



Submission by the

Consumer Action Law Centre,
Financial Counselling Australia, and the
Financial Rights Legal Centre

Financial Services Council

Draft Life Insurance Code of Practice

January 2016

About Consumer Action

Consumer Action is an independent, not-for-profit, campaign-focused casework and policy organisation. Consumer Action offers free legal advice, pursues consumer litigation and provides financial counselling to vulnerable and disadvantaged consumers across Victoria. Consumer Action is also a nationally-recognised and influential policy and research body, pursuing a law reform agenda across a range of important consumer issues at a governmental level, in the media, and in the community directly.

About Financial Counselling Australia

Financial Counselling Australia (FCA) is the peak body for financial counsellors. Financial counsellors provide information, support and advocacy for people in financial difficulty. They work in not-for-profit community organisations and their services are free, independent and confidential. FCA is the national voice for the financial counselling profession, providing resources and support for financial counsellors and advocating for people who are financially vulnerable.

About the Financial Rights Legal Centre

The Financial Rights Legal Centre (Financial Rights) 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 Credit & Debt Hotline, 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 2014/2015 financial year.

Introduction

Thank you for the opportunity for the Consumer Action Legal Centre and the Financial Rights Legal Centre to comment on the Financial Services Council's Draft Life Insurance Code of Practice. We will provide both general comments regarding the approach taken to the Code as well as specific comments on the drafting of the Code.

Summary and key recommendations

This joint consumer submission argues that the Life Insurance Code of Practice (LICOP) as currently drafted is not a best practice standard and has not fulfilled the expectations and obligations set by Government. The current draft does not require life insurers to meet any standard that is not already required of them by the law. It does not meet the minimum standards of enforceability set by ASIC. The draft Code includes a number of sections dictating how consumers should behave rather than self-regulating the industry's own conduct addressing consumer issues, concerns and problems with industry practice. The current draft also makes no attempt to address the problems with churn and poor sales practices, issues that initiated the process that ultimately led to the development of this draft LICOP.

Unless substantial changes and additions are made, consumers will have minimal confidence in the Code and our organisations will not be able to support it.

We expect the final version of the LICOP to be registered with ASIC in accordance with ASIC's *Regulatory Guidance 183*. However for registration to occur, considerable improvements would need to be made to bring it up to the standard expected by ASIC for Code approval. Adherence to the Code must be a term of the contracts of all life insurance policies and adherence to the Code should be compulsory for membership of the FSC. It is not appropriate, nor practical, for a code to dictate how consumers should behave. The relevant sections in the Code - "General Information" and "How you can assist with your application" should therefore be removed. The final Code should also set enforceable, best practice standards for advisers and licensees.

In addition to these general expectations for a final LICOP, we believe that life insurers should make the following specific commitments to improve consumer confidence in the industry:

1. Life insurers should commit to providing specific details of how they will address consumer concerns about someone selling or distributing life insurance products.
2. The Code should include additional advertising and marketing commitments specific to the life risk product industry that are not currently included in the ASIC good practice guidelines.
3. Life insurers should commit to providing greater transparency for beneficiaries of group policies and provide copies of policies to beneficiaries and take steps to improve disclosure generally.

4. Life insurers should commit to provide to policyholders:
 - a. projections of likely costs of the premium
 - b. information and contact details of the subscriber's internal dispute resolution and complaints process;
 - c. in the case of replacement policies, information on what a consumer may potentially be losing and specific information on pre-existing conditions
 - d. clear disclosure on the impact of offsets.
5. Where an insurer cannot provide insurance to a consumer they should commit to providing the reasons for their decision (in all cases), details of the subscribers complaints process and alternative insurance options.
6. If there is a need to increase the price of a policyholder's policy outside of the annual anniversary life insurers should commit to providing reasons as to why the price increase is warranted. Life insurers should also commit to providing the previous year's premium on the annual renewal notice.
7. Contact via a letter, email or text message should be sent on the same day that a cancellation occurs. The Code should also require life insurers to offer financial hardship assistance if a customer misses a payment, and be prepared to offer reasonable assistance if it is requested.
8. The life insurance industry should:
 - a. commit to improving the prominence of warnings and the risks and consequences of replacing a policy
 - b. commit signatories to investigate reported or suspected mis-selling of replacement policies
 - c. report where they uncover wrongdoing; and
 - d. ensure any customers who have suffered a loss are compensated.
9. The Code should include directions to the IDR and Complaints process on making a decision. For those policyholders experiencing financial difficulty whilst an investigation is taking place life insurers should commit to paying a portion of the income protection payments.
10. Life insurers need to commit to training staff on how to engage appropriately with vulnerable consumers. They should also put in place appropriate processes and procedures to accommodate consumer needs and work closely with vulnerable consumers to only provide insurance products that are suitable to their particular circumstances.
11. To assist life insurers to identify those consumers who require additional support, insurers should commit to including voluntary demographic questions on their application forms.

12. Insurers should commit to providing consumers with reasons why documents and information sought in a claim are relevant and including a referral to the dispute process where there is an issue. Insurers should also commit to correcting errors or mistakes that they have identified and not discourage a policyholder from lodging a claim.
13. We recommend that life insurers meet a 12 week minimum standard timeframe similarly met by general insurers in gathering third party service providers reports or if this deadline cannot be met a commitment be made to keep consumers informed of the progress in obtaining the report. Furthermore specific timeframes should be instituted when keeping claimants informed about the assessment and investigation of their claim.
14. Life insurers should commit to including more specific timeframes within the Code including a four month time limit from receipt of the claim.
15. The Code needs to include a commitment to fully inform consumers of the tax and legal implications of a lump sum payment and to ensure that consumers are provided with enough time before the end of the financial year to receive appropriate advice.
16. The Code should include specific timeframes limiting the frequency of ongoing contact to reasonable levels that do not impede upon the lives of policyholders experiencing hardship.
17. A specific timeframe needs to be included to require life insurers to contact a policyholder to let them know when an ongoing claim is coming to an end or their claim is expiring.
18. The Code should commit life insurers to using only licensed investigators and require them to abide by the requirements of the Privacy Act 1998 and relevant state surveillance legislation. It is the life insurer's responsibility to deal with all complaints regarding that service that is being provided on their behalf. We recommend that broader, more specific standards be set for investigators to address our concerns with respect to investigations including poor communication practices, aggressive or unethical investigator behaviour and unreasonable requests for documentation.
19. Reviews of the Code should be conducted by an independent party. The FSC should be empowered to develop the Code on an ongoing basis in consultation with consumer groups and other stakeholders.
20. The Code must include a section addressing issues of financial hardship including paying a portion of an income protection payment to assist those experiencing financial difficulty whilst an investigation is taking place, fast-tracking assessments for those claimants who have urgent financial need, and informing policyholders of options available if hard times hit.
21. The Code should commit insurers to addressing the high lapse rate of funeral insurance products; immediately stop sales of funeral cover for people under 18 years old; stop

allowing CCI to be sold through the 'add-on' sales technique; and not allow products to be sold through pressure sales techniques.

Further suggestions and recommendations are detailed throughout the submission.

