



**Submission by the
Financial Rights Legal Centre**

Insurance Council of Australia

General Insurance Code of Practice 2017 Review

April 2017

About the Financial Rights Legal Centre

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

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

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

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

Or sign up to our E-flyer at www.financialrights.org.au

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

Monday – Friday 9.30am-4.30pm

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Introduction

Thank you for the opportunity to comment on General Insurance Code of Practice 2017 Review.

The Insurance Law Service (**ILS**) is the only national, free and independent insurance advice service for consumers in Australia operated by the Financial Rights Legal Centre (**Financial Rights**). The ILS provides information and advice over the telephone or via e-mail. We have extensive resources for consumers available on our website www.insurancelaw.org.au and act for consumers in disputes with insurance companies by negotiation, or by assisting them to run a dispute in the Financial Ombudsman Service (**FOS**).

Since 2007, demand for the Financial Rights' national ILS has consistently increased from close to 700 calls in 2007-08 to over 8500 calls in the last financial year. Because of the wealth of experience we have gained over the years we are well-placed to comment on law reform and policy change in the insurance industry, including code reviews. We put in extensive submissions on behalf of consumers to the 2012 and 2009 General Insurance Code Reviews, many of which are repeated below.

Financial Rights believes that the general insurance industry is at least 20 years behind the banking sector in terms of addressing basic consumer issues be it in claims handling, mis-selling, unfair contract terms, disclosure problems and the creation of problem products and business models. Financial Rights strongly believes that that there needs to be a fundamental shift in the general insurance sector to one based upon the concepts of suitability (the insurance equivalent of responsible lending in the banking and credit sector) and the standard cover model.

List of Recommendations

ASIC Code approval

1. The ICA should seek approval from ASIC of an improved General Insurance Code in accordance with RG 183. Improvements should include (but not be limited to:
 - a. code enforceability including the General Insurance Code forming a part of the contract with a Consumer;
 - b. mandatory three year independent reviews;
 - c. addressing all stakeholder issues identified in this Review; and
 - d. bolstering appropriate remedies and sanctions.
2. ICA membership require mandatory subscription to the General Insurance Code

3. The General Insurance Code should be extended to incorporate all members of the industry involved in the insurance process, as much as is practicable to bind all insurance industry participants to the General Insurance Code. Adoption of the General Insurance Code should be a condition of authorisation by APRA under the Insurance Act 1973.

Section 4: Buying insurance

Suitability

4. Insurance products should be suitable and insurance companies should be required by the General Insurance Code to seek information from the consumer on what they need from their insurance and ensure the product sold is suitable.

No Advice Model

5. General Insurers give serious consideration to shifting away from a No Advice model and that consideration be given to whether this could be a commitment under the General Insurance Code.

Disclosure obligations for Insurers

6. PDS documents should not be eliminated, and should continue to be available to consumers for every insurance policy that they have purchased.
7. Insurers need to meet both the letter and the spirit of the KFS regulations and should make appropriate commitments under the General Insurance Code to ensure that:
 - a. KFSs are made available on websites in a consistent and obvious manner
 - b. Information provided on KFSs is not simply a list of links to PDSs but are actual brief explanations of the coverage.
8. Subscribers to the General Insurance Code should commit to providing cover for pre-existing defects when the consumer was not aware of the defect at the time they took out the insurance policy.

Duty of Disclosure: Point of Sale Verification of Consumer Disclosures

9. The General Insurance Code require insurers to check any consumer records that the insurer has ready access to at the point of sale in order to verify certain consumer disclosures including the consumer's:
 - a. Insurance report;
 - b. Driving history; and
 - c. Criminal history.

Standard Cover

10. The General Insurance Code should commit subscribers to no longer contracting out of the standard cover provisions in the *Insurance Contracts Act*; or in the alternative
11. The General Insurance Code should include a commitment to clearly state, in a standardised form, in all communications including the PDS and website that an insurance product diverges from standard cover.

Sales practices

12. In addition to the commitments with respect to sales practice already in the General Insurance Code, general insurers should make specific commitments on sales practices including:
 - a. standards for telephone and internet sales
 - b. the right to an interpreter when an insurer is put on notice that a person does not understand the terms being explained to them
 - c. banning automatic renewals
 - d. recording the sales process and keeping the recording for at least six years.

Sales Practices: Add-on Insurance

13. The General Insurance Code should include a commitment that insurers will stop allowing their products to be sold as add-ons.
14. Alternatively the General Insurance Code include an appropriately formulated delay regime including an opt-in days after the sale of the loan initiated by the consumer.
15. The General Insurance Code should establish a consistent public reporting regime requiring insurers to fully and transparently publicise their claims pay-out ratios, as occurs in the UK, as well as claims handling timeframes and dispute levels across all policy types. Data should be made available on an industry and individual insurer basis.
16. The General Insurance Code should commit Insurers to not sell single premium policies. Monthly instalment premiums should be affordable and not 'loaded' to take account of increased claims due to increased consumer awareness.

Sales Practices: Unauthorised Representatives

17. The General Insurance Code should include commitments for Code Subscribers to act, where there has been a breach of the General Insurance Code by an unauthorised seller of their insurance products, in order to rectify the harm caused.

Advertising and marketing

18. The General Insurance Code should include a section that makes commitments on advertising and marketing that extend beyond those that the industry is obligated to meet under law, regulation and ASIC guidance. This should include, but not be limited to:
 - a. prohibiting the use of terms such as “free,” “no cost,” “without cost,” “no additional cost” or “at no extra cost”
 - b. 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
 - c. not engaging in high pressure sales practices, practices based on exploiting anxiety or guilt, or other ethically or legally questionable selling techniques.

Affordability and Underinsurance

19. At a minimum the General Insurance Code commitments in “buying insurance” should be increased to include specifically:
 - a. Sales process that include:
 - o general guidelines about rebuilding costs and the implications of valuing a building, and helping consumers to ask questions about the details of their property
 - o Appropriate and effective disclosure in the sales process, including any caps or sub-limits
 - b. A review of the sales process, including through shadow shopping which is independently evaluated and reported to the CGC
 - c. Regular review and auditing processes of sum insured calculators, including it being built in to the sales process and where an error is identified with a calculator that the insurer commits to correcting the calculator and any affected consumers.
 - d. Where it is identified that the sales process materially contributed to the underinsurance, the insurer will remediate the consumer.
20. Consideration should be given to including a specific section headed “*Affordability and underinsurance*” which sets out an agreed set of principled-based conduct rules including but not limited to:
 - a. Product design and distribution obligation that products are designed in line with accepted building standards or relevant industry standards to the market for the insurance;

- b. Commitment of insurers to address affordability in insurance, including the development of appropriate products, commitment to an insurer of last resort;
 - c. Publication of data in relation to rates of refusal of insurance
 - d. Publication of data where home building insurance policies are priced above a set average or industry standard;
 - e. Publication of data on claims where there is identified under insurance;
 - f. Consumer testing of educational materials, disclosure materials including disclosure of key changes to improve consumer outcomes in identifying risk and selecting products.
21. Code Subscribers should commit to offer replacement value cover as an option for consumers. In the alternative, Code Subscribers should commit to developing an independent free service that estimates building costs.
22. Insurers should assist with better research into affordability and under-insurance issues by making more data publicly available regarding insurance cover refusals and home building policies with are priced at over \$3000 per annum.

Premium transparency and contestability

23. The General Insurance Code should require insurers to provide written reasons for why premiums were increased (or decreased) on request in writing from a policy holder. These reasons should include any increased risk factor that the insurer has become aware of.

Disclosure of Component Pricing

24. The General Insurance Code should require Insurers to provide component pricing of premiums.
25. The General Insurance Code should encourage Insurers to provide consumers greater access to natural hazard mapping and modelling information when it applies directly to their premium price.

Previous year's annual premium

26. The General Insurance Code require insurers to provide the previous year's premium on the annual renewal notice including
- a. the price of the new policy if the consumer renews;
 - b. any difference between the new price and the old price; and
 - c. the reasons for any change.

27. Insurers should provide premium hardship options under every policy they provide and provide this information on the renewal notice.

Section 5: Standards for employees, authorised representatives and authorised financial services licensees acting on behalf of a Code subscriber

&

Section 6: Standards for service suppliers

Application of the General Insurance Code

28. The General Insurance Code must apply to all Code Subscriber employees, Authorised Representatives, Service Suppliers as well as Authorised Financial Services Licensees Acting on behalf of the Code Subscriber.
29. The General Insurance Code should ensure that Subscribers will act where there has been a breach of the General Insurance Code by an unauthorised seller of their insurance products, to rectify harm caused.

Training

30. All employees, Authorised Representatives, as well as Authorised Financial Services Licensees Acting on behalf of the Code Subscriber should be appropriately trained to deal professionally with the public and particularly with respect to working with vulnerable consumers but not limited to those with a mental illness or mental health issues, mature age consumers, people with a developmental disability, people from a non-English speaking background, Aboriginal and Torres Strait Islanders, and those with a physical disability. There should also be specific training for those who have regular, direct contact with insured persons or applicants to be able to identify the signs of financial hardship.

Service Supplier Standards

31. Code Subscribers should commit to ensuring that all private investigators engaged as a service supplier be licensed.
32. Furthermore Code Subscribers should commit to only engaging private investigators who explicitly meet best practice standards for investigation - as recommended to be a part of the General Insurance Code in the following section.

Section 7: Claims

Standards and procedures for investigations

33. The Code must include a set of best practice standards for insurance investigations including the following:

- a. 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;
- b. 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;
- c. the right of the policyholder to be accompanied by an independent support person;
- d. the right of the policyholder to an interpreter where appropriate;
- e. the right to being interviewed by an investigator of the same sex;
- f. only recording an interview with the permission and authorisation of the policyholder;
- g. 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;
- h. 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;
- i. a commitment to comply with any reasonable restrictions placed on the interview by the interviewee and/or their legal representative;
- j. compliance with all state and federal surveillance and privacy laws;
- k. 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;
- l. 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;
 - m. a prohibition on any form of pretext activity, that is, any conduct or communication that conceals the true reason for that activity;
 - n. 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;
 - o. a prohibition on making any threat or promise, or offer any inducement to *any* person when conducting an investigation;
 - p. 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
 - q. 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.
 - r. a reasonable basis for believing that the policyholder has given inconsistent information to it on a claim 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.

34. The General Insurance Code should include an explicit statement committing insurers and their third party service providers to compliance with all relevant State and Commonwealth laws including the *Privacy Act 1988*, the *Racial Discrimination Act 1975*, the *Disability Discrimination Act 1992*, all relevant state Crime Codes, all relevant Private Investigator regulations, all relevant equal opportunity act and all relevant state surveillance, listening devices and privacy laws.

Best practice standards for working with vulnerable consumers

35. The General Insurance Code should include a section specific to acknowledging and addressing the particular needs of specific vulnerable consumers including, but not limited to those with a mental illness or mental health issues, mature age consumers, people with a developmental disability, people from a non-English speaking background (NESB), Aboriginal and Torres Strait Islanders, and those with a physical disability.
36. This section should include commitments to:
- a. ensure staff and third party service suppliers are adequately trained to recognise and understand potentially vulnerable customers at renewal, listen to their particular needs and be equipped with flexible options to help address those needs where appropriate.
 - b. implement business processes, with prescribed triggers, to ensure that the Insurer, where relevant, is satisfied that products offered and pricing for those identified as potentially vulnerable customers are fair and reasonable.
 - c. take account of the characteristics associated with vulnerability in making decisions on pricing and promotional practices in order to mitigate against the risks of poor customer outcomes for potentially vulnerable customers.
 - d. periodically review customers on legacy products and where potentially vulnerable customers can be identified take proactive steps to ensure that the product continues to meet their needs and that they are aware of any alternative products.
 - e. where possible proactively ask the customer if their current policy and renewal offer meets their ongoing needs and make clear to the Customer that they should review their cover at renewal.
 - f. Consider whether additional communication by letter, email, telephone, text etc. would be appropriate compared to their standard approach to customers at renewal, or whether a more inclusive renewal offering process, or specialised customer support is available to help address any identified risk factors for vulnerability.
 - g. Ensure communication always sets out the customer's options at renewal and how they go about exercising those options.

- h. Not explicitly encourage the Customer to do nothing at renewal as this may discourage active engagement in the renewal decision.
 - i. Explain to the Customer that factors affecting their premium may have changed since their last renewal and that the Customer can contact their Insurer or Third Party to satisfy themselves that the product is still suitable for their needs.
 - j. Provide an interpreter when an insurer is put on notice that a person does not understand the terms being explained to them;
 - k. Assist vulnerable persons (for example, people from Indigenous communities or those from non-English speaking backgrounds) may require support in meeting identification requirements when buying insurance or making a claim or Complaint
 - l. Assist people living in remote and regional communities to provide us with documents and to take part in assessments in the timeframes we set.
37. The section should also include a statement supporting the principals of diversity and anti-discrimination.
38. The General Insurance Code should include specific mental health standards addressing the unique issues faced by those with a mental illness including but not limited to:
- a. the development of mental health education and training for *all* staff and third party service providers
 - b. a commitment to remove all general mental health exclusions from all general insurance products and
 - c. explicit reference to complying with the *Disability Discrimination Act*.

Standards for use of interpreters

39. The General Insurance Code should include minimum standards in the use of interpreters.

Joint Insurance

40. The General Insurance Code should require insurers to notify each policy-holder about any changes to a joint insurance policy.

Claims Handling, Timeframes and Withdrawn claims

41. The General Insurance Code should commit subscribers to providing more information with respect to withdrawn claims including written notification of a claim withdrawal and the reasons, and notify consumers of their rights to access information underlying

the assessment of their claim, internal and external complaints and dispute resolutions processes when a claim is withdrawn.

Discouraging Claims

42. The General Insurance Code needs to include a broader commitment to neither discourage a claim nor encourage a withdrawal where there is a valid claim.

External Expert Reports

43. If an expert report cannot be provided within 12 weeks of the date of their engagement, the General Insurance Code should commit insurers to informing the policyholder every 10 days. If after 30 days the report has not been provided, the policy holder will be provided with details of the Complaints process.

Uninsured 3rd parties

44. The General Insurance Code should require subscribers to inform uninsured, not at fault, 3rd parties who are claiming under the other driver's insurer about:
- a. the process of dealing with the other driver's insurer;
 - b. the process of complaining to IDR; and
 - c. the ability to lodge a complaint through FOS's jurisdiction for uninsured not at fault drivers.

Written off vehicle register

45. The General Insurance Code should include the following commitments related to third parties:
46. Car owners should be given notice that their vehicle has been assessed by an insurer as a total loss at least 3 business days before the car is reported to a WOV.
47. Notice of a total loss assessment should include information about what kind of write-off the vehicle has been assessed as, whether the vehicle could legally be repaired, what the insurer is intending to do with the vehicle and information about the WOV.
48. Insurers should be more flexible about giving options to car owners that want to organise repairs to their own vehicles even if those repairs are uneconomical.

Repair workmanship and materials

49. Section 7.20 of the General Insurance Code should include the following:
- a. Where the insurer's repairer has engaged in poor or faulty repair of a motor vehicle which has resulted in the insured requiring hire car expenses including additional hire

car expenses over and above their current cover, the insurer agrees to pay or reimburse the insured for such expenses.

- b. Where the insurer's repairer has engaged in poor or faulty repair of a home building which has resulted in the insured requiring alternative accommodation including alternative accommodation over and above their current cover, the insurer agrees to pay or reimburse the insured for such expenses.

Section 8: Financial hardship

Financial Hardship request timeframes

50. Hard time limits should be introduced with respect to financial hardship requests, clarifying the current subsection 8.6. In line with the National Credit Code, the time limits should be as follows:
 - a. Within 21 calendar days, the Code Subscriber should assess a policyholder's application for hardship assistance and inform them in writing of its hardship decision, or inform them that it needs more information;
 - b. If the Code Subscriber needs more information, it should allow the policyholder at least 21 calendar days to provide it;
 - c. Within 21 calendar days of the policyholder providing the requested information, the Code Subscriber must make its hardship decision and inform the consumer of its decision in writing.
 - d. If the consumer fails to provide the requested information, then the Code Subscriber must make its hardship decision on the information available within 28 calendar days, and inform the policyholder of the decision in writing.

Premiums and Financial Hardship

51. Consumers in financial hardship should be able to enter into hardship arrangements if they cannot afford to meet regular premium payments. Consideration needs to be given to the following options:
 - a. Changing the coverage or amount covered for, in an appropriate and ethical manner;
 - b. Reducing or stopping payments for a short period with consequences for coverage
 - c. part payment of a premium with the remainder of the premium and the usual premium to be paid next month
 - d. delay payment of a premium with a double premium to be paid the next month
 - e. part payment of premiums for a few months then full payment of the outstanding value of the insurance premium in full.

52. Any notice of cancellation for non-payment of instalments should mention the availability of hardship arrangements.

Proactively identifying hardship

53. General insurers must commit under the General Insurance Code to:
- a. specifically train their employees, Collection Agents and Claims Management Services in identifying signs of financial hardship, and the obligations to assist these consumers under the General Insurance Code.
 - b. alter the language of the General Insurance Code placing the sole onus for financial hardship identification on the consumer to one that commits insurers to proactively identify hardship in consumers and where identified offered assistance. This should include ensuring that hardship processes are explained and made available whenever hardship becomes apparent.

Debt Waivers

54. The General Insurance Code should set basic criteria upon which debt waiver may be considered by subscribing insurers
55. Under the General Insurance Code insurers should apply the same criteria to proactively identifying customers who may be eligible for debt waiver.

Instalment Payments and Cancellation

56. Section 4.10 of the General Insurance Code should be amended to require subscribers to:
- a. Give notice in writing 14 days before cancellation through 2 different channels of communication (SMS, email or post); and
 - b. Give notice in writing within 14 days after cancellation

Providing IDR and EDR details on financial hardship refusal

57. General insurers must commit under the General Insurance Code to enable access for consumers to EDR to resolve purely financial hardship matters
58. General insurers must commit under the General Insurance Code to provide, in writing, consumers who have had a request for Financial Hardship assistance rejected with:
- a. details of the insurer's IDR and EDR processes
 - b. reasons for their rejection

59. Insurer IDR contact details and financial hardship information should be included on debt recovery letters.
60. The General Insurance Code should explicitly commit Subscribers to enabling consumers experiencing financial hardship to pay their excess or damages by instalments.

Centrepay and Fortnightly Instalment Payments

61. The General Insurance Code should commit insurers to allow all insurance policyholders to pay premiums fortnightly without penalties.
62. The General Insurance Code should include the option for policyholder to pay their premium through Centrepay if they so wish.

Payment of excess

63. Insurers should follow the FOS guidance relating to insurance policy excesses and financial difficulty.
64. The General Insurance Code should commit insurers to informing their policy-holders of the availability of the option to pay the excess in instalments when experiencing financial hardship.
65. The General Insurance Code should also allow access to EDR for uninsured persons who are unable to have their claim processed because of an insured inability to pay their excess.

Debt Collection of Third Parties

66. In relation to debt collection practices the General Insurance Code should address the following:
67. In addition to identifying the insurer on whose behalf the agent is acting and specifying the nature of the claim, correspondence to a consumer should:
 - a. include details of the claim including basic details of the claim e.g. date, time of accident, parties involved
 - b. provide a copy of the repair quote or itemised completed repairs;
 - c. provide a detailed breakdown of the damage that has been repaired so that a third party can assess the reasonableness of the claim and the extent of the damage for which they accept liability, if any;
 - d. provide third parties with witness statements, photographs and other relevant evidence relied on in making an assessment of liability

- e. inform the consumer that they have the right under Section 8 of the General Insurance Code to seek financial hardship assistance and be provided with information on where to seek independent legal advice.
68. The General Insurance Code should require insurers and their agents to confirm outcomes in writing in third party recovery of debt matters.
69. Third parties should also be provided with details of the complaints process and be able to access for third parties to IDR for disputes where liability and the amount claimed is disputed.
70. Access to EDR by consent of all Code participants for all disputes not resolved at IDR.
Note: FOS allows access to EDR by consent.

Section 10: Complaints and Disputes

Initiating a dispute during a claim

71. Code Subscribers should be required to notify the claimant in writing about the IDR and EDR processes within one month of lodgement of the claim if the insurer has not made a decision on the claim by this deadline.

Internal Dispute Resolution

72. The current two stage Internal Disputes Resolution process as described in Section 10 should be simplified and reduced to a single, simple streamlined process with a 15 day limit that can be extended to the regulated 45 days, where the Code Subscriber does not have all the necessary information or they have not completed the investigation.
73. An easy to understand complaints flow chart or visual guide should be designed to describe the IDR and EDR process and included in the General Insurance Code to assist with understanding.

Complaints and Disputes: Provision of documents

74. The General Insurance Code should include a commitment from insurers to provide the following information on request:
- a. Information and documents relied on in rejecting a claim;
 - b. Copies of the PDS and insurance certificate;
 - c. Copies of any expert or assessment reports relied on by the insurer; and
 - d. A copy of any recordings and transcript of the sale of insurance.

Section 13: Monitoring, enforcement and sanctions

Sanctions

75. The General Insurance Code should expand the number of sanctions available to include, as envisaged by RG186.70:
- a. formal warnings;
 - b. public naming of the non-complying organisations;
 - c. fines;
 - d. suspension or expulsion from the industry association;
 - e. suspension or termination of subscription to the General Insurance Code
 - f. require rectification or implementation of CGC recommendations from own motion inquiries within a reasonable period of time (to be specified by the CGC after consultation with the Code Subscriber);

CGC and Code Monitoring

76. The General Insurance Code must empower the General Insurance CGC to focus on supporting three core priorities for its monitoring role:
- a. investigations and analysis on gathering evidence of systemic noncompliance (common problems, complaint and reported breach trends, etc.)
 - b. transparency – by providing industry and the community with investigative, statistical and analytical information demonstrating the level of compliance with the General Insurance Code and identifying any trends and potential problem areas.
 - c. continuous improvement of insurance practices by providing feedback as to the effectiveness of the implementation of the General Insurance Code, and identifying and promoting good practice conduct and compliance, identifying areas for new or strengthened Code provisions or Industry Guidelines, and reporting about longer term Code-related projects to provide assurance to the community about progress.
77. The General Insurance Code should include a commitment to empower the CGC to arrange a regular independent review of its activities and to ensure a report of that review is lodged with ASIC. This review should coincide with the periodic reviews of the General Insurance Code.

CGC Visibility and Promotion

78. General insurers must resource the CGC appropriately to improve its visibility for consumers and consumer representatives.

Own Motion Inquiries, Data Collection and Resourcing

79. General Insurers should commit to explicitly empowering the CGC to undertake own motion inquiries and appropriately resource the CGC to be able to conduct more than one own motion inquiry at the same time.
80. Further the CGC must be explicitly empowered to require rectification or implementation of CGC recommendations from own motion inquiries within a reasonable period of time (to be specified by the CGC after consultation with the Code Subscriber).
81. Subsection 13.5 needs to be expanded to commit Code Subscribers to cooperating with the CGC with respect to:
- a. data collection to proactively and continually improve its performance.
 - b. ensure that the CGC has sufficient resources and funding to carry out its functions satisfactorily and efficiently.
82. The CGC should be explicitly tasked with progressively working with industry to develop the ability to publicly report on relevant insurance data and statistics including acting as the trusted translator of disparate information, producing equivalent information to enable broader reporting.
83. The General Insurance Code should empower the CGC to proactively gather relevant information about the effectiveness of and compliance with the General Insurance Code from all external sources including consumer advocates, state Legal Aid commissions, Community Legal Centres, consumer affairs departments and other government regulators.

Code Compliance Officers

84. General Insurers should commit to appointing a Code Compliance Officer.

Unfair Contract Terms in Insurance

85. The exemption for insurance products under the UCT regime be removed.

Expansion of the Scope of the Code

Insurance Reporting

86. A guide should be developed by the ICA which is enforceable through the General Insurance Code. The guide would cover consumer rights and insurer responsibilities in using insurance reports.
87. Each consumer is entitled to one free insurance report each year.

Uninsured Motorist Extension

88. The General Insurance Code should require that subscribers who offer Uninsured Motorist Extension (UME) insurance policies will not:
- a. Require policy-holders to prove that the at fault driver is uninsured; nor
 - b. Require policy-holders to provide the name, address and registration number of the at fault driver if that driver is uncooperative and the insurer is able to get that information itself without much difficulty.

Total Loss Protocol

89. Section 9 of the General Insurance Code should include a commitment to a Total Loss Protocol in catastrophe situations which avoids forcing policy-holders to itemise every lost personal item in order to make a claim.

ASIC Code approval

Financial Rights with other consumer representatives¹ wrote to the ICA to request that they seek approval of the General Insurance Code of Practice (**the General Insurance Code**) in accordance with the Australian Securities and Investments Commission's (**ASIC's**) *Regulatory Guidance 183*.² At the same time we also wrote to five other financial services sector associations administering codes to request that they take the same step.

We argued that ASIC approval would increase public confidence in the financial services sector, ensure that the General Insurance Code meets best practice standards and send a strong signal to consumers that the General Insurance Code is one in which they can have confidence. Approval would also demonstrate that the general insurance sector proactively responds to identified and emerging consumer issues and that the General Insurance Code works to deliver substantial benefits to consumers.

Code approval would also mean that:

- investigative or enforcement action can be undertaken if misrepresentations are made about the General Insurance Code;
- ASIC can monitor the General Insurance Code based on issues raised by consumers, External Dispute Resolution (**EDR**) schemes or industry consultations;
- there is greater certainty that consumer concerns and independent review recommendations will be taken seriously and more likely implemented – rather than what can occur now which is that some recommendations for change are watered down or rejected outright;
- consumers can have confidence that there is specific government/ASIC oversight of the General Insurance Code and its ongoing development;
- the insurance sector is making a public statement that it is strong and confident enough to subject its self-regulatory instrument for scrutiny against regulator standards;
- members will not walk away from the General Insurance Code.

We believe that the ICA should show leadership and send a strong message to consumers, subscribers and the financial services sector by seeking ASIC approval. Lifting the standards of other industry sectors by creating pressure for other industry bodies to also seek approval of their Codes can only benefit the industry and their customers as a whole.

1 including Consumer Action Law Centre, Consumer Federation Australia, CHOICE, Financial Counselling Australia, Redfern Legal Centre, CARE Inc and the CCLC SA

2 <http://download.asic.gov.au/media/1241015/rg183-published-1-march-2013.pdf>

Financial Rights notes that in the previous Independent Review of the Code of Practice the Final Report stated that the Independent Reviewer “recommend[ed] in [his] Report meets the ASIC RG 183 criteria.”³ Financial Rights further notes that in meetings with the ICA and Ian Enright, the ICA told consumer advocates that they would seek ASIC approval of the General Insurance Code. However after much delay, the recommendations of the Independent Reviewer’s report were not fully implemented by the ICA and approval was never sought.

RG 183 outlines the following list of approval criteria:

- Freestanding and written in plain language RG 183.55 & RG 183.129
- Body of rules (not single issue, unless Section E of this guide applies) RG 183.19 & RG 183.24
- Consultative process for code development RG 183.49–RG 183.54
- Meets general statutory criteria for code approval RG 183.28–RG 183.41
- Code content addresses stakeholder issues RG 183.55–RG 183.62
- Effective and independent code administration RG 183.76–RG 183.81
- Enforceable against subscribers RG 183.25–RG 183.27
- Compliance is monitored and enforced RG 183.79–RG 183.81 Appropriate remedies and sanctions
- RG 183.68–RG 183.73 Code is adequately promoted RG 183.78–RG 183.80
- Mandatory three-year review of code RG 183.82–RG 183.84

In order to meet the benchmarks set out in RG 183 the Insurance Code of Practice will need to ensure that the General Insurance Code meets the approval criteria. Financial Rights believes that the General Insurance Code is close to the level required for approval but falls down on a number of points:

Code enforceability

Financial Rights notes that under subsection 1.5 the General Insurance Code states that

By agreeing to this Code, we enter into a contract with the ICA to abide by this Code. This Code does not create legal or other rights between us and any person or entity other than the ICA.

The General Insurance Code should be amended to make it a term of the insurance contract to meet RG 183.27

In most cases, subscribers will incorporate their agreement to abide by a code by contracting directly with the independent person or body that has the power to administer and enforce that code. In some cases, subscribers will also incorporate their agreement in individual contracts with consumers (e.g. written directly into the terms and conditions of a particular product). We strongly encourage code owners to consider this approach.

³ General Insurance Code of Practice 2012–2013 Independent Review Final Report, para 4.7, page 24.

Precedents for this approach already exist in the Code of Banking Practice and the Customer Owned Banking Code of Practice. The decision to make the General Insurance Code a term of the insurance contract sends a clear message to the public that the insurance industry stands behind the General Insurance Code and takes the terms of the General Insurance Code as seriously as a contract of insurance. A decision not to include the General Insurance Code as a term of the insurance contract would send the opposite message, that is, that the General Insurance Code is weak and unenforceable, and that the General Insurance Code is not as effective as the Code of Banking Practice and the Customer Owned Banking Code of Practice.

Code Reviews

Financial Rights notes that the General Insurance Code review process has weakened over time. The 2012 Code stated at subsection 1.14 that:

An independent party will be appointed by the Insurance Council of Australia to review this Code every three years. (Footnote: Subsequent reviews will be arranged three years after the implementation of the initial review. In October 2009 a review was conducted by an independent reviewer, Mr. Robert Cornall AO)

This met the requirements of RG 183.82. However this was watered down in the 2014 Code at subsections 12.7 and 12.8 to:

The ICA is responsible for commissioning formal independent reviews of this Code from time to time. The CGC may recommend to the ICA Board that this Code be reviewed, if the CGC believes the application of this Code is not meeting the objectives outlined in section 2 of this Code.

