Joint Consumer Submission by the Financial Rights Legal Centre

on behalf of the Consumer Federation of Australia

Life Code Independent Review - Consultation Paper, October 2025

December 2025

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- Consumer Action Law Centre
- Dr Jane Tiller, Public Health Genomics, Monash University
- Financial Rights Legal Centre
- HIV/AIDS Legal Centre
- The Health and Law Partnership at the University of New South Wales
- Indigenous Consumers Assistance Network
- InsurePride
- Kate Seear, Professor, Deakin Law School
- Mob Strong Debt Help
- Super Consumers Australia

Overview and summary

Life insurance is - at its heart - a trauma-based business.

The purpose of life insurance and the range of associated financial products associated with it[1] - is primarily to mitigate against the risk of financial insecurity arising out of life's most challenging events: death, injury, and permanent disablement. In addition to the financial and practical support life insurance can provide when thing go wrong it can also provide significant peace of mind.

By its very nature then, life insurance involves considering and making decisions regarding the worst life can throw at you - circumstances that are for many difficult to conceive of and to deal with psychologically. Just the act of thinking through the consequences of these circumstances when considering purchasing a life insurance product can leave people susceptible to risks of exploitation and manipulation due to the multitude of complex feelings of familial obligation or expectation that can arise. When actually faced with these circumstances, engagement with the life insurance sector can either provide the reassurance and financial security that was offered and hoped for, or other cases can exacerbate somebody's distress and psychological and financial pain.

Given the intersection of trauma, anxiety and what is ultimately a hard-nosed, contract-based financial product - life insurers have a unique obligation to work with their customers in sensitive, ethical and compassionate ways to ensure that they do not make things worse, and not exploit them.

The evidence outlined in this submission however suggests a sector that is continuing to fail to meet this basic standard.

While we acknowledge that claims acceptance rates are generally high (with some notable exceptions),[2] and the estimated average duration of a claim are on *average* 'good'[3] – it is the proverbial 20% of the 80:20 rule whose experiences are far from 'good' who our services hear from and work with.

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[1] Including whole of life, income protection, total and permanent disability (**TPD**), funeral insurance etc

[2] APRA, for example, found that the admittance rate for death cover as at 30 June 2025 was 97% for individual advised and 93% for individual non-advised, while it was as low as 70% for TPD cover for Individual Non-Advised and 67% for Accident Cover for Individual Advised. See: APRA, APRA and ASIC publish latest data on life insurance claims and disputes - December 2024, 15 April 2025

[3] Death cover claims were on average 1 month in duration, while TPD cover was on *average* 3.9 months. It is unclear how long claims via super are taking, since there is no tracking of end-to-end timeframes by APRA, but it is likely the statistics are more concerning.

It is this group of people who are experiencing poor communications practices and never-ending delays, who feel they are being discriminated against when they find themselves subject to a blanket health exclusion or on the wrong end of a sector who has failed to proactively address a legacy of mis-selling. It is this cohort – who are commonly experiencing a range of chronic and transitory vulnerabilities – that the life insurance sector is failing.

This submission builds a case that the current Life Code – and the 'promises' life insurers make to its consumers within - has fallen behind community expectations and is in fact actively contributing to the problems they face. Whether it is:

- the overly broad get-out-of-gaol card "circumstances beyond our control,"
- the lack of practical limits on medical examinations and document requests that contribute to delays, frustration, anxiety and stress,
- the inconsistent, ambiguous and confusing application of protections to those obtaining life insurance directly or from group policy owner, or
- the limited support measures to assist First Nations people

the Life Code has added to the problems faced by those who deal with the life insurance sector. Even where there are clear rules – such as those regarding blanket exclusions for mental health, life insurers flout these seemingly at will.

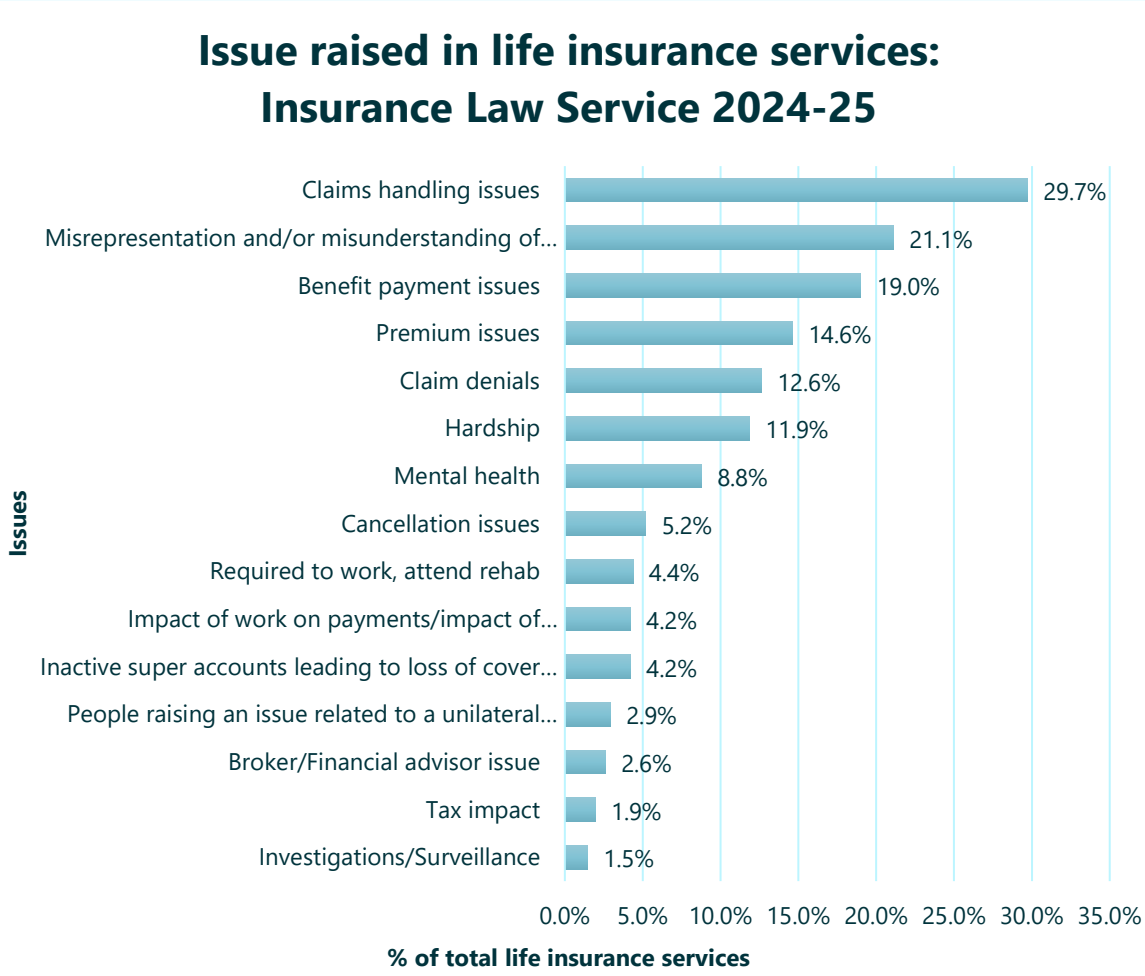
This Life Code review is therefore an opportunity to take stock and for life insurers to lift their game.

But responding positively and constructively to the 132 substantive recommendations outlined in this submission is only part of the solution to raising consumer confidence in the sector. Given the findings of the Life Code Compliance Committee's (**LCCC)** recent report into the treatment of customers who disclose mental health conditions, the life insurance sector is going to have to do more than add further commitments to a code that they have been shown to be systemically breaching. The Life Code must be made enforceable as a term of the contract with the consumer to appropriately incentivise subscribers to meet the promises they make. The Life Code should also be approved by ASIC. Consumers need to be able to rely on and enforce the Life Code to be confident that life insurers will do the right thing in the face of trauma and anxiety.[4] What is required in the face of a hard-nosed, contract-based financial product is hard-nosed, contract-based enforceability. Only then can consumers begin to re-build trust in a sector that has systemically contributed to and exacerbated the trauma that life insureds and their beneficiaries regularly experience.

[4] In line with the new expectations at ASIC RG 183.6, ASIC 183: Codes of conduct for the financial services and credit sectors

Data referenced in this submission

Throughout this submission, there are references to quantitative data relating to the issues and products raised by life insurance clients of the Insurance Law Service at the Financial Rights Legal Centre (**Financial Rights**). These figures are drawn from the life insurance services provided over the 18-month period of 1 January 2024 to the 30 June 2025. A full outline of this analysis is at **Attachment A**.



