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Blake Briggs
Deputy Chief Executive Officer
Financial Services Council
Level 24, 44 Market Street
Sydney NSW 2000,
by email: bbriggs@fsc.org.au
cc: policy@fsc.org.au.
Cc: Ashley Davies, Legal Policy Manager, FSC - ADavies@fsc.org.au

Dear Blake

Final Consultation draft of the Life Insurance Code of Practice

Thank you for the opportunity to comment on the final consultation draft of the new Life Insurance Code (**draft Code**). This submission is on behalf of Financial Rights Legal Centre, (**Financial Rights**), Consumer Action Law Centre (**Consumer Action**) and Redfern Legal Centre **(RLC).**

We have summarised and categorised the outstanding issues we have identified in **Attachment A**. We have also highlighted these issues in a tracked pdf version of the draft Code: **Attachment B**. Noting that specific details are provided in the Attachment A and B, we make the following recommendations.

Mental health provisions

1. The key mental health commitment in the current Life Code must be restored
2. The draft Code needs to meet the recommendations of the Parliamentary Joint Committee on Corporations and Financial Services (**PJC**) that have yet to be addressed
3. Appendix B on mental health should make up part of the draft Code and be enforceable

Medical definitions

4. Expand upon the limited number of medical definitions in the draft Code
5. Subscribers need to consult *independent* medical experts when updating definitions

6. Reviewing and updating medical definition must be applied to legacy life insurance products

Medical examinations and pre-existing conditions

7. A genuine upper limit on medical assessments needs to be implemented
8. A direct medical connection between the prognosis of a pre-existing diagnosed condition and the claim must be established

Claims and complaints timeframes

9. Timeframes for written decisions need to be 10 business days in total and remove the ability for insurers to extend the timeframe by including additional steps
10. The upper timeframe limit of 12 months needs to be restored
11. Reopening claims should continue to be considered within the allotted timeframes
12. Complainants should be provided with final decisions not simply responses that can be reopened at any time by a life insurer

Financial and legal advice

13. Remove the new lump sum payment threshold triggering the requirement to suggest seeking financial advice
14. Restore the requirement to suggest legal advice where appropriate

Pressure selling

15. Expand on the definition of "pressure selling"

Financial Hardship

16. Financial hardship provisions need improvement in line with stated ASIC expectations
17. Urgent financial need assistance needs to be returned to the commitment under the current code
18. Proactively communicate with consumers who have missed a premium payment

Family violence

19. Outline minimum standards for family violence policies

Vulnerability

20. Include positive obligation to make consumers aware of support measures
21. Interpreters should be arranged and provided free for consumers
22. Specific First Nations cultural training should be provided to all employees

Funeral insurance and consumer credit insurance

23. Further minimum standards should be set for the design and distribution of funeral insurance and consumer credit insurance

Investigations, interviews and surveillance

24. Investigation and surveillance processes need to be bolstered to meet best practice

Other outstanding issues raised in the consumer submission and ongoing consultation

25. Provide the previous year's premium to the customer
26. Complaints about Independent Service Providers and Distributors must be passed on to subscriber within 2 days.
27. Remove obligations on consumers
28. Redraft Code clauses with no obligation:
29. Remove weasel words such as "where possible," "as soon as possible/practicable," and "try to"
30. The moratorium on genetic testing in life insurance still does not meet the recommendation of the PJC and needs to be improved
31. The Life Code should be made enforceable
32. Name subscribers in all breach determinations
33. All green boxes should be removed and the relevant wording incorporated into the Life Code as commitments

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 me on the details below.

Kind Regards,

Drew MacRae
Senior Policy and Advocacy Officer
Financial Rights Legal Centre
Direct: (02) 8204 1386
E-mail: drew.macrae@financialrights.org.au

Appendix A: Recommendations for amendments to the draft Code

Mental health provisions

The key mental health commitment in the current Life Code must be restored

Clause 5.17 of the current Life Code regarding mental health and discrimination has been removed.[1] The Financial Services Council (**FSC**) have argued that "the Code should not restate existing obligations in legislation".[2]

This position is misleading and self-serving.

Restating the law is required for clarity and sense and is acknowledged by the FSC as such since reference to and restating of the law is done so in other areas of the proposed draft Code.

Excluding these important details in the draft Code also means that the LCCC is unable to monitor compliance, including receive complaints. This is a poor and inefficient outcome since relying on compliance monitoring processes under the *Disability Discrimination Act 1992*, requires HREOC to do so – but must cover all industries and is resource limited. Including this commitment under a new Life Code means the LCCC can focus on compliance in life insurance industry.

More importantly though, current clause 5.17 includes commitments that ***go beyond*** the law - commitments that are not carried through to the proposed draft Code.

To demonstrate this - it is best to break down current clause 5.17 into its component parts to identify the commitments made:

1. *Our decisions on applications for insurance will comply with the requirements of anti-discrimination law. Our decisions will be evidence based, involving relevant sources of information where this is available, and having regard to any other relevant factors where no data is available and cannot reasonably be obtained.*

This first part does state that subscribers will comply with the law and outlines wording that reflect section 46 of the *Disability Discrimination Act 1992*. However this is not exactly the case – since, for example, the words "evidence-based," do not appear in the words of section 46.

