



**Submission by the  
Financial Rights Legal Centre**

Royal Commission into Misconduct in the Banking,  
Superannuation and Financial Services Industry

General Insurance Background Paper 14

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10 July 2018

## 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 close to 25,000 calls for advice or assistance during the 2016/2017 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.

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## Introduction

Thank you for the opportunity to comment on the General Insurance Background Paper 14. The Financial Rights Legal Centre notes that the Background Paper encapsulates the author's views and is not expressing the views of the Commission. We further note that the aim of the Background Paper is to give the reader a guide to the law, regulation and practices in general insurance in Australia. The Background Paper in Financial Rights view is comprehensive and an impressive attempt at distilling an incredibly complex area.

This submission is therefore confined to providing a small number of key additional pieces of information or context on general insurance laws, regulations and practice that have either not been highlighted or mentioned in the background paper. We only bring these up where we believe the additional information is important to more fully understand the context and impact of the legal and regulatory landscape in general insurance. We believe it may also assist the Commissioner in identifying some of the failures of the current regime.

## Part Five: Overview of Insurance Relationships

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### Parties: Sales Process

Financial Rights wishes to note the lack of regulations relating to conflicted remuneration structures and commissions. The absence of any regulation around remuneration structures is having a significant impact upon the insurance sales process.

## Part Six: Regulation

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### Regulation Types

The Background Paper notes that there are “rules about advertising” as a consumer protection regulation. The only relevant rules applying to advertising are ASIC 2012's *RG 234 Advertising products and advice services including credit: Good practice guidance*<sup>1</sup> but we note that it is not specific to either general or life insurance industries and is in our view out of date. We wish to note that the General Insurance Code does not include any commitments related to the advertising and marketing of general insurance products. The Life Insurance Code of Practice has a section on sales practices and advertising: Clause 4.1.

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<sup>1</sup> <http://asic.gov.au/regulatory-resources/find-a-document/regulatory-guides/rg-234-advertising-financial-products-and-advice-services-including-credit-good-practice-guidance/>

## Consumer Protection Regulation

The “no advice model” or “general advice model” as defined by s766B of the *Corporations Act 2001* is mentioned briefly.<sup>2</sup> This is an important element of the sales process. It 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.*<sup>3</sup>

*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*

*(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.*<sup>4</sup>

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.
- 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);

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<sup>2</sup> at 3.11 -3.13, pages 43-44

<sup>3</sup> <http://download.asic.gov.au/media/4042960/rep-492-published-12-september-2016-a.pdf>

<sup>4</sup> p.33 <http://download.asic.gov.au/media/4042960/rep-492-published-12-september-2016-a.pdf>

- 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 fewer requirements.

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).<sup>5</sup> 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.*

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.

## **The 2014 General Insurance Code of Practice**

### ***Sanctions - Fines***

Financial Rights notes that the Background Paper states that the Code:

*“does not include amongst its sanctions financial penalties. Financial penalties would only deter if the amounts of the penalties were significant. And if that were the case, the Code would need to ensure natural justice for those facing penalties.”*

We agree with this. We do wish to note however that the recent Final Report of the Insurance Council of Australia makes a contrary assertion. They state at page 69:

*Although it has been a long-held position by the ICA that there is no need for fines to be used for rectification or compensation, there is already an ability for the Code to impose specific rectification or consumer compensation. Moreover, the ICA Board has the ability under its Constitution by resolution to censure, fine, suspend or expel a member from the ICA, “where a member wilfully refuses or neglects to comply with the provisions of the constitution...or is guilty of any conduct which in the opinion of the board is unbecoming of a member.”*

We do not agree with the ICA. If their assertion is correct, at best such power has been hidden and obfuscated, at worst it is an argument to maintain a status quo where fines are never considered or implemented. We remain strongly of the view that for the Code to be effective

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<sup>5</sup> 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](https://futureofadvice.treasury.gov.au/content/consultation/corporations_amend/submissions/Suncorp.pdf)

all other appropriate sanctions and tools should be made available to the CGC to incentivise compliance.

### **Sanctions - Naming**

Furthermore the background paper states that:

*Insurers stand or fall on their reputation, so publication of an insurer's noncompliance is a strong deterrent.*

While “arranging publication of our non-compliance” is a sanction it is not “publicly naming as foreseen” under ASIC RG183.70. We are not aware of any time an insurer has been named. Most publication of non-compliance is done so anonymously, ie with the insurer’s named removed. Compare this to the ABA’s Code of Banking Practice Clause 36(j), which explicitly empowers the equivalent body to name a bank.