Key areas for consideration

Mental health

3.1. Are the current commitments in the Code adequate to ensure that customers who experience mental ill-health are dealt with transparently and fairly?

The life insurance industry's approach to mental health conditions and consumers experiencing this has long been problematic. Many of the issue arise out of the originating exemption under section 46 of the *Disability Discrimination Act* (**DDA)**. The exemption allows discrimination *only* where:

> "[I]t is based on either actuarial or statistical data which, in all the circumstances, it is reasonable to rely on, and the discrimination is reasonable having regard to all other relevant factors as well." [5]

or:

> "Where there is no such data available and it cannot be reasonably obtained … if it is reasonable to discriminate having regard to all other relevant factors." [6]

In practice, however the exemption and its strict requirements have not prevented poor outcomes for consumers, especially those experiencing mental health problems. There is an extant wealth of evidence in the public sphere demonstrating that people living with mental health conditions, or who have experienced a mental health condition or symptoms of a mental health conditions find it more difficult than others to access many forms of insurance.

A 2011 Consumer Experiences Survey first raised this issue.[7] It found that people living with mental health conditions experience significant difficulty and discrimination when applying for insurance products and making claims against their policies. It noted that Australians with experience of mental health conditions often face increased premiums, excessive restrictions

[5] See Explanatory Memorandum, Disability Discrimination Bill 1992, p 17 and paragraphs (f) and (g) of s 46(1) and (2).
[6] As above
[7] See Mental Health Council of Australia and beyondblue, Mental Health Discrimination and Insurance: A Survey of Consumer Experiences 2011

on their policies and outright rejection of their applications and claims when a history of mental illness is disclosed.

These insights and findings were reconfirmed by the Public Interest Advocacy Centre (**PIAC**)[8] following long term research ultimately published in 2021.[9] They reported that their clients faced a series of problems including:

1. insurance cover being limited by a broad exclusion for mental health for the individual insured
2. having an application for insurance cover declined
3. insurers cancelling (avoiding) a policy and/or denying a claim because of an alleged failure to disclose a mental health condition
4. insurers charging an additional policy loading due to a mental health condition, and
5. insurance cover being limited by a blanket mental health exclusion applicable to all policies.

The Actuaries Institute identified several reasons for insurer difficulties in responding to mental health conditions, including a lack of available data about mental health condition prevalence.[10]

In 2017 the Joint Parliamentary Committee on Corporations and Financial Services conducted an inquiry into Life Insurance also examined this specific issue. That inquiry found that while a consumer has a right to know how an insurer reached its decision under section 75 of the *Insurance Contracts Act*, the customer must ask for such reasons and there is no positive obligation for insurers to explain to a consumer why an application has been denied.

PIAC provided evidence to the committee of how difficult it was to obtain written reasons for why a decision has been made. Even where written reasons are provided under section 75 of *Insurance Contracts Act*, they are not targeted to the part of a person's medical history relied on by the insurer when making a decision. PIAC provided evidence that consumers are not provided copies of the actuarial and statistical data or any other material relied and are required to lodge a formal complaint to the Disability Discrimination Commissioner.

[8] as the Justice and Equity Centre (**JEC**) was then known
[9] Public interest Advocacy Centre, Mental Health Discrimination in Insurance, 2021
[10] Actuaries Institute, Mental Health and Insurance Green Paper, October 2017

The Inquiry committee ultimately recognised the need for transparent processes in enabling consumers to understand how the decisions made by life insurers were reached and made the following recommendation 10.2:[11]

> The committee recommends that a requirement be inserted, where necessary, into both the *Insurance Contracts Act 1984* and the *Disability Discrimination Act 1992* to the effect that an insurer must provide a person with written reasons when an application for insurance has been rejected or an insurance claim denied. The committee further recommends that the written reasons be provided as a plain English summary of such evidence and be targeted to the part of a person's medical history relied on by the insurer. The committee also recommends that the statistical and actuarial evidence and other material relied on by the insurer be available on request.

The current commitments in the Life Code are the sector's attempt at addressing this but has clearly fallen short. The simple fact is that consumers continue to face the same challenges that have been known and acknowledged for almost 15 years.

In September 2025, the Life Insurance Code Compliance Committee (**Life CCC**) released a report into whether life insurers were meeting the commitments that they had made under their code of practice with respect to treatment of consumers with mental health conditions.[12] That report found that some life insurers are still relying on blanket mental health exclusions or rigid underwriting practices, limiting coverage for Australians who disclose a mental health condition. The inquiry found that insurers' underwriting processes too often default to exclusions or denials when applicants disclose a mental health condition. Of the underwriting guidelines reviewed by the Life CCC, almost all relied solely on exclusions rather than exploring alternative ways to manage risk, such as higher premiums, limits, or caps. This approach can limit access to cover and may unintentionally reinforce stigma by treating all mental health disclosures in the same way.

Most critically the inquiry found that insurers lack reliable data on their assessments of mental health disclosures and the outcomes of these cases. As the Life CCC stated when releasing its report,

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[11] Joint Parliamentary Committee on Corporations and Financial Services, *Report: Life Insurance Industry* (March 2018).
[12] Life CCC, Inquiry Report, Keeping the Promise: Mental Health and Life Insurance Commitments, September 2025

> "Without this information, insurers cannot meaningfully evaluate their practices, identify systemic issues, and improve."[13]

As the consultation paper has noted, CALI has recently initiated a process to develop a "sustainable disability insurance action plan." CALI has made it clear to consumer groups that this process will *not* address the issues raised in this report, nor the ongoing issues that have beset consumers for almost two decades. All CALI has stated is that it expects "CALI members to comply with the life code."

Given the results of the recent report and the long history of recalcitrance on this issue we have little faith that life insurers will act to improve their compliance with the Life Code, let alone the strictures of the DDA.

The Attorney General's Department are currently running a review of the DDA. Financial Rights – a signatory to this submission – has made a series of recommendations to amend the DDA to place stricter requirements on life insurers to do the right thing. In lieu of any potential update to the DDA and in line with the expectations of the 2018 Life Insurance Inquiry report, life insurers should commit to stronger positions in the Life Code.[14]

For example, Clauses 4.22 and 4.25 do not strictly require that the reasons be provided in writing, and it is unclear and inconsistent about the need to include specific evidence linked to the part of the person's medical history that the insurer relied on.

Further there is ambiguity about whether this Clause 4.25 can be relied on for medical conditions other than those related to mental health, family medical history, genetics and Human Immunodeficiency Syndrome. These clauses need amending and clarification.

Recommendations | Mental Health

1. **Amend Clauses 4.22 and 4.25 to ensure that life insurers provide written reasons when any application has been rejected. This should be provided with a plain English summary of the evidence and targeted to the part of a person's medical history relied on by the insurer.**[15]

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[13] Life CCC, "Media release: The need for fairer treatment of customers who disclose mental health conditions",16 September 2025

[14] in line with the recommendations of the Parliamentary Joint Committee on Corporations and Financial Services, Life Insurance Inquiry Report, March 2018

[15] Clauses 4.22 and 4.25 do not strictly require that the reasons be provided in writing, and it is unclear and inconsistent about the need to include specific evidence linked to the part of the person's medical history that the

2. **Life insurers must make available on request the statistical and actuarial evidence and other material relied on by the insurer. To enliven this, life insurers must be required to:**
    a. **tell applicants that they are entitled to this information.**
    b. **tell applicants how to request it, and**
    c. **specify a timeframe in which this information will be provided to the applicant.**
3. **Life insurers must not rely on out of date or irrelevant sources of information, and as such annually review and update the statistical and actuarial evidence and other material relied on in their underwriting decisions.**
4. **Specify the criteria and process an insured is required to satisfy to have an exclusion removed or premium reduced. Include this in communications with the customer before they apply for insurance, and/or in the written reasons for rejection.**
5. **Clearly explain which associated conditions that may arise from the initial condition, including mental health, are covered by an insurance policy.**
6. **Further amendments should include:**
    a. **develop, annually review and make public policies that reflect the above practices**
    b. **reinstate the commitment that insurers will explicitly comply with anti-discrimination laws in decision-making**[16]
    c. **consider a standard definition for mental health conditions**[17]

3.2. Do you have any feedback on the practical operation of the prohibition on blanket mental health exclusions? Are there changes to the Code that could support more consistent adherence to this requirement?