General Comments

ASIC Code Registration

We maintain that the final version of the Life Insurance Code of Practice (“LICOP” or “the Code”) must be registered with ASIC in accordance with ASIC’s *Regulatory Guidance 183: Approval of financial sector codes of conduct, March 2013*.¹ RG183 establishes the minimum benchmark for the development, content, enforceability, administration and review of industry Codes of Conduct. The Guide states that

*“It is not mandatory for any industry in the financial services sector to develop a code. Where a code exists, that code does not have to be approved by ASIC. **However, where approval by ASIC is sought and obtained, it is a signal to consumers that this is a code they can have confidence in.** An approved code responds to identified and emerging consumer issues and delivers substantial benefits to consumers.”² (our emphasis)*

We agree with ASIC that registering the Code is a signal to consumers that they can have confidence in the Code. Conversely, choosing not to register the Code would send a public signal that the life insurance industry’s unwillingness to meet the minimum standards set out by ASIC. This submission details how this current draft does not meet these minimum standards for ASIC approval including the fact that the draft Code is not enforceable and does not include any commitments beyond the current legislative requirements. It also outlines our concerns with respect to the current wording of the draft.

It is our strong view that it is incumbent upon the Financial Services Council (FSC) to register the Code, but to do this substantial changes are required to bring it up to the standard expected by ASIC for Code approval. If the FSC chooses not to register the Code it then should detail explicitly and publicly why the it has chosen not to meet the minimum standards set down by RG183.

Enforceable and binding

It is critical that the final version of this Code be binding on, and enforceable against, subscribers through contractual arrangements with consumers: RG 183.20(a) and RG183.25(a). In other words, adherence to the Code must be a term of the contracts of all life insurance policies. This is strongly encouraged by ASIC under RG 183.27.

We also believe that the FSC should make subscription and adherence to the Life Insurance Code of Practice compulsory for membership of the Council. This would speak to the industry’s collective determination to meet minimum standards of practice.

The role of Codes of Practice

¹ http://download.asic.gov.au/media/1241015/rg183-published-1-march-2013.pdf?_ga=1.175469355.84513953.1449719296

² *Regulatory Guidance 183: Approval of financial sector codes of conduct, March 2013, RG 183.3*

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. We are therefore concerned that the current draft of the LICOP includes a number of statements outlining the industry's expectations of consumers. These are outlined in the draft Code's "General Information" and "How you can assist with your application" sections. For example, under *Section 3. When You Buy Insurance* the draft Code states:

"To support us to assess your application correctly and charge you the correct price, we require you to tell us anything that you know might affect our decision to insure you. The law provides us with a number of options if we find out that information relevant to your policy is incorrect or incomplete after the policy has been issued.

"You should ensure the policy you are buying suits your needs, including whether it provides cover that is right for you, whether you will be able to afford the payments, and whether you are already covered under any existing policies. If you have a Representative, they may be able to assist.

If we request information from you or ask you to have an assessment such as a medical examination as part of the underwriting process, the sooner you can provide these, the quicker we can make a decision on your application.

Under section 4. *Replacement Policies* the draft Code states:

If you wish to replace your existing life insurance policy with a policy from another insurer, you may need to go through the application and underwriting process again. Under your new policy, you may not get coverage for any health issues that have come up during the term of the existing policy. You may also be subject to waiting periods before you can make a claim on the replacement policy.

If you apply for a replacement policy, it is important that you don't cancel your existing policy until your replacement application has been accepted, and any additional terms and conditions have been accepted by you, and your policy has commenced.

Section 5. *Non-disclosure and misrepresentation* the draft code states that:

"Before you enter into a contract with us, it is important that you answer any questions we ask you correctly and tell us anything that you know might affect our decision to insure you. This is called your "duty of disclosure"."

Similar expectations and obligations are detailed under section 7.

A Code is 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. A code is not about dictating how consumers should behave or adjusting their expectations.

The Code should therefore be drafted to improve consumer confidence in the industry, not tell consumers how they can assist their own application nor detail the expectations the industry

has of them. To do otherwise would demonstrate a fundamental misunderstanding of what a code of practice is designed to achieve.

To pick one example detailed above regarding buying suitable insurance products, a LICOP should detail how and what steps the industry itself will take to only sell life insurance products that are suitable to an individual's personal circumstances. As currently drafted though, the obligation to buy a suitable life insurance product falls wholly on the shoulders of the consumer. This is not appropriate for a code of practice.

Furthermore Section 4 of the Code regarding Replacement Policies is only about the industry's expectations of consumers and a description of how the industry currently acts, all of which serves to lower consumer expectation of what life insurance can do. There are no commitments, standards or obligations set for the industry to address consumer concerns around replacement policies. This too is not appropriate for a code of practice.

We note that the General Insurance Code of Practice does not include any equivalent wording or framing and only addresses the industry's obligations to consumers and the rights of consumers.

Consequently it is our strong view that the "General Information" and "How you can assist with your application" sections outlined above should be removed. If there are parts of these sections that provide important background information or deal with industry obligations or commitments, then these should be detailed and numbered in the Code. For example the Code should detail the standards the industry will set for itself with respect to the full and clear disclosure of "stepped premiums" and "level premiums" under section 3.

We acknowledge that at the FSC consultation it was suggested that these statements could be a separate set of information available from the FSC as "explanation tools" sitting outside the Code, similar to the general information provided by the Insurance Council of Australia through its "Understanding Insurance" website. We do not oppose the FSC producing materials targeted at consumers explaining life insurance products and processes as long as it sits outside of the Code and does not form part of the Code.

Expectations of Codes of Practice

One of our biggest concerns with the draft code is that, as it stands, the draft does not seem to require life insurers to meet any standard that is not already required of them by the law. If the draft Code does in fact improve on the law, it still only sets a standard which the minimum required of a decent life insurer. This falls far short of the 'best practice' code recommended by the Trowbridge report which stated:

Policy Recommendation 6: That a Life Insurance Code of Practice be developed that is modelled on the General Insurance Code of Practice and aimed at setting standards of best

*practice for life insurers, licensees and advisers for the delivery of effective life insurance outcomes for consumers.*³

A 'best practice' code is also required by the Retail Life Insurance Industry Reforms announced by the Assistant Treasurer in November 2015 which states that:

9. *Life Insurance Code of Conduct to be developed by the FSC by 1 July 2016. Similar to existing codes for Banking and General Insurance, the Code would set out best practice standards for insurers, including in relation to underwriting and claims management.*⁴

The draft also fails to meet the standard set by ASIC Regulatory Guide 183,⁵ that is:

*"effective codes should deliver stronger consumer protection outcomes because ...they set standards that elaborate on, exceed or clarify the law..."*⁶

and

*"It is essential that core rules address existing and/or emerging problems in the marketplace, rather than merely restating the law."*⁷

The draft Code also fails to meet its own objectives as described at cl. 1.6:

"The objectives of the Code are:

- a. To seek continuous improvement within the life insurance industry;*
- b. To commit us to high standards of customer service. "*

We are of the strong view that life insurers are obligated to create a code that sets out best practice for the life insurance industry. As it currently stands this draft does not meet this objective and has not fulfilled what the Government has required of the industry. Unless substantial changes and additions are made, consumers would have little confidence in the Code and we would not be able to support it.