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

This was disappointing and not in-line with RG 183.82. Financial Rights notes that the last review of the General Insurance Code was conducted in 2012-13 and not implemented until 2014. It has therefore been five years since there has been any opportunity for consumer representatives and other stakeholders to have input into the development of the General Insurance Code.

Furthermore this current Code review is limited and uncomprehensive – only addressing parts of the General Insurance Code.⁴ The ICA has stated that:

This is a targeted review, considering the operation and effectiveness of the key sections of the Code, in light of a number of recent external developments that have an impact on the general insurance industry.⁵

This review, therefore, does not cover critically important parts of the General Insurance Code including the Code's Principles.

4 Section 4, 5, 6, 7, 8, 10, 13

5 Correspondence with ICA and CALC re: Independent Oversight of Code Review, 6 March 2017

It was also originally announced as an ICA review with no mention of an Independent Reviewer. While this has since been rectified, it is concerning that the ICA felt that a non-independent process was appropriate. As RG 183.82 states:

Independent code reviews are essential to ensuring that a code remains current and continues to deliver real benefits to consumers and subscribers. Reviews provide an opportunity for stakeholders to give feedback on how a code has operated in the past and how it might operate in the future

Financial Rights submits that five years is too long and that the current limited review process is inadequate to fully address all the issues consumers concerns. It is important that the new Code re-implement mandatory independent three year reviews.

Code Content

Financial Rights notes that under RG 183.60:

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

We remain concerned that the General Insurance Code's content does not address stakeholder issues that have been raised with the ICA.

For example, Financial Rights brought up the issue of fraud investigations and claims handling in our submission to the 2012-13 Code review and the issue was not addressed. Financial Rights has subsequently published a detailed report⁶ into the issue demonstrating clear problems that can and should be addressed in part by the General Insurance Code.

The report found that close to one in four calls to the ILS are from policyholders with concerns relating to insurance investigations. While Insurers are entitled to investigate to ensure claims are genuine Financial Rights found a distinct lack of rules and protections for consumers being investigated. There are no specific standards for the conduct of claims investigations in the General Insurance Code. There are no guidelines for the use of interpreters or independent support people, no right to have the interview held in a neutral location, no reminder or suggestion to seek legal advice and no interview time limits. This is discussed in detail above.

Financial Rights provided this report to the ICA and requested a meeting to discuss the matter. The ICA never directly responded to Financial Rights on the matter, only providing comment to Insurance News:

In response, the Insurance Council of Australia (ICA) says the "anecdotal" report must be viewed in the wider claims context, and warns premiums will rise if investigations don't single out the frauds. ...

"The 40 anecdotes described in the report are not evidence of a systemic problem with insurance investigations," CEO Rob Whelan says. ...

⁶ Financial Rights, *Guilty Until Proven Innocent: Insurance Investigations in Australia*, March 2016, <http://financialrights.org.au/wp-content/uploads/2016/03/Guilty-until-proven-innocent.pdf>

ICA believes consumers are already well protected under the Insurance Contracts Act and the General Insurance Code of Practice.

However, it recognises being investigated can be stressful for policyholders, and they deserve to be treated in a “sensitive and respectful” manner.

“In the unusual circumstances in which this might not occur, insurers will take action to protect their customers and their corporate reputations,” Mr Whelan says.

“It is noteworthy that the report cites instances where contracted private investigators who allegedly behaved inappropriately were disciplined or sacked by the insurer.”

ICA says it would support a review of professional standards in the private investigation industry.

It also expects the Code Governance Committee to consider the report’s recommendations.⁷

This is one example of stakeholder issues that need addressing in code content. We expect these issues, among others to be addressed in the next iteration of the General Insurance Code.

Code Sanctions

Financial Rights notes that there are only four sanctions available to the Code Governance Committee (**CGC**) under the General Insurance Code at subsection 13.15:

- (a) a requirement that particular rectification steps be taken by us within a specified timeframe;*
- (b) a requirement that a compliance audit be undertaken;*
- (c) corrective advertising; and/or*
- (d) publication of our non-compliance.*

Financial Rights points out that RG 183.70 suggests the following:

- (a) formal warnings;*
- (b) public naming of the non-complying organisations;*
- (c) corrective advertising orders;*
- (d) fines;*
- (e) suspension or expulsion from the industry association; and/or*
- (f) suspension or termination of subscription to the code.*

The current Code only includes one of these suggestions under 13.15, i.e. corrective advertising. The “publication of our non-compliance” sanction is not “publicly naming as foreseen under 183.70. Financial Rights notes that the Enright Review recommended that

⁷ Claims investigations: a case to answer?, [insurancenews.com.au](http://www.insurancenews.com.au), 21 March 2016, <http://www.insurancenews.com.au/analysis/claims-investigations-a-case-to-answer>

The CGB Sanctions Committee should have a discretion to name the culprit in a serious, systemic or significant breach if the Code Participant did not self-report, was unco-operative in the Corrective Action phase or otherwise the breach merited the naming of the Code Participant.

This was not taken up by the ICA. We strongly believe that this must be included and that the all potential sanctions should be included in the General Insurance Code, as well as compensation for any direct financial loss or damage caused to an individual by the breach of the General Insurance Code.

Compulsory membership

It is vitally important that consumers can “assume” a certain level of commitment and standards when dealing with general insurers because:

- Leaving it up to consumers to have to investigate Code participation by each insurer prior to selecting insurance would require an expensive and extensive consumer education exercise (given the low base levels of awareness) that would be bound to fail; and
- It is in the interests of industry that uniform standards are applied both for competitive neutrality and to protect the reputation of the industry as a whole.

We submit that the General Insurance Code should apply to all general insurers carrying on business in Australia and be a condition of authorisation by Australian Prudential Regulation Authority (**APRA**) under the *Insurance Act 1973* (Cth). This submission is made on the belief that the General Insurance Code should be extended to incorporate all members of the industry involved in the insurance process, as much as is practicable to bind all insurance industry participants to the General Insurance Code.

Recommendations

1. The ICA should seek approval from ASIC of an improved General Insurance Code in accordance with RG 183. Improvements should include (but not be limited to:
 - a. code enforceability including the General Insurance Code forming a part of the contract with a Consumer;
 - b. mandatory three year independent reviews;
 - c. addressing all stakeholder issues identified in this Review; and
 - d. bolstering appropriate remedies and sanctions.
2. ICA membership require mandatory subscription to the General Insurance Code
3. The General Insurance Code should be extended to incorporate all members of the industry involved in the insurance process, as much as is practicable to bind all insurance industry participants to the General Insurance Code. Adoption of the General Insurance Code should be a condition of authorisation by APRA under the *Insurance Act 1973*.

Section 4: Buying insurance

Suitability

Financial Rights strongly believes that it is time for a major shift in insurance from the onus being almost entirely on the consumer to choose the right insurance product for his or her personal circumstances to much more responsibility on the insurer to design and sell products that are suitable.

There is considerable evidence that consumers are often buying insurance that is unsuitable for their needs. In our view, this is happening and will continue to happen because:

- Unless the consumer is using an insurance broker, there is never (or almost never) a conversation with the insurer about what the consumer needs;
- Disclosure is so poor that consumers find it hard to work out what their coverage is;
- There is enormous competition on price but little competition on coverage. Comparison websites deepen that problem;
- The insurance companies do very little work in the area of suitability; and
- Many consumers erroneously believe there is basic coverage.

In credit, there is a responsibility on credit providers to make sure the product they are providing or arranging is not unsuitable. There is no such requirement in insurance. The insurance industry has argued that 'suitability discussions' for insurance is tantamount to financial advice, but we contend that argument is misconceived.

We recognise that the Government is currently consulting on new powers for ASIC around the design and distribution of financial products, but in the mean time we believe the General Insurance Code should commit subscribers to a specific, individualised suitability requirement. Many insurance products are designed to enable consumers (including very unsophisticated consumers) to improve their financial resilience and protect very important personal assets like their homes and vehicles. In this case there needs to be clear obligations on insurers to ensure that these products are fit for purpose and that consumers are able to access the information they need to make informed decisions within a range of potentially suitable products.

*ASIC Report 415 Review of the Sale of Home Insurance*⁸ made a number of pertinent observations regarding insurer practices that are insufficient and suggestions for improvement (but we note this is not a comprehensive list):

⁸ <http://asic.gov.au/regulatory-resources/find-a-document/reports/rep-415-review-of-the-sale-of-home-insurance/>

- That the sales process was designed to meet the insurer’s needs rather than promote understanding of the product for the consumer (p6);
- That sales staff were sometimes poorly trained in relation to product features and/or trained to avoid giving any explanations or guidance (no advice model);
- That insurer’s telephone scripts could set out better ways for insurers to convey to their customers:
 - Insurance features and exclusions;
 - How cap and limits operate in practice (through the use of hypothetical examples);
 - Include a plain English explanation of what the sum insured means and how it should be estimated with calculator style questions or at least references to available calculators.

While the ASIC report was focused on the disclosure obligations of insurers, we submit that the above also spells out how a suitability obligation could potentially be implemented, with an obligation on the insurer to explore the objectives and requirements of consumers and match products accordingly.

The Financial Services Inquiry rejected the notion of an individual suitability or appropriateness test stating that

An individual appropriateness test, where no personal advice is provided, would introduce significant costs for issuers and distributors due to necessary changes to the sales process. Appropriateness tests are also open to manipulation.⁹

We believe that there are strong arguments to reconsider this finding. Financial Rights also asserts that there are significant structural problems in insurance leading consumers to end up with insurance products that are simply not appropriate or suitable to their needs. These include:

Sum Under-Insurance: that is, since most people are realistically unable to assess correctly the value of their home and content leading to systemic underinsurance.

Feature Under-Insurance: because insurance contracts and Product Disclosure Statements (**PDS’s**) are highly complex and not easily comparable, consumers are not able to properly assess the features and exclusions in their insurance products.

Lack of competition brought about through industry consolidation and complexity of products

Problem products and channels – as discussed extensively in this submission there are a number of types of products such as Consumer Credit Insurance (**CCI**), Sickness & Accident, etc. and channels such as car yard add-ons that are sold inappropriately.

Financial Rights acknowledges too that there will be costs involved in creating a suitability test but there are significant costs currently for insurance customers stuck with unsuitable

⁹ FSI Inquiry Final Report p203

http://fsi.gov.au/files/2014/12/FSI_Final_Report_Consolidated20141210.pdf

insurance products and the general community and government when they are forced to step and mop up the mess.

Financial Rights notes that a suitability test already exists in the financial services sector– that is, the responsible lending obligations in consumer credit. We believe that a similar approach must be introduced into the insurance sector.

In the absence of a specific suitability requirement, or to complement such a requirement, the General Insurance Code should improve the industry’s use of standard cover provisions under the *Insurance Contracts Act* which currently serve no practical purpose.¹⁰ This idea is discussed more below.

Recommendations

4. Insurance products should be suitable and insurance companies should be required by the General Insurance Code to seek information from the consumer on what they need from their insurance and ensure the product sold is suitable.
-

No Advice Model

Generally speaking Insurers sell insurance products under a general advice or no advice distribution model. This means that sales staff promote the product but do not tell the consumer whether or not it is suitable or meets their needs. Consequently consumers are provided with insufficient or inadequate information to inform their decisions or to engage with the complexities of these products.

In its 2016 *Report 492: A Market that is failing Consumers* Report into add-on insurance ASIC found that

all insurers sold add-on insurance products predominantly through a general advice model as defined under s766B of the Corporations Act 2001 (Corporations Act), although some insurers also used a no advice model where only factual information is provided to the consumer.¹¹

The use of these models means that intermediaries:

(a) are under no obligation to ensure the product is suitable or meets the consumer’s needs; and

¹⁰ The ICA provides for standard cover in certain types of common general insurance but allows insurers to contract out of these provisions so long as they clearly disclose this fact in writing. In practice all insurers contract out of the provisions, rendering them pointless.

¹¹ <http://download.asic.gov.au/media/4042960/rep-492-published-12-september-2016-a.pdf>

(b) receive commission payments that could create conflicts of interest.

A general advice model is likely to have adverse outcomes for consumers in the add-on insurance context as it allows car dealers to promote the sale of the products without considering whether the consumer needs cover, and then places the responsibility for poor purchasing decisions on the consumer. Consumers must review a large amount of information and documentation to assess which add-on insurance products are most suitable for them.¹²

ASIC Report 415 *Review of the Sale of Home Insurance* made a number of observations regarding insurer practices that are insufficient and suggestions for improvement. This included that:

- sales staff were sometimes poorly trained in relation to product features and/or trained to avoid giving any explanations or guidance no advice model.
- the sales process was designed to meet the insurer's needs rather than promote understanding of the product for the consumer;
 - insurer's telephone scripts could set out better ways for insurers to convey to their customers: Insurance features and exclusions;
 - How cap and limits operate in practice (through the use of hypothetical examples);
 - Include a plain English explanation of what the sum insured means and how it should be estimated with calculator style questions or at least references to available calculators.

ASIC Report 492 examined the training standards for those who sell financial products including insurance and found that Add-On insurance, for example, fell under a tier that required lesser requirements.

Financial Rights understands that the reason the no advice model has been adopted has been because the compliance of advice provisions under the *Corporations Act 2001* on a large scale is costly and time consuming. However this bottom-line focussed approach is producing poor consumer outcomes industry-wide. Financial Rights notes that some general insurance brands have, at least in the past, provided General Advice (for example, business insurance products sold by AAMI and GIO) and Personal Advice (for example Shannons and Apia, the latter providing targeted products to over 50s).¹³ In 2011 Suncorp stated that it was:

one of the few general insurance companies that currently provide personal advice to the retail consumer. The general insurance industry has generally found that the advice provisions of The Corporations Act are too onerous and costly to be successfully implemented. Indeed the provision of personal advice within our business is only viable in the unique operating environment of our niche brands, Shannons and Apia.

¹² p.33 <http://download.asic.gov.au/media/4042960/rep-492-published-12-september-2016-a.pdf>

¹³ Suncorp Submission to the draft Future of Financial Advice (FOFA) legislation, September 2011 https://futureofadvice.treasury.gov.au/content/consultation/corporations_amend/submissions/Suncorp.pdf

Personal Advice models are obviously viable in a financial sense at the very least in some circumstances. Where it is not viable it is however leading to poor outcomes for consumers. This is a major problem. Financial Rights is of the view that insurers need to give serious consideration to whether the no advice model remains appropriate, in all circumstances.

If general insurers are unwilling to take action under the General Insurance Code or individually to improve the information being provided to consumers, a shift in government policy towards mandating suitability requirements will be inevitable.

Recommendations

5. General Insurers give serious consideration to shifting away from a No Advice model and that consideration be given to whether this could be a commitment under the General Insurance Code.
-

Disclosure obligations for Insurers

In recent years, there has been a marked shift in the insurance industry's thinking about what constitutes effective disclosure. It has been almost unanimously agreed by regulators, the industry, consumer advocates and the Government that the PDS regime is not working. Consumers continue to face significant complexity, confusion and exhaustion when purchasing insurance products. Consumers know they need insurance but shopping around is difficult and time consuming. This leads to people choosing on price or brand rather than detailed consideration of features and coverage.

The Insurance Council's own research has confirmed that the PDS is not a widely used pre-purchase information source, and maintaining a predominant focus on the PDS will continue to result in missed opportunities to engage consumers through these other sources.¹⁴

However, Financial Rights does not support eliminating the PDS entirely. It is important that consumers always have access to the full terms and conditions of their insurance policies when they need to check something specific. But it has become clear that these documents can no longer be expected to serve the purpose of helping consumers choose the right policies for them at the time of purchase.

We submit that although improvements of disclosure are sorely needed, they are not sufficient to deliver adequate consumer outcomes in insurance markets. The General Insurance Code instead should be amended to improve the adequacy of consumer insurance coverage through suitability and standard terms requirements (as discussed in other sections of this submission).

¹⁴ Consumer Research on General Insurance Product Disclosures, February 2017
http://www.insurancecouncil.com.au/assets/report/2017_02_Effective%20Disclosure%20Research%20Report.pdf

Having said that, Financial Rights believes that insurers can commit to some obvious improvements relating to disclosure.

Key Fact Sheets

Firstly, insurers should commit to improving access to Key Fact Statements (KFS). Key Fact Sheets (KFS) for home building and/or home contents insurance¹⁵ were introduced in late 2012 with the *Insurance Contracts Amendment Regulation 2012 (No.2)* amending the *Insurance Contracts Regulations 1985*. The requirement commenced after a generous transition period in November 2014.

It requires that the insurer provide a consumer with a one page key fact sheet for insurance contracts containing certain home building and/or home contents insurance. Under the regulation, a KFS must be provided by the insurer when:

- a) the consumer seeks information about a contract (as soon as reasonably practicable, but not later than 14 days, after the consumer first requests information about the contract) and;
- b) and when a consumer enters (including renewals) into a contract or potential contract (again as soon as reasonably practicable, but not later than 14 days, after the consumer enters the contract). It excludes any extension, variation or reinstatement of the contract.

If it is not practicable to provide the KFS the requirement to provide the KFS as soon as reasonably possible will be considered to be before or at the same time as the provision of other disclosure documentation such as the PDS was provided (that is within 5 days).

The insurer may provide the KFS by electronic means at the consumer's request.

Financial Rights is currently undertaking research in collaboration with Monash University examining, in part, the effectiveness of the KFS for in terms of consumer engagement, comprehension and decision-making.

One thing that is clear in our preparation for this research though is the sheer variability in availability and access to KFS's on Insurer Websites, and variability in information provided in a KFS.

On some websites the KFS is highlighted amongst Important Documents¹⁶ on others it is a hyperlink within the text.¹⁷ Some pages don't include a link at all.¹⁸ Previous Financial Rights review of general insurer websites have demonstrated vast variability in where a KFS is located, be it above the fold, on a side bar or down the bottom. This make attempts at comparison by consumers difficult and has the potential to negate any positive impact a KFS may have on the purchasing and decision making process.

¹⁵ as defined in the Insurance Contracts Regulations 1985 (regulations 9 and 13)

¹⁶ <https://www.nrma.com.au/home-insurance/buildings-contents-combined?akamai-feo=off>

¹⁷ <https://financialservices.coles.com.au/insurance/home-insurance/home-insurance>

¹⁸ <https://www.youi.com.au/home-insurance/building-contents-insurance>

Financial Rights also notes that we have seen some KFS that seem to demonstrate that the Insurer is hardly trying, and in the process undermining the whole point of a KFS. The below is an example of a KFS we saw in 2016, although it should be noted that the insurer has now changed its approach to their KFS, after we made a complaint. However Financial Rights has not seen every KFS in the market and do not monitor them regularly.

The content of this Key Facts Sheet is prescribed by the Australian Government and is a requirement under the *Insurance Contracts Act 1984*

KEY FACTS ABOUT THIS HOME CONTENTS POLICY

Policy Name: **Contents Cover**
As at: **09 October 2014**



THIS IS NOT AN INSURANCE CONTRACT

STEP 1 Understanding the fact sheet

This Key Facts Sheet sets out some of the events covered and not covered by this policy and other information you should consider. This sheet does not provide a complete statement of the cover offered, exclusions, conditions and limitations that apply under the policy. You should carefully read the **Product Disclosure Statement (PDS)** and policy schedule for more details.

STEP 2 Check the maximum level of cover and the risks covered

Under this policy, you set the maximum level of cover and your payout is limited to that amount.

Event/cover	Yes/No Optional	Some examples of conditions, exclusions and limits that apply to cover (see PDS and other relevant policy documentation for full details)*
Fire and Explosion	Yes	Please click here to view: Insured Events, Limits & Exclusions.
Flood	Yes	Please click here to view: Insured Events, Limits & Exclusions.
Storm	Yes	Please click here to view: Insured Events, Limits & Exclusions.
Accidental breakage	Optional	Please click here to view: Insured Events, Limits & Exclusions.
Earthquake	Yes	Includes Tsunami. Please click here to view: Insured Events, Limits & Exclusions.
Lightning	Yes	Please click here to view: Insured Events, Limits & Exclusions (Storm).
Theft and Burglary	Yes	Please click here to view: Insured Events, Limits & Exclusions.
Actions of the sea	No	
Malicious Damage	Yes	Please click here to view: Insured Events, Limits & Exclusions (Intentional Damage).
Impacts	Yes	Please click here to view: Insured Events, Limits & Exclusions.
Escape of liquid	Yes	Please click here to view: Insured Events, Limits & Exclusions.
Cover for valuables, collections and items away from the insured address		
High value items and collections	Optional	Please click here to view: Insured Events, Limits & Exclusions.
Items away from insured address	Optional	Please click here to view: Insured Events, Limits & Exclusions.

Additional covers may be included or able to be added as optional extras. Please refer to your PDS for more details.

* This key facts sheet is a guide only. The examples provided are only some of many conditions, exclusions and limitations specific to the cover listed. You must read the PDS and policy documentation for all information about this policy.

1 of 2

Suffice it to say, insurers need to meet both the letter and the spirit of the KFS law and should make appropriate commitments under the General Insurance Code.

Existing defect exclusions

One issue related to disclosure which could be dealt with in the General Insurance Code is regarding existing defect exclusions in policies in circumstances when consumers are unaware of the defect. Under the *Insurance Contracts Act Section 46* states that

“Where, at the time when the contract was entered into, the insured was not aware of, and a reasonable person in the circumstances could not be expected to have been aware of, the

defect or imperfection, the insurer may not rely on a provision included in the contract that has the effect of limiting or excluding the insurer's liability under the contract by reference to the condition, at a time before the contract was entered into, of the thing."

We submit that the General Insurance Code should help clarify this provision for consumers. Subscribers to the General Insurance Code should commit to providing cover for pre-existing defects when the consumer was not aware of the defect at the time they took out the insurance policy.

Recommendations

6. PDS documents should not be eliminated, and should continue to be available to consumers for every insurance policy that they have purchased.
7. Insurers need to meet both the letter and the spirit of the KFS regulations and should make appropriate commitments under the General Insurance Code to ensure that:
 - a. KFSs are made available on websites in a consistent and obvious manner
 - b. Information provided on KFSs is not simply a list of links to PDSs but are actual brief explanations of the coverage.
8. Subscribers to the General Insurance Code should commit to providing cover for pre-existing defects when the consumer was not aware of the defect at the time they took out the insurance policy.

Duty of Disclosure: Point of Sale Verification of Consumer Disclosures

Financial Rights believes there is a growing problem regarding consumers that believe they are covered by insurance but are instead effectively uninsured because they failed to disclose something when they took out the insurance, which had they disclosed would have caused the insurer to decline to provide coverage. We believe there should be greater onus on the insurers to verify certain consumer disclosures at the point of sale.

In this digital age when insurers have easy access to consumer information through Insurance Reports, driver histories and criminal reports Financial Rights submits that there should be a protocol in place where insurers help verify certain consumer disclosures in order to prevent consumers from being ignorant of their lack of insurance coverage. We believe it fails to meet the standards of Utmost Good Faith for insurers who have access to consumer information to only verify consumer disclosures after a consumer has made a claim.

Below are four examples of this problem all from emails to our service in the last 12 months.

Case study –Emily’s story

Emily made a claim on her comprehensive insurance and after three weeks her claim was rejected because she had failed to disclose all the claims she had made with previous insurer. Emily had no idea what they were talking about. Emily had taken out the insurance two years prior over the phone and remembered it was a lengthy conversation. Emily believes she answered all questions as best as she could and remembers telling them that – i.e. she is answering as best as she can remember

Emily had to go back to past insurers to check after her claim was rejected, and it is true she had a few more claims in last 5 years than she remembered.

Emily said it is horrifying to think you're safe and covered and then it turns out you're not! She never thought she would be in a position where she would pay for insurance and then this could happen - why not just call her up when she started paying for the policy to tell her there was a problem with her application rather than wait for her to make a claim?

Case study: ILS Email – Partner organised over and didn’t know about DUI

I had my vehicle stolen and INSURER has refused my claim due to failure to disclose information. My partner deals with our Insurance's and health cover, my partner took out the policy and listed everything she was aware of. She didn't know about a DUI I had 3.5 years prior to taking out the policy and being the first time I have ever insured a car I was unaware of the details required. Due to the DUI INSURER has said they wouldn't have issued me insurance in the first place.

Case study: ILS Email – Son not covered as nominated driver

My son had an accident July 2016 and he is a nominated driver on a policy held by my husband and myself. He lodged a claim at which time he disclosed that he had a license suspension Aug 2014. INSURER has denied the claim stating that had we disclosed this, they would not have covered him. They advised us that insurance was cancelled and they would refund our premium back to May 2015 when policy was renewed and this information should have been disclosed. Our broker asked that it go to the IDR as they believed that they would have still covered our son albeit with a higher premium and/or excess. We have now received a letter stating they would uphold the denial and they will not refund the premium as they would have still covered my husband and I. We are very disappointed in this outcome. Had we known our son was not covered under the policy we

would have found insurance elsewhere.

Case study: ILS Email – increased premiums due to driving history

A lady bumped into my car, with her car. I was in the car at the time - we were in a shopping centre car park. I got out to look at the damage and made eye contact with her, indicating that she should get out of her car as there was damage. She shrugged her shoulders and drove off. I took her registration details and reported this to the police and then lodged a claim with my insurer. During this process they discovered that I had not disclosed a claim I had had with my previous insurer. They have informed me that I now have to pay a higher premium and that I owe the extra monthly payments in arrears and that they will not OK this claim until the backlog has been paid. This is my question - are they allowed to do that - I feel like I am being held to ransom!

Case study: ILS Email – dispute over whether info was disclosed or not

Claim rejected based on my non disclosure of a criminal record. I believe during my correspondence with INSURER that I had disclosed the information and was still given a policy that would not work for me. I have been attempting (for months) to request Transcripts of phone conversations to no response from the dispute centre. I wish to be sure that I had disclosed my criminal history and was offered a policy, then refused a claim based on non disclosure. I believe that the information was expressed and that my policy and claim should therefore not be refused.

Recommendations

9. The General Insurance Code require insurers to check any consumer records that the insurer has ready access to at the point of sale in order to verify certain consumer disclosures including the consumer's:
 - a. Insurance report;
 - b. Driving history; and
 - c. Criminal history.
-

Standard Cover

It is Financial Rights position that the government needs to intervene in the general and life insurance markets to ensure an improved Standard Cover regime given the current standard cover provisions of the *Insurance Contracts Act* serve no practical purpose and do not meet their original aims. While legislative change is clearly not something that the General Insurance Code can implement, Financial Rights believes that the General Insurance Code could intervene to require subscribers to stop contracting out of the existing standard cover provisions..

The *Insurance Contracts Act* under sections 35 and 37 provide for standard cover in certain types of common general insurance but allows insurers to contract out of these provisions so long as they clearly disclose this fact in writing. In practice all insurers contract out of the provisions, rendering them pointless.

The standard cover regime was originally enacted as a response to the Law Reform Commission's 1982 Report on Insurance Contracts.¹⁹ The Law Reform Commission argued that:

*difficulties caused by lack of information available to insureds are made worse by the wide of terms of insurance contracts offered by different insurers and the unusual terms which sometimes appear in them. In order to alleviate these difficulties, standard cover should be introduced ...*²⁰

The Law Reform Commission continued to state that:

*Policies contain numerous terms which affect in unexpected ways the cover offered. In a few cases, the insured's attention is drawn to the relevant limitation at the time when cover is arranged. In the vast majority of cases, however, nothing is said. The insured's ignorance remains undisturbed until he makes a claim. The market is at present distorted by the fact that purchaser discrimination is limited to matters like price, little or no account being able to be taken of differences in the nature of the products being sold.*²¹

The original vision for standard cover was one in which:

An insurer should be free to market policies which offer less than the standard cover. If it chooses to do so, it should have to draw the insured's attention to that fact and to the nature of the relevant diminution in cover. If it fails to do so, the contractual terms should be overridden to the extent to which they provide cover which is less than the standard.

¹⁹ <http://www.alrc.gov.au/report-20>

²⁰ p.xxvi <http://www.alrc.gov.au/report-20>

²¹ pp.44-45 <http://www.alrc.gov.au/report-20>

The problem with the implementation of this vision is that, as alluded to above, Section 35 includes a “get out of jail” clause stating that the standard cover regime:

does not have effect where the insurer proves that, before the contract was entered into, the insurer clearly informed the insured in writing (whether by providing the insured with a document containing the provisions, or the relevant provisions, of the proposed contract or otherwise).

In other words, insurers don’t have to “draw the insured’s attention” to the fact that they are providing less than standard cover – they just provide it in the PDS and contract. We note the recently released research by the Insurance Council of Australia (ICA) that found that only between 19% and 26% (depending on the type of general insurance) used the PDS in their pre-purchase decision making and even fewer (3%-7%) used it as their main source of information. Further, while many consumers believed they were aware of the terms of their policy, actual tested comprehension levels were low in comparison to confidence levels.²² In short, insurer’s can offer less than standard cover simply by tell their customers in a document few read and even less understand.

As we mentioned above Financial Rights strongly believes that the Government needs to take another look at standard cover and institute a more effective regime that ensures that consumers can better compare insurance products and decrease the possibility that consumers will end up with an unsuitable product.

However, general insurers under the General Insurance Code could improve on the current situation by making commitments not to contract out of the standard cover provisions as they were originally intended. In the alternative, the General Insurance Code could address this issue by committing Code Subscribers to clearly state, in a standardised form, in all communications including the PDS and website that an insurance product diverges from standard cover. This would be a significant step to improving the situation for consumers and acting now would demonstrate insurers’ willingness to improve the current untenable situation.