We also wish to reiterate Consumer Action’s point that the General Insurance Code is not and has never been ASIC-approved as implied in para. 5.13 on page 51 of the Background Paper.

### **Code Scope - Third Party Distributors operating under their own AFSL**

We wish to note that there is a significant gap in the scope and effectiveness of the General Insurance Code of Practice. Those distributors of general insurance that operate under their own AFSL are not subject to most of the General Insurance Code of Practice’s standards. The ICA argues in their Final Report of the 2017 GICOP Review that:

*those distributors that operate under their own AFSL are subject to ample regulation, through the law as well as self-regulation, without requiring duplication in the Code. Potential breaches of licence conditions can be reported to ASIC. For banks and brokers distributing insurance products, there are codes of practice in place that determine their standards of conduct.*

This is a significant hole in the self-regulatory framework, impacting upon many insurance consumers. The other Codes that the ICA are relying on to ensure compliance and high standards do not explicitly apply the same, industry specific standards as detailed in the General Insurance Code.

## **Part Eleven: Insurance Policy – Formation and Layout**

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### **Definitions and Conditions**

Financial Rights notes that the Background Paper does not raise the notion of standard definitions. There currently exists under the law one standard definition in general insurance: flood<sup>6</sup>, and the lack of standard definitions generally in general insurance. While the definition

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<sup>6</sup> as per Part 3, Division 2, *Insurance Contracts Regulations 2017*

of flood is referenced in Background Paper 15 on Catastrophes and Natural Disasters Insurance, the absence of a full discussion of standard definitions in this paper is notable as it is an important piece of contextual information in the current regulatory environment that needs to be considered by the Royal Commission given its potential to address many of the failures of disclosure.

The definition of Flood was introduced as a response to legal and regulatory failures arising out of the 2011 Queensland floods. These floods resulted in a number of people being adversely affected due to inadequate general insurance cover. Government consultation on the issue highlighted consumer confusion about what was and was not included in their insurance contracts; in particular, the extent to which contracts provide cover for flood and what flood cover means.

Subsequently, in an effort to reduce confusion and enable consumers to make better informed decisions about the purchase of insurance contracts, Parliament passed legislation amending the *Insurance Contracts Act* in 2012. The legislation provided for a standard definition of flood (and required insurers to provide a KFS for home building and contents policies).

To date, flood remains the only standard definition in general insurance.

Generally speaking, the industry has been positive about the definition of flood with the ICA Disclosure Taskforce stating that they had “identified possible benefits from proposals.” Allianz have stated that:

*I think we would all agree that having a standard definition of flood has been of great advantage to the industry and to consumers. I do not think we would be averse to standardising some other definitions like actions of the sea in a similar way*

Financial Rights has supported the increased use of standard definitions but we have also highlighted potential issues with their implementation. In Financial Rights’ experience many consumers are opting out, or simply finding it impossible to find cover at an affordable price. Financial Rights gets regular calls from consumers who are unhappy with the premium being asked in relation to their flood cover.

The other issue that arises out of the use of standard definitions is whether the definition is broad or narrow with subsequent flow on impacts on price. Financial Rights takes the view that standard definitions must be developed independent of industry and must be the most inclusive definition possible in order to ensure that the net result of the creation of standard definitions is not less cover.

## **Disclosure of Policy Terms**

Financial Rights notes that the Background Paper does not explicitly detail the Standard Cover regime as a key legal obligation to disclose fairly the policy terms to the policy holder. It is the failures of the current standard cover regime that has led to many of the difficulties in finding policy terms and any ability to compare.

Financial Rights notes that the Background Paper describes the process of the sale of insurance, and in particular describes the role of the product disclosure statement. One

important element missing from this is the role of the Product Disclosure Statement (**PDS**) in the Standard Cover regime.

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 – ie through the provision of a PDS. 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.<sup>7</sup> The Law Reform Commission argued that:

*difficulties caused by lack of information available to insureds are made worse by the wide diversity 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 ...*<sup>8</sup>

The Law Reform Commission continued:

*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.*<sup>9</sup>

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.*

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 describe the actual cover in the PDS and

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<sup>7</sup> <http://www.alrc.gov.au/report-20>

<sup>8</sup> p.xxvi <http://www.alrc.gov.au/report-20>

<sup>9</sup> pp.44-45 <http://www.alrc.gov.au/report-20>



contract. We note the recently released research by the Insurance Council of Australia<sup>10</sup> 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.<sup>11</sup> In short, insurer's can offer less than standard cover simply by tell their customers in a document few read and even less understand.

