Submission by the
Financial Rights Legal Centre
Financial Counselling Australia
Redfern Legal Centre

Financial Services Council

Life Insurance Code of Practice, Consultation Draft, November 2018

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About the Financial Rights Legal Centre

The Financial Rights Legal Centre is a community legal centre that specialises in helping consumers 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, and the Mob Strong Debt Help services which assist Aboriginal and Torres Strait Islander Peoples with credit, debt and insurance matters. Financial Rights took close to 25,000 calls for advice or assistance during the 2017/2018 financial year.

About Financial Counselling Australia

Financial Counselling Australia is the peak body for financial counsellors. Financial counsellors assist people experiencing financial difficulty by providing information, support and advocacy. Working in not-for-profit community organisations, financial counselling services are free, independent and confidential.

About Redfern Legal Centre

Redfern Legal Centre (RLC) is an independent, non-profit, community-based legal centre with a particular focus on human rights and social justice. Our specialist areas of work are domestic violence, tenancy, credit and debt, employment, discrimination and complaints about police and other governmental agencies. By working collaboratively with key partners, RLC specialist lawyers and advocates provide free advice, conduct case work, deliver community legal education and write publications and submissions. RLC works towards reforming our legal system for the benefit of the community. RLC recognises that the protection of financial and consumer rights is central to securing other rights and freedoms such as secure housing, effective education and social and economic participation. Since 1977, RLC has run a specialist credit and consumer law practice and targets our work towards vulnerable and disadvantaged consumers.
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Introduction

Thank you for the opportunity to comment to the Financial Services Council’s (FSC’s) draft second version of the Life Insurance Code of Practice (draft Life Code). The Financial Rights Legal Centre (Financial Rights) has drafted this submission. Financial Counselling Australia, the peak body for financial counsellors in Australia and Redfern Legal Centre, an independent, non-profit, community-based legal centre have endorsed this submission and concur with the concerns raised.

This submission provides feedback on:

- the consultation process of the second iteration of the Life Code;
- issues with respect to the specific questions raised by the FSC in its consultation document;
- issues with respect to the drafting of new additions to the Life Code that have been highlighted in the document;
- issues with respect to the re-drafting of the current iteration of the Life Code that have not been highlighted in the consultation document; and
- issues that have failed to be identified or addressed in the new draft Life Code.

We believe the length of the submission is a function of the poor consultation process implemented by the FSC – a consultation process that has lacked transparency, inclusion or any semblance of independence. We address these issues in the first section and make a series of recommendations that have been implemented elsewhere in the financial services sector that we believe will improve the process now and moving into the future.

Financial Rights also acknowledges and supports many of the new additions to the Life Code and believe that they go some way to addressing the concerns of consumers, regulators and government. We are however of the view that as a totality they do not go far enough. Financial Rights outlines our issues with these proposals and make a series of recommendations on how to improve these commitments from life insurers. In doing so we directly answer the four questions posed at the beginning of the consultation paper.

Financial Rights has also identified a series of issues with the re-drafting of the rest of the Life Code. While we understand that it may be inadvertent, many of the changes made have significant substantive impact upon existing consumer protections in the Life Code, most of which are a step backwards. This is disappointing and has involved a lot of work to identify, given the lack of a tracked changes view. We accept that it is the FSC’s view that a tracked changes version may be unwieldy, but respectfully disagree. We believe the identification of these voluminous substantive changes that have not been highlighted by the FSC demonstrate the necessity of a tracked changes version.

Finally Financial Rights raises a large number of issues that have failed to be addressed by the FSC arising out of our original close engagement on the drafting of the first iteration of the Life Code or from our work with clients on the Insurance Law Service. We believe that these issues
must be considered and acted upon now and not left to a review in 2022. This will only lead to four more years of poor consumer outcomes while waiting for the FSC to conduct a review.
Executive Summary

Financial Rights generally supports the attempt by the FSC to add consumer protections to the Life Code as going some way to addressing the concerns of consumers, regulators and government. However, as a totality they do not go far enough to meet community expectations.

The FSC needs to strengthen commitments with respect to the sale of funeral insurance, sales practices, and the treatment of people with a mental illness. This includes further restricting the sale of funeral insurance to those under the age of 50, Aboriginal and Torres Strait Islander people, and those already with a funeral insurance product as well as introducing a deferred sales process and capping premiums. Life insurers should meet the Disability Discrimination Act (DDA) requirements in underwriting for people with a mental illness, treating people with a mental illness in a fairer manner and severely restricting the surveillance of diagnosed mental health condition or who are making a claim based on a mental health condition. Poor and exploitative sales practices across the industry must be explicitly dealt with in serious Life Code commitments.

Financial Rights has identified a large number of recommendations made by the Parliamentary Joint Committee on Corporations and Financial Services (PJC) Inquiry into the Life Insurance Industry Report or ASIC Report 587 on the sale of direct life insurance that have failed to be addressed. These include standardising all definitions used in life insurance products, updating all medical definitions, providing upper limits on medical examinations, appropriately addressing pre-existing conditions, and implementing a moratorium on the use of genetic tests in line with the UK moratorium.

Financial Rights has also identified a large number of clauses that have been drafted or re-drafted in a manner that seems to solely benefit the life insurer. These need serious reconsideration to, for example, shift the onus on to the insurer away from the consumer to act or restore rights that currently exist under the Life Code but have been taken away.

A number of issues arising out of the first iteration of the Life Code have failed to be adequately addressed by the FSC or addressed at all. These include applying medical definition updating to all life insurance holders; expanding upon commitments for vulnerable consumers, particularly Aboriginal and Torres Strait Islander people; introducing explicit independence in defining and reviewing medical definitions; setting hard timeframes in claims and communications practices to reign in delays; curtailing fishing expeditions; automatically providing information; improving investigation, surveillance and interview processes; applying the Life Code to distributors and third parties; increasing potential sanctions; bolstering support and resources for the Life CCC; committing to enforcing the Life Code as a part of the contract with the consumer and gaining ASIC approval. All these issues and a long list of other concerns listed in this submission must be considered and acted upon now and not left to a review in 2022. This will only lead to four more years of poor consumer outcomes while waiting for the FSC to conduct a review.
Financial Rights also expresses its concerns with the consultation process undertaken by the FSC. We have recommended that the FSC establish a consumer consultation forum, appoint an independent reviewer, undertake a comprehensive plain English re-write of the Life Code, and better consult with the ACCC.
Recommendations

**Code Consultation Process and General Comments**

1. When proposing changes to the Life Code, the FSC should provide a fully tracked changed version to identify all major and minor alterations. Explanations should be provided for all proposed changes.

2. The FSC should establish an ongoing consumer liaison forum modelled on the ICA to facilitate ongoing, open discussions between the general insurance industry and consumer representatives with the aim of improving outcomes for consumers of life insurance products.

3. Given the current review’s lack of independence, the FSC must appoint an independent overseer to establish the effectiveness of the consultation process undertaken by the FSC.

4. The FSC must commit in future reviews to appointing an independent party to conduct public consultations and/or to make public recommendations about the Life Code in line with ASIC RG183.50(c).

5. The FSC should commit to establishing an independent assessment of the impact and effectiveness of the Life Code provisions to identify the extent to which the Life Code has achieved its stated objectives, as per the CFA’s Good Practice Principles.

6. A plain English re-write of the Life Code must be undertaken in line with current best practice and the Code’s own key promise.

7. The FSC must seek approval of the Life Code from ASIC in accordance with RG183. This includes ensuring that:
   a) the Life Code is binding on, and enforceable against, subscribers through contractual arrangements with consumers, i.e. the Life Code is a term of the contracts of all life insurance policies;
   b) subscription and adherence to the Life Code is compulsory for membership of the Council;
   c) independent review of the Life Code take place every three years;
   d) the number of sanctions available to the Life CCC be boosted; and
   e) all stakeholder issues raised in this current review with the FSC are addressed, as per the Key Criteria of ASIC RG 183.55–RG 183.62.

8. The FSC must begin discussions with the ACCC as soon as possible and life insurers must act to introduce strong sector-wide commitments on sales practices and junk insurance products.
Feedback on Specific Questions

Funeral Insurance

9. The Life Code should prohibit stepped premiums on funeral insurance products: draft clause 3.6(c).

10. In the event that stepped premiums on funeral insurance products are not prohibited under the Life Code, life insurers should commit to providing projections of total costs of funeral insurance policy for a customer if they live to 60, 70, 80 and 90 and the estimated periodical payment required at key stages: draft clause 3.6(c).

11. Life insurers should commit to:

   a) not selling to anyone under 50 via the outbound sales channel;

   b) where there is an inbound funeral insurance inquiry from a consumer under 50, there must be a presumption that the sale is unsuitable unless certain criteria are met;

   c) the onus should be on the life insurer to ensure that the consumer meets this set of criteria demonstrating suitability;

   d) this suitability criteria for anyone under the age of 50 could include:

      i. having a terminal disease, or other reason to believe they may have a risk to claim on the policy; or

      ii. having no super; and

      iii. understanding that it is not a savings plan documented through the sales process.

   e) All consumers must:

      f) have had the product’s cost, risk and purpose clearly explained to them (this should be everyone – not just the under 50 cohort) and;

      g) be clearly informed it is not a savings plan and that they will lose all amounts paid under the policy if it is cancelled or lapses at any time prior to their death.

12. Life insurers should explicitly commit (under draft clause 3.6(f) to providing the following basic details in all general marketing campaigns for funeral insurance:

   a) the age the product lapses;

   b) that there are other ways to provide for a funeral;

   c) the stepped or level nature of the premium; and

   d) an example of the total cost of a product over its lifetime.

13. The Life Code should include a comprehensive Guidance for the Design and Distribution of Funeral Insurance: draft clause 3.6(g).

14. The Life Code should include an individualised, suitability requirement for the provision of funeral insurance: draft clause 3.6(g).

15. Independent, post-purchase audit surveys of funeral insurance sales should be conducted to find out what consumer believes that they have purchased and whether this aligns with the product
design. A certain percentage of consumers should be required to have understood and purchased suitable insurance otherwise life insurers would be subject to increased monitoring to ensure their funeral insurance sales process meets best practice. Drop out rates and claim ratios must also be monitored. Any inappropriate funeral insurance sales would need to be addressed, as envisioned under draft clause 4.13.

16. Funeral insurance consumers experiencing financial hardship should be offered more flexible arrangements, including the chance to repay arrears over time to retain their cover and be eligible to claim: draft clause 3.6(h).

17. Funeral insurance consumers who have premium arrears in the six month prior to death should have their claims paid and the arrears deducted from the payout, regardless of whether the policy has been otherwise validly cancelled in the interim period.

18. Insurers should provide referrals to independent financial counsellors to assist them in developing a savings plan when the customer indicates that that is in fact what they are interested in: draft clause 3.6(i)(i).

19. The funeral insurance key fact sheet should:

   a) include a projection of the total cost of a funeral insurance policy if a customer lives to 60, 70, 80 and 90 and the estimated periodical payment required at key stages: draft clause 3.6(i)(iii);

   b) an explanation what the words “that you can cancel the insurance at any time” means under draft clause 3.6(i)(vii) – that is, you will lose all the money you have paid.

20. A deferred sales model should be committed to for the sale of funeral insurance: draft clause 3.6.

21. The Life Code should include specific commitments regarding the sale of funeral insurance to Aboriginal and Torres Strait Islander peoples including

   a) taking reasonable steps to ensure that dealings with Aboriginal and Torres Strait Islander peoples are conducted in a culturally appropriate manner taking into account the specific needs and cultural protocols of each community.

   b) ensure that any insurance products promoted and sold to Aboriginal and Torres Strait Islander peoples are suitable to their specific needs.

   c) insurers do not procure sales leads from remote Aboriginal and Torres Strait Islander communities by exploiting Aboriginal and Torres Strait Islander kinship ties.

22. The FSC must undertake further specific consultation with Aboriginal and Torres Strait Islander communities, peoples and peak level bodies is required to understand how to identify what the specific needs are and how to address them.

23. Life insurers should commit to offering capped funeral insurance products, so that premiums cease once the benefit amount is reached (or a very small % above that).

24. The Life Code should commit insurers to preventing the sale of additional funeral insurance plans to those who already own one.
People with a mental health conditions

25. Life insurers must commit under the Life Code to basing their underwriting and risk profiles on proper assessments of risk, that is, in the case of mental health, actuarial or statistical data that is reasonable to rely on, as per section 46 of the DDA.

26. In line with recommendation 10.7 of the PJC Inquiry into the Life Insurance Industry, draft clause 5.3D needs to include the following additional explicit commitments:

   a) referring applications for insurance that reveal a mental health condition or symptoms of a mental health condition to an appropriately qualified underwriter;

   b) giving an applicant for insurance the opportunity to either withdraw their application or provide further information, including supporting medical documents, before declining to offer insurance or offering insurance on nonstandard terms;

   c) where an insurer offers insurance on non-standard terms, for example, with a mental health exclusion or a higher premium than a standard premium, specify:

      i. how long it is intended that the exclusion/higher premium will apply to the policy;

      ii. the criteria the insured would be required to satisfy to have the exclusion removed or premium reduced;

      iii. the process for removing or amending of the exclusion/premium.

27. Surveillance of an insured who has a diagnosed mental health condition or who is making a claim based on a mental health condition should be prohibited.

28. If this prohibition is not included in the Life Code then at the very least, life insurers should:

   a) cease all surveillance once notified by a policyholder that they have a concern;

   b) allow evidence to be received by the policyholder’s own medical practitioner;

   c) if a surveyed policyholder disagrees with a decision not to cease, then life insurers need to commit to providing complaint details to the policyholder.

Sales

29. Short-term customer incentives should be prohibited: draft clause 4.1(h).

30. The use of phrases “free,” “guaranteed,” “no cost,” “without cost,” “no additional cost” or “at no extra cost” in advertising should be prohibited: draft clause 4.1(g).

31. The exploitative practice of using but not employing Aboriginal and Torres Strait Islander community members to recruit other community members to purchase insurance products should be prohibited under draft clause 4.1.

32. All forms of conflicted remuneration for sales staff (be they employees, authorised representatives third party distributors or otherwise) must be prohibited: draft clause 4.2A
33. Life insurers must commit to ensuring that all distributors of their products meet the applicable standards of the Life Code of Practice, via insurer/distributor contracts: draft clause 4.2B.

34. Draft clause 4.3 should be re-drafted to align better with current and draft clause 4.6 by replacing the word "prevent" with the word "prohibit" or phrase "not permit."

35. The definition of pressure selling should be amended to include the concept of a sales person attempting to take control of the sales interaction: draft clause 4.3.

36. The Life Code should include a best practice guideline to address issues of gratuitous concurrence in the sale of life insurance products. At a minimum this should include a commitment from insurers to question a consumer about what they understand about the contract, when the sales representative identifies signs of gratuitous concurrence. If it is clear from these answers that the client does not fully comprehend what they are purchasing then sale should cease the sale.

37. In line with expectation 1 of ASIC Report 587, the Life Code must explicitly commit insurers to explain the key exclusions and future costs in the direct sales calls including:
   a) explaining the key features, exclusions, limitations and future costs of products;
   b) explaining the impact of and treatment of pre-existing conditions;
   c) providing practical examples to assist in understanding these exclusions;
   d) not relying on lengthy pre-recorded or verbatim disclosures when explaining these exclusions.

38. Draft clause 4.3A(c) should be expanded to make the following explicit commitments:
   a) life insurers will have clearly documented sales rules to ensure sales staff and authorised representatives help customers decide on the amount of cover they should take out in an appropriate manner including:
      i. Explaining the range of cover that is available.
      ii. Asking the customer if they have a view about how much cover they should choose and, if so, prepare a quote for that amount.
      iii. If not, asking the customer how much they could regularly afford on life insurance to protect their family, and using that amount to prepare a quote.

39. Draft clause 4.3A(d) should be expanded to make the following explicit commitments:
   a) Life insurers will have clearly documented sales rules to ensure sales staff and Authorised Representatives we employ can identify vulnerable customers, for example where the person:
      i. discloses that they have a vulnerability.
      ii. appears to be having language difficulties.
      iii. is having difficulty answering basic questions, even after the question is repeated.
      iv. appears to be confused or under the influence of alcohol or drugs.
      v. the person is, or becomes, distracted by something going on around them.
40. In line with Expectation 1 of ASIC Report 587 the Life Code should commit insurers to taking specific steps with respect to a vulnerable customer once identified, including ceasing the call immediately, where appropriate.

41. Draft clause 4.3A(f) should be amended so that when an alternative type of policy is proposed the life insurer:
   
   a) spells out any and all differences be highlighted to the consumer with a clear explanation of the impact of these changes
   
   b) ensures that the consumer must initiate the subsequent sales call.

42. Draft clause 4.3A(g) should be amended to ensure that the consumer, not the insurer, initiates a call after a period to think about the policy and its suitability.

43. In line with expectation 1 of ASIC Report 587, the Life Code must expand upon draft clause 4.4 and establish:

   a) specific timeframes on the conduct of assessments
   
   b) specific timeframes regarding the contacting a consumer if an assessment identifies issues with consumer need or understanding
   
   c) other timeframes for the quality assurance process including how often they will be conducted, how long they should take etc.
   
   d) parameters for sample sizes
   
   e) processes to identify types of sales that have a higher risk of poor consumer outcome or misconduct due to, for example, incentives
   
   f) sanctions for failing to meet the quality assurance standards

44. Draft clause 4.6 must be re-drafted to ensure that a breach of the Life Code by a distributor entails actual consequences for both the distributor and the life insurer.

45. Regarding the sale of CCI, draft clause 4.7 must be re-drafted to:

   a) replace the words "we will take all reasonable steps so that we are satisfied" with "we will ensure"

   b) remove the words "(to the extent we can)"

   c) reinstate the subclauses 4.7 (b)(i), (b)(iii) and (c)

46. Regarding the separation of application process for CCI and credit products in digital channels, Draft Clause 4.10 should be amended to:

   a) replace "will not start" with "will not be made available" in draft clause 4.10(a);

   b) replace "only after you have completed the digital application for a credit card or loan" with "only after your digital application for a credit card or loan has been approved";

   c) remove the qualifier “for example by” in draft clause 4.10(c), and;
d) limit to the amount of material or the number of contacts that could be made providing factual material.

47. Additional remedies for poor sales practices are needed to be included at draft clause 4.13(a):
   
   a) reasonable compensation, where appropriate and
   
   b) fines.

48. The wording of current clause 5.9(b) needs to be reinstated in draft clause 4.13(b) to return the onus back on the life insurer.

49. Draft clause 4.13 regarding investigating and remedying poor sales practices needs to be expanded to capture concerns identified about the design and distribution process as outlined in draft clause 3.6, 3.6A and other design and distribution obligations.

Moratorium on Genetic Tests in Life Insurance

50. The draft Moratorium on Genetic Tests in Life Insurance must prohibit the use of the genetic test results in life insurance altogether.

51. If this is not implemented, the draft Moratorium on Genetic Tests in Life Insurance must be amended to meet the recommendations of the PJC Life Insurance Inquiry Report in the following ways:

   a) The draftMoratorium should exclude the application of genetic testing to premium pricing to all conditions unless the test has been assessed by a panel of experts and approved by Government.

   b) The financial limits must be increased in line with the UK to:

      i. AUD$901,050 for life insurance,
      
      ii. AUD$540,630 for critical illness insurance and

      iii. an annual benefits of AUD$54,063 for income protection insurance or $4500.25 per month.

   c) Limit genetic test conditions to monogenic conditions, late-onset conditions; and of high penetrance.

   d) Undertake specific measures to reassure customers that they are not deterred from taking a genetic test for fear of potential insurance consequences.

   e) Not place the consumer under any pressure to take a genetic test.

   f) Treat customers who have taken a predictive test before the date of the Moratorium the same way as customers taking tests after the introduction of the Moratorium.

   g) Not require customers to:

      i. disclose genetic test result from a test taken after the insurance cover has started, for as long as the cover is in force;
ii. disclose genetic test results of another person such as a family member or;

iii. disclose genetic tests acquired as part of clinical research.

h) Make available information to customers, before an application for insurance cover is completed, about what customers will and will not have to disclose about their genetic tests in line with the Moratorium.

i) Maintain stringent procedures for seeking access to relevant medical information held by a doctor, other clinician as agreed between the FSC and the AMA.

j) Protect personal medical information.

k) Destroy medical evidence when it is no longer relevant to them.

l) Publish information about the way they will, or will not, use such test results to inform their underwriting decisions.

m) Not use genetic information to underwrite other non-life insurances.

n) Not impose unjustified exclusions from cover, or other special terms or conditions, which have the effect of preventing a policyholder from making a claim for a condition that is not related to the genetic condition identified by an approved test.

o) Meet a series of compliance standards similar to that in the UK Moratorium.

p) Adhere to specific dispute and complaints resolution standards including allowing consumers to take legal action over any breaches, as detailed in the UK Moratorium.

q) Take into consumer impacts (for consumers generally, and for consumers who have adverse genetic test results) in the subsequent review of the Moratorium.

**Insurance in Superannuation**

52. Life insurers must commit to work with the Insurance in Superannuation Working Group members and a proposed joint regulator taskforce to enhance commitments under the Insurance in Superannuation Voluntary Code of Practice as reflected in Chapter 2 of the Life Code. Improvements. This should include:

a) cessation periods for accounts with low contributions must be introduced;

b) premium caps in line with the draft code released for public consultation in 2017 should be committed to by superannuation trustees with a time-bound public commitment to review these caps to ensure they are set at appropriate levels for a basic default products;

c) insurance terms used should be standardised including common eligibility and exemption definitions for TPD;

d) claims handling commitments need to be improved including committing to acting in the interests of the individual member;

e) any cover that is reduced in order to reduce premiums should still meet minimum standards, be worthwhile, suitable and appropriate;
f) the definition of ‘exceptional cases’ should be rewritten to tighten up the timeframe in which a review can take place;.

g) ensuring that the Code is enforceable as a part of the contract with the consumer.

53. The Life Code should include a clause in Chapter 2 that will ensure that a consumer will be no worse off under the application of the insurance in superannuation commitments as expressed in Chapter 2 of this Life Code versus the voluntary Insurance in Superannuation Code.

54. Financial Rights cannot support either option 1 or 2 for draft clause 13.9. If the FSC does not act to bind members with respect to salary limits, the Government must intervene.

Further comments on drafted alterations to the Life Code

Section 1 - Objectives

55. The Life Code wording should be clarified to ensure that life insurers understand that the Code involves a commitment to minimum standards and are in no way seen to be mere aspirational targets.

56. The explicit commitment to “communicate with our customers in plain language where possible” should be restored to draft clause 1.6.

Section 2: Scope of the Code

57. Examples used throughout the draft Life Code 2 should be included as commitments under the Life Code.

58. Draft clause 2.13 should be removed and replaced with a commitment to ensure that the Life Code is binding on, and enforceable against, subscribers through contractual arrangements with consumers.

59. Draft clause 2.14 should be amended to state that external dispute resolution bodies should consider whether life insurers have complied with the standards in Chapter 1.

Section 3 Policy and Design

60. Draft clause 3.1(e) should be re-drafted to ensure that regular product reviews be applied to all customers who have already purchased an insurance product.

61. In line with PJC Life Insurance Industry Report Recommendation 10.3 draft clause 3.2 must be re-drafted to ensure that all definitions, in all life insurance policies be aligned and updated regularly with current medical knowledge and research – those that are on-sale and those that are not;

62. In line with PJC Life Insurance Industry Report Recommendation 10.3 draft clause 3.2 must be expanded to ensure:

   i. all definitions across all types of polices are standardised;

   ii. clear and simple language is used in the creation of these definitions; and
iii. associated conditions that may arise from the initial condition, including mental ill health, and are covered by the insurance policy are clearly explained.

63. In line with The PJC Life Insurance Industry Report, draft clause 3.2 should be updated to ensure that medical definitions are updated in consultation with independent medical experts and such reviews should occur at least every three years.

64. The un-highlighted changes in draft clause 3.4(f) (h) & (i) should be rescinded and the original wording returned.

65. Draft clause 3.6A should commit insurers to restrict the sale of accident insurance to limited target markets and specify in any sales material that accident insurance does not cover deaths/disabilities caused or contributed to by any sicknesses or any pre existing injuries.

66. Draft clause 3.6B regarding insurance dependent on earnings must:
   a) expanded to include a commitment to provide information on how the benefit is calculated.
   b) clarify the definition of earnings for people with small businesses and sole traders.
   c) commit life insurers to specifying in any sales material that accident insurance does not cover deaths/disabilities caused or contributed to by any sicknesses or any pre existing injuries.

67. Draft clause 3.7 must be updated to commit insurers to providing the PDSs for all life insurance including group insurance.

Section 5 When You Buy Insurance

68. Draft Clause 5.3A(a) should:
   a) be expanded to clarify that preventative mental health measures not be included within the questions that an insurer asks as a Life Code commitment;
   b) have the words “noting that we expect you to have a reasonable understanding of your health, lifestyle and financial situation” removed.

69. Draft Clause 5.3B should be amended to replace “repeating a question” to “explaining the question in simple terms and plain English (where required).

70. The FSC needs to reconsider the use of the phrase “you can ask us” in the Life Code and in most cases remove it to shift the onus back to the life insurer to act. Where it is appropriate to be used, it needs to be supported by an explicit commitment on the life insurer’s behalf to act on this request: draft clause 5.3C, 5.14, 5.19, 6.8, 8.10, 8.11, 8.14A, 8.19, 8.27, 13.22, 16.26, and 26.2

71. The Life Code must either:
   a) commit insurers to either not accepting clinical notes or returning them if sent unread and requesting a report under draft clause 5.5.
   b) establish the same protocol under the consent regime with the Royal Australian College of General Practitioners.
72. Policyholders should be informed each and every time their consent is used. The words “where possible” should be removed from draft clause 5.5.

73. Every consumer too should be informed in writing, in order to maintain a “paper trail” with respect to the use of consent, under draft clause 5.5.

74. Consumers should also be given a choice as to their preferred means of contact with respect to every communication commitment under the Life Code.

75. Various references to “health practitioner” health professional” “doctor” and “examiner” throughout the Life Code need to be standardised and made consistent: draft clauses: 5.14, footnote 14, 5.20(b), 8.6(a), 8.8A, 8.9, 8.10, 8.14, 8.14A, 8.19, 8.26, 9.10(b), 9.12(b), 10.6, 22.5, 26.5(b)&(c), App1, definition of “Unexpected Circumstances.

76. The commitment to provide consumers the ability to be examined by an independent medical examiner of their own gender under draft clause 5.6 should be bolstered to be provided automatically to not place the onus on potentially vulnerable consumers to do the asking. Further the words “where possible” and “if you ask us.” Should be removed.

77. Clause 5.6 regarding only engaging an independent service provider where the insurer believes this to be relevant and reasonable should be reinstated.

78. In line with the PJC Life Insurance Industry Report recommendation 10.10, an upper limit on medical examinations is required under draft clause 5.6.

