Insurance Claim Delay

Description

This fact sheet is for information only. It only applies to general insurance claims (like home and contents, motor vehicle, sickness and accident, travel, pet, consumer credit policies). It does not apply to some types of insurance, such as life or health insurance. You should get legal advice about your personal situation.

Main ideas

• The insurer should process your claim within fixed timeframes (General Insurance Code of Practice).

• You can complain if there are unreasonable delays to your claim – even within the timeframes.

• If you are in urgent financial need, you can ask for the insurer to fast track your claim, or for an advance payment.

• If your insurer's complaints department won't help, you can go to the Australian Financial Complaints Authority (AFCA) – which is free and independent.

In this fact sheet:

Fast-tracking urgent claims

Complain if the delay is unreasonable
• Complain to the insurance company
• Complain to the Australian Financial Complaints Authority (AFCA)

These timeframes are defined in the General Insurance Code of Practice.

Claim to first decision – 10 business days

Within 10 business days of receiving your claim, the insurer must either:

- decide to accept or reject your claim
- tell you they need more information, or they are investigating or assessing your claim. They must tell you:
  o what information they need
  o whether a loss assessor will be appointed
  o an estimate of the time needed to decide your claim.

The insurer should do their best to ask for all the information they need from you in one go, to avoid having to come back with more requests. But sometimes they may have more questions after they later discover something new.

For total loss claims on home or contents policies, insurers should not ask you for a list of insured property that was lost or damaged –if your ownership of those items is clear and your proof of ownership was lost in the event you are claiming for. **Get legal advice if you think the insurer is acting unreasonably.**

How long does a claim take – 4 or 12 months

The Code sets out maximum timeframes for an insurer to decide on your claim. This does not mean the insurer can sit on your claim for that time, they must move your claim forward in a fair and reasonable way. They may be gathering more information, or getting expert reports, or quotes, or second opinions.

If no exceptional circumstances: they must decide to accept or deny your claim within 4 months of receiving it.

If there are exceptional circumstances: they must decide to accept or deny your claim within 12 months of receiving it.

Exceptional circumstances include:

- An extraordinary catastrophe or disaster – for example, floods or bushfires where there are a large number of claims at once. Announcements are made by Insurance Council of Australia and publicised in the media. High claims numbers and a shortage of assessors, experts and repairers can slow the process down.
- Fraud or a reasonable suspicion of fraud. See our Insurance Investigations fact sheet and get legal advice straight away if you are concerned.
- If you don't respond or don't provide documents or information the insurer reasonably asks for.
- If it is difficult for the insurer to contact or communicate with you, and it's beyond the insurer's control (for example, if you change your contact details without telling the insurer).
- You ask the insurer to delay your claim.

You do not need to wait 4 (or 12) months to complain. If you think the insurer is unreasonably delaying your claim, you can complain at any time.

When the insurer has all the information they need – 10 business days

When the insurer has all the information they need, they must either accept or deny your claim within 10 business days.

What happens with your claim?

There are some fixed timeframes for things that may happen with your claim:

The insurer appoints a loss assessor – 5 business days

Usually, the first step is the insurer will send out a loss assessor or adjustor to look at the damage. They form an initial opinion about how the damage happened and whether it should be covered by the policy, and the likely scope of repairs or amount of the claim. Sometimes they may say further experts or investigations are needed.

The insurer must tell you they have appointed a loss assessor or investigator within 5 business days of making the appointment.

Report from an external expert – 12 weeks

If an insurer decides they need an external expert to give them a report, the final report must be completed within 12 weeks. If it is not done by then, the insurer must keep you informed about the progress of the report.

You can ask for a copy of the report and any other information the insurer is using to decide your claim. There are very limited reasons for an insurer to withhold information or reports – if that happens, get them to explain in writing why they will not provide it and get legal advice.

When you ask for information – 10 business days

If you ask for information about your claim, the insurer must respond with 10 business days.

The insurer must keep you informed – every 20 business days

At least every 20 business days, the insurer must give you an update on the progress of your claim.

Other timeframes by agreement

If the timeframes are not practical, you can agree different timeframes with the insurer. If you don't agree to the timeframes suggested by the insurer, you can complain.

Fast-tracking urgent claims

If you show your insurer that you are in urgent financial need because of the claim event (for example, fire, flood), they can fast-track your claims process.

The insurer can also pay you an advance amount within 5 business days. But the insurer may need to first make sure you are entitled to benefits (sometimes there may be issues such as whether exclusions may apply).

Be careful about how you spend the advance payment, especially if there's any part of your benefit in doubt. Will there be enough money left later to finish essential repairs or replace essential items?

If your claim was finalised within 1 month after a catastrophe, you still have another 12 months from when your claim ended to ask for a review – even if you already signed a settlement or release. Catastrophes are high claims events like flood or bushfire, and you will see it announced by the Insurance Council of Australia (ICA) in the media. The ICA website has further details about help after disasters.

Complain if the delay is unreasonable

If you think the insurer is unreasonably delaying your claim, you can complain. You do not need to wait for 4 (or 12) months, or any of the other timeframes set out above.

Insurers must act fairly and reasonably towards you, and have to consider your

circumstances – so make sure the insurer understands any hardship or urgency you face. Tell them about any financial hardship, language or literacy barriers, family violence, remoteness, disability or mental health issues, or other issues. Insurers need to take extra care with customers who experience vulnerability.

Complain to the insurance company

Complain to your insurer's complaints department (internal dispute resolution) about the delay.

You can use our sample letter to make a complaint to your insurer. There is more information on our fact sheet about Insurance Complaints to AFCA.

The insurer should send you a written response to your complaint within 30 days, including the reasons for their decision.

Complain to the Australian Financial Complaints Authority (AFCA)

If the insurer does not resolve your complaint with 30 days, you can complain to AFCA online or by calling 1800 931 678. Make sure you get a complaint case number.

Complaining to AFCA is free. You do not need any legal representation to complain – but you might want legal advice if you are unsure of your rights or help understanding what evidence you need, or what outcomes to ask for. AFCA is independent and will not give you legal advice.

Our fact sheet about Insurance Complaints to AFCA has information about lodging with AFCA.

Ask for interest to be added to your claim

If the insurer has unreasonably delayed your claim, you can ask for interest to be paid from the date the insurer should reasonably have paid your claim.

Read AFCA's process for awarding interest.

Ask for compensation for non-financial losses

AFCA can award up to $5,400 for excessive inconvenience, stress or anxiety caused by the insurer. If possible, provide evidence of the problem, such as medical certificates, or a clear timeline of what happened during your claim. AFCA can be very conservative with this type of loss

Read AFCA's process for awarding non-financial loss.

Need more help?

For a list of other helpful resources visit our Useful Links page.

Last updated: November 2022