Recommendations

10. The General Insurance Code should commit subscribers to no longer contracting out of the standard cover provisions in the *Insurance Contracts Act*; or in the alternative
11. The General Insurance Code should include a commitment to clearly state, in a standardised form, in all communications including the PDS and website that an insurance product diverges from standard cover.

²² Consumer Research on General Insurance Product Disclosures Research findings report, February 2017, available at http://www.insurancecouncil.com.au/assets/report/2017_02_Effective%20Disclosure%20Research%20Report.pdf

Sales practices

Financial Rights notes that the General Insurance Code only includes two broad commitments relating to the sales practices of general insurers.

4.4 Our sales process and the services of our Employees and our Authorised Representatives will be conducted in an efficient, honest, fair and transparent manner, in accordance with this section.

4.5 We will take reasonable steps to ensure that our communications with you are in plain language.

Further there is a general commitment that service suppliers will “provide services ... in an honest, efficient, fair and transparent manner”: subsection. 6.2.

Financial Rights believes that these broad, vague and unspecific commitments have failed to rein in the worst excesses of the industry and should be supplemented with specific commitments addressing the issues faced by consumers. Below, we discuss two areas where specific commitments need to be made in respect to the sale of junk products and add on insurance – both of which have been shown by a plethora of ASIC reports to be incredibly problematic.

Financial Rights believes general insurers need to make specific commitments applying to all sales. Financial Rights notes that the last Review recommended that a number of issues merited further attention including standards for phone and internet sales.²³ The 2012 Issues paper detailed the dramatic shift towards telephone and internet sales which significant consequences for consumers with respect to understanding and the purchase of suitable products. The issues addressed in that paper continue to be the case.

From our experience, many disputes especially those in relation to allegations of non disclosure (e.g. of a previous driving history) and representations at the point of sale/inception telephone call (e.g. that someone is covered for flood) can be resolved by ensuring that there are standards for phone and internet sales.

Furthermore Financial Rights believes general insurers need to make the following commitments:

- non English speaking background clients should be provided with access to an interpreter during the sales process (as well as all other parts of the insurance

²³ p. 149

<http://www.insurancecouncil.com.au/assets/report/GI%20COP%20Independent%20Review%20Final%20Report%202012-13.pdf>

experience including claims) when the insurer is on notice that someone clearly doesn't understand the terms being explained to them.

- give information about the product at the time of sale (e.g. information from key facts sheet) including key conditions and exclusions in a manner consistent with the method of sale (For example, verbally when sold by telephone and via the internet in a prominent and unavoidable manner for internet sales, followed up in written policy disclosure material in either case)
- banning automatic insurance renewals
- recording the sales process and keeping it for a specified time of at least 6 years (unless the consumer specifically does not agree to the recording). This would be in line with the time limits for taking action in relation to a claim at law or raising a dispute in FOS.

Recommendations

12. In addition to the commitments with respect to sales practice already in the General Insurance Code, general insurers should make specific commitments on sales practices including:

- a. standards for telephone and internet sales
- b. the right to an interpreter when an insurer is put on notice that a person does not understand the terms being explained to them
- c. banning automatic renewals
- d. recording the sales process and keeping the recording for at least six years.

Sales Practices: Add-on Insurance

The Consumer Action Law Centre recently released a report on 'Junk Insurance' in Australia.²⁴ According to their report:

'Add-on insurance' is insurance which is added on at the point of sale when a consumer is buying another product like a credit contract or a car. Two products commonly sold as add-ons:

- *Consumer Credit Insurance: a product designed to protect a consumer's ability to meet their credit repayments in the event of death and/or involuntary unemployment and/or permanent disablement; and*

²⁴ Junk Merchants: How Australians are being sold rubbish insurance, and what we can do about it. December 2015. Available at: <http://consumeraction.org.au/Junk%20Merchants%20-%20Consumer%20Action%20Law%20Centre%20December%202015.pdf>

- *Gap insurance: if a motor vehicle is written off, Gap insurance is designed to cover the amount left to pay on the consumer's car loan once a comprehensive car insurance policy has paid out.*

These insurance policies and warranties are usually very low value. Consumer advocates have seen cases where people are tricked into buying 'add on' insurance and warranties that are virtually useless to them. Some customers buy the 'add-on' because they were told they have to buy it to get the loan, or worse, they may not even realise they were buying it.

The 'add on' sales process creates bad practices. The high commissions encourage salespeople to use dishonest tactics to make a quick buck. It's designed to make consumers buy on impulse and is proven to lead to you into buying products. Problems with add-on insurance, and particularly CCI, have been raised by consumer advocates for decades. Reports by ASIC from 2011 and 2013 demonstrated serious problems with CCI sales practices by Australian banks, and high profile Australian insurers collectively paid \$2.4 million in refunds for CCI mis-sold through payday lender The Cash Store.²⁵

Case study (Financial Rights email inquiry)

I only recently recognised the actual implications of what credit card insurance covered. I was sold this insurance in November 2009. I now feel that this was sold under unconscionable conduct. I had only just turned 18, the insurance was not explained to me, I'm not sure I was even informed about the insurance. I was opening a credit card account with a limit of \$2000. I cannot now fathom what they were thinking that I would need insurance on that amount of money. It is ridiculous.

I need to know what legal grounds I have of maintaining I was mis sold this service, and what I can legally hope to gain back from this situation. I am as of today writing a letter to cancel the insurance, writing a letter of complaint to both my bank and the insurance company and also a letter to my bank asking for all contract/documents in regards to the credit card itself.

Poor add-on insurance and sales practices have been an issue for many years highlighted by a string of Government inquiries²⁶ and ASIC investigations and surveillances including:

- *Report 413 Review of Retail life insurance advice, October 2014²⁷*

²⁵ Report 470: Buying add-on insurance in car yards: Why it can be hard to say no; February 2016. Available at: <http://asic.gov.au/regulatory-resources/find-a-document/reports/rep-470-buying-add-on-insurance-in-car-yards-why-it-can-be-hard-to-say-no/>

²⁶ Parliamentary Joint Committee on Corporations and Financial Services (PJC) inquiry into the Corporations Amendment (Future of Financial Advice) Bill 2011; and the PJC Inquiry into the Corporations Amendment (Further Future of Financial Advice Measures) Bill 2011. Both of these made specific recommendations about the need to monitor the quality of advice about the sale of risk insurance.

- *Report 454 Funeral insurance: A Snapshot, October 2015*²⁸
- *Report 470 Buying add-on insurance in car yards: Why it can be hard to say no, February 2016*²⁹
- *Report 471 The sale of life insurance through car dealers, February 2016*³⁰
- *Report 492 A Market that is failing consumers: The sale of add-on insurance through car dealers*³¹ and
- *Report 498 Life Insurance claims: An industry review*³²

ASIC Report 470 *Buying add-on insurance in car yards: Why it can be hard to say no*, February 2016³³ found that many consumers who had purchased add-on insurance products:

- (a) were not aware of which add-on products they had actually purchased, how much each policy cost and what risks it covered, or when they would be able to lodge a claim;
- (b) if they could recall the purchase, regretted their decision to buy add-on insurance;
- (c) had no awareness of add-on insurance products before entering a dealership to buy a motor vehicle;
- (d) were unaware of the cost of, or cover or value provided by, add-on insurance products and most purchases were made solely on the basis of information provided in the car dealership; and
- (e) were actively sold, and sometimes pressured to buy, add-on insurance products.

ASIC's 2011 report into CCI Sales practices by banks significant use of harassing tactics and high pressure sales approaches including

1. staff persisting with an insurance sales pitch to a consumer who has clearly indicated they do not wish to purchase the product;
1. the practice of keeping consumers 'captive' until after the insurance sales pitch has been completed;
2. using the insurance cooling-off period as a selling point;
3. highlighting the risks of not having insurance if the consumer became sick or

27 <http://download.asic.gov.au/media/2012616/rep413-published-9-october-2014.pdf>

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

29 <http://download.asic.gov.au/media/3549387/rep470-published-29-february-2016.pdf>

30 <http://download.asic.gov.au/media/3549384/rep471-published-29-february-2016.pdf>

31 <http://download.asic.gov.au/media/4042960/rep-492-published-12-september-2016-a.pdf>

32 <http://download.asic.gov.au/media/4042220/rep498-published-12-october-2016a.pdf>

33 <http://download.asic.gov.au/media/3549387/rep470-published-29-february-2016.pdf>

4. unemployed, without providing information about other alternatives such as financial hardship variations; and
5. deliberately masking the cost of the insurance in the loan repayment.

ASIC's most recent *Report 498 into the Life Insurance Industry* found that "problematic sales practices may lead to poor claims outcomes"³⁴ including policies sold that were manifestly unsuitable and consumers being misled about the cover under the policy.

The recently launched self-regulatory Life Insurance Code of Practice fails to fully address the serious concerns consumers have with sales practices, particularly commission-based and add-on models. While the General Insurance Code does include commitments to be clear and not misleading (clause 4.1) and ensure sales rules are in place to ensure staff conduct sales appropriately and prevent pressure selling or other unacceptable sales practices (clause 4.3), the General Insurance Code does not address add-on sales techniques, via effective methods such as mandated delay and opt-in days after the sale of the loan – a practice that has been introduced in the UK. The General Insurance Code does not address other problematic practices such as unsolicited marketing calls, the inclusion of which would have improved the protections offered under anti-hawking rules, which provides some exemptions for life insurance.³⁵

Many of the problematic sales techniques are known and can be addressed through the General Insurance Code by:

- introducing an appropriately formulated and monitored delay regime including an opt-in days after the sale of the loan initiated by the consumer; or
- requiring insurers to publicise their claims pay-out ratios, as occurs in the UK, in order to signal to the consumer whether these products are a problem.

As mentioned above Financial Rights believes that many of the aggressive tactics used by car yards and other add-on sales practices can be overcome by introducing an opt-in and delay mechanism. Under this process, consumers would have to call the salesperson themselves after a mandatory delay and say that they want to buy the product. The mandatory delay should be four days after the initial contact with the sales person aligning with best practice requirements in the UK's GAP insurance rules.³⁶ If there is genuine desire for the product or service the consumer will make contact. This will mean there will be fewer sales, but will simply decrease by the number of sales that were only successful through the implementation of high-pressure tactics and other unethical sales practices.

34 Op Cit. ASIC, para 93

35 Corporations Act 2001 (Cth) s 992A(3)(a)-(e).

36 Financial Conduct Authority, Guaranteed Asset Protection insurance: competition remedy Including feedback on CP14/29 and final rules June 2015 <https://www.fca.org.uk/publication/policy/ps15-13.pdf>

Finally, we support the recent recommendation by ASIC for insurers to stop using single premium insurance policies. In *ASIC Report 492 A Market that is failing consumers: The sale of add-on insurance through car dealers*³⁷ one of the main findings was:

The practice of having consumers pay for insurance upfront in a single premium can contribute to poor outcomes, including:

- interest costs, which the consumer will pay if they finance the premium through their car loan, reducing the value of the product;
- reduced consumer awareness, as the consumer pays for the policy in a lump sum at the start of the policy and may forget they have it; and
- no refunds of unused premium, which means a consumer may pay for insurance cover they do not receive as their insurance policy will terminate if they pay out their car loan early, further reducing the value of holding cover through these products.

Recommendations

13. The General Insurance Code should include a commitment that insurers will stop allowing their products to be sold as add-ons.
14. Alternatively the General Insurance Code include an appropriately formulated delay regime including an opt-in days after the sale of the loan initiated by the consumer.
15. The General Insurance Code should establish a consistent public reporting regime requiring insurers to fully and transparently publicise their claims pay-out ratios, as occurs in the UK, as well as claims handling timeframes and dispute levels across all policy types. Data should be made available on an industry and individual insurer basis.
16. The General Insurance Code should commit Insurers to not sell single premium policies. Monthly instalment premiums should be affordable and not 'loaded' to take account of increased claims due to increased consumer awareness.

Sales Practices: Unauthorised Representatives

Financial Rights notes that the CGC has identified a gap in the coverage under the General Insurance Code in relation to the selling of general insurance by entities who are not Authorised Representatives of a Code Subscriber as defined under the General Insurance Code, including insurance brokers, banks or credit unions. They state that:

³⁷ <http://download.asic.gov.au/media/4042960/rep-492-published-12-september-2016-a.pdf>

While subsection 5.5 of the Code enables a policyholder to ask a Code Subscriber to address concerns about the selling practices of these entities, and to report their concerns to us, we are unable to breach the Code Subscriber if these entities do not comply with the Code when selling its general insurance products under their own Australian financial services licenses. This is because subsection 13.4 of the Code stipulates that a Code Subscriber will be in breach of the Code only if its Employees, Authorised Representatives or Service Suppliers fail to comply with the Code while acting on its behalf.³⁸

The CGC go on to state that “given the concerns identified by ASIC and some consumer legal groups about selling arrangements, we intend to examine this area in 2016–17.” Financial Rights believes that this Review provides an opportunity for Code Subscribers to get ahead of the game and make commitments relating to unauthorised sellers.

Recommendations

17. The General Insurance Code should include commitments for Code Subscribers to act, where there has been a breach of the General Insurance Code by an unauthorised seller of their insurance products, in order to rectify the harm caused.

Advertising and marketing

Financial Rights notes that the General Insurance Code does not include any commitments related to the advertising and marketing of general insurance products. We note too that Regulatory Guide 234³⁹ provides detailed guidance about the advertising of financial products.

However we feel it is appropriate that the general insurance industry make commitments that extend beyond this guidance. Financial Rights points to the 2016 ASIC Regulatory Update⁴⁰ that raises the issue of misleading advertising and raises two examples of problematic advertising and marketing.⁴¹ The advertising and marketing of products is one of the key ways

³⁸ GICGC Annual Report 2015-16, p. 20 <http://codeofpractice.com.au/assets/GICGC%20AR%202015-16.pdf>

³⁹ RG 234 Advertising financial products and advice services including credit: Good practice guidance, Issued 15 November 2012, <http://www.asic.gov.au/regulatory-resources/find-a-document/regulatory-guides/rg-234-advertising-financial-products-and-advice-services-including-credit-good-practice-guidance/>

⁴⁰ Regulatory update to general insurance industry 2016: A speech by Peter Kell, Commissioner, Australian Securities and Investments Commission, Insurance Council of Australia Annual Forum 2016 (Sydney, Australia) 4 March 2016 <http://download.asic.gov.au/media/3560658/2016-ica-annual-forum.pdf>

⁴¹ Ibid, p3.

(if not in many cases the sole way) consumers are informed about the products that they are purchasing. As Peter Kell stated in this report misleading advertising both undermines insurance suitability and competition:

Misleading advertising can prevent consumers from making the right choices about products that suit their needs. But more than that, it also can undermine competition in the market, by giving an unfair advantage and potentially additional market share to those who fail to comply. We want to see competition, but it must take place on a level playing field.

Add to this the general undermining of confidence in the insurance industry as a whole when expectations are raised and then not met at claims time, it is clearly in the interests of both consumers and the industry to increase standards in this area.

We note that the Life Insurance Code of Practice have included a section on sales practices and advertising.⁴² Clause 4.1 addresses advertising practices head on:

When we advertise and market our Life Insurance Policies, we will:

- a. be clear and not misleading;*
- b. consider the target audience for the advertisement or marketing communication and whether it provides adequate information for that audience;*
- c. ensure statements in advertisements or marketing communications are consistent with the features of the relevant policy and the disclosures in any corresponding PDS;*
- d. ensure that any images used do not contradict, detract from or reduce the prominence of any statements used;*
- e. if price or premium are referred to, ensure that these are consistent with the price or premium likely to be offered to the target audience for the advertisement or marketing communication;*
- f. make clear if a benefit depends on a certain set of circumstances;*
- g. ensure any use of phrases such as “free” or “guaranteed” are not likely to mislead; and*
- h. comply with the Australian Securities and Investments Commission (ASIC)’s guidance for advertising financial products and services and guidance regarding unsolicited sales.*

We believe that the General Insurance Code should include similar clauses but that they should involve commitments that extend beyond the law and regulations that currently exist as per RG 183.22 and RG 183.60. That is the General Insurance Code should improve consumer protections available through advertising and marketing commitments specific to the general insurance industry that are not currently included in the ASIC good practice guidelines. For example,

- prohibiting the use of terms such as “free,” “no cost,” “without cost,” “no additional cost” or “at no extra cost”

⁴² Section 4: http://www.fsc.org.au/downloads/file/policy/2016_Dec_FINALCODEPDF.pdf

- 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.

Recommendations

18. The General Insurance Code should include a section that makes commitments on advertising and marketing that extend beyond those that the industry is obligated to meet under law, regulation and ASIC guidance. This should include, but not be limited to:
- a. prohibiting the use of terms such as “free,” “no cost,” “without cost,” “no additional cost” or “at no extra cost”
 - b. 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
 - c. not engaging in high pressure sales practices, practices based on exploiting anxiety or guilt, or other ethically or legally questionable selling techniques.

Affordability and Underinsurance

Affordability

There is a growing group of Australians who cannot afford insurance or obtain insurance. The consequences of being uninsured can be devastating including the loss of a home or car. Lack of insurance also has consequential effects including homelessness, reduced school attendance, reduced access to medical care to name a few.

There is a significant lack of data available on the issues with affordability and reduced access to insurance. The anecdotal information we have indicates that the following consumers either cannot afford insurance or cannot get insurance (without difficulty):

- Consumers living in areas with an identified (high) risk of natural disaster;
- Low income and unemployed consumers;
- Culturally and linguistically diverse consumers;
- Former bankrupts;
- Young people (particularly men) when it comes to car insurance; and
- People with criminal convictions.

There have been attempts to analyse the non-insurance and affordability problems in Australia.⁴³ The real difficulty is that the problem of non-insurance and affordability requires a multi-pronged policy solution. There is also a lack of publicly available data which insurers could provide including data on when they refuse to offer insurance, and data on how many home building policies cost over a benchmark or standardised average.

There is debate on what that solution should be. What can be agreed is that non-insurance for whatever reason can have a serious impact on the economy decreasing disposable income and increasing reliance on welfare.

Underinsurance

After the bushfires in Canberra ASIC issued a report in September 2005 called Report 54: *Getting Insurance Right. A Report on Home Building Underinsurance*.⁴⁴ The report found that:

- There is a high level of underinsurance in Australia
- The underinsurance is caused by a range of factors including:
 - Consumers having difficulty estimating rebuild costs
 - Lack of access to effective tools to estimate rebuild costs
 - Failure to change rebuild values with rising prices; and
 - Home building policies are difficult and complex to compare, including sub-limits and optional extras
 - Consumer may choose to be underinsured due to affordability reasons or just simply because they agree to bear some of the risk

It is significant that the above factors have not changed since the report. This is despite several major natural disasters and further reports.

Buying insurance and underinsurance have been the subject of many reports, including *ASIC Report 416 Insuring your home: Consumers' experiences buying home insurance October 2014*. A number of recommendations were made; however, not all have been adopted or integrated into insurers sales processes consistently or effectively.

We believe the sales process of insurance, particularly the commitments in “Buying insurance” section of the General Insurance Code should be improved to entrench some of these recommendations as part of the insurance industries commitment to addressing the underinsurance problem.

In an ideal world, all consumers should have access to replacement cover. However, we understand that this may not be viable for industry if insurers are exposed to uncapped risk and they cannot obtain enough reinsurance to meet the prudential risk. If sum insured policies

⁴³ Insurance Council: The Non-insured: Who Why and Trends by Tooth and Barker, Centre for Law and Economics 2007 at <http://www.insurancecouncil.com.au/assets/report/the%20non%20insured%20-%20report.pdf>.

⁴⁴ Available at [http://www.asic.gov.au/asic/pdflib.nsf/LookupByFileName/underinsurance_report.pdf/\\$file/underinsurance_report.pdf](http://www.asic.gov.au/asic/pdflib.nsf/LookupByFileName/underinsurance_report.pdf/$file/underinsurance_report.pdf)

are the necessary result, then the insurers must be held to higher standards in product design and distribution (including sales process), and ensuring consumers expectations are met to address the underinsurance problem. Financial Rights believes insurers have more to do in this regard, and that the General Insurance Code should have commitments by industry to consumers, including greater redress for a consumer where a consumer is underinsured due to a failure of an insurer's calculator or sales process in correctly setting a sum insured.

In setting the sum insured, consumers are left to estimate using calculators or rely on the insurer's estimate. This has led to many instances of over and underinsurance, which subsequently leads to further consumer dissatisfaction.

The calculators consumers currently use do not provide any audited trail. Consumers report that they cannot recall if they put in the incorrect information into the calculator (generating the wrong figure) or if a calculator provided them with an incorrect figure on correct information. To our knowledge currently calculators on insurers' websites or 3rd party websites, generally do not allow for any recording of the information submitted or resulting, due to the perceived risk of the liability. If an insurer has a calculator to be used by a consumer to determine their sum insured it should be entrenched into the sales process and the insurer should take some responsibility for any errors if an error is identified in the calculator (for example, outdated building estimates).

Improving the initial sales process however is not the only code commitment required to address the problem. Product design and distribution is also required to ensure that insurers are not contributing to the underinsurance problem with sub limits or caps in policies that result in consumers being underinsured. During the 2011 floods a number of consumers were subject to a sub-limit for flood cover. This is still occurring with caps or sub-limits on other general insurance products, such as contents sub-limits for electronic equipment, jewellery and other contents items. In some car insurance, sub-limits appear unexpectedly such as a sub-limit for claims for hire car or liability for hire car.⁴⁵

Underinsurance can also result due to renewals of policies where changes occur to the policy and the consumer misses the renewal notice. For example, home and contents policies may increase with CPI, but insurers may introduce sub-limits at renewal time that did not exist before. Further with respect to some motor vehicle policies, consumers may be unaware of the depreciation of the sum insured or change from agreed value to market value. Insurers need to commit to improving their notification of changes to policies, including consumer testing renewal notices and having greater justification for changes to policies including the reduction of benefits by the imposition of a sublimit to an existing policy. At a minimum, significant PDS changes need to be in any cover letter and effectively highlighted in the renewal notice.

Insurers currently rely heavily on disclosure of the sub-limits. We believe this is inadequate, as disclosure by PDS alone is insufficient in fully informing a consumer as to limitation of cover. Improving the sales process should occur, but in addition, insurers who are limiting or capping should have:

⁴⁵ See for example Eric Insurance Car Policy: <http://ericinsurance.com.au/wp-content/uploads/2016/06/Car-Insurance-V011016-for-Web-1.pdf>

- have consistent advertising;
- test the disclosure;
- standard industry terms to allow for comparison;
- standardised PDSs to allow for better comparison.

Recommendations

19. At a minimum the General Insurance Code commitments in “buying insurance” should be increased to include specifically:

- a. Sales process that include:
 - general guidelines about rebuilding costs and the implications of valuing a building, and helping consumers to ask questions about the details of their property
 - Appropriate and effective disclosure in the sales process, including any caps or sub-limits
- b. A review of the sales process, including through shadow shopping which is independently evaluated and reported to the CGC
- c. Regular review and auditing processes of sum insured calculators, including it being built in to the sales process and where an error is identified with a calculator that the insurer commits to correcting the calculator and any affected consumers.
- d. Where it is identified that the sales process materially contributed to the underinsurance, the insurer will remediate the consumer.

20. Consideration should be given to including a specific section headed “*Affordability and underinsurance*” which sets out an agreed set of principled-based conduct rules including but not limited to:

- a. Product design and distribution obligation that products are designed in line with accepted building standards or relevant industry standards to the market for the insurance;
- b. Commitment of insurers to address affordability in insurance, including the development of appropriate products, commitment to an insurer of last resort;
- c. Publication of data in relation to rates of refusal of insurance
- d. Publication of data where home building insurance policies are priced above a set average or industry standard;
- e. Publication of data on claims where there is identified under insurance;
- f. Consumer testing of educational materials, disclosure materials including disclosure of key changes to improve consumer outcomes in identifying risk and selecting products.

21. Code Subscribers should commit to offer replacement value cover as an option for consumers. In the alternative, Code Subscribers should commit to developing an independent free service that estimates building costs.
22. Insurers should assist with better research into affordability and under-insurance issues by making more data publicly available regarding insurance cover refusals and home building policies with are priced at over \$3000 per annum.

Premium transparency and contestability

Insurance prices throughout Australia can vary depending on the actuarial and statistical data held by the insurer. Insurance pricing is increasingly becoming more granular. More and more information is being collected about consumer habits and risk profiling. Financial Rights is concerned that the more that granular and specific data is collected the greater the exclusion will be for some sections of the insurance market. The use of granular data may lead to more targeted (and lower) pricing for some consumers, but others will be left underinsured or uninsured.

Additionally, the more data used to calculate risk and price premiums, the greater the risk for error. Current competition is in our view adversely affected by the lack of transparency in premium pricing. There is currently no adequate mechanism to review whether premiums are being calculated fairly.

For example, in March 2017 research by the Emergency Services Levy Insurance Monitor⁴⁶, which surveyed premiums across 11 suburbs, found an average variation of \$1100 between insurers for "basic home and contents polices". The monitor, Professor Allan Fels, said suburbs have different characteristics "and you would expect to see price differences across locations". "But it's very concerning there are such big differences in prices quoted for the same property," he said. "It suggests that competition is not fully effective in this industry."⁴⁷

Through the ILS, Financial Rights regularly receives complaints from consumers about the level of their premium. Consumers sometimes believe their premium has been incorrectly calculated given their claims history, or has been calculated based on incorrect information. From our experience, consumers who dispute their premium or excess pricing with the insurer are generally left feeling unsatisfied. We are told:

- a) the sales team cannot explain why the premium is priced as it is;
- b) they are provided generic answers; or

46 <http://www.eslinsurancemonitor.nsw.gov.au/>

47 Calls for transparency over variations in home insurance premiums, Sydney Morning Herald, Sean Nicholls, 21 March 2017 <http://www.smh.com.au/business/consumer-affairs/call-for-transparency-over-variations-in-home-insurance-premiums-20170320-gv1v3m.html>

- c) they do not feel the insurer has taken any steps to look at their particular situation.

For example, in flood coverage for home insurance products, an insurer may historically have priced premiums on a suburb level rather than an individual property level, creating a benefit to shopping around in some regions. Some consumers will benefit from using insurers which take into account specific hydrological data about their property (and price lower accordingly). Alternatively, where a specific property is assessed as high risk for its individual topography, a suburb-based premium could be more competitive. In some regions this does not occur because there are fewer insurers, or no insurers pricing on postcode or a higher peril.

Case study: Failure of contestability in North Queensland

Sally lives in North Cairns. Her property was built in the 1940's and is located in the White Zone outside the Storm Tide Zone as advised by her Local Council. Since buying the property and after Cyclone Yasi, Sally made some structural changes to the property and was advised by her builder that it was now "cyclone rated". She was insured for Storm, but not Storm Surge or Flood, and her premiums were \$5,000 per annum. She was happy with her policy in light of the property modifications. In early 2014 at renewal time, the insurer wrote to her and declined to renew her insurance policy on the basis her property was an "unacceptable risk".

Sally rang them and told them about the building works and that she was zoned in the White Zone. The insurer did not change its position, and continued to refuse to renew the policy.

Sally rang around other insurers, each time telling them at the point of sale about the works undertaken and that she was in the White Zone. No insurer would offer a policy of insurance to her.

Eventually, she contacted a broker, who arranged insurance for her at a higher price, so she would not be left completely uninsured.

Financial Rights helped her dispute the insurer's refusal to renew, by requesting written reasons under Section 75 of the *Insurance Contracts Act*. Shortly after ILS raised the written dispute, the insurer changed its mind and offered Sally a policy at the same price as it was the year before.

Sally was disheartened as Financial Rights had not done anything more than what she had previously done apart from quoting a section of the Act and using legal letterhead. She was still completely in the dark about the reasons for their original decision to decline to cover her, or indeed why this was later reversed. She chose to remain with her new insurer out of dissatisfaction.

Through our extensive advice experience we have found that consumers have difficulty contesting premium pricing by insurers (despite section 75 of the Insurance Contracts Act). Even when consumers do all the right things, they face impediments due to lack of competition and a lack of premium pricing transparency. It is commonly accepted that insurers' premium

pricing information is “commercially sensitive” and if pricing is known it would somehow detrimentally affect their ability to compete. This guarded approach leads to consumer suspicion, misunderstanding and sensitivity to change. It undermines the insurance industry’s credibility in being consumer focused and drives the perception of gouging.

The following case studies demonstrate the lack of information and explanations that insurance companies provide to customers about changes to premiums. Many of these case studies come from our ILS email inquiry form. In those examples identifying information has been removed for this submission, but the content comes directly from each consumer’s email.

Case study - Consumer awareness as to premium (Financial Rights email inquiry)

We have just received our renewal notice a while ago while discussing contents insurance we had been told that we were over insuring our contents which would be costing us more to insure so we rang INSURER and arranged to bring the figure down from \$80,000 to \$45,000, while on the phone we also changed our address details from QLD to NSW. This is when problems started we were told we live in a high risk area so it will cost us more. (we spoke to neighbour they claim rubbish) then our renewal came we had reduced the amount of cover we needed yet the renewal was going to cost us \$85.00 more than it did when we had double the amount my wife was told that it was because the government in different state charge more than others it is not the insurers fault but the government I realise that Australia is not one country but several all run by different people and we need passport it travel from one state to another. so is it true is there a cost hike caused be governments?