However, as noted, similar commitments to complying with the law are included elsewhere in the code: for example, draft clause 2.9(g) states

> "*we will ensure that … we comply with the relevant laws, ASIC regulations and guidance on advertising financial products and services, and on unsolicited sales.*"

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[1] *Our decisions on applications for insurance will comply with the requirements of anti-discrimination law. Our decisions will be evidence based, involving relevant sources of information where this is available, and having regard to any other relevant factors where no data is available and cannot reasonably be obtained. We will regularly review our underwriting decision-making processes to ensure we are not relying on out-of-date or irrelevant sources of information."*

[2] Page 24, Life Insurance Code of Practice 2.0 Review of Consultation Feedback November 2020

Draft clause 20(b) states:

> *"we will require that they comply with relevant state or territory laws"*

Further references are found at draft clause 3.1(b), 5.16, the green box under draft clause 4.4

If it is appropriate to reference the law in these cases (which we believe it is), it is just as appropriate to maintain the current reference and commitment from current clause 5.17. This is particularly the case since it is well documented that there has been poor compliance with the law by Life Code subscribers.[3]

While we agree that codes should not merely restate the law, a balance has to be struck between references to meeting obligations under the law, providing guidance or clarifying how those legal obligations will be met, and providing benefits that go beyond the law. This would provide customers with a more comprehensive outline of the commitments life insurers have made and the services that they will provide.

2. *We will regularly review our underwriting decision-making processes to ensure we are not relying on out-of-date or irrelevant sources of information.*

The second part of current clause 5.17 involves 2 commitments:

1. a commitment to review underwriting decision-making processes; and
2. a commitment to ensure that the subscriber is not relying on out of date or irrelevant sources of information

These are commitments that provide benefits that go beyond the law – i.e. that it will conduct a review and ensure that the information relied upon is up to date. Neither of these commitments are in the proposed draft Code.

This is a material loss for consumers and must be reinstated.

The draft Code needs to meet the recommendations of the PJC that have yet to be addressed

While the proposed draft Code addresses some recommendations of the Parliamentary Joint Committee on Corporations and Financial Services (**PJC**)[4] – including referring applications for cover which reveal a mental health condition or symptom of a health condition be referred to an appropriately qualified underwriter – it fails to meet the requirements set out by the PJC to

[3] Victorian Equal Opportunity & Human Rights Commission, *Mental health discrimination in the travel industry*, 2019, https://www.humanrights.vic.gov.au/legal-and-policy/research-reviews-and-investigations/mental-health-discrimination-in-the-travel-industry/report/

[4] Parliamentary Joint Committee on Corporations and Financial Services, *Life Insurance Industry*, March 2018 https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Corporations_and_Financial_Services/LifeInsurance/Report

address the key issues of concern. This despite the assertions to the contrary in the FSC's response.[5] These include:

- ***Clearly explain which associated conditions may arise from the initial condition, including mental health, are covered by an insurance policy.***

  While draft clause 3.5(a) commits to providing documentation re: the types of risks they are insuring – the requirements of PJC Recommendation 10.3 regarding "associated risks" are not explicitly addressed in draft clause 3.5, nor anywhere in Appendix B. If the intention is to address this recommendation with this clause, then this should be made explicit.

- ***Provide a written summary of the "statistical and actuarial evidence and any other material used to establish a pre-existing condition" in simple and plain language on request***.[6]

  This should be a part of clarifying how life insurers will meet their obligations under section 46 of the *Disability Discrimination Act 1992*. Nowhere in the code is there a commitment to provide this information in simple and plan language. If this is the purpose of draft clause 4.29 then that clause needs to be redrafted since that is not what the commitment actually states. We also note that draft clause 4.29 is not referenced for clarity's sake in the Mental Health Appendix as a specific measure upon which consumers can rely. This is similarly the case with draft clause 5.49.

- ***Ensure and inform prospective insureds that applications for insurance that reveal a mental health condition or symptoms of a mental health condition are not automatically declined***.

  While it may be implied at draft clause 4.18(a) that a prospective insured will not be automatically declined, explicitly saying so and informing all prospective insureds that this is the case will lift consumer confidence that they will be treated fairly.

- ***Specify:***
  - ***how long it is intended that the exclusion/higher premium will apply to the policy;***
  - ***the criteria the insured would be required to satisfy to have the exclusion removed or premium reduced;***
  - ***the process for removing or amending of the exclusion/premium***

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

[5] Page 24, Life Insurance Code of Practice 2.0 Review of Consultation Feedback November 2020, https://fsc.org.au/resources/2109-fsc-media-release-life-insurance-code-of-conduct-review-of-consultation-feedback/file

[6] See PJC Recommendation 10.6

We note that draft clause 4.26 states that if an insurer offers "alternative terms", they "will explain in plain language the alternative terms." This is not an explicit commitment to provide the information on how long it is intended that the exclusion/higher premium will apply to the policy and it is not a commitment to provide the criteria the insured would be required to satisfy to have the exclusion removed or premium reduced.

Draft clause 4.26(c) states that the insured "can ask [the insurer] to review any alternative terms [they] offer now or in the future if circumstances change, and how to do so." This is just a commitment to review - this is not the same as specifying "the process for removing or amending of the exclusion/premium."