79. The use of the word “promptly” through the Life Code must be replaced by hard timelines: draft clauses 5.5, 5.10, 8.13, 9.7, 16.21, 22.13 and 26.7.

80. Draft clause 5.14(b) needs to be re-drafted to ensure that consumers who request a review of the terms are provided with said review.

81. Draft clause 5.14A needs to be strengthened to highlight different terms, explaining them and their implications in factual terms and they should be provided in writing (in the form of the consumers choosing, be it electronic or hard copy).

82. New draft clauses 5.20 and 8.8A need to be broken down into multiple clauses to aid readability.

83. Draft clause 5.20 should be amended to ensure that:

   a) the information provided should be done so in writing (according to the consumer preferred method of communication)

   b) consumers are provided with explicit information regarding any decision or belief that the act of non-disclosure, error or omission was fraudulent.

Section 6 Policy Changes and Cancellation Rights

84. Life insurers should commit to disclosing previous years’ premiums at renewal under draft clause 6.3.

85. The onus under draft clause 6.5 should be shifted to the life insurer to take a more active role.
86. In line with Banking Code commitments the Life Code should, under draft clause 6.5, commit life insurers to:
   a) encourage policyholders to contact insurers if they are experiencing financial difficulty;
   b) act compassionately in trying to understand their situation and discuss ways to help;
   c) recommend and work with an independent financial counsellor;
   d) work with consumers and give you information about financial difficulty processes.

87. Draft clause 6.6 needs to be redrafted to reflect greater compassion and empathy.

88. Life insurance consumers experiencing financial hardship should be offered more flexible arrangements, including the chance to repay arrears over time to retain their cover and be eligible to claim: draft clause 3.6(h).

89. Life insurance consumers who have premium arrears in the six month prior to death should have their claims paid and the arrears deducted from the payout, regardless of whether the policy has been otherwise validly cancelled in the interim period.

90. The words the words "try to coerce you into keeping" should be replaced with "apply undue pressure on you to keep": draft clause 6.6A.

Section 7 Supporting Vulnerable Consumers

91. Section 7 regarding supporting vulnerable consumers should be linked to or amalgamated with the section on financial hardship.

92. The FSC should consult with the EARG to introduce a Guidance on Family Violence and reflect this as commitments in the Life Code. The Life Code could commit insurers to:
   a) train and assist employees to help identify, support and avoid harm to customers affected by signs of family violence, and people seeking to purchase insurance
   b) protect private and confidential customer information
   c) minimise the need for repeat disclosures of family violence by a customer
   d) assist claimants affected by family violence, including those suffering financial hardship
   e) provide options for referring customers to specialist family violence services
   f) provide support to employees affected by family violence or who experience vicarious trauma after dealing with affected customers;
   g) have a publicly available policy that states how insurers identify and support customers affected by family violence.

93. The Life Code must explicitly commit insurers to providing interpreting services – as draft clauses 15.7-15.9 do for Superannuation Trustees.

94. The Life Code must expand life insurer commitments to Aboriginal and Torres Strait Islander peoples by including commitments:
a) with respect to the sale of funeral insurance and other insurance products to Aboriginal and Torres Strait Islander communities;

b) with respect to Aboriginal and Torres Strait Islander cultural awareness training;

c) to make information about more appropriate insurance products available to Aboriginal and Torres Strait Islander peoples.

95. The scope and application of clause 7.5 should be expanded to all people experiencing a form of vulnerability as conceived under clause 7.1, and in particular Aboriginal and Torres Strait Islander whose cultural practices (such as sorry business) may impact upon their ability to meeting timeframes.

96. Engaging with people who may be experiencing financial hardship should be included in draft clause 7.2 and draft clause 7.1.

Section 8 When you make a claim

97. Draft clause 8.2 should be expand to commit life insurers to:

   a) not state that there is no difference if a claim is made or not

   b) track information to ensure consumers are not being deterred from making a claim. and

   c) investigate what might deter a consumer from making a claim to improve accessibility.

98. The Life Code should commit life insurers to:

   a) record the reasons for a withdrawal or ‘closure’ (if known);

   b) do so in a consistent manner;

   c) ensure the customer is aware that they can make a complaint if they wish; and

   d) make this information available to the LCCC as a part of their ongoing monitoring.

99. The Life Code should commit life insurers to explain the claims process in plain language to a policyholder and provide the claimant with contact details to get information about their claim.

100. The terms “initial assessment,” “decision,” “final decision,” “assessment” used throughout the draft Life Code should be consolidated for consistency and definitions provided.

101. The definition of “claims received” should be amended to align with APRA Reporting Standard LRS 750 Claims and Disputes.

102. The reasons why a life insurer needs to collect information should be provided automatically under draft clause 8.5.

103. The concept of relevance needs to be returned to draft clauses 8.5A and 8.6 following their removal.

104. The Life Code should commit life insurers to provide under draft clause 8.5, 8.6 and 8.8A:

   a) a list of every piece of information sought,

   b) an explanation of why that information is sort and how it is relevant
c) who other information is sought from and
d) an explanation why this third party information is being sought and how it is relevant.

105. The words "as soon as possible" should be replaced with a hard time frame under draft clause 8.7

106. Draft clause 8.8A needs to be clarified to ensure avoidance of insurance can only take place within three years and only if the consumer acted fraudulently, in line with section 29(3) of the Insurance Contracts Act 1984.

107. Life insurers should commit to informing a consumer in the first place that their claim is being investigated and that an interview will take place under draft clause 8.11.

108. Draft clause 8.11(b) should be reworded to:
   a) explain that a support person may be a family member, and
   b) provide information on their roles.

109. Consumers who will be interviewed should be provided with contact details of the insurer and the interviewer.

110. Specialist interviewers should be used in all cases where an interview subject is known to be experiencing a vulnerability, not just those listed at draft clause 8.11(j).

111. A 5 minute break should be automatic and mandatory under draft clause 8.11(k).

112. Consent should be sought when an interview is to be digitally recorded under draft clause 8.11(n)

113. A standard interview consent form should be developed and introduced under the Life Code.

114. A copy of the interview recording should be provided automatically under draft clause 8.11(o)

115. If Life Insurers never intend to interview minors, then this should be an explicit commitment. Otherwise, the Life Code should include specific commitments to interviewing minors based on Clause 2(h) of the Draft Standards on the Use of Investigators under the proposed General Insurance Code.

116. Life insurers should require external investigators to obtain their express and written authority before putting a fraud allegation to a claimant. This requirement should be included in contracts with external investigators and in their written instructions to external investigators.

117. Life insurers should include in their quality assurance programs measures to monitor interview duration and compliance with the Life Code through:
   a) regular reviews of current and closed claim files, including denied claims
   b) for employees who conduct telephone interviews – call audit reviews and review interview transcripts or recordings
   c) audit external Investigator running sheets, interview transcripts or recordings to check the duration of interviews
   d) review of complaints about interviews, including disputes referred to AFCA.
118. Surveillance of people on business premises should be prohibited under the Life Code.

119. Life insurers need to commit to letting the consumer know what claims information error has been identified, what additional information is required and why it is required under draft clause 8.13.

120. In line with recommendation 10.6 of the PJC Inquiry into the Life Insurance Industry, draft clauses 8.14-19 should include explicit commitments that:

   a) where a pre-existing condition is to be used by an insurer as the basis for denying a claim or avoiding a contract a direct medical connection between the prognosis of a pre-existing diagnosed condition and the claim must be established; and

   b) the statistical and actuarial evidence and any other material used to establish a pre-existing condition, as well as a written summary of the evidence in simple and plain language, are provided by the life insurer to the consumer/policyholder on request.

121. Commitments need to be made with respect to notifying the circumstances of closing a claim, how long it will take to close a claim and what information will be provided, under draft clause 8.14A.

122. Draft clause 8.16 needs to be redrafted for sense and clarity.

123. The inclusion of a $50,000 limit on meeting the current commitments with respect to lump sum payments under draft clause 8.18 should be removed.

124. In line with the PJC Inquiry into the Life Insurance Industry, all definitions should be up-to-date and standardised across all types of life insurance policies.

125. A time limit of two weeks on all reasonable enquiries under draft clause 8.21A. If reasonable enquiries cannot be completed in this time, the insurer should make a payment to meet its good faith duties.

126. The words “reasonably believe that we” should be removed from draft clause 8.21A(b).

127. Draft clause 8.21A(c) should be expanded to ensure that insurers provide a specific solid timeline that they will meet.

128. The words “try to” should be removed from draft clause 8.22.

129. The FSC must restore the original wording of clause 8.26.

130. Draft clause 8.26 should also be expanded to commit life insurers to proactively alert policyholders to any benefits the policyholder is entitled to under the policy for rehabilitation purposes and assist them in their claim.

131. Where a life insurer is aware that a customer who has applied for Financial Hardship assistance has a nominated representative, they should commit to asking if they want their representative to be kept updated.

132. Draft clause 8.28 should be extended to commit insurers to making requests as early as possible.

133. The FSC must restore the original wording of clause 8.29 to draft clause 8.30.
Section 9 Complaints

134. Life insurers should commit to requiring their third party service suppliers to notify the life insurer within two business days if they receive a complaint, so that they can address this through their complaints process as early as possible. The third party should also be obligated to notify the life insurer of any Life Code breach that they identify.

Section 10 Standards for third parties dealing with underwriting or claims

135. Life insurers should commit to addressing identified performance shortcomings in their third party service suppliers’ services, such as a requirement for further training.

136. When engaging an external investigator the Life Code should commit life insurers, under draft clause 10.9, to require:
   a) written instructions be provided to any external investigators that we engage, and we will confirm in writing any changes to our instructions
   b) a register of investigators’ licences (including expiry dates) is maintained internally and kept up to date, to ensure the licences of any investigators we engage are current;
   c) the investigator to not exceed written instructions without our prior consent;
   d) the investigator to not seek or accept from, or offer to, any person any gifts, benefits or rewards in connection with an investigation, other than modest hospitality such as light refreshments.

137. The FSC should work with the ICA to discuss with ANZIIF the possibility of developing a course to assist insurers to undertake investigation activity in a manner that complies with both the General Insurance Code and the Life Code and that meets community expectations.

Section 25 Monitoring, Enforcement and Sanctions

138. Life insurers should explicitly commit to providing appropriate funding and resources to the Life CCC for it to adequately meet its responsibilities outlined in the Life Code and its charter.

139. The FSC should establish an independent committee to provide advice and input on necessary resourcing levels, as the ICA has done for the Code Governance Committee.

140. Life insurers must commit to accepting the responsibility of any distributor’s breach of the Life Code with respect to their products under Draft clause 25.6.

141. In addition to the six responsibilities listed at Draft Clause 25.9 the following responsibilities should be explicitly included:
   a) Investigate serious or systemic breaches
   b) Apply sanctions
   c) Provide guidance and reports
d) Provide stewardship of the Code by helping industry understand and comply with our Code obligations, and identifying areas for improvement of insurance practices

e) Drive improvements

f) Promote awareness

g) Undertake other functions as reasonably determined from time to time.

142. All compliance cases should be published and reported in an identified manner in the Annual Report and on the website.

143. The Life Code Committee should be empowered under draft clause 25.11 to impose sanctions when a breach occurs, rather than when a failure to correct a breach occurs.

144. The words “failure to correct a” should be removed from draft clause 25.13.

145. All life insurers should report all systemic code breaches and serious misconduct to ASIC, and require the Life CCC to notify an insurer’s Chief Executive that it intends to do so.

146. Sanctions listed at draft clause 25.15 should be expanded to include:

a) public naming of the non-complying organisations (the “publication of our non-compliance” sanction is not “publicly naming as foreseen under 183.70”)

b) fines;

c) suspension or expulsion from the industry association; and/or

d) suspension or termination of subscription to the code.

Section 26 Access to Information

147. The inclusion of Section 26 in Chapter 3 should be reconsidered

148. Draft Clause 26.5(e) should be removed.

Section 27 Definitions

149. The words “that is reasonably determined by us to be significant” should be removed from the definition of “Significant Breach to ensure that the Life CCC is the sole determinant of whether a breach is significant.
Life Code 2.0 Consultation Process and general comments

We wish to express our concerns with the consultation process undertaken by the FSC with respect to the release of draft Life Code.

Redrafting the Life Insurance Code of Practice

We note that the FSC has both made additions to the Life Code but also undertaken extensive redrafting of the Code for clarity and consistency. In doing so, the FSC states that that “none of the redrafting is intended to change the policy intent” and that the FSC has “highlighted areas where the content is new or where the policy intent has changed.”

Whether inadvertent or otherwise, there are a significant number of examples throughout the redrafted Life Code where the redrafting has resulted substantive changes and a diminution of consumer protections from the first iteration of the Life Code. These changes have not been highlighted and it has taken a large amount of time to comb through the redrafted Life Code to identify all such changes.

These changes include:

- new draft clause 2.13 where the words “is not intended to create legal or other rights between us and any person” have been replaced with “does not create legal or other rights between us and any person”;
- new draft clause 3.1(e) seems to now explicitly limit the benefits of regular product reviews to new customers of those products;
- new draft clauses 3.4(f) (h) & (i) all involve minor rewording that could be interpreted in such a way that life insurers will have the ability to provide less information than they currently do;
- draft clause 4.7 has removed subclauses (b)(i), (b)(iii) and (c) for no clear reason;
- clause 5.6 regarding only engaging an independent service provider where the insurer believes this to be relevant and reasonable has been removed;
- draft clause 8.9 has removed a subclause relating to notification and provision of reasons if a payment is going to be delayed;
- draft clause 8.26 has introduced the words “we consider relevant” whereby allowing life insurers to themselves pick and choose which income-related claims they will “aim to” help (if any at all), as opposed to doing this for all income-related claims as the current clause states;

- draft clause 8.30 removes a definitive commitment to undertake a series of acts. The new draft clause is contingent on the life insurer deciding to act;
- draft clause 26.5 includes a new special circumstance to deny access to information under sub clause (c) with no explanation or justification.

This is neither helpful nor a good use of consumer representative scant resources in seeking to provide feedback on the Life Code redraft.

We recommend that, at the very least, an accessible, tracked change Word document version of the Life Code be made available – despite the complexity that that may entail in reading. It would at the very least assist readers to identify which words have been replaced or removed in order to determine their intentional or unintentional policy impact.

Consumer Consultation

Financial Rights wishes to express its concerns with the consultation process to date.

Financial Rights and other consumer representatives were closely consulted on the development of the original Code in 2016, through the establishment of a Life Code steering committee. No such consultation body was in place during the development of the current draft nor were we or any other consumer representatives that we know contacted to provide input.

Financial Rights were told by representatives of the FSC in the lead up to the introduction of the first iteration of the Life Code that given the number of issues that the FSC were unable to resolve in creating the first iteration of the Code that the FSC wished to begin a review leading to the second iteration 18 months from the launch of the Life Code in October 2016 – or approximately March 2018. This may have occurred but without the input from key stakeholders groups such as ourselves. The first time we were made aware of a new Life Code being developed was learning of a new draft iteration of the Life Code being provided to the Royal Commission as evidence. This is disappointing.

A transparent and open consultation process is required for the development of an industry code of practice. The Australian Securities and Investments Commission (ASIC) Regulatory Guide (RG) 183 expects Code administrators to “effectively consult with all stakeholders to identify the issues and debate appropriate responses” and adopt “transparent procedures.” We do not believe that the FSC has met these standards.

We note by comparison that the Insurance Council of Australia (ICA) involved consumer groups from the beginning of the consultation process for the next iteration of the General Insurance Code of Practice (General Insurance Code).

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The recommendations made in this submission are large in number and touch upon a wide range of issues that:

- the FSC agreed to address at the time of the release of the first draft launch,
- issues that have emerged since then via various Government Reports and inquiries
- issues that have emerged in the Royal Commission,
- other issues that we are aware of because our extensive contact with consumers through the Insurance Law Service.

This last element should be a valuable source of information for the FSC.

We direct the FSC to the Consumers’ Federation of Australia (CFA) Good Practice Principles with respect to consumer engagement and consultation that outlines the ways code administrators should consult and engage with consumer representatives that is meaningful, genuine and efficient. Specifically the principles refer to an

open process at the outset to identify all relevant issues, before narrowing on approaches to address those issues.\(^5\)

We also note the CFA’ principles with respect to resourcing consumer engagement recognise the limited resourcing available in the sector.

We also note that, in contrast, the ICA has established a Consumer Liaison Forum to facilitate open discussions between the general insurance industry and consumer representatives with the aim of improving outcomes for consumers of general insurance products – be it within or outside of the Code of Practice. The forum is held every quarter, made up of an independent chair, attended by the Chief Executive of the ICA and other key staff members, and a number of consumer representatives. The forum has a mandate to identify specific issues of concern for consumers of general insurance products, prioritise issues and present these issues to the ICA Board. In turn the ICA establishes working groups for each priority area, leading to the development of recommendations from these working groups to be taken back to the Board.

We recommend that the FSC establish a similar forum to assist improved outcomes for consumers of life insurance products. This will ensure that the life insurance sector is able to better identify and address issues of consumer concern in an ongoing manner.

**An Independent Review**

Financial Rights notes that the development of the second iteration of the Life Code has been conducted in-house. This fails to meet the expectation that code of practice reviews be conducted transparently and independently as per ASIC RG 183.

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\(^5\) Page 3 Consumers’ Federation of Australia, Good Practice Principles
In most cases, it will be necessary to appoint an independent party to conduct public consultations and/or to make public recommendations about the code.

The reason is that:

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.

We believe that development of Life Code 2.0 should be in accordance with the expectations of ASIC RG 183 with respect to independent reviews. This requires engaging an independent reviewer.

We also note that the Consumer Federation Australia’s Good Practice Principles recommends an independence of process and that includes appointing an independent reviewer with no direct relationship with the industry, expertise in the subject area, and who is provided with adequate resources to conduct the review. The Principles also suggest that it is good practice for the nominating body to consult with consumer representatives about the selection of an independent person or reviewer. None of these principles have been met by the FSC.

We made similar criticisms of the ICA’s approach to the current review of the General Insurance Code. The ICA addressed these concerns by appointing an independent person to provide oversight of the review, to ensure the review appropriately takes into account the submissions received and recent external developments.

At a minimum we believe that the FSC should do the same and appoint an independent overseer of this current review in order to establish the effectiveness of the consultation process taken by the FSC in identifying and addressing consumer concerns. This would necessarily involve an evaluation of the effectiveness or otherwise of, for example, holding “town halls” for consumers as publicised on AM Radio, the pros and cons of re-drafting the Life Code in-house, and whether all consumer concerns were captured and addressed in the redrafting process.

Further the FSC should commit to establishing an independent assessment of the impact and effectiveness of the Life Code provisions to identify the extent to which the Life Code has achieved its stated objectives, as per the CFA’s Good Practice Principles. This could involve:

- independent research or analysis of relevant complaints or files;
- conducting audits or mystery shopping exercises;
- close consideration of relevant processes adopted by code bodies (for example, file reviews or audits of processes).

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6 ASIC RG 183.50(c)
7 ASIC RG 183.82
8 Pages 2-3, Consumers’ Federation of Australia, Good Practice Principles
9 Page 3, Consumers’ Federation of Australia, Good Practice Principles
Plain Language

We note that the FSC asserts that:

*This Consultation Draft Code has been through an extensive redrafting process for clarity and consistency.*\(^{10}\)

While some of the work done may have clarified the language in the Life Code others have not. In this submission, we have raised a number of issues with the changes made that seem to inadvertently change the meaning, or made the meaning less clear. We also note that there remain significant inconsistencies. These include references to doctors, health practitioners etc. as well as inconsistency between the first chapter and the second superannuation chapter.

A lot of the language used in the Life Code is not plain English, overly-legalistic, un-empathetic and full of “weasel words” – a real problem if the FSC is looking to establish a more consumer friendly, principled Life Code that deals with consumer vulnerability and financial difficulties. We also note there are a lot of footnotes used – a strategy that looks as if it is hiding information in “the fine print” – a common complaint about life insurance generally. Most if not all the clauses require re-drafting to address this issue. A plain English re-write of the entire Code is warranted and necessary.

We note that the first Key Code Promise of the current Life Code states

*We will be honest, fair, respectful, transparent, timely, and where possible we will use plain language in our communications with you.*\(^{11}\) (our emphasis)

Given this, the Life Code itself should be an exemplar of this approach. Otherwise the Life Code will be repeating the same problems found in the sector’s already flawed communications strategies.

The Australian Bankers Association (ABA) recently undertook a re-draft of the Banking Code of Practice (Banking Code) for plain English purposes and Financial Rights believes the new Banking Code is better for it. We raised the same issue with the ICA in re-drafting the General Insurance Code and they have too agreed to do so and are currently going through the process of applying plain English principles to their code.

We would strongly encourage the FSC to take a similarly holistic approach to re-drafting the Life Code with a plain English drafting expert involved.

ASIC Approval

We note that the FSC stated at the launch of the first iteration of the Code that:

*The FSC will consider making an application for ASIC approval of the second iteration of the Code.*\(^{12}\)

\(^{10}\) Page 1, FSC, Consultation Draft Life Insurance Code of Practice, 12 November 2018

We also note that there is no reference in this consultation draft to the FSC’s current view on seeking ASIC approval. It is not clear what the FSC’s position is in this regard.

We note that the ABA have received approval for the new Banking Code, having met all the requirements of ASIC RG 183 including being enforceable as part of the contract with the consumer.

We maintain that the FSC must seek approval of the Life Code from ASIC in accordance with ASIC RG 183. RG183 establishes the minimum benchmark for the development, content, enforceability, administration and review of industry Codes of Conduct. The Guide states that

> It is not mandatory for any industry in the financial services sector to develop a code. Where a code exists, that code does not have to be approved by ASIC. However, where approval by ASIC is sought and obtained, it is a signal to consumers that this is a code they can have confidence in. An approved code responds to identified and emerging consumer issues and delivers substantial benefits to consumers.13 (our emphasis)

We agree with ASIC that garnering approval of a code is a signal to consumers that they can have confidence in the code. Conversely, choosing not to seek approval of the Life Code would send a public signal that the life insurance industry continues to be unwilling to meet the minimum standards set out by ASIC.

We believe that the FSC should show leadership and send a strong message to consumers, subscribers and the financial services sector by seeking and taking the necessary steps to achieve ASIC approval.

RG 183 outlines the following list of approval criteria:

- Freestanding and written in plain language.14
- Body of rules.15
- Consultative process for code development.16
- Meets general statutory criteria for code approval.17
- Code content addresses stakeholder issues.18
- Effective and independent code administration.19

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13 ASIC RG 183.3
14 ASIC RG 183.55 & ASIC RG 183.129
15 ASIC RG 183.19 & ASIC RG 183.24
16 ASIC RG 183.49–ASIC RG 183.54
17 ASIC RG 183.28– ASIC RG 183.41
18 ASIC RG 183.55– ASIC RG 183.62
19 ASIC RG 183.76– ASIC RG 183.81
• Enforceable against subscribers.\textsuperscript{20}
• Compliance is monitored and enforced.\textsuperscript{21}
• Appropriate remedies and sanctions\textsuperscript{22}
• Code is adequately promoted.\textsuperscript{23}
• Mandatory three-year review of code.\textsuperscript{24}

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

It is critical that the final version of this second iteration Life Code be binding on, and enforceable against, subscribers through contractual arrangements with consumers.\textsuperscript{25} In other words, adherence to the Code must be a term of the contracts of all life insurance policies. This is strongly encouraged by ASIC.\textsuperscript{26}

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

Reviews of the Code should take place every three years. We note that draft clause 24.2 states:

\begin{quote}
The FSC will commission formal independent reviews of the Code as appropriate. The first independent review will be in 2022, and not less than every three years thereafter. The Life CCC may recommend to the FSC Life Board Committee and/or the Superannuation Board Committee as appropriate that the Code be reviewed, if the Life CCC believes the application of the Code could better meet its objectives.
\end{quote}

We are not 100 per cent sure that this meets the requirement under RG 183 - 2022 being over three years after the beginning of this current review and there being a particular lack of clarity regarding updating the Superannuation chapter.

Financial Rights also notes that:

\begin{quote}
It is essential that core rules address existing and/or emerging problems in the marketplace, rather than merely restating the law.\textsuperscript{27}
\end{quote}

\textsuperscript{20} ASIC RG 183.25– ASIC RG 183.27
\textsuperscript{21} ASIC RG 183.79– ASIC RG 183.81
\textsuperscript{22} ASIC RG 183.68– ASIC RG 183.73
\textsuperscript{23} ASIC RG 183.78– ASIC RG 183.80
\textsuperscript{24} ASIC RG 183.82– ASIC RG 183.84
\textsuperscript{25} ASIC RG 183.20(a) and ASIC RG183.25(a)
\textsuperscript{26} under ASIC RG 183.27
\textsuperscript{27} under ASIC RG 183.60
We remain concerned that the Life Code’s content does not address stakeholder issues that we would like to raise with the FSC but have not yet had a chance until now given the limited consultation on this draft. We would expect that the problems described and information provided in this submission and the subsequent recommendations we make should be fully genuinely considered by the FSC and addressed in the second iteration of the Code, rather than held off to a future iteration.

We do not believe that is appropriate that consumers should have to wait until 2022 to even raise the issues that exist now and are continuing to cause serious problems and frustrations for consumers. That would be an unacceptable outcome.

We also believe that the FSC needs to boost the number of sanctions available to the Life Code Compliance Committee (Life CCC). We provide recommendations below under Draft Clause 25.15

ACCC Consultation

There are a number of commitments under a sector-wide code of practice that may have an impact on competition. Reigning in the worst excesses of the sale of junk insurance products such as funeral insurance, consumer credit insurance and accidental cover, for example, will require deliberation and approval from the competition regulator the Australian Competition and Consumer Commission (ACCC).

This was acknowledged by the FSC at the launch of the first iteration of the Life Code:

In response to recent ASIC reports on funeral insurance and consumer credit insurance, the industry will address the issues raised including through limitations on sales and premium structures. These standards would require the second iteration of the Code to be submitted for ACCC approval.28

In discussions with the FSC at the time, it was suggested that the FSC would begin speaking with the ACCC early after the launch of the first iteration of the Life Code. Our understanding is that these talks have yet to take place.

A cynic could suggest that this lack of action and discussion with the ACCC merely provides a plausible excuse for the sector not to act. The implication being that the sector’s hands are essentially tied by competition law.

The excuse no longer holds water. The FSC and life insurers have had over two years to have had these discussions. The harm revealed at the Royal Commission has clearly bolstered the case for action on these issues. The FSC must begin discussions with the ACCC as soon as possible and life insurers must act to introduce strong sector-wide commitments on sales practices and junk insurance products.

https://www.fsc.org.au/_entity/annotation/fe078546-30a7-e611-80c9-00155d252c17
Recommendations – Code Consultation Process and General Comments

1. When proposing changes to the Life Code, the FSC should provide a fully tracked changed version to identify all major and minor alterations. Explanations should be provided for all proposed changes.

