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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,

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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

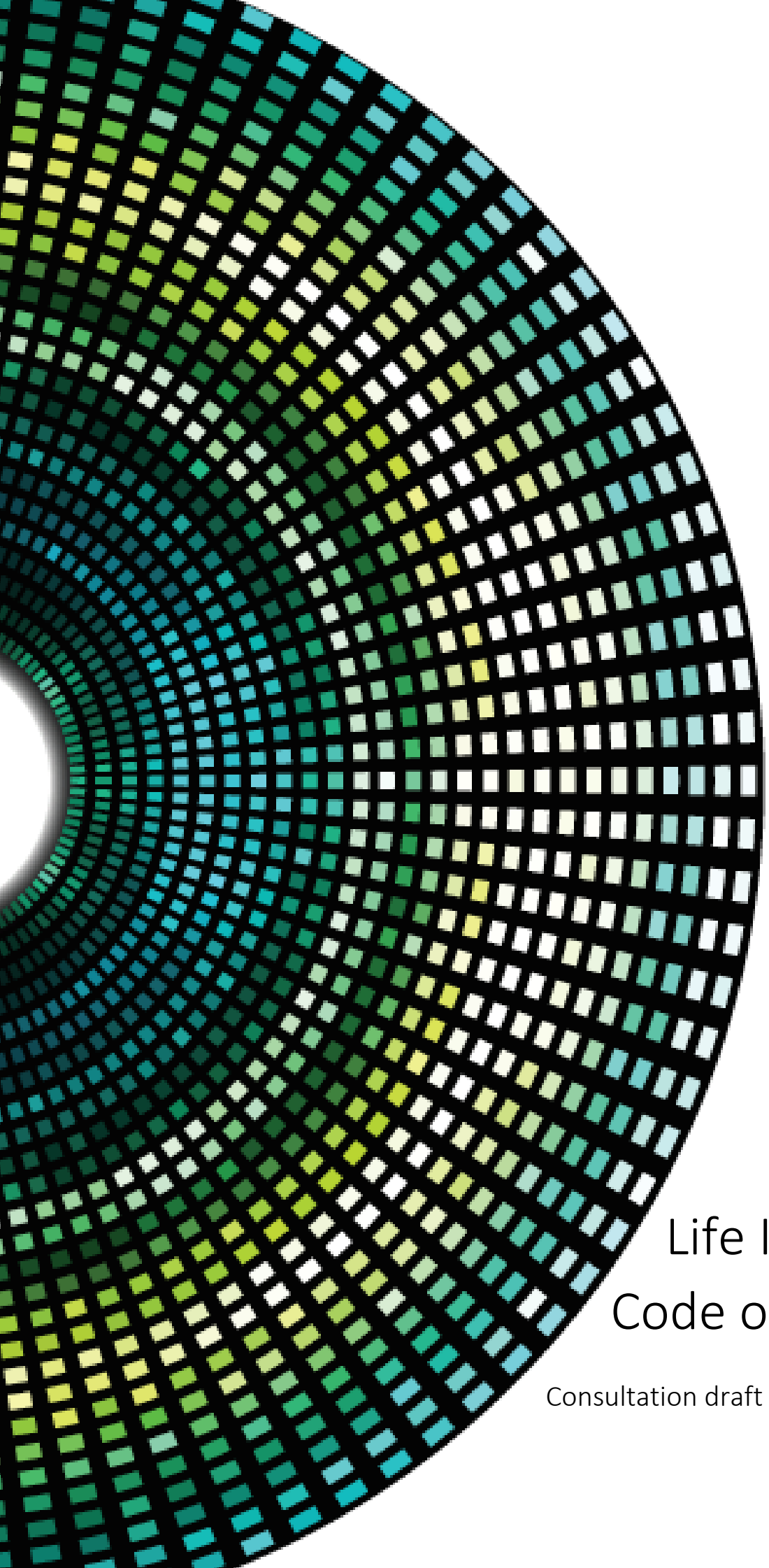
The green boxes – seemingly meant to provide contextual information – simply do not work and should be removed and the wording in them incorporated into the commitments in the Code.

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.



Life Insurance Code of Practice

Consultation draft | 18 August 2021

In this document

The Life Insurance Code of Practice

Subscribers to the Code make 10 key promises

The 10 promises are:

1. We will be honest, fair, respectful, transparent and timely when we communicate with you, and we will use plain language where possible.
2. We will ensure our staff and Authorised Representatives use appropriate sales and retention practices.
3. We will offer extra support if you have trouble with the process of buying insurance or claiming.
4. If we find that an inappropriate sale has occurred, we will talk to you about fixing it, such as by issuing a refund or replacement policy.
5. When you make a claim, we will explain the process and keep you informed about our progress assessing it.
6. We will decide on your claim within the Code's timeframes. But if we cannot, we will explain why and tell you how to make a formal Complaint.
7. If we decline your claim, we will explain why in writing and let you know what to do if you disagree.
8. We will restrict the use of investigators and Surveillance to preserve your legitimate right to privacy.
9. The independent Life Code Compliance Committee (Life CCC) will monitor our compliance with the Code.
10. We will be accountable for Code requirements, and the Life CCC can sanction us.

1 This Code of Practice

Aims of the Code

The Code protects life insurance customers

1.1 The Financial Services Council (FSC) has voluntarily developed the Code to protect you, the customer. We are bound by the Code and its goal is to ensure that we:

a) deliver a high standard of customer service throughout your relationship with us
b) continuously improve the services we offer you
c) communicate with you in plain language where possible
d) seek to increase consumer trust and confidence in the life insurance industry as a whole.

1.2 The Code also outlines our obligations during the life insurance process, including when:

a) you buy a policy, make a claim or deal with us
b) we deal with claims, Complaints and requests for information, or help you if you experience financial hardship or need extra support.

1.3 We will make sure you know about the Code by including details on our Website, and telling you how you can access the Code when we receive your claim or Complaint. The FSC also promotes the Code to customers through its members, and we will work with the FSC to do this.

1.4 This version of the Code will take effect no later than [TBA] and replaces the previous version. It applies to all interactions we have with you – including about an existing claim or Complaint – from that date or the date we are bound by the Code, whichever is later. But it does not apply to interactions we had with you before we were bound by this version of the Code.

1.5 The Code does not limit your rights under any existing laws and regulations. We acknowledge that a contract of insurance is based on the principle of utmost good faith which requires both us and you to act honestly and fairly towards each other, and for us to have due regard for your interests.

Seven key principles apply to products and services under the Code

1.6 Seven principles apply to the products and services the Code covers. These inform the key promises in the next section:

a) clarity
c) transparency
d) fairness
e) respect
f) honesty
g) timeliness, and
h) plain language.

Scope of the Code

The Code applies to Australian life insurance

1.7 The Code covers Life Insurance Policies issued in Australia, including policies commonly called:

a) term life or death and terminal illness insurance
b) total and permanent disability (TPD) insurance
c) trauma or critical illness insurance
d) disability insurance
e) income protection or salary continuance insurance
f) business expenses insurance
g) Funeral Insurance and funeral expenses insurance, and
h) consumer credit insurance (CCI), if issued by a life insurer.

Other insurances and circumstances are not covered

1.8 The Code does not cover:

a) whole-of-life and endowment insurance products
b) products issued by general insurers
c) health insurance products issued by health insurers, or
d) annuities and investment life products, as defined in sections 9(1)(c), (d), (f) and (g) of *the Life Insurance Act 1995* (the Act).

1.9 It also does not cover other products issued by an entity that is not:

a) registered as a life insurance company with the Australian Prudential Regulation Authority (APRA) under the Act, or
b) authorised to issue Life Insurance Policies under the Act.

1.10 The Code does not apply to the following entities, unless they have adopted it:

a) superannuation fund trustees
b) financial advice companies or financial advisers, or
c) other industry participants.

1.11 Sections of the Code that do not apply to certain parties will be clearly stated.

Insurers and third parties

Insurers will follow the Code

1.12 The FSC Website lists the organisations that subscribe to the Code and any brands they use (see www.fsc.org.au/policy/life-insurance/code-of-practice). The FSC works with the Life CCC, regulators and stakeholders to encourage all life insurers, Reinsurers and relevant industry bodies in Australia to adopt it.

1.13 The Code binds:

a) FSC members who are registered life insurance companies issuing Life Insurance Policies
b) other FSC members who are authorised to issue Life Insurance Policies, and
c) any other industry entity that formally agrees with the FSC and Life CCC to adopt the Code.

1.14 The Code also sets responsibilities for the Life CCC, which monitors and enforces our compliance with the Code.

1.15 As we have adopted the Code, we will ensure that our staff and Authorised Representatives comply with it when they are acting for us. Certain standards also apply to Distributors and these can be found at clauses 2.11 and 2.19.

1.16 FSC members who are Reinsurers are bound by the principles in clause 1.6. They will comply with the Code if they:

a) comply with these principles, and
b) help us meet our commitments under the Code.

1.17 Before we enter an agreement with a Reinsurer who is not an FSC member and has not formally adopted the Code, we will take reasonable steps to satisfy Ourselves that they will:

a) comply with the principles in clause 1.6, and
b) help us meet our commitments under the Code.

Independent Service Providers will meet Code conditions

1.18 We may use Independent Service Providers to help us underwrite and administer policies, and manage claims. If we do, any service agreements we enter or renew after we are bound by the Code will meet the Code's standards relevant to the services they provide.

1.19 This means we will require providers to:

a) follow the principles in section 1.6 when dealing with you and us
b) get our approval before subcontracting their services
c) tell us if you make a Complaint about their services, such as an application for cover or a claim they are involved in, and
d) keep your information confidential, and only use that information for the purpose of the service they are providing.

1.20 If the provider is a medical assessor or examiner, we will require them to comply with the Australian Medical Association's Ethical Guidelines on Independent Medical Assessments, or an equivalent international guideline for providers overseas.