Finally, we wish to note that the Government has supported a recommendation by the Senate Economics References Committee to initiate an independent review of the current standard cover regime with particular regard to the efficacy of current disclosure requirements.<sup>12</sup>

## **Renewal – Provision of Reasons for Cancellation or Premium Increase**

One important element of the legal and regulatory framework that is not considered is the lack of any real ability for consumers to obtain full reasons for a cancellation or increase in premiums at renewal time.

The current mechanism available to consumers to find out reasons is 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.

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.

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. The FOS Terms of Reference provides:

*Clause 5.1 - The service may not consider a dispute:*

*b) about the level of a fee, **premium**, charge or interest rate – unless:*

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<sup>10</sup> Insurance Council of Australia, Consumer Research on General Insurance Product Disclosures, Research Findings Report, February 2017  
[http://www.insurancecouncil.com.au/assets/report/2017\\_02\\_Effective%20Disclosure%20Research%20Report.pdf](http://www.insurancecouncil.com.au/assets/report/2017_02_Effective%20Disclosure%20Research%20Report.pdf)

<sup>11</sup> 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](http://www.insurancecouncil.com.au/assets/report/2017_02_Effective%20Disclosure%20Research%20Report.pdf)

<sup>12</sup> *Australian Government response to the Senate Economics References Committee report: Australia's general insurance industry: sapping consumers of the will to compare*, December 2018  
<https://static.treasury.gov.au/uploads/sites/1/2017/12/p2017-t248756.pdf>

- (i) *the Dispute concerns non-disclosure, misrepresentation or incorrect application of the fee, premium, charge or interest rate by the Financial Services Provider having regard to any scale or practices generally applied by that Financial Services Provider or agreed with that Applicant; ...*
- e) *in the case of a Dispute about a General Insurance Policy – about rating factors and weightings the insurer applies to determine the insured’s or proposed insured’s base premium which is commercially sensitive information;*
- f) *about a decision to refuse to provide insurance cover except where:*
  - (i) *the Dispute is that the decision was made indiscriminately, maliciously or on the basis of incorrect information; or*
  - (ii) *the Dispute pertains to medical indemnity insurance cover; ...*

In the 2015/16 financial year 32 consumers lodged disputes about insurance cover refusals (under clause 5.1(f)) and were excluded from FOS, and 215 consumers lodged disputes about Level of fee/premium/charge and had the dispute refused.<sup>13</sup> The Annual Report does not indicate whether FOS accepted any disputes made by consumers under the above sections.

A review of all of the decisions made by FOS to date shows that 15 determinations have been issued in their jurisdiction about “incorrect premiums”, the majority of decisions relate to consumers being misled.

Significantly, determination number 218234 recognises that an insurer can make 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.

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<sup>13</sup> see the 2015/16 FOS Annual Review on page 58:  
<https://www.fos.org.au/custom/files/docs/20152016-fos-annual-review.pdf>

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 a robust dispute mechanism was in place creating greater transparency and contestability of premium pricing, Financial Rights would expect 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 remain in the dark and may be making poor decisions. If they could have a premium pricing decision reviewed by an independent body, consumers may be more likely to believe the risk assessments on their properties.

## Part Nine: Utmost Good Faith

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### Reliance on a provision as a breach of the duty

Financial Rights notes at Footnote 324 the Background Paper states:

*The URCT regime in s. 14 applies when a term is operating unfairly in breach of the duty of the duty of utmost good faith. The breach may be situational and in other circumstances reliance on the provision may not be a breach. However, a UCT regime, only operates if a term is inherently unfair, which terms of insurance contracts seldom are. It is tolerably clear that an insurer's reliance on a term that is inherently unfair would most likely be considered to be a breach of the insurer's duty of utmost good faith under s. 14.*

Financial Rights fundamentally disagrees with much of this footnote. The assertion that "insurance contracts seldom are...unfair" is not based in fact and provides no evidence to support this claim. We invite the Royal Commissioner to read Consumer Action's recent research *Denied: Levelling the playing field to make insurance fair*<sup>14</sup> to see some examples of the unfair contract terms that have been found in insurance contracts.

Further, an unfair contract term may be considered to be a breach of the insurer's duty of utmost good faith but is rarely used or considered – as indicated by the Background paper when it states: Section 14 appears to have been underutilised.