Addressing the problems that prompted development of the Code

Further to the above, we are disappointed that the current draft makes no attempt to address (nor even acknowledge) the problems with churn and poor sales practices that drove the FSC to write the Code in the first place. As mentioned above, this Code was a recommendation of

³ John Trowbridge, Review of Retail Life Insurance Advice: Final Report, 26 March 2015, [http://www.fsc.org.au/downloads/file/MediaReleaseFile/FinalReport-ReviewofRetailLifeInsuranceAdvice-FinalCopy\(CLEAN\).pdf](http://www.fsc.org.au/downloads/file/MediaReleaseFile/FinalReport-ReviewofRetailLifeInsuranceAdvice-FinalCopy(CLEAN).pdf)

⁴ The Hon. Kelly O'Dwyer MP, Minister for Small Business, Assistant Treasurer, *Government announces significant improvements to life insurance industry*, 6 November 2015 <http://kmo.ministers.treasury.gov.au/media-release/024-2015/>

⁵ ASIC, *Regulatory Guide 183: Approval of financial services sector codes of conduct*, March 2013, <http://asic.gov.au/regulatory-resources/find-a-document/regulatory-guides/rg-183-approval-of-financial-services-sector-codes-of-conduct/>

⁶ RG 183.22

⁷ RG 183.60

John Trowbridge's *Review of Retail Life Insurance Advice*,⁸ in turn commissioned by the FSC and the Association of Financial Advisors as a response to ASIC's report 413, *Review of Retail Life Insurance Advice*.⁹ A code written in this context that does not discuss sales practices is at best a missed opportunity. At worst it suggests life insurers are still not willing to face up to the sales and churn problems.

At recent consultation sessions held by the FSC it was suggested that the LICOP cannot set standards for advisers and licensees as they are not bound by the Code and insurers cannot control the conduct of advisers. This is not true. Insurers can set enforceable sales standards through their contracts with advisers and licensees, and require that those parties hold any subcontracted party to the same standard. This would be similar to the enforcement of standards set under Section 9 of the draft Code applying to "third parties dealing with underwriting or claims."

If standards are set down in an industry Code, this will be easy for life insurers to implement – life insurers would simply refer to the Code in their contracts. If all (or most) life insurers are signatories to the Code, then licensees and advisers will be held to the Code standard if they wish to contract with insurers. We think this is the kind of impact John Trowbridge had in mind when he proposed a Code that would raise the standard of the whole industry even though it only bound insurers. For example the Trowbridge report stated that:

*'... lifting life insurer standards will have flow on effects on licensees and advisers and seems the quickest and most effective way for change to be implemented through the industry. This approach has been successful in banking and general insurance.'*¹⁰

Moreover, insurers should want to take an interest in how their products are sold if they care about their reputation, the reputation of their industry, and the welfare of their customers.

One way insurers could encourage improved sales practices would be to conduct random audits of how its products are being sold, and assess sales against a standard set out in the Code. This kind of standard was envisaged by the Financial System Inquiry's recommendation for a product design and distribution obligation.¹¹ Life insurers have an opportunity to lead the financial services industry in introducing this kind of standard for members, as well as getting the opportunity to test how this recommendation would work in practice in their industry. The Code standard could be based on the 'Warning signs of poor advice'¹² and the Life Insurance Advice Checklist¹³ in ASIC's Report 143, and any other standards life insurers choose to include. Life insurers would require parties they contract with to submit to audits as a term of their agreement.

⁸ Policy Recommendation 6.

⁹ ASIC, *Report 143: Review of retail life insurance advice*, October 2014 <http://asic.gov.au/regulatory-resources/find-a-document/reports/rep-413-review-of-retail-life-insurance-advice/>

¹⁰ *The Trowbridge Report* at page 64

¹¹ *Financial Services Inquiry: Final Report*, November 2014

http://fsi.gov.au/files/2014/12/FSI_Final_Report_Consolidated20141210.pdf The obligations proposed by Recommendation 21 include that "issuers should agree with distributors on how a product should be distributed to consumers. Where applicable, distributors should have controls in place to act in accordance with the issuer's expectations for distribution to target markets."

¹² ASIC Report 143, pp62-64

¹³ ASIC Report 143, pp68-71

We have also made further related recommendations below under 'Who does the code apply to' and 'Replacement Policies'.

Detailed comments

The following comments detail our view on the current drafting of the Code and provide recommended corrections, amendments and changes.

Introduction and Objectives

Under Clause 1.7 the draft Code refers to “utmost good faith” rather than the “duty of utmost good faith.” This should be corrected.

Scope of the Code

Who does the Code apply to?

Clause 2.1b references “other industry participants ... who can adopt the Code...” It seems that this should reference those “who adopt” the Code rather than those who can adopt the Code. As we understand it the Code will only apply to those who adopt it.

Clause 2.4 states that

“If you tell us that you have a concern about someone selling or distributing our products, we can tell you how you can have the matter addressed.”

We do not believe this is a sufficient response. Concerns about sales of life insurance were, as mentioned above, the driving force behind ASIC report 413, the Trowbridge report and the current draft Code. Clause 2.4 is an opportunity to acknowledge and respond to those concerns. Where someone raises concerns about how a life insurer’s products are being sold, that insurer should take the report seriously and take responsibility for investigating whether misconduct has occurred. This is consistent with the Trowbridge report’s vision of a Code that raises standards of not only the signatory insurers, but licensees and advisers as well. It would also be more likely to promote trust and confidence in the life insurance industry. At a minimum, we believe this to be too vague and should be more specific and directed. The clause should be expanded to provide specific details of how subscribers will address these concerns. It should also state “we will tell you” rather than “we can tell you” to ensure that this will actually take place. An investigation by the insurer shouldn’t prevent a consumer making their own complaint to the relevant bodies.

When you buy insurance

Advertising and marketing

We note that industry codes should improve consumer protection outcomes and set standards that elaborate on, exceed or clarify the law, as per RG 183.22 and RG 183.60. Clause 3.1 as currently drafted simply states that subscribers will comply with the ASIC good practice guidance. The LICOP should improve consumer protections available through advertising and marketing commitments specific to the life risk product industry that are not currently included in the ASIC good practice guidelines. For example,

- making explicit the nature of stepped premiums and level premiums and not simply giving “a realistic impression of the overall level of fees and costs a consumer is likely to pay”
- prohibiting the use of terms such as “free,” “no cost,” “without cost,” “no additional cost” or “at no extra cost”
- not promoting products to customers in situations where it is evident that the product is worthless or of very low value to that customer; and
- not engaging in high pressure sales practices, practices based on exploiting anxiety or guilt, or other ethically or legally questionable selling techniques.

Application

We note that the standards in this section do not apply to cover under a Group Policy. We understand that under the current law it is the policyholder to whom disclosure rules apply and not beneficiaries, but we question why this should necessarily be the case. We are regularly contacted by clients who are beneficiaries under a Group Policy but are unable to access the disclosure documents or policy. This is particularly problematic in the case of denials. There is a substantial gap here and the formulation of the LICOP provides a real opportunity for life insurers to make group policies more transparent.

We note that in other cases of group insurance – for example travel insurance available via a credit card – the policies are available on the web. It is unclear why this does not similarly occur for life insurance.

We therefore recommend that life insurers at the very least commit to providing greater transparency for beneficiaries of group policies and provide copies of policies to beneficiaries and take steps to improve disclosure generally in this regard.

Underwriting

We note that cl. 3.5 is already a part of the law and does not further address consumer concerns in this area – that is the lack of independent medical assessments. Again we believe that the Code should improve consumer protection outcomes and set standards that elaborate on, exceed or clarify the law, as per RG 183.22 and 183.60. For example, the Code provides an opportunity for the industry to develop standards for the provision of genuinely independent medical assessment – that is, independent of the policyholder and the life insurer.