1.21 If you make a Complaint about an Independent Service Provider, we will follow our internal Complaints process unless we are satisfied they have a comparable process of an equivalent standard.

1.22 We will only enter contracts with providers who:

a) reasonably satisfy us of their expertise, experience, qualifications and integrity, and
b) hold any required federal, state, territory or industry licences.

1.23 Our contracts with them will refer to the relevant state or territory Expert Witness Code of Conduct.

1.24 We will seek impartial and objective medical reports from treating doctors, allied health professionals or Independent Service Providers and we will take all details in the report into account.

2 Policy design, advertising and sales standards

Policies we design will be clear, easy to understand and up to date

2.1 We will design products which:
- a) are designed to meet a genuine need of consumers in the target market, and
- b) are likely to be consistent with the likely objectives, financial situation and needs of consumers for whom the product is designed (known as the target market).

2.2 We will periodically review the target market so that policies are distributed to the relevant class of consumers who have a genuine need for the policy in light of its design.

2.3 When we design and introduce new Life Insurance Policies, we will:
- a) use plain language in our sales and policy information where possible
- b) consumer-test the plain language information required in clauses 3.5 and 3.8 which deals with policy documentation and yearly statements, and
- c) provide clear information to help customers make informed decisions, especially for policies that are available for new customers to buy without a financial adviser, planner or Group Policy Owner, and
- d) ensure products are designed with a view to meet a genuine need of consumers in the target market, and which are likely to be consistent with the likely objectives, financial situation and needs of consumers of the target market.

Updating Medical Definitions

2.4 For policies available to new customers where benefits are payable after a defined medical event, we will review all medical definitions at least every 3 years, with help from relevant medical specialists.

2.5 We will update these medical definitions if needed and tell you when we do.

2.6 When we design and introduce new policies that depend on the amount you earn when you make a claim, where we increase your benefit each year to match inflation, we will link the increase to an index that broadly reflects wage growth in Australia.

2.7 We will tell you that you can opt out of these increases.

2.8 Clauses 2.5–2.7 do not apply to cover under a Group Policy.

Advertising and sales practices

Advertising will meet certain standards

2.9 When we advertise and market our Life Insurance Policies, we will ensure that:
- a) our advertising will be clear and not misleading
- b) any images we use do not detract from or reduce the prominence of any statements
- c) any price or Premium we refer to is consistent with what members of the campaign's target audience will likely pay
- d) any specific circumstances a benefit depends on are clear
- e) any phrases like 'free' or 'guaranteed' are not likely to mislead
- f) short-term incentives that are not part of the policy, such as gift cards or reward points, do not encourage customers to buy the policy solely for these incentives
- g) we comply with the relevant laws, ASIC regulations and guidance on advertising financial products and services, and on unsolicited sales, and

h) any information in our advertising campaign is consistent with the product design and the target audience for whom the product has been designed to meet their genuine consumer needs and the disclosures in any corresponding Product Disclosure Statement.

Staff and Authorised Representatives will follow good sales practices

2.10 We will have clearly documented sales rules to ensure our salespeople and Authorised Representatives sell our policies appropriately and do not use unacceptable practices such as Pressure Selling.

2.11 We may use a Distributor to sell our policies. If we do, we will take reasonable steps to ensure that they do not use Pressure Selling.

2.12 Our sales rules will include:

a) what information we or our Authorised Representatives will give you about the policy's Premium, features, benefits, exclusions, limits and cooling-off period
b) how to identify if you are unlikely to ever be eligible to claim a policy's benefits and, if so, not sell you the policy
c) when they must stop selling if you indicate you do not want a Life Insurance Policy, and
d) how to keep records that you agreed to buy the policy.

2.13 We will monitor our staff's compliance with these rules through:

a) quality assurance measures such as call monitoring, mystery shopping and post-sale customer surveys
b) analysis of and reports on key data, such as sales results, lapses, declined claims and Complaints.

2.14 We will agree with our Authorised Representatives their sales approach, staff training requirements, and monitoring and reporting framework so we are satisfied that their staff and businesses meet:

a) their agreed commitments
b) our sales rules, and
c) the Code's requirements.

2.15 We will also monitor our Authorised Representatives' conduct through arrangements such as:

a) mystery shopping
b) independent audits, and
c) analysis of key data, such as sales results, lapses, declined claims and Complaints.

Insurers will provide appropriate sales training

2.16 Our staff and the staff of our Authorised Representatives who sell our policies will receive ongoing role-appropriate training, as Well as extra training to correct any shortcomings we find.

2.17 The training will cover:

a) The customer perspective
b) our Life Insurance Policies and the characteristics of customers in the target audience
c) acceptable and unacceptable sales practices
d) the legal duties owed to customers that they have when they provide personal advice, and
e) the Code's relevant standards.

2.18 We will ensure our salespeople's remuneration is consistent with good customer outcomes and complies with relevant laws. This includes having compliance performance measures in

any staff sales incentive programs, with consequences for unacceptable sales practices, such as Pressure Selling or inappropriately using deferred Premiums or cooling-off periods.

2.19 If we use a Distributor, we will ensure that their processes and procedures are consistent with good customer outcomes and the Code's relevant obligations that apply to the activities we have contracted them to do.

Insurers will investigate concerns about sales practices

2.20 We will investigate any concerns raised or identified about the sales practices of our employees, any Authorised Representative or any Distributor.

2.21 If we find out that any of our employees, Authorised Representatives or Distributors have made an inappropriate sale, we will talk to you about fixing it and we will fix the issue by:

a) cancelling your policy
b) refunding your Premiums
c) paying you interest on the refunded Premiums
d) adjusting your cover or arranging for more suitable cover
e) correcting information
f) honouring a claim
g) another measure appropriate to the circumstances, and/or
h) saying sorry.

2.22 If we find out that any of our employees, Authorised Representatives or Distributors have made an inappropriate sale, we will also correct the practice, including where appropriate with further education and training.

2.23 Where we contact you about an inappropriate sale and how we will fix it, we will consider the method you prefer where practical, in line with clause 3.1.

2.24 If you tell us you are not satisfied with the remedy we propose, we will review it and tell you:

a) that you can ask us to review any remedy we propose
b) how to make a Complaint.

Insurers will have rules for direct sales

2.25 A direct sale occurs when a consumer contacts us to buy a Life Insurance. Where these sales are made verbally or face to face, we will have sales rules that state we will:

a) periodically, as appropriate, ask if you understand the information the salesperson has given you
b) allow you time to ask questions
c) give you information to help you decide how much cover you want
d) tell you at the start of the application process that you are now applying to buy a Life Insurance Policy, and ask for your explicit agreement to proceed
e) not sell you the policy or take your payment details if you ask for time to think about the policy before applying, and offer to set up a call or meeting to discuss it later, and
f) that sales staff should never take advantage of vulnerable customers and when to stop selling.

2.26 If you are not eligible for the policy and we offer a different policy instead, we will give you details about it including the PDS and offer to set up a call or meeting to discuss it later.

Funeral Insurance will be clearly explained

2.27 If we offer you a Funeral Insurance Policy, we will clearly explain in plain language:

a) that it is an insurance policy not a savings plan, and what this means
b) the benefits you are entitled to
c) how your beneficiaries can claim these benefits when you die

d) any pre-existing medical condition exclusions and how they apply
e) any period during which your policy only pays out if you die in an accident
f) that you can cancel at any time and what happens if you do so after the cooling-off period, including if we will refund Premiums
g) level and stepped Premiums, and an illustration of how they might go up if stepped
h) that the total Premiums you pay could be more than the benefits we pay, if applicable, and
i) what happens if you stop paying your Premiums, including if we refund them.

2.28 If you purchase a Funeral Insurance Policy from us, we will let you choose level or stepped Premiums if stepped Premiums are offered. Along with the key facts sheet, we will explain:
a) If you purchase a Policy with stepped Premiums, how stepped Premiums may increase, along with a warning about future affordability if your income changes, such as when you retire or enter aged care, and
b) what will happen if you allow the policy to be cancelled.

2.29 Some Funeral Insurance Policies require little or no Premium to be paid initially. In these cases, we will:
a) tell you before the policy starts what the first full Premium is or we estimate it will be
b) give you 10 to 20 Business Days' notice of when we will collect the first full Premium
c) not collect the first full Premium until we provide such notice, and
d) provide you with a 30–calendar day cooling-off period from the day you pay your first full Premium

Insurers will clearly explain consumer credit insurance (CCI)

In some cases, you may purchase a CCI Life Insurance Policy together with a credit product. If you do, unless there is an exemption we will not offer or sell to you the CCI Life Insurance Policy until 4 days after you have purchased the credit product. This is known as the 'deferred sales period' which is required by law in certain instances.

We can still provide you with factual information about CCI for you to consider during the deferred sales period.

2.30 Before you buy CCI with us or through our Authorised Representative or Distributor, we or They will give you clear information to help you make an informed decision. This will include:
a) the cost, as Well as any interest you will pay on the Premium
b) the monetary limits on the key benefits payable
c) the period you would be insured for, and
d) the date your insurance ends, if different from the date the underlying credit product ends.

2.31 We will only sell you CCI if you give us your explicit consent to do so. If we do, we will allow you to change your mind and get a full refund within 30 days in line with Clause 4.33.

2.32 If the CCI Life Insurance Policy is an add-on to a loan and you can pay the Premium through the loan, we will give you at least 1 non-financed payment option, such as a monthly direct debit.

2.33 If the CCI Life Insurance Policy is an add-on to a loan and the Premium is paid through the loan, we will tell you that you will pay interest on the Premium, and your initial loan repayments will be shown with and without the Premium to compare.