Clause 2.1(b) is- prima facie - clear. Yet life insurers seemingly breach this commitment at will.

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insurer relied on. Further there is ambiguity about whether this Clause 4.25 can be relied on for medical conditions other than those related to Mental health, family medical history, genetics and Human Immunodeficiency Syndrome. This needs to be clarified.

[16] As the 2017 Code had previously committed at clause 5.17

[17] See below under Question 3.20

Case study 1. Veronika's story

Sydney marketing worker Veronika Birnkammer was knocked back when she applied to Medibank for life insurance and income protection after she told the insurer she had ADHD.

"As part of the application form they asked about mental health issues; I just added the anxiety that I'd been diagnosed with 20 years ago. Then it also asked about neurodivergence. I have ADHD … and I added that, but not as a mental health issue, because it's not," she said.

"Then when I submitted it I got what I suspect is an automated response saying that I can't be offered insurance based on the information I provided.

"It had other questions around: Does the ADHD impact my work? Does it impact my life? And I answered 'no' to all of those questions, but it didn't seem to make a difference."

Two of Ms Birnkammer's children have ADHD and autism, increasing her anger that the life insurance sector seems not to have kept pace with social attitudes to destigmatise mental health.

It's a very blunt instrument they are using, and it's doing nothing to dispel the myth that people who are neurodivergent aren't contributing to society as much as anybody else," she said.

"I found it really confronting that something that's just inherent in a person from when we're born – whether that's ADHD (or being) autistic – is immediately seen as a risk.

"It's the same for my children, and that's what made me feel sad for them. I don't want them growing up thinking they're a risk to society, or a risk in general."

James Dowling, Life Insurance report finds coverage gap for disclosed mental health conditions, The Australian, 19 September 2025

However, without access to the "actuarial or statistical data which, in all the circumstances, it is reasonable to rely on" it is not clear whether insurers are in fact meeting requirements to be "consistent with … obligations under the DDA 1992."

Without transparency, oversight and enforcement of the requirements under the DDA and commitments under the Life Code, insurers are practically immune to consequences. The reality is that consumers, advocates, regulators, AFCA and others have no way of knowing whether insurers have complied with the DDA.

Implementing the recommendations under **Question 3.1** would assist. Four explicit additional measures would go further to ensure greater compliance.

Recommendations | Blanket Exclusions

7. **Life insurers should collect data on the number of policies with loadings, exclusions, and the number of refusals as well as claims, acceptance, timeframes and disputes data etc and provide this to the LCCC for publishing annually. This data must include claims made via group policies including superannuation.**
8. **Empower the LCCC to undertake independent actuarial reviews at the cost of the insurers when considering breaches.**
9. **Provide specific training for product managers and staff involved with product design and development on the prohibition of blanket mental health exclusions or limitations.**
10. **Review of all current policies issued with a blanket mental health exclusion and close the products for sale. Notify all consumers that they hold a policy with a blanket mental health exclusion. Insurers should not rely on the exclusion for any policy entered after the commitment was made, and review all decisions that relied on the exclusion.**

3.3. How could the Code promote compliance with the Disability Discrimination Act 1992 and best practice in mental health underwriting?

The Life Code is failing to promote compliance with the DDA and best practice in mental health underwriting. The recent LCCC report evidences a life insurance sector that is acting with impunity in flagrantly breaching their Life Code commitments meant to improve compliance with the DDA.

The Life Code must be strengthened in line with the:

- specific recommendations we've outlined under **Questions 3.1 and 3.2**, as well as
- strengthened enforceability requirements under **Question 6.8**,
- improved sanctions powers under **Question 6.6** and
- increased powers for the LCCC under **Question 6.5**.

It is only with this combined strengthened approach will consumers have the confidence that the Life Code can promote compliance with the DDA.

Given the parlous state of compliance with the Life Code, the consumer movement is in parallel with this review advocating for amendments to the DDA to constrain life insurer's ability to discriminate and act in ways that are unfair and produce poor consumer outcomes for those with mental health problems.

3.4. How useful is Appendix B of the Code? Are there other ways that the Code or related guidance could set out the commitments that insurers make when dealing with customers with mental health conditions? Could this information be made available to consumers in a form that increases accessibility and understanding of how insurers support people with mental health conditions?

The consumer movement has argued during the previous code review that the Life Code include a specific section directed at collating all the commitments relating to mental health issues to make it more accessible for those consumers and their representatives.

The Financial services Council (**FSC**) chose instead to keep the commitments spread throughout but that it would produce an easy to read/access guide. The result was Appendix B to the Life Code that simply collated the relevant material.

There is some value in reconsidering this approach and developing a consumer-tested, easy to read and comprehensive guide – separate to the Life Code – to inform consumers of their rights and protections with respect to mental health and life insurance. This should include information about consumers rights under the DDA.

Recommendation | Mental Health communications

11. **Develop a consumer-tested, easy to read and comprehend guide to consumer rights with respect to the interaction of mental health, the Life Code and the law, to ultimately replace Appendix B. This should focus on making it clear to people their rights and what they can do to enforce them, and the support available to do that.**

Supporting customers experiencing vulnerability

3.5. Are the Code commitments in relation to vulnerability, including specific areas such as FDV, in line with community expectations? Are there areas where the commitments could be improved?

The Life Code commitments in relation to vulnerability are not in line with community expectations, with its vague commitments to 'support' and handful of specific support measures. This approach has led to many of the poor consumer outcomes we see in the case studies detailed throughout this submission, for example Lina's story, Patricia's Story and others.

Life insurance is by its very nature a trauma-based financial product and service. Life insurers should by rights be leading the financial services sector on the issue. They are not. Both the banking sector[18] and the general insurance sector[19] are well ahead of the life insurance sector in this regard. Further, the development of ISO 22458:2022[20] and AS22458:2025 [21] on vulnerability, and the expected inclusion of vulnerability concepts in the Scams Protection Framework, the Superannuation Services Standard[22] and the Australian Tax Office's Vulnerability Framework[23], evidence a sector that has fallen behind community expectations.

To help insurers improve their support for those who need extra care, the Life Code should be improved by:

- **maintaining and updating a broad principles-based approach**

The Life Code has, to date, largely taken a principles-based approach to vulnerability by committing to "taking extra care" to support vulnerable customers and lists examples of factors.[24] This has been supplemented with some broad commitments[25] and a smaller number of specific commitments[26] to customers to implement this support.

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[18] ABA, Extra care for customers experiencing vulnerability Industry Guidance, November 2024
[19] With its announced Vulnerability Framework, see Insurance Council, Industry Action Plan: Improving Outcomes For Insurance Customers June 2025.
[20] International Standards Organisation, ISO 22458:2022, Consumer vulnerability — Requirements and guidelines for the design and delivery of inclusive service, April 2022
[21] AS 22458:2025 Consumer vulnerability - Requirements and guidelines for the design and delivery of inclusive service (ISO 22458:2022, MOD)
[22] See: The Hon Jim Chalmers MP, Mandatory service standards for the superannuation industry, 28 January 2025
[23] Australian Taxation Office, Our Vulnerability Framework
[24] Clause 6.1
[25] For example, treat customers (and their family, carers, or support people) with empathy, compassion, and respect at Clause 6.2. Other broad examples include clause 6.5, 6.9, 6.10.
[26] Specific support measures include:

A principles-based approach is in theory important to ensure flexibility and to acknowledge that unique circumstances may require unique responses. We continue to support such a commitment. However, this needs to be supplemented with further detail and prescription to ensure that the broad commitments lead to minimum standards that consumers can expect from their life insurer and promote consistency.

It is worth revisiting the principles spread across a number of commitments to consolidate and make clearer.[27] These should be reconsidered with reference to the new international consumer vulnerability standard developed by the International Standard Organisation (**ISO**).[28] This new standard provides both broad principles and specific detail that can be easily tailored to the life insurance sector.

Central to the ISO standard is a call for firms to provide a "clear commitment to improving outcomes for consumers in vulnerable situations and minimising the risk of consumer harm."[29] This is more of a proactive, outcomes-focussed approach to service delivery and product design, which should be used as the basis for a renewed and re-drafted commitment at Clause 6.1.

Further, the principles identified in the standard including accountability, empathy, empowerment, fairness, flexibility, inclusivity, privacy, innovation, and transparency, should also be included and referenced in the Life Code.