2. The FSC should establish an ongoing consumer liaison forum modelled on the ICA to facilitate ongoing, open discussions between the general insurance industry and consumer representatives with the aim of improving outcomes for consumers of life insurance products.

3. Given the current review’s lack of independence, the FSC must appoint an independent overseer to establish the effectiveness of the consultation process undertaken by the FSC.

4. The FSC must commit in future reviews to appointing an independent party to conduct public consultations and/or to make public recommendations about the Life Code in line with ASIC RG183.50(c).

5. The FSC should commit to establishing an independent assessment of the impact and effectiveness of the Life Code provisions to identify the extent to which the Life Code has achieved its stated objectives, as per the CFA’s Good Practice Principles.

6. A plain English re-write of the Life Code must be undertaken in line with current best practice and the Code’s own key promise.

7. The FSC must seek approval of the Life Code from ASIC in accordance with RG183. This includes ensuring that:

   a) the Life Code is binding on, and enforceable against, subscribers through contractual arrangements with consumers, i.e. the Life Code is a term of the contracts of all life insurance policies;

   b) subscription and adherence to the Life Code is compulsory for membership of the Council

   c) independent review of the Life Code take place every three years;

   d) the number of sanctions available to the Life CCC be boosted; and

   e) all stakeholder issues raised in this current review with the FSC are addressed, as per the Key Criteria of ASIC RG 183.55–RG 183.62.

8. The FSC must begin discussions with the ACCC as soon as possible and life insurers must act to introduce strong sector-wide commitments on sales practices and junk insurance products.
Feedback on Specific Questions

1. Funeral Insurance

Question: The Consultation Draft Code has significantly more protections for people taking out funeral insurance than the current Code. Do these go far enough and, if not, what further protections are needed?

Funeral insurance as it is currently sold is a junk insurance product that provides little to no value to consumers. We have recommended in our submission to the Royal Commission that funeral insurance – along with accident death and accidental injury policies be prohibited outright.29

The problems with funeral insurance are multiple, well documented and have been the subject of ASIC investigation.30 Premiums increase steeply with age, with the structure of the policies creating the very real possibility that a consumer would pay significantly more in premiums than the policy is worth. Consumers also drop the policy because of a lack of affordability before they ever get to claim. Others fail to pay their premiums when they become ill in the months prior to their death and are incapable of paying sufficient attention to their financial affairs, and their relatives later find the policy has been cancelled and is therefore worthless despite sometimes years of premium payments prior to that period.

While approximately 50% of consumers with funeral insurance are aged between 50 and 74, 50% of Aboriginal and Torres Strait Islander consumers with funeral insurance are under 20.31 Young people are extremely unlikely to need to rely on funeral insurance. Funeral insurance is also a product where the value proposition decreases for consumers the longer they have the policy, with sales to young Aboriginal and Torres Strait Islander consumers indicating significant issues with the distribution of products. In addition, funeral insurance products are fundamentally poor value when compared with funeral bonds, pre-paid funeral options, some life insurance products or simple savings. Consumers often do not understand key features of the product including in particular, the increasing premiums, or that they will lose the benefit of the policy and all amounts paid if they stop paying at any time before they die. Unfair sales tactics and unfair pressure are also placed on vulnerable consumers, exploiting genuine concerns for the financial future of their families for the sake of increasing sales.

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29 Financial Rights accepts that there is a demand for funeral insurance, or at least for a suitable product to assist some members of the community ensure that they have adequately provided for their funeral prior to their death. We also accept that a small, affordable insurance component may have some role in an appropriately designed product. We are not aware of any insurance product (or hybrid) currently available in the market that meets this definition.


31 Ibid.
Accepting that this Life Code will not be prohibiting the sale of funeral insurance altogether, in the absence of a ban, we believe that the Life Code can go some way to restrict the worst excesses of the sale of this junk product.

We raised our concerns with funeral insurance with the FSC in the drafting of the first Life Code. At the time, significant clauses drafted were removed and we were told that their consideration would be deferred until the drafting of the second iteration of the Life Code.

First we will address the issues with the current new drafting that we have. We will then put forward further suggestions.

**Draft Clause 3.6(c) – Stepped premiums should be prohibited under the Code**

Premiums should be fixed for the life of a funeral policy. Subsequently the Life Code should prohibit stepped premiums.

Our experience with stepped premium products in funeral insurance is that they are used to hide the true cost of the product. The confusion that stepped premiums create means they should be avoided whenever possible. It is not appropriate to market a low premium to attract customers in the knowledge that those customers may not understand how premiums will rise in future. In our view this borders on misleading or deceptive conduct or classic “bait and switch” practices.

The 2014 ASIC Report 413 found a strong correlation between stepped premiums and high lapse rates. Four years later the same problems arose in ASIC’s review of sales calls finding that there was a significant failure to discuss stepped premiums:

> The increasing cost of the policy was not discussed with consumers in 29% of sales calls where the premium later increased and the policy lapsed at the time of or after the premium increase notice.

> ... In our call review six of the eight firms did not discuss the increasing cost of stepped premiums unless prompted by the consumer. This accounted for 58% of the sales we reviewed with stepped premiums.  

Recommendation 2 of ASIC in Report 587 was that life insurers should provide adequate explanations of key exclusions and future cost:

> Sales staff must provide a clear explanation to consumers about the future cost of the policy and the features that will result in the premium increasing, such as stepped premiums and

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32 ASIC Report 413 Review of retail life insurance advice, October 2014  

33 ASIC Report 587: The sale of direct life insurance, August 2018  

34 Para 177, ASIC Report 587
automatic indexation increases. These explanations should be in simple English and provided at a relevant time during the call (e.g. when confirming the cost of the policy).  

Given it is unlikely the FSC will prohibit stepped premiums, at the very least insurers should commit to providing this clear explanation. We do not believe that the wording proposed in draft Clause 3.6(c) adequately meets this standard. The draft Clause states:

Allow you to choose level premiums. If stepped premiums are offered, to include an illustration about how future premiums might be expected to increase and a warning about future affordability in the light of how your future income might change, for example, after you retire or need age care, and what will happen if you allow the policy to be cancelled. (our emphasis)

To include “an illustration about how future premiums might be expected to increase” is not a “clear explanation to consumers about the future cost of the policy.” The words are less than definite suggesting possible scenarios that may occur. This is unacceptable.

We believe that this should be expanded to include projections of likely costs of the premium. It is critical that pricing information is spelt out clearly to consumers for the sake of transparency. Insurers should commit to providing the total cost of the policy for a customer if they live to 60, 70, 80 and 90 and the estimated periodical payment required at key stages.

Draft Clause 3.6(d) – Do not sell to people under the age of 50

We note that draft 3.6(d) states:

Not knowingly promote the policy to people under age 40.

While we support the addition of an age limit in the Code, the FSC have provided no justification to land on the 40 year age limit. 40 years of age is far too young to knowingly sell a junk product like funeral insurance particularly since there are a range of better alternatives available to people at this age.

We note that ASIC found that over half (51.2%) of consumers with funeral insurance were aged 50–74. 36 This seems a reasonable cut off point.

Further we do not believe that insurers should sell funeral insurance at all to people under 50, given the alternatives. To simply “not knowingly promote” is weak and a set of weasel words that will allow their continued sale, despite the well documented problems.

There is an easy fix for this. In the inbound sales process - be it over the internet or over the phone - insurers must commit to asking the age of the customer to assist in identifying the appropriate sales approach as described further below. 37

35 Para 216, ASIC Report 587
36 Pages 6 and 14 ASIC Report 454
37 We limit this recommendation to inbound calls since we support the prohibition of outbound life insurance sales as per ASIC Report 587 and discussed further below.
Our view that draft Clause 3.6(d) is particularly weak is reinforced by the wording of draft Clause 3.6(e) which states:

For people under age 40, as part of the sales process tell you that the appropriateness of funeral insurance depends on a number of factors such as health, lifestyle, age and financial objectives.

This reads like a sales pitch rather than a commitment to not sell or at the very least avoid selling to those under 40.

Funeral Insurance should not be knowingly promoted to people under the age of 50, and banned from outbound sales.

However, we acknowledge there are exceptional situations where it may be appropriate for a consumer under the age of 50 to obtain funeral insurance. Equally, there are situation where consumers over the age of 50 should not be offered an insurance policy. What we wish to see is a commitment from insurers to ensure that they are appropriately selling the product to the right customer.

We therefore recommend that in order to avoid the most egregious and exploitative sales of funeral insurance then the following commitments should be made:

- life insurers should commit to not selling to anyone under 50 via the outbound sales channel;
- where there is an inbound funeral insurance inquiry from a consumer under 50, there must be a presumption that the sale is unsuitable unless certain criteria are met;
- the onus should be on the life insurer to ensure that the consumer meets this set of criteria demonstrating suitability;
- this suitability criteria for anyone under the age of 50 could include:
  o having a terminal disease, or other reason to believe they may have a risk to claim on the policy; or
  o having no super; and
  o understanding that it is not a savings plan documented through the sales process.
- All consumers must:
  o have had the product’s cost, risk and purpose clearly explained to them (this should be everyone – not just the under 50 cohort) and;
  o be clearly informed it is not a savings plan and that they will lose all amounts paid under the policy if it is cancelled or lapses at any time prior to their death.

**Draft Clause 3.6(f) - General marketing campaigns should be highly regulated**

Our view is that general marketing campaigns for funeral insurance should be highly regulated given the fundamental exploitative nature of the product. This should include committing
under the Life Code to providing an explicit list of information. At the very least these campaigns should make clear:

- the age the product lapses;
- that there are other ways to provide for a funeral;
- the stepped or level nature of the premium; and
- an example of the total cost of a product over its life time.

To do less will continuing the borderline misleading nature of the advertising that has taken place to date.

**Draft Clause 3.6(g) – Design and distribution obligations**

We note that draft clause 3.6(g) states that insurers will:

> Design funeral insurance products to suit the target market, which includes designing a policy structure which is appropriate for the target market and supports affordability over the life of the policy.

This is simply a summary of the legal obligations that insurers will be subject to following the enactment of the *Treasury Laws Amendment (Design and Distribution Obligations and Product Intervention Power) Bill 2018*. This does not move beyond anything expected of life insurers under the law.

This is disappointing. Life insurers have an opportunity to get ahead of the law and make serious commitments to appropriately design and distribute their products – this is especially relevant to products like funeral insurance which are often such poor value, or so inappropriately sold, that they are justifiably classified as junk insurance products. We note that the ICA have decided to do so in drafting a Guidance for the Design and Distribution of Add-on Insurance Distributed through Motor Dealer Intermediaries – their equivalent problematic insurance product. A significant number of best practice principles are outlined in the draft, many of which move general insurers beyond the law as proposed.

We strongly recommend life insurers do the equivalent for funeral insurance or the issues highlighted by both ASIC and the Royal Commission will persist, causing great harm to vulnerable consumers and ongoing reputational damage to the industry. Life insurers have been aware for some time that this was coming and should be prepared to take significant steps to outline best practice standards to meet under the Life Code.

Moreover we suggest life insurers should extend the commitment here by ensuring that the funeral insurance product is suitable to the specific individual. Insurance products are designed to enable consumers (including very unsophisticated consumers) to improve their financial resilience. Given the marginal nature of the funeral insurance as a junk insurance

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product, there needs to be clear obligations on insurers to ensure that these products are fit for purpose.

One way, the Life Code could ensure that people are purchasing funeral insurance products that genuinely suit their circumstances is by committing to undertake post-purchase audit surveys to find out what consumer believes they have purchased and whether this aligns with the product they have purchased. This post-purchase audit should be compulsory, conducted independently and require a certain percentage of consumers to have understood what they have purchased and that it matches the product as designed. If these percentages are not met, life insurers should be subject to increased monitoring to ensure their funeral insurance sales process meets best practice. Drop out rates and claim ratios must also be monitored. Any inappropriate funeral insurance sales would need to be addressed, as envisioned under draft clause 4.13.

**Draft Clause 3.6(h) – Premium arrears**

Draft clause 3.6(h) states:

> Ensure that we have options available if you suffer financial hardship in accordance with section 6.6 including:

  1. Allowing your premium to remain unpaid for at least 60 days before we cancel your policy.
  2. Allowing you to stop paying your premium for a fixed period, during which time you will not be eligible to make a claim.

While we support the inclusion of this draft clause as a positive step forward, we believe that consumers who miss payments do not have their insurance cancelled after 60 days but are offered more flexible arrangements, including the chance to repay arrears over time to retain their cover and be eligible to claim. Otherwise it is further punishment for financial hardship.

As noted above, it is almost inevitable that people who are very ill prior to death will neglect their financial affairs through no fault of their own. They carer’s will be equally pre-occupied and may not even be aware of the insured person financial commitments. Where premium arrears occur in the 6 months prior to death, the claim should be honoured and the premium arrears deducted from the payout figure where this is practical.

The problem of people neglecting their premiums due to circumstances beyond their control also applied to life insurance and is dealt with under the financial hardship below.

**Draft Clause 3.6(i) – Provide an improved key fact sheet before the sale of funeral insurance**

Financial Rights supports the improvements to the key fact sheet including the explanation that a funeral insurance policy is not a savings plan as per draft clause 3.6(i)(i)’s. This is a common mistake and we believe life insurers have been benefiting from this misapprehension for years.

However draft clause 3.6(i)(i) should also be improved to commit insurers to asking a customer if that is what they are looking for and providing referrals to independent financial counsellors...
to assist them in developing a savings plan when the customer indicates that that is in fact what they are interested in.

Draft clause 3.6(i)(iii) repeats the vague provision of an illustration of how future premiums might increase. This should be changed to “projection” the total cost of the policy for a customer if they live to 60, 70, 80 and 90 and the estimated periodical payment required at key stages.

We support the inclusion of the words “that you can cancel the insurance at any time” under draft clause 3.6(i)(vii) but that insurers should also commit to explaining what this means – that is, you will lose all the money you have paid – again emphasising that funeral insurance is not a savings plan.

**Draft Clause 3.6 – Deferred sales process**

We believe that a deferred sales model should be committed to for the sale of funeral insurance. This is particularly the case if outbound sales calls ultimately remain a feature of the market. We support the calls to ban all outbound sales calls in life insurance.

In the case of inbound calls it could be argued that the applicants are motivated customers. It is our strong view that the vast majority of these people are under the misapprehension that funeral insurance is a savings policy and do not genuinely understand the nature of the product they are purchasing. Life insurers should be able to provide all the information required to inform the consumer about a product but should not be able to conclude a sale until 4 business days after providing the information – with the contact to finalise the sale initiated by the consumer.

**Draft Clause 3.6 – Commitments with respect to the sale of funeral insurance to Aboriginal and Torres Strait Islander consumers**

The sale of funeral insurance to Aboriginal and Torres Strait Islander consumers is particularly problematic and exploitative given the specific cultural needs of this community.\(^{39}\)

We note that ASIC found\(^{40}\) that insurance sold to Aboriginal and Torres Strait Islander consumers had a much younger age profile (50% were aged under 20). A higher proportion of Aboriginal and Torres Strait Islander consumers also had their policies cancelled for non-payment of premiums. The impact of unaffordable premiums which may result in direct debits failing cannot be underestimated. It can lead to significantly overdrawn accounts, dishonour fees and financial difficulty, often for some of the most financially disadvantaged consumers.

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\(^{39}\) As referenced in ASIC Report 454 In 2013, a coalition of consumer and older-Australian advocacy groups released a strategy paper on funeral insurance in response to concerns raised with the cost and value of funeral insurance, and the ways in which it is marketed and promoted, including to particular communities such as the elderly and Aboriginal and Torres Strait Islander consumers

\(^{40}\) ASIC Report 454 Page 6
The Royal Commission has also graphically demonstrated the worst excesses of the sector. ASIC has recommended that insurers:

> do more to ensure that consumers understand key features of a funeral insurance product when it is sold to them (whether over the phone, in person or online), especially when selling to vulnerable groups like Indigenous consumers.

No such commitment has been made under draft Life Code 2.0

At a minimum life insurers should make the following commitment under the Code:

- take reasonable steps to ensure that dealings with Aboriginal and Torres Strait Islander peoples are conducted in a culturally appropriate manner taking into account the specific needs and cultural protocols of each community.
- ensure that any insurance products promoted and sold to Aboriginal and Torres Strait Islander peoples are suitable to their specific needs
- insurers do not procure sales leads from remote Aboriginal and Torres Strait Islander communities by exploiting Aboriginal and Torres Strait Islander kinship ties (see further information below at draft Clause 4.1).

We believe that further consultation with Aboriginal and Torres Strait Islander communities, peoples and peak level bodies is required to understand how to identify what the specific needs are and how to address them.

**Draft Clause 3.6 – Offer Capped Funeral Insurance Premiums**

As we have recommended previously the Life Code should commit insurers to offer capped funeral insurance products, so that consumers do not pay more in premiums than they will be entitled to claim for. Premiums should cease once the benefit amount is reached (or a very small % above that). Insurers have the benefit of holding the money paid in premiums, which should be sufficient for their profit.

**Draft Clause 3.6 – Prohibit the sale of multiple funeral insurances to individuals**

The poor sales practices identified have led to significant misunderstandings regarding the nature of the products being sold with significant consumer confusion. An unfettered sales culture has also led to the situation where somebody can hold 10 funeral insurance plans.

We believe at a minimum the Code can commit insurers to preventing selling additional funeral insurance plans to those who already own one.

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41 For example, Stephanie Chalmers and Michael Janda, Banking royal commission hears funeral plan targeted Aboriginal customers, ABC, 4 July 2018 https://www.abc.net.au/news/2018-07-03/bank-royal-commission-funeral-insurance/9936696

42 Page 6, ASIC Report 454
**Case study – Daniel’s story - C136333**

60 year old Daniel is on the Disability Support Pension. He has Bipolar Disorder and an acquired brain injury. He lives alone in community housing. When he contacted Financial Rights he was paying for 11 funeral insurance policies – 5 of which were with the same insurer, 2 with another! $140 in premiums he could not afford was coming out of his fortnightly benefit payments.

Daniel instructed Financial Rights that the insurer kept ringing him and offering him more insurance, knowing he had existing policies. The products are stepped, meaning the cost will simply increase over time. Daniel’s income will remain substantially the same. With the increase in premiums and the costs of living, it was highly likely Daniel’s policies would have lapsed before he was able to claim. Financial Rights assisted Daniel to cancel his policies and seek refunds of the premiums but we are concerned about other vulnerable people in similar circumstances. Further Daniel underwent considerable stress and financial deprivation before seeking assistance.

**Draft Clause 4.2B – Application of the Code to distributors of funeral insurance**

For the Life Code to work effectively, it needs to apply to the distributors of all funeral insurance products. Insurers who sell insurance, such as funeral insurance, through third party distributors ought to be bound and the current drafted requirement at draft clause 4.2B is insufficient to ensure distributor conduct is captured.

**Question: Should the Code include age limits below which funeral insurance should never be available?**

As outlined above, funeral insurance should not be knowingly promoted to people under the age of 50, and banned from outbound sales.

However, we acknowledge there are exceptional situations where it may be appropriate for a consumer under the age of 50 to obtain funeral insurance. Equally, there are situation where consumers over the age of 50 should not be offered an insurance policy. What we wish to see is a commitment from insurers to ensure that they are appropriately selling the product to the right customer.

We therefore recommend that in order to avoid the most egregious and exploitative sales of funeral insurance then the following commitments should be made:

- life insurers should commit to not selling to anyone under 50 via the outbound sales channel;
- where there is an inbound funeral insurance inquiry from a consumer under 50, there must be a presumption that the sale is unsuitable unless certain criteria are met;
• the onus should be on the life insurer to ensure that the consumer meets this set of criteria demonstrating suitability;

• this suitability criteria for anyone under the age of 50 could include:
  o having a terminal disease, or other reason to believe they may have a risk to claim on the policy; or
  o having no super; and
  o understanding that it is not a savings plan documented through the sales process.

• All consumers must:
  o have had the product’s cost, risk and purpose clearly explained to them (this should be everyone – not just the under 50 cohort) and;
  o be clearly informed it is not a savings plan and that they will lose all amounts paid under the policy if it is cancelled or lapses at any time prior to their death.

*Question: Should funeral insurance only be available with level premiums?*

Yes. Again for the reasons stated above.

**Recommendations – Funeral Insurance**

9. The Life Code should prohibit stepped premiums on funeral insurance products: draft clause 3.6(c).

10. In the event that stepped premiums on funeral insurance products are not prohibited under the Life Code, life insurers should commit to providing projections of total costs of funeral insurance policy for a customer if they live to 60, 70, 80 and 90 and the estimated periodical payment required at key stages: draft clause 3.6(c).

11. Life insurers should commit to:
   a) not selling to anyone under 50 via the outbound sales channel;
   b) where there is an inbound funeral insurance inquiry from a consumer under 50, there must be a presumption that the sale is unsuitable unless certain criteria are met;
   c) the onus should be on the life insurer to ensure that the consumer meets this set of criteria demonstrating suitability;
   d) this suitability criteria for anyone under the age of 50 could include:
      i. having a terminal disease, or other reason to believe they may have a risk to claim on the policy; or
      ii. having no super and;
      iii. understanding that it is not a savings plan documented through the sales process.
   e) All consumers must:
f) have had the product’s cost, risk and purpose clearly explained to them (this should be everyone – not just the under 50 cohort) and;

g) be clearly informed it is not a savings plan and that they will lose all amounts paid under the policy if it is cancelled or lapses at any time prior to their death.

12. Life insurers should explicitly commit (under draft clause 3.6(f) to providing the following basic details in all general marketing campaigns for funeral insurance:

a) the age the product lapses;

b) that there are other ways to provide for a funeral;

c) the stepped or level nature of the premium; and

d) an example of the total cost of a product over its lifetime.

13. The Life Code should include a comprehensive Guidance for the Design and Distribution of Funeral Insurance: draft clause 3.6(g).

14. The Life Code should include an individualised, suitability requirement for the provision of funeral insurance: draft clause 3.6(g).

15. Independent, post-purchase audit surveys of funeral insurance sales should be conducted to find out what consumer believes that they have purchased and whether this aligns with the product design. A certain percentage of consumers should be required to have understood and purchased suitable insurance otherwise life insurers would be subject to increased monitoring to ensure their funeral insurance sales process meets best practice. Drop out rates and claim ratios must also be monitored. Any inappropriate funeral insurance sales would need to be addressed, as envisioned under draft clause 4.13.

16. Funeral insurance consumers experiencing financial hardship should be offered more flexible arrangements, including the chance to repay arrears over time to retain their cover and be eligible to claim: draft clause 3.6(h).

17. Funeral insurance consumers who have premium arrears in the six month prior to death should have their claims paid and the arrears deducted from the payout, regardless of whether the policy has been otherwise validly cancelled in the interim period.

18. Insurers should provide referrals to independent financial counsellors to assist them in developing a savings plan when the customer indicates that that is in fact what they are interested in: draft clause 3.6(i)(i).

19. The funeral insurance key fact sheet should:

a) include a projection of the total cost of a funeral insurance policy if a customer lives to 60, 70, 80 and 90 and the estimated periodical payment required at key stages: draft clause 3.6(i)(iii);

b) an explanation what the words “that you can cancel the insurance at any time” means under draft clause 3.6(i)(vii) – that is, you will lose all the money you have paid.

20. A deferred sales model should be committed to for the sale of funeral insurance: draft clause 3.6.

21. The Life Code should include specific commitments regarding the sale of funeral insurance to Aboriginal and Torres Strait Islander peoples including

a) taking reasonable steps to ensure that dealings with Aboriginal and Torres Strait Islander peoples are conducted in a culturally appropriate manner taking into account the specific needs and cultural protocols of each community.
b) ensure that any insurance products promoted and sold to Aboriginal and Torres Strait Islander peoples are suitable to their specific needs

c) insurers do not procure sales leads from remote Aboriginal and Torres Strait Islander communities by exploiting Aboriginal and Torres Strait Islander kinship ties.

22. The FSC must undertake further specific consultation with Aboriginal and Torres Strait Islander communities, peoples and peak level bodies is required to understand how to identify what the specific needs are and how to address them.

23. Life insurers should commit to offering capped funeral insurance products, so that premiums cease once the benefit amount is reached (or a very small % above that).

24. The Life Code should commit insurers to preventing the sale of additional funeral insurance plans to those who already own one.
2. People with a mental health condition

Draft Clause 5.3D – Advising on one’s mental health

Draft clause 5.3D states

If we ask you questions about your health to assess your application for a policy and you tell us about a mental health condition you have, or have had in the past, we will take into account the individual circumstances, such as the history and severity of the mental health condition, in making our decision about whether to insure you and, if so, the terms we offer you.

We understand the FSC’s intention with this clause is to ensure that life insurers will not automatically decline an application that reveals a mental health condition.

Insurers however could severely restrict their coverage on the basis of any signs of poor mental health at all, and they could do so in a discriminatory manner without any reference to relevant statistics or data.

The FSC and life insurers must include a commitment in the Code to base the insurance underwriting and risk profile of the product on proper assessments of this risk, that is, in the case of mental health, actuarial or statistical data that is reasonable to rely on, as per section 46 of the Disability Discrimination Act 1992 (DDA).

The goal should be that every insurer be in the market of providing cover relating to mental health and that insurers should seek to cover and manage risk through pricing, exclusions, limits and caps rather than not provide cover at all. A risk appetite of zero is not warranted. The industry should endeavour to promote practices which encourage people to be transparent about their mental health conditions and to seek appropriate treatment at an early stage. Policies and practices which have the opposite effect are clearly not in the public interest.

Furthermore, clause 5.3D and the Life Code generally do not address three elements of the PJC Inquiry into the Life Insurance Industry recommendation 10.743, namely:

a) referring applications for insurance that reveal a mental health condition or symptoms of a mental health condition to an appropriately qualified underwriter;

b) giving an applicant for insurance the opportunity to either withdraw their application or provide further information, including supporting medical documents, before declining to offer insurance or offering insurance on nonstandard terms;

c) where an insurer offers insurance on non-standard terms, for example, with a mental health exclusion or a higher premium than a standard premium, specify:

o how long it is intended that the exclusion/higher premium will apply to the policy;

o the criteria the insured would be required to satisfy to have the exclusion removed or premium reduced;

o the process for removing or amending of the exclusion/premium.

We note that that while draft clause 5.3D will commit insurers to providing information on the terms they will offer the insurance, this does not go into the detail as required above with respect to these non-standard terms. We believe that this needs to be explicitly spelt out.

We note that there is a non-exhaustive list in the clause referring to circumstances, such as the history and severity of the mental health condition. This should include duration as a particularly relevant issue.

**Draft Clause 8.12(f) – Surveillance impact on health**

Financial Rights has submitted to the Royal Commission that life insurers be prevented from engaging in surveillance of an insured who has a diagnosed mental health condition or who is making a claim based on a mental health condition.

