9 September 2016

Financial Services Council
Level 24, 44 Market Street
SYDNEY NSW 2000

Dear Sir/Madam,

RE: Draft Life Insurance Code of Practice issued by the Financial Services Council dated 10 August 2016

Thank you for the opportunity to provide feedback to you in relation to the draft Code.

We understand that the current version is version 16. We note some further amendments and changes have been made following the last round of feedback and submissions. In particular, we note that there have been steps taken to improve various sections of the Code around investigations, surveillance and interviews, and problematic sales practices and products.

We note that Mr Josh Mennen on behalf of the Australian Lawyers Alliance (ALA) provided some previous feedback in an email to Ms Sarah Philips on 26 July 2016. We **attach** that email to this submission and reiterate comments therein.

We note we also support the feedback you received from the Financial Rights Legal Centre (FRLC) and the Consumer Action Legal Centre (CALC).

We have had the advantage of reviewing the further joint submission from the FRLC and CALC dated 21 July 2016, and continue to support the submission and feedback made by those two legal centres.

Turning to the latest version of the draft we provide the following further feedback.

Clause 2.11 - Communicating with you under the Code

We note our previous recommendation that a sub-clause be included here such that if a policy owner, not being the insured person, did not respond appropriately to an enquiry or request for information then the insurer would assist in that process.

Section 13(3) of the *Insurance Contracts Act 1984* extends the duty of utmost good faith to third party beneficiaries. Given the Code promotes that duty, this is an area in which the insurer can assist a third party beneficiary in compliance with its duty.

We reiterate our recommendation to incorporate this sub-clause.

Clause 2.20 - Legal status of Code

Clause 2.20 continues to provide that the Code does not apply once proceedings are commenced in a court, tribunal or external alternative dispute resolution process with the exception of the Financial Ombudsman Service (FOS) and the Superannuation Complaints Tribunal (SCT).

There is no good reason why the Code should cease to apply just because court proceedings are commenced. If the industry is to provide a genuine commitment to the principles being adopted by the Code then the issue of court proceedings should not change that.

In particular we note in some circumstances where a claim has been made but there has been a long delay by the insurer in making any decision, court proceedings can be commenced based on a deemed refusal of the claim. In those circumstances there is still an obligation on the insurer to ultimately make a decision and there is again no good reason why that decision making process should be different just because court proceedings have issued.

We reiterate our recommendation to adopt the amendment contained in our previous feedback to this clause which was that the following be inserted instead:

> "The Code will continue to apply if **you** have commenced proceedings in any court, tribunal or external alternative dispute resolution process unless and until **we** and **you** agree it should not do so.."

Clause 3 - Policy design and disclosure

We note the principles adopted in clause 3.1 of the draft Code.

We recommend that group coverage be specifically mentioned here. It is a common problem that group coverage can commence or cease based on a member's employment status, account balance or the regularity of contributions from employers to the superannuation fund. Often in

circumstances where coverage ceases, it is not immediately apparent to the life insured who does not have ready access to the policy terms and conditions.

We recommend an addition to this clause to require that the insurer use its best endeavours to ensure that a superannuation group policy owner provide regular ongoing information as to the status of their members' vis-a-vis policy. This in turn will encourage the policy owner to seek out that information either from its employer or employee members.

We are sure you would agree that an insured member should be informed as soon as possible when coverage has ceased under a group policy so that they can review their situation and, if necessary, gain alternative coverage to ensure they are protected.

As you are no doubt aware there is a significant underinsurance problem in Australia and this is an opportunity to contribute to a solution to that underinsurance problem.

In relation to clause 3.5 we also recommend that the key information include the circumstances in which coverage can cease under the policy. This is a critical piece of information that an insured person needs to know.

Clause 4.7 - Sales practices and advertising

In clause 4.7 there is reference to a "CCI life insurance policy". Given the likelihood that most members of the public will not be aware of what CCI stands for we recommend that the full description of the policy be provided with an abbreviation in brackets.