2.34 Clauses 2.32 and 2.33 do not include CCI that protects a credit card, line of credit facility or overdraft where the Premium is charged regularly to that card, credit facility or overdraft. In these cases, the information we give you in clause 2.30 may not include the cost or any interest you will pay on the Premium.

3 Communicating with you

Documents and notices

Communication will vary based on policy type and owner

If your application requires an Underwriting decision, we will send all communications about the Underwriting decision to the Policy Owner.

3.1 We will use the method you prefer where practical, unless the Code specifies that we will communicate with you in writing. We will comply with this requirement if we communicate with the Applicant, Policy Owner, Group Policy Owner, Life Insured, Third Party Beneficiary or Representative. This may be:

a) verbal, such as face to face or by phone, or
b) in writing, such as by mail, email, text message or any other way the law or a regulation allows.

3.2 If you are not the Policy Owner, we will not share your personal information with the Policy Owner without your consent, in line with privacy and confidentiality requirements.

3.3 If an employer or superannuation fund trustee owns the Life Insurance Policy, we will sometimes interact with them as appropriate. They will communicate with you as needed.

Insurers will provide policy information and notices in writing

3.4 Before you apply for a new Life Insurance Policy, you can read the PDS online or ask us to send you a copy. But if you ask us for a PDS we did not prepare, we will refer you to the relevant party – such as a superannuation If fund trustee or other Group Policy Owner – for a copy.

3.5 After you buy a Life Insurance Policy (but not a Group Policy), we will give you documentation including information about:

a) the types of risks we insure you for
b) how much you are insured for, if there is a fixed amount assigned to your cover, and the Premium you will pay
c) a description of how the price you pay is structured or how premiums could change, for instance whether the cover has stepped or level premiums or a single premium
d) the cooling-off period of 30 days
e) any exclusions or waiting periods that apply
f) the impact a claim could have on other benefits or income if it is relevant to your policy
g) our claims and Complaints processes
h) if benefits are payable after a defined medical event, and
i) whether benefits are payable when a medical condition is diagnosed or after you meet extra criteria.

3.6 Once you own a policy, we will send the Policy Owner a copy of your policy documents if you ask us to. But we will first meet any legal requirements for releasing them.

3.7 If we automatically upgrade your policy, we will tell the Policy Owner about any key changes, unless your policy is a Group Policy.

3.8 Before each policy anniversary, we will send the Policy Owner a notice in writing outlining:

a) what and how much we insure you for
b) an explanation for any increase in your Premiums
c) how to claim
d) the risks of cancelling and replacing your policy, and

e) how to contact us if you want to change the policy or are having trouble paying your Premium.

3.9 We will also remind you in the notice in writing, if applicable, at least once a year how the maximum you can claim depends on how much you earn at the time of claim.

3.10 Clauses 3.8 and 3.9 do not apply to CCI or Group Policies. For a CCI policy, the notice in writing we send before each policy anniversary will show:

a) the period of cover
b) the types of cover, and
c) our contact details for questions or claims.

Insurers will tell you if they cannot provide information

3.11 We will tell you if we cannot meet a deadline in the Code for giving you information because we are waiting for a third party to let us release it This will not be a Code breach if we tell you before the deadline.

3.12 If we decide not to disclose information you ask us for, we will:

a) do so reasonably
b) give you a list of the items we have not disclosed
c) give you details of our Complaints process, and
d) explain our reasoning, for example where privacy laws allow us to withhold it.

Insurers will tell you about errors, omissions or inconsistencies when they impact you

3.13 If we find that we have made an error, omission or inconsistency that impacts you, we will tell you within 10 Business Days how we will address it. We may need extra information to address it. These timeframes will not apply if the error is identified as part of a broader remediation program affecting multiple customers.

Communicating certain medical or health information

3.14 Some information about your health may be better communicated to you by your doctor. If so we will provide this information to your doctor.

4 Buying a Life Insurance Policy

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 this carefully, in line with your duty to take reasonable care. It also describes who can make the underwriting decision and what we will tell you about it.

Duty to take reasonable care

Giving you information about your duty

4.1 When you start your application for a Life Insurance Policy, we will explain:
- a) that you have a duty to take reasonable care not to make a misrepresentation when you answer our questions, and
- b) the possible consequences of not taking reasonable care.

4.2 We will ensure that you are not required to have specialist knowledge to answer our questions, but we do expect you to have a good understanding of your health, lifestyle and financial situation. We will ensure that the questions we ask are in plain language where possible.

4.3 If we ask you questions face to face or on the phone, we will:
- a) do so carefully, to help you understand what we are asking you to help you meet your duty to take reasonable care not to make a misrepresentation
- b) repeat a question as many times as you reasonably ask us to,
- c) give you time to ask questions, and
- d) ask if you have understood.

4.4 We will give you a record or summary of the answers we use to assess your application no later than 10 Business Days of the cover starting.

When you apply for Life Insurance cover, you have a legal duty in relation to the information you provide to the life insurer.

If you do not comply with your duty, the Insurance Contracts Act may allow us to vary or avoid your life insurance cover. Our options may include:
- charging a higher premium, changing the amount we insure you for, or applying an exclusion, or
- avoiding your cover, which means cancelling it as if it never existed.

Insurers will give consumers a chance to explain

4.5 Before we make a decision to vary or avoid your cover pursuant to the Insurance Contracts Act, we will send you a 'Show Cause' letter that:
- a) includes copies of any information that may be relevant to our decision
- b) explains any remedies and the impact our decision may have on your cover under the Life Insurance Policy, and
- c) gives you a chance to explain and provide any further information or documents you would like us to consider.

4.6 In line with the Code's fairness principle, we will consider any response you provide to the Show Cause letter before we make our decision.

Insurers will confirm variations or avoidances in writing

4.7 If we decide to vary or avoid your cover, we will then write to the Policy Owner to:
a) explain our decision and reasoning, including each variation or avoidance being applied
b) confirm what impact our decision has on your cover under the Life Insurance Policy
c) tell you that you can ask us for copies of the information about you that we relied on, that we will give these to you within 10 Business Days, subject to any legal requirements,
d) tell you that you can ask us to review our decision, and
e) tell you how to make a Complaint.

Underwriting decisions

Insurers can seek more information about a consumer's health

4.8 We will only ask for information about your health that we reasonably need to assess your application, such as by asking:
a) you about your health
b) a third party, such as your doctor, for a report, or
c) you to undergo a medical exam from an Independent Service Provider we choose.

4.9 If the information you give us is enough to make our decision, we will let the Policy Owner know the outcome within 5 Business Days of receiving the information.

4.10 Clause 1.20 outlines the standards that independent medical assessors or examiners will meet. While we will choose the provider referred to at clause 4.8, we will tell you that you can choose the gender of the examiner where this is possible.

4.11 If we ask you to have a medical exam with an Independent Service Provider, we will pay for:
a) the appointment, but not any fees if you miss it without a good reason,
b) any reports, and
c) any reasonable travel costs and out of pocket costs we agree in advance.

4.12 We will ask the Independent Service Provider to give us their report within 10 Business Days of your appointment.

4.13 If we ask an Independent Service Provider for a report that does not require you to attend an assessment, we will ask them to send it within 20 Business Days of our request.

4.14 If the Independent Service Provider does not meet the deadlines in clauses 4.12 and 4.13, we will tell the Policy Owner and periodically update you on our progress getting the report.

4.15 We will ask for any extra information to assess your application as early as possible and try to avoid multiple requests. We will also explain why we need it and that you can ask us to review our request. If you are unhappy with the outcome of our review, we will treat this as a Complaint.

Insurers will ask consumers for consent

4.16 We will ask for your consent to access any information about your health using the wording that the FSC and the Royal Australian College of General Practitioners agreed. You can find this wording on the FSC Website at www.fsc.org.au.

4.17 We will tell you each time we use this consent. We will contact you by phone, SMS, email or similar when possible, unless you tell us you have a different preference.

Mental health, family medical history and genetics

4.18 If you tell us about a diagnosed mental health condition or symptoms of a mental health condition you have or have had, we will:

a) allow you the opportunity to provide information about the history, severity or type of condition before making our decision about whether to insure you and, if so, the terms we offer you, and

b) take into account your circumstances such as the history, severity or type of condition, when deciding whether we can offer you cover. If we do not offer you cover, or we offer you alternative terms, we will explain to you why in line with clause 4.26.

4.19 If we ask you about any family history of illness, we will only ask you to tell us about:

a) the family history that you know about

b) your first-degree blood relatives (parents, children and siblings), without giving their names or dates of birth, and

c) their illness and age at diagnosis and/or death.

4.20 When we assess your application, we will not consider any family medical information about your family that relatives have given us about themselves, for example when they took out their own policies with us.

4.21 If you have had a genetic test, we will comply with the Moratorium on genetic tests at Appendix A:. It explains what we can ask you about the results and how we can use that information.

Underwriters will have appropriate skills

4.22 We will ensure our underwriters have the appropriate skills and training, including for mental health where applicable. They will not make decisions for us until they have shown technical competency and an understanding of all relevant laws, Code requirements, and FSC standards and guidance.

4.23 While assessing an application, our underwriters will have access to professional advice and support in relevant disciplines – such as from medical specialists and accountants – if needed.

Offering insurance

Insurers will explain the terms of any offer, including alternative terms

4.24 We will tell you if we accept your application and, if so, on what terms within 5 Business Days of:

a) receiving all the information we reasonably need, and

b) completing all reasonable enquiries, including to any Reinsurer.

4.25 If we issue temporary insurance during the Underwriting process, we will let you know what it does and does not cover, and when it will end.

4.26 If we offer you alternative terms, we will explain in plain language:

a) the alternative terms

b) that if you agree to buy the policy, we will take this as your agreement to the alternative terms

c) that you can ask us to review any alternative terms we offer now or in the future if circumstances change, and how to do so, and

d) the elements in clause 4.29.