Our decision

Clause 3.7(g) states that a subscriber to the Code will provide to a policyholder a description of how the price you pay is structured, including whether the policy has “stepped premiums.” We believe that this should be expanded to include projections of likely costs of the premium. It is critical that pricing information is spelt out clearly to consumers for the sake of transparency. Consumers have great difficulty with fully comprehending the financial implications of life insurance products and this leads to a large number of complaints.

Furthermore on the list of information to be provided with policy documentation Clause 3.7 should include

- information and contact details of the subscriber's internal dispute resolution and complaints process;
- in the case of replacement policies, information on what a consumer may potentially be losing and specific information on pre-existing conditions; and
- clear disclosure on the impact of offsets.

With respect to clause 3.8 we note that the draft code states that if the subscriber cannot provide insurance to a consumer they will provide "the reasons for our decision where possible for us to do so." It is unclear to us what circumstances exist that would cause the subscriber to be unable to provide reasons. The obligation arises under s75(4) of the Insurance Contracts Act 1980 that an insured must provide reasons when it relates to the state of health of the life insured. There is no exception. What are the circumstances that would make it not possible to provide reasons? Under the GICOP subscribers to that Code have committed to simply providing the reasons full stop: cl. 4.8. We recommend that life insurers commit to providing the reasons for their decision, with no qualifier. This will promote transparency and understanding in the community.

We further note that this draft Code also differs from the GICOP with respect to what information will be provided on refusal to insure. The draft LICOP does not refer refused consumers to the FSC for information about alternative insurance options or another insurer as GICOP 4.8(c) does. Rather than providing details of the complaints process (as GICOP 4.8(d) does) the draft Code merely states that "you can discuss this with us, and request a review." We do not agree with this approach. Customers should not only be entitled to request a review, they are entitled to have that request heard and to receive a response. We recommend that the draft Code clearly state that consumers who have had their request for insurance refused be provided with details of the subscribers complaints process as well as alternative insurance options.

Ongoing communication

In notifying a policyholder in writing if there is a need to increase the price of their policy outside of the annual policy anniversary under cl. 3.9, subscribers to the Code should provide reasons as to why an extraordinary price increase is warranted.

We also believe that life insurer subscribers to the Code should commit to providing the previous year's premium on the annual renewal notice. Such a move would be an important step in improving price transparency and assist consumers in making more informed decisions. The information at renewal is an important opportunity for consumers to consider their financial situation and make appropriate decisions. Information about (a) the risks of switching and (b) any premium hardship options available under their existing policy may be of benefit to consumers. The industry should consider what best practice may apply at the point of renewal to prevent lapses, unnecessary churning, and other consumer harms. This would be our preference to the "General Information" statements included in the Code.

Cancellation rights

We note that the standards in this section do not apply to cover under a Group Policy. Again we question why this should be the case. Providing information on what the expected standards are for Group Policies and cancellation procedures would be of great benefit so that all life insured consumers can be aware of their rights.

We welcome that customers will be given 20 business days notice before a policy will be cancelled for non-payment of premium: cl. 3.12. This gives consumers two pay cycles to catch up with a missed payment, which will assist people in short term financial hardship. We also note it exceeds the notice required under the GICOP.

However, clauses 3.12 still needs improvement. Providing notice of policy cancellation as late as 28 days after the cancellation is far too slow. We do not see why a letter, email or text message (depending on what contact details the insurer has) cannot be sent on the same day that the cancellation occurs. The Code should also require insurers to offer financial hardship assistance if a customer misses a payment, and be prepared to offer reasonable assistance if it is requested. This is discussed further in our “Financial Hardship” section below.

Replacement Policies

As argued above, we do not believe that the wording in this section is appropriate for a code of practice. However as it currently stands there is no information or commitments made under the replacement policy section. This Code provides an opportunity for life insurers to commit to improving information and disclosure with respect to replacing policies. Rather than providing general information in the Code on what consumers should expect, at a minimum the industry could commit to improving the prominence of warnings and the risks and consequences of replacing a policy.

But moreover, it is unacceptable for this Code to contain no new commitment to prevent irresponsible sales of replacement policies (that is, ‘churn’) given that this problem has dominated all recent debates about consumer protection in life insurance. If the LICOP is going to promote trust and confidence in the industry, this problem needs to be acknowledged and addressed. We suggest that the Code should:

- commit signatories to investigate reported or suspected mis-selling of replacement policies. This investigation could use ASIC's Life Insurance Advice Checklist from report 413 as a way to determine whether replacement advice was appropriate
- report back (at least to ASIC) where they uncover wrongdoing and
- ensure any customers who have suffered a loss are compensated.

Non-disclosure and misrepresentation

We note that clause 5.1 is again simply repeating the law and we would encourage the FSC to elaborate on, exceed or clarify the law in this regard.

There are a number of issues relating to non-disclosure and misrepresentation that we believe should be addressed in the LICOP.

Investigations into non-disclosure and misrepresentation can take place when a claim has been made and is subsequently assessed as well as a random audit during the first 12-36 months of a policy. For those policyholders who have made a claim on income protection insurance it is important that during an investigation that they are not left in the cold through the withholding of payments. For many people, income protection payments are their only source of income. We understand that in a number of cases life insurers do pay a portion of the income protection payments to assist those experiencing financial difficulty whilst an investigation is taking place. This would meet an insurer's duty of utmost good faith. We believe that this should be acknowledged and should be included in the Code.

It is also important that when a policyholder is subject to an investigation into non-disclosure or misrepresentation that they are given the opportunity to review the material that the insurer is relying on – be they application forms or other written or recorded material. Life insurers should commit to providing this material to policyholders – particularly in the case of a claim.

In order to further minimise existing or potential financial hardship non-disclosure and misrepresentation investigations should be prioritised and sped up.

We recommend that the Code include directions to the IDR and Complaints process on making a decision.

Consumers requiring additional support

We support the inclusion of a section that acknowledges the needs of particularly vulnerable consumers. Vulnerable consumers including Indigenous people, those from non-English speaking backgrounds, mature age Australians, those with a mental illness or mental health issues, people with a developmental disabilities, and those with a physical disability need to be identified in the text of the Code. All face considerable difficulties and disadvantages when seeking out life insurance and engaging with life insurers in the claims and complaints process. These needs should be generally acknowledged with specific obligations and commitments made.

The Australian Law Reform Commission has previously recommended that insurance codes:

“contain a diversity statement or objects clause that encourages consideration of the needs and circumstances of a diverse range of consumers. Such a statement should include reference to mature age persons, among other consumers.”¹⁴

We believe that this should be the aim of section 6. However, the draft clauses are far too limited in scope.

The education program proposed in cl. 6.1, for example, is limited *merely* to identifying consumers who are having particular difficulty engaging with life insurers. Once identified the

¹⁴ <http://www.alrc.gov.au/publications/6-insurance/insurance-codes-practice>

draft Code does not commit insurers to actually doing anything about this difficulty. While cl. 6.2 is a positive step with respect to working with vulnerable consumers it is however unclear what it will mean in practice. As a minimum life insurers should commit to training staff on how to engage appropriately with vulnerable consumers at all stages of the life insurance relationship (buying, claims, assessment and investigation). For example, cultural sensitivity training should be a standard practice. Insurers should commit to having appropriate processes and procedures in place to accommodate consumer needs. For example, life insurers should commit to the use of interpreters or TTY services when and where appropriate. Life insurers should also commit to working closely with vulnerable consumers to only provide insurance products that are suitable to their particular circumstances.