Surveillance and the awareness that one is being surveyed can exacerbate some mental illnesses through increased paranoia and/or increased stress levels. It is unclear what surveillance can reveal with respect to mental illness. Mental illness is by its very nature a hidden affliction. Any evidence captured can be interpreted and misinterpreted in ways that cannot in most cases establish clear intent. If a claimant is captured socialising when they, for example, have stated that they cannot leave the house due to anxiety, is this evidence that they have misrepresented their illness or is it evidence that they are actively working to resolve their problems with say exposure therapy? There are also others ways to obtain relevant evidence where an insurer has reasonable doubts in relation to the validity of a claim.

While we note that there have been significant drops in surveillance usage since the introduction of the Life Code as detailed by Senior Counsel assisting the Royal Commission 44, but there remains significant continued usage in mental health claims.

If life insurers do not agree to a prohibition of surveillance of an insured who has a diagnosed mental health condition or who is making a claim based on a mental health condition, then changes must be made to draft clause 8.11(f). Draft clause 8.11(f) states:

*We will stop the surveillance if we receive evidence from an independent medical practitioner that it is having a negative impact on your health.*

The problem with this clause is that the onus is on the surveyed policyholder to:

- establish that they are being surveyed by an insurer;

• contact their insurer;
• request the insurer to engage an independent medical practitioner to examine them (i.e. not their own medical practitioner, although they are likely to have done so in addition to this);
• attend a medical examination to establish that there is a negative health impact;
• wait for this material to be presented to the insurer and
• wait for a decision to be made.

This is an unacceptable burden on someone genuinely experiencing a mental health condition. The TAL case from the Royal Commission included evidence from the consumer’s own medical practitioner.

At a minimum this clause should be re-drafted to:

• cease all surveillance once notified by a policyholder that they have a concern;
• allow evidence to be received by the policyholder’s own medical practitioner;
• if a surveyed policyholder disagrees with a decision not to cease, then life insurers need to commit to providing complaint details to the policyholder.

Recommendations – People with a mental health conditions

25. Life insurers must commit under the Life Code to basing their underwriting and risk profiles on proper assessments of risk, that is, in the case of mental health, actuarial or statistical data that is reasonable to rely on, as per section 46 of the DDA.

26. In line with recommendation 10.7 of the PJC Inquiry into the Life Insurance Industry, draft clause 5.3D needs to include the following additional explicit commitments:

d) referring applications for insurance that reveal a mental health condition or symptoms of a mental health condition to an appropriately qualified underwriter;

e) giving an applicant for insurance the opportunity to either withdraw their application or provide further information, including supporting medical documents, before declining to offer insurance or offering insurance on nonstandard terms;

f) where an insurer offers insurance on non-standard terms, for example, with a mental health exclusion or a higher premium than a standard premium, specify:

i. how long it is intended that the exclusion/higher premium will apply to the policy;

ii. the criteria the insured would be required to satisfy to have the exclusion removed or premium reduced;

iii. the process for removing or amending of the exclusion/premium.

27. Surveillance of an insured who has a diagnosed mental health condition or who is making a claim based on a mental health condition should be prohibited.

28. If this prohibition is not included in the Life Code then at the very least, life insurers should:
a) cease all surveillance once notified by a policyholder that they have a concern;
b) allow evidence to be received by the policyholder’s own medical practitioner;
c) if a surveyed policyholder disagrees with a decision not to cease, then life insurers need to commit to providing complaint details to the policyholder.
3. Sales – section 4

**Question:** The Consultation Draft Code introduces additional protections to ensure that people are not pressured into taking out life insurance they do not want. Do these go far enough and, if not, what further protections are needed?

**Draft Clause 4.1 – Advertising and marketing**

Draft clause 4.1(h) states life insurers will:

Ensure that short-term customer incentives that are not part of the life insurance policy (such as gift cards or reward points) do not encourage customers to take out the policy solely for the incentive, rather than primarily for the features and benefits of the cover.

While we support the introduction of new wording at draft clause 4.1(h) this should be strengthened to prohibit the use of any short term customer incentives at all.

Current and draft clause 4.1(g) regarding the use of phrases such as “free” or “guaranteed” should be expanded to include the phrases “no cost,” “without cost,” ”no additional cost” or “at no extra cost.”

Further, Financial Rights is aware of an exploitative practice by some distributors of insurance where Aboriginal and Torres Strait Islander community members are used (without employing them) to recruit other community members to purchase insurance products. This practice cynically exploits Aboriginal and Torres Strait Islander kinship ties for profit and should be prohibited under draft clause 4.1.

**Draft Clause 4.2A – Remuneration practices**

While a good first draft, Financial Rights does not believe that draft clause 4.2A goes far enough.

All forms of conflicted remuneration must be prohibited as they are the key driver of the poor conduct and culture identified by the Royal Commission.

Current remuneration structures lead to a series of conflicts of interest. Conflicted remuneration should be banned, not just in sales, but other areas of the customer’s interaction with the insurer such as at claims handling. The prohibition should be included earlier in the Life Code and not limited to section 4, where it might be construed as limited to conflicted remuneration in sales.

Nothing short of a total prohibition on conflicted remuneration will remove the risks of poor consumer outcomes. The conflicted remuneration ban should extend to third party distributors.

**Draft Clause 4.2B – Distributors not staff or Authorised Representatives**

Financial Rights supports the development of draft clause 4.2B which states:

*If we use a distributor to sell our policies that is not our staff or our Authorised Representative, we will take reasonable steps so that we are satisfied that the distributor*
maintains processes and procedures that are consistent with good customer outcomes and the obligations in the Code. (our emphasis)

However we do not believe “take reasonable steps” is anywhere near strong enough to address the problems raised in the Royal Commission and elsewhere.

The poor behaviour of distributors is not just a major concern for consumers and regulators but should be a major concern for life insurers who claim that their reputations are the key to the sector’s ongoing relationship with consumers and their confidence. The poor behaviour of distributors reflects poorly on life insurers. The public does not differentiate between the two. If distributors are not held to account for their poor behaviour either through the application of the Code or through contracts with insurers that require they meet the Code, distributors will continue to behave in ways that do not meet community standards and expectations. And the life insurance sector will continue to suffer from a poor reputation.

We recommend that life insurers commit to ensuring that all distributors of their products meet all the applicable standards of the Life Code. This can and should be included in all insurer/distributor contracts. This should not be limited to sales practices.

Currently, the placement of this obligation in section 4 suggests it is limited to sales.

The Life Code itself already has subscribers entering into contract obligations with Independent Service Providers per clause 10.4. There is no reason the same could not or should not occur for distributors.

**Draft Clause 4.3 – Documented sales rules**

Financial Rights supports the addition of the words “and if applicable not sell you the policy” to draft clause 4.3(a).

We also support the addition of a definition of pressure selling but believe that draft clause 4.3 should align better with current and draft clause 4.6 by using the word “prohibit” or phrase “not permit” pressure selling or other unacceptable sales practices – rather than the word “prevent”.

Further, the definition put forward should be improved to include the concept of a sales person attempting to take control of the sales interaction – as per the definition used by Monash Business school in order to broaden the concept. 45

We also recommend that Example 5 be converted into an actual Code commitment:

> We will have clearly documented sales rules that require sales staff and Authorised Representatives we employ to end a sales meeting or telephone call if the person clearly expresses the view more than once that they do not want to take out an insurance policy.

45 A selling approach in which the salesperson attempts to control the sales interaction and pressure the customer to make a purchase. [https://www.monash.edu/business/marketing/marketing-dictionary/h/high-pressure-selling](https://www.monash.edu/business/marketing/marketing-dictionary/h/high-pressure-selling)
**Question:** The Consultation Draft Code has a placeholder for cold calling (at section 4.3A), which is already subject to legal restrictions – see section 992A of the Corporations Act 2001 (Cth) commonly known as the “anti-hawking provisions”. What further restrictions, if any, should apply to outbound unsolicited calls?

ASIC has stated that is intends to:

> to restrict outbound sales calls for life and funeral insurance. We are considering what regulatory tools we will use to implement this reform. In the meantime, the small number of firms who are still engaged in outbound sales will need to move away from this practice.\(^{46}\)

We strongly support this prohibition.

If a prohibition is not forthcoming and consumers remain reliant upon with Life Code commitments self-regulating behaviour with respect to outbound calls we would recommend that a deferred sales structure be committed to at draft Clause 4.3A(a) where the current placeholder is.

With respect to the sales rules at draft Clause 4.3A then we have the following comments and recommendations:

**Draft Clause 4.3A(b) - Gratuitous concurrence**

We note that draft clause 4.3A (b) states

> During the sale, periodically check that you have understood the information the sales person has given you and allow time for you to ask questions.

While prima facie this is a positive step forward we do wish to raise the serious issue of gratuitous concurrence – i.e. the tendency for people to appear to assent to every proposition put to them even when they do not agree. This is a phenomenon that arises in particular cultures – especially Aboriginal and Torres Strait islander People, and some east Asian cultures.

ASIC has raised this issue with general insurers directly. In a letter to the ICA’s Denise Hang dated 19 June 2018\(^ {47}\)

> Gratuitous concurrence is when a person consents to a proposition even though they do not necessarily agree with or accept the proposition. As discussed at our meeting, gratuitous concurrence takes two broad forms. Firstly, it is when an Indigenous consumer will consent to what they are being offered, because they believe that accepting is the polite answer, or the answer they believe the questioner wants them to give. Secondly, it can mean that an Indigenous consumer agrees to a proposition because it is easier to consent then admit that

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\(^{46}\) ASIC Report 587 Para 78

\(^{47}\) Letter from Christian Mikula, Senior Specialist, Deposit Takers, Credit and Insurers, ASIC to Denise Hang Principal Policy Advisor Insurance Council of Australia, dated 19 June 2018

they do not understand what is being asked of them. In both instances, it is important to recognise that no substantive confirmation has taken place and that an affirmative response does not necessarily convey a genuine intention to agree to the proposal put to them. The behaviour also relies on the expectation the questioner will not follow up on the consumer’s consent or enquire further. In other words, Indigenous consumers feel that it is the best way to end the conversation quickly, without being rude. Gratuitous concurrence is therefore a relationship issue as well as a language issue.

The main area in which managing the consequences of gratuitous concurrence has been examined is in relation to Indigenous witnesses in court. In R v Aboriginal Dulcie Dumaia1 it was described in the following way: “An answer in the affirmative could indicate that the Aboriginal witness is trying to understand the question, that he has understood it, that he has understood part of it, that he may not have understood it at all, or that he does not want the question to go unanswered, or that he thinks that an affirmative answer is more likely to be acceptable to the questioner than a negative answer.” There is now a broad recognition within the judicial system that ‘yes’ answers to direct questions put to Indigenous witnesses may not always be accurate. The 2002 Aboriginal Benchbook for Western Australian Courts2 includes many references to gratuitous concurrence. The benchbook was released to provide guidance for judicial officers presiding over criminal proceedings in Western Australia. The benchbook addresses many of the complexities of cross-cultural communication and describes ways of addressing language barriers in court proceedings. In response, other states have also released benchbooks with similar material. Legal Aid Queensland and the Queensland Department of Justice have also released best practice guidelines and a handbook that include references to gratuitous concurrence and a recognition of the need to adapt communication styles for Indigenous clients.

It has also been recognised that an Indigenous consumer’s capacity to speak fluent English does not necessarily mean they comprehend exactly what is being said. This can be attributed to the difference between Aboriginal English and Standard Australian English (SAE).6 In crosscultural communication, many cultural assumptions are made that can significantly impact the effectiveness and fairness of the exchange. For example, in SAE, it is believed that the most effective way to find out information is to ask multiple questions.7 However in Aboriginal English, asking multiple questions is regarded as rude.8 Similarly, direct questions regarding personal matters are also seen as invasive. In relation to the sale of add-on insurance the lack of comprehension can be exacerbated by the complexity of some of these products (for example, the amount payable in the event of a claim can vary over time or depend on factors that are not easily understood).

ASIC’s view is that the operation of these cultural and linguistic differences needs to be recognised by general insurers in their dealings with Indigenous consumers. As mentioned above, gratuitous concurrence is also a relationship issue that is not limited to face to face sales. It can also operate in relation to phone sales as it is difficult for a salesperson to establish a direct and positive rapport over the telephone. Given the complexity of insurance products, and the generally lower levels of financial literacy of Indigenous consumers, then, in the absence of a lengthy period of interaction to build rapport, the consumer is likely to view the salesperson as an expert, and so more likely to exhibit gratuitous concurrence in their
responses so that they do not sound ill-informed and also to ensure they do not offend someone they perceive is in a ‘senior position’.

In summary, ASIC considers that gratuitous concurrence is not only harmful in relation to the possibility that no real confirmation has taken place, but it also leaves scope for manipulation. A provider of products could or an intermediary could, for example, use this to secure apparent consent when there has been no substantive engagement or affirmation by the consumer.

The issues detailed by ASIC apply equally to life insurers. ASIC then recommend that:

a short-term working group with ASIC, the ICA and other relevant members could be formed to develop best practices guidelines in addressing gratuitous concurrence in the sale of insurance products. These could then be included as non-binding obligations as an Appendix to the General Insurance Code of Practice. They could be improved and refined over time in light of the experience of your members.

We support this and believe life insurers should also be involved to develop similar guidance. We would however differ in one respect: that adherence to these be binding on insurers. At a minimum the Life Code should include a commitment from insurers to question a consumer about what they understand about the contract, when the sales representative identifies signs of gratuitous concurrence, particularly for those people experiencing vulnerability as defined under Section 7. If it is clear from these answers that the client does not fully comprehend what they are purchasing then the salesperson should cease the sale.

_Draft Clause 4.3A(b) - Explanations of key exclusions and future costs_

Financial Rights notes that ASIC Report 587 recommends the following:

We expect the revised Code to set rigorous standards to address our findings, including requiring insurers to:

(a) Provide adequate explanations of key exclusions and future cost—Firms should clearly explain these features and limitations as part of their sales calls. Firms should not rely on including this information in lengthy pre-recorded or verbatim disclosures. Pre-existing condition exclusions in particular should be clearly explained to the consumer, with practical examples to highlight the breadth of this exclusion.\(^{48}\)

We do not believe that the Life Code as drafted adequately addresses this recommendation. The Life Code needs to explicitly commit insurers to explain the key exclusions and future costs in direct sales calls. The Life Code should state something similar to the following

We will explain to you the key features, exclusions, limitations and future costs of our products.

We will explain the impact of and our treatment of pre-existing conditions to you.

\(^{48}\) Para 66, ASIC Report 587
We will provide practical examples to assist you in understanding these exclusions.

We will not rely on lengthy pre-recorded or verbatim disclosures when explaining these to you.

**Draft Clause 4.3(c) – Deciding on the amount of cover**

The commitment under draft clause 4.3A(c) can be boosted significantly by including the information under Example 6 into the commitment.

*We will have clearly documented sales rules to ensure sales staff and Authorised Representatives we employ help customers decide on the amount of cover they should take out in an appropriate manner including:*

1. Explaining the range of cover that is available.
2. Asking the customer if they have a view about how much cover they should choose and, if so, prepare a quote for that amount.
3. If not, asking the customer how much they could regularly afford on life insurance to protect their family, and using that amount to prepare a quote.

This is should be a simple commitment and beef up of draft Clause 4.3A(c).

**Draft Clause 4.3A(d) – Sales to vulnerable people**

Example 7 provides details around potential ways to identify vulnerable consumers to expand upon the weak and vague commitment at draft clause 4.3A(d) which states:

*That sales staff should never take advantage of vulnerable customers and when to stop selling.*

The commitment should be expand to include the following:

*We will have clearly documented sales rules to ensure sales staff and Authorised Representatives we employ can identify vulnerable customers, for example where the person:*

Discloses that they have a vulnerability.

Appears to be having language difficulties.

Is having difficulty answering basic questions, even after the question is repeated.

Appears to be confused or under the influence of alcohol or drugs.

The person is, or becomes, distracted by something going on around them.

Furthermore ASIC Report 587 recommended that insurers:

*Strengthen protections for vulnerable consumers—Firms should build on the existing provisions in the Code and set clearer expectations about how sales staff should behave when dealing with vulnerable consumers, including when it will be appropriate to end a call. Quality
assurance frameworks should test whether sales staff identified and responded to vulnerable consumers.49

We do not believe that the FSC have met this in the Life Code draft. Specifically there needs to be a commitment to:

taking specific steps with respect to a vulnerable customer once identified, including ceasing the call immediately, where appropriate

Draft Clause 4.3A(f) – Alternative types of policies

Draft clause 4.3A(f) states:

If you are not eligible for the policy we originally proposed, if we propose an alternative type of policy, we will give you details of the alternative (including the PDS) at the time and offer to arrange a future call or meeting to discuss it if you wish.

We understand this section is designed to prevent on the spot sale of a “downgrade”, and instead operate as a quasi-deferred sales model – for example, a person seeking life insurance who is instead offered accident insurance. We are concerned that this clause does not go far enough.

The fact a consumer has been denied a product needs to be very clear to the customer, including any rights to reasons (section 75 of the Insurance Contracts Act).

Any and all differences between the policy sought and the policy offered should be highlighted to the consumer with a clear explanation of the impact of these changes spelt out.

We believe a clearer deferred sales model should be implemented and consumers should be required to initiate any follow up contact. We do not support the insurer arranging a future call or meeting with the consumer’s consent.

Draft Clause 4.3A(g) – Deferring sales

Draft clause 4.3A(g) states:

If you say that you want time to think about the policy or whether it is suitable for you before applying to buy it, [we will] not sell you the policy or take your payment details and offer to arrange a future call or meeting to discuss it. (our inclusion)

We believe that there is a “we will” is required for the clause to make sense.

Nevertheless, we do not support the position that the insurer can initiate a follow-up call. We believe that the consumer should initiate the call to enact an effective deferred sales process that is customer centric.

49 Para 66(f) ASIC Report 587
Draft Clause 4.4 – Quality Assurance framework

ASIC Report 587 recommends that insurers:

Implement training and quality assurance frameworks that establish standards, monitor sales conduct, and resolve poor consumer outcomes—Firms must establish clear standards for sales conduct and establish quality assurance assessments that specifically test sales staff against the Code obligations. Assessments must be conducted within a short timeframe and firms must promptly contact the consumer if an assessment identifies issues with consumer need or understanding. The Code should mandate minimum timeframes for quality assurance processes.50

We do not believe that the Life Code draft meets the expectations of this recommendation—namely that it does not establish:

• specific timeframes on the conduct of assessments
• specific timeframes regarding the contacting a consumer if an assessment identifies issues with consumer need or understanding
• other timeframes for the quality assurance process including how often they will be conducted, how long they should take etc.
• parameters for sample sizes – ASIC has recommended ambitious minimum sampling targets that ensure that the quality assurance framework is effective in picking up problems and acting as a deterrent51
• processes to identify types of sales that have a higher risk of poor consumer outcome or misconduct due to, for example, incentives
• sanctions for failing to meet the quality assurance standards

We recommend that the Life Code include all of the above as a minimum standard to be met.

Draft Clause 4.6 – Distributors and pressure selling

We note that the current and new 4.6 do not place any obligations on life insurers other than that they will “make it clear” that pressure selling is not permitted. If pressure selling is found to have been employed by a distributor there is no consequence. There is no commitment to:

• not work with a distributor who engages in pressure selling; and
• ensure affected consumers are appropriately remediated if pressure selling is identified.

There is also no code breach by the life insurer if their distributor engages in pressure selling. The only way a Life Insurer could be held accountable is if they “do not make it clear” to the

50 Para 66(h) ASIC Report 587
51 Para 505, ASIC Report 587
Financial Rights recommends that the FSC reconsider its commitments respect to distributors to ensure that a breach of the Code by a distributor entails actual consequences for both the distributor and the life insurer.

**Draft Clause 4.7 - Consumer credit insurance**

Financial Rights believes that CCI is a junk insurance product that provides little to no value to consumers. We have recommended in our submission to the Royal Commission that CCI – along with accidental death, accidental injury and funeral insurance policies (as they are currently designed) be prohibited outright. This is likely going to have to be done via legislation however we think add-on sales practices could be prohibited under the Code.

The problems with consumer credit insurance are multiple and have been the subject of extensive ASIC investigations including:

- Report 413 Review of Retail life insurance advice, October 2014
- Report 454 Funeral insurance: A Snapshot, October 2015
- Report 470 Buying add-on insurance in car yards: Why it can be hard to say no, February 2016
- Report 471 The sale of life insurance though car dealers, February 2016
- Report 492 A Market that is failing consumers: The sale of add-on insurance through car dealers
- Report 498 Life Insurance claims: An industry review

CCI is a demonstrably poor value product—a loss ratio of 23% indicates that it pays far less in claims as a proportion of premiums than any other type of insurance for which the Australian Prudential Regulation Authority (APRA) records are available. CCI also receives fewer claims, and rejects a higher proportion of the claims it receives, than any other line of insurance.

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58 Data on loss ratios is from APRA, data on claims is from the Financial Ombudsman Service. More explanation and full references are in Consumer Action Law Centre’s report Junk Merchants: How Australians are being sold rubbish insurance and what we can do about it, December 2015, pp 8-10.
We raised our concerns with CCI with the FSC in the drafting of the first Life Code. At the time, significant draft clauses were removed and deferred until the drafting of the second iteration of the Life Code.

Accepting that this Life Code will not be prohibiting the sale of CCI altogether, in the absence of a ban, we believe that the Code can go some way to restrict the worst excesses of the sale of this junk product.

We do not think that draft clause 4.7 goes far enough. The weasel words “we will take all reasonable steps so that we are satisfied” ensure that life insurers will not be held strictly liable for the distribution of a CCI product that does not meet sections 4.7(a) to 4.11. This needs to be replaced with the words “we will ensure.”

Draft Clause 4.7(a) states:

\[
\text{Before you buy CCI, you will receive clear information to help you make an informed decision} \\
\text{– including (to the extent we can): …}
\]

The inclusion of the words “(to the extent we can)” should be removed. Either life insurers make a commitment to providing the material or not. The inclusion of the phrase allows insurers to not provide the material if – on their own subjective judgement – they cannot provide the material.

We note that a number of current commitments under current 4.7(c) have been removed i.e.

\[
\begin{align*}
(b) \ (i) \ & \text{a clear statement that the purchase of the Life Insurance Policy is optional;} \\
(b) \ (iii) \ & \text{a clear explanation of the eligibility criteria for the Life Insurance Policy, the main exclusions that apply and the cooling-off period;} \\
(c) \ & \text{inform you how the premiums will be structured;}
\end{align*}
\]

Financial Rights does not understand why these have been removed and recommends that they be reinstated.

\[
\text{Draft Clause 4.10 – Separation of application process for CCI and credit products in digital channels}
\]

Financial Rights notes that much of the deferred sales model wording in Draft Clause 4.10 is based upon the wording found in the new Banking Code: Clauses 64-66. However there are a number of differences that have been instituted in the drafting of these Code commitments that weaken what is found in the Banking Code.

\[
\text{Application process versus availability of CCI}
\]

Clause 64 of the Banking Code states:

\[
\text{We will refer to the availability of CCI only after you have completed the digital application for a credit card or loan.}
\]

This clause is focused on referring to the availability of CCI. However the draft clause 4.10(a) refers to the digital application process starting, not the availability of the CCI:
The digital application process for CCI will not start until you have completed\textsuperscript{11} the digital application for a credit product, such as a credit card or loan.

The difference is a matter of degree however it assumes the digital application process will begin and removes the step before this – letting people know of the availability of CCI. The Banking Code drafting implies a choice will be put to consumers, the Life Code does not.

We believe that the clause should refer to amended to read

\textit{The digital application process for CCI will not be made available until you have completed\textsuperscript{11} the digital application for a credit product, such as a credit card or loan.}

to match the intention of the Banking Code.

The joint consumer submission to the review of the Banking Code advocated for this provision to go one step further and only provide information about CCI after an application for a credit card or loan has been \textit{approved}. This would have removed any misapprehension that the approval for the loan was in anyway connected to taking out the insurance policy. While the ABA did not take up that drafting in their Code it remains the consumer position and we would argue reflects best practice. At the very least the Life Code should meet the equivalent standard to the Banking Code. Ideally it would take this extra step to ensure greater consumer protection.

\textbf{CCI digital disclosures}

Draft clause 4.10(c) states

\textit{As you navigate through the digital experience, to help you understand CCI there will be clear disclosures, for example by:}

\begin{itemize}
  \item[i.] Using filtering questions \ldots (our emphasis)
\end{itemize}

The equivalent Banking Code Clause 66 states:

\textit{We will use clear disclosure for CCI on credit cards and loans to enable customers, as they navigate through the digital experience, to better understand this type of insurance. This will be through:}

\begin{itemize}
  \item[a.] Use of filtering questions...
\end{itemize}

The use of the qualifier “for example by” is not used in the Banking Code. The impact of the use of “for example by” in the draft Life Code clause is such that it modifies the commitment to allow Life Insurers to pick and choose what tools they use in disclosure or indeed none of those listed. The Banking Code has committed Banks to institute all six disclosure tools. The draft Life Code does not.

We recommend that the words “for example by” be removed from the clause.

\textbf{CCI phone disclosures}

We note that the draft clause 4.11 is very similar to the Banking Codes clauses 67-68. The only thing we would note about both these approaches is the need to curtail the amount of and any potential spamming or multiple phone calls providing this factual information. There is no limit to the amount of material or the number of contacts that could be made providing factual
material. We recommend that such a commitment be made to only provide this material once and only once.

**Draft Clause 4.13 – Investigating your concerns**

**Remedies**

Draft Clause 4.13(a) lists a number of remedies for the inappropriate sale of a life insurance product. Other remedies should include:

- Reasonable compensation, where appropriate and
- Fines to encourage compliance.

Again, conduct by distributors should be covered.

**Onus placed on consumer**

The draft clause 4.13 (b) states that

*If you tell us that you are not satisfied with the remedy we propose, we will review it and tell you how to make a Complaint.* (*our emphasis*)

Currently the equivalent Clause 5.9 (b) states:

*if you are not satisfied with our proposed remedy, we will review this and tell you how to make a Complaint;*

While a subtle shift, the new clause places the entire onus on the consumer to tell the insurer they are dissatisfied, while the current clause allows for the possibility of a life insurer representative discovering the dissatisfaction with the remedy in conversations with them. We recommend that this clause remain as currently drafted.

**Design and Distribution concerns**

Financial Rights notes that draft new Code introduces new design and distribution obligations under draft clause 3.6A with respect to the design and distribution of an accident product, and under draft clause 3.6 for funeral insurance, in addition to other design and distribution obligations under section 3.

Current clause 4.9 and draft clause 4.13 commits life insurers to investigating concerns about the sales practices. Financial Rights supports this. However we believe that this needs to be expanded to capture any concerns identified about the design and distribution process at all. There is no commitment to ask whether the design of a target market or the distribution model itself has led to poor consumer outcomes – in addition to the sales practices. Low claims ratios and policy lapse rates, for example, are significant indicators that a product is not working for consumer whether due to poor design, or inappropriate distribution, or both and should act as triggers for insurer’s to investigate potential problems and respond appropriately.