Insurers will explain the general risks of replacing an existing policy

4.27 If you are applying for a Life Insurance Policy with us and you tell us that you are replacing an existing Life Insurance Policy, we will tell you that you shouldn't cancel any existing cover until we accept your application.

4.28 We will also explain the general risks of replacing an existing Life Insurance Policy, including, where relevant, the:

a) loss of any accrued benefits
b) possibility of waiting periods starting again, and
c) implications of any errors or omissions in your new application.

Insurers will share information they relied on to make decisions

4.29 If we do not offer you insurance, we will explain to you in plain language:

a) the reasons for our decision
b) that you can ask us for the information about you that we relied on to make this decision
c) that you can contact us if you think the information we relied on is incorrect or out of date
d) that you can ask us to review our decision or give us extra information to consider, and
e) our Complaints process.

4.30 We may sometimes learn information about you that could be significant to your health or that you may not know about. If this is the case, we may give the information in clause 4.29 to your treating doctor to explain to you.

4.31 If you ask us for the information about you that we relied on in clause 4.29, we will give it to you or your doctor within 10 Business Days. But clauses 3.11 and 3.12 apply.

Policy cancellations

Customers can cancel policies they do not want

4.32 We will tell the Policy Owner that they have at least 30 calendar days from the day they buy the policy to change their mind and get a full refund, unless the duration of cover is designed to be 3 months or less, in which case we will provide a refund in line with the terms of the policy. This is the cooling-off period.

4.33 In line with the policy terms, we may owe the Policy Owner a refund when they cancel the policy. If so, we will send them any money we owe within 15 Business Days.

4.34 We will not pressure you to keep a policy you no longer want.

4.35 If we cancel a policy because the Policy Owner has not paid the Premiums, we will let them know if there is an option to reinstate the policy. If this reinstatement is at our discretion, we may ask for extra information.

4.36 Clauses 4.32–4.35 do not apply to cover under a Group Policy, as the Group Policy Owner is responsible for communication about changes.

5 Claims

Communication during a claim

Insurers will work with you throughout the claims process

5.1 We acknowledge that claims time is difficult for you and that each situation is unique. We will treat you with empathy, compassion and respect throughout the claims process.

5.2 We will not discourage you from making a claim.

5.3 If you tell us that you are having trouble providing the information we need, we will work with you to try to find a solution. This may mean that we try to collect it for you.

5.4 If you make an income-related claim because you are ill or injured and cannot work, if we consider it appropriate, we will:

a) ensure you have an assigned claims assessor throughout the claims process
b) identify and act upon ways to support your recovery early on
c) identify and act upon ways to encourage best practice rehabilitation and return to work programs, and
d) work with your doctor, other healthcare providers and your employer to improve your health.

Insurers will keep in regular contact about claims

5.5 Within 10 Business Days of the Claim Received Date, we will tell you:

a) how you can access the Code, in line with clause 1.3
b) about your cover and any waiting periods that may apply
c) about all of the relevant benefits under the Life Insurance Policy you are claiming on, and
d) about the claims process and who to contact for more information.

5.6 We will update you on your claim's progress at least every 20 Business Days, unless you, the Group Policy Owner or your Representative agrees to a different timeframe. We will do this until:

a) we have made a decision, or
b) started the Show Cause or Procedural Fairness process.

5.7 If you ask us for information about your claim at any point, we will respond within 10 Business Days.

5.8 If your benefit period for income-related payments is expiring, we will tell you at least 3 months before your last payment is due to be made. If you are no longer eligible for payments, we will tell you as soon as possible.

5.9 If there is a change in the definition under which you are being assessed after a stated period of time, we will also:

a) give you at least 3 months' notice, and
b) try to do the assessment before the change takes effect so your income is not disrupted if you are still eligible.

5.10 If the benefit you are insured for is going to reduce (except for where offsets or partial payments reduce your benefits), we will give you at least 3 months' notice.

5.11 If you make a claim that is covered by a Group Policy, we may be required to communicate with the Group Policy Owner. If the trustee asks us to communicate with them, we will agree

with them the relevant communications to send them. We or they will let you know who will contact you and help with your claim.

Required information

Insurers will ask you to provide information or agree to it being collected

5.12 Every time you make a new claim, we will ask for your consent for us to collect information about you, such as about your finances, job or health. We may ask you to consent to us requesting information from more than 1 source. We will tell you each time we use your consent by phone, SMS, email or similar when possible, to ensure you know quickly. If you do not agree that we need some of this information, we will review our request.

5.13 We will ask for the information we reasonably need from you and third parties as soon as possible and will avoid multiple information requests over time where possible.

5.14 When we assess your claim, we will respect your privacy by only asking for information we reasonably need to make our assessment. We can fully investigate the history of any condition you are claiming for. We will only try to verify the information you gave us when you applied for cover about conditions that are not related to your claim if we have reasonable grounds. We will explain those grounds and how you can make a Complaint.

5.15 If you tell us that you do not agree that the grounds are reasonable, we will review them. We will tell you the outcome of our review and how you can make a Complaint.

5.16 From time to time, we may use information that is available online about you. If we do this, we will do so within the relevant laws and regulations and only rely on information that is in the public domain.

5.17 For income-related claims, such as for income protection or business expense cover, we:

a) may need medical and financial information regularly to assess if you are entitled to ongoing benefits or calculate your benefit payments
b) will not ask you for a statement from your doctor more often than we reasonably need to assess your condition
c) will not ask your doctor for a statement solely to process your regular benefit payment,
d) will only request financial information if we need it to assess if you are entitled to benefits or calculate the amount, and
e) may ask your doctor for information every 6 months, even if your condition is stable.

Medical exams

5.18 If we ask you to have an independent medical examination we will tell you that you can ask us:

a) for a list of doctors to choose from, and
b) to include at least 1 doctor of each gender on the list where practical.

5.19 Clause 1.20 outlines the standards that independent medical examiners will meet.

5.20 If the doctor you choose has limited availability, we will tell you that this may delay your claim.

5.21 If we ask you to have a medical examination, we will pay for:

a) the appointment, but not if you miss it unless we are satisfied you had a good reason for missing it,
b) any reports, and
c) any reasonable travel and out of pocket costs we agree in advance.

5.22 We 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.

5.23 We will ask the doctor to give us a report within 20 Business Days after our request or your appointment, if you need to attend one. You can ask us for a copy, and we will send it to you or to your doctor if we think that is more appropriate. If the doctor fails to meet this timeframe we will inform you of this and keep you informed of our progress in obtaining the report.

Interviews

5.24 If we ask you to be interviewed (not an independent medical examination) to establish some facts, we will check our records before we hire an interviewer to see if you need one who speaks your preferred language, or a support person or interpreter to attend. If you do need an interpreter, we will pay for it.

5.25 We will arrange an interviewer that:

a) is a certain gender, if you ask and one is reasonably available
b) we are satisfied has the appropriate training and experience to discuss a claim involving a mental health condition, if relevant
c) can help if you have limited English, or
d) can help if you have known cognitive decline or impairment.

5.26 We will tell the interviewer to contact your Representative before arranging the interview with you if you have asked us to communicate with your Representative.

5.27 You can ask us to be interviewed at a place we both agree to outside your home, unless interviewing you at your home is essential to establishing your entitlement to a benefit. If it is, we will explain why.

5.28 Before the interview, you will receive a key information sheet that explains the process and your rights, including:

a) that we will provide a record of the interview,
b) that you can have a Representative or support person with you,
c) how to make a Complaint, and
d) Whether the interview will be recorded. If you ask us, we will give you a copy.

5.29 At the start of the interview, the interviewer will:

a) tell you who they are, what the interview is for, how long it should take and what it will cover, and
b) explain that they are acting for us.

5.30 We will ensure that all interviews are conducted respectfully and take no more than 90 minutes, unless you agree to an extension.

5.31 We will offer you a 5 minute break at least every 30 minutes during the interview, and you can ask for more breaks or to end the interview early.

5.32 The interviewer will end the interview right away if it becomes clear that you need a support person or interpreter and do not have one.

5.33 We will arrange another interview if we reasonably need it, but not within 24 hours of the first one unless you agree.

5.34 If you withdraw your claim after an interview, a different person will contact you to discuss your reasons and ask if you would like to restart your claim.

Restricting the use of surveillance

5.35 If we have reason to believe that the information we have about your claim is inconsistent with other information available to us, we will try to resolve those inconsistencies without using Surveillance by an investigator.

5.36 If Surveillance is justified, we will document the inconsistencies and ask a senior member of our team to review and approve it.

5.37 If approved, we may appoint an investigator to help us with your claim. If we do, we will require that they:

a) are a licensed private investigator
b) comply with relevant state or territory laws, and clauses 1.19 and 1.22
c) only collect information that is relevant to the assessment of your claim
d) uphold the Code's standards for interviews (clauses 5.24–5.34) and Surveillance (clauses 5.35–5.38)
e) keep a record of all investigation activities in line with the *Privacy Act 1988*, and
f) do not use illegal methods, threaten anyone, make any promise or offer, or cause anyone to do anything they wouldn't have done otherwise during the surveillance.

5.38 If we appoint an investigator, we will direct them:

a) not to conduct Surveillance in any court or judicial facility, medical or health facility, bathroom, changing or lactation room, or inside your home
b) not to intentionally film your family members, neighbours, friends, acquaintances or colleagues with you
c) if filming them cannot be avoided, to pixelate or blur any video they appear in before giving it to any external party such as a court or External Dispute Resolution Body
d) not to communicate with those people in ways that might reveal the Surveillance, and
e) to stop the Surveillance if we receive evidence from a doctor or psychologist that it is negatively affecting your health, including your mental health.