To assist life insurers in identifying those consumers who require additional support, we suggest that life insurers commit to including demographic questions on their application forms. This would need to be implemented in a way that makes it clear that the information collected will not impact upon assessment and would need to be voluntary to meet the requirements of the National Privacy Principles (NPP). Under the NPP an organisation cannot require somebody to provide information, but an organisation can collect “sensitive information” including race/and or ethnicity with the consent of the individual.

Clause 6.3 as currently drafted merely recognises that “some groups of consumers ... may require support in meeting identification requirements when buying insurance or making a claim or Complaint.” This is far too limited in scope.

When you make a claim

Making a claim

It is our view that when a life insurer responds to a claim (under cl. 7.3) it should be done so in writing.

Clause 7.4 refers to only asking for and relying on information that the life insurer believes to be relevant to a claim, circumstances and policy. Disputes can arise over what is “relevant” and is an issue that arises with many of our clients. We therefore recommend insurers committing to providing consumers with reasons why the documents and information sought are relevant and include a referral to the internal dispute resolution process where there is an issue on this point.

Furthermore, we have seen authorities seeking medical information from decades before, sometimes over 30 years. This stretches the meaning of “relevancy” beyond what is reasonable and is tantamount to a fishing expedition. We recommend that these kind of practices are constrained and specifically addressed in the Code – particularly with respect to cll. 7.4 and 7.9

Under cl. 7.5 subscribers will only correct errors or mistakes when they are brought to their attention. We believe that this should be extended to include correcting errors or mistakes that subscribers have identified themselves. As it stands there would be no obligation on a life insurer subscriber to correct an error or mistake they discovered themselves. The GICOP cl. 7.4 does have such an obligation. It is therefore recommended that the wording found in GICOP cl. 7.4 should replace the current draft LICOP cl. 7.5:

“Where we identify, or you tell us about, an error or mistake in dealing with your claim, we will immediately initiate action to correct it.”

The GICOP also includes a statement that commits general insurers to not discouraging policyholders from lodging a claim. GICOP cl. 7.8 states:

“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.”

We have had a number of clients who have said that they have been told not to bother lodging a claim or there is no point in lodging a claim, when there is an arguable case that the claim would meet the policy. We recommend a similarly phrased clause be included in the final LICOP.

Assessment and investigation

It is our view that the current wording of cl. 7.7 is unclear and potentially confusing. Specifically it is unclear whether the reference to an “*independent assessment*” in the second sentence is different to the “*assessment by Third Party Service Provider, who is selected by us*” in the first sentence. A truly *independent* assessment is one independent of the consumer and the life insurer. If the draft Code is referring to the same thing in the use of these two phrases then it needs to use the same phrase. At the very least this needs clarifying but we would ideally expect independent assessors – that is independent of the consumer and independent of the life insurer - in all cases.

We are concerned that there is currently no time limit placed upon the provision of a Third Party Service Provider report. This means that the investigation can continue for an unlimited amount of time with little or no recourse provided to policyholders. One of the key complaints Financial Rights receives in its Insurance Law Service is the lengthy timeframes that policyholders are faced with during assessments and investigations. This Code as currently draft does not improve this situation in a number of instances. We therefore recommend in this instance that life insurers meet a 12 week minimum standard timeframe similarly met by general insurers in gathering reports from third party service providers. Clause 7.15 of GICOP states:

If we engage a Third Party Service Provider to provide a report which is necessary to assess your claim, we will ask them to provide their report to us within 12 weeks of the date of their engagement. If the Third Party Service Provider cannot meet or fails to meet this timeframe, we will inform you of this, and keep you informed of our progress in obtaining the report.”

This clause should be included in the final version of the LICOP. Such a clause would provide significant benefits to consumers and insurers alike. One of the key factors in increasing stress levels of consumers is the sheer lack of information regarding how long an assessment will take. By letting consumers know that a report will be gathered in three months this will at the very least ease the stress brought on by the unknown. Consumers would similarly benefit from being told after three months that a report has not been completed, the reasons why and be provided with a timeline for it to be completed, in the situation where it has taken an expert

assessor longer than the three months. This decrease in consumer stress can have positive side effect for insurers in potentially decreasing the number of constructive denial claims. Finally introducing a three month timeframe could also lift standards in report writing by third party service providers.

Furthermore specific timeframes should be instituted when keeping claimants informed about the assessment and investigation of their claim. Clause 7.10 as currently drafts merely states that the insurer will make an arrangement for keeping the consumer regularly informed. This is not acceptable. We recommend that life insurers commit to keeping claimants informed of the progress of their claim at least every 20 days as general insurers do under cl 7.13 of the GICOP.

We support the recommendation made by the Australian Lawyers Alliance in its submission with respect to cl. 7.9, that is, that life insurers should commit to notifying the policyholder of their need to speak to the policyholder's doctor and seek the policyholder's signed authority before doing so.

Our decision

The current draft of the LICOP does not place a time limit of the total amount of time it will take to assess and investigate a claim. General insurers have committed to a four month time limit from receipt of the claim: GICOP cl. 7.17. We see no reason why life insurers could not make a similar commitment. We therefore recommend the inclusion of the following clause:

Our decision will be made within four months of receiving your claim. If we do not make a decision within four months, we will provide details of our Complaints process

We note that the current draft cl. 7.12 commits subscribers to make a decision within 10 business days once they have all the information they need and have completed the investigation. The interaction of this clause with cl. 7.3 regarding responding to a claimant within 10 days is confusing. It is unclear whether this means that when a policyholder makes a claim and, at the time of making that claim they provide all the information that the insurer requires, the maximum amount of time a life insurer has to finalise the claim is 20 days or 10 days. We recommend to avoid confusion that the following sentence (drawn from GICOP cl. 7.9) should be included in the current draft 7.3:

If you make a claim and we do not require further information, assessment or investigation, we will decide to accept or deny your claim and notify you of our decision within ten business days of receiving your claim

We are also concerned about the impact upon consumers when an insurer makes a lump sum payment. We are aware of a number of clients who have been provided with a lump sum payment days before the end of the financial year. This has significant detrimental tax implications for the policyholder. We believe that the Code needs to include a commitment to fully inform consumers of the tax and legal implications of a lump sum and to ensure that consumers are provided with enough time before the end of the financial year to receive appropriate financial advice.

Ongoing management

Clause 7.15 and 7.16 state the following:

If your claim requires ongoing management, we will make an arrangement with you for keeping in regular contact to review the progress of your claim.

We will tell you what information we need you to provide and when it needs to be provided in order to assess your claim on an ongoing basis. This can include regular medical reports, although in some cases, we may determine that you do not require these.