- ***Develop, implement and maintain policies that reflect the above practice.***

  There is no commitment in the draft Code to maintain policies that reflect the above practices – since they are not in the draft Code. Once the above are committed to in the draft Code, the draft Code should also commit subscribers to have a publicly available policy on their website about how subscribers will support consumers if they are experiencing vulnerability due to a mental health condition.

- ***Introduce appropriate timeframes for claims decisions on mental health claim.***[7]

  We note that there has been a backward step in terms of timeframes particularly with respect to the 12 months: see further below.

- ***Introducing 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.***

  The phrasing of draft clause 5.22 does not provide a genuine upper limit on medical examinations: see further below.

Appendix B on mental health should make up part of the Code and be enforceable.

The draft Code includes an Appendix B supporting customers experiencing a mental health condition. While this goes some way to addressing PJC Report Recommendation 10.7[8] that recommends a part of the Life Code be dedicated to addressing mental health life insurance claims and related issues, there are a number of fundamental problems with this approach.

Appendix B states that it is not part of the draft Code. This is in no way acceptable for consumers who are looking to be able to rely on the commitments made in this document. As we understand it – the aim of not making this Appendix a part of the draft Code was to avoid insurers potentially breaching two separate clauses of the Code. This should not be an overriding consideration. The message being sent by the statement – at least superficially – is that it is not a part of the draft

[7] Recommendation 10.9

[8] Recommendation 10.7 states: "*… the Financial Services Council establish a mandatory and enforceable Code of Practice for its members, **or a dedicated part of its existing Code of Practice**, specifically in relation to mental health life insurance claims and related issues.*"

Code and the approach being taken is that these commitments specifically made to address issues facing this particularly vulnerable cohort of consumers are not important enough to be a part of the draft Code. This is not treating people with "empathy, compassion and respect".

These clauses should be enforceable under the draft Code and the industry's specific commitment on these issues need to be clearly spelt out as a dedicated part of the draft Code. Having a separate identifiable section is important for those people making claims or seeking to buy life insurance which may touch on issues relating to mental health.

Medical definitions

Expand upon the limited number of medical definitions in the Code

There has been no new standard medical definitions added despite a commitment from the FSC to investigate further standardisation.[9] The PJC also recommended standardising definitions across all types of policies.[10] This has not been implemented by the FSC.

Subscribers need to consult independent medical experts when updating definitions

The draft Code does not implement the PJC recommendation that medical definitions be updated in consultation with independent medical experts.[11] Draft clause 2.4 limits this to "relevant medical experts." The word relevant is not the same as independent and allows life insurers to obtain conflicted medical advice. The word "relevant" needs to be replaced with "independent."

Reviewing and updating medical definition must be applied to legacy life insurance products

Code subscribers still only have to review medical definitions in policies that are on-sale, with off-sale policies being excluded. Consequently those Australians with off-sale legacy policies are currently paying premiums for policies that are not fit for purpose as the medical definitions in their policies are outdated and restrictive. If these insureds were to make a claim, there is a possibility that they would be declined. This is unfair. Life insurers know that these clauses are out of date but continue to rely on them.

This decision by the FSC leads to a moral hazard – that is, it is in the interests of life insurers to develop and churn through new products to avoid having to review and update medical terms that are out of date.

[9] See FSC, 11 October, 2016, Media Release, Life Insurance Code Of Practice, https://www.fsc.org.au/resources-category/media-releases/778-2016-1110-mediarelease-lifeinsurancecodeofpractice-final/file

[10] See Recommendation 10.3, PJC Report

[11] See para 10.58 and Recommendation 10.3, PJC Report

Medical examinations and pre-existing conditions

A genuine upper limit on medical assessments needs to be implemented

There remains no upper limits to the number of medical examinations to be undertaken as recommended by the PJC.[12] Draft clause 5.22 does state that subscribers:

> *will avoid asking for more than 1 examination from the same type of specialist within 6 months, where possible. But if we do, such as for a claim for terminal illness or where superannuation law requires, we will tell you why*

The use of the phrase "where possible" and the non-exhaustive list of reasons found in the second sentence – as opposed to the recommended "specific circumstances in which this upper limit can be deviated from" – means that in practice there is no genuine limit on medical assessments. The commitment as drafted, is, in effect, meaningless.

To meet the recommendation, draft clause 5.22 must remove the words "where possible" and provide a strictly limited list of specific circumstances where subscriber will be allowed to deviate from this upper limit.

A direct medical connection between the prognosis of a pre-existing diagnosed condition and the claim must be established

There is no explicit requirement to provide a direct medical connection between a prognosis and a pre-existing diagnosed condition, as recommended by the PJC.[13]

We note that draft clause 5.49 provides a broad commitment to tell a claimant in writing the subscribers "reasons and a summary of the information about [the] claim that [the subscriber] relied on." However this does not necessarily entail the detail required regarding the link between prognosis and a pre-existing diagnosed condition. If it is the case that the FSC believes that draft clause 5.49 captures this, or it is somehow implied that this will occur, then the FSC should be amenable to making this explicit. Otherwise, there is too much room for life insurers to avoid providing this important information.