Clause 6.3 - Policy changes, cancellation rights and replacement policies

In clause 6.3 we recommend including a summary of any changes to the policy effected in the previous 12 months in the proposed annual statement, that have not otherwise been notified directly to the insured person.

Clause 8.2 - When you make a claim

We note our previous recommendation that a new clause 8.2 include a requirement that where a policy owner does not provide requested information, then a request directed to the insurer will be actioned unless there is good reason not to do so. We again recommend the inclusion of such a

provision, which is consistent with the insurer's duty of utmost good faith owed to third party beneficiaries.

Clause 8.10 - What we require to assess your claim

We note we have previously provided comment in relation to clause 8.10, which we reiterate below. The clause as currently drafted could promote "doctor shopping" and unnecessarily repetitive examinations. This is out of step with the principle that courts are generally loathe to permit a multiplicity of experts on a specific issue; *Tvedsborg v Vega (2009) NSWCA 57; Hinset Pty Ltd v Lane Cove Council (2011) NSWLEC 120*.

We refer to our previous comments and suggestions for a clearer statement as to an insurer's obligations in the claims assessment process. We note in our earlier email we suggested that some additional provisions be inserted at the commencement of this section as follows:

> "When **we** assess **your** claim **we** are committed to:
>
> 8.10.1 processing claims quickly, efficiently and in a user friendly manner;
>
> 8.10.2 providing reasonable and relevant information and documentation on request;
>
> 8.10.3 communicating clearly and simply;
>
> 8.10.4 strict compliance with the complaints process as set out in the *Superannuation (Industry) Supervision Act 1993* (Cth);
>
> 8.10.5 providing a fair, effective and independent complaints dispute mechanism; and
>
> recognising that **you** have a right to access legal help to assist **you** through the claims process."

Those statements identify some fundamental principles upon which a claims assessment process should be conducted. We are sure that insurers would agree and strive to meet those principles whenever the circumstances allow.

Clause 9.3

There is still no requirement to provide an explanation of the claims process at clause 9.3. We submit that a timetable with rigorous timelines that are enforceable with sanctions if breached should be included through the claims process clauses.

Clause 9.9

This clause still does not adequately address the issues that have arisen in the life insurance industry in recent times and specifically the systemic issues seen in the CommInsure scandal. It still requires a definitive statement that insurers will respect the opinion of the professional employees of life insurers and not seek to have this change their opinion.

Clause 9.11 – Medical examinations

The current version of the Code does not adequately address concerns we have previously raised with regard to independent medical examinations. The word "avoids" is still in clause 9.11(c). This should be replaced with definitive language such as "we will not request…". Our view is that clause 9.11 still does not adequately prevent the issues of "doctor shopping" and multiple examinations with multiple independent medical examiners of the same discipline. This is a significant concern which needs to be adequately addressed.

Clause 10 – Standards for third parties dealing with underwriting or claim

We note that you have not made any change to the previous draft in relation to the engagement of third party service providers who are medical assessors or examiners. The CommInsure scandal involved an internal medical assessor and unnecessary pressure being brought to bear on internal professionals.

We again recommend that this situation be specifically dealt with in the Code to ensure that the CommInsure scandal is not repeated.

Clause 14 – Access to information

We note that you have retained clause 14.5(c) despite our suggestion that be removed. Clearly an insurer acting with the utmost good faith will disclose information that might assist a claimant but be prejudicial to the insurer. We note that during the course of any litigation arising from claims,

disclosure of such information would be required. There is no good reason why such information ought not to be disclosed under the Code. We note that the "prejudice" exception is not contemplated by the *Privacy Act 1988* and there is simply no good reason why a further exclusion should be provided for in the Code. This clause undermines fundamentally what the Code is trying to do when it comes to access to information. The clause must be removed.