Claim decisions

Training and remuneration for claims assessors

5.39 We will ensure our claims assessors have the appropriate skills and training to make objective decisions. They will not make decisions for us until they have shown technical competency and an understanding of all relevant laws, Code requirements, and FSC standards and guidance.

5.40 We will ensure our claims assessors' remuneration, including their entitlement to any bonuses:

a) is consistent with the principles set out in clause 1.6, and
b) is not directly based on financial targets for claims outcomes.

Timeframes apply for handling claims

We complete our assessment of your claim by:

- making a decision on your claim, or
- issuing a Show Cause or Procedural Fairness letter.

Making a decision on your claim may include:

- admitting, closing or declining your claim, or
- making an initial decision for income-related benefits.

5.41 If your claim is for income-related benefits, unless there are or have been Circumstances Beyond Our Control, we will complete our assessment of your claim within 2 months of:
a) the Claim Received Date, or
b) if later, the end of the waiting period your policy specifies.

5.42 If your claim is for a lump sum benefit, unless there are or have been Circumstances Beyond Our Control, we will complete our assessment of your claim within 6 months of:
a) the Claim Received Date, or
b) if later, the end of any waiting period your policy specifies.

5.43 Once we receive all the information we reasonably need to complete our assessment – including your response to the Procedural Fairness or Show Cause letter, if relevant – and have taken all steps to finalise our decision, we will:
a) tell you our decision within 5 Business Days, and
b) confirm our decision in writing within 10 Business Days of telling you, if we have not already done so at a) above.

5.44 Depending on your policy and the benefit you are claiming, we may tell you that you may be required to do rehabilitation or retraining before we can make a decision on the claim.

5.45 If we accept a death claim, we will tell you that we may be unable to pay the benefits until your estate's Representatives confirm that they have obtained probate or letters of administration.

5.46 If we need a medical or financial report to assess your claim, we will ask the provider to give us their report within 20 Business Days of our request or the appointment, if relevant. If they do not meet this deadline, we will tell you and update you on our progress getting the report, in line with clause 3.11.

5.47 Before we close your claim because we need outstanding information, such as from you or your doctor, we will follow up with you at least twice using different methods of communication.

5.48 If we close or decline your claim, you or the Policy Owner can ask us to reopen or reassess it. If you do, we will treat it as a new claim with a new Claim Received Date, and the timeframes under the Code will restart once the claim is reopened.

5.49 If we decline your claim, we will tell you in writing:
a) our reasons and a summary of the information about your claim that we relied on
b) that You can ask us for copies of the documents about your claim that we relied on, which we will send to you, or to your doctor if we think that is more appropriate. We will send these copies within 10 Business Days in line with privacy provisions,
c) that You can ask us to review our decision, or give us extra information to consider, and
d) about our Complaints process.

Circumstances Beyond Our Control may affect our claims timeframes

5.50 Circumstances Beyond Our Control can affect our timeframes for assessing claims. If they mean we cannot meet a claims timeframe, we will not have breached the Code. Where we identify that there are Circumstances Beyond Our Control we, or the Group Policy Owner, will:
a) let you know what they are in writing
b) tell you about our Complaints process, and
c) update you on your claim's progress at least every 20 Business Days, unless we have agreed to a different timeframe in line with clause 5.6.

5.51 If we believe the Circumstances Beyond Our Control will likely continue for more than 12 months after the Claim Received Date, before the end of the 12 months timeframe we will:

a) refer your claim to a senior member of our team or review committee to review the circumstances
b) let you know the outcome of our review in writing, and
c) tell you about our Complaints process.

Insurers may suggest independent advice for some benefits and payments

5.52 For a claim that is not income related, if we accept it and the amount is at least $50,000, we will provide information to help you obtain independent financial advice to help manage your payment, unless the recipient is a superannuation trustee.

5.53 If we accept an income-related claim and offer you a lump sum settlement instead of future income payments we will suggest that you get independent financial advice before you make a decision. But we will not do this for lump sum payments that do not require you to make a decision, such as make advance payments.

Paying you promptly

5.54 For any income-related benefit we owe you, we will:
a) pay you by the later of the due date or within 5 Business Days of when we have completed all reasonable enquiries, have all the information we reasonably need to assess your claim, and have taken all the steps we need, or
b) tell you that your payment will be late within 5 Business Days of us finding out.

5.55 We will also not stop or withhold any income-related benefit payment during a non-disclosure or misrepresentation investigation, unless we reasonably believe we have evidence that will lead to your claim being declined or your policy being cancelled or avoided.

Specific definitions apply to medical trauma and critical illness claims

5.56 The definitions in the 'Medical definitions' section apply to the first $2 million of trauma or critical illness cover for Life Insurance Policies we issued or group schemes that started on or after 1 July 2017. But they do not apply:
a) to such cover that we reinstate after a claim
b) where the amount we pay varies based on how severe the condition is, or
c) to benefits included with income protection or TPD.

5.57 Where your trauma/critical illness cover includes cancer, a heart attack or a stroke (but not the exclusions listed in the 'Medical definitions' section) and you make a claim, we will assess your claim against these 2 definitions so that you get the better of the following 2 definitions:
a) the applicable definition in our PDS/policy document linked to the full benefit amount
b) if different, the definition in the 'Medical definitions' section that is current at the time of the insured event.

6 Supporting customers experiencing vulnerability and financial hardship

Vulnerable people

A range of circumstances can cause vulnerability

6.1 We recognise that some customers may experience vulnerability due to age, disability, injury, a mental health condition, physical health condition, language barriers, literacy barriers, cultural background, remote location, Aboriginal or Torres Strait Islander status, family violence or financial distress. We are committed to taking extra care to support vulnerable customers.

6.2 We will treat you with empathy, compassion and respect.

6.3 We will ask for your permission to keep a record of the support or assistance you require.

6.4 We understand that some customers' may also have unique needs which makes them vulnerable because of their circumstances and this makes it harder to access our products and services.

6.5 We will have a publicly available policy on our website about how we will support you if you are affected by family violence.

6.6 We will arrange relevant training for our employees who are likely to be involved in communications requiring an interpreter.

6.7 On our website there will be an easy-to find link to:
a) information on interpreting services
b) teletypewriter services (TTYs)
c) any information on our products that we have translated into other languages, and
d) any other relevant information for people with language barriers.

Vulnerable people can ask for help

6.8 If you tell us or we identify that you need extra support to access our services due to vulnerability, we will work with you and find a suitable, sensitive and compassionate option where possible. We will do this as early as practical.

6.9 We encourage you to tell us about your vulnerability and if you need extra support, we can arrange support or help to access our services. Otherwise we may not find out about it.

6.10 We will protect your right to privacy.

6.11 If you tell us that you need extra support from someone else or if we identify that you need extra support – such as a lawyer, consumer representative, interpreter or friend – we will recognise this and allow it in all reasonable ways. We will make sure our processes are flexible enough to recognise the authority of your support person where possible.

6.12 If you need support to meet verification and identification requirements, we will take reasonable steps to support you, especially if you are from an Aboriginal or Torres Strait Islander community or a non-English speaking background. Our approach will be flexible in line with AUSTRAC guidance, while still meeting our legal obligations.

6.13 We will have internal policies and role-appropriate training to help our employees:
a) identify and understand if you are vulnerable
b) consider your unique needs or vulnerability
c) decide how we may be able to help you engage with us and to what extent, and

d) engage with you with empathy, compassion and respect.

6.14 We recognise that people living in remote and regional communities may have trouble meeting the timeframes we set to give us documents or to take part in assessments. We will consider this in our Underwriting and claims processes.

Financial hardship

Customers experiencing financial hardship

6.15 If you tell us you are having trouble paying or can no longer afford your Premium due to financial hardship, we will tell you about available options. Some of these options may include:

a) changing your, benefits or the amount we insure you for to reduce your premium
b) asking for urgent benefits due to an illness or injury your policy covers, in line with clauses 6.18–6.21, or
c) not collecting your Premium for a short time, noting that you may not be able to claim for anything that happens, is diagnosed or becomes apparent during this time.

6.16 We will let you know what help we can offer based on reasonable evidence we ask you to give us. We will only ask for evidence we reasonably need to assess your request for extra support due to financial hardship. This could include:

a) your Centrelink statements if you are a Centrelink client
b) your bank statements or other financial documents, or
c) a statement showing your employment ended.

6.17 Clauses 6.15 and 6.16 do not apply to cover under a Group Policy, as the Group Policy Owner is responsible for changes.

Customers can ask for help when making a claim

6.18 If you need help with the claim process, in understanding what is required of you, completing claim forms or providing requested claim information, we will work with you to find a solution. This may include endeavours to collect the information on your behalf, with your permission.

6.19 If you tell us that you urgently need the benefits of your Life Insurance Policy due to a condition that your policy covers, we will assess your request for urgent access to your benefits. We may ask you for evidence of this urgent need.

6.20 We will let you know what help we can offer you within 5 Business Days of receiving all the evidence we need. We will let you know that you can ask us to review our decision and give you details about our Complaints Process. If you disagree with our decision, we will review it.

6.21 If we accept your request, we will confirm any help we offer in writing. This might be:

a) prioritising your claim assessment and our decision, or
b) advancing part of your claim payment.

6.22 Where you have cover under a Group Policy, we will tell you who to contact about your urgent need for benefits. The law limits access to superannuation benefits.

7 Complaints

Making a Complaint

7.1 We will not discourage you from making a Complaint.

7.2 If you make a Complaint to us, we will tell you how you can access the Code, in line with clause 1.3 and acknowledge your Complaint within 24 hours (or 1 Business day) of receiving it, or as soon as practicable.

Customers can make a complaint

7.3 If you tell us that you have a concern about us and someone who is not our Authorised Representative, we will tell you how to have the matter addressed.

7.4 We will give you the name and contact details of the person assigned to or dealing with your Complaint.

7.5 The person assigned to your Complaint will not be the person or people whose decision or conduct is the subject of your Complaint.