Case study - (Financial Rights email inquiry)

My insurance premium for my investment property and my house insurance have gone up 600% in the last 4 years, this company said there is nothing they can do for us and you will find the same quotes elsewhere so I wouldn’t even try. My investment property is the problem, as we have fixed the first one. The problem is the [address in SUNSHINE COAST QLD]. the last year’s premiums were \$347 a month. I could no longer afford this and tried a few insurance companies to see if they could help. I recently had to cancel my policy with INSURER1 and joined INSURER2, their charge was \$90.00 a month. I feel like I’ve been ripped off and would like to make a claim, if I look back at the other house premiums and they were as bad so there might be a case there as well. can you please help ??

Case study: Lack of transparency in premium pricing (Financial Rights email inquiry)

My policy has increased by 20 percent on last year when I rang to ask why they said it was because they increase your level of insurance each year with inflation .when I stated that our cover only went up by 4.9 percent he had no other reason that it increased so I asked how can there be such a difference he had no answer I ask for some one to call me back and they have

not I just can't get an answer how they can justify this.

Case study: (Financial Rights email inquiry)

Between one policy renewal schedule and the next, my excess increased from \$100 to \$500. My concerns are these:

1. The extent of the increase is 500%. This seems excessive and unreasonable, to say the least.
2. The only notification of the increase was a one-liner in the wording of the schedule itself, and a note at the foot of the reverse of the schedule. There was no prior notification warning of the increase - no letter warning that this might be coming. In my view, INSURER has acted in bad faith in not pre-announcing such a significant increase and therefore failing to allow its customers to consider their continued association with INSURER.

Renewal schedules come out as a matter of course; but a 500% increase in excess is something so out of the ordinary that it should have been flagged separately, and well in advance.

Had I not heard an INSURER Customer Service officer mention in passing a few days ago that the excess had increased by 500%, I would have been in the dark.

Case study: No notice of increase in premiums

I have been with this insurance company for a couple of years and my premium has remained the same. Several days ago I received a email notice regarding the automatic renewal of the policy which had just taken place. However this time my premium has increased from \$365 to \$505 per year. Looking through all the documents I have received I can't see any notification that my premium may be increased without any forewarning. Fair-trading think generally that you can't roll over a contract with out letting the consumer aware of a price increase.

I would like to know where I stand regarding this, especially as INSURER charge an exit fee if I decide to go elsewhere. I'd like to know what my consumer rights are regarding this so I can question my premium increase and decide whether to stay with them.

Case study: Unexplained decrease in premiums

Matthew has an apartment in Queensland. He was paying contents insurance of \$740 in 2012, and then \$841 in 2013 but his renewal this year was for \$231; a reduction of \$500 and over 50%. He rang them and asked what the reason for the reduction was and the

insurer has told him they can't tell him. Now he wonders whether they calculated it correctly before and whether he has been overcharged. He worries he may not be covered for events and is now suspicious.

Case study: Lack of clarity around multiple policy discounts

I have to pay my house and contents today. They keep changing my insurance dates and amount I have to pay. They sent me a 12 month renewal in March instead of for May. They also do not give me my 15% discount for multiple policies. They do not list the amount of discount when they now say they have applied it, but the amount is more than when they said I did not have the discount. They keep charging me extra for something not listed on my policy. They asked me security questions and date of birth and proceed with my inquiry and then after 30 minutes tell me they have to charge me extra because they had my DOB wrong. I have been told to talk to IDR but they will not talk to me. I want these points clarified before I attempt to ring again as to what \$ do I need to pay today and what am i covered for.

Case study: Unexplained discounts

John has insured his cars and homes with INSURER for over 15 years. John rang up to switch his building insurance to landlord's insurance and was told that he should ring back when the rent is known as that may affect the premium. John did so and spoke to another representative; they noted the rental and the new policy price changed. In the course of the call, the representative said "I'll just make sure all your discounts have been applied, for all the policies" after a few minutes they came back and further reduced the policy price plus reduced the price on his other policies. John was irritated, why hadn't the first person done that and he has had these policies for over 15 years. Had they been doing it before?

Case study: Claims history of strangers affecting premiums

Jane lives in an apartment. She was renting in Unit 1 and then she moved to Unit 3. She rang her comprehensive motor insurer to change her address. Her insurance increased by \$7 per month. She queried about the increase and was advised it was the claims history of the previous occupant. Jane fails to understand how the claims history of a stranger has any bearing on her premiums; given there has been no change to the location of her car or her own driving history.

In our view, the lack of transparency surrounding how premiums are priced is detrimental to the insurance industry, and it does not foster accountability. The insurance industry should not

be able to shield relevant information on the grounds that there are using “commercially sensitive” rating factors and weightings. Consumers should have access to such information if they have a legitimate dispute about the reasons behind a premium or excess price or changes to their insurance policy conditions. There is currently no dispute resolution mechanism for a consumer notwithstanding the consumer’s insurance policy may:

- Be offered with a premium the consumer believes to be unreasonable due to inappropriate assessment of risk; or
- Have complex terms and conditions the consumer cannot understand and, as a consequence, the consumer finds they have an inappropriate policy.

In its 2014 publication entitled “*Enhancing the consumer experience of home insurance: Shining a light into the black box*”⁴⁸ the Fire Services Levy Monitor in Victoria (FSLM) reasoned that by improving the efficiency of insurance markets, through removing information asymmetry and making competition more effective, policyholders will be better informed and premiums will fall, thereby making insurance more accessible. In order to achieve this goal and to improve consumer awareness the FSLM specifically recommended that FOS:

Provide easier access to information and dispute resolution – by removing hurdles to information provision by insurers and dispute resolution by the Financial Ombudsman Service, consumers are less likely to be disadvantaged by opaque risk rating practices of insurers.

The FSLM report argued there is a need for greater contestability of premium pricing and cost pricing.

Currently, the main way premiums or insurers’ decisions in relation to offering insurance is “reviewed” is by consumers shopping around to see what other insurers are offering, a mechanism next to useless in some pockets of Australian, such as northern Australia.

Outside of market forces the only other mechanism available is for an insured to make a request in writing under section 75 of the *Insurance Contracts Act 1986*. An insured however can only use section 75 when either their insurance is cancelled or by reason of some special risk relating to the insured or to the subject-matter of the contract, or when the insurer offers insurance cover to the insured on terms that are less advantageous to the insured than the terms that the insurer would otherwise offer.

However, the Act and section 75 provide no guidance as to what information the insurer is obliged to provide in its written reasons, and there is no mechanism for review in the event the decision of the insurer is erroneous or based on incorrect information.

48 Fire Services Levy Monitor of Victoria, *Enhancing the consumer experience of home insurance - Shining a light into the black box*, July 2014. available at:
<http://www.firelevymonitor.vic.gov.au/home/news+and+information/publications/publication+shining+a+light>

In insurance markets with limited suppliers such as Northern Australia, competition is not an adequate mechanism for consumers to 'review' insurance premiums. If all insurers are using incorrect data or not taking into account localised factors, then competition fails.

As a possible alternative, a consumer may make an application to FOS. However FOS has a very limited decision making power when it comes to reviewing premiums. In 2011, FOS determination number 218234 recognised that an insurer has the commercial decision to increase premiums, but must disclose the basis of the increase beyond providing a general explanation. In Financial Rights' view, this was a good decision of FOS as it enabled a consumer some degree of contestability of an unexplained premium increase when the consumer's personal circumstances (and risk assessment) had not changed and the insurer could not justify the increase in the cost. However, this represents only one decision of FOS and has not resulted in any insurers giving reasons on renewals as to increases in insurance costs.

It is Financial Rights' view that insurers should not be able to hide behind vague reasons and unsubstantiated assertions about how premiums are priced. They should have to substantiate premium pricing across all forms of insurance. In the home and contents space it is essential.

The failure of industry to have any mechanism of review of the fairness and consistency of premium calculations is of significant detriment to consumers. This failure also provides no guarantee that any household mitigation strategies or idiosyncratic household conditions are taken into account when determining premiums. Consequently, premium prices cannot be said to be "accurate" signalling of risk as there is no contestability or transparency in their calculation.

A consumer may reject the premium as an inaccurate reflection of their risk, and where there are few insurers in the market place (or they are all relying on the same incorrect information) a consumer may decide to self-insure or be forced to be uninsured not only for the risk of the hazard but for all claims (where they cannot get any level of cover).

If the General Insurance Code committed subscribers to greater transparency and contestability of premium pricing, Financial Rights expects the following benefits to arise:

- a) consumers may be persuaded they are at risk, and decide to incur the cost to insure;
- b) consumers may undertake personal mitigation strategies; or
- c) consumers may lobby local government for local mitigation strategies.

In the absence of this information, consumers are in the dark and may be making poor decisions. If consumers could trust the transparency and contestability of premium pricing decisions by insurers, consumers may be more likely to believe the risk assessments on their properties.

Further, issues of premiums also arise in other general insurance products such as pet insurance. Financial Rights receives a lot of complaints from consumers who experience increasing premiums in pet insurance, as their pet ages and when they need insurance the most. The industry needs to ensure that they are treating consumers fairly, and are not pricing

some of the most vulnerable consumers out of the market just as they may need the cover the most.

Case study: Increasing pet insurance premiums

Sandra is a disability support pension and she insured her dog Hunter 10 years ago when Hunter was 8 weeks old. Originally the premiums were \$35 per month. Sandra continued to insure her pet every year as the policy guaranteed continued benefits for chronic conditions. Hunter had developed a skin condition and needed ointment prescribed by the vet. After 8 years she cost of the premium was now \$106 per month or \$1270 per annum. This increase was a 158% increase in cost. In addition to the premiums increasing steadily, the excess for each claim increased from \$150 to \$200 and when Hunter turns 9 she will also have to co-contribute 35% of each vet visit. Sandra is shocked, her annual premium now represents 6% of her income.

Financial Rights notes that ASIC have recently announced a “no-claims discounts health check” examining whether insurers have implemented measures that improved consumers understanding of how they work and ensuring “insurers are complying with their obligations to provide consumers with accurate information”.⁴⁹ Financial Rights supports this examination into what is yet another layer of complexity confusing consumers and a lack of transparency from insurers.

Recommendations

23. The General Insurance Code should require insurers to provide written reasons for why premiums were increased (or decreased) on request in writing from a policy holder. These reasons should include any increased risk factor that the insurer has become aware of.

Disclosure of Component Pricing

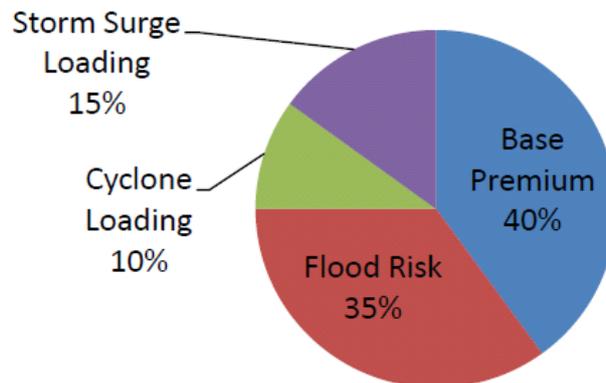
Financial Rights strongly submits that insurers should be required to provide information as to the components in their premium pricing. Knowing what makes up the price of a premium will better inform consumers about risk and what effect mitigation strategies may have on reducing insurance premiums or what behaviours or conditions might increase premiums. Component pricing information should apply uniformly across all insurers but will be particularly helpful in addressing a lot of the issues faced by those in parts of Australia that

⁴⁹ Greg Medcraft, ASIC, Regulatory Update to the general insurance industry, 17 February 2017, http://www.insurancecouncil.com.au/assets/media_release/2017/annual%20forum%20day/greg-medcraft-speech-ica-annual-forum-17-february-2017.pdf

face severe weather risks. It would provide an easy to read, easy to understand signal to consumers of the risk factors taken into account when premiums are set. For example:

J. Smith - Home Building Policy 2015

1234 North Street, Cairns QLD



The above would communicate to a consumer the risk, and the potential benefits of changing behaviour to mitigate that risk. To assist homeowners even further, information could be provided directly below the chart detailing practical tips on how a homeowner could mitigate cyclone risk and lower their premiums.

Financial Rights recognises that such a proposal may face objections from some in the insurance industry on the basis that pricing information is “commercially sensitive”. Even if “commercial sensitivity” is accepted to be an issue, Financial Rights does not believe that it is insurmountable and asserts that there are simple and creative ways to ensure such information is sufficiently obscured without denying homeowners the right to basic information about their insurance. For example, the component pricing could use percentage figures that are heavily rounded up or even display information using graphics and images only. The number of solutions available is in our opinion limited only by the will of vested interests rather than anything unique about insurance as a product. It is Financial Rights’ view that “commercial sensitivity” must no longer be used as an excuse to continue to keep homeowners in the dark about an essential and important product and should not be wielded as some sort of trump card to prevent any and all changes aimed at improving information asymmetry in the insurance market.

Financial Rights also supports greater access to information on natural hazard mapping, modelling, exposure and risk. Insurance companies are not currently required to make this information available to consumers even when it applies directly to their premium price.

Recommendations

24. The General Insurance Code should require Insurers to provide component pricing of premiums.

25. The General Insurance Code should encourage Insurers to provide consumers greater access to natural hazard mapping and modelling information when it applies directly to their premium price.

Previous year's annual premium

Financial Rights believes that all insurers should commit to providing the previous year's premium on the annual renewal notice. Information can include

- the price of the new policy if the consumer renews;
- any difference between the new price and the old price; and
- the reasons for any change.

Such a change will alter consumer behaviour by prompting consumers to think about their insurance, ask their insurer about the price and features, and make informed decisions.

This 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.

Case study: ILS Email from January 2017

INSURER reassessed our postcode area as being an increased flood risk in October and accordingly increased the premium from \$160 to \$462 a month. They sent out a policy saying it was time to renew and that I should read carefully the Supplementary PDS because some changes had been made. I read it thoroughly and did not observe the premium increase. I only found out two months later when I received my VISA card statement. Recently I've had increases in Health Care charges and Power charges. On both occasions the increases were minor, however on both occasions I was informed in a very clear letter highlighting the increases. I'd expect that INSURER increasing my premium by 288%, would have provided the same service to me. I believe the policy renewal was formatted in a way as to avert my attention from the premium increase. I'm no longer insured with INSURER. I am now insured with OTHER INSURER with the same coverage as INSURER for \$170.

We note that Medibank Private provide this service already in a separate statement sent to their members.



March 2017



T [redacted] 000
[redacted]
[redacted]
CREMORNE NSW 2090

Medibank Private Limited
ABN 47 080 890 259

GPO Box 9999
in your capital city
Telephone 132 331

medibank.com.au

Membership number: [redacted]

Your health cover premium is changing

Dear Ms [redacted]

We're writing to let you know that your premiums will be increasing as of 1 April 2017, following the government's approval of our premium review.

Your premium

Top Hospital \$500 excess and Basic Extras 70	
What you pay now	\$339.05 monthly
What you'll pay extra	\$20.00 monthly
What you'll pay from 1 April 2017	\$359.05 monthly

So why the change?

Put simply, we're living longer, we enjoy some of the best healthcare in the world, and we're using it more than ever. These are some of the things that affect what we all pay for health cover. That's why reviewing our premiums is important, so we can continue to support you, and all our members, to be healthier.

Here's what we're doing for you

We're providing 100% back on select services that can help millions of members live better lives. We've also introduced round-the-clock support for you online, and extended our call centre hours to Saturdays from 9am to 4pm. So, if you have any questions about your health cover or claims, our helpful team will be there for you any time.

If you'd like to know more about the cost of health cover, plus some helpful tips to get more from yours, visit medibank.com.au/premiumchanges

Kind regards,

David Koczkar
Chief Customer Officer

Your cover includes:



24/7 Health Advice line

Need health support or health advice? Our members can speak with a Medibank nurse 24/7 on 1800 644 325.



Cover for Accidents

If you have an Accident you'll get all of the coverage of our Top Hospital Cover - no matter what level of Cover you have¹.



100% back on dental check-up

On top of your dental limit, get 100% back on at least one dental check-up yearly at any Members' Choice dentist¹.



Medibank Mobile App

Manage your health cover from your mobile anywhere, anytime.

For full details on what you're covered for, visit medibank.com.au/members

Recommendations

26. The General Insurance Code require insurers to provide the previous year's premium on the annual renewal notice including
- the price of the new policy if the consumer renews;

- b. any difference between the new price and the old price; and
- c. the reasons for any change.

27. Insurers should provide premium hardship options under every policy they provide and provide this information on the renewal notice.

Section 5: Standards for employees, authorised representatives and authorised financial services licensees acting on behalf of a Code subscriber & Section 6: Standards for service suppliers

Application of the General Insurance Code

Financial Rights is of the view that all aspects of the General Insurance Code must apply to all Code Subscriber employees, Authorised Representatives, Service Suppliers as well as Authorised Financial Services Licensees Acting on behalf of the Code Subscriber.

With respect to Authorised Financial Services Licensees Acting on behalf of the Code Subscriber, Financial Rights notes that the CGC has identified a gap in the coverage under the General Insurance Code in relation to the selling of general insurance by entities who are not Authorised Representatives of a Code Subscriber as defined under the General Insurance Code, including insurance brokers, banks or credit unions. They state that:

While subsection 5.5 of the Code enables a policyholder to ask a Code Subscriber to address concerns about the selling practices of these entities, and to report their concerns to us, we are unable to breach the Code Subscriber if these entities do not comply with the Code when selling its general insurance products under their own Australian financial services licenses. This is because subsection 13.4 of the Code stipulates that a Code Subscriber will be in breach of the Code only if its Employees, Authorised Representatives or Service Suppliers fail to comply with the Code while acting on its behalf.⁵⁰

The CGC go on to state that “given the concerns identified by ASIC and some consumer legal groups about selling arrangements, we intend to examine this area in 2016–17.” Financial Rights believes that this Review provides an opportunity for Code Subscribers to get ahead of the game and make commitments relating to unauthorised sellers. With respect to Authorised Representatives and Authorised Financial Services Licensees Acting on behalf of the Code Subscriber, this is a distinction without a difference – particularly when it comes to consumers. The distinction needs to be removed and all contractual arrangements should be treated equally.

⁵⁰ GICGC Annual Report 2015-16, p. 20 <http://codeofpractice.com.au/assets/GICGC%20AR%202015-16.pdf>

Recommendations

28. The General Insurance Code must apply to all Code Subscriber employees, Authorised Representatives, Service Suppliers as well as Authorised Financial Services Licensees Acting on behalf of the Code Subscriber.
 29. The General Insurance Code should ensure that Subscribers will act where there has been a breach of the General Insurance Code by an unauthorised seller of their insurance products, to rectify harm caused.
-

Training

All employees, Authorised Representatives, as well as Authorised Financial Services Licensees Acting on behalf of the Code Subscriber should be appropriately trained to deal professionally with the public and particularly with respect to working with vulnerable consumers but not limited to those with a mental illness or mental health issues, mature age consumers, people with a developmental disability, people from a non-English speaking background (**NESB**), Aboriginal and Torres Strait Islanders, and those with a physical disability. There should also be specific training for those who have regular, direct contact with insured persons or applicants to be able to identify the signs of financial hardship.

Financial Rights goes into greater detail on this in the Claims Handling section that follows.

Recommendations

30. All employees, Authorised Representatives, as well as Authorised Financial Services Licensees Acting on behalf of the Code Subscriber should be appropriately trained to deal professionally with the public and particularly with respect to working with vulnerable consumers but not limited to those with a mental illness or mental health issues, mature age consumers, people with a developmental disability, people from a non-English speaking background, Aboriginal and Torres Strait Islanders, and those with a physical disability. There should also be specific training for those who have regular, direct contact with insured persons or applicants to be able to identify the signs of financial hardship.
-

Service Supplier Standards

Financial Rights goes into significant detail on the issue of third party private investigators and claims assessors in the Claims Handling section that follows. We direct you to read that section with respect to the details of the issues faced by consumers.

In addition to this though Financial Rights has significant concerns with respect to the appointing of Service Suppliers and what should be expected of them by Code Suppliers.

Firstly, subsection 3(b) of the General Insurance Code requires third party investigators (service suppliers) to hold a current licence but only “if required by law”. However there is significant ambiguity over whether private investigators working for insurance companies are actually required to be licensed under their state regulations.

All state licensing schemes exempt insurance companies, loss adjusters and their employees from the need to be licensed as a private investigator.⁵¹ If private investigators working on insurance investigations are exempt from the protections provided by the state regulations and codes, this would be of significant concern to Financial Rights. It would mean that private investigators working for insurers would not be subject to any limitation or constraints on their powers outside of those voluntarily entered into through membership of an association, any internal investigation procedures, processes or policies developed and maintained by insurance companies, or the minimal guidance provided by section 6 of the General Insurance Code. It would mean that for particularly egregious breaches of expected investigator conduct there would be little recourse for a consumer against the private investigator.

Some insurance companies do require their external investigators to be licenced. However this means that some of the investigators working in insurance investigations will be licenced and others will not. Not that this ultimately means much to a policyholder given the variability of regulations, dearth of standards and lack of clear avenues of redress applying to their conduct. Financial Rights’ *Guilty Until Proven Innocent* paper details the significant problems with private investigator regulations.⁵²

While Financial Rights has called for the Federal and State Governments through the Council of Australian Governments to intervene and develop uniform private investigator licensing regulations with an enforceable code of conduct, we also believe that the General Insurance

⁵¹ 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.” (AIPD 2008,

⁵² at 70-76

Code could assist to increase standards. Code Subscribers should commit to ensuring that all private investigators engaged as a service supplier be licensed. This would be separate and distinct to the current commitment for service suppliers generally at subsection 6.3(b) – who may or may not be private investigators and therefore have no licensing requirements at all.

Furthermore Code Subscribers should commit to only engaging private investigators who explicitly meet best practice standards for investigation - as recommended to be a part of the General Insurance Code in the following section.

Recommendations

31. Code Subscribers should commit to ensuring that all private investigators engaged as a service supplier be licensed.
 32. Furthermore Code Subscribers should commit to only engaging private investigators who explicitly meet best practice standards for investigation - as recommended to be a part of the General Insurance Code in the following section.
-

Section 7: Claims

Standards and procedures for investigations

Since Financial Rights established its ILS in 2007 our solicitors have felt that a large portion of their time has been dedicated to providing advice to clients on how to deal with the experience of being investigated by insurers. Solicitors regularly heard – and continue to hear – stories of bullying, threats and intrusive surveillance, with clients often reporting they feel they are being treated like a criminal or racially profiled.

In our submission to the Enright Review in 2012, Financial Rights alerted the ICA to our concerns with respect to investigation practices and the behaviour of general insurance employees and service providers. These concerns were neither acted on nor acknowledged in the Enright Review Final Report or subsequent 2014 Code of Practice.

Subsequent to this Financial Rights decided to take a closer look at the issue and in March 2016 published its findings in a report titled *Guilty until proven innocent: Insurance investigations in Australia*.⁵³

The report found that close to one in four calls to the ILS are from policyholders with concerns relating to insurance investigations. While insurers are entitled to investigate to ensure claims are genuine Financial Rights found a distinct lack of rules and protections for consumers being investigated. There continues to be no specific standards for the conduct of claims investigations in the General Insurance Code. There are no guidelines for the use of interpreters or independent support people, no right to have the interview held in a neutral location, no reminder or suggestion to seek legal advice and no interview time limits.

In examining queries and complaints relating to life insurance through our ILS phone and email advice services the most significant categories of concern related to:

- Delays in claims handling and financial hardship brought about or exacerbated by claims delays
- Unreasonable requests for information or piecemeal evidence gathering;
- Concerns with surveillance tactics;
- Concerns with investigation tactics;
- Impossible to meet definitions and out of date medical terminology;
- Disputes over whether a policyholder is capable of working;
- Disputes centred on non-disclosure or mis-representation;
- Complaints relating to problematic products.

⁵³ <http://financialrights.org.au/wp-content/uploads/2016/03/Guilty-until-proven-innocent.pdf>

Guilty until proven innocent detailed the lived experience of over 40 consumers subject to investigations who have contacted the ILS to seek advice and assistance with respect to their insurance claim. These case studies provide an insight into the common problems faced by consumers during an investigation.

In summary consumers routinely feel bullied, harassed and intimidated by investigators. They often describe being “treated like a criminal” and that the investigator has prejudged their guilt with little or no basis, putting forward theories that bear scant resemblance to reality.

Consumers are grilled with repetitive and seemingly irrelevant questions about highly personal and sensitive issues like past relationships and medical conditions. Consumers report being threatened with the rejection of their claim and other serious repercussions (such as the reporting of relatives to immigration) if they do not act in the way the investigator demands. There is little transparency or consistency with “insurance reports.”

Consumers from a Middle Eastern background have felt they have been racially profiled, others with poor English skills have not had access to appropriate translators, and consumers with mental health problems have been denied the use of a support person.

Consumers are provided with little or no explanation of the investigation process and no mention of any rights or standards. They are asked to sign documents that are not explained, asked to hand over personal and sensitive documents without warning and with no reasons given, and have had their neighbours, family, friends and business associates or clients questioned without the policyholder being notified.

The onerous demands placed on consumers by an investigation lead many to withdraw their claim, not due to any admission of fraudulent behaviour but simply because the process is too burdensome or invasive for many consumers to bear.

Other issues that policyholders face include poor internal dispute handling processes and disputes over whether a policyholder is capable of working, and no PDS available.

And despite the dismissal of the ICA of the 40 representative case studies that we outlined in *Guilty Until Proven Innocent* as “anecdotal” and “not evidence of a systemic problem”⁵⁴ we respectfully disagree. The ILS continues to hear from clients detailing poor behaviour by general insurance investigators.

In response to the release of the report the General Insurance CGC expanded its inquiry into arrangements with services suppliers to one that also examined claims investigations. In our submission to this inquiry, less than six months later, Financial Rights provided a further 29 case studies.

Financial Rights wonders how many case studies are required to demonstrate proof that there are fundamental systemic issues in the area of investigation practices but in order to

54 Claims investigations: a case to answer?, [insurancenews.com.au](http://www.insurancenews.com.au), 21 March 2016, <http://www.insurancenews.com.au/analysis/claims-investigations-a-case-to-answer>

demonstrate that this is an ongoing issue that Financial Rights continues to hear about on a daily basis we provide still further case studies below from the last six months:

Case study – George and Sarah’s story – CLASS C137021

- *overlong interview; poor behavior; request for different venue denied; irrelevant questioning*

George and his family moved out of their family home because his young son was sexually assaulted there. George would go to the property every month to check on it and had a neighbour looking over it. There was however a house fire and George’s Insurer began an investigation.

The Insurer interviewed George and his wife Sarah which George’s wife found an upsetting experience. The reason she was unhappy was that

- a) she was told the interview would go for one hour, it went for two and a half hours
- b) the investigator probed about the details of their son's sexual assault which she felt was not relevant and didn't feel comfortable in disclosing distressing details
- c) the investigator was “quite rude” - when she asked for a copy of the interview he said simply "no I don't have to provide it".
- d) when Sarah asked for the interview to be held at another venue not at her house, Sarah was refused.

The investigator asked Sarah to take part in a second interview. Sarah contacted the ILS to ask whether she had to given she had had such a traumatic first experience.

The investigator has asked for large number of documents repeatedly. George and Sarah have provided their phone records and bank statement five times as the Insurer keeps saying they don't have the documents. They are exasperated and feel harassed. They are sick of the whole process and are very upset.

Case study – Judy’s story – CLSIS 128379

- *Poor claims handling, breach of Code, overlong interview, delays*

Judy lodged a claim under her car insurance following the theft of her car which was later found burnt out. Judy’s insurer alleged that Judy could not establish that the theft had occurred because their forensic locksmith concluded that if the vehicle was started and driven, then it was by the use of a correctly coded key.

Consequently because both keys for the cars were with client and her partner, the forensic locksmith concluded that Judy must have staged the theft. The Insurer concluded that Judy made a fraudulent claim.

FOS found otherwise, that Judy did establish that a theft under the policy and did not stage the theft because

1. Judy's insurer didn't provide a police report in support of its position that Judy was involved in the theft
2. The notes between the investigator and the police showed the police did not suspect our client
3. There was no evidence which physically linked Judy to the theft or burning of the vehicle, and
4. FOS also found the forensic reports were not conclusive as to how the vehicle was stolen. FOS found Judy did not commit fraud because there was no evidence Judy had a financial motive to commit fraud, and Judy's Insurer didn't provide enough evidence to say Judy lacked credibility.

In the process of investigating there were significant delays including six weeks to organise investigator. Judy was interviewed for two hours after being told the interview would take just one hour.

The Insurer also did not provide their expert reports in breach of the General Insurance Code until after lodging in FOS.

Case Study – Erik's story - CLSIS 143846

- *Stressful process for man with mental illness*

Erik is being investigated after his boat caught fire and was completely destroyed. Erik hasn't been able to work lately because he suffers from severe anxiety, which also means he has been living with his parents. Erik had only taken out the insurance policy a few weeks before the boat fire so he understands why the insurance company is investigating, but he says the process has been very upsetting and he is thinking about withdrawing his claim because of how he is being treated. He says the investigator makes him feel like a criminal or like a child being scolded. The investigator keeps telling him that he is trying to catch Erik lying. The investigator also keeps wanting to talk to Erik's parents, but they are in their 80s and this is starting to cause them a lot of stress too. Additionally, Erik says the forensic assessor told him to his face that the claim looked very straightforward and there was no forensic evidence to show arson, but then when Erik saw the formal report it said arson was suspected and Erik might be making a fraudulent claim. Erik feels demoralised by the whole process.

Case Study - Tatiana's story - CLSIS 143849

- *Potential racial profiling*

Tatiana is from Georgia and speaks with a heavy Eastern European accent. She was recently in a car accident where she rear-ended another woman at a busy intersection after the other woman slammed on her brakes. Tatiana made a claim on her own insurance and now she is being investigated, but she has no idea why. She did not know the other woman but she says she was wearing a head scarf and had an Arabic sounding name. Her insurer has been telling Tatiana she will need to be interviewed and will need to produce phone records, financial records, and lots more. She keeps asking "Why is this happening to her?" She has had this insurance policy for over nine months, her car was not over-insured, and she has only made one claim in the last two years.