Complaints and disputes

In our previous comments under the heading “Our Key Promises under the Code”, we recommended that the Code require insurers to advise insured persons of their right to independent legal advice at the point where a claim had been declined. We note that you have not adopted this recommendation.

An insured person's access to independent legal representation is a fundamental right and one which ought to be respected by insurers in all circumstances. Where a claim has been declined there is immediately a divergence of interests between the insurer and the insured person. Insurers cannot independently advise insureds at this point and it is incumbent on insurers to ensure that insured persons have access to independent advice.

We would urge you to adopt our previous suggested changes in this regard.

Insurers who have complied with the Code should have nothing to fear from the involvement of independent legal representatives. Claims that have been properly denied are unlikely to be disputed with legal representation. The provision of legal advice at this point will assure the insured person that the insurer has made the correct decision if that is the case. This can only benefit the relationship between the insurer and the insured person and avoid acrimony or misunderstandings as to the insurer's decision.

Complaints about a life insurance policy owned by a superannuation fund trustee

As you are aware, section 101 of the *Superannuation Industry (Supervision) Act 1993* provides for a maximum 90 day complaint turn around period.

There is no good reason why, from a life insurer's perspective, the turnaround time between a policy within superannuation and policy outside of superannuation should be any different.

We recommend that the Code provide for a 45 day turn around in both circumstances. This then enables the superannuation trustee to have a reasonable time to then meet the 90 day maximum (and we reiterate this is a maximum timeframe) contained in the Act.

We have previously noted that a large and increasing proportion of life insurance claims are made by members of superannuation funds against group life policies, but also noted that the Life Code refers to fund trustees who are policy owners, but does not bind them automatically nor does it bind life insurers who provide group policies. It contemplates an opt-in arrangement. The current draft fails to address these issues. It is ALA's position that both FSC members who provide insurance policies to superannuation fund trustees as well as superannuation trustees should be obligated to meet Code requirements.

Sales and financial advice provisions

we reiterate our previous position and specifically note that whilst there has been some improvements following the recent round of feedback as noted earlier, we remain concerned that issues such as cross-selling and vertical integration, approved product lists, the FOFA best interests duty, policy tuning, fee disclosure obligations, and compliance with the suitability rule have not been adequately addressed.

It continues to be our position that to deliver customer confidence and achieve broad support any Code dealing with financial advice will need to engage adequately and rigorously with these issues.

In conclusion

It is our overall conclusions that the current draft fails to address some key issues including the failure to set enforceable timeframes for the claims handling process and document requests. Throughout the Code generally there has been a lack of commitment to provision of timeframes. The clients that our members represent are continually frustrated and suffer significant distress associated with the excessive time taken in the claims handling process, and the final Code needs to address this issue.

We concur with the submissions previously made that this Code should be registered with ASIC in accordance with Regulatory Guidance 183. To be enforceable it should be expressly binding on and enforceable against subscribers through contractual arrangements with consumers.

Particularly in relation to group insurance, as has been noted earlier, most life insurance is accessed via superannuation. Therefore, steps must be taken, in our view, to ensure that the Code adequately and rigorously binds those superannuation trustees and the life insurers who provide those group policies to superannuation trustees. Many ALA members represent thousands of clients who are members of superannuation funds and who are accessing group insurance. We strongly submit that the Code will fail these thousands of consumers should it fail to address this important issue.

Finally, we again reiterate our support for the submissions made by representatives of the consumer movement. We also submit that the consultation process has failed to include our members who represent significant numbers of consumers who are accessing life insurance policies or who have been victims of unscrupulous practices in the sales practices and problem products.

For the Code to have significant and broad support with stakeholders, we concur that a range of stakeholder views should be considered. We submit that including ALA in this process is essential.

We again thank you for the opportunity to provide a further submission in relation to the draft Code and look forward to your continued collaboration and consultation with us on this important reform process.

Yours sincerely,

Tony Kenyon
National President
Australian Lawyers Alliance

Encl. Email from Josh Mennen to Sarah Phillips dated 26 July 2016