7.6 We will only ask for and rely on information relevant to our investigation into your Complaint and our response.

Complaints about declined or closed claims

7.7 If you make a Complaint about a declined or closed claim or the value of a claim, our final response will include the final outcome of your complaint, including if we will reconsider or reopen your claim, or if we maintain or overturn the decision. We will then close your Complaint.

7.8 If the outcome of your Complaint is that we will reconsider or reopen your claim, we will also confirm the name and contact details of the claims assessor assigned to liaise with you.

Handling your Complaint

Insurers will respond directly to some Complaints

7.9 We will only close your Complaint within 5 Business Days of receiving it, if we have:

a) resolved your Complaint to your satisfaction, or
b) give you an explanation and/or apology where we cannot take further action to reasonably address the complaint.

7.10 If we do this, clauses 7.12–7.18 below do not apply, as long as:

a) your Complaint is not about hardship, a declined insurance claim, the value of an insurance claim or a superannuation trustee's decision, and
b) you have not asked for a response in writing.

7.11 We will provide a written response to your Complaint, even if we resolve your Complaint within 5 Business Days, if:

a) your Complaint is about hardship, a declined insurance claim, the value of an insurance claim or a superannuation trustee's decision, or
b) you have asked for a response in writing.

7.12 We will give you our final written response to your Complaint in writing within 30 calendar days, unless clause 7.14 applies. Our final response will include:

a) the action taken to resolve the complaint or the reasons for our decision
b) identifying and addressing the issues raised in the Complaint with a summary of the information relied on
c) that you can ask us for a copy of documents and information relied on in assessing your Complaint, and
d) that you have the right to take your Complaint to an External Dispute Resolution Body if you are not satisfied with our decision, along with how to contact them and any time limit for doing so.

7.13 If you ask for the documents and information relevant to your Complaint that we relied on, we will send them to you within 10 Business Days, in line with clauses 3.11 and 3.12.

7.14 We may not be able to respond within 30 calendar days if the Complaint is complex and/or there are circumstances that are beyond our control causing a delay. If we cannot respond to your Complaint within 30 calendar days, before this time is up we will tell you:
a) why there is a delay,
b) keep you regularly updated about progress, and
c) that you may have the right to take your Complaint to an External Dispute Resolution Body if you are not satisfied with our explanation, along with how to contact them and any time limit for doing so.

Superannuation fund trustees will respond to other Complaints

7.15 If you make a Complaint about a Life Insurance Policy a superannuation fund trustee owns, you can complain to us or to the trustee.

7.16 The trustee must give you a final written response to your Complaint within 45 calendar days of us or them receiving the Complaint. This will include:
a) the action taken to resolve the complaint or the reasons for their decision
b) identifying and addressing the issues raised in the Complaint with a summary of the information relied on
c) that you can ask for a copy of documents and information relied on in assessing your Complaint
d) that you have the right to take your Complaint to an External Dispute Resolution Body if you are not satisfied with their decision.

7.17 If they do not respond within 45 calendar days, we will tell you that you can ask them to explain the delay in writing.

7.18 We will give You our final decision in writing or give it to the superannuation fund trustee so that they can give it to you. This will include everything from clause 7.12.

8 Code governance

The FSC and the Life CCC

The Financial Services Council develops the Code

8.1 The FSC develops this Code. It will:

a) consult with the Life CCC, External Dispute Resolution Bodies, consumer and industry representatives, regulators and other stakeholders about the content, and

b) commission formal independent reviews as needed starting in 2024, and at least every 3 years after that.

The Life Code Compliance Committee monitors governance

8.2 The FSC also developed the Life CCC charter, which sets out the Life CCC's functions and powers. The Life CCC is made up of:

a) an independent chair

b) a consumer representative, and

c) an industry representative.

8.3 The Life CCC will regularly report to the FSC's Life Board Committee on industry issues and Code compliance. It may recommend:

a) improvements to the Code to address weaknesses or non-compliance, and

b) that the Life Board Committee review the Code if it could better meet its goals.

8.4 The Life CCC also publishes an annual report with consolidated, de-identified analysis on compliance.

8.5 The Life CCC may outsource its functions to an appropriate body, but not its powers to sanction.

Breaches and sanctions

Entities will comply with both the law and the Code

8.6 The Code only creates legal or other rights between the entities bound by it and the FSC. It does not create rights for any other parties, except where it identifies enforceable provisions. The enforceable provisions of the Code are: [Placeholder to identify ECPs]

8.7 If there is a conflict or inconsistency between the Code and any law or regulation, the law or regulation prevails. But where the Code has higher standards than the law, entities will comply with both the law and the Code.

8.8 Life insurance companies may agree with a Group Policy Owner to service standards that are higher than the Code standards.

8.9 Only the enforceable provisions apply to proceedings in a court or tribunal. But External Dispute Resolution Bodies, if allowed, may consider if the entities bound by it have met their obligations in the Code when they Determine disputes.

Insurers will ensure compliance with the Code

8.10 Any organisation bound by the Code (see clause 1.12) will meet Code standards for all products and services it provides. We will:

a) have appropriate systems and processes to enable compliance

b) report to the Life CCC yearly about our compliance, and
c) have a governance process to report to our Board of Directors or executive management about our compliance.

8.11 We will be in breach of the Code if our staff or our Authorised Representatives do not comply with the Code.

8.12 If We find a Significant Breach in our organisation, we will report it to the Life CCC within 30 Business Days of discovering it. But we will not do this if we have already reported (or will report) a Significant Breach to the relevant regulator, and they know the matter may also involve a Code breach. If so, the relevant regulatory timeframes will apply.

8.13 Anyone – including you and External Dispute Resolution Bodies – can report an alleged Code breach to the Life CCC. The Life CCC may then:
a) tell us about the allegation and give us a chance to respond
b) investigate as it sees fit
c) decide if there was a Code breach
d) decide if we should deal with the allegation through our internal Complaints process, and refer you to us if so
e) agree with us to any fair and reasonable corrective actions we will take and the relevant timeframes (considering any related actions that a regulatory body has imposed), and
f) monitor our actions and decide if they are effective and on time.

8.14 The Life CCC may also impose sanctions, in line with clauses 8.17–8.20.

8.15 We will cooperate with the Life CCC's reviews of our compliance with the Code, investigations of alleged Code breaches and reasonable requests at any time. For any Code breach they find, we will also take fair and reasonable corrective actions in agreed timeframes. But any corrective actions that a regulatory body imposes on us will take precedence.

8.16 In line with FSC Standard No. 1, the FSC Board can discipline us if we do not correct a Code breach. This includes if we do not comply with a Life CCC sanction, which is regarded as a breach of an FSC Standard.

The Life CCC can sanction insurers

8.17 If the Life CCC finds a Significant Breach or if we cannot agree on corrective actions, it will:
a) tell our Chief Executive Officer (CEO) in writing
b) give us 15 Business Days to respond
c) consider our response before making a final decision and imposing any sanctions, and
d) tell our CEO and the FSC its decision in writing.

8.18 The Life CCC's decisions are binding on us.

8.19 When deciding any sanctions, the Life CCC will consider:
a) the Code's principles and goals
b) if the sanction is appropriate, and
c) any related actions that a regulatory body has imposed on us.

8.20 A sanction may mean giving a formal warning or requiring us to:
a) take steps to fix the Code breach in a set timeframe, considering any related actions that a regulatory body has imposed on us
b) audit our Code compliance
c) put out corrective advertising
d) write to customers affected by the Code breach, and
e) publish our non-compliance on our Website and the FSC Website.

9 Definitions

General definitions

These acronyms appear throughout the Code

Acronym	Meaning
APRA	Australian Prudential Regulation Authority
ASIC	Australian Securities and Investments Commission
CCI	Consumer Credit Insurance
FSC	Financial Services Council Limited
Life CCC	Life Code Compliance Committee
PDS	Product Disclosure Statement
TPD	Total and Permanent Disability

These definitions apply to the Code (but not to Appendix A: Moratorium on Genetic Tests in Life Insurance)

Term	Meaning
Applicant	A person who applies for a Life Insurance Policy with us to become a Policy Owner or Life Insured.
AFS license	Australian Financial Services licence
Authorised Representative	Person, company or other entity we authorise to provide financial services on our behalf under our AFS licence, in line with the *Corporations Act 2001*. It does not include a person, company or entity that is an Authorised Representative of any other holder of an AFS license, including a holder of an AFS license that is a related company to us.
Business Day	Monday to Friday, except public holidays.
Circumstances Beyond Our Control	Any of the following: a) We have not received reports, records, evidence or information we reasonably requested from you, your Representative, the Policy Owner, the Group Policy Owner, an Independent Service Provider, your doctor, a government agency, or another person or entity (but not a Reinsurer). b) You, your Representative, the Policy Owner or the Group Policy Owner have not responded to our reasonable enquiries or requests for documents in a reasonable timeframe. c) There are difficulties communicating with you, your Representative or the Policy Owner about the claim. d) You are or will be undergoing rehabilitation, retraining or further treatment, which may impact our ability to form a view on your claim. e) You, your Representative, the Policy Owner or the Group Policy Owner have asked for a delay or extension to part of the claims process.