To ensure that a more proactive, outcomes-focussed approach is taken by subscribers, insurers should also specifically commit to applying inclusive design principles when developing service delivery processes and designing products. This means not starting "from an imaginary 'average user'" of a target market but designing services and products for people "who have additional or out-of-the-ordinary experiences and needs".[30] By designing for those with additional needs insurance sales, underwriting, claims handling - the entire insurance journey - becomes more inclusive and benefits all other insureds at the same time. It also necessitates including a wide range of people throughout the service and product

- Clause 6.3 re: taking additional care with respect to gratuitous concurrence.
- Clause 6.4 re: recording ongoing support – presumably to avoid re-traumatising by avoiding the need to repeat stories
- Clause 6.8 re: interpreting, TTY and other culturally and linguistically based support measures
- Clause 6.14 re: identification requirements
- Clause 6.17 re: remote and regional communities

[27] At Clauses 6.1, 6.2 6.5, 6.9, 6.10, and 6.12
[28] ISO 22458:2022
[29] Para 4.1, ISO 22458:2022
[30] Page 15, Fair by Design, Inclusive Design in Essential Services A practical guide for firms and suppliers, 2021

design process, particularly those with additional needs – and requires a "humble and open-minded" mindset.[31]

The approach to listing vulnerabilities at Clause 6.1 should also be expanded to capture a more nuanced understanding of the concept and touch upon notions of situational vulnerability as well as the key drivers of vulnerability.

The Financial Conduct Authority, UK (**UK FCA**) approach, for example, identifies 4 key characteristics that drive an increased risk of vulnerability that could provide some initial guidance to developing an appropriate approach in the Code.[32] These characteristics are:

1. Health conditions or illnesses
2. Life events such as bereavement, job loss, relationship shocks and natural disaster
3. Resilience – ability to withstand financial or emotional shocks
4. Capability – knowledge of financial matters or low confidence in managing financial matters[33]

The ISO standard identifies a similar set of risk factors including:

- Personal characteristics, e.g. age, culture, geographic location
- Health and abilities e.g. mental health, cognitive ability, addiction
- Access and skills, e.g. language, literacy
- Life events e.g. income shock, abuse
- External conditions, e.g. environment and natural disasters

The effects of historical and inter-generational trauma inflicted by government and corporate entities in their dealings with certain groups, including First nations people and refugees, should also be included.

A further factor that can compound vulnerability arises from the consumer's engagement with the life insurance sector itself which can exacerbate somebody's distress and psychological and financial pain. It can also be because of the impact of poorly sold legacy products that have yet to be remediated.

[31] As above
[32] Financial Conduct Authority, UK, FG21/1 Guidance for firms on the fair treatment of vulnerable customers, February 2021,
[33] Paras 2.4-2.12, FCA UK (2021)

Case study 2. Phil's story[34]

ICAN has recently been assisting Phil and his First Nations family who lost a loved one and whose claim under their life insurance policy had been rejected. Phil's sister passed away in the belief that she had been paying for a life insurance product which her family could access on her death. However, due to misleading conduct at the time of sale in 2014, she was unaware that the product sold to her was in fact an Accidental Death and Serious Injury policy. Because she died as a result of illness, the claim by her family on the policy was declined outright. The rejection of the claim (and how it was communicated) caused immense distress and cultural harm for the family and meant that the family could not afford to bury her and she remained in the morgue for more than 7 weeks.

Not understanding why the claim was rejected, the family sought assistance from ICAN.

Following requests for information, including the policy documents and call recordings from the sale of the policy, ICAN learned that the family's loved one (the deceased) had signed up for two policies: an Accidental Death and Serious Injury Policy and a Funeral Insurance with Accidental Death Benefit. It is very clear from the call recordings of the Accidental Death and Serious Injury policy, that an unsolicited call was made to the deceased, and that misleading and deceptive conduct and very high pressure sales tactics were used to obtain her entry into the policy.

At the time of the sale and until her passing the deceased's sole income was Centrelink and her family advise that she would not have understood what she had signed because she had very limited financial literacy. However, ensuring her family was looked after when she passed was incredibly important to her and they recall her saying that she was going without essentials to pay for the policy. The family are adamant that the deceased would only have signed up to the policy in the belief that it would cover her if she died as a result of her illnesses.

In addition to the sales conduct leading to the rejection of the family's claim, the family spoke about the insensitive way in which the claims assessor dealt with their claim in circumstances where they had only just lost their loved one. No empathy was shown and the family did not feel heard or supported. This is highly concerning in any circumstance in which a loved one has passed and a family is needing to make a life insurance claim. However, it is particularly concerning in this situation where the family knew that in the absence of the insurance, they would be required to fundraise to pay for the funeral.

[34] Note that all the names used in the case studies in this submission have been changed

Aboriginal and Torres Strait Islander communities celebrate the life of their loved ones with family, food, and togetherness, and providing a dignified and culturally appropriate burial is of the utmost significance. Many people are obligated to travel great distances to attend these events so, to begin the process of Sorry Business, appropriate resources are required to lay the deceased to rest. In this case, the deceased and her family believed appropriate preparations had been made to accommodate funeral expenses as well as the travel costs and incidentals of family and friends. To have their claim so unceremoniously declined with no avenue of recourse caused great harm to the immediate family, broader relatives, friends, and the dignity of the deceased.

Having to crowd source money from their family and community to pay for the funeral, the family experienced great anxiety and distress, as this not only disrupted funeral planning but also meant that many friends and relatives were unable to attend the celebrations. Inexcusably, it also resulted in the body of the deceased remaining in the morgue for over 7 weeks, their spirit in limbo and unable to move onto the next life.

ICAN has supported the family to lodge a complaint with AFCA on the grounds that they are entitled to a full claim payout. This accords with AFCA's Approach to Misleading Conduct. Yet despite this guidance, all that the insurer offered during the initial IDR was a refund of the premiums paid.

Given the prevalence of mis-selling in life insurance over many years, we are concerned that this issue may be impacting many families making claims on life insurance products that were sold in breach of consumer laws when their loved ones passes. In our experience, many of these families are First Nations families who will not have access to legal assistance.

Indigenous Consumer Assistance Network

A definition of vulnerability should be considered too to ensure a consistency of approach by Life Code subscribers. The consumer movement has put forward to Treasury the following definition of a "vulnerable consumer" based on the above, in the development of the Scams Protection Framework:

> "Someone who, due to the presence of one or more personal, situational and market environment factors, which can be temporary, sporadic or permanent, is especially susceptible to harm – particularly when a firm is not acting with appropriate levels of care."

The range of vulnerabilities listed at Clause 6.1 should therefore be expanded to better reflect the above notions.

- **supplementing this with further specific commitments to enliven these principles and provide insurers and consumers more certainty in operationalising these commitments, and**

The principles-based approach outlined above needs to be supplemented with specific commitments to enhance the broader commitment, providing greater direction to life insurers to improve outcomes for their customers and assist insureds to understand the minimum standards they can expect from an insurer – as opposed to having to argue for vague notions of "extra care." In our experience, life insurers struggle with how to meet their commitment to provide "extra care." Most insurers want to do the right thing but ultimately need greater specificity and proscription to do so. We hear from others that greater proscription would lead to it all being a 'tick-a-box' compliance exercise. Our response would be this: please tick the boxes, it's more than consumers get now. Furthermore, our proposed approach is not either/or. It is both. A principle-based approach supplemented with specific commitments maintains both the flexibility needed and provides the base-level certainty craved.

More explicit commitments therefore need to be made regarding, for example:

- forms of ongoing training to be provided to all relevant internal and external/outsourced staff (including management), as outlined under **Question 4.1**
- a more proactive approach to identifying those experiencing vulnerability to shift the onus away from customers having to tell the insurer that they are vulnerable – something that they are in many cases unlikely to do – towards practices that proactively capture and identify customer vulnerabilities. This should include identifying and creating mechanisms and opportunities along the customer journey to flag, capture and record information with consent and using data analysis to identify customers who may need assistance
- providing specific commitments to address specific issues facing cohorts subject to risks – for example, see the recommendations below with respect to the factors under **Question 3.1, 3.2, 3.6**, **3.9**, **3.11**, **3.12**, and **3.13.**

With respect to the commitments that are currently in the Life Code, we make the following suggestions for improvement:

- Clause 6.3 references 'gratuitous concurrence' solely in the context of Aboriginal or Torres Strait Islander peoples, but can be present in other cultural and non-English speaking settings
- Clause 6.5 does not commit to anything and is merely a statement. Given its connection to products and services, this should be bolstered to be a commitment to universal and or inclusivity- and safety- by design principles

- Clause 6.6 re: family violence policies needs to be expanded in line with the recommendations under **Question 3.6**
- Clauses 6.7, 6.15 and 6.16 need to be updated in line with recommendations under **Question 4.1**
- Clause 6.8(e) re: First Nations peoples who have difficulty understanding certain health issues, needs to expand on the type of specific support envisioned by this commitment.
- Clauses 6.8 and 6.13 need to be redrafted to ensure that there is a clear continuity of passive information availability and proactive provision of support measures.
- Clause 6.11: re: protecting privacy should provide further details regarding consent and recording of information
- Clause 6.14: identification requirements need to be updated in line with recommendations under **Question 3.11**
- Clause 6.17: re: remote and regional communities needs further details about the types of support that will be provided.