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<sup>14</sup> <https://consumeraction.org.au/consumer-action-asks-insurance-companies-show-australians-love-media-release/>

Insurers have long argued that the duty of utmost good faith covers the same issues that arise with unfair contracts. 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. Further it's virtually impossible for a non-lawyer to understand or even be aware of the duty of utmost good faith. The duty is not commonly known by consumers and, in our experience, consumers only ever become aware of the duty when it applies to their own conduct when the duty of utmost good faith is raised by the insurer. Subsequently, most consumers do not argue on the basis of good faith at the FOS and it is not commonly relied upon unless FOS itself identifies it, if at all as a basis, for relief from an unfair term. 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. This is why there are few reported cases – as mentioned by the Background Paper at footnote 326.

Financial Rights further notes that the Government has acknowledged the need to introduce an unfair contracts regime with its recent proposals paper” *Extending Unfair Contract Terms Protection to Insurance Contracts*.<sup>15</sup> The Paper states at

*The [Parliamentary Joint Committee on Corporations and Financial Services] found that the symmetrical nature of the good faith duty is incompatible with the highly asymmetrical nature of the relationship between an individual or small business dealing with large powerful life insurance companies.*

## Part Fourteen: Claims

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### Claims handling

Financial Rights notes that the Background Paper focusses on the duty of utmost good faith as the key consumer protection in the claims handling area. It is Financial Rights' experience that the duty of utmost good faith is used far more successfully by insurers in seeking cooperation and compliance from customers. Insurers rely upon the consumer's duty of utmost good faith regularly in, for example, interview requests, excessive document requests, third party information requests and other insurer requirements as outlined in *Guilty Until Proven Innocent: Insurance Investigations in Australia*.<sup>16</sup> Duty of utmost good faith is in this sense used as leverage in both appropriate and inappropriate ways. Consumers are rarely aware of the reciprocal nature of the duty of utmost good faith, if ever. When it comes to claims handling

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<sup>15</sup> <https://treasury.gov.au/consultation/c2018-t284394/>

<sup>16</sup> <http://financialrights.org.au/wp-content/uploads/2016/03/Guilty-until-proven-innocent.pdf>

consumers are subject to the structures, systems and whims of the insurer, usually on a take it or leave it basis. There is rarely room for negotiation or a discussion of rights or mutually agreed upon outcomes. The duty of utmost good faith on the insurer's side only arises once a consumer has actually complained. There is rarely an acknowledgement of such a duty before this occurs.

While not the strongest of protections, there are some claims handling protections present in Section 7 of the General Insurance Code of Practice, which the Background Paper makes no mention. This is an important area of self-regulation and seeks to ensure that general insurers handle claims in an 'honest, fair, transparent and timely manner", provide for people in urgent need of benefits and comply with timeframes.

As with Consumer Action, we too have concerns with insurers not complying with some elements of section 7 of the GICOP, particularly in relation to claims assessment, investigations and timeframes.

Further it needs to be highlighted that ASIC cannot investigate misconduct in relation to insurance claims handling, because claims handling is not considered a financial service.<sup>17</sup> We too support ASIC's view that removing this exemption would 'enhance ASIC's ability to seek improvements in claims handling practices'.<sup>18</sup> As we understand, the Minister for Financial Services has stated that:

*Due to the overlap with the remit of the Royal Commission, the work being done by Treasury to enhance ASIC's oversight of insurance claims handling will now be considered pending the outcome of the Royal Commission<sup>19</sup>*

## Fraudulent Claims

It is again notable that there are very few regulations in place to curb the excesses and abuses of general insurer behavior with respect to insurance investigations, as outlined in our report: *Guilty Until Proven Innocent: Insurance Investigations in Australia*.<sup>20</sup>

*Guilty Until Proven Innocent* outlines the key consumer protections in this space including the codification of the duty of utmost good faith, the limitation on the reliance of reliance by an insurer on unusual and 'non-standard' clauses (ICA 1984, ss. 35 & 37), safeguards relating to the reliance by an insurer on non-disclosure and misrepresentation (ICA 1984, ss. 21, 21A, 26

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<sup>17</sup> *Corporations Regulations 2001* (Cth) reg 7.1.33 provides an exemption under s 766A of the Corporations Act.

<sup>18</sup> Peter Kell, *Life insurance claims handling, Speech to Money Management's Claims Handling Breakfast* (Sydney, Australia), 16 March 2017, p 4.