The case studies detailed above demonstrate a wide range of poor investigation practices and procedures. While Financial Rights found in its *Guilty Until Proven Innocent* Report that internal insurer standards policing investigations do exist, they are hidden from consumers and the public eye largely for commercial-in-confidence reasons. This has led to a lack of confidence in the process and healthy suspicion of insurance investigators. There is also a clear lack of effective statutory regulation with respect to investigator behaviour.

Financial Rights strongly recommends that general insurance industry establish a set of best practice standards for insurance investigations to be included in the General Insurance Code.

Financial Rights notes that the Financial Services Council's (FSC's) recently launched Life Insurance Code of Practice includes at 8.11 and 8.12 extensive minimum standards for the conduct of interviews and surveillance. Much of this is based on the recommended set of best practice standards that Financial Rights outlined in *Guilty Until Proven Innocent* as well as WorkSafe Victoria's Code of Practice for Private Investigators.⁵⁵

A set of best practice standards should ensure standard, clear and thorough communication practices to policyholders subject to investigation. As a minimum policyholders should be informed both verbally and in writing of their rights and obligations under the reciprocal duty of utmost good faith, the name and contact details of the investigator, the precise reason for the investigation, the standards of behaviour expected of the investigator, the timeframes that they will be working to and the internal and external complaints processes.

A set of best practice standards should detail standards and behaviours expected to be upheld in organising and conducting interviews including providing a choice of venue, limits on both the duration of an interview and the number of interviews, the right to request breaks, shorter interviews to help consumers meet family and employment responsibilities, and the right to be accompanied by an independent support person.

⁵⁵ WorkSafe Victoria, Code of Practice for Private Investigators, Effective July 2016, http://www.worksafe.vic.gov.au/__data/assets/pdf_file/0004/8707/Code-of-practise-for-Private-investigators.pdf

Furthermore a set of best practice standards should outline how investigators and insurers handle document requests, including providing clear reasoning as to the relevance of the documents requested.

Financial Rights directs the Reviewer to *Guilty Until Proven Innocent* which details a full set of standards that should be considered for inclusion in the General Insurance Code. We however do think it is worth listing (below in the recommendations) the issues that must be addressed in the General Insurance Code. Financial Rights believes that the inclusion of such clauses in the General Insurance Code are neither controversial nor difficult and will greatly improve procedural fairness in the insurance industry.

Recommendations

33. The Code must include a set of best practice standards for insurance investigations including the following:

- a. a commitment to standard, clear and thorough communication practices to policyholders subject to investigation including:
 - o investigators fully identifying themselves and on whose behalf they are acting;
 - o investigators explaining the exact reason for contacting the policyholder;
 - o investigators leaving a business card if the policyholder is unavailable;
- b. setting standards and behaviours expected to be upheld in organising and conducting interviews including:
 - o providing the policyholder with their choice of venue;
 - o 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;
 - o the right to request breaks;
 - o the right to a shorter interview to meet responsibilities;
- c. the right of the policyholder to be accompanied by an independent support person;
- d. the right of the policyholder to an interpreter where appropriate;
- e. the right to being interviewed by an investigator of the same sex;
- f. only recording an interview with the permission and authorisation of the policyholder;
- g. 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;

- h. 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;
- i. a commitment to comply with any reasonable restrictions placed on the interview by the interviewee and/or their legal representative;
- j. compliance with all state and federal surveillance and privacy laws;
- k. stricter surveillance commitments to ensure that an investigator:
 - o does not conduct surveillance on business premises;
 - o 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;
 - o does not record film inside any court, tribunal, conciliation or mediation service or centre, or any other quasi-judicial facility;
 - o does not record film inside any medical or health service or centre;
 - o 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;
- l. 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;
- m. a prohibition on any form of pretext activity, that is, any conduct or communication that conceals the true reason for that activity;
- n. 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;
- o. a prohibition on making any threat or promise, or offer any inducement to *any* person when conducting an investigation;
- p. 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
- q. 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.

- r. a reasonable basis for believing that the policyholder has given inconsistent information to it on a claim 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.

34. The General Insurance Code should include an explicit statement committing insurers and their third party service providers to compliance with all relevant State and Commonwealth laws including the *Privacy Act 1988*, the *Racial Discrimination Act 1975*, the *Disability Discrimination Act 1992*, all relevant state Crime Codes, all relevant Private Investigator regulations, all relevant equal opportunity act and all relevant state surveillance, listening devices and privacy laws.

Best practice standards for working with vulnerable consumers

Financial Rights believes that in addition to the inclusion of best practice standards outlined above there should also be a specific section developed to focus on the needs of vulnerable persons, generally. This term captures a large array of people that have distinctive needs or require special consideration when they interact with an insurance company. They include those with a mental illness or mental health issues, mature aged consumers, people with a developmental disability, people from a NESB, Aboriginal and Torres Strait Islanders, and those with a physical disability. Our report *Guilty Until Proven Innocent* details significant issues faced by two of these groups those with a mental health issue and people from a non-English speaking background.⁵⁶

The Association of British Insurers (**ABI**) and the British Insurance Brokers Association's (**BIBA's**) recent Code of Good Practice, January 2016 provides a good discussion on the definition of vulnerability in an insurance context.⁵⁷ The aim of the Code of Good Practice:

*is to ensure that customers, who may, at any given time in their interaction with their insurance provider, be significantly less able than a typical consumer to protect or represent his or her interests, do not unduly suffer detriment as a result.*⁵⁸

The ABI and BIBA rely on the Financial Conduct Authority's (**FCA's**) list of risk factor for vulnerability including:

56 pp. 50-57, <http://financialrights.org.au/wp-content/uploads/2016/03/Guilty-until-proven-innocent.pdf>

⁵⁷ The Association of British Insurers and the British Insurance Brokers Association's recent Code of Good Practice, January 2016
<https://www.abi.org.uk/globalassets/sitecore/files/documents/publications/public/2016/vulnerable-customers/abi-biba-code-good-practice-support-potentially-vulnerable-motor-household-customers-renewal.pdf>

⁵⁸ Ibid paragraph A.2

- a. *Low literacy, numeracy and financial capability skills.*
- b. *Physical disability.*
- c. *Severe or long-term illness.*
- d. *Mental health problems.*
- e. *Being 'older old' for example over 80, although this is not absolute (may be associated with cognitive or dexterity impairment, sensory impairments such as hearing or sight, onset of ill-health, not being comfortable with new technology).*
- f. *Change in circumstances (e.g. job loss, bereavement, divorce).*
- g. *Lack of English language skills.⁵⁹*

The Code of Good Practice then describes the ways vulnerability can manifest themselves:

- *A reduced understanding of alternative products or providers;*
- *Perceptions of barriers to exit from their existing provider (whether real or perceived);*
- *A reduced access to the market or an ability to shop around;*
- *A reduced ability to compare products or a lack of understanding of their features and how they may impact on the customer.*
- *A heightened 'trust' in the product and premium offered by their current insurer or broker.*

Financial Rights believes that this work by the British equivalent of the ICA should guide it in the development of a similar approach under the General Insurance Code.

Other organisations already do so, leaving the general insurance sector well behind the eight ball.

Police forces across Australia recognise and acknowledge the need to identify and institute appropriate procedures when, for example, interviewing vulnerable persons. While Financial Rights acknowledges the differences between insurance investigation and police investigations, the process falls within a similar procedural context raising similar issues. It is Financial Rights' view that it is appropriate for insurers to take into account the needs of vulnerable persons when interviewing but also when accessing insurance, making a claim, making a complaint or generally communicating with a general insurance company.

Financial Ombudsman Service recognises and acknowledges the needs of vulnerable people through its FOS Accessibility Guideline and "is committed to being accessible to all people and to meeting any particular needs people using our service may have".⁶⁰ This guideline explicitly details some of the factors that affect access to the service including: language barriers, physical impairments, medical conditions, literacy barriers, mental health issues and social and

⁵⁹ Ibid paragraph A.3.

⁶⁰ FOS, Accessing FOS – how can we help? <https://www.fos.org.au/custom/files/docs/consumer-fact-sheet-on-accessibility.pdf>

economic barriers. The Financial Ombudsman collects statistics on those vulnerable people who use the service. In 2014-15, 817 requests were made for special assistance up from 808 in 2013-14⁶¹ Mental Health issues made up 45% of this figure at 366 applicants. 590 applicants requested assistance of a translator, up from 573 from the previous year.⁶² These figures demonstrate the extant and increasing need in the community for assistance as well as the need for a flexible and constructive approach in engaging with vulnerable people.

Financial Rights strongly supports this approach and is of the view that vulnerable people are routinely treated poorly by a system that fails to acknowledge the needs of particular sections of the community.

Financial Rights notes that the FSC has included a section in the Life Insurance Code titled Consumers requiring additional support. The section commits life insurers to the following:

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

7.2 We will have processes in place to train our staff to help identify and engage appropriately with consumers who are having particular difficulty with the process of buying insurance, making an inquiry, making a claim or making a Complaint, or who may not be capable of making an informed decision, and to refer these consumers for appropriate additional support where required.¹³ We will take into account someone's capability when making decisions that impact them.

7.3 We acknowledge that we will not always be able to identify when someone requires additional support at the time of their insurance application. If we later become aware that we or our Authorised Representative has sold a Life Insurance Policy to a customer who was not provided with the additional support they needed to make an informed decision, we will investigate this and if the Life Insurance Policy was sold inappropriately, we will remedy this in accordance with section 4.9. If the person who recommended our Life Insurance Policy (for example, your financial adviser) is not our staff or our Authorised Representative, we will tell you how you can have the matter addressed.

7.4 We recognise that some groups of consumers (for example, people from Indigenous communities or those from non-English speaking backgrounds) may require support in meeting identification requirements when buying insurance or making a claim or Complaint.

⁶¹ Financial Ombudsman Service (FOS), (2015). Annual Review 2014-2015, <https://www.fos.org.au/custom/files/docs/20142015-fos-annual-review.pdf> Financial Ombudsman Service (FOS), (2014). Annual Review 2013-2014, <http://www.fos.org.au/custom/files/docs/20132014-annual-review.pdf>

⁶² Ibid

We will undertake reasonable measures to assist those consumers and still meet our obligations under the law.

7.5 We recognise that people living in remote and regional communities may have trouble meeting their obligations to provide us with documents and to take part in assessments in the timeframes we set. We will take this into account when going through the underwriting and claims processes.

The current Australian Bankers Association (**ABA**) Code of Banking Practice includes an acknowledgement of Customers with Special Needs and Customers in Remote and Indigenous Communities

7. Customers with special needs

We recognise the needs of older persons and customers with a disability to have access to transaction services, so we will take reasonable measures to enhance their access to those services.

8. Customers in remote Indigenous communities

If you are a member of a remote Indigenous community, we will take reasonable steps to:

(a) make information about banking services that may be relevant to you available in an accessible manner;

(b) at your request, provide you with details of accounts which may be suitable to your needs, including in a remote location. This information may include details of our accounts which attract no or low standard fees and charges;

(c) assist you with meeting identification requirements (having regard to our obligations under the Anti- Money Laundering and Counter- Terrorism Financing Act 2006);

(d) appropriately train staff who are regularly dealing with you in a remote location to be culturally aware; and

(e) consider publicly-announced key Commonwealth, State and Territory government programs, such as income management programs, that may be relevant in providing our banking services to you.

The current Independent Khoury Review into the Code of Banking Practice has also recommended a raft of principle based changes to this section to boost banks commitment to customers with special needs.⁶³ The ABA has responded positively and has stated that they will implement the recommendation including, among others:

- *Support[ing] a commitment by banks to financial inclusion and recognition of the diverse needs of some customer groups.*
- *ensuring the accessibility of banking products and services for all Australians, including people with a disability.*

63 Recommendations 70-77, Phil Khoury, Independent Review of the Code of Banking Practice, 31 January 2017 <http://cobpreview.crkhoury.com.au/wp-content/uploads/sites/2/2017/02/Report-of-the-Independent-Review-of-the-Code-of-Banking-Practice-2017.pdf>

- *Agree[ing] that the Code should be clearer about commitments to customers with disabilities.*⁶⁴

It is also worth detailing in full the specific clauses of the ABI and the BIBA Code of Good Practice regarding support for potentially vulnerable motor and household customers at renewal.⁶⁵ We believe that this should act as a model for the General Code:

C. Customer commitments

(a) Business processes at renewal for potentially vulnerable customers.

Insurers and Brokers should:

- 12. Ensure staff are adequately trained to recognise and understand potentially vulnerable customers at renewal, listen to their particular needs and be equipped with flexible options to help address those needs where appropriate.*
- 13. Implement business processes, with prescribed triggers, to ensure that the Insurer or Broker, where relevant, is satisfied that products offered and pricing for those identified as potentially vulnerable customers are fair and reasonable.*
- 14. Take account of the characteristics associated with vulnerability in making decisions on pricing and promotional practices in order to mitigate against the risks of poor customer outcomes for potentially vulnerable customers.*
- 15. Periodically review customers on legacy products and where potentially vulnerable customers can be identified take proactive steps to ensure that the product continues to meet their needs and that they are aware of any alternative products.*

(b) Proactive communication.

In renewal communications with those identified as potentially vulnerable customers Insurers and Brokers should:

- 16. Where possible proactively ask the customer if their current policy and renewal offer meets their ongoing needs and make clear to the Customer that they should review their cover at renewal.*
- 17. Consider whether additional communication by letter, email, telephone, text etc. would be appropriate compared to their standard approach to customers at renewal, or whether a more inclusive renewal offering process, or specialised customer support is available to help address any identified risk factors for vulnerability.*
- 18. Ensure communication always sets out the customer's options at renewal and how they go about exercising those options.*

64 pp25-6, ABA, Code of Banking Practice Response by Australian Bankers' Association to Review Final Recommendations, 28 March 2017

⁶⁵ January 2016

<https://www.abi.org.uk/globalassets/sitecore/files/documents/publications/public/2016/vulnerable-customers/abi-biba-code-good-practice-support-potentially-vulnerable-motor-household-customers-renewal.pdf>

19. *Not explicitly encourage the Customer to do nothing at renewal as this may discourage active engagement in the renewal decision.*
20. *Explain to the Customer that factors affecting their premium may have changed since their last renewal and that the Customer can contact their Insurer or Third Party to satisfy themselves that the product is still suitable for their needs.*

Closely related to the acknowledgement of, and addressing the needs of vulnerable consumers is the need for general insurers to make a public statement supporting the principals of diversity and anti-discrimination.

Financial Rights notes that in its 2013 report *Access All Ages – Older Workers and Commonwealth Laws*,⁶⁶ the Australian Law Reform Commission recommended that the General Insurance Code include a general statement on diversity and anti-discrimination encouraging insurers to consider the needs and circumstances of a diverse range of consumers, including mature age persons.

The 2012 Independent Review of the General Insurance Code briefly examined the issue of discrimination and while stating it was “terribly important” suggested that it was not possible in the timeframe to examine it more thoroughly.

Financial Rights recommends that this current Review consider the issues around diversity and anti-discrimination and introduce clause that address the needs of mature age people, people from non-English speaking backgrounds, those with a disability or with a mental illness. Such a clause should apply to third party service providers and to all stages of the insurance process including investigations.

People with a mental illness or mental health issue/s

There are a significant number of unique issues faced by policyholders with mental health problems including the discrimination they face in obtaining insurance in the first place, increased premiums, excessive restrictions on their policies, exclusions written into policies without regard for section 54 and rejection of their claims when a history of mental illness is disclosed. In addition to these issues, Financial Rights receives calls from policyholders with mental health problems who are under investigation and have significant concerns – either that the investigation process may impact negatively upon their mental illness, or that their mental illness will impact on their claim and the investigation in a negative way. Financial Rights also hears from policyholders who do not want to be interviewed, wish to be interviewed in a particular way or wish to have a support person present because of their mental health condition.

Other callers are concerned that the information provided in their interview was not clear enough because of an issue related to their mental illness or the medication that they were taking. Financial Rights understands that at least some investigators do ask whether the interview participant is on any medication (or any other substances) that would impair their ability to take part in the interview. Policyholders with a mental illness are concerned whether the simple fact that they have mental illness will impact negatively upon their claim.

⁶⁶ https://www.alrc.gov.au/sites/default/files/pdfs/publications/whole_final_report_120.pdf

Another issue that arises frequently is the situation where a third party's mental health becomes the central focus of an insurer's investigation and is relied upon in an attempt to defeat a claim.

Financial Rights details a number of case studies in our *Guilty Until Proven Innocent* Report.

Financial Rights notes that FOS have recently issued a landmark determination⁶⁷ with respect to general exclusions relating to mental illness is unlawful as it offends section 24 of the *Disability Discrimination Act 1992* and that the insurer did not have the actuarial and statistical data to enable it to meet the exemptions under section 46 of the *Disability Discrimination Act 1992*. This decision will have a significant impact upon general insurers given the prevalence of general mental health exclusions, particularly in travel insurance. Financial Rights strongly believes that this Review must examine this determination closely and develop an appropriate response that acknowledges and deals with this determination within the General Insurance Code.

Much work has been undertaken by the mental health sector and the life insurance industry in tackling these issues including the development of a memorandum of understanding between life insurers and a coalition of mental health sector stakeholders.⁶⁸ However it seems less work has taken place in the General Insurance context.

In the development of the recent Life Insurance Code of Practice, there were few clauses that address the issues faced by insurance consumers with a mental illness. Clause 5.16 states that life insurers will comply with "all relevant FSC Standards and Guidance" which includes Standard No. 21 - Mental Health Education Program and Training, and Guidance Note No. 15 - Underwriting Guidelines for Mental Health Conditions. Within the next 18 months though, the FSC is looking to develop the next iteration of the General Insurance Code and have stated publicly that they will be looking to introduce mental-health specific standards into their Code:

"seek to increase obligations on insurers when interacting with consumers suffering mental health issues. ... [and] work with groups like Beyond Blue, Lifeline, Mental Health Australia

67 FOS Determination 428120, 31 March 2017

68 In 2003, the then Investment and Financial Services Association (IFSA) (now the Financial Services Council) representing life insurers developed this MOU with the coalition of mental health sector stakeholders (MHSS) in recognition of the issues faced by people with a mental health disorder. The MHSS included the Mental Health Council of Australia, Beyond Blue the Australian Psychological Society and five other representative organisations. The aim of the memorandum was to "improve the industry's understanding of mental health conditions, their risk management practices and ultimately the life insurance outcomes for Australians with mental health conditions." The memorandum has led to a number of significant developments including new guidelines for underwriting and claims treatment, a mechanism to address complaints, consumer facts sheets detailing the process, information sheets to assist the community to understanding the implications of applying for insurance products and the importance of making accurate statements about their health, annual data collection and the introduction of the Financial Services Council's Standard No. 21 Mental Health Education Program and Training.

and the Public Interest Advocacy Centre to determine how to better serve those consumers with mental health issues.”⁶⁹

Following the lead of the FSC, Financial Rights recommends that the Insurance Council of Australia work with mental health stakeholders to develop specific standards to be included in the General Insurance Code.

The FSC’s Standard No. 21 regarding Mental Health Education Program and Training for example requires that life insurance members of the FSC must implement a Mental Health Education Program for its representatives which:

- Increases their general awareness and understanding of the causes, signs and symptoms of common mental health conditions in the community
- Increases their understanding of what it’s like to have a mental health concern
- Helps them to develop communication skills for interacting with consumers who may have mental health concerns.

Financial Rights believes similar program should be implemented in the General Insurance industry. In addition, employees who have regular, direct contact with insured persons or applicants should have specific training in relation to:

- a. Communicating the process and outcome of insurance applications that involve the disclosure of a mental health concern; and
- b. Managing a policyholder’s claim with mental health conditions/concerns.

There is extensive and growing literature on communicating with people who suffer from a mental illness that has fed into police interviewing techniques, legal aid interviewing clients and interviewing people with a mental illness in other contexts. Financial Rights believes that general insurers and investigators should be appropriately trained to interviewing and communicating with people with a mental health issue.

Recommendations

35. The General Insurance Code should include a section specific to acknowledging and addressing the particular needs of specific vulnerable consumers including, but not limited to those with a mental illness or mental health issues, mature age consumers, people with a developmental disability, people from a non-English speaking background (NESB), Aboriginal and Torres Strait Islanders, and those with a physical disability.

36. This section should include commitments to:

- a. ensure staff and third party service suppliers are adequately trained to recognise and understand potentially vulnerable customers at renewal, listen to their particular

⁶⁹ FSC, Media Release: Life Insurance Code of Practice, 11 October 2016, http://www.fsc.org.au/downloads/file/MediaReleaseFile/2016_1110_MediaRelease_LifeInsuranceCodeofPractice_final.pdf

needs and be equipped with flexible options to help address those needs where appropriate.

- b. implement business processes, with prescribed triggers, to ensure that the Insurer, where relevant, is satisfied that products offered and pricing for those identified as potentially vulnerable customers are fair and reasonable.
 - c. take account of the characteristics associated with vulnerability in making decisions on pricing and promotional practices in order to mitigate against the risks of poor customer outcomes for potentially vulnerable customers.
 - d. periodically review customers on legacy products and where potentially vulnerable customers can be identified take proactive steps to ensure that the product continues to meet their needs and that they are aware of any alternative products.
 - e. where possible proactively ask the customer if their current policy and renewal offer meets their ongoing needs and make clear to the Customer that they should review their cover at renewal.
 - f. Consider whether additional communication by letter, email, telephone, text etc. would be appropriate compared to their standard approach to customers at renewal, or whether a more inclusive renewal offering process, or specialised customer support is available to help address any identified risk factors for vulnerability.
 - g. Ensure communication always sets out the customer's options at renewal and how they go about exercising those options.
 - h. Not explicitly encourage the Customer to do nothing at renewal as this may discourage active engagement in the renewal decision.
 - i. Explain to the Customer that factors affecting their premium may have changed since their last renewal and that the Customer can contact their Insurer or Third Party to satisfy themselves that the product is still suitable for their needs.
 - j. Provide an interpreter when an insurer is put on notice that a person does not understand the terms being explained to them;
 - k. Assist vulnerable persons (for example, people from Indigenous communities or those from non-English speaking backgrounds) may require support in meeting identification requirements when buying insurance or making a claim or Complaint
 - l. Assist people living in remote and regional communities to provide us with documents and to take part in assessments in the timeframes we set.
37. The section should also include a statement supporting the principals of diversity and anti-discrimination.
38. The General Insurance Code should include specific mental health standards addressing the unique issues faced by those with a mental illness including but not limited to:
- a. the development of mental health education and training for *all* staff and third party service providers

- b. a commitment to remove all general mental health exclusions from all general insurance products and
 - c. explicit reference to complying with the *Disability Discrimination Act*.
-

Standards for use of interpreters

Financial Rights recommends that explicit inclusion of minimum standards in the use of interpreters in the General Insurance Code is warranted, given the practices described in this Report.

Financial Rights notes that in the FOS 2008 Referee Report the Referee concluded that insurers needed to review and bolster their guidelines to promote better practice.⁷⁰ However it is unclear whether this has occurred or has led to any perceivable changes in industry practice. Given the case studies detailed in our *Guilty Until Proven Innocent* Report the issue remains a significant one.

Financial Rights further notes that the Commonwealth Ombudsman recently examined the use of interpreters in government agencies including the Federal Police. While not examining investigation practices exclusively, the Ombudsman developed a set of eight Best Practice Principles for the Use of Interpreters. They include amongst others: promoting access to interpreter services; providing fair, accessible and responsive services; specifying who can be used as an interpreter (i.e. an independent interpreter should be used not a family member or friend); staff should be appropriately trained and good records should be maintained.⁷¹ These principles would be a sound starting point for the development of minimum standards in the use of interpreters for inclusion in the General Insurance Code.

Recommendations

39. The General Insurance Code should include minimum standards in the use of interpreters.

⁷⁰ “I would strongly recommend to all insurers that they audit their guidelines for the use of interpreters, in particular where statements taken by investigators are to be used to highlight inconsistencies and form the basis of an allegation of fraudulent conduct. Ensuring they have a robust process for determining the use of interpreters should help resolve a number of ‘inconsistencies’ to the benefit of all parties” (IOS 2008, p11).

⁷¹ Commonwealth Ombudsman, McMillan, Prof. J. (2009). Use of Interpreters, Report No 3, http://www.ombudsman.gov.au/files/investigation_2009_03.pdf; Commonwealth Ombudsman, (2009). Fact Sheet 4: Use of Interpreters, <http://www.ombudsman.gov.au/docs/factsheets/onlineFactSheet4-interpreters.pdf>

Family Violence standards

Financial Rights understands that the ICA is in the preliminary stages of reviewing and addressing internal procedures relating to the family violence issues that arise in general insurance. We support this work and strongly encourage the ICA to include commitments in the General Insurance Code to ensure that subscribers implement appropriate underwriting and cancellation processes and protocols for insurance. Abusive partners should be prevented from committing financial abuse through the purchase and/or cancellation of insurance.

We also refer the ICA to:

- the EARG's recent Good Practice Industry Guideline for Addressing the Financial Impacts of Family Violence, and
- the submissions of other consumer advocates to this Review which comment on family violence issues in detail.

Joint Insurance

An issue related to family violence, but one that also occurs in normal family breakdown scenarios is lack of notification to both parties when changes are made to a joint insurance policy. Financial Rights has spoken to a caller whose partner was able to unilaterally cancel their insurance policies leaving the caller uninsured when damage occurred at a jointly-owned property. We have also spoken to a caller whose policy had been changed into just the name of her estranged brother and she was unable to make a claim on the policy when she needed to.

Recommendations

40. The General Insurance Code should require insurers to notify each policy-holder about any changes to a joint insurance policy.

Claims Handling, Timeframes and Withdrawn claims

Financial Rights notes the CGC recent 2015-16 Industry data report findings that show that there have been a significant increase in the number of breaches of the 10 day decision time frame set by subsection 7.16. The CGC found there were 363 breaches of 7.16 from 2014-15 a 56% increase from the previous year. There were a further 491 breaches of clause 7.9. The

CGC further note that they have concerns about the number of breaches being recorded against these sections as they rank second and third in the top five areas of non-compliance.

The CGC recommend a series of actions from Code Subscribers including

- *review complaints about delays in making claim decisions to try and identify areas of emerging risk*
- *conduct regular reviews of current and closed claim files, including denied claims, to assess whether employees and Service Suppliers are complying with subsection 7.16*
- *test claim decision making processes to ensure they operate at optimal efficiency*
- *assess and ensure resourcing of claims handling areas is adequate to allow for timely and efficient claim decisions.*

The CGC further noted that there were 560 breaches of subsection 7.10, a 63% increase compared to the previous year. Subsection 7.10 (c) relating to the provision of an initial estimate of the timetable and process for making a claim decision made up 50% of the breaches here. This finding is supported by a survey question we asked in our *Guilty Until Proven Innocent* Report where we asked callers:

Did the insurance company or investigator provide any information in writing about the investigation process?

Did the insurance company or investigator explain the process of investigation to you?

While not exactly asking whether callers were provided an estimated timetable, it is clear that if a caller has not been provided information in writing nor has had the process explained that is highly unlikely an estimated timetable has not been provided in these circumstances.

The survey found that 81% of respondents were not provided with information in writing about the investigation process by the insurance company or investigator and 62% were not explained the process of investigation.

The CGC expressed concern “about the ability of Code Subscribers to comply and actively engage with consumers.” Financial Rights too hold serious concerns in this regard. The CGC state that:

“the standards in subsection 7.10 aim to promote a higher level of transparency with consumers so they are clear on:

- *what is required to progress their claim*
- *what Code subscribers need to do to make a claim decision*
- *how long the decision may take”*

While this is obvious it is important to reiterate, what the CGC do not go on to say but is clear to Financial Rights is that the extraordinary lengths of time involved in claims handling generally and the uncertainty with respect to how long a claim will take to be processed is the key source of frustration for consumers and lead many to simply withdraw their claims.

Financial Rights notes with interest that the CGC Industry Data Report 2015-16 demonstrates a disturbing trend with respect to withdrawn claims, that is, they have been trending upwards.

Chart 3 Retail declined claims, withdrawn claims & internal disputes about declined claims from 2011–12 to 2015–16



The CGC suggest that the reasons for this are because due to “enhancements Code Subscribers made to their systems and reporting frameworks” as well as “gaps in consumer understanding of how some of these products operate in practice” and “some withdrawn retail insurance claims may represent claims that would otherwise have been declined.”⁷² Financial Rights would suggest that there may be further reasons. That is frustration by the length of time claims take to get settled and the onerous demands of investigations leading to withdrawal of claims.

While Financial Rights understands that claims handling can take some time and is not necessarily straightforward in many cases, there are reasonable delays and there are prima facie unreasonable delays.

Financial Rights found that, when examining 130 disputes from 2015 where the Financial Ombudsman made a determination on a dispute involving a denial of a claim on the basis of a

⁷² p. 4.

<http://codeofpractice.com.au/assets/documents/March%202017%20General%20Insurance%20Code%20Governance%20Committee%20-%202015-16%20Industry%20Data%20Report%20FINAL.pdf>

fraud allegation, the average length of time policyholders had to face was 521 days or a little under a year and a half. Examining those disputes where the Financial Ombudsman actually found in favour of the policyholder, the average was slightly less at 503 days.

Financial Rights suspects that delays, poor investigation behaviour and other tactics are so widespread that in many cases they amount to business models.