- **embedding these commitments throughout the Code (in line with inclusive design principles) to ensure that the notion of vulnerability is not siloed but considered at every step of the insurance journey.**

Vulnerability should not be seen as something discrete to address, separate to the functions and life cycle of insurance. Nor should it be kept separate to the other commitments made in the Life Code. In this sense, the principles of inclusive design should be applied to the Life Code itself and the commitments within.

Reviewing the drafting of the Life Code with an inclusive design approach can assist in helping life insurers understand that designing service delivery and products with an inclusive lens can lead to significant improvements for all consumers.

While some commitments to address specific risk factors as outlined above will need particularly focussed commitments, others can be built into other sections of the Life Code.

Recommendations | Vulnerability

12. **Insurers' approach to vulnerability should be improved by updating the broad, principles-based approach to vulnerability the Life Code has taken, supplemented with more specific commitments to enliven these principles, and embedding these commitments throughout the Code in line with inclusive design principles.**

13. **The Life Code should commit subscribers to apply inclusive design principles and safety by design principles when developing service delivery processes and designing products.**

14. **A definition of vulnerability needs to be embedded into the Life Code that captures a broader understanding of the concept and touches upon notions of situational vulnerability as well as the drivers of vulnerability.**

15. **Part 6 should be expanded to include:**

    a. **specific forms of training that should be provided**

    b. **a more proactive approach to assisting those experiencing vulnerability, and**

    c. **commitments to address specific factors, outlined above and in Question 3.6.**

16. **Inclusive design principles should be applied to the Life Code itself to ensure that all commitments under the Life Code are designed with those with additional needs in mind.**

3.6. Should the Code address additional areas of vulnerability? If so, should this include any additional commitments?

Yes, the Life Code should address additional vulnerability factors with further specific commitments with respect to:

- family and domestic violence
- LGBTQIA+ customers
- blood borne viruses, and
- sex work

Family and domestic violence

Clause 6.6 of the current Life Code commits subscribers who provide retail insurance products to merely:

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

To support their subscribers, the **FSC** (the original code owner) developed a FSC Life Insurance Family and Domestic Violence Policy which set out how insurers could identify and support people affected by family violence. The guide outlined 11 areas to be covered by subscribers in a family violence policy. The guide, and its 2025 update[35] are however voluntary and do not require insurers to meet the standards therein.

Given the 'aspirational' nature of the document and lack of monitoring and oversight regarding the quality of policies produced, Financial Rights undertook a desktop analysis examining life insurers' written policies to identify best practice and benchmark all subscribers to encourage ongoing improvements to these policies.[36]

Only one Life Code subscriber - Noble Oak - achieved an 11 out of 11 score with a policy found to have definitive language and specific measures that detail how they will help people who experience family violence. However disappointingly only a little over half the subscribers scored 5.5 out of 11 or less.

Life insureds subject to family violence should not have to be subject to a lottery when approaching their life insurers for support. The 2024 analysis however demonstrated that Australians are likely to receive a very different response depending on whether their life insurer has a good policy or a minimal or poor policy.

People experiencing family violence are some of the most vulnerable people in Australia. Their well-being should not be the source of differentiation and competition in the life insurance market. Commitments need to be made in the Life Code to establish minimum standards that people experiencing family violence consumers can expect.

As mentioned above CALI published an updated Best Practice Guidance (**BPG**) on supporting people affected by family and domestic violence. We view this document as best practice across the financial services sector – at least in in writing. The reality remains though that there is no requirement for any subscriber to actually meet the best practice as outlined.

To this end, we recommend that the Life Code incorporate more specific commitments on family violence to set minimum standards and ensure that the LCCC has a greater ability to oversee and monitor life insurers compliance with those standards. This could be done one of two ways. The Life Code should either commit insurers to meeting the requirements outlined in a redrafted 'guidance' or incorporate the key standards from the document directly into the Life Code.

[35] CALI, Best Practice Guidance Family and Domestic Violence Policies, February 2025
[36] Financial Rights, Family Violence and Life Insurance: Desktop audit of family violence policies, May 2024

Finally, the current approach to the concept of "family and domestic violence" is too constraining and should be expanded to capture all the range of behaviours referenced in the definition in the guidance including financial abuse, elder abuse and coercive control.

Recommendations | Family and domestic violence

17. **Insurers should commit to meeting the requirements outlined in a redrafted guidance that changes the language of the document from one of aspiration to one of minimum standards; or alternatively update clause 6.6 to require that life insurer policies meet the requirements of the content of a policy as outlined from (a) to (l) on pages 4-5 of the BPG and include more specific support measures as outlined in the BPG to set minimum expectations for consumers including:**
    a. **safeguarding privacy and confidentiality including:**
        i. **protecting the customer's contact, address and location information and preventing its disclosure to the perpetrator**
        ii. **acting on requests for policy communication and information to be sent to different addresses**
        iii. **using flags in its systems with consent etc**
        iv. **sending correspondence or communication via the customer's preferred method and discussing this with them**
        v. **engaging with customer's nominated support person**
        vi. **not requiring the customer to make any contact with the alleged perpetrator**
    b. **minimising the need for customers to repeatedly disclose information about their abuse, including:**
        i. **providing the customer with consistency in speaking to one staff member, or a single pathway for escalation**
        ii. **providing copies of documents to the customer without charge so life insurers can help victim-survivors obtain documents they may no longer be able to access**
    c. **providing specialised teams or a designated specialist with expertise in supporting customers affected by family and domestic violence**
    d. **providing training and development to staff**

e. **raising awareness about information and assistance available to customers experiencing family and domestic violence, including, for safety reasons, incorporating a large button onto websites to navigate quickly to another site**

f. **handling claims involving family violence sensitively including not requiring notification to the police about a perpetrator of family or domestic violence**

g. **providing access to financial hardship assistance, including**

    i. **providing options to retain the policy if premiums cannot be paid**

    ii. **assessing financial hardship applications involving joint policyholders without requiring the consent of the other policyholder**

    iii. **recognising reluctance to obtain joint policyholder consent as a potential sign of financial abuse**

    iv. **minimising the information and documentation required**

h. **considering family and domestic violence in product design including**

    i. **on the cancellation of a life insurance policy, notifying each insured life of the cancellation**

    ii. **seeking consent from people who will be included as insured lives under a life insurance policy**

    iii. **considering situations where the forfeiture rule may (or may not) apply and whether it would be appropriate to pay the benefit into the Court for claims resulting from family and domestic violence, where the perpetrator is the beneficiary**

i. **assisting customers with jointly held policies including:**

    i. **helping insureds understand the steps required to legally alter or separate the policy**

    ii. **not requiring them to contact or directly obtain consent from the perpetrator, and**

    iii. **helping them identify any other policies that may require changed arrangements**

j. **providing referrals to support services.**

18. **Expand the reference to family and domestic violence to financial abuse and coercive control to capture all the range of behaviours captured in the definition in the guidance.**

LGBTQIA+ customers

In June 2022, InsurePride, supported by the Victorian Pride Lobby, released its landmark *Worth the Risk* report[37] into LGBTIQA+ experiences with both general and life insurance providers, seeking to understand challenges faced by groups within the LGBTIQA+ community, aspects of the customer journey that may be problematic for LGBTIQA+ customers, and potential barriers to LGBTIQA+ customers accessing or utilising insurance.

The research sought to redress this issue, acknowledging that, when we talk of vulnerability, it is not a person's sexual orientation, gender identity or sex characteristics that is the reason for their disadvantage, but rather the failure of institutions and wider society (including financial services like insurers) to ensure that everyone has equal access to services and equal rights when dealing with service-providers.