Term	Meaning
	f) We reasonably suspect there was non-disclosure or misrepresentation before the cover or policy started that we believe may impact your claim, and we need further investigation, evidence and/or information. g) We reasonably suspect that your claim is fraudulent and need further investigation, evidence and/or information.
Claim Received Date	The date a life insurer records it has received the first piece of information, but not necessarily all information, to allow it to commence the assessment of a claim.
Code	This Life Insurance Code of Practice.
Complaint	An expression of dissatisfaction made to or about an organisation about its products, services, staff or handling of a Complaint, where a response or resolution is: a) explicitly or implicitly expected, or b) legally required.
Determine	When an External Dispute Resolution Body makes a final decision.
Distributor	A person or entity we appoint to distribute our policies on our behalf, excluding independent financial advisors and platform operators.
External Dispute Resolution Body	An external organisation that is relevant to your Complaint, which may include the Australian Financial Complaints Authority or a Complaints handling process that legislation mandates.
Funeral Insurance Policy	A Life Insurance Policy which is issued for the purpose primarily to cover funeral, burial or cremation expenses for the Life Insured or their family members.
Group Policy	A Life Insurance Policy owned by an employer, superannuation fund trustee, or another person or entity that: a) covers a group of eligible Life Insured, and b) includes any extra cover purchased at the request of the Life Insured.
Independent Service Provider	A person or entity we enter an agreement with to help with Underwriting, administration or claims management, such as a/an: a) independent medical assessor b) allied health professional c) rehabilitation provider d) accountant e) investigator, or f) claims management service. A Reinsurer is not an Independent Service Provider.

Term	Meaning
Life Insurance Policy	Any of the following issued in the Australian market, but not a contract of reinsurance: a) An insurance contract that provides for the payment of money on the death of a person or on the happening of a contingency dependent on the ending or continuation of human life (Section 9(1)(a), *Life Insurance Act 1995*). b) An insurance contract that is subject to payment of Premiums for a term dependent on the ending or continuation of human life (Section 9(1)(b). c) A continuous disability policy (Section 9(1)(e). d) Another insurance contract, if we carry on life insurance business (other than annuity business) by issuing or undertaking liability under such a contract due to a declaration by APRA under section 12A of the *Life Insurance Act 1995*.
Life Insured	A person insured under a Life Insurance Policy covered by this Code, whether or not they are a party to the policy. A Third Party Beneficiary is not a Life Insured.
Plain Language	A communication is in plain language if its wording, structure and design are so clear that the intended audience can easily find what they need, understand what they find and use that information. Plain language can include technical terms where these words are the most relevant or precise.
Policy Owner	Any person, company or entity that owns a Life Insurance Policy covered by this Code, including joint Policy Owners. A Third Party Beneficiary is not a Policy Owner.
Premium	The amount you pay, or another person or entity pays for your insurance cover.
Pressure Selling	Using certain techniques to pressure, compel or otherwise encourage someone to buy a policy they do not want.
Procedural Fairness	When we write to you with our preliminary view on your claim and give you a chance to respond before we make our decision.
Procedural Fairness letter	A letter we write to you with our preliminary view on your claim and which states you have a chance to respond before we make a decision.
Reinsurer	An entity that provides insurance to issuers of Life Insurance Policies (known as reinsurance). A Reinsurer does not have a contract of insurance with you.
Representative	Someone you choose or who is authorised to communicate with us on your behalf, such as a: a) lawyer or person with power of attorney b) financial adviser or planner c) Group Policy Owner d) interpreter, or e) family member or guardian.

Term	Meaning
Show Cause letter	A letter we will send you before we make a decision to vary or avoid your cover, that: a) includes copies of any information that may be relevant to our decision, b) explains any remedies and the impact our decision may have on your cover under the Life Insurance Policy, and c) gives you a chance to explain and provide any further information or documents you would like us to consider.
Significant Breach	Any Code breach that we or the Life CCC reasonably determine to be significant by referring to the: a) number and frequency of previous similar breaches b) actual or potential financial loss it causes c) impact it has on our ability to provide our services, or d) extent to which it suggests that our arrangements to ensure compliance with Code obligations are inadequate.
Surveillance	When an investigator watches or films your activities in public.
Third Party Beneficiary	Any person or entity who is entitled to benefits from a claim but is not a Life Insured or Policy Owner. This may include someone: a) a Life Insurance Policy covered by the Code specifies or refers to, by name or otherwise, as someone who may receive the benefit of the insurance, or b) seeking the benefits of the insurance.
Underwriting	The process we use to decide whether to offer you insurance and the terms that should apply to that insurance when you apply for cover. Underwriting requires medical and other personal information from you, which we will consider.
We, us, our	A life insurance provider that is bound by the Code. This includes its Authorised Representatives. 'Us' means the Code subscribers acting individually and independently, not collectively.
You, your	Means, as the context may require: a) the Applicant, Life Insured or Policy Owner b) a person authorised to act on your behalf, such as a named Representative, adviser, parent, guardian or a person with power of attorney, or c) a Third Party Beneficiary, if relevant.

Medical definitions

Three medical terms have specific definitions

Term	Meaning
Cancer, excluding certain early stage cancers	Cancer means any malignant tumour diagnosed with histological confirmation and characterised by: the uncontrolled growth of malignant cells; and invasion and destruction of normal tissue beyond the basement membrane. The term malignant tumour includes leukaemia, sarcoma and lymphoma.

Term	Meaning
	The following are not covered: • All tumours which are histologically classified as any of the following: a) pre-malignant; b) non-invasive; c) high-grade dysplasia; d) borderline or low malignant potential. • Carcinoma in situ except carcinoma in situ of the breast where a total mastectomy with full removal of the breast has been undertaken and was considered by treating doctors to be the appropriate and necessary treatment. • All cancers of the prostate unless: a) histologically classified as having a Gleason score of 7 or above; or b) having progressed to at least clinical stage T2bN0M0 on the TNM clinical staging system; or c) where a total prostatectomy has been undertaken where the procedure was specifically to arrest the spread of malignancy and was considered by treating doctors to be the appropriate and necessary treatment. • All cancers of the thyroid unless: a) having progressed to at least TNM classification T2N0M0; or b) where a total thyroidectomy has been undertaken and was considered by treating doctors to be the appropriate and necessary treatment. • All cancers of the bladder unless having progressed to at least TNM classification T1N0M0. • Cutaneous lymphoma confined to the skin. • Chronic lymphocytic leukaemia unless having progressed to at least Rai stage I. • All non-melanoma skin cancers unless having spread to the bone, lymph node, or an other distant organ. • All melanoma skin cancers unless having progressed to at least TNM classification T2bN0M0.
Heart attack, with evidence of severe heart muscle damage	Heart attack means the death of a portion of the heart muscle as a result of inadequate blood supply, where the diagnosis is supported by the detection of a rise and/or fall of cardiac biomarker values with at least one value above the 99th percentile upper reference limit (URL) and with at least three of the following: a) Symptoms of ischaemia. c) New significant ST-segment–T wave (ST–T) ECG changes or new left bundle branch block (LBBB). d) Development of new pathological Q waves in the ECG. e) Imaging evidence of new regional wall motion abnormality present at least six weeks after the event. If the tests specified in a) to d) above are inconclusive or unable to be met, then the definition will be met if at least three months after the event the insured's left ventricular ejection fraction is less than 50 per cent. The following are not covered: a) A rise in biological markers as a result of an elective percutaneous procedure for coronary artery disease. b) Other acute coronary syndromes including but not limited to angina pectoris.
Stroke in the brain resulting	Stroke means death of brain tissue caused by one of the following: a) Ischaemic infarction of brain tissue.

Term	Meaning
in specified permanent impairment	b) Intracranial haemorrhage (cerebral, intraventricular or subarachnoid). The diagnosis must be supported by both of the following: a) Evidence of permanent neurological deficit with persisting symptoms confirmed by a specialist physician as a definite result of the stroke at least six weeks after the event. b) Findings on MRI, CT, or other reliable imaging evidence consistent with the diagnosis of a new stroke. The following are not covered: • Transient ischaemic attacks. • Brain damage due to an accident, injury, infection, or non-vasculitic inflammatory disease. • Vascular disease affecting the eye or optic nerve. • Ischaemic disorders of the vestibular system. • Strokes caused by or related to illicit drug use or substance abuse. • Migraine. • Hypoxic events. Words within the stroke definition that have special meaning *"Permanent neurological deficit with persisting symptoms"* means dysfunction in the nervous system that is present on clinical examination and expected to last throughout the insured person's life. It includes outcomes such as: numbness, hypertonicity, hemiplegia, monoplegia, hemiparesis, monoparesis, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, coma and objectively documented significant loss of cognitive function. The following do not constitute "permanent neurological deficit with persisting symptoms": • An abnormality seen on brain or other scans without definite related clinical symptoms. • Neurological signs occurring without symptomatic abnormality, such as brisk reflexes without other symptoms. • Symptoms of psychological or psychiatric origin.

Appendix A: Moratorium on Genetic Tests in Life Insurance

A.1 This Moratorium

Life insurance should not dissuade people from Genetic Testing

a) Genetic Testing has the potential to play an important role in informing people about their health and enabling them to manage their health risks through preventative actions and personalised medicine.

b) It is important that public concerns about the use of Genetic Test results in life insurance do not dissuade people from taking Genetic Tests or taking part in genetic research.

c) The objective of the Moratorium on Genetic Tests in Life Insurance (the Moratorium) is to ensure people can access a level of life insurance without being asked about the result of a previously taken Genetic Test.

d) The Moratorium covers an Applicant for individually underwritten life insurance (including individually underwritten life insurance in group insurance) with an FSC member.

e) The Moratorium starts for applications received on or after 1 July 2019 and applies until 30 June 2024.