The CGC notes that

Unlike the requirements that apply to declined retail insurance claims, Code Subscribers are not under any obligation to provide written notification of a claim withdrawal or the reasons, or to notify consumers of their rights to access information underlying the assessment of their claim, internal and external complaints and dispute resolutions processes

Financial Rights believes that this should be the case to provide a clearer picture

Further:

Not all Code Subscribers were able to provide data about withdrawn retail insurance claims due to changes and improvements to their legacy systems. As a result, the data remains incomplete. We continue to work with Code Subscribers to develop a more complete data set to enable better analysis.

We believe increased sanctions need to be considered with respect to time delays. Fines may be one option. For further discussion see our section below re: sanctions.

Recommendations

41. The General Insurance Code should commit subscribers to providing more information with respect to withdrawn claims including written notification of a claim withdrawal and the reasons, and notify consumers of their rights to access information underlying the assessment of their claim, internal and external complaints and dispute resolutions processes when a claim is withdrawn.

Discouraging Claims

Further to the above discussion of claims time frames and withdrawals, Financial Rights notes subsection 7.8 commits Code Subscribers to the following

*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.***

Financial Rights believes that this commitment is limited in two ways.

Firstly, the commitment to not discourage a consumer from claiming is limited to the situation where a consumer asks if their insurance policy covers a particular loss before a claim is

lodged. There are many scenarios where a consumer is not specifically asking that question but are nevertheless discouraged from lodging a claim generally.

Secondly and more importantly Financial Rights speaks regularly to consumers who have been or are being encouraged to withdraw their claim during the claims process itself. This leaves the consumer unable to access dispute resolution mechanisms. Financial Rights notes with concern that the CGC have recently reported a 29% increase in withdrawn claims⁷³ and submit that some proportion of these withdrawn claims would involve consumers encouraged to withdraw without a sound basis.

Financial Rights believes that the General Insurance Code needs to include a broader commitment to neither discourage a claim nor encourage a withdrawal where there is a valid claim.

Recommendations

42. The General Insurance Code needs to include a broader commitment to neither discourage a claim nor encourage a withdrawal where there is a valid claim.

External Expert Reports

As mentioned above one significant issue raised by callers to the ILS subject to an investigation is the time and long delays involved.

Financial Rights notes that under subsection 7.15 of the General Insurance Code an external expert engaged to provide a report must do so within 12 weeks. If they do cannot meet this deadline or fail to meet this time frame the only obligation upon the insurer then is to “inform you of this and keep you informed of our progress in obtaining the report.”

The second part of subsection 7.15 is problematic for two reasons. Firstly it provides a “get out of jail free card” for failure to produce a report in the 12 week timeframe, because there is neither a time frame around keeping a policyholder informed (is it every week, two weeks, month, three months?) nor is there a hard line endpoint to when a report can be reasonably produced.

Financial Rights recommends that this be tightened.

⁷³ CGC GI Industry Data Report 2015-16, p. 4

<http://codeofpractice.com.au/assets/documents/March%202017%20General%20Insurance%20Code%20Governance%20Committee%20-%202015-16%20Industry%20Data%20Report%20FINAL.pdf>

Recommendations

43. If an expert report cannot be provided within 12 weeks of the date of their engagement, the General Insurance Code should commit insurers to informing the policyholder every 10 days. If after 30 days the report has not been provided, the policy holder will be provided with details of the Complaints process.

Uninsured 3rd parties

Currently the General Insurance Code provides some provisions in relation to the position of uninsured 3rd parties.

There are many circumstances where insurers and uninsured 3rd parties have interactions. We believe the General Insurance Code should improve the claims handling of insurers when dealing with 3rd parties. The mutual benefits include:

- the reduction of involvement of “demurrage” or claims handling firms;
- more efficient claims handling and reduced claims in FOS and Court; and
- improvement of consumer attitudes towards insurers.

Specifically we have concerns about uninsured and not at fault drivers who are making claims through the insurance of the at fault driver. First we strongly support the FOS jurisdiction for these consumers to be increased from \$5000 to \$20,000. The ABA recently supported expanding the general jurisdiction of FOS in relation to consumer disputes in response to its own Code review.⁷⁴ We would like to see the ICA similarly support expanding FOS’s jurisdiction for uninsured motorists.

Financial Rights also strongly supports better communication from insurers towards uninsured 3rd parties in regards to the process of dealing with the insurer, explaining how to make a complaint through the insurer’s IDR, and the special FOS jurisdiction for uninsured not at fault drivers.

Recommendations

44. The General Insurance Code should require subscribers to inform uninsured, not at fault, 3rd parties who are claiming under the other driver’s insurer about:

- a. the process of dealing with the other driver’s insurer;

⁷⁴ http://retailbankingremreview.com.au/wp-content/uploads/2017/03/ABA_response_to_Issues_Report_Remuneration_Review.pdf

- b. the process of complaining to IDR; and
- c. the ability to lodge a complaint through FOS's jurisdiction for uninsured not at fault drivers.

Written off vehicle register

Financial Rights regularly gives advice to callers regarding problems arising from their car being declared a write off by an insurance company after an accident. There are some differences in each State and Territory as to terminology, but generally all insurers acknowledge two classifications of written-off vehicles (**WOV**):

- a) Statutory Write-Off: WOVs that are unrepairable because they are unsafe to repair (sometimes called "non-repairable write off"); and
- b) Uneconomical to Repair: WOVs that are repairable but the cost of repairs plus the salvage value is greater than the market value of the vehicle before the accident ("repairable write off")

Financial Rights recognises that there are legal definitions for a 'Statutory Write-Off' and assessors have no choice but to put such vehicles on the Written-Off Vehicle Registry (**WOVR**), which will mean they are immediately de-registered. However, we believe insurers have more flexibility when it comes to declaring a car a WOVR simply because it is uneconomical to repair. Financial Rights accepts the beneficial purpose of the legislation is not for the insured or insurer, but for other road users, however, we believe insurers are making the significant decision to write off vehicles where there is a clear conflict of interest.

Financial Rights believes the General Insurance Code should re-dress the imbalance. Insurers should be more transparent, willing to discuss option and considerate in their decision making.

The issues arise in two scenarios:

- Insureds dealing with their own insurer;
- Uninsured 3rd parties dealing with the at fault party's insurer.

The most difficult situations arise when a not-at-fault driver's car has been written off as uneconomical to repair by another driver's insurer, and the car owner has had no warning that the insurer can write the car off. Further, the owner has no right to dispute the decision or conduct of the insurer in FOS.

This is the main complaint that we hear: the lack of adequate notification about a motor vehicle being placed on the WOVR

The implications of assessment

We regularly hear from car owners that believe their car is repairable and they are willing to pay for the repairs, but the car has already been de-registered and listed on the WOVR by the insurer of the at fault party. The insurer insists on "assessing" the car, and does not inform the

owner that if they determine the car to be written off that this will lead to the car being deregistered.

Not at fault consumers feel poorly treated and feel strongly that the insurer's actions are conflicted, preferring their own interests of reducing the damages than being fair or interested in the safety of other road users.

Consumers do not have to have the at fault parties insurer assess their car to be entitled to damages.

It is Financial Rights' view that an insurer should not insist upon "assessing" a vehicle of the non-insured without clearly informing the owner that:

- their car may be written off;
- written off means that the vehicle registration will be cancelled; and
- the car may not be re-registered without an authorisation to repair which may be hard to obtain.

The car is deregistered and should not be driven

We regularly hear complaints from car owners given no notification before his/her car was declared a write off and was listed on the WOV. This is a particular problem when the car is still drivable and the owner is now driving a deregistered vehicle.

Insurers must notify consumers and comply with WOV legislation in affixing notices to cars that have been declared a write off.

Case study - Deidre's story - caller from April 2017

Deidre was in car accident which was not her fault. She was comprehensively insured but decided to let the other driver's insurance handle things at first. The other driver's insurance assessed her car as a total loss and said it was worth \$3000, but Deidre was not happy with this amount. She had an "estimated value" in her own comprehensive policy for \$5800 so she told the insurer to forget it, she would claim on her own insurance. In the meantime her car was still driveable, so she continued to use it.

A few weeks later she received a letter from her local Motor Vehicle Authority informing her that her car has been deregistered at least 10 days prior to her receipt of the letter. The other driver's insurer had reported her vehicle as a total loss to the WOV.

The other driver's insurer had given her no notice or warning that it was going to send through the total loss paperwork to the WOV. Deidre had been driving around in a deregistered vehicle for over a week. The insurer apologised, said yes that was their fault, they can see in their file that she had told them she would claim on her own insurance, so they offered her a rental car, but she doesn't need it. She is terrified to think about what could have happened had she had another accident while she was driving around in an unregistered car.

Case study – Raelene’s story

After an accident Raelene made a claim and her vehicle was assessed right away. One week later she was told that her car was a ‘repairable write off’. Raelene immediately contacted the insurer to discuss her options because she understood that the vehicle had no structural damage and was mechanically in very good condition. Raelene said she wanted to keep the vehicle and she was very clear with the insurer about this. She was told that a manager would return her call to discuss the claim within 24-48 hours. She immediately sent through an email to the insurer to confirm their discussion.

The next day she received two phone calls from an Auctions company wanting to arrange the pick-up of her vehicle on behalf of the insurer. The following day she called the insurer again with her concerns since no manager had called her within the 24-48 hour period. She was then told it is within 24-48 Business hours that her call would be returned. The next day when the insurer called she was told the car had already been reported to the WOVV and would be deregistered.

Case study – Kelly’s story

Kelly is an elderly pensioner who only drives her car to church on the weekends and sometimes to the shops. One Sunday she was hit in the parking lot of her church by another driver. There was some damage to the front passenger door and wheel frame. Kelly’s insurer accepted Kelly’s claim for damage to her vehicle following the accident, but upon assessing the vehicle, the insurer deemed it to be a total loss and was seeking to pay her the agreed value (\$10,000). Kelly did not want the car to be deemed a total loss but within 24 hours the car had already been reported to the WOVV. Kelly prevented the vehicle from being deregistered by physically appearing at the Motor Vehicles Authority office and removing the WOVV sticker from her car and driving it away.

Kelly organised two separate quotes for repairs, both were for about \$5000. However, the insurer maintained its position that the car was a total loss, and the dispute went to FOS.

During the FOS dispute Financial Rights helped Kelly gather copious amounts of evidence that her car could be repaired for far less than the agreed value of the vehicle. This evidence included 2 independent repair quotes, a third independent assessor’s report, an engineer’s report from the manufacturer, a letter of support from the manufacturer, a letter of support from the Divisional Manager of a motor vehicle traders association, and a suspension report. Finally, FOS Determined that the insurer was not entitled to settle the claim as a total loss because the Applicant has provided evidence to demonstrate that the cost of repairs and salvage is less than the agreed value. The Insurer was instructed to pay \$4950 to Kelly so she could organise her own repairs.

Recommendations

45. The General Insurance Code should include the following commitments related to third parties:
 46. Car owners should be given notice that their vehicle has been assessed by an insurer as a total loss at least 3 business days before the car is reported to a WOVV.
 47. Notice of a total loss assessment should include information about what kind of write-off the vehicle has been assessed as, whether the vehicle could legally be repaired, what the insurer is intending to do with the vehicle and information about the WOVV.
 48. Insurers should be more flexible about giving options to car owners that want to organise repairs to their own vehicles even if those repairs are uneconomical.
-

Repair workmanship and materials

A large proportion of claims disputes brought to the attention of the ILS are about the extent of repairs required, the adequacy of repairs completed and poor workmanship. From our experience although subsection 7.20 exists in the General Insurance Code to protect customers in case of poor workmanship by insurer's selected and authorised repairers, the General Insurance Code should also be amended to address the following situations as detailed in the two case studies below:

Case study – Brian's story – Telephone advice

Brian's car was damaged as a result of a motor vehicle accident. His insurer accepted the claim and authorised a repairer to conduct the repairs.

Brian had hire car cover under his policy but it was due to expire and as a result of the insurer's authorised repairer's dodgy repair works, his car will be out of service for an additional unknown period. His insurer refused to provide hire car over and above what the policy provides for even though they admit that they are by virtue of the General Insurance Code, responsible for the poor workmanship of the repairer. Brian needs a car to go to work.

Case study – Lorenzo's story – Telephone advice

Lorenzo's house was damaged as a result of a fire that started in the laundry. His insurer accepted the claim and authorised a builder to conduct repairs to the building. However the house remains uninhabitable due to shoddy repair work. Lorenzo had been provided

with temporary/emergency accommodation whilst his house was being fixed but as a result of the builder's shoddy workmanship he will need to extend the time he needs alternative accommodation. His insurer refused to pay for additional accommodation expenses required as a result of the shoddy workmanship of their authorised builder.

Recommendations

49. Section 7.20 of the General Insurance Code should include the following:

- a. Where the insurer's repairer has engaged in poor or faulty repair of a motor vehicle which has resulted in the insured requiring hire car expenses including additional hire car expenses over and above their current cover, the insurer agrees to pay or reimburse the insured for such expenses.
 - b. Where the insurer's repairer has engaged in poor or faulty repair of a home building which has resulted in the insured requiring alternative accommodation including alternative accommodation over and above their current cover, the insurer agrees to pay or reimburse the insured for such expenses.
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Section 8: Financial hardship

Financial Hardship request timeframes

Currently General Insurers have made various commitments to policy holders and non-policy holders relating to hardship. Code subscribers will for example fast track an assessment, make an advance payment and provide details of the complaints process for policy holders subsection 7.7. Section 8 provides that an insurer will have financial hardship protocols for the Insured, Third Party Beneficiary and an uninsured third party.

Under Subsection 8.6 General Insurers have committed to notifying policyholders and non-policy holders about their entitlement to financial hardship assistance “as soon as reasonably practicable.” Financial Rights believes that this is too vague a timetable to be of any use.

Financial Rights notes that the CGC have recently examined this issue and have too expressed concerns:

The Committee is concerned that the Code does not define what “reasonably practicable” means or specify a timeframe for assessing a hardship request. In the hardship cases highlighted earlier, both Code Subscribers unreasonably delayed the assessment of the hardship request. In addition, their hardship procedures did not provide any guidance as to what a reasonable timeframe could be. This was also apparent from the desktop audits of 14 Code Subscribers’ compliance with the financial hardship obligations during the reporting period: only 3 Code Subscribers specified a timeframe for assessing a hardship request, ranging from 7 to 21 calendar days.

The CGC then proceed to recommend that Code subscribers align their timeframes with the National Credit Code:

- *Within 21 calendar days, the Code Subscriber should assess the consumer’s application for hardship assistance and inform them of its hardship decision, in accordance with subsection 8.6, or inform them that it needs more information.*
- *If the Code Subscriber needs more information, it should allow the consumer at least 21 calendar days to provide it.*
- *Within 21 calendar days of the consumer providing the requested information, the Code Subscriber must make its hardship decision and inform the consumer of its decision in accordance with subsection 8.6.*
- *If the consumer fails to provide the requested information, then the Code Subscriber must make its hardship decision on the information available within 28 calendar days, and inform the consumer of the decision, in accordance with subsection 8.6.*

Financial Rights generally supports this approach being included explicitly in the General Insurance Code of Practice save for one minor clarification: that the policyholder should be informed of the decision in writing.

Recommendations

50. Hard time limits should be introduced with respect to financial hardship requests, clarifying the current subsection 8.6. In line with the National Credit Code, the time limits should be as follows:
- a. Within 21 calendar days, the Code Subscriber should assess a policyholder's application for hardship assistance and inform them in writing of its hardship decision, or inform them that it needs more information;
 - b. If the Code Subscriber needs more information, it should allow the policyholder at least 21 calendar days to provide it;
 - c. Within 21 calendar days of the policyholder providing the requested information, the Code Subscriber must make its hardship decision and inform the consumer of its decision in writing.
 - d. If the consumer fails to provide the requested information, then the Code Subscriber must make its hardship decision on the information available within 28 calendar days, and inform the policyholder of the decision in writing.
-

Premiums and Financial Hardship

Currently the General Insurance Code explicitly excludes financial hardship applying to the payment of premiums: subsection 8.2. Opportunity should be given for consumers in financial hardship with an instalment payment plan to enter into a financial hardship arrangement to avoid cancellation of policy. Equivalent obligations have existed in relation to banking and energy products for some time. Financial Rights notes that the Financial Services Council's recently introduced Life Insurance Code of Practice includes a section on premiums and financial hardship:

Life Insurance Policy changes and financial hardship

6.5 If you wish to change the terms of your Life Insurance Policy, or if you are having trouble meeting your premium payments, we will tell you about the options that may be available to you, such as:

- a) changing your benefit structure or how much you are insured for;*
- b) reducing your benefits and/or removing or altering benefit options in order to reduce your premium; or*
- c) stopping your payments for a short period. You would not be able to make a claim for any event that occurs or condition that is diagnosed or first becomes apparent*

during this period, but your Life Insurance Policy would not be cancelled, in accordance with our hardship procedures.

6.6 If you ask us to consider an arrangement on the basis of financial hardship, you may be required to provide reasonable evidence of your hardship, such as:

- a) for Centrelink clients, your Centrelink statements;*
- b) financial documents including bank statements; or*
- c) a statement of termination from your employment.*

Financial Rights sees no reason why the General Insurance Code should not include an equivalent section catering to the unique issues faced by general insurance consumers. Consideration needs to be given to the following options:

- Changing the coverage or amount covered for, in an appropriate and ethical manner;
- Reducing or stopping payments for a short period with consequences for coverage
- part payment of a premium with the remainder of the premium and the usual premium to be paid next month
- delay payment of a premium with a double premium to be paid the next month
- part payment of premiums for a few months then full payment of the outstanding value of the insurance premium in full.
- Notices about non-payment should invite the consumer to call the insurer to discuss their options if payment is not possible in the period required.

Recommendations

51. Consumers in financial hardship should be able to enter into hardship arrangements if they cannot afford to meet regular premium payments. Consideration needs to be given to the following options:

- a. Changing the coverage or amount covered for, in an appropriate and ethical manner;
- b. Reducing or stopping payments for a short period with consequences for coverage
- c. part payment of a premium with the remainder of the premium and the usual premium to be paid next month
- d. delay payment of a premium with a double premium to be paid the next month
- e. part payment of premiums for a few months then full payment of the outstanding value of the insurance premium in full.

52. Any notice of cancellation for non-payment of instalments should mention the availability of hardship arrangements.

Proactively identifying hardship

Case study – Marina’s story

Marina was not at fault in a car accident. Her car was side-swiped by a garbage truck. She has the name of the company, a witness and details of the company. She has comprehensive insurance. She contacts the insurer and makes a claim. The insurer informs her she has to pay her excess. Marina is furious as she was not at fault, she says she should not have to pay an excess.

Marina ring Financial Rights, and a lawyer takes her through her policy wording. Her policy states she needs to pay an excess unless she meets some conditions. She does not have the name of the driver, and that is why the insurer says she must pay. In speaking with Financial Rights it is apparent that Marina is on an Aged pension. She can’t pay the excess.

Case study – Belinda’s story - CLSIS 127336

Belinda is an undischarged bankrupt who had a car accident when not insured. Belinda became bankrupt in January this year and had the accident in May. The debt is \$6000 and Belinda cannot afford this. The Insurer found that the accident was Belinda’s fault and threatened to commenced legal action. The car was damaged and she could not afford to fix it. Belinda is 65, on the pension and cannot work. She also has osteoporosis and asthma. Belinda told the other party that she was bankrupt but the Insurer told her that “[we] don’t care, we will come and take your furnishings.” Following Financial Rights intervention the Insurer entered into a long term repayment arrangement with Belinda.

The CGC in its recent Industry Data Report have emphasised the need for insurers to work with policyholder customers and proactively establish whether they are suffering hardship:

*It is particularly important for a Code Subscriber to correctly identify those individuals experiencing financial hardship as soon as reasonably practicable, and then work with them to determine what assistance is appropriate for their circumstances.*⁷⁵

In Financial Rights’ experience insurance companies do not offer appropriate solutions for consumers experiencing financial hardship often until a third party representative becomes involved in negotiations. Our experience is that it is through our intervention and representation that Insurers respond positively to requests based on hardship, but those not represented or helped with letters being drafted that may articulate the GICOP obligations consumers are left hanging.

⁷⁵ p. 30. <https://www.fos.org.au/custom/files/docs/general-insurance-code-governance-committee-industry-data-report-201516.pdf>

Case study – Nadia’s story - CLSIS 133436

Nadia lives in Department of Housing, has mental health problems and is on the Disability Support Pension. Her car was comprehensively insured when she had a motor vehicle accident in which she disputed who was at fault. The excess was payable however she could not afford it. The Insurer sent her paperwork to complete to pay excess in instalments. Nadia however struggled. She could not afford her day to day living expenses let alone to pay her excess of \$600. Nadia contacted Financial Rights who requested the Insurer deduct excess and settle the claim with the other party Insurer per the NSWCA and FOS guidelines. It is unclear whether the Insurer would have deducted excess without Financial Rights’ intervention. Financial Rights also sought the claim number from the Insurer to assist with negotiation with the remainder. However the Insurer failed to pass the number on, and Nadia may or may not be debt collected. Nadia is now unclear as to whether the 3rd party insurer will pursue her or not.

Case study – Adede’s story - CLSIS 132569

Adede received a claim from her landlord’s Insurer for damages to their house. She was reversing her car out of the driveway but accidentally put her car into gear instead of reverse – she drove through garage door and cause substantial damage to the garage and adjoining wall of the house. The Insurer was seeking recovery of \$20,000. Adede called in on ILS with her support worker from St Vincent de Paul Society’s Settlement Services and a Swahili interpreter. Financial Rights took on the matter given her disadvantage to request that Insurer write-off the debt.

We submitted information about her personal and financial circumstances. Adede is 35 years old and originally from Somalia. She fled Somalia to Dadaab with her 3 kids where she spent 5 years in a refugee camp. She had been a victim of physical and sexual trauma and witnessed the murder of many people including her first husband. She met her 2nd husband whilst at the refugee camp, had another child at the camp before arriving in Australia in 2013 on a refugee visa. She has had 2 more kids with her 2nd husband but is now a single parent to all her 6 kids after separating from her husband following a domestic violence incident. Her sole source of income is Centrelink benefits of approximately \$2200 a fortnight however, after paying rent and meeting living expenses for her 6 kids (who are all under 18 years of age – 2 in high school , 1 in primary and 2 with her at home) she doesn’t have much left over to pay the debt to the landlord’s Insurer.

With our intervention the landlord’s Insurer agreed to write-off the debt.

The CGC recommended that the industry sustain and increase monitoring of compliance with financial hardship standards.

The CGC goes on:

Code Subscribers need to ensure their employees, Collection Agents and Claims Management Services are aware of their immediate obligation to assist consumers, not only when they receive an explicit request for assistance but also when a response indicates possible financial hardship. It is imperative that Code Subscribers also put in place similarly vigilant procedures for monitoring their Collection Agents' and Claims Management Services' compliance with financial hardship standards. Consumers experiencing financial hardship are often vulnerable individuals. This accentuates the importance of having appropriate processes for dealing with financial hardship assistance requests – processes that are responsive, flexible and, above all, fair.

Financial Rights agrees with the CGC here and believes that insurers must commit under the General Insurance Code (beyond the commitments to train already under the General Insurance Code at subsection 5.1) to specifically train their employees, Collection Agents and Claims Management Services in identifying signs of financial hardship, and the obligations to assist these consumers under the General Insurance Code.

Further general insurers should commit to be more proactive in their identifying hardship. Financial Rights notes that the wording of subsections 8.3 and 8.4 is such that it places the entire onus on the policyholder to identify themselves as suffering from financial hardship.

*8.4 If you owe us money, and you experience Financial Hardship, **you may ask us** to assess whether you are entitled to assistance.*

*8.5 **If you inform us** that you are experiencing Financial Hardship, we will supply you with an application form for Financial Hardship assistance, and contact details for the national financial counselling hotline 1800 007 007*

It is, in many cases, unrealistic to expect the consumer to identify themselves in this manner. Consumers that we work with are unlikely to identify that they on a low income to an insurer, unless the issue is raised by the insurer. Insurers should now be able to more easily identify people who would likely be facing financial hardship through the data they collect from their policyholders. If red flags can be developed for insurance fraud indicators, surely a similar red flag system can be easily implemented for signs of financial hardship. Signs can include, but not limited to:

- illness
- unemployment
- disability (physical and/or mental including psychiatric problems);
- homelessness
- low income.

However there is no compulsion on the insurer to look out for the signs of hardship or raise them with the consumer when identified. We believe this needs to be changed.

Recommendations

53. General insurers must commit under the General Insurance Code to:

- a. specifically train their employees, Collection Agents and Claims Management Services in identifying signs of financial hardship, and the obligations to assist these consumers under the General Insurance Code.
- b. alter the language of the General Insurance Code placing the sole onus for financial hardship identification on the consumer to one that commits insurers to proactively identify hardship in consumers and where identified offered assistance. This should include ensuring that hardship processes are explained and made available whenever hardship becomes apparent.

Debt Waivers

Case study- Fiona's story - CLSIS 133253

Fiona had a motor vehicle accident in which she disputes fault. The other party began pursuing her for \$30,000. Fiona does not have the means to pay this money – she lives in Department of Housing accommodation, is on the Disability Support Pension, suffers from lupus, recently had a stroke and has depression and anxiety. Fiona last worked about 8 years ago and has no prospects of working in the future. She does not have access to the Internet or email.

Fiona wrote to the Insurer to explain her situation and the Insurer did not respond rather sending the case off to debt collectors instead.

Under subsection 8.8 where an insurer has determined that a consumer is entitled to Financial Hardship assistance the consumer then:

(c) ... may ask us for a release, discharge or waiver of a debt or obligation; however, you are not automatically entitled to a release, discharge or waiver;

(d) if we agree to release, discharge or waive a debt or obligation, we will confirm this in writing, and if you are an Insured or Third Party Beneficiary, at your request we will notify any financial institution with an interest in your insurance policy;

The character of the debt waiver process therefore is one in which firstly, the onus is on the consumer to ask for a debt waiver and secondly, one in which is entirely within the arbitrary purview of the insurer with no guide whatsoever as to when and under what circumstances a waiver may be provided.

Financial Rights believes it is time to implement a standard process that will be adopted uniformly by all insurers rather than simply relying on the arbitrary discretion of insurers.

It is our view that it is appropriate to introduce factors into the General Insurance Code that an insurer will reasonably consider when deciding to release a debtor from a debt. These include

- The debtor’s sole source of income is Centrelink or he or she has no income
- The debtor is likely to remain on Centrelink as their sole source of income for the foreseeable future
- The debtor has no significant assets

Insurers have recognised for many years that there are circumstances where a debt should be waived on compassionate grounds because the consumer is in long term financial hardship and cannot reasonably repay the debt. It is commendable that this “common sense” approach to debt waiver has been available and continues to be available. Financial Rights is simply requesting that insurers take the next step to provide more certainty around these types of debt waiver requests.

In addition to the type of criteria above, there could be a range of other potentially relevant factors (if not definitive):

- Domestic or Family violence (leading to the incidence of the debt, or simply adding to the customer’s hardship)
- Serious illness or disability (including mental illness)
- Other compassionate grounds.

While Financial Rights acknowledges that it would be difficult to set specific criteria as every single case is different, but we believe that there is some scope to include some general criteria with insurers maintaining the ultimate discretion to waive a debt.

We also submit that insurers should commit to pro-actively identifying consumers who may meet the relevant criteria through their collections and hardship departments.

Recommendations

54. The General Insurance Code should set basic criteria upon which debt waiver may be considered by subscribing insurers

55. Under the General Insurance Code insurers should apply the same criteria to pro-actively identifying customers who may be eligible for debt waiver.

Instalment Payments and Cancellation

Under the General Insurance Code subscribers have committed to giving notice in writing to consumers who have missed an instalment payment 14 days before any cancellation. Financial Rights recognises that this commitment goes above and beyond the requirements in the *Insurance Contracts Act* which allow an insurer to cancel an instalment contract for non-payment without notice as long as *before the contract was entered into, the insurer clearly informed the insured in writing of the effect of the provision (Section 62(2)(b))*.

However, Financial Rights still regularly receives complaints from consumers whose instalment contracts were cancelled and they were completely unaware until they made a claim. We recognise that keeping up to date with instalment payments is the responsibility of the insured, but we think a few small tweaks to Section 4.10 of the General Insurance Code could help consumers avoid such a crisis.

Instead of requiring subscribers to only “give notice in writing” 14 days before cancellation, the General Insurance Code should commit insurers to giving notice in writing through at least 2 different communication channels (SMS, email or post) 14 days before cancellation. The second part of 4.10 should also be amended to require subscribers to always give the second set of notices (through 2 different channels) within 14 days after the policy has been cancelled. We believe a notification that a consumer’s policy has been cancelled will be the most effective means of motivating them to take action before an insurable event takes place.

Recommendations

56. Section 4.10 of the General Insurance Code should be amended to require subscribers to:

- a. Give notice in writing 14 days before cancellation through 2 different channels of communication (SMS, email or post); and
 - b. Give notice in writing within 14 days after cancellation
-

Providing IDR and EDR details on financial hardship refusal

Financial Rights notes that the Enright Review recommended in its draft Financial Hardship Guidelines that:

4.6 If we notify the Customer that the Customer or Third Party, respectively, does not have Financial Hardship Status, we commit to:

(a) including in the notice information about our Internal Complaints Process and the EDR processes consistent with the Code, section x; and

(b) treating any complaint about that decision and notification in accordance with our Internal Complaints Process.⁷⁶

This was not taken up in the 2014 Code. Under subsection 8.9 it merely states that:

If we determine you are not entitled to Financial Hardship assistance in relation to an amount we seek from you, and your circumstances change, you can make a further request for

⁷⁶ p. 177 Enright Report

Financial Hardship assistance in relation to that amount. While assessing your further request, it will be at our discretion whether we again put any recovery action on hold.