We recommend that either new clause be drafted or the draft clause 4.13 be amended to commit insurers to investigating concerns raised or identified with the design and distribution of a product.
Recommendations – Sales

29. Short-term customer incentives should be prohibited: draft clause 4.1(h).

30. The use of phrases “free,” “guaranteed,” “no cost,” “without cost,” “no additional cost” or “at no extra cost” in advertising should be prohibited: draft clause 4.1(g).

31. The exploitative practice of using but not employing Aboriginal and Torres Strait Islander community members to recruit other community members to purchase insurance products should be prohibited under draft clause 4.1.

32. All forms of conflicted remuneration for sales staff (be they employees, authorised representatives third party distributors or otherwise) must be prohibited: draft clause 4.2A.

33. Life insurers must commit to ensuring that all distributors of their products meet the applicable standards of the Life Code of Practice, via insurer/distributor contracts: draft clause 4.2B.

34. Draft clause 4.3 should be re-drafted to align better with current and draft clause 4.6 by replacing the word “prevent” with the word “prohibit” or phrase “not permit.”

35. The definition of pressure selling should be amended to include the concept of a sales person attempting to take control of the sales interaction: draft clause 4.3.

36. The Life Code should include a best practice guideline to address issues of gratuitous concurrence in the sale of life insurance products. At a minimum this should include a commitment from insurers to question a consumer about what they understand about the contract, when the sales representative identifies signs of gratuitous concurrence. If it is clear from these answers that the client does not fully comprehend what they are purchasing then sale should cease the sale.

37. In line with expectation 1 of ASIC Report 587, the Life Code must explicitly commit insurers to explain the key exclusions and future costs in the direct sales calls including:
   a) explaining the key features, exclusions, limitations and future costs of products;
   b) explaining the impact of and treatment of pre-existing conditions;
   c) providing practical examples to assist in understanding these exclusions;
   d) not relying on lengthy pre-recorded or verbatim disclosures when explaining these exclusions.

38. Draft clause 4.3A(c) should be expanded to make the following explicit commitments:
   a) life insurers will have clearly documented sales rules to ensure sales staff and authorised representatives help customers decide on the amount of cover they should take out in an appropriate manner including:
      i. Explaining the range of cover that is available.
      ii. Asking the customer if they have a view about how much cover they should choose and, if so, prepare a quote for that amount.
      iii. If not, asking the customer how much they could regularly afford on life insurance to protect their family, and using that amount to prepare a quote.

39. Draft clause 4.3A(d) should be expanded to make the following explicit commitments:
   a) Life insurers will have clearly documented sales rules to ensure sales staff and Authorised Representatives we employ can identify vulnerable customers, for example where the person:
i. discloses that they have a vulnerability.
ii. appears to be having language difficulties.
iii. is having difficulty answering basic questions, even after the question is repeated.
iv. appears to be confused or under the influence of alcohol or drugs.
v. the person is, or becomes, distracted by something going on around them.

40. In line with Expectation 1 of ASIC Report 587 the Life Code should commit insurers to taking specific steps with respect to a vulnerable customer once identified, including ceasing the call immediately, where appropriate.

41. Draft clause 4.3A(f) should be amended so that when an alternative type of policy is proposed the life insurer:
   a) spells out any and all differences be highlighted to the consumer with a clear explanation of the impact of these changes
   b) ensures that the consumer must initiate the subsequent sales call.

42. Draft clause 4.3A(g) should be amended to ensure that the consumer, not the insurer, initiates a call after a period to think about the policy and its suitability.

43. In line with expectation 1 of ASIC Report 587, the Life Code must expand upon draft clause 4.4 and establish:
   a) specific timeframes on the conduct of assessments
   b) specific timeframes regarding the contacting a consumer if an assessment identifies issues with consumer need or understanding
   c) other timeframes for the quality assurance process including how often will they be conducted, how long should they take etc.
   d) parameters for sample sizes
   e) processes to identify types of sales that have a higher risk of poor consumer outcome or misconduct due to, for example, incentives
   f) sanctions for failing to meet the quality assurance standards

44. Draft clause 4.6 must be re-drafted to ensure that a breach of the Life Code by a distributor entails actual consequences for both the distributor and the life insurer.

45. Regarding the sale of CCI, draft clause 4.7 must be re-drafted to:
   a) replace the words "we will take all reasonable steps so that we are satisfied" with "we will ensure"
   b) remove the words "(to the extent we can)"
   c) reinstate the subclauses 4.7 (b)(i), (b)(iii) and (c)

46. Regarding the separation of application process for CCI and credit products in digital channels, Draft Clause 4.10 should be amended to:
   a) replace “will not start” with “will not be made available” in draft clause 4.10(a);
   b) replace "only after you have completed the digital application for a credit card or loan" with "only after your digital application for a credit card or loan has been approved";
c) remove the qualifier “for example by” in draft clause 4.10(c), and;

d) limit to the amount of material or the number of contacts that could be made providing factual material.

47. Additional remedies for poor sales practices are needed to be included at draft clause 4.13(a):

   a) reasonable compensation, where appropriate and

   b) fines.

48. The wording of current clause 5.9(b) needs to be reinstated in draft clause 4.13(b) to return the onus back on the life insurer.

49. Draft clause 4.13 regarding investigating and remedying poor sales practices needs to be expanded to capture concerns identified about the design and distribution process as outlined in draft clause 3.6, 3.6A and other design and distribution obligations.
4. Moratorium on Genetic Tests in Life Insurance (the Moratorium) – Appendix 4

Financial Rights does not support the life insurance industry self-regulating the use of genetic tests in life insurance. This is because of the clear conflict of interest arising out of the industry's desire to gain as much information as possible for legitimate commercial reasons and the subsequent genetic discrimination that will inevitably result. This is a matter that needs to be taken up by government and legislated.

The Australian people need to make a collective decision through their representatives in Government regarding where the line needs to be drawn in producing fair outcomes in risk pooling and premium pricing. While gaining as much information as possible about individuals in a pool may better reflect the risk profile of the collective and individuals, the outcome of this is far from desirable for individuals and society as a whole.

Some consumers will be losers and some will be winners in the genetic information lottery. This may be what occurs now just with more accurate information but the question that remains at the centre of this is: is it fair to charge higher prices to people with conditions they are powerless to change. The answer is clearly no.

In simple terms – there are risks that are within the control of an individual and risks that are not within the control of an individual. Including controllable risks within the pricing of an insurance premium has the potential to produce improved outcomes for individuals and society more generally. Encouraging (or signalling to) someone that a healthier lifestyle through exercise and improved diet can produce better outcomes for them (through lower risk of, for example, heart attack) and society (through decreased strain on the health system and improved well-being among community members) is a potentially positive outcome. Even in this context it is important to consider economic and other structural disadvantage and its impacts on people’s realistic ability to effect changes in their lifestyle or health profile.

However price signalling to someone that their genetic make-up is poor – something they have zero control over – produces no useful outcomes for individuals or society as a whole. In fact it will lead to actively poor outcomes through people avoiding potentially helpful genetic testing, inhibiting scientific research and leading to increased numbers of uninsured people and a subsequent increased reliance on the welfare state. In other words including genetic testing in premium pricing leads to poor health outcomes, a stratified society of genetic haves and genetic have-nots, and increased strain on government resources.

Australia must follow international examples and introduce a legislated ban on the use of genetic testing in life insurance.

Accepting that the FSC will not act against its own conflicted self interest and prohibit the use of genetic testing via the Life Code nor support a legislated prohibition, Financial Rights provides the following input on the proposed moratorium.
We note that the Australian Genetic Non-Discrimination Working Group, appear to not to have been consulted about this proposed moratorium.\textsuperscript{59} This is against the explicit recommendation of the PJC Life Insurance Inquiry Report.\textsuperscript{60} This reflects our own experience on consultation on Life Code 2 as described above. This is disappointing. Given the outcome we see in the draft moratorium presented, this lack of consultation is demonstrative of the conflicts of interest inherent in the FSC dealing with this issue and the lack of trust the community can have in the FSC self-regulating on genetic testing.

At a minimum this needs to be rectified and the FSC work closely with the Australian Genetic Non-Discrimination Working Group to improve the draft Moratorium.

The PJC Life Insurance Inquiry Report also recommended that the Moratorium take a form similar to the United Kingdom’s Moratorium, noting that the prohibition “should not prevent a consumer from being able to provide genetic information to a life insurer in order to demonstrate that they are not at risk of developing an inherited condition.”\textsuperscript{61}

We do not believe that the draft Moratorium has met this recommendation.

Firstly the UK Moratorium ensures that

\begin{itemize}
  \item \textit{customers making relevant insurance applications will be required to disclose a predictive genetic test result only if all of the following apply;}
  \item i. the customer is seeking insurance cover above the financial limits set out in the Moratorium;
  \item ii. the test has been assessed by a panel of experts and approved by Government. To date, the only test that people are required to disclose under the agreement is for Huntington’s Disease for life insurance where the insured sum is over £500,000.\textsuperscript{62}
\end{itemize}

No such panel of expert’s assessment has been conceived of or established in the draft Moratorium to approve its application to particular health conditions. The draft Moratorium subsequently applies to all conditions, in a way that the UK Moratorium is specifically designed not to work.

The FSC have claimed that “it would treat people with all genetic conditions equally”\textsuperscript{63} implying that only applying the limit to Huntington’s disease in the UK moratorium as unfair. We would

\textsuperscript{59} “Ms Tiller, a founding member of the Australian Genetic Non-Discrimination Working Group, is also disappointed not to have been consulted about the proposed moratorium” in Industry defends genetic testing regime, insurancenews.com, 5 November 2018, https://www.insurancenews.com.au/life-insurance/industry-defends-genetic-testing-regime

\textsuperscript{60} At para 9.93 Parliamentary Joint Committee on Corporations and Financial Services Life Insurance Inquiry Report.

\textsuperscript{61} At para 9.93 Parliamentary Joint Committee on Corporations and Financial Services Life Insurance Inquiry Report.


\textsuperscript{63} Page 2, Consultation draft. Life Code
counter this by pointing out that (a) the decision is based on a panel of expert’s assessment and approved by government and (b) fairness would be to exclude the application of genetic testing to premium pricing to all conditions not to include it. The FSC have clearly taken the path that most benefits life insurers rather than consumers.

Secondly the financial limits being applied do not in any way match the UK’s levels. The UK moratorium’s financial limits apply as follows:

Customers will not be required to disclose the results of predictive genetic tests for policies up to £500,000 of life insurance, or £300,000 for critical illness insurance, or paying annual benefits of £30,000 for income protection insurance.64

The equivalent figures in today’s exchange rate are:

- AUD$901,050 for life insurance,
- AUD$540,630 for critical illness insurance and
- an annual benefits of AUD$54,063 for income protection insurance or $4500.25 per month.

The figures in the draft moratorium are significantly lower at:

- $500,00 for life insurance, lump sum death cover and TPD ($400,000 lower)
- $200,000 for trauma or critical illness insurance ($340,000 lower) and
- $4000 a month of income protection or salary continuance ($500 per month lower or $6060 lower on an annual basis).

Counter to the recommendation, and with no justification whatsoever the FSC have based it’s figures on the German and Swiss moratorium. The use of these figures only seem to be cherry picked on the basis that they are the lower than the UK position. This decision is clearly in the sole interest of life insurers.

Thirdly, the UK Moratorium clarifies that the use of genetic tests will only be conditions that are:

monogenic (single gene disorders that are inherited in a simple fashion); b. late-onset (symptoms are delayed until adult ages); and of c. high penetrance (a high probability that those with the gene will develop the disorder).65

No such limitations are present in the FSC’s draft Moratorium.

The UK Moratorium also commits insurers to:

64 Clause 26, HM Government & Association of British Insurers, Concordat and Moratorium on Genetics and Insurance
65 Clause 17, HM Government & Association of British Insurers, Concordat and Moratorium on Genetics and Insurance
• undertake specific measures to reassure customers that they are not deterred from taking a genetic test for fear of potential insurance consequences. Draft clause 2 makes a broad statement but no commits to no action.

• not place the consumer under any pressure to take a genetic test. Draft Clause 7 only states that Life insurers will not ask.

• treat customers who have taken a predictive test before the date of the Moratorium the same way as customers taking tests after the introduction of the Moratorium. No such limit to the scope appears in draft clauses 4 and 5 of the draft FSC Moratorium.

• not require customers to:
  o disclose genetic test results from a test taken after the insurance cover has started, for as long as the cover is in force;
  o disclose genetic test results of another person such as a family member or;
  o disclose genetic tests acquired as part of clinical research.

Draft Clause 7 of the FSC Moratorium limits asking questions at the application process only, not for the balance.

• make available information to customers, before an application for insurance cover is completed, about what customers will and will not have to disclose about their genetic tests in line with the Moratorium.

• maintain stringent procedures for seeking access to relevant medical information held by a GP or other clinician, agreed between the ABI and the British Medical Association.

• protect personal medical information in accordance with the ABI Confidentiality Policy.

• destroy medical evidence when it is no longer relevant to them.

• publish information about the way they will, or will not, use such test results to inform their underwriting decisions.

• not use genetic information to underwrite other non-life insurances.

66 Clause 19-20
67 Clause 21(a)
68 Clause 21(b)
69 Clause 21(c)
70 Clause 21(e)
71 Clause 21(g)
72 Clause 21(h)
73 Clause 21(i)
74 Clause 22
• not impose unjustified exclusions from cover, or other special terms or conditions, which have the effect of preventing a policyholder from making a claim for a condition that is not related to the genetic condition identified by an approved test.\textsuperscript{76}

• meet a series of compliance standards.\textsuperscript{77}

• adhere to specific dispute and complaints resolution standards including allowing consumers to take legal action over any breaches.\textsuperscript{78}

None of these commitments have been included in the draft FSC Moratorium.

Finally, the PJC Life Insurance Inquiry Report recommended that the review to take place will take into account:

consumer impacts (for consumers generally, and for consumers who have adverse genetic test results).\textsuperscript{79}

The draft Moratorium has not included consumer impact but will take into account:

• The rates of participation in genetic research.

• Advances in the field of genomics and genetic testing.

• Any adverse impacts of The Moratorium on the sustainability of the life insurance industry.

The inclusion of adverse impacts on the life insurance industry to the exclusion of consumer impacts is brazen and nakedly self interested and again goes directly to the reason why the FSC cannot be trusted with self-regulating in this space.

Financial Rights notes that the PJC Life Insurance Inquiry Report stated that:

If life insurers fail to implement and abide by the revised Code and standards, then the committee suggests that the government implement legislation to ban the use of genetic information by life insurers, except where the consumer provides genetic information to a life insurer to demonstrate that they are not at risk of developing a disease.

Unless changes are made to address the serious flaws in the draft Moratorium as outlined above and recommended below, the life insurance must be deemed to have failed and the government should act swiftly to ban the use of genetic information by life insurers.

\textsuperscript{75} Clause 24(a)
\textsuperscript{76} Clause 24(c)
\textsuperscript{77} Clauses 27-31
\textsuperscript{78} Clause 32-34
\textsuperscript{79} Para 9.93, Parliamentary Joint Committee on Corporations and Financial Services Life Insurance Inquiry Report
Recommendations – Moratorium on Genetic Tests in Life Insurance

50. The draft Moratorium on Genetic Tests in Life Insurance must prohibit the use of the genetic test results in life insurance altogether.

51. If this is not implemented, the draft Moratorium on Genetic Tests in Life Insurance must be amended to meet the recommendations of the PJC Life Insurance Inquiry Report in the following ways:

a) The draft Moratorium should exclude the application of genetic testing to premium pricing to all conditions unless the test has been assessed by a panel of experts and approved by Government;

b) The financial limits must be increased in line with the UK to:
   i. AUD$901,050 for life insurance,
   ii. AUD$540,630 for critical illness insurance and
   iii. an annual benefits of AUD$54,063 for income protection insurance or $4500.25 per month.

c) Limit genetic test conditions to monogenic conditions, late-onset conditions; and of high penetrance;

d) Undertake specific measures to reassure customers that they are not deterred from taking a genetic test for fear of potential insurance consequences.

e) Not place the consumer under any pressure to take a genetic test.

f) Treat customers who have taken a predictive test before the date of the Moratorium the same way as customers taking tests after the introduction of the Moratorium.

g) Not require customers to:
   i. disclose genetic test result from a test taken after the insurance cover has started, for as long as the cover is in force;
   ii. disclose genetic test results of another person such as a family member or;
   iii. disclose genetic tests acquired as part of clinical research.

h) Make available information to customers, before an application for insurance cover is completed, about what customers will and will not have to disclose about their genetic tests in line with the Moratorium.

i) Maintain stringent procedures for seeking access to relevant medical information held by a doctor, other clinician as agreed between the FSC and the AMA.

j) Protect personal medical information.

k) Destroy medical evidence when it is no longer relevant to them.

l) Publish information about the way they will, or will not, use such test results to inform their underwriting decisions.

m) Not use genetic information to underwrite other non-life insurances.
n) Not impose unjustified exclusions from cover, or other special terms or conditions, which have the effect of preventing a policyholder from making a claim for a condition that is not related to the genetic condition identified by an approved test.

o) Meet a series of compliance standards similar to that in the UK Moratorium.

p) Adhere to specific dispute and complaints resolution standards including allowing consumers to take legal action over any breaches, as detailed in the UK Moratorium.

q) Take into consumer impacts (for consumers generally, and for consumers who have adverse genetic test results) in the subsequent review of the Moratorium.
5. Chapter 2 Insurance in Superannuation

We support the inclusion of the Insurance in Superannuation Voluntary Code of Practice in the Life Code to make it binding upon FSC members, with a view for the remaining industry participants to sign up and mandate compliance.

While we understand that it is not the intention of the FSC to make any changes to the Insurance in Super Code we do wish to place the FSC membership and the broader Insurance in Superannuation voluntary signatories on notice that the Code is far from sufficient to protect the interests of fund members.

This must be improved sooner rather than later. Improvements required include:

- cessation periods for accounts with low contributions must be introduced;
- premium caps in line with the draft code released for public consultation in 2017 should be committed to by superannuation trustees with a time-bound public commitment to review these caps to ensure they are set at appropriate levels for a basic default products;
- insurance terms used should be standardised including common eligibility and exemption definitions for TPD;
- claims handling commitments need to be improved including committing to acting in the interests of the individual member;
- any cover that is reduced in order to reduce premiums should still meet minimum standards, be worthwhile, suitable and appropriate;
- the definition of ‘exceptional cases’ should be rewritten to tighten up the timeframe in which a review can take place..

We note that the recent Productivity Commission Inquiry Report into Superannuation\(^\text{80}\) has similarly highlighted the insufficient nature of the current code:

\[
\text{The code is unenforceable, falls well short of what is needed, and does not reflect best practice for an industry code of conduct. Its effectiveness will depend on the extent of voluntary take up and the strength of its provisions (which are yet to include standard definitions and a short-form annual insurance statement for members). In its current state, it will only herald modest improvements in member outcomes.}^\text{81}\]

In fact, the Productivity Commission Inquiry Report into Superannuation has recommended that action be taken immediately to improve the Code:


\(^{81}\) Page 20 Productivity Commission Inquiry Report into Superannuation:
The Australian Government should immediately establish a joint regulator taskforce to advance the Insurance in Superannuation Voluntary Code of Practice and maximise the benefits of the code in improving member outcomes. The taskforce should:

- monitor and report on adoption and implementation of the code by funds
- direct and monitor enhancements to strengthen the code, particularly implementation of standard definitions and moving to a short-form annual insurance statement for members
- direct the industry to take further steps for the code to meet ASIC’s definition of an enforceable code of conduct, and to give ASIC an enforcement role under the code.

Both ASIC and APRA should be members of the taskforce, with ASIC taking the lead. The taskforce should annually report findings on industry progress on the code.

The code owners should be given two years to strengthen the code and make it binding and enforceable on signatories. At this point, adoption of the code should become a condition of holding a Registrable Superannuation Entity Licence for all superannuation funds that offer insurance.

We therefore recommend that the FSC work constructively with a joint regulator taskforce and with other Insurance in Superannuation representatives to establish an effective, enforceable and must improved Code.

Further we recommend that the FSC include a clause in Chapter 2 that will ensure that a consumer will be no worse off under the application of the insurance in superannuation commitments as expressed in Chapter 2 of this Life Code versus the voluntary Insurance in Superannuation Code.

13.9 Salary Caps for Automatic Insurance Members

Financial Rights notes that the FSC has provided 2 options to walk back the commitment under the voluntary Insurance in Superannuation Code of Practice with respect to placing a 1% salary limit for premiums on automatic insurance provided in superannuation. This is accomplished in one of two ways. Under Option 1 the following statement is added:

We will uphold this clause (section 13.9) on an "if not, why not basis" when providing insurance benefits to you.

As an aside we would suggest that this wording is not immediately clear and will be difficult for a consumer to understand.

Under Option 2 the walk back is actuated by stating in part (c) that:

the rationale for instances where we have provided cover to Automatic Insurance Members and the cost exceeds 1% of the estimated level of salary for our membership generally, and/or for segments within the membership.

Financial Rights cannot support either of these options as it will involve a significant diminution in consumer protections to ensure that unacceptable levels of account erosion are curtailed.
As we understand it, there is legal advice that may mean that for competition reasons or Trustee obligations under legislation that the Life Code cannot bind signatories to a salary cap of this sort. As we have stated above under ACCC consultation, the FSC and life insurers have had over two years to have had these discussions with the relevant government bodies and cannot use their own inaction as an excuse for inaction on this issue.

If the FSC do not act to bind their members to a salary cap, we believe they must support the Government intervening to legislate a cap.

**Recommendations – Insurance in Superannuation**

52. Life insurers must commit to work with the Insurance in Superannuation Working Group members and a proposed joint regulator taskforce to enhance commitments under the Insurance in Superannuation Voluntary Code of Practice as reflected in Chapter 2 of the Life Code. Improvements. This should include:

a) cessation periods for accounts with low contributions must be introduced;

b) premium caps in line with the draft code released for public consultation in 2017 should be committed to by superannuation trustees with a time-bound public commitment to review these caps to ensure they are set at appropriate levels for a basic default products;

c) insurance terms used should be standardised including common eligibility and exemption definitions for TPD;

d) claims handling commitments need to be improved including committing to acting in the interests of the individual member;

e) any cover that is reduced in order to reduce premiums should still meet minimum standards, be worthwhile, suitable and appropriate;

f) the definition of ‘exceptional cases’ should be rewritten to tighten up the timeframe in which a review can take place.;

g) ensuring that the Code is enforceable as a part of the contract with the consumer.

53. The Life Code should include a clause in Chapter 2 that will ensure that a consumer will be no worse off under the application of the insurance in superannuation commitments as expressed in Chapter 2 of this Life Code versus the voluntary Insurance in Superannuation Code.

54. Financial Rights cannot support either option 1 or 2 for draft clause 13.9. If the FSC does not act to bind members with respect to salary limits, the Government must intervene.
Further comments on the Life Code

Section 1: Introduction and Objectives

Draft Clause 1.3 – Use of the phrase standard versus commitment

We note that the new draft Life Code has replaced the word commitment with the word standard. This is somewhat confusing given that there are also FSC standards. This may need to be reconsidered.

Ultimately we wish to ensure that the Code commitments/standards are minimum standards from which to improve upon not aspirational targets. We have been extremely concerned with language from the FSC on this issue. We note FSC CEO Sally Loane’s evidence to the Royal Commission stated that the obligations under the Life Code were “aspirational”. When pushed on the matter Ms. Loane admitted that “It may not be the best use of the word.”

Consequently the language is used in the Life Code must be such that they are minimum standards. Any phrasing that suggests that the Life Code is an aspirational document should be removed altogether and that the commitments made are adhered to and improved upon by insurers.

Draft Clause 1.6 – Plain Language

We note that the commitment to “communicate with our customers in plain language where possible” has been removed from what was previously clause 1.4 and now draft clause 1.6. While we note that “communications remains a principle applying to our products and services” in draft Clause 1.7 (current 1.6), the removal of this aim from the objective of the Code is disappointing.

Recommendations – Section 1 - Objectives

55. The Life Code wording should be clarified to ensure that life insurers understand that the Life Code involves a commitment to minimum standards and are in no way seen to be mere aspirational targets.

56. The explicit commitment to “communicate with our customers in plain language where possible” should be restored to draft clause 1.6.

82 Ms. Loane, ROYAL COMMISSION 21.9.18 P-6454
Section 2: Scope of Chapter 1 of the Code

Draft Clause 2.12A – Examples

Financial Rights notes that throughout the new draft Life Code, examples have been included for “illustrative purposes” only as indicated by draft clause 2.12A.

Industry codes are a set of enforceable rules that set the standard for expected conduct by signatories to that code. An industry code is therefore first and foremost about self-regulating an industry’s own conduct. The use of examples may assist in the readability of the Life Code and illustrate some of the issues, but if they do not create obligations on signatories to the Life Code then they should not be included.

We believe that in spite of draft Clause 2.12A, the inclusion of examples throughout the Life Code raises a significant expectation in the minds of consumers and other stakeholders. These expectations are reasonable. If they are to be included in the Life Code then they should be commitments, and treated with the same weight as the clauses.

Financial Rights is not averse to the use of examples to assist consumers. We believe that it could be a part of a separate set of information available from the FSC as “explanation tools” sitting outside the Life Code, similar to the general information provided by the ICA through its “Understanding Insurance” website. We do not oppose the FSC producing materials targeted at consumers explaining life insurance products and processes as long as it sits outside of the Life Code and does not form part of the Life Code.

If there are parts of these examples that provide important background information or deal with industry obligations or commitments, then these should be detailed and numbered in the Life Code.

For example, Example 6 on “Helping you decide how much cover to take out” includes basic information that should be provided to consumers. It states that

A life insurance company trains its sales staff to help customers decide on the amount of cover they should take out by:

(1) Explaining the range of cover that is available.

(2) Asking the customer if they have a view about how much cover they should choose and, if so, prepare a quote for that amount.

(3) If not, asking the customer how much they could regularly afford on life insurance to protect their family, and using that amount to prepare a quote.

We believe this could easily be turned into commitments under the Life Code in order to expand upon the very general commitment at 4.3 to “have clearly documented sales rules to ensure sales staff and Authorised Representatives we employ conduct sales appropriately” and to move beyond it.

Draft Clause 2.13 – Legal rights and enforceability

Financial Rights notes that the current Clause 2.16 states:
The Code is not intended to create legal or other rights between us and any person or entity other than the FSC. (our emphasis)

The equivalent new Draft Clause 2.13 states

Chapter 1 does not create legal or other rights between us and any person or entity other than the FSC. (our emphasis)

This is a substantive difference between the two statements, the current draft indicating that the Code is not intended to create rights implying that there is a potential that they could (and we believe do) create such rights, as opposed to the new Draft Clause that is definitive in its language that the Code does not create rights. This is a backward step.