These clauses are too vague and unclear and lack any real commitment to improve the consumer experience of an ongoing claim. The Code should include actual timeframes, limiting the frequency of ongoing contact to reasonable levels that do not impede upon the lives of policyholders experiencing hardship. The most common complaint heard by solicitors in the Insurance Law Service from life insurance policyholders is the frequent, disruptive, highly bureaucratic and sometimes unwarranted ongoing management practices of life insurers. Financial Rights solicitors regularly hear from policyholders suffering from serious, debilitating health issues that are either not improving over time or are deteriorating, but where the policyholders are subjected to monthly reporting. It is our view that in many of these cases this level of reporting is excessive and burdensome on those experiencing from significant physical and/or mental health issues. We would expect this key consumer issue to be acknowledged and addressed in a constructive manner in the final Code. As it currently stands, the draft Code does little to assuage these concerns and provides no framework in which to limit inappropriate life insurer behaviour and poor industry practice.

Clause 7.19 requires signatories to contact a customer to let them know when an ongoing claim is coming to an end. This clause should include a timeline, for example, that the insurer will make the contact at least 90 days before the claim is coming to an end, or 'as early as possible'. Furthermore, the Code should include a commitment to providing policyholders with a warning a month before the expiration of a claim.

Compliance with timeframes

The requirement in cl. 7.21 that a life insurer must comply with timeframes is completely undermined by the qualifier 'unless our conduct and the timetable were reasonable in all the circumstances'. This allows a signatory to unilaterally decide that they need not adhere to a timeline imposed by the Code. These words should be removed.

We are also concerned that there is no clause under Section 7 that deals with claimants who have an urgent financial need. This is a common problem and needs to be addressed. The GICOP includes the following cl. 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.”

We believe the same or similar clause should be included in the final Life Insurance Code of Practice as it is consistent with the duty of utmost good faith and current practice.

Complaints and Disputes

We note that a complaint about a life insurance product owned by a superannuation fund is twice as long at 90 days as one not owned by a superannuation fund. This is presumably because of s. 19 of the Superannuation (Resolution of Complaints) Act 1993. We believe that a total of three months to deal with a complaint is completely unreasonable and would have a severe impact upon policyholders suffering financial hardship, injury and/or illness. This Code provides the opportunity to improve this service and we recommend that a shorter timeframe be considered.

Standards for third parties dealing with underwriting or claims

We support the recommendation made by the Australian Lawyers Alliance in its submission with respect to cl. 9.3, that is that life insurers should require third party service providers act with honesty, fairness, transparency and timeliness to the policyholder claimant when providing their services..

Clause 9.4 states that subscribers will

“only enter into contracts with Third Party Service Providers who reasonably satisfy us of their expertise, experience or qualifications, and who hold any required Federal, State or industry licensing.”

We note that there is substantial ambiguity with respect to whether some insurance investigators need to be licensed at all. For example, there are no investigator licensing regulations or scheme in the ACT. All existing state licensing schemes exempt insurance companies, loss adjusters and their employees from the need to be licensed as a private investigator.¹⁵ This means that some of the investigators working in insurance investigations will be licenced and others will not. The variability of regulations, dearth of minimum standards applying to private investigator behaviour and a lack of clear avenues of redress applying to the conduct of investigators is a disappointing feature of this broader regulatory framework.

We recommend that to remove any potential ambiguity and variability in whether a third party investigator needs to be licensed, life insurers should commit to using only licensed investigators. To ensure the highest quality of provider is used by the industry these providers

¹⁵ Tasmania requires the loss adjuster to be a member of the Australian Institute of Chartered Loss Adjusters. Significantly South Australia exempts “a person employed under a contract of service by a [loss adjuster] while acting in the ordinary course of that business.” This has the potential of including private investigators solely working in the fraud investigation field for loss adjusters under a contract of service. In its Code of Conduct the Australian Institute of Private Detectives refers to this potential ambiguity when it states:

it is contestable in the majority of the State based licensing regimes in relation to Commercial Investigations, as to whether a person requires a license at all in order to conduct investigations when engaged by insurance companies or authorised deposit taking institutions (ADI's) under the Commonwealth Banking Act 1959. (p14 http://www.aipd.com.au/pdf/COP_Adopted220908.pdf)

should demonstrate their expertise, experience, education, training *and* qualifications. As currently drafted providers do not have to demonstrate that they have been appropriately trained as an investigator. For example they simply have to demonstrate that they have “experience” in the area. This minimal standard could potentially mean anything and is a very low bar. We note that the GICOP cl. 6.3(a) refers to “education” and “training”. We therefore recommend amending cl. 9.4 as follows:

“only enter into contracts with Third Party Service Providers who satisfy us of their expertise, experience, education, training and qualifications, and who hold Federal, State or industry licensing.”

We note and support the inclusion of cl. 9.5 which states that

“We will only rely on reports we request Third Party Service Providers to prepare in relation to your policy or claim that are impartial and objective.”

In order to bring further clarity to this objective approach, we recommend the inclusion of a subsequent sentence stating:

“All circumstances detected in the production of a Report, whether positive or negative for the parties involved, shall be taken into account with equal weight.”

Clause 9.6 of the draft Code asserts that subscribers will:

“require Third Party Service Providers to maintain confidentiality of your information, and only use that information for the purpose of the service they are providing.”

In order to clarify this further we recommend including the following sentence:

“Third Party Service Providers will meet requirements of the Privacy Act 1998 and all state surveillance legislation”

Clause 9.7 deals with the complaints process with respect to Third Party Service Providers. We note that subscribers will handle the complaint if:

“It has not already been addressed by the Third Party Service Provider.”

We cannot accept this. The reason is that we have serious concerns with respect to the complaints processes of third party private investigator services. There are a large number of private investigator services engaged by the life insurance industry. Very few of them have complaints procedures in place. There are also over 12 private investigator associations in Australia and while a few of the associations have outlined disciplinary procedures in their codes, only a handful of associations include clear processes and information relating to the raising of complaints on their websites.¹⁶A particularly noteworthy example is the process of the Institute of Mercantile Agents who provide significant details of their complaints

¹⁶ The Australian Investigators and Security Professionals and National Security Association of Australia (Qld) Inc have somewhat difficult to find complaints policies on their websites. The Australian Security Industry Association has an online dispute resolution form on their website.

procedure on their website¹⁷ include a lodgement fee of \$220.00 (incl GST) for each complaint, payable by the complainant at the time the complaint is lodged. This is completely unacceptable.

Ultimately third party service providers are acting on behalf of a life insurer and representing that insurer to policyholders. It is therefore the life insurer's responsibility to deal with all complaints regarding the service being provided on their behalf. We also note that General Insurers have committed to dealing with all complaints about Service Providers in Section 6 of the GICOP. We therefore recommend removing the words:

"if has already been addressed by the Third Party Service Provider."

Standards for Investigators

We recommend that the standards set for investigators be bolstered. Consumers hold serious concerns with respect to the process of investigation including poor communication practices, aggressive or unethical investigator behaviour or investigation processes, unreasonable requests for information and/or documentation and the ongoing pursuit of investigations with little or no evidence.