As the consultation paper acknowledged, the life insurance industry has taken some action to address several issues raised in the *Worth the Risk* report. We welcome the steps taken by CALI in the amending the Life Code in 2025 regarding underwriting for HIV and AIDS. However, the changes did not address all of the recommendations in that report and need to be incorporated in this Life Code review.

Most particularly, the Darlington Statement, a community consensus statement by intersex organisations and advocates, calls for "an end to genetic discrimination, including in insurance."[38] Genetic discrimination occurs when insurance companies charge higher premiums due to genetic conditions.

This is particularly so in the case of genetic traits that predispose a person to cancer. Some intersex variations are associated with high rates of gonadal cancer and may therefore be subject to higher premiums. Some people with an intersex variation have reported to InterAction for Health and Human Rights unduly high insurance premiums for life insurance cover, though insurers often have little or no idea of the actuarial risks involved with insuring someone with a genetic condition or an intersex variation.

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[37] Sean Mulcahy, *Worth the Risk: LGBTIQA+ Experiences with Insurance Providers* (Victorian Pride Lobby, 2022).
[38] The Darlington Statement: Joint consensus statement from the intersex community retreat in Darlington, March 2017

The Government has now introduced a ban on the use of adverse genetic testing results in life insurance into Parliament.

The Reviewer should consider the impacts of the ban on genetic tests in life insurance on people with an innate variation of sex characteristics, noting that, in many cases, intersex people will have undergone genetic testing during childhood without personal consent.

Recommendations | LGBTQIA+ customers

19. In line with the recommendations of the Worth the Risk report the Life Code should include the following:

- **a. a provision in Clause 2.1 that insurers will design new products that do not discriminate against consumers based on their sexual orientation, gender identity, or intersex status, consistent with obligations under the Sex Discrimination Act 1984 and equivalent state and / or territory law**
- **b. sexual orientation, gender identity, and sex characteristics in the list of risk factors at Clause 6.1 that can cause vulnerability**
- **c. the amendments proposed in response to question 3.1 (above)**

20. The Life Code should also include a new section in Chapter 4 on LGBTIQA+ customers, including the following:

- **a. a provision that insurers will not impose exclusions or premiums based solely on the applicant's sexual orientation, gender identity, or sex characteristics**
- **b. a provision that insurers will ensure that:**
  - **i. data on sexual orientation, gender identity or variation of sec characteristics, are only collected where reasonably required**
  - **ii. the reasons for collection of data on sexual orientation, gender identity or variation of sex characteristics and privacy protections in place are made clear at the point of collecting the data**
  - **iii. questions are asked in a sensitive and gender-neutral manner as far as is practicable**
  - **iv. titles are only used where required**
  - **v. non-binary options for gender and titles are included**

vi. **policies are in place directing staff do not default to certain genders or titles based on assumptions about a customer's gender or that of their partner**

vii. **dead names and former genders or titles are removed from all records, except where required under law**

viii. **all systems are updated when a customer changes their name, gender, or title**

ix. **a customer who is changing their name, gender or title need only speak to one customer service representative.**

Blood-borne viruses

Access to life insurance remains a significant concern for people with blood-borne viruses, including HIV and hepatitis. Despite medical advancements that have dramatically improved life expectancy and health outcomes, people with HIV continue to be denied insurance coverage or offered coverage on substantially less favourable terms, reinforcing stigma and financial insecurity.

The HIV/AIDS Legal Centre – Australia's only specialist legal centre assisting people with bloodborne virus-related legal issues – is regularly approached by people denied insurance coverage due to their condition. The experiences of these clients have included:

- A lack of explanation for coverage decisions, including after requests.
- During claim assessments, intrusive and inappropriate questions that are not relevant to evaluating risk, such as questions about how they acquired HIV, which suggest that insurers may regard intravenous drug use as a proxy for overdose risk or otherwise be assuming risk associated with certain sexual practices.
- An unsolicited offer of funeral cover in the event of death, as opposed to the life insurance cover requested.
- Denial of access to information and/or data upon which the insurer is relying to refuse the claim.
- Emotional distress, including feelings of hurt, offense, and discrimination, often resurfacing past trauma associated with their health condition
- A need to undertake an appeals process adding unnecessary stress to an already difficult situation.
- Anxiety regarding a potential inability to cover future living expenses in the event of illness or injury.

The *Worth the Risk* report found that just 6% of respondents living with HIV feel comfortable disclosing their HIV status or other factors to insurance companies and that 55% of people living with HIV always assumed that they would be excluded from taking out certain insurance policies.[39] These concerns remain despite the advent of antiretroviral drugs, through which HIV can be effectively treated, with thousands of Australians receiving this treatment each year.[40]

We note that CALI has updated the Life Code to introduce commitments regarding HIV and AIDS, reflecting advances in medical treatment and addressing inappropriate underwriting practices for insureds taking PrEP which were out of step with evidence that this form of preventive health practice reduces (rather than increases) a customer's risk profile. This is reflected in CALI's HIV and life insurance consumer fact sheet. However, we note that the FSC's out-of-date HIV/AIDS underwriting guidelines are currently still promoted on their website.

These concerns are also not unique to HIV. In relation to hepatitis, the Anti-Discrimination Board of New South Wales found that:

> 'people with hepatitis C are being routinely refused insurance or dissuaded from applying for insurance'[41]

and community organisation Hepatitis Victoria advises that:

> 'chronic hepatitis is considered a "risk" to many insurance providers, and you may not be approved for a policy or the costs may be increased.'[42]

Importantly, with the advent of new treatments known as direct-acting antivirals, hepatitis C is now curable, and thousands of Australians have undergone treatment and cleared the virus.[43] Antibodies of the virus remain behind, however, and there is evidence that some – including key professionals – may confuse this as evidence of the virus still being

[39] Sean Mulcahy, *Worth the Risk: LGBTIQA+ Experiences with Insurance Providers* (Victorian Pride Lobby, 2022) 17.
[40] Pharmaceutical Benefits Scheme, *HIV Antiretroviral Medicines: Utilisation Analysis Using PBS Data* (2021).
[41] Anti-Discrimination Board of New South Wales, *C-Change: Report of the Enquiry into Hepatitis C Related Discrimination* (2011) 80.
[42] 'Stigma and discrimination FAQs', *LiverWELL*.
[43] Kirby Institute *Monitoring Hepatitis C Treatment Uptake in Australia* (2020).

present/active, with potential implications for those so affected.[44] Issues such as these need to be addressed for people with a history of hepatitis C.

In a 2022 article on insurance discrimination and hepatitis C,[45] Sean Mulcahy et al proposed that:

> 'insurers should review their questionnaires around hepatitis C to ensure that the questions they ask are both necessary and posed in sensitive ways that are not stigmatising, for example, by not [...] demanding an unreasonably extensive medical history, or assuming connections between hepatitis C and liver conditions or intravenous drug use',

as this may encourage non-disclosure.

Recommendations | Blood-borne viruses

21. **For ease of reading, the Life Code should separate out the provisions on mental health,[46] family medical history,[47] genetics[48], and HIV.[49]**

22. **In line with the recommendations above and further academic literature, the Life Code should:**

    a. **expand the provisions on HIV at Clauses 4.17A-C to other blood-borne viruses, such as hepatitis C**

    b. **update the phrase "Human Immunodeficiency Syndrome" to "Human Immunodeficiency Virus"**

    c. **update Clause 4.17C to require consumer information to be reviewed annually**

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[44] Kate Seear et al, 'Echoes and antibodies: Legal veridiction and the emergence of the perpetual hepatitis C subject' (2023) 32(2) *Social and Legal Studies*.
[45] Sean Mulcahy, Kate Seear, Suzanne Fraser, Adrian Farrugia, Dion Kagan, Emily Lenton, Liam Elphick, and Nic Holas, 'Insurance discrimination and hepatitis C: Recent developments and the need for reforms' (2022) 23 *Insurance Law Journal*.
[46] Clauses 4.12-4.14
[47] Clauses 4.15-4.16
[48] Clause 4.17
[49] Clauses 4.17A-4.17C

d. **include an additional provision that people with (a history of) blood-borne viruses will only be asked questions directly relevant to assessing their insurance risk**

e. **include an additional provision that insurers will not impose blanket exclusions for blood-borne viruses but, where risk necessitates coverage of people with blood-borne viruses on less favourable terms, may impose higher premiums or exclusions**

f. **include an additional provision that, where a blood-borne virus is being managed or has been cured through treatment, insurers will review, with a view to removing, exclusions or premium loadings**

g. **include an additional provision that insurers will annually review and update the statistical and actuarial evidence and other material relied on in their underwriting decisions, so as to not rely on out-of-date or irrelevant sources of information**

h. **include an additional provision that, where medical evidence is obtained to assist in assessing an application for coverage, it will be reviewed by people with requisite expertise in blood-borne viruses.**

23. **Similar to the recommendations regarding mental health applications above, Clause 4.25 of the Life Code should be amended to require insurers to:**

    a. **provide applicants written reasons when an application for insurance has been rejected or offered on less favourable terms**

    b. **inform applicants about their right of access to the statistical and actuarial evidence and other material relied on by the insurer in making their decision**

    c. **inform applicants about both the insurer's complaints process and external dispute mechanisms.**

24. **Similar to the recommendations regarding mental health applications above, the Life Code should be amended to reinstate a commitment that insurers will explicitly comply with anti-discrimination laws in decision-making.**[50]

25. **CALI should establish a working group to enable insurance providers to collaborate with HIV and hepatitis organisations to implement the requirements of the Life Code relating to HIV and other blood-borne viruses, including ensuring that assessment**

[50] as the 2017 Code had previously committed at clause 5.17

processes and risk evaluation questions are as appropriate, relevant, and non-stigmatising as possible.