We maintain our view that the Life Code must be binding on, and enforceable against, subscribers through contractual arrangements with consumers as the Banking Code does and is recommended under ASIC RG 183.20(a), RG183.25(a) and RG 183.27. In other words, adherence to the Code must be a term of the contracts of all life insurance policies.

**Draft Clause 2.14 - External dispute resolution and enforceability**

We note that draft Clause 2.14 states that:

External dispute resolution bodies, if permitted to do so, may consider whether we have complied with the standards in Chapter 1 when determining a dispute.

Our view is that the word "may" should be replaced with "will". If the commitments made in this Life Code are worth anything to a consumer then they must be at the very least enforceable in external dispute resolution. The phrase "permitted to" also seems out of place. They are empowered to do so currently and will continue to be.

**Recommendations - Section 2: Scope of the Code**

57. Examples used throughout the draft Life Code 2 should be included as commitments under the Life Code.

58. Draft clause 2.13 should be removed and replaced with a commitment to ensure that the Life Code is binding on, and enforceable against, subscribers through contractual arrangements with consumers.

59. Draft clause 2.14 should be amended to state that external dispute resolution bodies should consider whether life insurers have complied with the standards in Chapter 1.
Section 3 Policy and Design

Draft Clause 3.1 - Information about policies

Draft clause 3.1(d) states:

3.1 When we design and introduce new Life Insurance Policies we will do the following:

d) Ensure that information about our policies is clear and informative, particularly for policies that are available for new customers to buy without a financial adviser, planner or Group Policy-owner so that they can make an informed decision about whether the policy is suitable. (our emphasis)

We note that the word “they” probably should be “you”.

We suggest that this section will need to be reviewed as soon as the Treasury Laws Amendment (Design and Distribution Obligations and Product Intervention Powers) Bill 2018 is enacted.

We would also recommend that the FSC take a similar approach that the ICA have taken under the draft new General Insurance Code by introducing a section on Design and Distributions standards that move beyond the expectations of the law, as recommended above.

Finally we note an un-highlighted change to current clause 3.1(e).

Current clause 3.1 (e) states that insurers will:

regularly review our on-sale products to ensure they remain generally suitable for the relevant customers. We will re-design our on-sale products where necessary.

The draft new Clause 3.1(e) states:

Regularly review, and re-design where necessary, our policies that are available for new customers to buy to ensure they remain suitable for the customers we designed them for.

It may be implied that the new clause limits the regular review in the following way. The current review is to on-sale products and it could (and should) be implied that those reviews be applied to customers who have already purchased an on-sale product. The new clause now can be read to limit the benefits of these reviews to new customers of those products.

We believe that the review must apply to all products and apply to current customers.

Draft Clause 3.2 - Medical definition updating

Draft clause 3.2 states:

For policies that are available for new customers to buy, at least every three years we will review, and update if necessary, any medical definitions for benefits payable after a defined medical event to ensure they remain current. We will do this in consultation with relevant medical specialists. We will tell you when we update any medical definitions in your Life Insurance Policy.

As with current clause 3.2, the draft clause 3.2 limits the updating of terms only to new policy purchases. This has been further emphasised by the use of the phrase “policies that are available for customers to buy”.

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The issue of out of date medical definitions has been a key concern of the Royal Commission during its hearings and two case studies relating to CommInsure out of date heart attack and breast cancer definitions. The Royal Commission has subsequently asked the question:

3. Should the requirements of the Life Insurance Code of Practice in relation to updating medical definitions be extended to products other than on-sale products?83

Our answer to the Royal Commission and to the FSC is an emphatic yes.

The PJC Life Insurance Industry Report also clearly recommends that:

The committee recommends that in relation to definitions in life insurance policies, the life insurance industry must:

- regularly update all definitions in policies to align with current medical knowledge and research;
- standardise definitions across all types of polices;
- use clear and simple language in definitions; and
- clearly explain which associated conditions that may arise from the initial condition, including mental ill health, are covered by the insurance policy.84

We do not believe that the FSC have come close to meeting this recommendation.

All definitions, in all life insurance policies should be aligned and updated regularly with current medical knowledge and research – those that are on-sale and those that are not. Draft Clause 3.2 only limits this to those that are on-sale.

The people who hold current life insurance policies are the most vulnerable to out-of-date policies and will not benefit from this clause.

More than that, there is a risk insurers will engage in regulatory arbitrage and simply circumvent passing on upgrades by simply discontinuing the sale of a product and switching to a new product.

Draft Clause 3.2 states that “policies that are available for customers to buy” will be reviewed and updated and insurers will tell "you" that it has been updated. Does “you” refer to applicants for the new policy available to buy or does “you” refer to the current holders of a policy. If the policy has been pulled from the market – will those policies continue to be reviewed and updated? If not, this would be patently unfair and gives insurers a huge advantage over their customers and must be addressed.

We also recommend that the Life Code commit life insurers to:

- standardising definitions across all types of polices;

84 Para 10.60 Recommendation 10.3, Parliamentary Joint Committee on Corporations and Financial Services Life Insurance Industry Report, March 2018
• use clear and simple language in definitions; and
• clearly explaining which associated conditions that may arise from the initial condition, including mental ill health, are covered by the insurance policy.

Another outstanding concern Financial Rights raised in the drafting of the first Life Code is with respect to the commitments to update medical definitions in life insurance products “in consultation with relevant medical specialists.” Financial Rights remains concerned that the FSC refer to “relevant” medical specialists” in the Life Code rather than “independent” medical specialists. Who is a “relevant” medical specialist is entirely at the discretion of insurers and the FSC. This not only fundamentally undermines the appearance of impartiality; it is an actual conflict of interest and raises questions as to the validity of every medical definition in the Life Code.

The PJC Life Insurance Industry Report also recommended that this be changed stating:

The committee also believes that the FSC and the Insurance in Superannuation Working Group should seek the views of a panel of independent medical experts— that is, medical experts independent of the life insurance industry —when reviewing the appropriateness of all definitions, noting a review may need to occur more frequently than every three years.85

We express further views on medical definitions below in reference to Draft Clause 8.20A.

**Draft Clause 3.4 – Information provided**

Draft clause 3.4 states:

When you buy a Life Insurance Policy, you will receive the following information in plain language:

(f) For benefits payable following a defined medical event, a general description of the circumstances where benefits are payable, and specifically whether benefits are payable on diagnosis of a medical condition or whether additional criteria need be met.

The current Clause 3.4 (f) however states:

...the following key information in plain language:...

(f) for key medical definitions in cover where a benefit is payable for a defined medical event, a general description of circumstances in which benefits would be paid, and specifically whether or not benefits are payable on diagnosis or require a certain degree of severity in order to be payable;

The removal of “or not” is an un-highlighted substantive change that will decrease the amount of information being provided to a policyholder – specifically information about where benefits will not be paid. This may be unintentional in that on first blush it does not appear to have much consequence. We however do believe it does involve a decrease in information being provided to policyholders.

85 Para 10.58 PJC Life Insurance Inquiry Report
Financial Rights also notes that 3.4(h) states:

*A description of how the premiums you pay might change, for example whether regular premiums are stepped or level.* (our emphasis)

The words “or a single premium” have been removed. Are single premiums not available anymore?

We also note that draft clause 3.4(i) has been changed and is now drafted as:

*The effect, if any, a claim would have on other lump sum or income benefits.*

where previously it stated:

*information about the impact a claim could have on other benefits or income if it is relevant to your policy;*

We believe that the new phrasing is more limited than the current preferable phrasing and a diminution of the commitment.

**Draft Clause 3.6A – Accident insurance**

We have put to the Royal Commission that there is already substantial evidence to support a prohibition on the sale of accidental death and accidental injury products and that their sale should be prohibited.

In the event they continue to be sold, there needs to be commitments to restrict their sale to limited target markets.

In addition, we note the continued presence of accident insurance products that exclude coverage where the deaths or disabilities are caused or contributed to by any sicknesses or any pre-existing injuries. These, in our view, are unfair terms and we would expect such terms to be captured by an unfair contract terms regime when one applying to life insurance is implemented. In the absence of such a regime, we believe it is appropriate to include a commitment under draft clause 3.6A to ensure insurers specify in any sales material that accident insurance does not cover deaths/disabilities caused or contributed to by any sicknesses or any pre-existing injuries.

**Draft Clause 3.6B – Insurance dependent on earnings**

We wish to raise three issues with the clause as currently drafted.

Firstly there needs to be a commitment from life insurers to provide information to consumers on how the benefit is calculated including how the indemnity works, how it will apply in the circumstances, whether it is averaged over 12 months if the consumer’s income varies. This should be embedded in the application/sales process and not left to a product disclosure statement.

Secondly the commitment needs to define earnings or a requirement the consumer is informed during the application as to what earnings means in plain English or a worked example. Earnings should be defined as a standard definition otherwise this is particularly unfair to small
businesses, sole traders or consumers clearly informed as to what is meant by earning. The current definitions in PDSs are not sufficient in defining earnings.

**Draft Clause 3.7 - Product Disclosure Statements**

Given the inclusion of Chapter 2’s commitments re: superannuation trustees, could the commitment here to refer the policyholder to “the relevant party for a copy and we will encourage them to make these available online” be expanded further to simply providing the Product Disclosure Statement (PDS). It is well within the power of life insurers to come to an agreement through their contracts to provide full access to PDSs for all parties they work with, employers, super funds and other groups. We believe this can be done with both signatory and/or FSC member super trustees and other non-members and non-signatories.

**Recommendations - Section 3 Policy and Design**

60. Draft clause 3.1(e) should be re-drafted to ensure that regular product reviews be applied to all customers who have already purchased an insurance product.

61. In line with PJC Life Insurance Industry Report Recommendation 10.3 draft clause 3.2 must be re-drafted to ensure that all definitions, in all life insurance policies be aligned and updated regularly with current medical knowledge and research – those that are on-sale and those that are not;

62. In line with PJC Life Insurance Industry Report Recommendation 10.3 draft clause 3.2 must be expanded to ensure:
   i. all definitions across all types of polices are standardised;
   ii. clear and simple language is used in the creation of these definitions; and
   iii. associated conditions that may arise from the initial condition, including mental ill health, and are covered by the insurance policy are clearly explained.

63. In line with The PJC Life Insurance Industry Report, draft clause 3.2 should be updated to ensure that medical definitions are updated in consultation with independent medical experts and such reviews should occur at least every three years.

64. The un-highlighted changes in draft clause 3.4(f) (h) & (i) should be rescinded and the original wording returned.

65. Draft clause 3.6A should commit insurers to restrict the sale of accident insurance to limited target markets and specify in any sales material that accident insurance does not cover deaths/disabilities caused or contributed to by any sicknesses or any pre existing injuries.

66. Draft clause 3.6B regarding insurance dependent on earnings must:
   a) expanded to include a commitment to provide information on how the benefit is calculated
   b) clarify the definition of earnings for people with small businesses and sole traders.

67. Draft clause 3.7 must be updated to commit insurers to providing the PDSs for all life insurance including group insurance.
Section 5: When You Buy Insurance

Draft Clause 5.3A – Application process questions

Draft clause 5.3A(a) states:

We will ensure that the questions we ask:

(a) are in plain language where possible, are easy to understand and are not ambiguous, noting that we expect you to have a reasonable understanding of your health, lifestyle and financial situation.

In attempting to explain draft clause 5.3A(a) the FSC has included an example that reads:

Example 10. Being clear about what needs to be disclosed

In its application form, a life insurer asks a series of questions about mental health conditions to help applicants understand what needs to be disclosed. One of these asks whether applicants have had a mental health condition that has resulted in taking any time off work or being prescribed medication for the condition.

In presenting this example, the FSC has raised the issue of mental health conditions that are situational – i.e., grief from the death of a family member, stress arising from a workplace incident, versus those that are medicalised or diagnosable or diagnosed conditions. The example is “ambiguous” to the extent conceived in the clause. If the intention is to not include these preventative mental health measures within the questions that an insurer asks, then this needs not just to be stated in the example, but it should be made clear in the Life Code as a Life Code commitment.

This ambiguity is made a little clearer in example 11, which states:

As they have had no recurrence and the normal grief cycle has passed, the life insurance company insures them at standard premium rates with no exclusion.

This example confirms the above intention but, again, the example is not a commitment, although a reader will reasonably assume that this situation could and should apply to their case.

If on the other hand, it was not the intention of the FSC to raise this issue and in fact leave this to insurers to decide whether such reasonable, preventative steps taken by people can be underwritten and can be asked about, then this need serious re-consideration. It essentially penalises those people who take reasonable steps to look after themselves in short term mental health care situations that, like a broken leg, could be fixed in the short term with no long term impact. By placing the best case scenario there for consumers to read will unreasonably raise expectations. The opposite could very well be the case in a different example 11, i.e. the insurer could very well have underwritten a scenario that includes ситуational mental health such as a grief cycle or work stress.

Either way, this example points to the need for the FSC to reconsider these examples and their use in the Life Code more generally: see the discussion above at draft clause 2.12A. The intention laying behind many the examples should be included as Life Code commitments.
In addition to the above, we note that the second clause of the sentence “noting that we expect you to have a reasonable understanding of your health, lifestyle and financial situation” is understandable from a life insurer’s perspective it reads poorly in a code of practice as placing an expectation on the consumer. We suggest that this clause is redundant and should be removed.

**Draft Clause 5.3B – Asking questions in the application process**

Financial Rights supports the inclusion of draft clause 5.3B however note that “repeating a question” to somebody who may not understand the question as foreseen under subclause (a) may not be helpful at all. We recommend that this be amended to committing to explaining the question in simple terms and plain English (where required).

This goes to another point with respect to non-English speakers. Non-English speakers are identified as vulnerable consumers under draft clause 7.1. As such the Code should commit insurers to providing interpreting services – as draft clauses 15.7-15.9 does for Superannuation Trustees. The provision of interpreting services should be referenced here in draft clause 5.3B but also under draft Clause 7.1.

For further information and recommendations on this point see below under comments made on draft clause 7.1.

**Draft Clause 5.3C – Requesting a copy of answers used to assess an application**

Draft clause 5.3C states that:

> You can ask us to send you a copy of your answers we used to assess your application for insurance.

This is not a commitment. This merely gives permission to a consumer (permission they do not need) to ask a question with no obligation on the life insurer to do anything in response to that question being asked. A Code of Practice is not a document outlining the industry’s expectations of consumers. It is a document about self-regulating an industry’s own conduct.

We recommend this clause simply commit insurers to automatically providing in every case, the answers the insurer used to assess an application.

We note that this “you can ask us” is the first of many times this phrase is used in the Code with no explicit commitment made to act on this request: see draft clauses. 5.14, 5.19, 6.8, 8.10, 8.11, 8.14A, 8.19, 8.27. 13.22, 16.26, and 26.2. They will all need to be amended to ensure that any implied action are turned into explicit commitments to act as they do in other clauses including clause 9.10.

Further we note that draft Clause 5.3A states:

> Are in plain language where possible, are easy to understand and are not ambiguous, noting that we expect you to have a reasonable understanding of your health, lifestyle and financial situation. (our emphasis)
While the second clause of the sentence is understandable from a life insurer’s perspective it reads poorly in a Code of Practice as placing an expectation on the consumer. We suggest that this clause is redundant and should be removed.

Draft Clause 5.5 – Consent

General consents: medical reports versus clinical notes

We note that the PJC recommended in its report that:

Recommendation 8.2

8.94 If the Financial Services Council and the Royal Australian College of General Practitioners have not agreed to protocols within six months, the committee recommends that at the time of application, life insurers must only ask a consumer’s General Practitioner, or other treating doctor where relevant, for a medical report specific to the consumer’s relevant medical conditions. In circumstances where such a report cannot be prepared, life insurers cannot ask for access to clinical notes regarding the consumer/policyholder. (our emphasis)

Recommendation 8.3

8.95 If the Financial Services Council and the Royal Australian College of General Practitioners have not agreed to protocols within six months, the committee recommends that at the time of a consumer/policyholder making a claim, life insurers can only ask a policyholder’s General Practitioner, or other treating doctor where relevant, for a medical report that is specifically targeted to the subject matter of the claim. In circumstances where such a report cannot be prepared, life insurers cannot ask for access to clinical notes regarding the consumer/policyholder. (our emphasis)

We note that the implementation of these recommendations is dependent on an agreement on a protocol with the Royal Australian College of General Practitioners. The issue relating to the obtaining of a medical report pertaining to the specific condition being claimed on (or applied for) is critical to ensure that general authorities are no longer used for fishing expeditions to avoid a policy.

These issues are discussed further under new draft clause 8.5A but it is necessary to ensure that the issue is clarified in the life code or in these protocols explicitly. As yet they are not and the PJC recommendations have not been addressed.

To be clear it will require either:

- the Code committing insurers to either not accepting clinical notes or returning them if sent unread and requesting a report under draft Clause 5.5

- or establish the same protocol under the consent regime with the Royal Australian College of General Practitioners.

See further discussion, below at draft clause 8.5A

Keeping you informed

Draft Clause 5.5 states, in part:
Where possible we will do this by phone or electronic means (SMS, email or similar) to ensure that you receive notifications promptly to keep you informed.

The use of the modifier “where possible” should be removed. Policyholders should be informed each and every time. We cannot conceive of a circumstance where it is not possible.

Inform in writing

Every consumer should be informed in writing of their consent being used, in order to maintain a “paper trail” with respect to the use of consents. This can be in electronic written form if requested and consented to by the consumer. Consumers should also be given a choice as to their preferred means of contact. This concept will be introduced in the next General Insurance Code and has been introduced in the Banking Code. It states at clause 18:

Anything that we are required to give to you under this Code may be given to you:

- in writing, electronically or by telephone;
- by telling you that the information is available on a website or other electronic forum;
- as otherwise agreed with you.

However, if the Code specifies the method of communication, then we will comply with that method.

Consumers should be similarly empowered under the Life Code.

We note that this issue also needs to be addressed at draft clauses 8.6B and 13.17 and should be similarly addressed.

Consistency in reference to medical practitioners/doctor

Finally we note the reference to “examiner” in this draft Clause and the multiplicity of terminology in referring to a medical practitioner across the Code including “health practitioner” “health professional” “doctor” etc.: clauses. 5.14, footnote 14, 5.20(b), 8.6(a), 8.8A, 8.9, 8.10, 8.14, 8.14A, 8.19, 8.26, 9.10(b), 9.12(b), 10.6, 22.5, 26.5(b)&(c). App1, definition of “Unexpected Circumstances” We believe that the Code would be immensely improved if there were consistency across the Code and any intentional differences in terminology are clearly defined and the need for them explained.

Draft Clause 5.6 – Independent Medical Examination

Assessment by an independent medical examiner of one’s own gender

Financial Rights supports the introduction of wording that provides consumers the ability to be examined by an independent medical examiner of their own gender. We however believe that this choice should simply be automatically provided to all consumers and not place the onus on potentially vulnerable consumers to do the asking – particularly in circumstances where they do feel it they have the power to ask.

We therefore recommend two amendments. The words “Where possible” – yet again a weasel phrase that gives life insurers an out, and the words “if you ask us” should be removed.
Reasonable and relevant

More significantly though we note that a commitment to:

    only engage an Independent Service provider where we believe this to be relevant and reasonable for the assessment of your application

in current clause 5.6 has been removed.

This is a significant removal since it places an onus on the life insurer to only undertake medical examinations where it is reasonable – thereby potentially cutting down on the number of examinations. We presume that the FSC believes that the obligation to explain why would cover this issue off however we would disagree since a life insurer could come up with any explanation – reasonable or unreasonable - and still meet this commitment. We strongly recommend that this is reinstated.

Upper limit to medical examinations

Finally, we note that Recommendation 10.10 of the PJC Life Insurance Inquiry was as follows:

    The committee recommends that after consultation with relevant stakeholders, including medical professionals that are independent of the life insurance industry and mental health advocacy groups, the Financial Services Council and the Insurance in Superannuation Working Group mandate through the Life Insurance Code of Practice and the Insurance in Superannuation Code of Practice an upper limit on the number of medical assessments that can be requested of a policyholder and the specific circumstances in which this upper limit could be deviated from.

There remains no upper limit on the number of medical examinations. We believe that there should be.

Draft Clause 5.10 – Addressing errors or omissions

As with the first draft of the Code, Financial Rights wishes to raise its objection to the use of the phrase “promptly” since it is vague, subjective and in the eye of the beholder. We believe a reasonable time frame should be committed to by insurers. This goes for all other clauses where this word is used: draft clauses. 5.5, 8.13, 9.7 as well as chapter 2 commitments 16.21, 22.13 and 26.7.

Draft Clause 5.14 – Reviewing a decision of insurance on different terms

We note that as currently drafted, draft clause 5.14(b) either does not make grammatical sense or is intentionally (and inexplicably) contingent. Either way we believe it should be amended. It currently states:

    If we offer you insurance with a higher premium, revised terms, or with an Individually Agreed Special Term or Exclusion, whether you can ask us to review the terms, and if so, under what circumstances and how to do so.

The clause should simply be re-drafted to ensure that consumers who request a review of the terms are provided with said review.
Draft Clause 5.14A –Disclosure obligations for insurance sold on different terms

We strongly support the inclusion of this clause to better inform consumers of the revised terms however we believe that this should be strengthened. Insurers should commit to highlighting these terms, explaining them and their implications in factual terms and they should be provided in writing (in the form of the consumers choosing, be it electronic or hard copy).

Draft Clause 5.19 – Electronic underwriting

We note that this clause states that the consumer “can ask” the insurer to review, without any explicit commitment to actually review the decision. While it could be implied, it is not necessarily so. We recommend that the clause be amended to state “and we will review the decision.”

Draft Clause 5.20 – Non-disclosure

This additional clause is seven paragraphs long. This needs to be broken down to discrete individual commitments for ease of reference.

With respect to the final paragraph including the list of information to be provided, we have the following comments.

First, the information described here should be provided in writing (according to the consumer preferred method of communication).

Second, life insurers should commit to providing consumers with explicit information regarding any decision or belief that the act of non-disclosure, error or omission was fraudulent. A new sub-clause (f) should state:

(f) if we believe the error or omission was fraudulent, we will tell you if this information is recorded and relevant to your duty of disclosure for other insurance products.

Recommendations - Section 5 When You Buy Insurance

68. Draft clause 5.3A(a) should:
   a) be expanded to clarify that preventative mental health measures not be included within the questions that an insurer asks as a Life Code commitment;
   b) have the words “noting that we expect you to have a reasonable understanding of your health, lifestyle and financial situation” removed.

69. Draft clause 5.3B should be amended to replace “repeating a question” to “explaining the question in simple terms and plain English (where required).

70. The FSC needs to reconsider the use of the phrase “you can ask us” in the Life Code and in most cases remove it to shift the onus back to the life insurer to act. Where it is appropriate to be used, it needs to be supported by an explicit commitment on the life insurer’s behalf to act on this request: draft clause 5.3C, 5.14, 5.19, 6.8, 8.10, 8.11, 8.14A, 8.19, 8.27, 13.22, 16.26, and 26.2
71. The Life Code must either:
   a) commit insurers to either not accepting clinical notes or returning them if sent unread and requesting a report under draft clause 5.5.
   b) establish the same protocol under the consent regime with the Royal Australian College of General Practitioners.

72. Policyholders should be informed each and every time their consent is used. The words "where possible" should be removed from draft clause 5.5.

73. Every consumer too should be informed in writing, in order to maintain a "paper trail" with respect to the use of consent, under draft clause 5.5.

74. Consumers should also be given a choice as to their preferred means of contact with respect to every communication commitment under the Life Code.

75. Various references to "health practitioner" health professional" "doctor" and "examiner" throughout the Life Code need to be standardised and made consistent: draft clauses: 5.14, footnote 14, 5.20(b), 8.6(a), 8.8A, 8.9, 8.10, 8.14, 8.14A, 8.19, 8.26, 9.10(b), 9.12(b), 10.6, 22.5, 26.5(b)&(c), App1, definition of "Unexpected Circumstances.

76. The commitment to provide consumers the ability to be examined by an independent medical examiner of their own gender under draft clause 5.6 should be bolstered to be provided automatically to not place the onus on potentially vulnerable consumers to do the asking. Further the words "where possible" and "if you ask us." Should be removed.

77. Clause 5.6 regarding only engaging an independent service provider where the insurer believes this to be relevant and reasonable should be reinstated.

78. In line with the PJC Life Insurance Industry Report recommendation 10.10, an upper limit on medical examinations is required under draft clause 5.6.

79. The use of the word "promptly" through the Life Code must be replaced by hard timelines: draft clauses 5.5, 5.10, 8.13, 9.7, 16.21, 22.13 and 26.7.

80. Draft clause 5.14(b) needs to be re-drafted to ensure that consumers who request a review of the terms are provided with said review.

81. Draft clause 5.14A needs to be strengthened to highlight different terms, explaining them and their implications in factual terms and they should be provided in writing (in the form of the consumers choosing, be it electronic or hard copy).

82. New draft clauses 5.20 and 8.8A need to be broken down into multiple clauses to aid readability.

83. Draft clause 5.20 should be amended to ensure that:
   a) the information provided should be done so in writing (according to the consumer preferred method of communication)
   b) consumers are provided with explicit information regarding any decision or belief that the act of non-disclosure, error or omission was fraudulent.
Section 6 Policy Changes and Cancellation Rights

Draft Clause 6.3 - Communication during the term of your policy

We note that general insurers have agreed to include a new obligation in the General Insurance Code to disclose last year’s premium at renewal. We recommend that life insurers commit to the same in order to provide more context to the information provided under clause 6.3(b) – an explanation for any increase in your premiums.

Draft Clause 6.5 – Life Insurance changes and financial hardship

Consideration needs to be given to including this in a Financial Hardship section including the Urgent Financial Needs section at clauses 8.27-8.30.

Draft clause 6.5 maintains an onus on the consumer to approach the insurer about financial hardship issues. We believe that the Banking Code has taken important steps to ensure the bank takes a more proactive role in identifying financial difficulties and acting to support consumers.

We believe that an onus shift is warranted in this case. Draft Clause 6.5 states:

If you tell us that you want to change the terms of your Life Insurance Policy, or that you are having trouble paying your premiums, we will tell you what options are available.

We recommend this should be changed to:

If you contact us about your premium and indicate that you are struggling to afford this, we will tell you about our options for customers in financial hardship.

We believe that other commitments made under the Banking Code could easily be made under the Life Insurance Code. These include:

- Encouraging policyholders to contact insurers if they are experiencing financial difficulty;\(^{86}\)
- Act compassionately in trying to understand their situation and discuss ways to help;\(^{87}\)
- Recommend and work with an independent financial counsellor;\(^{88}\)
- Work with consumers and give them information about financial difficulty processes.\(^{89}\)

Draft Clause 6.6 – Reasonable evidence of Financial Hardship

This clause lacks compassion and empathy. We draw your attention to the Banking Code’s equivalent clause 169:

\(^{86}\) Banking Code clause 158
\(^{87}\) Banking Code clause 161
\(^{88}\) Banking Code clause 162
\(^{89}\) Banking Code clauses 167-8
When we are deciding whether, and how, to help you with financial difficulty, we will take into account the information available to us, including information you give us about your financial situation.