The Victoria Workcover Authority has developed a Code of Practice for Private investigators that seeks to address many of the issues policyholders have with investigator behaviour.¹⁸ NSW Motor Accidents Authority too has a Code of Conduct for Claims Assessors¹⁹ and Claims Handling Guidelines for CTP insurers.²⁰ Given the particular concerns in this area and the precedent set by the Victorian Workcover Authority and the NSW Motor Accidents Authority, cl. 9.8 of the LICOP should include the following:

- a commitment to standard, clear and thorough communication practices to policyholders subject to investigation including:
 - investigators fully identifying themselves and on whose behalf they are acting;
 - investigators explaining the exact reason for contacting the policyholder;
 - investigators leaving a business card if the policyholder is unavailable;
- setting standards and behaviours expected to be upheld in organising and conducting interviews including:
 - providing the policyholder with their choice of venue;
 - a limit on both the duration of an interview and the number of interviews, that is no more than two interviews of two hours each;
 - the right to request breaks;
 - the right to a shorter interview to meet responsibilities;
- the right of the policyholder to be accompanied by an independent support person;
- the right of the policyholder to an interpreter where appropriate;

¹⁷ http://www.imal.com.au/index.php?option=com_content&view=article&id=40&Itemid=51

¹⁸ Victorian WorkCover Authority, Code of Practice for Private Investigators Version 2.0, Effective 1 November 2014, https://www.worksafe.vic.gov.au/_data/assets/pdf_file/0004/8707/VWA-Code-of-Practice-for-PIs-Final-Authorised-2014.pdf

¹⁹ <http://www.maa.nsw.gov.au/media/publications/for-professionals/Claims-Assessor-Code-of-Conduct-2013-to-2016MAA292.pdf>

²⁰ <http://www.maa.nsw.gov.au/media/publications/about-us/maa-claims-handling-guidelines>

- the right to being interviewed by an investigator of the same sex;
- only recording an interview with the permission and authorisation of the policyholder;
- if an investigator knows that a policyholder is legally represented, it must make all reasonable efforts to contact the legal representative to obtain consent to interview the policyholder;
- ensure that if an investigator does not know whether a policyholder is legally represented, it must first ask the policyholder if they are legally represented;
- a commitment to comply with any reasonable restrictions placed on the interview by the interviewee and/or their legal representative;
- compliance with all state and federal surveillance and privacy laws;
- stricter surveillance commitments to ensure that an investigator:
 - does not conduct surveillance on business premises;
 - does not communicate with a neighbour, work colleague or other acquaintance of a policyholder, in a way which might directly or indirectly reveal that surveillance is being, will be, or has been conducted or imply that the policyholder is involved in dishonest conduct;
 - does not record film inside any court, tribunal, conciliation or mediation service or centre, or any other quasi-judicial facility;
 - does not record film inside any medical or health service or centre;
 - avoid any act or behaviour which might unreasonably interfere with a person's legitimate expectation of, or right to, privacy including but not limited to the recording of family or friends, the recording of someone within their residential premises, within change rooms, showers, toilets bedrooms, lactation rooms, swimming pools, gyms, educational facilities or at religious or ceremonial occasions;
- in mental injury claims, insurers commit to the use of only investigator with a minimum of 5 years relevant experience and who has completed appropriate training;
- a prohibition on any form of pretext activity, that is, any conduct or communication that conceals the true reason for that activity;
- a prohibition of entrapment or the use of dishonest or illegal means including any attempt to induce a policyholder to enter into a situation in which that person would not ordinarily enter;
- a prohibition on making any threat or promise, or offer any inducement to *any* person when conducting an investigation;
- a prohibition on seeking or accepting from, or offer to, any person any gifts, benefits or rewards in connection with an investigation, other than modest hospitality such as light refreshments; and
- maintaining and keeping written contemporaneous records of all investigation activities (including conversations held in person; telephone conversations, unanswered calls and messages left, letters and other correspondence; travel, statements obtained and electronic checks including on government and social media sites) and retained for 7 years.

We also support the recommendation made by the Australian Lawyers Alliance in its submission with respect to cl. 9.8 regarding the life insurer having a reasonable basis for

believing that the policyholder has given inconsistent information to it on a claim. This reasonable basis must be held prior to initiating surveillance and not be based on an unconfirmed suspicion which the life insurer hopes to later confirm through surveillance.

Information and Education

Clause 10.1 states that subscribers will:

make our customers aware of the Code, which may include providing information about the Code on our websites and in our product information where it is appropriate to do so.

We cannot think of a time when it would be inappropriate to make customers aware of the Code. We therefore recommend the removal of the words “where it is appropriate to do so.”

Clause 10.4 states that

The FSC may develop guidance documents from time to time, which are not binding on us but assist us in meeting our obligations under the Code.

We believe there is no point to developing guidance documents that are not binding. It is therefore a meaningless clause with no commitment whatsoever. We also note that this non-binding nature is not included in the equivalent clause under the GICOP cl.11.3. We recommend replacing the words “which are not binding on us but” with the word “to”.

The GICOP also includes clauses relating to the reporting of any recommendations on the Code (cl. 11.4) and initiating programmes to promote literacy and education (cl. 11.8 and 11.9). We cannot see any reason why these would not be supported by the life insurance industry. We note that ASIC RG 183.78 (f) and (g) state that:

The Code administrator should also be responsible for...

(f) recommending amendments to the code in response to emerging industry or consumer issues, or other issues identified in the monitoring process;

(g) ensuring that the code is adequately promoted

We therefore recommend the insertion of the following three clauses:

The Life CCC may include any recommendations on Code promotion in its quarterly reports to the FSC Board.

We will work with the FSC to initiate programmes to promote insurance, financial literacy and the insurance industry, and we will support FSC initiatives aimed at education on general insurance.

The Life CCC may include any recommendations on education relevant to the operation of this Code in its quarterly reports to the FSC Board.

Code Governance

Role of FSC

Clause 11.2 asserts that the FSC is responsible for “commissioning formal reviews of the Code.” It is important that these reviews are conducted by an independent party and not simply the FSC or related organisation. We note that the equivalent clause under the GICOP (cl. 12.7) does involve “independent reviews”. There is no reason why this cannot be the same here. To do otherwise would not meet the minimum standard set by ASIC RG 183.82-85 which requires reviews of a Code to be independent. We therefore recommend amending this clause to ensure that reviews are conducted by independent parties.

Furthermore the Code should include the ability for the FSC to develop the Code on an ongoing basis in consultation with consumer groups and other stakeholders, similar to clause 12.8 of the GICOP. We recommend the inclusion of the following words in the Code:

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

Monitoring, enforcement and sanctions

Our responsibility

Clause 12.7 asserts that subscribers will:

apply fair and reasonable corrective measures within set timeframes, in consultation with the Life CCC, in response to a Code breach.

We note that the equivalent GICOP cl. 13.6 ensures that corrective measures will be *agreed with* the CGC – not *in consultation*. By including the words “in consultation” there is no compulsion upon the subscriber to come to an agreement with the Life CCC when instituting corrective measures. This indirectly undermines the binding nature of the Code. We therefore strongly recommend that the words “in consultation” be removed and replaced with “as agreed.”

Life CCC Responsibility

It is our view that there should be a statement in this section that explicitly states the following:

The Life CCC is responsible for monitoring and enforcing compliance with this Code

We are also concerned with some of the wording found in this section. Firstly cl. 12.8(c) states that the Life CCC will “use its discretion to investigate alleged breaches in accordance with the Code.” This should not be a sweeping discretion and should only be used in the case where the allegation is clearly frivolous. Otherwise the Life CCC should investigate every alleged breach in accordance with the Code.