26. **The LCCC should conduct an inquiry on how insurers approach decisions for customers who disclose HIV or other blood-borne viruses that includes:**
    a. **insurers' procedures and policies implemented to ensure compliance with requirements of the Life Code and anti-discrimination legislation relating to HIV and other blood-borne viruses**
    b. **statistics on coverage denials or less favourable terms offered to people with HIV and other blood-borne viruses.**
27. **CALI should work with the FSC to remove or update its HIV/AIDS underwriting guidelines to reflect recent updates to the Life Code.**

Sex work

Life insurance (and other insurances) can be difficult to obtain for sex workers. The *Worth the Risk* report found that 83% of respondents who were a current or former sex worker had experienced discrimination or exclusion by an insurance advisor or broker.[51] The occupational categorisation of sex work often sees sex workers excluded from life insurance or subject to restrictive definitions and conditions.[52] Over 70% of sex workers experienced intrusive questioning, including questions about sexual history and questions on insurance forms using outdated language like 'prostitute', which may dissuade sex workers from disclosing their occupation in applications and claims.[53]

Recommendations | Sex work

28. **The Life Code should include a new section in Chapter 4 on sex work, including the following:**
    a. **a provision that sex work is treated like any other occupation in determining the cover insurers offer**

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[51] Sean Mulcahy, *Worth the Risk: LGBTIQA+ Experiences with Insurance Providers* (Victorian Pride Lobby, 2022) 30.

[52] Sean Mulcahy, *Worth the Risk: LGBTIQA+ Experiences with Insurance Providers* (Victorian Pride Lobby, 2022) 30-31. See, for example, in addition to the case cited in the *Worth the Risk* report, the categorisation of sex work in the Colonial First State Occupation rating guide (8 March 2025) (Heavy blue collar, eligible for death cover only, defined as "Skilled occupations with a heavy amount of manual work or where the potential for disability is high, and/or the potential for rehabilitation into other forms of employment is low"); or the exclusion of sex work from the income protection policies offered through Unisuper: Income Protection | UniSuper.

[53] Sean Mulcahy, *Worth the Risk: LGBTIQA+ Experiences with Insurance Providers* (Victorian Pride Lobby, 2022) 30.

b. **a provision that sex workers will only be asked questions about that work directly relevant to assessing their insurance risk and that irrelevant questions will not be asked about sex work as part of an underwriting assessment**

c. **a provision that insurers will annually review and update the statistical and actuarial evidence and other material relied on in their underwriting decisions in relation to sex work, including occupational risk ratings, so as to not rely on out-of-date or irrelevant sources of information**

d. **a provision that insurers will provide clear, publicly accessible information regarding coverage options and conditions for people who are sex workers, and**

e. **a provision that insurers will not impose exclusions or premiums based purely on the applicant's history of providing sex work.**

3.7. Should the Code promote inclusive product design to better address customer vulnerability? If so, how?

Yes. An explicit commitment to apply inclusive design principles and safety-by-design principles to developing service delivery, distribution and product design processes, as recommended above. This would be in line with the expectations of ASIC RG 183.5 (a) and (b).[54] This commitment would elaborate on the broad requirements of the Design and Distribution Obligations, specifically the need to take a consumer-centric approach to product design outlined at RG 274.47.[55]

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[54] ASIC, RG183 Approval of financial services sector codes of conduct, December 2025. RG183.4 states:
We expect an effective code to do at least one, one, and preferably more than one, of the following::
(a) address specific industry issues and consumer problems not covered by legislation;
(b) elaborate on legislation to deliver additional benefits to consumers …

[55] ASIC RG274: Product design and distribution obligations, September 2024. RG 274.74 states:
Taking a consumer-centric approach involves placing consumer outcomes front and centre: see RG When considering the design of its financial product and how it will reach consumers in the target market, in order to take a consumer-centric approach an issuer should:
(a) apply its existing knowledge and experience about how consumers are influenced in order to achieve the objectives of the design and distribution obligations—for example, many firms are already adept at capturing consumers' attention and influencing their behaviour through shaping product design, marketing and sales tactics. Issuers should avoid engaging in conduct that is likely to impede consumers from obtaining products that are consistent with their likely objectives, financial situation and needs or that will result in consumers receiving unsuitable products; and
(b) consider consumer vulnerabilities, and how those vulnerabilities may increase the risk that consumers are sold products that do not meet their objectives, financial situation and needs, and will lead to poor consumer outcomes.

The focus of inclusive design should be to remove barriers in the products/services for as many customers as possible to reduce the risk of vulnerability. It takes a strengths-based approach that doesn't focus on the customer in the deficit, rather focus on the barriers in the system. The principled commitment should therefore be supplemented with specific commitments to address a wide range of customer barriers and experiences throughout the service and product design process, particularly groups with additional needs.

Alternatively, CALI could develop enforceable guide to assist life insurers to meet the expectations of inclusive design.

3.8. How could the Code encourage better and earlier identification of potential vulnerabilities rather than insurers relying on customer disclosure?

As outlined and recommended above, the Life Code must shift the onus away from customers having to tell their insurer that they are vulnerable – something that they are in many cases unlikely to do – towards practices that proactively capture and identify customer vulnerabilities via a needs-based approach. For example:

- requiring training to elicit information in a trauma-informed, culturally safe, supportive and compassionate way, and in line with the requirements of the *Privacy Act*
- creating mechanisms and opportunities built into communications channels to share relevant information
- collecting, recording, flagging, and sharing information with consent – including for example First Nations status. In other words, Clause 6.4 should be updated to require consent in line with best practice privacy principles
- collating with vulnerability data from other sources including Australian Bureau of Statistics and regulator reports, and
- proactively using data analysis to identify customers who may need assistance.

These should be outlined and embedded in the Life Code.

(c) Note 1: Consumers can experience vulnerability as a result of any number of factors, including:

- *personal or social characteristics that can affect a person's ability to manage financial interactions (e.g. speaking a language other than English, having different cultural assumptions or attitudes about money, or experiencing cognitive or behavioural impairments due to intellectual disability, mental illness, chronic health problems or age);*
- *the actions of the market or individual providers (e.g. vulnerabilities created by a product's choice architecture); and*
- *experiencing specific life events or temporary difficulties (e.g. an accident or sudden illness, family violence, job loss, having a baby, or the death of a family member).*

Further, it is important that the language not focus solely on people disclosing their circumstances but that it reflects a needs-based approach for support. As stated above, people are not going to raise their "vulnerability". They are more likely to respond to being offered forms of support that address their unique needs. The Insurance Council has, for example, recently acknowledged this and are taking a needs-based approach to the development of their own vulnerability framework such that people can express their circumstances via the support measures that they need from their insurer.

Supporting customers experiencing financial hardship

3.9. Do the Code commitments adequately ensure customers facing financial difficulties are obtaining suitable and appropriate assistance from insurers? If not, how can the Code be improved?

Financial hardship and its link to the expense of life insurance is common. The issue makes up 11.3% of the calls that the Insurance Law Service has received about life insurance. These are commonly associated with premium increases, delays, mis-sold products, excess payments, underpayment of benefits or the clawing back of alleged overpayments.