We believe this could be re-drafted in a way that does not sound interrogatory.

Premium arrears

Premium arrears can occur because of serious illness or other circumstances beyond the control of the policy holder. As with Funeral Insurance, there are also even more likely to be serious bouts of illness in the final months prior to a policy holder's death.

Case study – Madelaine's story - C170389

In April 2018, Madelaine was hospitalised. For the next couple of months her partner, Mark who held her enduring power of attorney, was extremely traumatised and stressed as he was required to make a number of major decisions about Madelaine’s future. As a result, Mark failed to make the April payment on her life insurance.

In May, the insurer sent a letter to Madelaine informing her that the April payment was late. This letter outlined that if payment was not received by 18 June 2018 then insurer intended to cancel Madelaine's policy. Mark did not receive this letter as he was in and out of hospital during May while he attempted to look after Madelaine. Around 8 June 2018, Madelaine was admitted into an aged care facility arranged by Mark.

On 20 June 2018, Mark attended the insurer’s office to pay the $245 late April premium. A few days later Mark received a letter dated 19 June 2018 stating that Madelaine’s policy had been cancelled as a result of non-payment. Mark called to explain his and Madelaine's personal circumstances. The insurer let Mark know that they were willing to refund the premium but they were not willing to reinstate the original policy at the same premiums.

Insurers should be more flexible about arrangements for payment of arrears and reinstatement of policies on the original terms when there are reasonable grounds for the oversight and a plan in place to address the issue going forward.

Further, where premium arrears occur in the six months immediately prior to death, the claim should be paid and the arrears deducted from the pay out.

Draft Clause 6.6A – Cancellation Rights.

Draft clause 6.6A states:

*We will not try to coerce you into keeping a policy you no longer want.* (our emphasis)

We believe the words “try to coerce you into keeping” should be replaced with “apply undue pressure on you to keep” since coercion implies a degree of force and there are forms of undue pressure that fall short of force that are clearly inappropriate. Again the clause could be re-drafted to be more compassionate and empathetic.
In Madelaine’s case above the insurer reversed their decision when we raised a dispute and reinstated the policy on the original terms. However the family then reviewed their circumstances and, in the light of the stepped premiums on the policy, and the possibility Madelaine would outlive its termination date (albeit with dementia), they decided to cancel the policy after all and use the money they would have paid in premiums to make Madelaine’s life more comfortable while she was alive. This is very reasonable and compassionate decision and insurers should be supportive when customers choose to cancel.

**Recommendations - Section 6 Policy Changes and Cancellation Rights**

84. Life insurers should commit to disclosing previous years’ premiums at renewal under draft clause 6.3.

85. The onus under draft clause 6.5 should be shifted to the life insurer to take a more active role.

86. In line with Banking Code commitments the Life Code should, under draft clause 6.5, commit life insurers to:
   a) encourage policyholders to contact insurers if they are experiencing financial difficulty;
   b) act compassionately in trying to understand their situation and discuss ways to help;
   c) recommend and work with an independent financial counsellor;
   d) work with consumers and give you information about financial difficulty processes.

87. Draft clause 6.6 needs to be redrafted to reflect greater compassion and empathy.

88. Life insurance consumers experiencing financial hardship should be offered more flexible arrangements, including the chance to repay arrears over time to retain their cover and be eligible to claim: draft clause 3.6(h).

89. Life insurance consumers who have premium arrears in the six month prior to death should have their claims paid and the arrears deducted from the payout, regardless of whether the policy has been otherwise validly cancelled in the interim period.

90. The words the words “try to coerce you into keeping” should be replaced with “apply undue pressure on you to keep”: draft clause 6.6A

**Section 7: Supporting Vulnerable Consumers**

**Draft Clause 7.1 - Supporting vulnerable consumers**

**Vulnerability and Financial Difficulties**

This section should be linked to financial hardship or amalgamated in some way. Those experiencing financial hardship are usually consumers experiencing some form of vulnerability.
**People experiencing family violence**

We note that the only reference made to people experiencing family violence is in Clause 7.1. This needs to be re-considered.

**Why is this an important issue?** As the Economic Abuse Reference Group (EARG) states:

*Family violence can have a significant detrimental impact on a woman's financial wellbeing, both during the violent relationship, and if (and when) a woman leaves the perpetrator. Financial insecurity is one reason a woman may stay in a violent relationship. Leaving a violent relationship must sometimes be done quickly and suddenly. A woman may not be able to take much with her, or may have to move far away from her home due to safety concerns. This can leave a family violence survivor (and often her children) with few financial resources and make it difficult to find secure housing and establish a new life.*

Economic abuse as a form of family violence can exacerbate the situation faced by many women. Economic abuse can currently include, among other things:

- taking out an unwanted life insurance policy;
- disposing of a policy against the person's wishes;
- seeking out identifying and confidential information like addresses;

Financial Rights understands that the ICA is about to introduce a Guidance on Family Violence attached to the new version of the General Insurance Code.

We support this work and strongly encourage the FSC to initiate a similar process with the EARG to include commitments in the Life Code. Abusive partners should be prevented from committing financial abuse through the purchase and/or cancelation of insurance.

The Life Code could commit insurers to:

- train and assist employees to help identify, support and avoid harm to customers affected by signs of family violence, and people seeking to purchase insurance
- protect private and confidential customer information
- minimise the need for repeat disclosures of family violence by a customer
- assist claimants affected by family violence, including those suffering financial hardship
- provide options for referring customers to specialist family violence services
- provide support to Employees affected by family violence or who experience vicarious trauma after dealing with affected customers;
- have a publicly available policy that states how insurers identify and support customers affected by family violence.

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91 Recommendations 4 and 5, Page 7, GICOP Review Report
Explicit Commitment to the use of Interpreters

We note that people from non-English speaking background and Aboriginal and Torres Strait Islander people are identified as vulnerable consumers under Clause 7.1 and that where insurers identify that a person requires additional support “we will take reasonable measures to ensure that we provide it.” While this is a catch all and could conceivably include providing interpreting services, it is not an explicit commitment to providing interpreting services. It is a subjective test of reasonableness solely at the discretion of the insurer that could be interpreted in such a way that could deny a person access to an interpreter.

We note further that the inclusion of new Chapter 2 introduces a new obligation on Superannuation Trustees to support people from non-English speaking backgrounds under 15.7, 15.8 and 15.9. These state:

15.7 provide access to an interpreter at your request, or where we need an interpreter to communicate effectively with you. We may use an interpreter who is a member of our staff, or an external interpreter.

15.8 We will record your interpreting needs and plan ahead to meet these needs. Where an interpreter is offered but declined, this will also be recorded.

15.9 We will provide a direct link on our website to information on interpreting services and any other relevant information for non-English speakers, including any insurance information that we have translated into other languages.

Similar commitments are expected to be made under the General Insurance Code. The General Insurance Code Review Final Report has recommended that the General Insurance Code be amended to include:

Best Practice standards for the use of interpreters

We strongly believe that these commitments should also be included in Chapter 1 applying to all life insurers – not just Superannuation fund trustees who hold Life Insurance Policies.

Draft Clause 7.4 and 7.5 – Aboriginal and Torres Strait Islander peoples

We note that the sole commitments made to working with Aboriginal and Torres Strait Islander peoples relate to meeting identification requirements, timeframes re: documents and a general commitment to take reasonable measures to ensure support under clause 7.1.

We believe that the Life Code needs to expand Life Insurer commitments to Aboriginal and Torres Strait Islander peoples.

The key step that needs to be taken is including commitments with respect to the exploitation of Aboriginal Communities through funeral insurance and other insurance products. We have outlined recommendations on funeral insurance above.

92 Recommendation 2, Page 6, GICOP Review Report
Another important step would be to make commitments with respect to cultural awareness training. We note clause 7.2 includes a commitment to training staff to help identify and engage appropriately with consumers who are having particular difficulty with the processes involved in insurance but this does not explicitly commit to improved cultural awareness. The Banking Sector has taken this step at clause 37:

*We will provide cultural awareness training to staff who regularly assist customers in remote Indigenous communities.*

We also believe that life insurers could make commitments to make information about more appropriate insurance products available to Aboriginal and Torres Strait Islander peoples.

Financial Rights notes that life insurers have made an appropriate commitment under clause 7.5 to supporting people living in remote and regional communities with respect to providing documents or taking part in assessments. We would recommend expanding upon the scope and application of this clause to all people experiencing a form of vulnerability as conceived under clause 7.1, and in particular Aboriginal and Torres Strait Islander whose cultural practices (such as sorry business) may impact upon their ability to meeting the timeframes referred to in this clause.

**Recommendations - Section 7 Supporting Vulnerable Consumers**

91. Section 7 regarding supporting vulnerable consumers should be linked to or amalgamated with the section on financial hardship.

92. The FSC should consult with the EARG to introduce a Guidance on Family Violence and reflect this as commitments in the Life Code. The Life Code could commit insurers to:
   a) train and assist employees to help identify, support and avoid harm to customers affected by signs of family violence, and people seeking to purchase insurance
   b) protect private and confidential customer information
   c) minimise the need for repeat disclosures of family violence by a customer
   d) assist claimants affected by family violence, including those suffering financial hardship
   e) provide options for referring customers to specialist family violence services
   f) provide support to employees affected by family violence or who experience vicarious trauma after dealing with affected customers;
   g) have a publicly available policy that states how insurers identify and support customers affected by family violence.

93. The Life Code must explicitly commit insurers to providing interpreting services – as draft clauses 15.7-15.9 do for Superannuation Trustees.

94. The Life Code must expand life insurer commitments to Aboriginal and Torres Strait Islander peoples by including commitments:
   a) with respect to the sale of funeral insurance and other insurance products to Aboriginal and Torres Strait Islander communities;
b) with respect to Aboriginal and Torres Strait Islander cultural awareness training;

c) to make information about more appropriate insurance products available to Aboriginal and Torres Strait Islander peoples.

95. The scope and application of clause 7.5 should be expanded to all people experiencing a form of vulnerability as conceived under clause 7.1, and in particular Aboriginal and Torres Strait Islander whose cultural practices (such as sorry business) may impact upon their ability to meeting timeframes.

96. Engaging with people who may be experiencing financial hardship should be included in draft clause 7.2 and draft clause 7.1.

Section 8: When You Make a Claim

Draft Clause 8.2 – Not discouraging claims

Financial Rights supports draft clause 8.2. Insurers could however go further.

Insurers should:

• commit to not stating to consumers that there is no difference if a claim is made or not, because there invariably is a difference;

• track information to ensure consumers are not being deterred from making a claim, and;

• investigate what might deter a consumer from making a claim to improve accessibility.

Further the Life Code should require that when a claim is withdrawn or “closed”, insurers should endeavour to record the reasons for this (if known) and ensure the customer is aware that they can make a complaint if they wish. This should be done so in a consistent manner, and should make this information available to the LCCC as a part of their ongoing monitoring.

Draft Clauses 8.2-8.4 – Explaining the claims process

There is currently no commitment by life insurers to explain the claims process in plain language to a policyholder. The vagaries and unclear nature of the claims process is a common complaint we hear and taking steps to assist consumers through this process will go a long way.

We note that the General Insurance Code Review Report has recommended that general insurers commit to the following:

When a claim is made, require insurers to provide the claimant with an overview of the claim process ... They will also provide the claimant with contact details to get information about their claim. 93

93 Recommendation 22, page 10, GICOP Review Report
We believe that the Life Code could easily commit life insurers to do the same. The commitment should also include providing information about time frames and the information insurers are likely to require.

**Draft Clause 8.4 – Assessing a claim**

The current clause 8.4 refers to

> Prior to making a decision on your claim, we will keep you informed about the progress of your claim...

This has been changed to:

> until we make our initial assessment about your claim

However, “initial assessment” is not defined.

We further note that there are a variety of phrases in addition to “initial assessment” used throughout the draft Life Code including: “decision”, “final decision,” “assessment.” This is confusing. These terms should be consolidated for consistency with definitions provided for clarity.

Critically, the timeframes under the Life Code do not commence until a claim is “received”. We note the definition is not consistent with the APRA definition.94 We also note it would be difficult for a consumer to understand what “sufficient information” is, as opposed to “the first piece of information (not necessarily all information)” used by APRA. The use of “sufficient information” allows an insurer to extend the timeframes in the Life Code in relation to decision making. It will also not prevent the drip feed of information insurers elicit from consumers to make up “sufficient information”. Delays in insurer decision making has been long identified as one of the core problems in claims handling practices by life insurers. We oppose any watering down of the claims timeframes in this regard.

**Draft Clause 8.5 – What we need to assess your claim**

Draft clause 8.5 states:

> We will get your consent for us to collect the information about you (for example, about your finances, your job or your health) on each occasion that you make a new claim and, if you ask us, explain why we need it. If you disagree about whether we need any particular information, we will review our request. If you are not satisfied with the outcome of our review, we will explain the implications and tell you how you can make a Complaint. (our emphasis)

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“Claim Received” refers to the point in time where the first piece of information (not necessarily all information) is received by the insurer to allow it to commence the assessment of a claim. At this stage, the insurer has confirmed there is a policy in force that could potentially cover the indicated Claim Event and has recorded the existence of a claim. The ‘Claim Received Date’ is the date on which the insurer records a claim being received.
We do not believe that the onus should be on the consumer to have to ask the insurer for an explanation on why they need to collect information – this should be provided automatically. This should not be a stretch for insurers.

We also believe that the phrase “collection the information about you” is clunky? What is “the information” in this context? This phrasing needs to be reconsidered.

**Draft Clause 8.5A – Investigating your history**

Draft clause 8.5A states:

*We will respect your privacy by only asking for information we need to assess the eligibility of your claim. We can fully investigate the history of any condition you are claiming for when we assess your claim. We will only seek to assess the accuracy of the information you gave us about conditions that are not related to your claim when you applied for the cover if we have reasonable grounds for doing so. If you ask us, we will explain to you what those reasonable grounds are. If you disagree that the grounds are reasonable, we will review them. If you are not satisfied with the outcome of our review, we will explain the implications and tell you how you can make a Complaint.* *(our emphasis)*

Again the onus should not be on the consumer to have to ask for what the reasonable grounds are. These should be provided automatically.

The presumed intent of the inclusion of this clause and the re-wording of draft clause 8.6 is to restrict the use of general authorities. Current wording of clause 8.6 states:

*We will only use a general authority to obtain information that we reasonably believe is relevant to your claim.*

Relevance however is however not a factor referenced in the new clause 8.5A and draft clause 8.6. Presumably the argument would be that “relevance” is captured by the phrase “if we have reasonable grounds to do so.” We, however, do not necessarily believe this to be the case. The information needs to be based upon relevance, not upon a life insurer’s own subjective view as to what is reasonable. We believe that relevance needs to be returned. For example the clause should commit insurers to get your consent to connection information about you that is relevant to your claim.

Moreover the issue of what “reasonable grounds” is raises a complex set of issues.

It is not altogether clear what reasonable grounds could be and when they can be relied upon. If someone is claiming on, say breast cancer, anything to do with breast cancer would be fair game. But anything to do with a back complaint or a serious mental health condition would not be within bounds. It is hard to see in what scenario there would be reasonable grounds to search for information about these latter conditions. If this is indeed limiting, then this is a positive step as it will prevent fishing expeditions.

There is at least one scenario that we can conceive that could lead to reasonable grounds arising or otherwise. For example, a doctor could provide a report on the breast cancer or, possibly counter to the intention of draft clause 5.5, the full clinical notes. If they do send through the notes, the insurer may have inadvertently seen information that they were not fishing for but are not connected the condition being claimed on. Would this inadvertent...
discovery be reasonable grounds? If it were to be considered as such this could lead to an additional premium being added on or in some other cases the policy being avoided altogether. There are then other complicating factors of the 3 year time frame and whether it was fraudulent non-disclosure. Either way the ability for the insurer to make these decisions rests on the reasonable grounds test.

To clarify this it may be necessary to ensure that either:

- the Code commits insurers to either not accepting clinical notes or returning them if sent unread and requesting a report under draft Clause 5.5
- or establish the same protocol under the consent regime with the Royal Australian College of General Practitioners.

**Draft Clause 8.6 - Asking for information from other sources**

The use of the words “the information” is presumably referring to the information sought in draft Clause 8.5A, however it is confusing due to its lack of specificity.

Insurers should commit to providing:

- a list of every piece of information sought,
- an explanation of why that information is sort and how it is relevant
- who other information is sought from and
- an explanation why this third party information is being sought and how it is relevant.

**Draft Clause 8.6B – Multiple Information Requests**

As addressed at Draft Clause 5.5, contact with a consumer should also be done in writing (to provide a trail) and in their preferred mode or medium.

**Draft Clause 8.7 – Asking for information as soon as possible**

Similar to the wording in the current Clause 8.7 (“as early as possible"), the words “as soon as possible” are vague and subjective and require a hard timeframe.

**Draft Clause 8.8A – Non-disclosure**

Similar to the new draft clause 5.20, draft clause 8.8A is too long and needs to be broken down into sub-clauses and distinct commitments.

In part the draft clause reads:

- *we may ask for further information:*
  - a) *From you.*
  - b) *With your consent, from other parties such as your doctor, accountant or financial adviser.*
In line with the commitments to provide explanations at draft Clauses 8.5-8.6, we believe that the clause should cross reference to the requirements to provide explanations for the information requests and that they explicitly state that they will provide:

- a list of every piece of information sought,
- an explanation of why that information is sought and how it is relevant
- who other information is sought from and
- an explanation why this third party information is being sought and how it is relevant.

We also believe that the draft clause needs to be redrafted to be more clearly in line with the restrictions of section 29(3) of the *Insurance Contracts Act 1984*. We do not think it satisfactorily does. It is confusing and potentially misleading. It needs to be made clear, for example, that avoidance of the insurance can only take place within three years and only if the consumer acted fraudulently. We note the use of the footnote but this is not clear in the drafting of the main content.

**Draft Clause 8.9 – Income-related claims**

Financial Rights notes two sub-clauses have been removed from the current draft clause 8.9. These are:

- e) if you disagree with the relevance of any requested information, we will review this; and
- f) if your payment is going to be delayed, we will notify you prior to this and let you know the reasons for the delay.

We note that (e) may now be covered by the new draft clauses 8.5 and 8.5A, however we think for clarity there needs to be cross reference here or simply re-instate the sub-clause.

We cannot see why (f) has been removed, and cannot see where this has been replaced in the Code. It should be re-instated.

**Draft Clause 8.10 – Independent medical examination**

As discussed above, draft Clause 8.10 includes the phrase “you can ask us” to, in this case, give the consumer a list of doctors, however there is no actual commitment to doing this. This needs to be reworded appropriately. We do not agree that insurers should be able to only give people a list of at least one doctor of each gender where this is practical. This could lead to significant issues for some cultural groups and remains a significant “get out of gaol card free” for insurers. We believe this should not be a difficult commitment to make.

**Draft Clause 8.11 – Interviews**

There are no commitments to inform a consumer in the first place that their claim is being investigated and that an interview will take place. We note that the way 8.11 is worded in such a way that could be interpreted to mean that interviewers could tell the interviewee who they are during the actual interview rather than before the interview. This needs to be clarified.
The ICA will introduce a new General Insurance Code commitment related to this point. They propose to include the following commitments:

Where we require formal interviews to be carried out as part of a claim: a) you will be advised before the interview of the following information:

i) the purpose of the interview;

ii) who will conduct the interview;

...

We believe the new General Insurance Code delineates the commitments more clearly.

**Draft Clause 8.11(b) – Information provided by an interviewer**

Current and draft clause 8.11(b) states in part:

your right to have a Representative or other support person present,

The new draft General Insurance Code clause regarding interviews and support people states that the insurer will provide the consumer with information regarding:

your right to have a legal representative or a support person, who may be a family member, friend or other person, to support you through the interview, including information on their role, such as they may not answer questions on your behalf;

These details explaining that a support person may be a family member, and providing information on their roles, are preferable and should be included in the Life Code either here at clause 8.11(b) or (h).

Further insurers and interviewers should provide:

our contact details if you would like to contact us with any questions about the interview or the interviewer

as per clause 2(a)(v) of the Draft Standards on the Use of Investigators under the proposed General Insurance Code.

**Draft Clause 8.11(j) – Interviewing vulnerable persons**

The Life Code limits under clause 8.11(j) the range of vulnerabilities that will lead to using specialist interviewers to three categories:

- claims involving a mental health condition,
- the consumer has limited English, or
- the consumer has known cognitive decline or impairment.

By contrast clause 2(d) of the Draft Standards on the Use of Investigators under the proposed General Insurance Code expands this to all those people who are experiencing a vulnerability:

where we are aware or you tell us that you require additional support as you may be experiencing vulnerability, we will only use an interviewer who we are satisfied has appropriate training or experience to conduct the interview;
The same should be committed under the Life Code.

**Draft Clause 8.11(k) – Interview breaks**

We believe that rather than an offer of a 5 minute break, a 5 minute break should be automatic and mandatory.

**Draft Clause 8.11(n) – Recording of Interviews**

Draft clause 8.11 (n) states:

> If the interview is to be recorded, you will be told before the interview starts.

By contrast clause 2(g) of the Draft Standards on the Use of Investigators under the proposed General Insurance Code expands this to state:

> if the interview is not digitally recorded, you will be asked to complete an interview consent form that contains the information contained in the Guide. In circumstances where the interview is digitally recorded, the interviewer will ask you a series of questions covering the information contained in the Guide as part of the interview, for the purpose of confirming your consent;

The same elements in this clause should be included in the Life Code.

**Draft Clause 8.11(o) – Interview transcripts**

Draft clause 8.11(o) states:

> We will give you a transcript of the interview and, if the interview was recorded, you can ask us for a copy of the recording.

Again, as identified above, the clause allows somebody to ask for a copy, with no obligation on the insurer to actual provide the copy. This needs to be re-drafted to make an actual commitment.

**Draft Clause 8.11 – Other missing commitments from interview**

Clause 2(h)) of the Draft Standards on the Use of Investigators under the proposed General Insurance Code makes commitments related to the interviewing of minors:

> if we intend for a minor to be interviewed, or our investigators inform us that they wish to interview a minor, we will:

i) assess whether the interview is necessary and whether the interviewee is capable of distinguishing truth from fiction;

ii) only use an interviewer who we are satisfied has appropriate training or experience to conduct the interview;

iii) ensure that any interview takes place only in the presence of a responsible adult; and

iv) ensure that the interview is suspended if at any time the minor is distressed by the interview process or at the request of the responsible adult;
If Life Insurers never intend to interview minors, then this should be an explicit commitment. Otherwise, we believe the above clause should be replicated under the Life Code.

We further note that the ICA is proposing to commit all general insurers to a standard interview consent form as following

GUIDE

Interview consent form

Interviewer’s name and contact details:
Insurer’s details:
Interviewee’s name and contact details:
Date:
Subject matter of interview:

“I agree to be interviewed by the representative of [insurer] in relation to the above matter. Following discussion with the interviewer regarding the interview options available to me, I agree to participate in: (Please select)

Digital audio interview
Digital videotaped interview
Provision of a typed statement
Provision of a Q&A
Provision of a handwritten statement
Other”

Privacy statement, acknowledgement and consent:
Authority to access information from third parties:
Scope of authority
Type of information to be requested
Period of information requested
Impact on the claim if the information is not provided
Date of issue and expiry of authority
Signature:

A similar a consent form should be committed to by life insurers.

We also wish to direct Life Insurers to the CGC’s 2017 Own Motion Inquiry on the use of investigators and outsourced providers. While this is obviously directed at general insurance investigations, we believe there are a number of recommendations that should also be committed to under the Life Code. These include:

Recommendation 3 – External Investigators to obtain authority before alleging fraud
Code Subscribers should require external Investigators to obtain their express and written authority before putting a fraud allegation to a claimant. This requirement should be included in Code Subscribers’ contracts with external Investigators and in their written instructions to external Investigators.

Recommendation 15 – Monitoring interview duration

Code Subscribers should include in quality assurance programs measures to monitor interview duration and compliance with the Code through:

- regular reviews of current and closed claim files, including denied claims
- for Employees who conduct telephone interviews – call audit reviews and review interview transcripts or recordings
- audit external Investigator running sheets, interview transcripts or recordings to check the duration of interviews
- review of complaints about interviews, including disputes referred to FOS.

Draft Clause 8.12(c) – Surveillance locations

We recommend that life insurers take the step to prohibit surveillance of people on business premises as was committed to under the Victorian WorkCover Code of Practice for Private Investigators 2014:

surveillance will not be conducted on business premises unless a reasonable person would believe that those business premises were open for persons to enter without necessarily expecting them to enter into any form of transaction;

Draft Clause 8.13 – Errors in claims Information

Draft clause 8.13 states

If we become aware of any errors in the information we have about your claim, we will address these promptly. We may need additional information to correct the error.

Life insurers need to commit to letting the consumer know what the error is that has been identified, what additional information is required and why it is required.

Draft Clause 8.14-8.19 – Decisions on pre-existing claims

There are no explicit commitments relating to the treatment of pre-existing conditions in a claims decision. We note that the PJC Life Insurance Inquiry recommended that:

the Financial Services Council’s Life Insurance Code of Practice include explicit commitments that:

- where a pre-existing condition is to be used by an insurer as the basis for denying a claim or avoiding a contract a direct medical connection between the prognosis of a pre-existing diagnosed condition and the claim must be established; and
• the statistical and actuarial evidence and any other material used to establish a pre-existing condition, as well as a written summary of the evidence in simple and plain language, be provided by the life insurer to the consumer/policyholder on request.  

While the reasons for the decision provided pursuant to draft clause 8.19 could conceivably include some of the information referred to here, the recommendation was for explicit reference in the Life Code. We agree that this should be spelt out clearly as a discrete commitment under the Code.

_Draft Clause 8.14A – Closing claims_

Draft clause 8.14A states:

> If we close your claim because information we need, such as from you or your doctor, remains outstanding, you can ask us to reopen the assessment of your claim at any time. Any applicable timeframes in Chapter 1 will restart from when we reopen your claim.

We note that the FSC has not made any commitments with respect to the circumstances of closing a claim. How will a consumer be notified that their claim is closed? By mail, phone, by communication medium of their choosing? How long after seeking the information foreseen in draft clause 8.14 will an insurer decide to close a claim? A week, a month, a year? This is unclear. What information will be provided at notification? Will information on how to complain be provided? ...how to have it reviewed? ...how to seek an extension of time?

The fact that the timeframes start all over again seems punitive for what may not in fact be the consumer’s fault.

_Draft Clause 8.16 – Income related claims timeframes_

As we raised above the definition of the words initial assessment and received, by not aligning the definition with that of APRA’s, provides insurers with the ability to delay decision-making process depending on their own subjective interpretation of the phrase “sufficient information”.

What is particularly confusing in the context of draft clause 8.16 is the ability to extend even further the timeframes based on unexpected circumstances which could include not having received all the required information. This is a step backwards.

