging a claim, and will inform you that the question of coverage will be fully assessed if a claim is lodged. (GICOP 7.8)

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. (LICOP 8.2)

Financial Rights recommends that similar commitments are made under the Superannuation Code.

Recommendations

The Code of Practice should include a commitment not to discourage a member of beneficiary from making a claim.

Financial Hardship

Financial Rights believes that the Code should make commitments to claimants who have an urgent financial need. This is a common problem and needs to be addressed. The General Insurance Code of Practice includes the following subsection 7.7:

Where you reasonably demonstrate to us that you are in urgent financial need of the benefits you are entitled to under your insurance policy as a result of the event causing the claim, we will:

- (a) fast-track the assessment and decision process of your claim; and/or*
- (b) make an advance payment to assist in alleviating your immediate hardship within five business days of you demonstrating your urgent financial need; and*
- c) provide details of our Complaints process, if you are not happy with our decision.”*

The Life Insurance Code of Practice includes the following

8.29 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,²⁰ 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.

While we understand that superannuation funds do not have the power to make advance payments, they could commit to prioritising their own assessments and decisions in relation to claims and seeking to advocate on the consumer's behalf to the insurer under the Life Insurance Code that the claim be prioritised.

We believe the same or similar clause should be included in the final Life Insurance Code of Practice.

Case study – Tim’s story –C121261

Tim has multiple medical conditions (including brain clot, seizures) that prevents his from working. He put in a claim for TPD with his insurer in March 2014. Tim said he supports his household including his mother, wife and their 3 kids. Tim is in arrears of \$6500 in rent. Tim relies on Newstart Allowance. Centrelink rejected his application for DSP due to telling them that he has put in a claim for his life insurance.

Tim said he has been waiting for 7 months for an answer as to whether his claim will be approved. Tim called the ILS to seek advice because he is unable to financially support his family on his Centrelink benefit. His wife does not work. His mother is on the DSP. He also wants to know what will happen with his pending insurance claim. He has cooperated with insurer and provided all requested medical documentation.

Five months later (or a full 12 months after he applied) he contacts the ILS to say that he has received an email from the insurer saying that the claim is in the final stages and with the trustee. Tim is distressed because he puts the entire amount of his Centrelink into paying rental arrears but he is constantly behind. He hardly has any money for living expenses. He mentioned self harm on the call.

Recommendations

The Superannuation Code of Practice should include a section on Financial Hardship committing to prioritising their own assessments and decisions in relation to claims from members or beneficiary experiencing financial hardship. It should also commit superannuation funds to advocate on the consumer’s behalf to the insurer the claim be prioritised.

Claims Handling Governance

8. Do you agree with the development of guidance in relation to governance standards for superannuation in relation to claims handling set out in section B.4 above?

The discussion paper lists the regulations that apply to the superannuation funds and then goes on to state:

"In light of the above, we do not believe that there is need for additional or heightened regulatory requirements in relation to claims handling by superannuation funds. Additional good practice guidance could provide assistance to funds to improve the experience of people claiming.

Financial Rights does not agree that there is no need for additional or heightened regulatory requirements in relation to claims handling by superannuation funds. Financial Rights notes that the recent ASIC Report 498 states in relation to superannuation trustees that

A number of particular issues apply in relation to insurance cover made available to superannuation fund members via a group insurance policy issued by a life insurer to the fund trustee which are integral to the claims handling process. We are aware of situations where trustees are not as involved as they should be in the claims process, with fund members instead corresponding directly with the insurer. However, some trustees appear to be aware of issues in claims handling and the reputational risk this presents. For example, one trustee we have spoken with made a decision to have insurance matters handled in the trustee office rather than by the fund administrator.

The report then stated that

ASIC will work with APRA, the insurance industry and stakeholders to establish a consistent public reporting regime for claims data and claims outcomes, including claims handling timeframes and dispute levels across all policy types.

This will help ASIC and APRA to monitor claims trends and identify any potential issues of concern from changes in data. We expect insurers to:

- *invest in systems and staff to meet future needs; and*
- *ensure that incentives and performance measurements for claims handling staff and their management are not in conflict with their obligation to assess each claim on its merit*

We support this oversight and believe that this should be applied to superannuation funds claims handling processes. Financial Rights also supports ASIC oversight of all claims handling issues in insurance including in relation to superannuation funds.

Furthermore, Financial Rights believes that the Code should include actual commitments with respect to governance arrangements in relation to claims handling – rather than good practice guidelines. The Code should include minimum standards that improve claims handling governance. Committing to avoiding conflicts of interest or procedural fairness or ensuring staffing are appropriately trained should not be a guidance. They should be actual Code commitments.

Recommendations

The Superannuation Code of Practice should include commitments with respect to governance arrangements in relation to claims handling – rather than good practice guidelines. These should include commitments in relation to avoiding conflicts or interest, procedural fairness, ensuring staff are appropriately trained amongst others.

Concluding Remarks

Thank you again for the opportunity to comment. If you have any questions or concerns regarding this submission please do not hesitate to contact the Financial Rights Legal Centre on (02) 9212 4216.

Kind Regards,



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