Claims and complaints timeframes

Timeframes for written decisions need to be 10 business days in total and remove the ability for insurers to extend the timeframe by including additional steps

The timeframe for a written decision has been weakened by extending the timeframe in the current Code clause 8.15 from 10 business days to 15 business days at draft clause 5.43. The draft clause has been misleadingly drafted. Draft clause 5.43 requires the subscriber to "tell" the customer of the claims decision within 5 business days, but will only confirm this decision in writing "within 10 days of "telling" the claimant – i.e. 15 days in total.

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[12] See Recommendation 10.10, PJC Report, cf: Draft clause 5.22 Life Code.

[13] See Recommendation 10.6, PJC Report

The draft clause is even more slippery since the insurer now only has to communicate the decision once the subscriber has 'taken all steps to finalise its decision'.[14] This can mean anything to a claims team who could include any and all steps they wish to take and not fall afoul of the "timeframe." This drafting is fundamentally unfair since it places all the power in the life insurer's hands to make the timeframe whatever they wants it to be.

The upper timeframe limit of 12 months needs to be restored

Overall claims handling timeframes remain weak given the operation of the "circumstances beyond our control" clause that is subjective.[15] Clause 8.17 in the current Code requires subscribers to make a decision on the claim 'no later than 12 months after we are notified of your claim'. This obligation has been removed in in draft clause 5.51.

Reopening claims should continue to be considered within the allotted timeframes

Draft clause 5.48 states that if a closed or declined claim is reopened, the subscriber is entitled to restart the clock with respect to claims timeframes under the draft Code. This runs contrary to the fairness principle since the subscriber has already had the opportunity to review the claim and provide its decision on the claim, and is counter to current LCCC guidance which uses the complaint response timeframe at current clauses 9.10 and 9.12 as the timeframe for the subscriber to provide its decision on a reopened claim.[16] The complaints timeframe at current clauses 9.10 and 9.12 should remain in place.

Complainants should be provided with final decisions not simply responses that can be reopened at any time by a life insurer

The draft Code has altered the terminology of complaints from a final "decision" in relation to the complaint[17] to requiring a final written "response" to the complaint.[18] This should be returned to "decision".

The reason for this drafting change seems to be that draft clause 7.7 now states that the subscriber's final *response* to a complaint about a declined or closed claim can be a response noting that the subscriber will reconsider or reopen the claim. However this is not how the Life Insurance CCC interprets this. In its guidance note,[19] the Life CCC states that the decision to reopen the claim does not qualify as a final decision in relation to the complaint.

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[14] Draft clause 5.43 Life Code

[15] Clauses 50.50, 50.51 and the definitions.

[16] https://lifeccc.org.au/app/uploads/2019/10/GN-No.2-Interpreting-and-applying-Life-Insurance-Code-of-Practice-9.10-_-Final.pdf

[17] See current Life Code clauses 9.10, 9.12 and 9.15

[18] See draft clauses 7.11, 7.12 and 7.16.

[19] Guidance Note No. 2 Interpreting and applying Life Insurance Code of Practice section 9.10, November 2019 https://lifeccc.org.au/app/uploads/2019/10/GN-No.2-Interpreting-and-applying-Life-Insurance-Code-of-Practice-9.10-_-Final.pdf

The draft clause 7.7 seems to be an attempt to avoid this guidance, which – if it proceeds - will increase uncertainty for consumers through the ability to always reconsider and reopen the claim. This is not fair, and places all the power to the subscriber to always be able to avoid a final decision.

Financial and legal advice

Remove the new lump sum payment threshold triggering the requirement to suggest seeking financial advice

Draft clause 5.52 has added in a new requirement for a lump sum payment amount to be at least $50,000 before the subscriber is required to provide this information to consumer. This restriction is not in its equivalent clause 8.18 of the current Code. It should be removed as it limits the numbers of consumers who will receive this important suggestion.

Restore the requirement to suggest legal advice

Further, draft clause 5.53 has removed the requirement to suggest to the insured that they seek legal advice before the consumer makes a decision. This should be restored.

Pressure selling

Expand on the definition of "pressure selling"

We note that the definition of pressure selling is limited:

> *Using certain techniques to pressure, compel or otherwise encourage someone to buy a policy they do not want.*

We have previously recommended that the definition include the concept of a sales person attempting to take control of the sales interaction and remove consumer control and free choice – as per the definition used by Monash Business school in order to broaden the concept.[20]

ASIC too – in their *Report 587 The sale of direct life insurance* – recommended that the Life Code should include the following specific commitments:

> *This must include that firms stop using the cooling-off period and deferred payment arrangements to conclude sales and provide a written quote and policy information to consumers if requested. Firms must also have clear guidelines for staff to end a sales call the first time a consumer states that they do not want to proceed.*

These specifics (including reference to cooling off period and deferred payment arrangements) should be included in the definition of pressure selling or otherwise be included in the Life Code.

[20] 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

Financial Hardship

Financial hardship provisions need improvement in line with stated ASIC expectations

During the COVID-19 crisis, we note that life insurers introduced a series of initiatives to assist those people impacted by COVID-19 including:

- ensure that frontline healthcare workers were not prevented from obtaining life insurance cover purely through exposure, or potential exposure, to COVID-19;
- if policyholders lost their job, were stood down, or had reduced working hours due to COVID-19—this would not affect their total and permanent disability (**TPD**) cover if they made a claim

These initiatives were welcome.