A.2 Test results

Insurers can ask for test results in some circumstances

a) The overriding principle is that for all applications, regardless of the amount of Cover and any other clause in the Moratorium, we can ask you to disclose, and use as part of our Underwriting process, any diagnosis of a condition, even if the diagnosis resulted directly or indirectly from a Genetic Test.

b) For all applications, regardless of the amount of Cover, we will not ask or otherwise encourage you to:
   i. take a Genetic Test as part of your application and Underwriting process
   ii. disclose the result of a Genetic Test that was taken as part of a medical research study conducted by an accredited university or medical research institution where the test results have not been and will not be provided to you, or you have specifically asked not to receive them.

c) As part of the application process for the benefits listed below, we may only ask for or use the results of a Genetic Test if the total amount of Cover you would have – including both the Cover being applied for and any existing individual and group insurance Cover with all life insurers – is more than any of the following:
   i. $500,000 of lump sum death Cover
   ii. $500,000 of total permanent disability (TPD) Cover
   iii. $200,000 of trauma and/or critical illness Cover
   iv. $4,000 a month of any combination of income protection, salary continuance or business expenses Cover.

d) If your total amount of Cover exceeds any of the limits in clause A.2c), we may ask for and use the result of a previously taken Genetic Test or planned test when assessing the full amount of Cover being applied for across all types. A planned test means you have consented to a Genetic Test. We can do this provided that an evidence base shows that the test has relevance to the Cover applied for, in line with the Disability Discrimination Act.

e) We will take the following into account as part of our Underwriting assessment:
   i. a favourable Genetic Test result you choose to disclose, regardless of the amount of Cover, for example to show that you are not carrying a gene pattern associated with developing an illness that runs in your family
   ii. evidence based preventative treatment, or adherence to evidence based preventative measures, which reduce the possibility of developing an illness that runs in your family.

f) We will only ask for or use Genetic Test results as part of the process to decide the terms offered for Cover in line with clause A.2c). For example, this means that we will not ask for or use adverse Genetic Test results, even if the limits in clause A.2c) are exceeded due to an increase in Cover without Underwriting through automatic yearly increases in Cover.

g) We will ensure that Underwriting staff can consult a medical professional (such as a Chief Medical Officer) where a Genetic Test result is deemed to be relevant in the Underwriting assessment.

h) We will comply with privacy law regarding sensitive information in asking for, using and retaining Genetic Test results in our life insurance operations.

i) For the purposes of governance and compliance, and to inform the review in clause A.3a), we will record anonymous details of all Genetic Test results received as part of the Underwriting process, whether or not we asked for them, on the FSC database of Genetic Test results.

Undisclosed results might not breach duty of reasonable care

j) When assessing claims, we will not treat the Life Insured as having breached their duty to take reasonable care not to make a misrepresentation for not disclosing the results of a Genetic Test that we were not entitled to ask for or use as part of our Underwriting process in line with the Moratorium.

A.3 Moratorium governance

The Financial Services Council (FSC) will review this Moratorium

a) During 2022, the FSC will review the Moratorium in consultation with stakeholders with a view to extending the date, taking account of its objectives and:
   i. feedback from consumer groups and expert stakeholders
   ii. the appropriateness of the amounts of Cover in clause A.2c), taking into account any cross-subsidy between customers who have a genetic pre-disposition and those who do not
   iii. the rates of participation in genetic research
   iv. advances in the field of genomics and Genetic Testing
   v. impacts of the Moratorium on the sustainability of the life insurance industry.

b) The FSC will not reduce the term of, or otherwise change, the Moratorium outside this review process.

These definitions apply to the Moratorium

c) For the Moratorium, the following terms have the associated meaning:

Term	Meaning
Applicant	A person who applies for a Life Insurance Policy with us to become a Policy Owner or Life Insured.
Cover	Any type of life insurance, including: • lump sum death cover • total permanent disability (TPD) cover • trauma/critical illness cover • income protection, salary continuance or business expenses cover.
Genetic Test	A test that examines a person's chromosomes or DNA. It does not include any non-genetic medical tests (such as blood or urine tests for proteins, cholesterol, liver function or diabetes), even if they are to test for a condition that may have a genetic origin.
Underwriting	The process we use to decide whether to offer you insurance and the terms that should apply to that insurance when you apply for Cover.
We, Us, Our	A life insurance provider that is bound by the Code. 'Us' means the entities acting individually and independently, not collectively.
You, Your	The Applicant.

Appendix B - supporting customers experiencing a mental health condition

People with mental health conditions

This Appendix B sets out sections of the Code which we believe may be of particular interest to customers experiencing mental health conditions. In this Appendix B we also refer you to certain parts of the Code containing more detailed information which you may wish to read. **Please note that this Appendix B is not part of the Code.**

We will take extra care if you are vulnerable due to your mental health

1. We recognise that some customers may experience vulnerability due to a mental health condition. We are committed to taking extra care to support you. We will treat you with empathy, compassion and respect. See Clause 6.1 and 6.2 of the Code.

You can ask us for extra support

2. If you tell us or we identify that you need extra support to access our services due to a mental health condition, we will work with you and find a suitable, sensitive and compassionate option. We will do this as early as practical. See Clause 6.5 of the Code.
3. We encourage you to tell us about your mental health condition and if you need extra support, we can arrange support or help to access our services. Otherwise we may not find out about it. See Clause 6.6 of the Code.
4. If you tell us that you need extra support from someone else – such as a lawyer, consumer representative, interpreter or friend – we will recognise this and allow it in all reasonable ways. We will try to make sure our processes are flexible enough to recognise the authority of your support person. See Clause 6.8 of the Code.
5. If you need support to meet verification and identification requirements, we will take reasonable steps to support you. Our approach will be flexible in line with AUSTRAC guidance, while still meeting our legal obligations. See Clause 6.9 of the Code.
6. We will have internal policies and role-appropriate training to help our employees:
   a) identify and understand if you are vulnerable
   b) consider your unique needs or vulnerability
   c) decide how we may be able to help you engage with us and to what extent, and
   d) engage with you with empathy, compassion and respect. See Clause 6.10 of the Code.

Buying a Life Insurance Policy

7. When you apply for a Life Insurance Policy, if you tell us about a diagnosed mental health condition or symptoms of a mental health condition you have or have had, we will:
   a) allow you the opportunity to provide information about the history, severity or type of condition before making our decision about whether to insure you and, if so, the terms we offer you, and
   b) take into account your circumstances such as the history, severity or type of condition, when deciding whether we can offer you cover. If we do not offer you cover, or we offer you alternative terms, we will explain to you why in line with Clause 4.26. See Clause 4.18.
8. We will ensure our underwriters have the appropriate skills and training. They will not make decisions for us until they have shown technical competency and an understanding of all relevant laws, Code requirements, and FSC standards and guidance. See Clause 4.22 of the Code.

9. While assessing an application, our underwriters will have access to professional advice and support in relevant disciplines – such as from medical specialists and accountants – if needed. See Clause 4.23 of the Code.

Making a claim under a Life Insurance Policy

10. We acknowledge that claims time is difficult for you and that each situation is unique. We will treat you with empathy, compassion and respect throughout the claims process. See Clause 5.1 of the Code.
11. We will not discourage you from making a claim. See Clause 5.2 of the Code.
12. If you tell us that you are having trouble providing the information we need, we will work with you to try to find a solution. This may mean that we try to collect it for you. See Clause 5.3 of the Code.
13. If you make an income-related claim because you are ill or injured and cannot work, if we consider it appropriate, we will:
    a) ensure you have an assigned claims assessor throughout the claims process
    b) identify and act upon ways to support your recovery early on
    c) identify and act upon ways to encourage best practice rehabilitation and return to work programs, and
    d) work with your doctor, other healthcare providers and your employer to improve your health. See Clause 5.4 of the Code.
14. Within 10 Business Days of the Claim Received Date, we will tell you:
    a) how you can access the Code, in line with Clause 1.4
    b) about your cover and any waiting periods that may apply
    c) about all of the relevant benefits under the Life Insurance Policy you are claiming on, and
    d) about the claims process and who to contact for more information. See Clause 5.5 of the Code.

Claim interviews will follow set rules

15. If we ask you to be interviewed (not an independent medical examination) to establish some facts, we will check our records before we hire an interviewer to see if you need one who speaks your preferred language, or a support person or interpreter to attend. If you do need an interpreter, we will pay for it. See Clause 5.24 of the Code.
16. We will arrange an interviewer that:
    a) is a certain gender, if you ask and one is reasonably available
    b) we are satisfied has the appropriate training and experience to discuss a claim involving a mental health condition, if relevant
    c) can help if you have limited English, or can help if you have a known cognitive decline or impairment. See Clause 5.25 of the Code.
17. We will tell the interviewer to contact your Representative before arranging the interview with you if you have asked us to communicate with your Representative. See Clause 5.26 of the Code.

Restricting the use of surveillance

18. If we have reason to believe that the information we have about your claim is inconsistent with other information available to us, we will try to resolve those inconsistencies without using Surveillance by an investigator. See Clause 5.35 of the Code.
19. If Surveillance is justified, we will document the inconsistencies and ask a senior member of our team to review and approve it. See Clause 5.36 of the Code.

20. If approved, we may appoint an investigator to help us with your claim. If we do, we will require that they:
    a) are a licensed private investigator
    b) comply with relevant state or territory laws, and Clauses 1.20 and 1.23
    c) only collect information that is relevant to the assessment of your claim
    d) uphold the Code's standards for interviews (Clauses 5.25-5.33) and Surveillance (Clauses 5.34-5.36)
    e) keep a record of all investigation activities in line with the *Privacy Act 1988*, and
    f) do not use illegal methods, threaten anyone, make any promise or offer, or cause anyone to do anything they wouldn't have done otherwise during the Surveillance. See Clause 5.37 of the Code.

21. If we appoint an investigator, we will direct them:
    a) not to conduct Surveillance in any court or judicial facility, medical or health facility, bathroom, changing or lactation room, or inside your home
    b) not to intentionally film your family members, neighbours, friends, acquaintances or colleagues with you
    c) if filming them cannot be avoided, to pixelate or blur any video they appear in before giving it to any external party such as a court or External Dispute Resolution Body
    d) not to communicate with those people in ways that might reveal the Surveillance, and
    e) to stop the Surveillance if we receive evidence from a doctor or psychologist that it is negatively affecting your health, including your mental health. See Clause 5.38 of the Code.