<sup>19</sup> Kelly O'Dwyer MP, Minister for Revenue and Financial Services Speech Address to the Insurance Council of Australia Annual Forum Sydney 7 March 2018, [http://www.insurancecouncil.com.au/assets/media\\_release/20180307%20-%20Speech%20-%20Address%20to%20the%20Insurance%20Council%20of%20Australia%20Annual%20Forum.pdf](http://www.insurancecouncil.com.au/assets/media_release/20180307%20-%20Speech%20-%20Address%20to%20the%20Insurance%20Council%20of%20Australia%20Annual%20Forum.pdf)

<sup>20</sup> <http://financialrights.org.au/wp-content/uploads/2016/03/Guilty-until-proven-innocent.pdf>

and 28), and preventing the insurer from relying on fraud if the fraud was minor and it would be unfair to reject the entire claim (ICA 1984, s. 56).

It also details the relevant obligations placed upon Australian Financial Services Licences under the *Corporations Act*, the *ASIC Act 2001*, the *Australian Consumer Law*, prohibit misleading and deceptive conduct or unconscionable conduct (s. ASIC Act 2001, CA 2001 s1041H; ACL s 18), the *Racial Discrimination Act 1975 (Cth)*, the *Disability Discrimination Act 1992 (Cth)* and the *Privacy Act 1988 (Cth)*.

There are also trespass, property access, harassment and nuisance laws, privacy law and the use of surveillance devices that apply to the work of insurers and investigators.

Despite this, Financial Rights wishes to note three particularly glaring absences.

Firstly, there are currently few if any standards set under the General Insurance Code of Practice. This may change however, with the recent Final Report of the ICA's Review of the General Insurance Code of Practice, June 2018<sup>21</sup> which is proposing to introduce a mandatory set of investigations standards.

Secondly, it is particularly noteworthy finding of *Guilty Until Proven Innocent* that the state of private investigator licensing in Australia is a mess with vast variability across jurisdictions offering few, if any, consumer protections. *Guilty Until Proven Innocent* goes into great detail on this issue<sup>22</sup> and argues the need for significant reform. The current dearth of regulations around private investigators and insurance investigations has contributed to much of the distrust of insurers and led to significant issues, as outlined in the paper.

Finally, the general insurance industry has a process of sharing information about the claims history of every consumer that has purchased insurance. The database is managed and supported by Illion (formerly Dunn and Bradstreet) on behalf of Insurance Reference Services Ltd – a member organisation owned by Australian insurers. Outside of the application of the Australian Privacy Principles, there are no specific regulations applying to the collection storage and sharing of this information in the same way there is for credit reporting. Insurers tracking consumers who make fraudulent or excessive claims to reduce the instances of fraud and calculate premiums has potential value but there are many opportunities for misreporting and abuse without adequate rules and oversight. Indeed in Financial Rights' discussions with insurers, the reports are haphazard, inconsistent and largely unreliable so that the current reports provide minimal benefit to insurers or consumers and have a serious potential of creating harm.

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<sup>21</sup>

[http://www.codeofpracticereview.com.au/assets/Final%20Report/250618\\_ICA%20Code%20Review\\_Final%20Report.pdf](http://www.codeofpracticereview.com.au/assets/Final%20Report/250618_ICA%20Code%20Review_Final%20Report.pdf)

<sup>22</sup> pp.70-76

## Dispute Resolution

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### IDR – Complaints

Financial Rights notes that the background paper details the two stage complaint process as outlined by the 2014 Code of Practice. While this may seem benign on the surface it is important to understand the lived reality of such self-regulation that is, that two stages is a source of major issues for consumers. The key concerns with two-stage IDR are that:

- it is confusing – many people do not know what stage they're at and what to do at a particular point;
- it deters people from pursuing legitimate complaints – we see consumers abandon legitimate complaints because the process seems laborious,
- it protracts the time taken up by internal disputes, for both insurers and consumers, particularly for less complex disputes; and
- damages consumer trust, as people feel confused and unheard.

Insurers have in short designed a system that works for the insurer's best interest and regularly fails consumers.

### FOS

The Background Paper states that:

*FOS also monitors and enforces the Code.*<sup>23</sup>

This is incorrect, although FOS may apply the Code in the resolution of individual disputes. The General Insurance Code Governance Committee (**CGC**) monitors and enforces the General Insurance Code of Practice. FOS provides secretariat services for the CGC and other committees as agreed.

### 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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<sup>23</sup> At para 4.5, p 119



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