ASIC examined the practices of life insurers to ensure that they were doing everything possible to support consumers who are experiencing financial hardship to both maintain their life insurance cover, and be able to claim when eligible. In this work ASIC identified a number of areas where life insurers could make improvements to support consumers "during both challenging and stable economic cycles."[21] ASIC then proceed to set out their expectations of insurers:

> *in line with their general obligation as Australian financial services (AFS) licensees to act efficiently, honestly and fairly to effectively support consumers experiencing financial hardship or vulnerability*

In other words, ASIC made recommendations that life insurers implement minimum standards in their working with people experiencing financial hardship now (during the COVID-19 crisis) ***and*** in an ongoing way. Given this expectation, we believe it is appropriate that life insurers commit to the following minimum standards in the Life Code, where they have not already. They are as follows:

- ***Offer a range of flexible support options to help consumers maintain cover***

  Draft code clause 6.15 only lists three potential options when there should be more available to reflect the fact that consumer circumstances vary significantly. As demonstrated in the response to the COVID-19 crisis – life insurers broadened the range of support options available to policyholders. The lessons learnt here should be benchmarked and included in the Life Code. Other options could include:

  - providing short-term premium *discounts*
  - repaying arrears over time to retain their cover and be retain eligibility to claim

[21] ASIC's expectations of life insurers: responding to consumers in financial hardship, 22 April 2021 https://download.asic.gov.au/media/ifenrvcr/letter-to-life-insurers-about-financial-hardship-22-april-2021.pdf

- changing premium payments timing (say from annual to quarterly or monthly) for no additional cost
- removing the loading for monthly premiums
- waiving cancellation and administration fees for customers who cancel their policies
- providing a review of policy cover or reassessing the consumer's risk profile – rather than simply changing benefits to reduce a premium (as per draft clause 6.15(a))
- implementing non-insurance initiatives such as access to free counselling, welfare checks and gift vouchers.

- ***Provide proactive, clear and transparent communication about support options including***
  - ***proactively communicate with consumers (including those identified as experiencing or potentially experiencing financial hardship) in a clear and transparent manner about support options available,;***
  - ***ensure that this information is easily available and prominently displayed not just on websites but in written communications;***
  - ***explain the effect on insurance cover if an option is applied (e.g. any reduction in cover) and any relevant timeframes (e.g. end date of the support option).***

  Draft clause 6.15 commits to "telling you about the options available" with no specifics. The latest iteration of the General Insurance Code of Practice (to be launched 5 October 2021) will have general insurers committing to:

  > *We will have information about applying for Financial Hardship support on our website. The information will set out the types of support options that may be available, and how you can access Financial Hardship support*

  During the COVID-19 crisis there has been significant confusion and difficulties for consumers in obtaining and identifying financial hardship assistance measures provided by individual insurers to help them with their financial struggles.

  The Life Code should be redrafted to include at least this minimal commitment to ensure greater transparency. However more is required than simply directing people to a website. ASIC recommended the following:

- ***Prepare behaviourally informed communication and use multiple means of communication***
  - ***use multiple means of communication, and***
  - ***tailor messaging to ensure consistent outcomes across each distribution channel (e.g. retail advised, group and direct).***

- ***Continue to review and refine flexible support options***

  It is important that given the inherently changing nature of vulnerability and issues facing consumers, life insurers should have a process to continually review and refine their support options and develop new solutions to adapt to changes in the community.

- ***Support consumers experiencing vulnerability including:***
    - ***have robust processes and procedures in place to identify and support consumers experiencing vulnerability (noting that the concept of vulnerability can change over time)***

  We note that draft clause 6.15 is a reactive commitment – that is, life insurers will only tell a consumer about available support options "if you tell us". The onus remains on the consumer. This needs to be more proactive. We note that Banking Code clause 165 states:

  > *We will employ a range of practices that can identify common indicators of financial difficulty. If we identify that you may be experiencing difficulty paying what you owe under a loan (or are experiencing financial difficulty), then we may contact you to discuss your situation and the options available to help you. We will do this on a case-by-case basis*

  In line with ASIC's expectations of proactivity–a similar clause should be included in the Life Code. This would be in line with the Life CCC's recommended best practice in the Life CCC's section 6.5 Guidance Note.[22]

- ***Proactively engage with consumers before the end of support options to consider the consumer's circumstances and whether any ongoing assistance is needed;***

  Too many times consumers reach the end of their support measures and do not hear from their insurer, and do not themselves proactively contact their insurer (for a range of understandable reasons). When this occurs they simply end up in the same vulnerable position they were to begin with. It is critical that insurers have a conversation with their customer about their circumstances and provide ongoing assistance where available.

- ***Regularly collect and monitor data to identify and proactively help consumers in hardship;***

  The Life Code should explicitly commit life insurers to have systems and processes in place to regularly collect and monitor data to understand when consumers are experiencing financial hardship and then proactively contact them to offer help.