While providing the opportunity to reassess the request is broadly supported, it is more useful for this to be done in an IDR and EDR process. Without triggering IDR the consumer can potentially be left in limbo with the potential for recovery action. This is not appropriate in circumstances of genuine but unrecognised financial hardship.

Reasons for a denial of financial hardship assistance should also be provided to a consumer upon having their application rejected.

Financial Rights also speak to consumers who are advised they cannot make payments in instalments of their excess or the damages, and the insurer would not accept payment unless in a lump sum. This is absurd.

A consumer who can commence making payments should not be discouraged from making payments to reduce the indebtedness.

Recommendations

57. General insurers must commit under the General Insurance Code to enable access for consumers to EDR to resolve purely financial hardship matters
58. General insurers must commit under the General Insurance Code to provide, in writing, consumers who have had a request for Financial Hardship assistance rejected with:
 - a. details of the insurer's IDR and EDR processes
 - b. reasons for their rejection
59. Insurer IDR contact details and financial hardship information should be included on debt recovery letters.
60. The General Insurance Code should explicitly commit Subscribers to enabling consumers experiencing financial hardship to pay their excess or damages by instalments.

Centrepay and Fortnightly Instalment Payments

Financial Rights and the broader consumer movement have long been arguing for the general insurance industry to work with the Government and the Department of Human Services to enable Centrepay to be used as an option for the payment of premiums. The issue has been brought up repeatedly over the years from Financial Right's 2009 and 2012 submissions, the 2011 "A Fair Go in Insurance" campaign, submissions to the Independent Review of Centrepay

and the 2013 Centrepay: A good idea that has lost its way report.⁷⁷ Inclusion of essential insurances was also a recommendation of the 2011 National Disaster Insurance Review.⁷⁸

The Enright Review of the General Insurance Code stated that

...the insurance industry has identified a number of obstacles which limit insurance companies from accepting fortnightly payments through Centrepay. Additionally, there are a number of other issues which arise from fortnightly Centrepay insurance premium payments. Consequently, Centrelink and the Insurance Council of Australia agreed to work together to consider these issues and provide a report to the Government with recommendations by 28 February 2012.

It seems this never occurred and that the insurance sector shifted tack. In its submission to the Independent Review of Centrepay the ICA stated that

"The ICA has recently convened a Financial Inclusion Committee which will consider strategies to support financial inclusion objectives within the Australian community in relation to general insurance. This committee acknowledges that fortnightly payment mechanisms are an important option for some Australians."⁷⁹

The ICA proceeds to push the responsibility of the issue back to government:

However given that some Centrelink payment recipients may be currently interested in insurance options via Centrepay, the ICA has provided a submission to the 2013-14 pre-Budget process which proposes appropriate funding by the Federal Government to Centrepay to facilitate the necessary adjustments to accommodate monthly insurance premium payments. The significant benefit of this proposal is that only one payment system requires adjustments, rather than multiple systems if insurers were to adjust their own systems to accommodate fortnightly payments."⁸⁰

Financial Rights would also posit that another significant benefit to this proposal for the insurance industry was that general insurers would not have to pay for any changes

⁷⁷

<https://www.financialcounselingaustralia.org.au/getattachment/Corporate/Publications/Reports/Centrepay-A-Good-Idea-that-Has-Lost-Its-Way-February-2013.pdf>

⁷⁸ NDIR Recommendation 30

That access to insurance be enhanced through the development of alternative payment options, in particular:

(a) by the Commonwealth Government arranging for Centrelink customers to be able to pay insurance premiums fortnightly through Centrepay; and

(b) by State, Territory and/or local governments and community housing organisations arranging insurance premiums for contents to be able to be incorporated into rent for social and community housing tenants.

⁷⁹ ICA, Submission to the Independent Review of the Centrepay System, 15 February 2013
<https://www.humanservices.gov.au/sites/default/files/documents/submission-8-ica.pdf>

⁸⁰ Ibid

themselves. The Report of the Independent Review of Centrepay went on to simply report on this lobbying effort.⁸¹

From what we can see this lobbying has not been successful. Financial Rights also believes that this is an abdication of responsibility to support financial inclusion by insurers who have simply shifted the onus on to Government to sort the mess out.

The issues as we understand them are as follows:

- Insurer payment systems are not capable of receiving fortnightly payments without costly upgrades;
- Centrepay requires payments to be at least \$10 per fortnight and many policies for low income consumers would cost less than this amount;
- Centrepay charges businesses a standard fee per transaction, but does not offer discounts based on a high volume of transactions. At \$10 per fortnight minimum the profit margins for insurers are therefore less than higher payments.

It is Financial Rights view that it is 100 per cent in the general insurance industry's interest to upgrade their systems to allow fortnightly payments. It is the insurance industry, not the government or the rest of the Australia that is out of step here. The grand majority of salaried consumers receive payments fortnightly. It is beyond belief that with the technology available today that insurers are unable to upgrade their systems. Insurers are decades behind the rest of the financial services industry in this respect. If there is a cost involved it is one paid off by increased numbers accessing insurance and addressing underinsurance at the same time.

Financial Rights notes that some insurers offer fortnightly payment options – although many charge higher premiums for the privilege. Budget Direct, for example includes the option but states that “If you choose to pay by instalments the total premium may be higher, and fees will apply.”⁸² ECU Insurance offers fortnightly payments “at no extra cost”.⁸³ AAMI's Essentials products include a fortnightly payment option with “no extra charge for instalment payments.”⁸⁴ Clearly the software has been taken up by some insurers and not others. In the case of AAMI it is available to be used in some areas of the business but not others – all other AAMI insurance products do not provide a fortnightly option.

⁸¹ Ibid p. 24. Financial inclusion requires people to be able to access financial services such as insurance products in order to mitigate the risk of loss of property or life. In some cases it appears that there are logistical and/or administrative reasons why these service providers are not making greater use of Centrepay for their clients. ... The Insurance Council of Australia advises that the feasibility of making extensive system changes is prohibitive for most of their members, and instead they are lobbying the Federal Government to invest in changes to the Centrepay system to allow it to administer monthly payments.

⁸² <https://www.budgetdirect.com.au/about-us/insurance-payment-options.html>

⁸³ <https://www.ecu.com.au/insurance.html>

⁸⁴ <https://www.essentialsbyaai.com.au/>

We also note fortnightly premiums seem to be available in some products and not others. Of particular concern is where the option is available for low value products or products targeted at low income consumers such as Funeral Insurance but not available for essential insurance like car and home.

We strongly believe that the insurance industry need to enter the modern world and make available fortnightly payments to all customers, without penalties such as increased total premiums.

As for the \$10 per fortnight limit we believe that this too can be negotiated with the government to address financial inclusion issues. We also feel that this should not stop insurers working with Centrepay policyholders who are above the \$10 minimum amount.

Financial Rights notes that the previous Review included Centrepay as an option in the mooted Financial Hardship guideline. We remain strongly of the view that the General Insurance Code should be updated to include this option.

Ultimately, even if it is conceded that there is a cost, even a significant cost, to insurers to implement fortnightly payment options and to allow Centrepay payments, we feel this should be absorbed by insurers as part of their corporate social responsibilities. Doing so will go a long way to attacking the issue of under-insurance and financial exclusion. Given the industry's attempt to pass the buck it is time for the industry to step up.

Recommendations

61. The General Insurance Code should commit insurers to allow all insurance policyholders to pay premiums fortnightly without penalties.

62. The General Insurance Code should include the option for policyholder to pay their premium through Centrepay if they so wish.

Payment of excess

Another issue that continues to arise is that related to those people who cannot afford to pay an excess up front. Those who can't pay their excess upfront should be provided with an option to pay the excess in affordable instalments or where relevant, have the excess deducted from the payout of the claim.

We note the case of *Calliden Insurance Limited v Chrisholm* [2009] NSWCA 398 confirmed that a failure to pay the excess upfront should not be a bar to claiming under an insurance policy. FOS supports this view:

When considering disputes about insurance excess, FOS takes the view that:

- *an insurer cannot automatically reject a claim because you can't pay the excess if that claim would otherwise be covered by your insurance policy*
- *your inability to pay the excess does not prevent FOS from considering a dispute about the claim.*⁸⁵

We believe that once an uninsured party claims against the insurer and the insurer knows that the reason their policy-holder is not claiming (by asking their policy-holder directly) is because they can't pay the excess in one go, then the insurer should inform their policy-holder of the availability of the option to pay the excess in instalments. The General Insurance Code should therefore be amended to reflect this and to allow access to EDR for the uninsured person in this case.

FOS has already stated that "consumers experiencing financial difficulty may be unable to pay a policy excess. This should not mean the claim cannot progress." FOS commented on this problem in its FOS Circular from July 2010^[1]:

FOS takes the view that:

- *an applicant's inability to pay the policy excess does not automatically allow an insurer to avoid liability for a claim which would otherwise fall within the policy terms*

....

The applicant is obligated to pay the policy excess to the insurer, but an arrangement should be made to:

- *pay this excess over time, or*
- *allow the insurer to pay a sum of cash in settlement of the claim from which the excess can be deducted.*

Case study- James' story - S175913

James is uninsured. He is hit in the back by Mark.

Mark tells him he is insured and provides him the claim details. Mark and James keep in contact in the claims process. Mark tells James that he is having trouble paying the excess. He has the cash, but his insurer says they need him to pay it by credit card.

James is frustrated. He rings Marks insurer and offers to pay the excess and get the cash from Mark. Marks insurer refuses.

James feels like he is stuck in the middle

⁸⁵ A guide to insurance excesses. <https://www.fos.org.au/custom/files/docs/a-guide-to-insurance-excesses.pdf>

[1] Financial Ombudsman Service: THE CIRCULAR - Issue 3 - July 2010

https://www.fos.org.au/custom/files/docs/the_circular_issue_3_july_2010_pdf.pdf

Case Study Lacey's story – CLSIS 137975

Lacey is on DSP and lives in a remote town. She was in a minor motor vehicle accident and insured. She needs a car. She has paid for a hire car benefit with her insurer however her insurer has told her that they have an exclusive hire car agreement with a specific Car Hire Company only, the nearest one being 100 kms away from her. The 3 hire companies close to her have no agreement with her insurer. Lacey's solution is that she pays for the hire car herself and they will reimburse her. The problem is she is on DSP and has no money to pay for the hire car. In addition, her insurer has said her \$600 excess is payable and without paying it she cannot get her car back from the repairs. Lacey has saved \$400 and will try and get remainder \$200 by next week. She needs a hire car for when her car is scheduled to go in for repairs. She also needs car for health and family reasons. There is only 2/3 buses per day in her area.

Case study- Charlie's story - CLSIS 135710

Charlie is 17 years old and was in a motor vehicle accident which was his fault. The excess was \$2,100 with a further \$10,000 in damages claimed. The Insurer refused the claim unless she paid the excess. She explained that she was 17, at school and unlikely to be able to pay her excess or claim to the other party. She was considering bankruptcy. The Insurer did not provide Charlie the option of deducting excess from her claim and processing claim in line with the NSW Court of Appeal decision and FOS guidelines. Financial Rights drafted Charlie an email to send to her Insurer and the other party's Insurer. Charlie's Insurer then responded that they would deduct the excess as requested and the insurer informed her that the other party's insurer would contact her to seek payment of the balance. Charlie should have been offered this option without needing Financial Rights to draft the request for her.

Financial Rights believes there should be commitments in the General Insurance Code that help avoid the problems described above.

The insurer should provide options including:

- deducting the excess from the claims amount; or
- allow the policy-holder to pay off the excess in instalments.

Such a commitment is in line with their existing legal obligation under section 51 of the *Insurance Contracts Act 1980*, it would simply provide insurers guidance as to what "cannot, after reasonable inquiry be found" to include the situation where an insured can be located but is not able to pay the excess.

Recommendations

63. Insurers should follow the FOS guidance relating to insurance policy excesses and financial difficulty.
 64. The General Insurance Code should commit insurers to informing their policy-holders of the availability of the option to pay the excess in instalments when experiencing financial hardship.
 65. The General Insurance Code should also allow access to EDR for uninsured persons who are unable to have their claim processed because of an insured inability to pay their excess.
-

Debt Collection of Third Parties

Complaints from consumers being pursued for debts by insurance companies, most commonly as a result of a motor vehicle accident remain a significant proportion of the calls received by the ILS.

The General Insurance Code addresses debt collection under subsections 8.10-13:

8.10 If we authorise an agent to send you any communication about money you owe us, that communication will identify us as the insurer on whose behalf the agent is acting, and it will specify the nature of our claim against you.

8.11 We will require our agents to notify us, or to tell you to notify us, if you inform them that you are experiencing Financial Hardship, and require them to provide you with details of our Financial Hardship process.

8.12 We and our agents will comply with the ACCC and ASIC debt collection guideline when taking any recovery action.

8.13 If you inform us that you intend to declare bankruptcy, we will work with you or your representative to provide a written confirmation of the debt you owe us for the purposes of bankruptcy. If we cannot reach an agreement, we will provide details of our Complaints process.

While Financial Rights supports these subsections, we believe that insurers should go further.

Firstly correspondence from insurers, debt collectors, debt collection lawyers, insurance company lawyers about the money they owe should inform the consumer that they have the right under Section 8 of the General Insurance Code to seek financial hardship assistance and be provided with information on where to seek independent legal advice. Currently section 8.11 merely requires the agent to notify the insurer, or to tell the consumer to notify the insurer if the consumer informs them that they are experiencing Financial Hardship. Again the

onus is on the consumer to inform. It is not unreasonable for the insurer and their agent to provide this information up front to make them aware that they have options if they are struggling financially.

Secondly the General Insurance Code merely commits insurers to specifying the nature of the claim against them: 8.10. They should commit to provide full details of the claim, including providing a repair quote/invoice (in some cases), the date and time of the accident and the parties that are involved (in most cases).

Insurers and their agents wishing to enforce a debt should give alleged debtors reasonable access to information on which they have relied in establishing liability and an itemised account of damage and repairs completed/anticipated.

Insurers should also commit themselves and their agents to responding in writing confirming outcomes of any settlements.

Recommendations

66. In relation to debt collection practices the General Insurance Code should address the following:

67. In addition to identifying the insurer on whose behalf the agent is acting and specifying the nature of the claim, correspondence to a consumer should:

- a. include details of the claim including basic details of the claim e.g. date, time of accident, parties involved
- b. provide a copy of the repair quote or itemised completed repairs;
- c. provide a detailed breakdown of the damage that has been repaired so that a third party can assess the reasonableness of the claim and the extent of the damage for which they accept liability, if any;
- d. provide third parties with witness statements, photographs and other relevant evidence relied on in making an assessment of liability
- e. inform the consumer that they have the right under Section 8 of the General Insurance Code to seek financial hardship assistance and be provided with information on where to seek independent legal advice.

68. The General Insurance Code should require insurers and their agents to confirm outcomes in writing in third party recovery of debt matters.

69. Third parties should also be provided with details of the complaints process and be able to access for third parties to IDR for disputes where liability and the amount claimed is disputed.

70. Access to EDR by consent of all Code participants for all disputes not resolved at IDR.
Note: FOS allows access to EDR by consent.

Section 10: Complaints and Disputes

Initiating a dispute during a claim

A particular challenge for consumers using insurance is moving from the “claim” stage to a “dispute”. It is possible to be trapped in a claims process and never get to a dispute no matter how much delay occurs, even when the customer has expressed dissatisfaction. Currently under the General Insurance Code a policyholder making a claim will only be provided details of the complaints process once their claim has been rejected, which could take months, even a year or more. This is unreasonable and the General Insurance Code needs to address this issue.

This problem is why it is so vitally important that a “complaint/dispute” is defined very widely to include any indication of dissatisfaction. Any narrower definition would just make it harder for consumers to raise a complaint/dispute. It is also why consumers must be told in writing one month after a claim has been lodged about their rights to raise a dispute/complaint and go to EDR if the dispute is not resolved (whether or not they have indicated that they wish to complain or raise a dispute). The fact that a claim that has not yet been accepted or rejected after one month should be a sufficient reason to trigger the requirement to provide this information.

Recommendations

71. Code Subscribers should be required to notify the claimant in writing about the IDR and EDR processes within one month of lodgement of the claim if the insurer has not made a decision on the claim by this deadline.

Internal Dispute Resolution

Financial Rights notes that the Internal Disputes Resolution Process is known as the “Internal Complaints Process” under Section 10 of the General Insurance Code. Most insurers refer to Internal Dispute Resolution (IDR) and IDR Teams. While insurers also refer variously to “complaints handling”, “complaints and resolutions” etc. we believe for consistencies sake and plain English purposes, this process should be known as Internal Dispute Resolution and remain as such.

Currently the IDR process under section 10 of the General Insurance Code is a complicated two stage process. This complexity we believe benefits only the Code Subscribers rather than providing any ease or assistance for consumers. Put simply the two stage IDR process is confusing for consumers and adds to frustrations, annoyance and dissatisfaction.

The first stage is a 15 business day period beginning from the date of complaint, where the Code Subscriber will respond in writing with a decision and reasons and provides information on the complainer's right to take the complaint to Stage Two.

Stage Two is another 15 day period but this time it will be reviewed

“by an Employee or Employees with the appropriate experience, knowledge and authority, who is/are, to the extent it is practical, different from the person or persons whose decision or conduct is the subject of the Complaint, or who was/were involved in the Stage One decision.”

It is not clear whether an employee with appropriate experience, knowledge or authority has been involved in the first stage of the process.

Both Stages allow the Code Subscriber to extend the length of the 15 days on the basis that they do not have all the necessary information or they have not completed the investigation (subsections 10.12, 10.17, 10.18).

The General Insurance Code does impose a 45 calendar day upper limit as mandated.

It also needs to be noted that there is another 5 business day complaint process that exists under subsection 10.9 of the General Insurance Code that occurs if the Code Subscriber can, somewhat arbitrarily, resolve the complaint within that time and the complainer has not requested a letter.

Meeting the 15 day time limit remains the “largest area of non-compliance” according to the CGC.⁸⁶

The CGC Data Report notes 28,587 internal disputes in Stage Two in 2015-16. Where outcomes were reached in this time 25,563 period 71 per cent or 18,077 were outcomes that favoured the Code Subscriber. There is no data provided with respect to how many complaints are made and resolved in Stage One of the process. However FOS reports in its Annual Report that 6,411 domestic insurance disputes were accepted.⁸⁷ While it is clear many of the other approximately 12,000 cases may not have been warranted, it is clear to Financial Rights that many of consumers involved in those disputes would have given up despite having an actionable case.

In Financial Rights' experience many consumers are forced to jump through the hoops and simply wait for the 45 days in order to get to EDR. Clearly at least 6,411 consumers a year are having to wait the full 45 days to get there too.

Financial Rights believes that the General Insurance Code should be revised to reflect that IDR should be a simple, seamless one stage process for consumers of no more than 45 calendar days, and then access to EDR if the dispute is not resolved. The General Insurance Code should remove any suggestion (eg 10.14) that a consumer must complain again or 'request' that their complaint be moved from one stage to the next.

⁸⁶ p. 40 CGC GI Industry Data Report 2015-16

⁸⁷ p. 69 <https://www.fos.org.au/custom/files/docs/20152016-fos-annual-review.pdf>

It is Financial Rights' view it would make little difference to Code Subscribers to simply eliminate Stage Two of the process. The complaints process would be 15 days (as it currently) is unless the Code Subscriber does not have all the necessary information or they have not completed the investigation, in which case a new timetable – up to an overall maximum of 45 calendar days – is instituted. The complaint should be dealt with from the beginning by an employee with the appropriate experience, knowledge and authority who is different from the person or persons whose conduct is the subject of the Complaint.

This would also ensure that (a) there is one less letter having to be written (b) there is no new request required from the Consumer. Stage Two adds little to nothing to the process. There are no new additional rights for the consumer other than they can at last have the complaint reviewed by somebody in authority. If a Code Subscriber needs 30 days as foreseen by the current two stages, they have the ability under the 15 day process to extend it. There is nothing that justifies a second stage. There really is nothing in Stage Two that assists either the Code Subscriber or the Consumer.

We also believe that a flow chart explaining the IDR/EDR process should be included in any rejection letters when consumers are told how to make a complaint. Such a visual guide should also include information about how the IDR/EDR process relates to code breaches and how consumers can complain about a code breach directly to the CGC.

Financial Rights submits that IDR should be independent of the claims department and the initial claims decision maker. Under the 2014 Code there is no explicit requirement that IDR is separate from the claims department. In fact, Code section 10.15 envisages that the employee considering the complaint could be the employee whose decision or conduct caused the complaint.

We submit that the General Insurance Code should set out guidelines to ensure an independent internal review as part of the IDR processes. These guidelines are necessary as in our experience, customers are very wary of any veneer of independence when referring matters back to an insurer after that insurer has already made a decision against them. However, where an insurer has chosen to deal with a complaint without genuine independent review, this should not be cause to delay the complainant's access to EDR for a further 45 days.

Recommendations

72. The current two stage Internal Disputes Resolution process as described in Section 10 should be simplified and reduced to a single, simple streamlined process with a 15 day limit that can be extended to the regulated 45 days, where the Code Subscriber does not have all the necessary information or they have not completed the investigation.

73. An easy to understand complaints flow chart or visual guide should be designed to describe the IDR and EDR process and included in the General Insurance Code to assist with understanding.

Complaints and Disputes: Provision of documents

Consumers that contact the ILS often do not have adequate information about their claim to be able to properly advance a complaint to IDR and EDR. It is essential that consumers have a right in the General Insurance Code to access information and documents that they reasonably need for the complaints process.

Financial Rights believes that the General Insurance Code should have a clause requiring information to be provided on request including:

1. Information and documents relied on in rejecting a claim;
2. Copies of the PDS and insurance certificate;
3. Copies of any expert or assessment reports relied on by the insurer; and
4. A copy of any recordings and transcript of the sale of insurance.

The current Code states at 10.6:

We will only ask for and rely on information relevant to our decision in dealing with Complaints. We will supply you with the information we relied on in assessing your Complaint within ten business days, if you request it, in accordance with section 14 of this Code.

While this subsection requires insurers to provide information relied upon within 10 business days it is consistently not met and does not mention specifically the documents we have listed above which would assist both consumers and insurers.

In Financial Rights' experience when assisting consumers, consumers almost always have make a complaint to FOS in order to access forensic or other expert reports and copies of telephone or investigation recordings from the insurer. This is an unnecessary waste of the consumer's, FOS's and the insurer's resources and time. If the consumer was able to reliably access this information at the time of claim rejection (or at the time of an IDR complaint about excessive delays) some, if not a majority of complaints could be resolved quite quickly without the need for a FOS complaint.

Recommendations

74. The General Insurance Code should include a commitment from insurers to provide the following information on request:

- a. Information and documents relied on in rejecting a claim;
 - b. Copies of the PDS and insurance certificate;
 - c. Copies of any expert or assessment reports relied on by the insurer; and
 - d. A copy of any recordings and transcript of the sale of insurance.
-

Section 13: Monitoring, enforcement and sanctions

Sanctions

Financial Rights notes that RG 183.70 recommends the following sanctions should be considered under a Code of Practice:

- (a) *formal warnings;*
- (b) *public naming of the non-complying organisations;*
- (c) *corrective advertising orders;*
- (d) *fines;*
- (e) *suspension or expulsion from the industry association; and/or*
- (f) *suspension or termination of subscription to the code.*

In contrast, the current Code includes four sanctions at subsection 13.15:

- (a) *a requirement that particular rectification steps be taken by us within a specified timeframe;*
- (b) *a requirement that a compliance audit be undertaken;*
- (c) *corrective advertising; and/or*
- (d) *publication of our non-compliance.*

The current Code therefore only includes one of the recommended sanctions from RG183.70, that is corrective advertising. The subsection “publication of our non-compliance” sanction is not “publicly naming as foreseen under 183.70. As can be seen in the recent Annual Report, Code Subscribers who breached the General Insurance Code in significant ways remain anonymous.

We strongly believe that consumers have the right to know which general insurers have breached the General Insurance Code. Given the significant information asymmetry that generally exists in insurance, the knowledge that a particular general insurer has breached the General Insurance Code in a significant manner is important information that would assist guiding consumer decision making. It would also act as a clear deterrent to breaching the General Insurance Code and improve competition in the industry to ensure fewer Code breaches with insurers improving their systems to meet Code requirements.

Financial Rights notes that the public naming of a Code Subscriber is an available sanction under the current Code of Banking Practice and the Code Compliance Monitoring Committee (CCMC) may name the breaching Code Subscriber on their website or in their Annual Report.⁸⁸

⁸⁸ Subsection 36(j).

The Banking Code indeed goes into particularly detail that should act as a guide to help re-draft the General Insurance Code:

(j) to empower the CCMC to name us on the CCMC's website, in the next CCMC annual report, or both, in connection with a breach of this Code, where it can be shown that we have:

- i. been guilty of serious or systemic non-compliance;*
- ii. ignored the CCMC's request to remedy a breach or failed to do so within a reasonable time;*
- iii. breached an undertaking given to the CCMC; or*
- iv. not taken steps to prevent a breach reoccurring after having been warned that we might be named.*

Financial Rights notes that the Enright Review recommended that:

The CGB Sanctions Committee should have a discretion to name the culprit in a serious, systemic or significant breach if the Code Participant did not self-report, was unco-operative in the Corrective Action phase or otherwise the breach merited the naming of the Code Participant.

This was not taken up by the ICA. We strongly believe that this must be included and that the all potential sanctions should be included in the General Insurance Code, as well as compensation for any direct financial loss or damage caused to an individual by the breach of the General Insurance Code.

A penalty regime would have the following advantages:

- it would be a clear indicator of the insurer's commitment to the General Insurance Code;
- it would be a strong incentive for consumers to engage with the General Insurance Code;
- it would motivate insurers to take Code commitments seriously and train staff accordingly; and
- it would assist in identifying breaches (and therefore discouraging them) that are unlikely to come to light otherwise.

Take, for example, the commitment at Subsection 7.8 in relation to the insured's right to claim and not being discouraged from lodging a claim. Where a policyholder has been discouraged because, the claims handler has stated that say only 60% of claims are paid, few if any of these consumers will lodge a complaint for a Code breach. Further, as there is no claim or dispute that will ever be reviewed by anyone else, the breach will not be later identified as part of that process either (such as a breach of a time line which becomes apparent in relation to a disputed claim lodged in FOS).

Thus the insurer has very little incentive to comply with the clause and plenty of incentive to ignore it. The harm for those consumers who have been discouraged from lodging a valid claim, however, can range from significant to catastrophic and the reputational risk to the particular

insurer and the industry more generally considerable. If there were a monetary penalty payable to the consumer for a breach of this clause, then consumers would have an incentive to report the conduct and insurers would be much more motivated to avoid a breach, thereby greatly reducing the probability that valid claims will be discouraged.

We do not advocate for this financial penalty regime applying to all sections of the General Insurance Code, but only to certain specific sections which have the potential to significantly impact on the rights of consumers including for example:

1. Subsection 7.8 on the insured's right to claim and not being discouraged from lodging a claim;
2. Subsection 7.19 on the insured's right to written reasons when insurers deny their claim, insurers to inform insureds of their right to ask for copies of information relied on in assessing the claim, insurers to provide information about complaints handling procedures and provide on request external experts and service providers' reports within 10 days of the request;
3. Subsection 10.17 and 10.18 on responding to complaints within 15 business days; and
4. Section 10.10 and 10.22 on the issue of insurers informing insureds of their rights to take complaints already in IDR for 45 days or more to EDR.

All of the above sections involve potential breaches that may never come to light if the consumer does not exercise their right to a review (possibly because they have not been told about their right to a review and/or because they have insufficient information on which to judge whether they have grounds for lodging a dispute).

The above is not intended to be an exhaustive list. We would be happy to consult on exactly which sections of the General Insurance Code should be included within this penalty regime and the amount of the penalties. The penalty schedule should be detailed in the General Insurance Code guidelines. We envisage a schedule similar to the Compensation schedule in the Victims' Compensation Act where it states that for breaches of key provisions, a certain amount is payable.

A penalty regime would send a clear message to the public that the insurance industry takes the General Insurance Code seriously and is prepared to pay some compensation to consumers for failure to comply with the General Insurance Code. Any decision on the compensation would need to be made by the Code Compliance Committee and procedural fairness used in the decision making process.

Recommendations

75. The General Insurance Code should expand the number of sanctions available to include, as envisaged by RG186.70:

- a. formal warnings;
- b. public naming of the non-complying organisations;

- c. fines;
- d. suspension or expulsion from the industry association;
- e. suspension or termination of subscription to the General Insurance Code
- f. require rectification or implementation of CGC recommendations from own motion inquiries within a reasonable period of time (to be specified by the CGC after consultation with the Code Subscriber);

CGC and Code Monitoring

Financial Rights believes that as has been recommended for the CCMC by the Khoury Report into the Code of Banking Practice, the General Insurance CGC needs to develop into a “mechanism for community assurance through active monitoring and promoting higher standards and continuous improvement of”⁸⁹ general insurance practice and focus on supporting three core priorities for its monitoring role:

- i) investigations and analysis on gathering evidence of systemic noncompliance (common problems, complaint and reported breach trends, etc.)
- ii) transparency – by providing industry and the community with investigative, statistical and analytical information demonstrating the level of compliance with the General Insurance Code and identifying any trends and potential problem areas.
- iii) continuous improvement of insurance practices by providing feedback as to the effectiveness of the implementation of the General Insurance Code, and identifying and promoting good practice conduct and compliance, identifying areas for new or strengthened Code provisions or Industry Guidelines, and reporting about longer term Code-related projects to provide assurance to the community about progress.⁹⁰

Financial Rights also recommends that like the Code of Banking Practice under subsection 35 (h), that the General Insurance Code include a commitment to empower the CGC to arrange a regular independent review of its activities and to ensure a report of that review is lodged with ASIC. This review should, like the ABA’s Code, coincide with the periodic reviews of the General Insurance Code.