Further it is not clear what the term “procedural fairness process” is in the context of footnote 29 in its attempt to define “initial assessment.”

Finally we do not believe that the following sentence is not clear at all:

> Where Unexpected Circumstances apply, we will make our decision within 12 months of your claim being received or, if later, within 2 months of the end the waiting period.

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95 Para 10.82, Recommendation 10.6, Parliamentary Joint Committee on Corporations and Financial Services Life Insurance Inquiry Report
This requires re-drafting.

**Draft Clause 8.18 – Lump sum payments**

We note that the floor of $50,000 has been imposed on the current commitment to lump sum payments. We do not understand the reasoning behind this decision, nor has it been explained. We do not support this as lower amounts can still be significant for people experiencing financial hardship. This is a step backward and should be removed.

**Draft Clause 8.18 – Declining your claim**

We again note that the “you can ask us” phrase rears its ugly head in draft Clause 8.19(c) without any commitment to do anything. This needs to be re-drafted.

**Draft Clause 8.20A – Medical Definitions**

We do not understand the intention of introducing the word “Foundation” into this section – and the medical definitions. Nor has it been explained anywhere.

The minimum standard medical definitions in the Life Code only apply to the first $2 million of trauma/critical illness cover issued after 1 July 2017. Those people who have held and paid for life insurance policies for years are those most likely to have definitions that have not kept up with science. Many vulnerable Australians are therefore left to the hapless winds of luck. A mechanism to facilitate the rationalisation of legacy products in the life insurance sector is required.

The existing definitions in the Life Code are also limited in number and do not cover many common illnesses. The PJC Life Insurance inquiry report stated that:

> the committee is firmly of the view that all definitions should be up-to-date and standardised across all types of life insurance policies. (our emphasis)

The FSC have taken no steps to address this recommendation.

The definitions are ambiguous and unclear. The definition of “Cancer – excluding early stage cancers”, for example, does not define “early”. The stage of cancer may also not necessarily be correlated with the severity of the cancer. Many cancers are aggressive and even if discovered early can kill quickly. This is particularly significant given the intention to differentiate between a clinical definition and an insurance definition which “takes into account severity of the condition.”

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96 Clause 8.20A


98 The Life Code defines three medical events: cancer (excluding early stage cancers); severe heart attack (measured by specific tests) and stroke (resulting in permanent impairment).

99 Parag10.57 Parliamentary Joint Committee on Corporations and Financial Services Life Insurance Inquiry Report
How the definitions were developed whether in-house at the Financial Services Council (FSC) without reference to independent medical experts or with reference to medical experts is not transparent. We are not medical experts, just as most consumers are not. Similarly, reviews of medical definitions as stipulated by the Life Code, do not have to be conducted by independent medical specialists. Without the reassurance that the definitions have been drafted, finalised and reviewed transparently by independent medical experts neither we nor consumers can have any confidence or trust in the definitions laid out in the Life Code.

Draft Clause 8.21A – Income related payments

Never-ending income-related payment delays

Draft clause 8.21A states:

a) We will pay you by the due date or, if later, within 5 business days of receiving all the information we reasonably need and have completed all reasonable enquiries for the corresponding period.

The wording of this clause is incredibly slippery and will allow insurers to actually delay payment for any amount of time it likes. Completing “all reasonable inquiries” could take as long as a piece of string and is totally up to the insurer how they go about this process. The draft clause does not commit to a time frame in which to complete these “reasonable enquiries” or an appropriate process in which to conduct such enquiries to ensure that it is done so in a prompt and efficient manner. The insurer could decide to take a month between unanswered enquiries and still fall within the circumstances enunciated in this clause to allow for a delay of payment.

The number one issue raised by consumers who contact us is frustration from delays. Consumers demand speedier claims processing and life insurers are notoriously not meeting this community expectation. It is time life insurers make time line solid commitments.

A time limit of two weeks on all reasonable enquiries is reasonable from our perspective. If reasonable enquiries cannot be completed in this time, the insurer should make a payment to meet its good faith duties.

Reliance on mere suspicion to delay payments

Subclause (b) states:

b) We will not stop or withhold your benefit payments during a non-disclosure or misrepresentation investigation (in accordance with section 8.8A) unless we reasonably believe that we have evidence that will lead to your claim being declined, or your Life Insurance Policy being cancelled or avoided.

Financial Rights objected to the wording used in this clause during the drafting of the first iteration of the Life Code and continue to object to it. If an insurer reasonably believes that they have evidence that will lead to the claim being denied - put that evidence forward. If there is a genuine issue that requires this to be considered, a further sub-time limit should be set of two weeks. Suspicions cannot be used to arbitrarily lengthen a claim or permanently delay a claim. If there is a genuine suspicion, “put up or shut up” within a set amount of time. Otherwise this exception is open to abuse.

**Payment delay explanations**

Subclause (c) states:

*If your benefit payment will be delayed, we will tell you in advance and explain why.*

More than just explanation, consumers want and deserve a solid time line to which the insurer will work towards and meet. Consumers in this situation are incredibly vulnerable and the delays with no end in sight simply add to the stress of the situation and frustrate people to no end. This commitment needs to be expanded to ensure that insurers provide a specific solid timeline that they will meet. If the timeline is not met the consumer must be given the opportunity to complain in IDR and EDR.

**Draft Clause 8.22 – Income related payments notice period**

We note the addition to draft clause 8.22 which states:

*We will try to assess your continuing eligibility before the change takes effect so that your benefit payments are not interrupted if you continue to be eligible (our emphasis)*

Committing to “try to” assessment is really no commitment at all. They are prima facie weasel words that will allow an insurer not to meet a commitment if they have not actually assessed. Any effort however minimal is trying to do something.

**Draft Clause 8.26 – Helping you on the road to recovery**

We note that a substantive change has been made to clause 8.26.

Current Clause 8.26 states:

*For income-related claims we will:*

Draft clause 8.26 states:

*For income-related claims we consider relevant we will aim to:*

The FSC has introduced the words “we consider relevant” allowing life insurers themselves to pick and choose which income-related claims they will “aim to” help (if any at all), as opposed to doing this for all income-related claims as the current clause commits insurers to.

This is a major step backwards, places all the power with the insurer to decide whether to meet this clause and also weasels out of whether the insurer will actually do something when they choose to do something by inserting the words “aim to”. This again is the sort of weasel words that end up in terms and conditions that we deem unfair contract terms, and this approach is
being taken to the re-draft of this Code. What is all the more galling is that such a change has not been highlighted and needed to be found.

We strongly recommend that the FSC restore the original wording to this clause.

In addition we recommend that life insurers should proactively alert their policyholder to any benefits the policyholder is entitled to under the policy for rehabilitation purposes and assist them in their claim. This is a simple, proactive measure that will go a long way to helping policyholders on the road to recovery. It would also be in line with the principle set by new Draft Clause 8.2A. An additional Clause needs to be inserted at (e) to implement this.

Draft Clause 8.27 – Urgent Financial Need

Again the words “you can ask us” have been included with no corresponding commitment to actually doing anything in the clause. The subsequent clause implies that something may happen but we believe the Life Code should state that we will consider the policyholder’s request with empathy, compassion and in good faith.

Training

Financial Rights notes that the ICA has recommended in their recent review of the General Insurance Code that they will:

Require insurers to have internal policies and train relevant employees to help with the identification of consumers who may be experiencing financial hardship.\textsuperscript{101}

There is currently no equivalent commitment in the Life Code. We do note that draft clause 7.2 does commit insurers to train staff to:

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

However we do not believe this is the same thing. At a minimum engaging with people who may be experiencing financial hardship should be include in Draft Clause 7.2 and Draft Clause 7.1.

Nominated representatives

Financial Rights notes that the ICA has recommended in their recent review that they will commit to the following:

Where an insurer is aware that a customer who has applied for Financial Hardship assistance has a nominated representative, an obligation for the insurer to ask if they want their representative to be kept updated.\textsuperscript{102}

\textsuperscript{101} Recommendation 3, Page 6 GICOP Code Review Report
\textsuperscript{102} Recommendation 3, Page 7, GICOP Review Report
We note that the Life Code does not have an equivalent commitment. The Life Code does include a commitment to work with representatives during an investigation under draft clause 8.11. We believe the same should be applied to financial hardship applications.

**Draft Clause 8.28 – Evidence of Financial Need**

We believe that draft clause 8.28 should be extended to commit insurers to making requests as early as possible. Repeat requests after long periods is a common complaint we hear on the Insurance Law Service, an issue that has already been acknowledged under the Life Code with respect to claims handling; see draft clauses 8.6B and 8.7.

Financial Rights notes that the ICA has recommended in their recent Review that they will commit to the following:

> An obligation for insurers to make requests for further information, when assessing Financial Hardship, as early as possible so that the request does not unreasonably or unnecessarily delay the application.\(^{103}\)

The same should be committed under the Life Code.

**Draft Clause 8.30 – Confirming urgent financial need arrangements**

We note that the current Clause 8.29 states:

> If you reasonably demonstrate to us that you are in urgent financial need, we will:
> a) prioritise the assessment and decision in relation to your claim; and/or
> b) make an advance payment to assist in alleviating your immediate hardship.

while the new equivalent draft clause 8.30 states:

> If we accept your request, we will confirm the arrangement in writing. The help we offer might be to:
> a) Prioritise our assessment of your claim and reaching our decision.
> b) Advance part of your claim payment to help alleviate your immediate hardship. (our emphasis)

This redrafting – that has not been highlighted – is a substantive change and a step backwards. The current clause is a definitive commitment to undertake a series of acts. The new draft clause is contingent on the life insurer deciding to act in a particular way as described in a non-exhaustive list. In fact, the insurer could act in none of the ways listed and may come up with some other way that does not actually assist someone experiencing financial hardship.

We strongly recommend that this commitment be returned to its original drafting.

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\(^{103}\) Recommendation 3, Page 7, GICOP Review Report
Recommendations - Section 8 When you make a claim

97. Draft clause 8.2 should be expanded to commit life insurers to:
   a) not state that there is no difference if a claim is made or not
   b) track information to ensure consumers are not being deterred from making a claim.
   c) investigate what might deter a consumer from making a claim to improve accessibility.

98. The Life Code should commit life insurers to:
   a) record the reasons for a withdrawal or ‘closure’ (if known);
   b) do so in a consistent manner;
   c) ensure the customer is aware that they can make a complaint if they wish; and
   d) make this information available to the LCCC as a part of their ongoing monitoring.

99. The Life Code should commit life insurers to explain the claims process in plain language to a policyholder and provide the claimant with contact details to get information about their claim.

100. The terms “initial assessment,” “decision,” “final decision,” “assessment” used throughout the draft Life Code should be consolidated for consistency and definitions provided.

101. The definition of “claims received” should be amended to align with APRA Reporting Standard LRS 750 Claims and Disputes.

102. The reasons why a life insurer needs to collect information should be provided automatically under draft clause 8.5.

103. The concept of relevance needs to be returned to draft clauses 8.5A and 8.6 following their removal.

104. The Life Code should commit life insurers to provide under draft clause 8.5, 8.6 and 8.8A:
   a) a list of every piece of information sought,
   b) an explanation of why that information is sought and how it is relevant
   c) who other information is sought from and
   d) an explanation why this third-party information is being sought and how it is relevant.

105. The words “as soon as possible” should be replaced with a hard time frame under draft clause 8.7.

106. Draft clause 8.8A needs to be clarified to ensure avoidance of insurance can only take place within three years and only if the consumer acted fraudulently, in line with section 29(3) of the Insurance Contracts Act 1984.

107. Life insurers should commit to informing a consumer in the first place that their claim is being investigated and that an interview will take place under draft clause 8.11.

108. Draft clause 8.11(b) should be reworded to:
   a) explain that a support person may be a family member, and
   b) provide information on their roles.

109. Consumers who will be interviewed should be provided with contact details of the insurer and the interviewer.
110. Specialist interviewers should be used in all cases where an interview subject is known to be experiencing a vulnerability, not just those listed at draft clause 8.11(j).

111. A 5 minute break should be automatic and mandatory under draft clause 8.11(k).

112. Consent should be sought when an interview is to be digitally recorded under draft clause 8.11(n).

113. A standard interview consent form should be developed and introduced under the Life Code.

114. A copy of the interview recording should be provided automatically under draft clause 8.11(o).

115. If Life Insurers never intend to interview minors, then this should be an explicit commitment. Otherwise, the Life Code should include specific commitments to interviewing minors based on Clause 2(h) of the Draft Standards on the Use of Investigators under the proposed General Insurance Code.

116. Life insurers should require external investigators to obtain their express and written authority before putting a fraud allegation to a claimant. This requirement should be included in contracts with external investigators and in their written instructions to external investigators.

117. Life insurers should include in their quality assurance programs measures to monitor interview duration and compliance with the Life Code through:
   a) regular reviews of current and closed claim files, including denied claims
   b) for employees who conduct telephone interviews – call audit reviews and review interview transcripts or recordings
   c) audit external Investigator running sheets, interview transcripts or recordings to check the duration of interviews
   d) review of complaints about interviews, including disputes referred to AFCA.

118. Surveillance of people on business premises should be prohibited under the Life Code.

119. Life insurers need to commit to letting the consumer know what claims information error has been identified, what additional information is required and why it is required under draft clause 8.13.

120. In line with recommendation 10.6 of the PJC Inquiry into the Life Insurance Industry, draft clauses 8.14-19 should include explicit commitments that:
   a) where a pre-existing condition is to be used by an insurer as the basis for denying a claim or avoiding a contract a direct medical connection between the prognosis of a pre-existing diagnosed condition and the claim must be established; and
   b) the statistical and actuarial evidence and any other material used to establish a pre-existing condition, as well as a written summary of the evidence in simple and plain language, be provided by the life insurer to the consumer/policyholder on request.

121. Commitments need to be made with respect to notifying the circumstances of closing a claim, how long it will take to close a claim and what information will be provided, under draft clause 8.14A.

122. Draft clause 8.16 needs to be redrafted for sense and clarity.

123. The inclusion of a $50,000 limit on meeting the current commitments with respect to lump sum payments under draft clause 8.18 should be removed.
124. In line with the PJC Inquiry into the Life Insurance Industry, all definitions should be up-to-date and standardised across all types of life insurance policies.

125. A time limit of two weeks on all reasonable enquiries under draft clause 8.21A. If reasonable enquiries cannot be completed in this time, the insurer should make a payment to meet its good faith duties.

126. The words “reasonably believe that we” should be removed from draft clause 8.21A(b).

127. Draft clause 8.21A(c) should be expanded to ensure that insurers provide a specific solid timeline that they will meet.

128. The words “try to” should be removed from draft clause 8.22.

129. The FSC must restore the original wording of clause 8.26.

130. Draft clause 8.26 should also be expanded to commit life insurers to proactively alert policyholders to any benefits the policyholder is entitled to under the policy for rehabilitation purposes and assist them in their claim.

131. Where a life insurer is aware that a customer who has applied for Financial Hardship assistance has a nominated representative, they should commit to asking if they want their representative to be kept updated.

132. Draft clause 8.28 should be extended to commit insurers to making requests as early as possible.

133. The FSC must restore the original wording of clause 8.29 to draft clause 8.30.

Section 9 Complaints and Disputes

Draft Section 9 – Complaints

We note that the ICA has recommended the following for the General Insurance Code:

Require Service Suppliers to notify the insurer within two business days if they receive a Complaint, so that the insurer can address this through their Complaints process as early as possible. They must also notify the insurer of any Code breach that they identify. 104

An equivalent clause is not present in the Life Code. It should be.

104 Recommendation 21, Page 9 GICOP Review Report
Recommendation - Section 9 Complaints

134. Life insurers should commit to requiring their third party service suppliers to notify the life insurer within two business days if they receive a complaint, so that they can address this through their complaints process as early as possible. The third party should also be obligated to notify the life insurer of any Life Code breach that they identify.

Section 10: Standards for Third parties Dealing with Underwriting or Claims

Draft Section 10 – Standards for third parties

We note that the ICA has recommended the following for the General Insurance Code:

*Require insurers to address identified performance shortcomings in their Service Suppliers’ services, such as a requirement for further training.*

An equivalent clause is not present in the Life Code. It should be.

Draft Clause 10.9 - Standards for investigators

The Draft Standards on the Use of Investigators under the proposed General Insurance Code makes commitments related specifically to the use of external investigators that do not currently exist under Draft Clause 10.9:

3) If we engage an external investigator to assist us with your claim, we will require that:

   a) written instructions be provided to any external investigators that we engage, and we will confirm in writing any changes to our instructions

   b) a register of investigators’ licences (including expiry dates) is maintained internally and kept up to date, to ensure the licences of any investigators we engage are current;

   d) the investigator must not exceed our written instructions without our prior consent;

Life insurers should also commit to ensuring that:

the investigator must not seek or accept from, or offer to, any person any gifts, benefits or rewards in connection with an investigation, other than modest hospitality such as light refreshments.

Training for investigators

We note that the ICA has recommended the following:

105 Recommendation 21, Page 9 GICOP Review Report
The ICA proposes to discuss with members and ANZIIF the possibility of developing a course to assist members to undertake investigation activity in a manner that complies with the Code and that meets community expectations.\textsuperscript{106}

We recommend that the FSC work with the ICA on this project.

**Recommendation - Section 10 Standards for third parties dealing with underwriting or claims**

135. Life insurers should commit to addressing identified performance shortcomings in their third party service suppliers’ services, such as a requirement for further training.

136. When engaging an external investigator the Life Code should commit life insurers, under draft clause 10.9, to require:
   a) written instructions be provided to any external investigators that we engage, and we will confirm in writing any changes to our instructions
   b) a register of investigators’ licences (including expiry dates) is maintained internally and kept up to date, to ensure the licences of any investigators we engage are current;
   c) the investigator to not exceed written instructions without our prior consent;
   d) the investigator to not seek or accept from, or offer to, any person any gifts, benefits or rewards in connection with an investigation, other than modest hospitality such as light refreshments.

137. The FSC should work with the ICA to discuss with ANZIIF the possibility of developing a course to assist insurers to undertake investigation activity in a manner that complies with both the General Insurance Code and the Life Code and that meets community expectations.

**Section 25: Monitoring, enforcement and sanctions**

**Draft Clause 25.4 – Our responsibility**

We note that the General Insurers commit to having

*appropriate systems and processes in place to enable the CGC to monitor compliance with this Code*\textsuperscript{107}

By contrast, the Life Code only commits life insurers to:

*appropriate systems and processes in place to enable compliance with the Code*

The key difference here is that general insurers support their compliance committee to monitor compliance with the General Insurance Code and imply that they will resource them

\textsuperscript{106} Recommendation 20, GICOP Review, Page 9.

\textsuperscript{107} Clause 13.2
to do so. The Life Code does not make this same commitment limiting it to their own processes and systems. This needs to be amended.

There should be an explicit commitment to provide appropriate funding and resources to the Life CCC for it to adequately meet its responsibilities outlined in the Life Code and its charter.

We also recommend that the FSC establish an independent committee to provide advice and input on necessary resourcing levels, as the ICA has done for the Code Governance Committee (CGC).

**Draft Clause 25.6 – Distributors and Code breaches**

Draft clause 25.6 states:

> We will be in breach of the Code if our staff or our Authorised Representatives fail to comply with the Code.

As we have argued above, life insurers must be responsible for distributors of their life insurance products. The poor behaviour of distributors reflects poorly on life insurers. The public does not differentiate between the two. It is in the reputational interests of life insurers to ensure that there are consequences to breaches of the Code by distributors and they are held to account.

Life insurers must commit to accepting the responsibility of any distributor’s breach of the Life Code with respect to their products.

**Draft Clause 25.9 – Life CCC responsibility**

In addition to the six responsibilities listed we recommend the following should also be explicitly stated in line with other Life CCC responsibilities under the General Insurance Code and the Banking Code:

- Monitor and enforce compliance with the Code,
- Investigate serious or systemic breaches
- Apply sanctions
- Provide guidance and reports
- Provide stewardship of the Code by helping industry understand and comply with our Code obligations, and identifying areas for improvement of insurance practices
- Drive improvements
- Promote awareness
- Undertake other functions as reasonably determined from time to time.

**Draft Clause 25.10 – Annual report**

We are of the view that life insurers need to commit to full transparency and that all compliance cases be published and reported in an identified manner in the Annual Report and on the website. Consumers have a right to know how life insurers are breaching the Code (no
matter how minor) as this is important information that feeds into the decision to purchase life insurance and from which provider.

It will also act as a powerful incentive for insurers to actually meet their obligations. If reputation is the most important commodity for insurers to protect, as insurers claim, then we would expect compliance rates to soar.

The continued anonymity that the sector enjoys in breaching its own self regulated commitments is in our view is wholly unjustified.

**Draft Clause 25.11 – Sanctions**

The Royal Commission noted during the testimony of FSC CEO Sally Loane that there have been no Life Code breaches and that Code breaches can only occur if there has been a failure to “correct a Code breach” as per current Clause 13.10 and draft clause 25.11. This needs to be changed.

The Life Code Committee should be empowered to impose sanctions when a breach occurs - rather than when a failure to correct a breach occurs. This will act as a stronger deterrent to ensure insurers do not breach their commitments under the Code.

**Draft Clause 25.13 – Informing CEOs and Systemic Issues**

Draft clause 25.13 states:

> The Life CCC will inform our Chief Executive Officer and the FSC in writing of its decision regarding any failure to correct a Code breach and any sanctions to be imposed.

We recommend the removal of the words “failure to correct a” as per the recommendation above at draft clause 25.11.

We note that the ICA has recommended that their General Insurance Code:

> Enable the CGC to report systemic code breaches and serious misconduct to ASIC, and require the CGC to notify an insurer’s Chief Executive that it intends to do so. The ICA will work closely with the CGC to ensure there is a common understanding of the meaning of “systemic breach” or “serious misconduct”, to provide insurers with clarity.

We believe the same should be committed to in the Life Code.

**Draft Clause 25.15 – List of possible sanctions**

The ICA has recommended that an additional sanction be included in the General Insurance Code:

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Clarify that the sanctions in the Code enable compensation for any direct financial loss or damage cause to an individual, in line with ASIC Regulatory Guide (RG) 183.\textsuperscript{109}

The same should be committed to by life insurers under the Life Code as (f):

\textit{Compensation for any direct financial loss or damage caused to an individual.}

Financial Rights points out that RG 183.70 suggests the following:

- formal warnings;
- public naming of the non-complying organisations;
- corrective advertising orders;
- fines;
- suspension or expulsion from the industry association; and/or
- suspension or termination of subscription to the code.

The current Life Code does not include:

- public naming of the non-complying organisations (the “publication of our non-compliance” sanction is not “publicly naming” as foreseen under 183.70)
- fines;
- suspension or expulsion from the industry association; and/or
- suspension or termination of subscription to the code.

The Life CCC should be empowered as such and the Life Code should include these in the list of possible sanctions.

\textbf{Recommendation - Section 25 Monitoring, Enforcement and Sanctions}

138. Life insurers should explicitly commit to providing appropriate funding and resources to the Life CCC for it to adequately meet its responsibilities outlined in the Life Code and its charter.

139. The FSC should establish an independent committee to provide advice and input on necessary resourcing levels, as the ICA has done for the Code Governance Committee.

140. Life insurers must commit to accepting the responsibility of any distributor's breach of the Life Code with respect to their products under Draft clause 25.6.

141. In addition to the six responsibilities listed at Draft Clause 25.9 the following responsibilities should be explicitly included:

a) Investigate serious or systemic breaches
b) Apply sanctions

\textsuperscript{109} Recommendation 26, page 11, GICOP Review Final Report
c) Provide guidance and reports

d) Provide stewardship of the Code by helping industry understand and comply with our Code obligations, and identifying areas for improvement of insurance practices

e) Drive improvements

f) Promote awareness

g) Undertake other functions as reasonably determined from time to time.

142. All compliance cases should be published and reported in an identified manner in the Annual Report and on the website.

143. The Life Code Committee should be empowered under draft clause 25.11 to impose a sanctions when a breach occurs, rather than when a failure to correct a breach occurs.

144. The words “failure to correct a” should be removed from draft clause 25.13.

145. All life insurers should report all systemic code breaches and serious misconduct to ASIC, and require the Life CCC to notify an insurer’s Chief Executive that it intends to do so.

146. Sanctions listed at draft clause 25.15 should be expanded to include:

   a) public naming of the non-complying organisations (the “publication of our non-compliance” sanction is not “publicly naming as foreseen under 183.70)

   b) fines;

   c) suspension or expulsion from the industry association; and/or

   d) suspension or termination of subscription to the Life Code.

Section 26: Access to information

Draft Clause 26.2 – Access to Information

We note that Section 26 regarding a consumer’s right to access information has been kept in the Code Governance Chapter. We would suggest this structure be reconsidered as it does not necessarily relate to Code Governance solely.

Current Clause 14.2 states:

Subject to section 14.5, you can access the information about you that we have relied on in assessing your application for insurance cover, your claim or your Complaint

Draft Clause 26.2 states

Subject to section 26.5, you can ask us for the information about you that we relied on in assessing your application for insurance cover, your claim or your Complaint.

The inclusion of “you can ask us” in this Clause diminishes the current commitment and, as with the other “you can ask us” clauses does not include a commitment to act on this request. This needs to be amended to ensure that the life insurers provide this access to information.
Draft Clause 26.5 – Special circumstances to deny access to information

Commercial-in confidence

Furthermore we wish to reiterate our objection from the first iteration of the Life Code to subclause (e) which states:

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

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

Recommendation - Section 26 Access to Information

147. The inclusion of Section 26 in Chapter 3 should be reconsidered
148. Draft Clause 26.5(e) should be removed.

Section 27: Definitions

Definitions – Significant Breach

The definition of “significant breach” states:

Significant Breach means a Code breach that is reasonably determined by us to be significant by reference to:

a) The number and frequency of similar previous breaches.

b) The impact of the breach on our ability to provide our services.

c) The extent to which the breach indicates that our arrangements to ensure compliance with Code obligations are inadequate.

d) The actual or potential financial loss caused by the breach. (our emphasis)

This clause empowers life insurers to be the sole determinant of whether a breach is significant and subsequently be subject to reporting requirements and possible sanctions, as per current clauses 13.4 and 13.13 (draft clauses 25.5, 25.14).

This is a subjective, a patent conflict of interest and wholly within the self-interest of life insurers. The life insurer has every right under the clause to not consider its action to be a significant breach and therefore avoid any action at all. This is fundamentally counter to the interests of consumers and the community. If this is not changes, consumers will have every
right to be as cynical as they current are with respect to insurer inability to police their own behaviour.

The power to determine whether a breach is significant should be within the purview of the Life CCC.

Recommendation - Section 27 Definitions

149. The words "that is reasonably determined by us to be significant" should be removed from the definition of "Significant Breach to ensure that the Life CCC is the sole determinant of whether a breach is significant.

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 Policy and Advocacy Officer Drew MacRae at drew.macrae@financialrights.org.au or on (02) 8204 1386.

Kind Regards,

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