- ***Work closely with superannuation trustees to:***
    - ***proactively communicate with consumers who are at risk of losing their group life insurance cover as a result of early release of superannuation, and***
    - ***ensure that these consumers are made aware of all options available, and the steps necessary, to maintain or reinstate their insurance cover (e.g. in the case of low or no superannuation account balances).***
- ***Work closely with trustees and employers of ordinary group schemes to***

[22] LCCC, Guidance Note No. 4 Section 6.5 – Life Insurance Code of Practice November 2020 https://lifeccc.org.au/app/uploads/2020/11/Section-6.5-Guidance-Note.pdf

- ***regularly communicate with consumers in group schemes about key benefits, limits and exclusions in their group life insurance policies (e.g. key policy terms such as offsets to benefits and how these are applied), and***
- ***explain to these consumers how and where they can access additional support or information***

Urgent financial need assistance needs to be returned to the commitment under the current code.

We note that draft clause 6.21 provides an either or option but not both in terms of the assistance that may be offered. The current clause 8.29 presents both options as either/or or both, through the use of "and/or." This needs to be reinstated.

Proactively communicate with consumers who have missed a premium payment

Draft clause 6.15 is written so that the commitment to tell the consumer about financial hardship options is only enlivened once the consumer tells the subscriber. However, subscribers have an obvious indication that there may be an issue when the consumer has missed a premium payment. This should be re-drafted to require subscribers to proactively contact consumers where there premium payment has been missed and to provide them with options if they are experiencing financial hardship. This would be in line with Life CCC's *Guidance Note No 4: Section 6.5 – Life Insurance Code of Practice*[23]

Family violence

Outline minimum standards for family violence policies

We support the new commitment under draft clause 6.5 to have a family violence policy and place it on subscriber's websites.[24] While this is a positive step there are a couple of key issues with the commitment as it stands.

First, there is no guideline to assist life insurers to develop a family violence policy. We note that the ICA at least produced a guideline to accompany their commitment.[25]

Second, the absence of any commitments to include minimum standards for the content of family violence policies (either in the draft Code or in a guideline accompanying the draft Code) will mean significant variance in the quality and quantity of support measures available to life insureds. This will lead to the same problem that Financial Rights recently identified with respect to family violence policies required under the General Insurance Code, that is,

[23] Life CCC, *Guidance Note No.4*, *Section 6.5 – Life Insurance Code of Practice*, November 2020 https://lifeccc.org.au/app/uploads/2020/11/Section-6.5-Guidance-Note.pdf

[24] Clause 95

[25] ICA, *Guide to helping customers affected by family violence*, https://insurancecouncil.com.au/wp-content/uploads/2020/01/2021_07_REPORT_Family_Violence.pdf

significant inconsistency of standards applying to those experiencing family violence across 47 subscriber general insurers.[26]

Whether someone experiencing family violence is able to be supported in an appropriate manner will therefore be wholly dependent on chance and the vagaries and willingness of individual life insurers who may provide minimal support, best practice support or somewhere in between.

Family violence support should not be an area of competitive tension.

Minimum standards need to be set to ensure all life insurance policyholders and beneficiaries, no matter who they have signed up with or have to deal with – are able to afford themselves of the appropriate support they need.

While the interaction, impact and effects of family violence with life insurance are different to general insurance, the ICA guidance does however provide a good base from which to start in terms of what should be included in a Family Violence policy. Clause 17 of that guideline states:

Each insurer should develop and implement a family violence policy that covers the following areas:

- *a. making sure that safety is paramount for anyone affected by family violence;*
- *b. early recognition of family violence;*
- *c. training to improve employees' responses to someone affected by family violence;*
- *d. protecting private and confidential information of customers affected by family violence;*
- *e. minimising the number of times a customer affected by family violence needs to disclose information about family violence;*
- *f. ensuring appropriate and sensitive claims handling processes for claimants affected by family violence;*
- *g. ensuring collection arrangements are handled sensitively;*
- *h. arranging access to Financial Hardship help;*
- *i. informing customers, employees, distributors and service suppliers about information and assistance available to people experiencing family violence;*
- *j. referring customers, employees and distributors to specialist services; and*
- *k. supporting employees and distributors who:*
    - *i. are affected by family violence; or*
    - *ii. experience vicarious trauma after serving affected customers.*

[26] Financial Rights Legal Centre, *Family Violence and General Insurance: Desktop audit of family violence policies*, August 2021 https://financialrights.org.au/wp-content/uploads/2021/08/210823_FamilyViolenceResearch_FINAL.pdf

Vulnerability

Include positive obligation to make consumers aware of support measures

The draft Code appears vague in relation to the extent of insurer's positive obligations to offer assistance when vulnerability is identified: clauses 6.8 and 6.11. For example, it is not clear what the positive obligations are on subscribers in the situation of selling an insurance product without making the client aware of the extra support available (when there are indications that the person is vulnerable) in circumstances when the person has not directly asked for support.

We recommend amending draft clause 6.11 to include a commitment along the following lines:

> *Where appropriate, we will offer to make you aware of the additional supports and services available to assist you to make an informed decision if you choose.*

Further, we recommend amending the subheading from "Vulnerable people can ask for help' to "Supporting customers experiencing vulnerability."