⁸⁹ p. 183, Khoury Report

⁹⁰ cf: Recommendation 79, Khoury Report, p 79.

Recommendation

76. The General Insurance Code must empower the General Insurance CGC to focus on supporting three core priorities for its monitoring role:

- a. investigations and analysis on gathering evidence of systemic noncompliance (common problems, complaint and reported breach trends, etc.)
- b. transparency – by providing industry and the community with investigative, statistical and analytical information demonstrating the level of compliance with the General Insurance Code and identifying any trends and potential problem areas.
- c. continuous improvement of insurance practices by providing feedback as to the effectiveness of the implementation of the General Insurance Code, and identifying and promoting good practice conduct and compliance, identifying areas for new or strengthened Code provisions or Industry Guidelines, and reporting about longer term Code-related projects to provide assurance to the community about progress.

77. The General Insurance Code should include a commitment to empower the CGC to arrange a regular independent review of its activities and to ensure a report of that review is lodged with ASIC. This review should coincide with the periodic reviews of the General Insurance Code.

CGC Visibility and Promotion

Financial Rights has provided information to the recent CGC Own Motion Inquiry and have been involved from time to time with CGC consultations, noting that under its charter the CGC “may also consult with other organisations and individuals with an interest in the General Insurance Code, as the CGC sees fit.”⁹¹

Financial Rights notes that despite this awareness of the CGC amongst consumers and other consumer advocates is minimal.

Consumer Representatives believe that the visibility of the CGC needs to be improved. We note for example that the Committee’s name does not include the word Insurance - a similar problem that has arisen with the Banking Code’s CCMC. There also seems to be some confusion between the roles of the FOS and the CGC, particularly with respect to code compliance now being physically housed within FOS but remaining separate. While the FOS

⁹¹ <http://codeofpractice.com.au/assets/The%20Code%20Governance%20Committee%20Charter.pdf>

Code Compliance and Monitoring Team is separately operated and funded business of FOS, it supports independent committees to monitor compliance with the various codes of practice.

Recommendation

78. General insurers must resource the CGC appropriately to improve its visibility for consumers and consumer representatives.

Own Motion Inquiries, Data Collection and Resourcing

The CGC has since its inception has only established one Own Motion inquiry into Code compliance – one into Service Suppliers to general insurance, which was later expanded following the release of Financial Rights' *Guilty Until Proven Innocent* Report into Investigation of Claims and Outsourced Services. As at time of writing, this has yet to be completed and released publicly.

The current Code of Banking Practice states at clause 36(d) that their subscribers agree

“to ensure that the CCMC has sufficient resources and funding to carry out its functions satisfactorily and efficiently.”

There is no equivalent section in the General Insurance Code. There really is no explicit reference to empowering the CGC to conduct an own motion inquiry as is the case under the Code of Banking Practice Section 36(b)(ii) nor under its Charter. Presumably the CGC does so under broad interpretation of Charter section 1(e) “to investigate at its discretion, reports of alleged Code breaches.”

It is Financial Rights' view that the general insurers should commit to explicitly empowering the CGC to undertake own motion inquiries and appropriately resource the CGC to be able to conduct more than one own motion inquiry at the same time. Furthermore the CGC must be empowered to act on those own motion inquiries and be provided with appropriate sanction powers to ensure systemic compliance. In other words the CGC must be explicitly empowered to require rectification or implementation of CGC recommendations from own motion inquiries within a reasonable period of time (to be specified by the CGC after consultation with the Code Subscriber).

Furthermore the General Insurance Code should empower the CGC to proactively gather relevant information about the effectiveness of and compliance with the General Insurance Code from all external sources including consumer advocates, state Legal Aid commissions, Community Legal Centres, consumer affairs departments and other government regulators.

Financial Rights believes that General Insurers should also boost it's commitments with respect to cooperating with the CGC under subsection 13.5. This should include a commitment to cooperate with the CGC in its requests for comprehensive, consistent and reliable industry

data. The CGC has noted a number of issues with industry data integrity in both the CGC GI Data Industry Report 2015-16 and its 2015-16 Annual Report.⁹² Cooperating with the CGC with respect to data collection is critical if the industry is to proactively and continually improve its performance. While Financial Rights notes that under 13.8 “the CGC will prepare annual public reports containing aggregate industry data and consolidated analysis on Code compliance” this is a CGC responsibility not a Code Subscriber responsibility to assist in this task.

Finally we also note that the Khoury Report examined the notion of sharing more of the bank’s data publicly and recommended that:

The CCMC should be explicitly tasked with progressively working with industry to develop the ability to publicly report on relevant signatory bank data and statistics, including acting as the trusted ‘translator’ of disparate bank information, producing equivalent information to enable broader reporting.

Financial Rights believes the same level of transparency must be provided by the general insurance sector to improve transparency and consumer trust.

The ABA supported the Khoury recommendation stating:

*The industry will consider how best to ensure consistency in the information requested from banks. An example could include standardised template reporting.*⁹³

Recommendation

79. General Insurers should commit to explicitly empowering the CGC to undertake own motion inquiries and appropriately resource the CGC to be able to conduct more than one own motion inquiry at the same time.

80. Further the CGC must be explicitly empowered to require rectification or implementation of CGC recommendations from own motion inquiries within a reasonable period of time (to be specified by the CGC after consultation with the Code Subscriber).

81. Subsection 13.5 needs to be expanded to commit Code Subscribers to cooperating with the CGC with respect to:

- a. data collection to proactively and continually improve its performance.
- b. ensure that the CGC has sufficient resources and funding to carry out its functions satisfactorily and efficiently.

82. The CGC should be explicitly tasked with progressively working with industry to develop the ability to publicly report on relevant insurance data and statistics including acting as

⁹² GICGC Annual Report 2015-16 p 1 and CGC GI Industry Data 2015-16, p1.

⁹³ p. 34, ABA Response to Khoury Report

the trusted translator of disparate information, producing equivalent information to enable broader reporting.

83. The General Insurance Code should empower the CGC to proactively gather relevant information about the effectiveness of and compliance with the General Insurance Code from all external sources including consumer advocates, state Legal Aid commissions, Community Legal Centres, consumer affairs departments and other government regulators.

Code Compliance Officers

Financial Rights believe that insurers should consider including in the General Insurance Code a commitment to appointing a Code Compliance Officer. While such a position is potentially implied in the banks commitment to “prepare an annual return to the CGC on our compliance with this Code”⁹⁴ Financial Rights believe that there is value in ensuring that this role is identified, highlighted and committed to, to ensure that there is a direct point of contact for the CGC to engage on compliance issues with subscribers.

Recommendation

84. General Insurers should commit to appointing a Code Compliance Officer.
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Unfair Contract Terms in Insurance

When the ACL commenced in January 2011 it replaced and amalgamated 17 existing laws and included new unfair contract terms (UCT) provisions. However, as recently noted in the ACL Review Issues paper, the UCT regime does not apply to insurance contracts. The *Insurance Contracts Act 1984* (Cth) does not include protections against unfair contract terms and excludes any Commonwealth, state or territory laws regarding contractual ‘unfairness’ from applying to contracts of insurance regulated under that Act, such as the unfair contract terms provisions in the ACL and ASIC Act.

This means that unfair contract term protections currently apply to every other contract an Australian consumer is ever likely to enter apart from insurance including financial products and service contracts under Subdivision BA of Division 2 of Part 2 of the *ASIC Act 2001* (Cth).

⁹⁴ Subsection 13.2(b)

It has long been the view of consumer advocates that there is no sound reason to exempt the insurance industry.

There have been a number of arguments put forward by the insurance industry against imposing the UCT regime on insurers. One, for example is that the duty of utmost good faith as codified in the *Insurance Contracts Act 1984* (Cth) is adequate to ensure consumers are protected. Insurers have argued that this duty covers the same issues that arise with unfair contracts and imposing the UCT regime on insurers would add an additional layer of regulatory complexity. Financial Rights strenuously disagrees with this view and believes that the duty of utmost good faith has neither prevented the spread of unfair terms in insurance contracts nor has it provided the courts or external resolution schemes with any power to provide a remedy to consumers when an unfair term has been used.

Sections 13 and 14 of the *Insurance Contracts Act* do not provide that an insurer is in breach of the duty of utmost good faith merely because of the fact that they wish to rely on a contractual term that is unfair. Most consumers do not argue on the basis of good faith at the FOS and it is not commonly relied upon, if at all as a basis, for relief from an unfair term. The FOS has struggled in determinations to deal with unfair contract terms due to the limitation in the *Insurance Contracts Act 1984* and the limited scope of the duty of utmost good faith.

Unfair terms are usually hidden away in the fine print of an insurance contract or PDS and are rarely read or understood by a consumer when selecting coverage.

Financial Rights regularly comes across unfair contract terms in insurance causing a significant imbalance in the parties' rights and obligations arising under the contract. These terms are not reasonably necessary in order to protect the legitimate interests of the party who would be advantaged by the term, and they cause detriment (whether financial or otherwise) to a party if it were to be applied or relied on.

Financial Rights provides the following general insurance examples to illustrate

The insurer RAA included the following statement in its comprehensive car insurance:

*"If your claim has been investigated and you withdraw your claim or we refuse to accept it, you may have to pay any costs incurred for the investigation of your claim."*⁹⁵

This term is both a significant incentive for the insurer to investigate every case and delay payouts. It also acts as a significant disincentive to make a claim when the policyholder knows that they could be up for the cost of an investigation.

AVEA include the following term in their Motor Vehicle Insurance:

If You are responsible for damage to another person's Vehicle, We will pay the costs of hiring a substitute Vehicle for that person at publicly available commercial rates not exceeding

95 RAA, (2014). Comprehensive Car Insurance, Product Disclosure Statement
<http://www.raa.com.au/documents/comprehensive-car-insurance-pdsapr15 p22>

*\$100.00 per day to a total of \$1,500.00. See Additional Benefits Section for details about how rates are calculated.*⁹⁶

and

*If You are responsible for damage to another person's Vehicle, We will pay the reasonable costs of hiring a substitute Vehicle for that person at the lowest publicly available commercial rate, not exceeding \$100.00 per day. This benefit is limited to \$1500.00*⁹⁷

These terms limit liability for 3rd parties seeking damages against the at fault party insured with AVEA. They limit the cover to \$1500 when most other policies have liability cover up to \$20 million.

RSPCA Pet Insurance includes the following cancellation term:

*We will only accept notices of cancellation given in writing and signed by you. We will not accept cancellation requests by telephone or email unless agreed to by us. If you return your policy during the cooling off period, we will refund any premiums paid since commencement or renewal, less any reasonable administrative and other transaction costs incurred by us which we are unable to recover and any taxes or duties that we are unable to refund.*⁹⁸

Limiting cancellation to the provision of notice in writing “unless agreed by us” and retention of “reasonable administrative costs” that are not specified unreasonably disadvantages the consumer and causes enormous difficulties to consumers trying to cancel a policy.

Youi's Uninsured motorist extension provides cover in the following limited circumstances:

Under Third Party, Fire and Theft or Third Party Property Only cover, up to \$5,000 or the car's market value, whichever is the lesser, for accidental damage to the car, if there was an uninsured third party motorised vehicle involved and if:

...

we agree that the third party was completely to blame for the accident;

*you provide us with the name, residential address, contact phone number and vehicle make and registration number of the other party; ...*⁹⁹

This term permits the insurer to make an arbitrary decision to exclude if they do not agree and do not have to base this on the facts or evidence before them. The requirement to provide name, residential address, contact phone, vehicle make, model and rego is unreasonable if the

96 AVEA Product Disclosure Statement – Motor Vehicle Insurance

https://www.avea.com.au/download/product_disclosure_statements/MotorVehicle_V011214_Web.pdf
p.6

97 AVEA Product Disclosure Statement – Motor Vehicle Insurance

https://www.avea.com.au/download/product_disclosure_statements/MOT_V011115_Web.pdf p.8

98 RSPCA Pet insurance p24. <https://www.rspcapetinsurance.org.au/RSPCA/media/Document/rspca-policy-booklet.pdf>

99 Youi, Car Product Disclosure Statement p12 <https://www.youi.com.au/GetPDS/?riskType=VEH>

driver at fault refuses to provide the details or flees the scene. The cover here is not limited in this way under comprehensive cover policies.

Finally Financial Rights solicitors regularly see terms that involve the automatic renewal of policies or fixed term contracts. The UK FCA lists automatic renewal of a fixed-length contract where the deadline to cancel is unreasonably short, as an unfair contract term. In Australia, ASIC last year reviewed six insurers' car insurance renewal practices.¹⁰⁰ They found that:

“consumers were not always clearly informed by insurers, when first purchasing the policy, that it would automatically renew unless the consumer advised otherwise. In most cases consumers were only informed about the automatic renewal practice in the product disclosure statement (which may not be received by the consumer until after the insurance is purchased) and renewal notice.”

The law does not prevent insurers from automatically renewing insurance policies and in some cases consumers seek this feature out, however by structuring the sales and disclosure practice in such a way that does not fully inform consumers of this renewal practice unreasonably advantages the insurer. Where consumers inadvertently find themselves insured twice, they struggle to obtain a refund for the full premium and are often limited in only recovering 50% of the overpaid premium on the basis the insurer was “on risk”.

With respect to life insurance claims, Financial Rights points to the ABC 7:30 report on a life insurance claim being rejected on the basis that MLC would only pay out if a patient had been intubated in intensive care with a tube down their throat for 10 days. The patient in the report had had this for 7 days and therefore his claim was not paid. The average for intubation is 4 days. This clearly is unfair and a definition that is simply impossible to meet. In a sense life insurance is providing illusory cover.

We believe that these terms and the examples provided above prima facie meet the definition of an unfair term in that they cause a significant imbalance in the parties' right and obligations arising under the contract, are unnecessary and can and do cause detriment to consumers. Furthermore none of these terms could arguably fall within the duty of utmost good faith nor be remedied by a court or EDR service.

Financial Rights suggests that the wheel does not have to be re-invented with respect to designing an appropriate UCT regime applying to insurance contracts. Financial Rights points to the previous attempt to enact such a regime with the Government's development of an *Insurance Contracts Amendment (Unfair Terms) Bill 2013*. The Federal Government introduced this Bill to extend the protections from unfair contract terms available for consumer contracts of other financial products and services to general insurance contracts. The Bill never entered into law. Financial Rights notes that the UK banned unfair terms in insurance contracts under their *Consumer Rights Act 2015 (UK)*.

100 ASIC, 15-345MR ASIC drives better disclosure of automatic renewal of car insurance, 19 November 2015

<http://asic.gov.au/about-asic/media-centre/find-a-media-release/2015-releases/15-345mr-asic-drives-better-disclosure-of-automatic-renewal-of-car-insurance/>

Before describing the design of 2013 Bill it is worth noting that it would have applied to general insurance contracts only. We are strongly of the view that any unfair contract terms regime should apply to all insurance contracts with no exceptions. Just as it is an unwarranted and unreasonable anomaly that insurance contracts are exempted from the UCT regime, exempting one part of the insurance sector from any new regime would be similarly unreasonable. The issues of fairness of terms in life insurance policies are as important and relevant as those that relate to general insurance and extend to and include group life products that can provide TPD and death cover to the most vulnerable members of the community. Consumer groups, including ourselves did not oppose this approach at the time on the understanding that the Government would consult further on how unfair terms would be extended to life insurance contracts.

The principles for the design of the *2013 Insurance Contracts Amendment (Unfair Terms) Bill* were set out by the then Minister as follows:

Principles for extending Unfair Contract Terms laws to general insurance contracts

Unfair contract terms (UCT) laws for insurance will be introduced into the Insurance Contracts Act 1984(IC Act), based on the UCT regime that applies under the Australian Securities and Investments Commission Act 2001 (ASIC Act) and with the following elements which includes some tailoring for insurance:

- *the regime will apply to consumer contracts that are standard form insurance contracts;*
- *it will be included as part of the duty of utmost good faith;*
 - *that is, if a term is found to be unfair, the insurer will be in breach of the duty of utmost good faith;*
- *the remedy available where a term is found to be unfair will be that the party may not rely on the term;*
- *in addition to the above remedy, a court may consider whether there is another more appropriate remedy;*
- *ASIC and consumers will both have the right to take action under UCT laws;*
- *ASIC will have the range of enforcement powers that are currently available to it to administer the UCT laws in the ASIC Act replicated in the IC Act for the purposes of enforcing the UCT laws in the IC Act;*
- *the UCT regime will not apply to a term to the extent it:*
 - *defines the main subject matter of the contract;*
 - *sets the upfront price payable under the contract; or*
 - *is a term required, or expressly permitted by a law of the Commonwealth or a State or Territory.*
- *the definition of an unfair term is that the term:*

- *would cause a significant imbalance in the parties rights and obligations under the contract;*
 - *would cause detriment to a party if relied on;*
 - *is not reasonably necessary to protect the legitimate interests of the party advantaged by the term. For the purposes of determining whether a term in an insurance contract is reasonably necessary to protect a legitimate interest, a term will be reasonably necessary if it reflects the underwriting risk accepted by the insurer.*
- *the insurer will have the onus of proof that a term is reasonably necessary to protect their legitimate interests; and*
 - *the UCT regime will not apply to life insurance contracts at this stage.*¹⁰¹

This proposal by the Minister came out of extensive consultation by Treasury, the Assistant Treasurer and his office with insurers and consumer advocates. The proposal—in particular the decision to insert new elements in the *Insurance Contracts Act* rather than simply extend the existing *ASIC Act* provisions to insurance—was not the preferred option for consumer advocates at the time.¹⁰² However we took the view that the legislation was a workable compromise with the insurance sector, had importantly had the support of the ICA and was a considerable improvement on the current situation. It was also achieved through genuine negotiation between both sides of the debate. Any argument from the ICA against such a regime is disingenuous and simply one of political opportunism.

Financial Rights implores this inquiry to consider yet again the full sweep of options considered in 2013 but we would support the compromise design developed at that time. The only exception to this is we believe that the regime should be extended to both general and life insurance contracts for the reasons of inherent unfairness as outlined above.

Recommendations

85. The exemption for insurance products under the UCT regime be removed.

101 Minister Bradbury, Media Release: Protection from unfair terms in general insurance contracts. <http://ministers.treasury.gov.au/DisplayDocs.aspx?doc=pressreleases/2012/171.htm&pageID=003&min=djba&Year=&DocType=>

102 A full description of the options canvassed can be found in Treasury's Unfair terms in insurance contracts – Options Paper: http://icareview.treasury.gov.au/content/_download/unfair_terms_options/unfair_terms_options_paper.pdf There were five options put forward: Maintaining the status quo; Option A – Permitting the unfair contract terms provisions of the *ASIC Act* to apply to insurance contracts; Option B – Extending *IC Act* remedies to include unfair terms provisions; Option C – Enhancing existing *IC Act* remedies; and Option D – Encouraging industry self-regulation to better prevent use of unfair terms by insurers.

Expansion of the Scope of the Code

Insurance Reporting

Financial Rights understands that in late 2016 Dunn and Bradstreet launched a 'new' Insurance Reference Services (**IRS**) database of Australian motor and home insurance claims, which it was appointed to build, host and manage.

The database makes available to insurers information about the claims history of every consumer that has purchased insurance through member motor and home insurers representing "some 90% of the Australian home insurance market."¹⁰³

The database contains the following information on consumers in Australia:

- Name, date of birth, driver's license, gender and residential address;
- Enquiries made by agents of insurance companies - such as loss assessors, adjustors or insurance investigators;
- Claims made under insurance policies; and
- Details of fraud investigations.

According to Dun & Bradstreet the IRS membership database allows members to:

- improve efficiency and customer experience at onboarding and time of claim;
- accurately assess and price risk;
- optimise underwriting practices; and
- identify suspicious, unusual or potentially fraudulent claims.

However a consumer can only obtain a copy of their insurance report (called My Insurance Claims Report) from Insurance Reference Services Ltd¹⁰⁴ for \$22 (incl. GST). There is no free access available to an insurance report for a consumer.

Insurers regularly check insurance reports when a claim has been made. The consumer purchasing insurance is told about the possibility of reporting to an "insurance reference bureau" (or similar) in the PDS, often close to the end of the PDS. There does however seem to be inconsistency in obtaining consent to provide this information.

¹⁰³ Dun & Bradstreet Launches New Australian Insurance Industry Database, 4 October 2016, <http://dnb.com.au/article-media-Australian-Insurance-Industry-Database.html>

¹⁰⁴ at www.insurancereferenceservices.com.au It was previously only available via Veda www.myinsurancepassport.com.au for \$29.95 but this service has ceased and is now only available from Insurance Reference Services Ltd.

For consumers though, the selling point of an insurance passport put forward by Insurance Reference Services is that:

“See what information Australian insurance companies know about your home and motor insurance claims history.

General insurance companies are required to disclose to policy holders, in their Privacy Statements and Privacy Policies, the extent to which your personal information may be shared with other insurance companies, loss assessors, claims agents and insurance reference bureaus. IRS is an insurance reference bureau and is one of the key resources that insurance companies rely upon for sharing and verifying your insurance claims history across other insurers, to assist in claims management and detection of insurance fraud.

This information may be used by insurers to validate information provided to them when quoting, assessing your claim or setting your premium. My Insurance Claims Report is based upon the aggregated home and motor claims records of the IRS home and motor claims database.”¹⁰⁵

A consumer being able to access a central database of claims information that assists in answering disclosure questions holds some potential value but Financial Rights is unaware to what extent consumers have taken up the opportunity. Insurers tracking consumers who make fraudulent or excessive claims to reduce the instance of fraud and calculate premiums also has potential value but there are many opportunities for misreporting and abuse without adequate rules and oversight.

In Financial Rights’ discussions with insurers in 2016, we were told that the reports were haphazard, inconsistent and largely unreliable so that the current report provides minimal benefit to insurers or consumers.

It is also Financial Rights’ understanding that insurers may be using the database inconsistently, and are not aware of what the information contained on the report may mean. This could lead to a consumer being disadvantaged in unfair premiums, rejections for non-disclosure and inconsistent treatment. The utility and value for a consumer in having the report at the cost of \$22 is therefore undermined if the information it records is not consistent, accurate or up-to-date.

Financial Rights has several additional concerns. First, very few consumers know that insurance reports exist, their purpose and when their information is recorded.

Secondly, if information on a consumer’s insurance history is collected and shared amongst insurers, access to this report should at the very least be free. Consumers need to be able to access information held by insurers about them to ensure that that information is accurate.

Finally, Financial Rights is concerned that there are no specific regulations covering insurance reports stipulating the permitted contents of the report, the type and the meaning of listings

¹⁰⁵ <http://insurancereferenceservices.com.au/about>

and the length of time the information is retained on a report.¹⁰⁶ The information held in an insurance report has the potential to be very prejudicial to a consumer in obtaining insurance or in making a claim. The lack of specific regulation in insurance reporting is in stark contrast with credit reports where there is extensive regulation about what information can be held, how consumers can get access and correction procedures.¹⁰⁷ Fraud is a serious allegation and the reporting of fraud on an insurance report is potentially defamatory and needs to be tightly regulated.

Under subsection 4.8 of the General Insurance Code insurers have committed to giving reasons why they cannot provide insurance and supplying consumers with the information they have relied on, if requested. In Financial Rights' experience these reasons are often vague and rarely have information regarding an insurance report. This means consumers are not even aware of the problem on their insurance report.

In summary, insurance reports drawn from the database are haphazard, inconsistent and largely unreliable providing minimal benefit to both consumers and insurers. Very few consumers know that insurance reports exist. Access to a consumer's own information is not free. There are no specific regulations defining and limiting the permitted contents of the report, the time information stays on the report, and no systems in place to ensure that incorrect, prejudicial and potentially defamatory information can be removed.

Financial Rights has recommended to the Government in a number of recent inquiries into insurance that, similar to the regulation in place already for consumer credit reporting, the ICA work with the Federal Government, the Office of the Australian Information Commissioner and the insurance industry to overhaul the insurance reporting system through regulation. Central to any regulations should be rules to address issues of accuracy, timing, consistency of information, dispute resolution and the application of natural justice. Consumers should also have free access to the information held on them.

In the alternative, insurers could go on the front foot and make the same commitments to consumers via the General Insurance Code.

Recommendations

86. A guide should be developed by the ICA which is enforceable through the General Insurance Code. The guide would cover consumer rights and insurer responsibilities in using insurance reports.

87. Each consumer is entitled to one free insurance report each year.

¹⁰⁶ According to Veda Advantage insurance enquiries are held for five years and claims for ten years, calculated on the date the information was added to the file and are based on the time limits provided in the Privacy Act 1988.

¹⁰⁷ Part IIIA of the Privacy Act 1988 (Cth) regulates consumer credit reporting in Australia and is supported by the Privacy Regulation 2013 (Cth) and the Privacy (Credit Reporting) Code 2014 (Cth).

Uninsured Motorist Extension

Financial Rights has concerns about the ability of consumers to claim on their Uninsured Motorist Extension (UME) policies. In recent years we have received increasing calls from consumers that find it impossible to meet some of the conditions that insurers impose in order to claim on this product. Generally UME policies require a policy holder to show they were in a motor vehicle accident with another driver who was at fault and is uninsured. The policy holder also needs to provide the insurer with the name, address and registration number of the uninsured driver.

Providing the name, address and registration of another driver is sometimes easy, but if the other driver is being uncooperative (or even aggressive), it can be very difficult for a consumer to get these details. If the insurer is able to get this information itself without much difficulty (for example, from a police report) we submit that the policy-holder should not be required to provide it in order to make a claim.

What is of more concern is the UME requirement to show that the at fault driver is uninsured. If the policy-holder is not in contact with the other driver, how is he or she supposed to prove that the other driver is uninsured? The policy-holder is being asked to prove a negative! We submit that insurers should commit to not including this requirement in their UME policies. It is not even relevant to whether or not the insurer can recover from the other driver.

Recommendations

88. The General Insurance Code should require that subscribers who offer Uninsured Motorist Extension (UME) insurance policies will not:

- a. Require policy-holders to prove that the at fault driver is uninsured; nor
 - b. Require policy-holders to provide the name, address and registration number of the at fault driver if that driver is uncooperative and the insurer is able to get that information itself without much difficulty.
-

Total Loss Protocol

Financial Rights supports the work that has been done by Legal Aid NSW with General Insurers to create a Total Loss Protocol after various natural disasters. We submit that the spirit behind this example of good industry practice should be enshrined in the General Insurance Code.

Immediately following the bushfires in the Blue Mountains in 2013, residents who had suffered a total loss of their properties were asked by various insurers to provide an itemised list of everything they had lost. Legal Aid NSW and Financial Rights both received complaints about this practice. Forcing homeowners to consider and itemise every destroyed possession was unnecessarily arduous given the trauma homeowners had experienced. Insurers' assessors had other ways to easily determine total loss without reference to such a list. Within the first few days following the disaster, Legal Aid NSW negotiated with the major insurers who agreed to cease this practice.

Since then Legal Aid NSW has also led discussions with industry representatives, FOS and the ICA about this matter which resulted in a general consensus as to the standard for good industry practice in this regard. It is time for that consensus to make its way into the General Insurance Code.

Recommendations

89. Section 9 of the General Insurance Code should include a commitment to a Total Loss Protocol in catastrophe situations which avoids forcing policy-holders to itemise every lost personal item in order to make a claim.

Climate Change

Financial Rights notes that there is one reference to climate change in the Taskforce's Interim Report stating that "uncertainty about long-term cycles and possible changes in climate make both forecasting cyclone activity in the near term and predicting future cyclone activity very difficult climate." However Financial Rights directs the Taskforce to recent reports from the Climate Council that make it clear that there are "dramatic changes to the climate system happening across the globe" and that "Climate change is increasing the frequency and severity of many extreme weather events" posing "substantial and escalating risks for health, property, infrastructure, agriculture and natural ecosystems."¹⁰⁸

With respect to cyclones the Climate Council agrees that climate prediction is difficult stating that "the influence of climate change so far on the nature of tropical cyclones themselves is [not] well known, in part due to limited and inconsistent datasets of cyclone behaviour over the

108 Climate Council's latest report: "Climate Change 2015: Growing Risks, Critical Choices" By Lesley Hughes And Will Steffen (28/8/15), available at: <https://www.climatecouncil.org.au/climate-change-2015-growing-risks-critical-choices>

past several decades,” it does state that “in general, tropical cyclones are projected to become more intense but less frequent.”¹⁰⁹

It is therefore prudent to factor in climate change and the risks this poses for the environment, communities, industry and individual homeowners, when recommending intervention in the insurance market for high risk regions, particularly with respect to consideration of the length of any intervention.

Indeed, Financial Rights notes that the insurance industry themselves have long factored in the impact of climate change and extreme weather events into their business models and have been arguing for some time for governments to support resilience policies to protect vulnerable communities.

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 Financial Rights on (02) 9212 4216.

Kind Regards,



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¹⁰⁹ <http://www.climatecouncil.org.au/uploads/417d45f46cc04249d55d59be3da6281c.pdf> also note p.25 of the “Climate Change 2015: Growing Risks, Critical Choices” By Lesley Hughes And Will Steffen (28/8/15), which states: Tropical cyclones may occur less often but become more intense (medium confidence), and could reach further south (low confidence).