Secondly, the Life CCC will “agree with [the subscriber] any fair and reasonable corrective measure(s) to be implemented by [the subscriber]”. This suggests that the Life CCC would not be able to impose any sanction unless the life insurer agrees on the sanction. If this is a correct reading this should be re-worded to ensure that a life insurer cannot escape an appropriate sanction from an independent committee. We also note that the words “fair and reasonable”

are not found in the equivalent clause 13.9(c) in the GICOP and, when combined with the previous observation, looks to be a potential subjective judgement to further avoid potential corrective measures and relevant timings.

Thirdly, this same subclause includes the words “taking into account any corrective measures related to the breach agreed with us or imposed on us by any regulatory body.” This too has the potential to lower or avoid a corrective measure on the basis that life insurers have been directed elsewhere. We recommend its removal.

Finally, we recommend that the Life CCC be empowered to provide recommendations on Code improvements to the FSC board, just as the CGC is empowered to do under GICOP cl. 13.10. This is an important power to ensure that the life insurance Code is a living document that responds to issues that arise. We therefore recommend the insertion of a cl. 12.10 that states:

The Life CCC may provide any recommendations on Code improvements as a response to its monitoring and enforcement, in its quarterly reports to the FSC Board.

Sanctions

We note similar to cl. 12.8 the phrases:

“any measures related to the breach agreed with us or imposed on us by any regulatory body;”

and

“taking into account any rectification related to the breach agreed with us or imposed on us by any regulatory body”

appear in cll. 12.13 and 12.16 in relation to the determination of sanctions. Neither phrase appears in the equivalent GICOP clauses. We are concerned that these will be used to avoid the imposition of effective sanctions with claims that the life insurer has already had a sanction or recitation imposed upon them elsewhere. We therefore recommend their removal.

Access to information

Under cl. 13.4 the draft Code lists those special circumstances that subscribers may decline access to or disclosure of information. Included at 13.4(f) is:

“where we reasonably believe that the information is commercial-in-confidence.”

We do not support the inclusion of this subclause. Anything and everything can be deemed commercial-in-confidence from the way an investigation is conducted to a proprietary form of document storage or handling. It is unreasonable to deny access to information on this ground and denies consumers natural justice. We note that this clause does not appear in the equivalent clause in GICOP: cl. 14.4. There is no significant qualitative difference between the general insurance sector and the life insurance sector that would necessitate or justify its inclusion in a final LICOP. This should be removed.

At cl. 13.5 when a subscriber declines a claim the draft Code commits the subscriber to “provide details of our Complaints process if you are unsatisfied with our response.” This unreasonably places the burden on the consumer to inform the life insurer that they are unsatisfied before they receive the information regarding their complaints process. We are of the view that this information should be provided in all circumstances as a matter of course. This is what occurs in the general insurance sector as per GICOP cl. 14.5. Again we see no reason why this should be any different in the life insurance sector.

Clause 13.6 states that if a consumer requests any of their policy documents from their life insurer, the subscriber will provide this to the policyholder “promptly and in an electronic form” if they request. “Promptly” is far too vague and subjective. We recommend that this be within one business day.

Furthermore life insurers should commit to providing policyholders with a copy of the applicable underwriting guidelines that were in operation at the time the insurance contract was entered into and a supporting statutory declaration as per the Australia Lawyers Alliance submission. This would be consistent from the FOS Circular regarding the Duty of Disclosure regarding insurance contracts.²¹

Financial Hardship

A major omission in the draft Code is any consideration of Financial Hardship. This is a key concern of our clients who generally face significant financial pressures and hardship. It is unclear why a Financial Hardship section has not been included in the draft. Addressing the financial hardship of customers in appropriate ways has become standard operating practice for the banking, utilities and general insurance industries. It is important that the life insurance industry also address this issue within its code of practice. While section 8 of the General Insurance Code deals largely with financial hardship issues with respect to monies owed to an insurer, it can act as an example of the type of commitment that the FSC should make in its own Financial Hardship section.

We recommend addressing a number of issues. Firstly, as outlined above, income protection insurance payments are often a policyholder’s only source of income. Withholding these payments in the circumstances of a claims investigation can have a significant financial impact upon the policyholder. We understand that in a number of cases life insurers pay a portion of the income protection payments to assist those experiencing financial difficulty whilst an investigation is taking place. This would meet an insurer’s duty of utmost good faith. We believe that this should be acknowledged and consideration should be included in the Code.

We also reiterate the need to consider the fast-tracking of assessments, where possible, for those claimants who have urgent financial need. Clause 7.7 of the GICOP provides a good basis from which this Code can draw.

Finally, any hardship section in a LICOP should apply to customers who are having difficulty paying premiums. We note that there are a significant proportion of policyholders who have a premium waiver option included in their policy. This is an important protection in times of

²¹ <https://www.fos.org.au/circular3/Nondisclosure.html>

illness, injury and financial hardship. In many cases the policyholder is unaware that they have a premium waiver option and have subsequently sought a replacement policy when hard times have hit. Life insurers should commit to ensuring that these policyholders are aware of this option and any other options available before replacing their coverage. This could involve a commitment to providing this information on renewal notices and conducting semi-regular reviews of older policies.

Problem products and sales practices

There is now ample evidence about consumer problems with funeral insurance²² and consumer credit insurance.²³ It is time for the life insurance industry to acknowledge those problems and commit to either improving the value of these products or stop selling them.

As a start, we recommend the Code commits insurers to:

- addressing the high lapse rate of funeral insurance products by
 - capping premiums at the benefit amount, and applying the caps retrospectively;
 - providing real responses for consumers who buy funeral insurance and later struggle to make payments because of financial hardship;
 - not selling funeral insurance cover without first making a proper assessment of whether the customer can afford the cover;
 - giving a proper explanation of how the cost of a funeral insurance premium will change over the life of a policy. This should involve customers having access to standard, interactive modelling software that shows them how much their product will cost over the life of the policy;
- immediately stop sales of funeral cover for people aged under 18; and
- stopping allowing any life cover to be sold through the 'add-on' sales technique;
- not allowing products to be sold through pressure sales techniques, by preying on guilt and anxiety or any other sales tactics that are legally or ethically questionable. Insurers should make their sales scripts publicly available to prove that they are making an effort to improve sales processes.

Definitions

²² Most recently, see ASIC Report 454, *Funeral Insurance: A Snapshot*, 29 October 2015

<http://asic.gov.au/regulatory-resources/find-a-document/reports/rep-454-funeral-insurance-a-snapshot/>

²³ See ASIC reports 256: *Consumer credit insurance: A review of sales practice by authorised deposit taking institutions*, 19 October 2011 <http://asic.gov.au/regulatory-resources/find-a-document/reports/rep-256-consumer-credit-insurance-a-review-of-sales-practices-by-authorised-deposit-taking-institutions/> and ASIC Report 361: *Consumer credit insurance policies: Consumers' claims experiences*, 31 July 2013, <http://asic.gov.au/regulatory-resources/find-a-document/reports/rep-361-consumer-credit-insurance-policies-consumers-claims-experiences/> and Consumer Action Law Centre's *Junk Merchants* report, December 2015 <http://consumeraction.org.au/junk-merchants-report-how-australians-are-being-sold-rubbish-insurance-and-what-we-can-do-about-it/>

The definition of “Significant Breach” in this draft Code is almost exactly the same as that found in the GICOP except that the draft LICOP definition has removed “duration of the breach.” We recommend including “duration of the breach” since this is an important factor in determining significance.

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 us on the details below.



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