Interpreters should be arranged and provided free for consumers

We note that draft clauses 5.24 commit insurers paying for interpreters. This is not the case under the commitment under draft clause 6.11. This commitment needs to be extended to arrange for and provide for free interpreting service where required.

Specific First Nations cultural training should be provided to all employees

We note draft clause 6.13 includes a commitment to training staff re: vulnerability but this does not explicitly commit to improved cultural awareness. The Banking Sector has taken this step at clause 37 of the Banking Code:

> *We will provide cultural awareness training to staff who regularly assist customers in remote Indigenous communities.*

Funeral insurance and consumer credit insurance

Further minimum standards should be set for the design and distribution of funeral insurance and consumer credit insurance

The draft Code has shad tripped out of it a number of current and previously proposed commitments with respect to particularly harmful products such as funeral insurance and consumer credit insurance (**CCI**).

The FSC assert that these have been taken out because of the introduction of the new Design and Distribution Obligations regime. However the new Design and Distribution Obligations regime does not set any minimum standards for how certain products will be designed and distributed. It requires life insurers to design products to be consistent with the likely objectives, financial situation and needs of the consumers for whom they are intended and to take 'reasonable steps' to result in financial products reaching consumers in the target market defined by the issuer.

The Life Code is an important opportunity for the sector to set basic standards while the Design and Distribution Obligations regime is applied to individual firms that are likely to vary from these basic standards.

The draft Code does include some minimum standards previously proposed but has removed others. It can include more. For example

- ***Stepped premiums should be prohibited under the draft Code (for both funeral insurance and all other insurances)***
- ***Do not sell to people under the age of 50 via any 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***
- ***Suitability criteria for anyone under the age of 50 could include:***
    - ***having a terminal disease, or other reason to believe they may have a risk to claim on the policy; or***
    - ***having no super***
- ***Full disclosure of estimated total costs should be disclosed upfront and in advertising,***
- ***Standards to set a greater time period before a policy is cancelled if premiums fall into arrears.***

With respect to CCI minimum standards for all life insurers offering this product should include:

- ***Using filtering questions to alert the consumer to key policy exclusions such as age, residency and employment status, and if they are not eligible to claim under significant parts of the CCI policy, not offering it.***
- ***Disclosing the circumstances in which a payout will be made and the amount of the payout.***
- ***Disclosing any incentives the insurer employee/distributor might receive from taking out the CCI product and their effect.***
- ***Before you complete the purchase, if the premium is calculated by reference to an associated financial product, an explanation of how it is calculated, and show the consumer an example. Otherwise, the insurer must tell you the cost of the CCI.***
- ***Telling the consumer how the premium is to be paid.***
- ***A minimum claims ratio as a review trigger for example if payout falls below 80% of premiums, life insurer will commit to review the TMD to make sure product is directed to insureds who benefit: see clause 2.2 and in the sections on funeral insurance and CCI.***

None of the above are minimum requirements under the Design and Distribution Obligations regime nor the new deferred sales regime; nor the Anti-Hawking reforms. The above commitments – many of which were originally committed to by the FSC in its draft 2019 Life Code - should be included in a final new Life Code.

Investigations, interviews and surveillance

Investigation and surveillance processes need to be bolstered to meet best practice

Since the introduction of the new General Insurance Code of Practice – the Life Code's standards on interviews and surveillance are no longer best practice – having been surpassed by general insurers. We list the following additional commitments that life insurers should made to reach parity with general insurers.

- ***If an interpreter is required this should be arranged by the subscriber***

  Draft clause 5.24 only states that the subscriber will pay for it, not arrange it. Incorporate clause 207 of the General Insurance Code to this effect.

- ***A standard interview consent form should be developed and introduced***

  This should be in line with the Interview consent form template in the General Insurance Code.

- ***Consent should be sought when an interview is to be recorded and a free copy should be provided automatically***

  Draft clause 5.28 does not consider consent nor does it provide a copy of the *recording* automatically – see Clause 222 of the General Insurance Code.

- ***Provide an upper limit to the overall interview time***

  Clause 216 of the General Insurance Code sets an upper limit of 4 hours upon which written permission to extend this time is required. This should be incorporated into the Life Code.

- ***Provide a record of previous interviews before a subsequent interview***

  Clause 223 of the General Insurance Code should be incorporated

- ***Introduce specific commitments for interviewing people under 18***

  Clause 211 of the General Insurance Code sets standards for interviewing people under 18 which should be replicated here.

- ***Require external investigators to obtain the subscribers express and written authority before putting a fraud allegation to a claimant***

  Clause 231(g) of the General Insurance Code should be replicated.

- ***Surveillance of people on business premises should be prohibited***

  Clause 233(e) of the General Insurance Code should be incorporated into draft clause 5.38(a).

- ***Make and retain contemporaneous records of all investigation activities***

  The specifics found in clauses 221, 226 and 229 of the General Insurance Code should be incorporated into draft clause 5.37(e)

- ***Provide greater oversight of external investigators***

  Clause 225 of the General Insurance Code should be incorporated into draft clause 5.37

- ***Commit to conducting quality assurance programs***

  Clause 195 of the General Insurance Code should be replicated in the Life Code

- ***Commit to reviewing an investigation that has gone on too long***

  Clauses 196-199 of the General Insurance Code should be replicated in the Life Code

- ***Ensure investigations are appropriately focused***

  Clause 200 of the General Insurance Code should be replicated in the Life Code

- ***Improve information provided to the interview subject***

  Incorporate clause 201 and 205(b), (d), (e), (f) (g) and (e) of the General Insurance Code into draft clause 5.28

- ***Explain the role of the external investigator***

  Incorporate clause 202 of the General Insurance Code into draft clause 5.28

- ***Keep insureds up to date with an investigation***

  Incorporate clause 204 of the General Insurance Code into draft clause 5.28

- ***Provide several options for interview locations outside of the home and allow the insured to schedule the time that best suits***

  Update draft clause 5.27 to incorporate the provision of options as per clause 210 of the General Insurance Code.

- ***Subscribers must be held accountable for the actions of investigators when surveilling customers***

  Draft clause 5.38 states that insurers will "direct" investigators rather than "require" investigators. Directing them allows wriggle room for the subscriber to only be held accountable for saying the words – not the outcome.

Other outstanding issues raised in the consumer submission and ongoing consultation

A number of outstanding issues remain unaddressed by the FSC, including:

Provide the previous year's premium to the customer

Draft clause 3.8 states that insurers will only provide an explanation, not the actual figure.

Complaints about Independent Service Providers and Distributors must be passed on to subscriber within 2 days.

In line with Clause 26 of the General Insurance Code Independent Service Providers and Distributors must tell the subscriber about a complaint within 2 Business Days.

Remove obligations on consumers

Draft clause 4.2 states that: "we do expect you to have a good understanding of your health, lifestyle and financial situation." This is inappropriate. The draft Code also places obligations on the consumer to inform the life insurer of their hardship under draft clause 6.15, via the omission of any proactivity on the subscriber's part to identify these issues. The final sentence of clause 6.9 also places the obligation wholly on the consumer to disclose any vulnerability, and reads as an excuse for the subscriber to rely upon. Clause 6.19 requires action on the part of the consumer before any obligation arises on the subscriber. This should be redrafted to commit subscribers to proactively providing information about urgent access to all policyholders.

Redraft code clauses with no obligation

There remain draft clauses that do not contain an obligation e.g. clauses 2.8, 2.34, 3.3, 3.14, 4.36, 5.11, 5.19 and 6.17. Then there are poorly drafted, weak commitments such as draft clause 6.1 which should be improved to state that "We will take extra care to support vulnerable customers" not simply be "committed to taking extra care"

Remove weasel words such as "where possible," "as soon as possible/practicable," and "try to"

"Where possible" is used in Promise 1, and draft clauses 1.1, 2.3, 4.2, 5.13, 5.22, 6.8, and 6.11. These should be removed since they introduce an ability for subscribers to not meet the commitment due to reasons of say, resourcing, or other self-serving reasons that do not go to an actual inability to meet a commitment.

Hard timeframes should be included in the draft clauses 5.8, 5.13 and 7.2.

Do or do not – there is no try. Trying to do something can be used as an excuse for that something to not happen. "Trying to" does not take account for degrees of trying, such as a weak attempt to help versus a comprehensive and exhaustive attempt. The commitment must be to *do* that something, not simply trying to do something. Remove the words "try to" from draft clauses 4.15, 5.3, 5.9, 5.14, 5.35 (and subsequently edit 5.36 as outlined in the Appendix to this submission).

The moratorium on genetic testing in life insurance still does not meet the recommendation of the PJC and needs to be improved

The Moratorium on Genetic Test in Life Insurance fails to meet the standards set by the PJC to be in line with the UK's moratorium including rules around expert panels, having lower financial limits than the UK, and limiting the scope of genetic testing, amongst many other failings.[27] This moratorium needs to be strengthened.

[27] For full details see Pages 65-71 of the Joint Consumer Submission to the Life Insurance Code Review, https://financialrights.org.au/wp-content/uploads/2019/01/190112_LifeCode2_Submission_FINAL.pdf

The Life Code should be made enforceable

The FSC has not committed to making the Life Insurance Code enforceable by contract (as the Banking Code and the COBA Code is) nor have they identified the clauses that would be enforceable under the new enforceable code regime.

Name subscribers in all breach determinations

The Life CCC should be provided with the power to name all subscribers in all published determinations, in line with AFCA's position on this issue.

All green boxes should be removed and the relevant wording be incorporated into the Code as commitments

The green boxes – seemingly meant to provide contextual information – simply do not work and should be removed and the wording in them incorporated into the commitments in the Code.

Many of the green boxes are simply inappropriate directives to the consumer to do something: e.g.:

> *Section 4 sets out what information we may require from you, such as about your health and family medical history, It is vital that you do so carefully, in line with your duty to take reasonable care.*

As outlined above - it is inappropriate for a code of practice to place obligations on consumers. Remove them.

Some of the green boxes provide commentary on consumer's obligations under the law, for example, the green box found on page 11. Again this is inappropriate for a code of practice, which is a document detailing life insurer commitments to consumers. This information should be provided to consumers under the commitments under draft clause 4.1. This information will be more useful to consumers in those communications than as a directive under the Code.