Case study 3. Yolanda's story[56]

Yolanda has been waiting on an Insurance Protection claims she lodged last year. Yolanda and her family are now in financial hardship. Yolanda has a formal diagnosis for her serious condition and has submitted all the necessary medical documentation. However, her insurer continues to repeatedly request the same documents from her doctor – three times thus far, which is a key factor behind the delays. Yolanda has requested a new claims manager because she feels dismissed and bullied by her current claims manager

Financial Rights Legal Centre

See also case studies for **Neville**, **Larry**, **Elle**, **Sharelle**, **Angela**, **Steve**, **Killian** and **Gladys** below.

We have seen examples of insurers failing to offer or provide hardship including when represented by our consumer organisations. We have also seen insurers failing to recognise insureds in unsuitable products that they were mis-sold when they are in financial hardship from the product down the line, particularly with legacy policies.

[56] Note that all the names used in the case studies in this submission have been changed

Financial hardship is a major driver of vulnerability and often correlated with a range of other forms of vulnerability.[57] As such, the financial hardship section of the Life Code needs to be seen as a part of subscribers' broader commitment to building more inclusive service delivery and product design. The current financial hardship section provides a solid platform upon which to build a more comprehensive approach to supporting those experiencing long- and short-term financial difficulties.

The Life Code should improve upon and adopt expectations not addressed already in the code as identified by the Australian Securities and Investments Commission (**ASIC**) in its letter to ASIC's expectations of life insurers: responding to consumers in financial hardship. Outside of ASIC's expectations, there are also a number of ways to improve the life insurance sector's approach to financial hardship drawn from insights in other financial services.

Recommendations | Financial Hardship

29. **Amend Clause 6.20 to include a timeframe for contacting someone before a flexible support options come to an end.**
30. **Amend Clause 6.21 from periodically reviewing existing support options to annually reviewing.**
31. **Include a commitment to regularly collect and monitor key data to identify and proactively help consumers experiencing hardship. Such data or indicators of potential hardship can include hardship requests, arrears, reduction in the amount or type of cover, unsuccessful payment attempts, existing or previous hardship arrangements, and conversations with consumers that indicate difficulty in paying premiums.**
32. **Amend Clause 6.18 to**
    a. **establish a timeframe for contacting the consumer to tell them about the support options available**
    b. **amend and outline a more complete list of options that will be made available by all life insurers including premium deferrals, payment plans, debt recovery pauses, or temporary suspension of cover**
    c. **require staff to be trained to recognise early indicators of financial hardship.**

[57] See International Standards Organisation (**ISO**), ISO 22458:2022, Consumer vulnerability — Requirements and guidelines for the design and delivery of inclusive service, April 2022, Table 1

33. Reduce delays in claims by improving general timeframes and tightening up on or removing the exceptions clause altogether[58] as outlined under Question 3.14.

34. Proactively identify mis-sold legacy products including:

- **a. holding multiple policies**
- **b. tracing known cases of mis-selling**
- **c. identifying likely cohorts of legacy product holders who may hold inappropriate products.**

35. Add commitments that minimise harm and support people through hardship including:

- **a. reviewing how products and services can be changed to reduce risks of harm**
- **b. helping people to access individual assistance, including from a financial counsellor**
- **c. developing, implementing and publishing a vulnerability policy**
- **d. support financial counsellors and case workers to help their clients, including by:**
  - **i. accepting third-party authorities from registered financial counsellors using a standard form (such as Financial Counselling Australia's authority form)**
  - **ii. allowing financial counsellors to assist their clients when seeking to verify their identity with the fund**
  - **iii. offering a dedicated phone number for financial counsellors to contact the fund when assisting a client, and**
  - **iv. proactively assist existing members to verify their identity, including those who are unable to meet standard ID requirements, including AUSTRAC alternatives.**

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[58] see below under question 3.14 claims handling

3.10. Is there a need for the Code to distinguish between measures that might address short term financial hardship compared to more entrenched hardship?

It is important to acknowledge that there is a difference. Short term hardship assistance should be aimed at helping consumers who are experiencing financial hardship to maintain their insurance cover during a difficult time. Long term hardship support relates to cases where the life insurance cover (be it mis-sold, misunderstood or otherwise) is contributing to the financial hardship itself.

The former is generally addressed by the specific options that exist in the Life Code. These need to be improved upon as outlined above, re: meeting and improving upon ASIC expectations.

The latter however requires deeper analysis to proactively identify and act on systemic hardship arising out of a consumer's engagement with life insurance itself. Specifically addressing issues with respect to claims handling delays and requiring more proactive identification of mis-sold legacy products will assist in addressing the latter.

First Nations customers

3.11. How effective are the Code commitments relating to First Nations customers?

3.12. Are there ways that insurers can adopt a more proactive and culturally safe approach to identifying First Nations customers to better meet Code obligations?

3.13. Is there a need for the Code to include additional commitments to address specific issues with life insurance experienced by First Nations customers, such as culturally appropriate communication practices? If so, what should they be?

As the consultation paper notes there are a small number of commitments that specifically reference First Nations people (or "Aboriginal or Torres Strait Islander status" or "peoples") in the Life Code.[59] These commitments are limited and could be improved or strengthened.

[59] They are: a broad recognition that Aboriginal and Torres Strait Islander customers may experience vulnerability: Clause 6.1; given the practice of gratuitous concurrence, taking extra care when dealing with people of Aboriginal or Torres Strait Islander background to ensure their consent is genuine: Clause 6.3; providing a link on insurers' websites to any support targeted towards Aboriginal and Torres Strait Islander peoples: Clause 6.8; Providing

They also do not necessarily address all the issues that First Nations people face in dealing with the life insurance sector.

First Nations experience with insurance

Due to the impact of colonisation and the financial exclusion imposed on First Nations peoples, First Nations people are often only first- or second-generation money earners and are new to asset owning, asset building and asset protection. This means generational wealth has been denied to First Nations peoples who are less likely to be in a position to pass on financial assets and security to their children. They are often a communal culture where they share the costs and burdens of their family or community members who have become disabled or passed away. While this is a cultural strength, it can also create broader financial hardship. They are also more likely to experience an injury in a more common physical labour workforce, be unable to work and have a lower life expectancy. Because of this, life insurance is viewed by some First Nations peoples as one of the few means by which they can ensure they don't become a financial burden on their family and their family will be looked after financially when they pass. This perception has been reinforced and exploited by the life insurance industry over many years through advertising and sales practices targeting First Nations peoples.

Life insurance is a complex product with numerous exclusions, eligibility requirements and significant financial implications – including diminishing returns after retirement age. These complexities are not understood by many in the community. They may be even less understood if a person's experience of financial systems is limited as a result of systematic financial exclusion. This financial literacy gap and the knowledge asymmetry that exists for many First Nations peoples has been exploited by insurers who do not go to the trouble of explaining these complexities in plain English or through culturally sensitive communications.

This view of insurance needs to be considered in the product design and service delivery of insurance. Equally, insurers need to avoid exploiting (intentionally or not) the knowledge asymmetry by genuinely committing to improving their engagement with First Nations consumers.

To truly close the gap, insurers must understand that there is a gap in the first place and address it at each step of engagement. Doing so will increase First Nations understanding

support to meet verification and identification requirements, including adopting a flexible approach in line with AUSTRAC guidance: Clause 6.14.

and knowledge of insurance, so they can benefit from the product and protect their assets. Insurers can also play a part in Closing the Gap.[60]

First Nations consumers may also not be fully aware of their rights and obligations under the insurance contract and be prejudiced by this. A good example of this would be the duty of disclosure where the disclosure questions might be difficult to understand or create mistrust and/or shame that prevents disclosure. The insurer has a right to open an investigation and the insured has a duty to cooperate. However, for someone experiencing intergenerational trauma, including with authorities, engaging with an insurance investigation could be a very triggering event and can result in the consumer not wanting to engage with the insurer, impacting their claim due to the duty of utmost good faith. There is also the difficulty in complying with the requirements of insurance claim administration and investigation including providing documents and information when it could be impossible for logistical reasons. Even if these documents are provided, a simple administrative mistake from the insurer could mean requiring the insured to endure far more hardships.

Inappropriate insurance sales to First Nations consumers have been notorious. As the LCCC stated in its recent report:

> *There has been a history of poor outcomes and significant harm for Aboriginal and Torres Strait Islander customers, particularly in relation to funeral insurance products and the collapse of the Youpla Group. This legacy has contributed to mistrust in the financial services sector among some communities.*[61]

The financial services sector's exploitation of First Nations cultural practices and obligations widely known as Sorry Business - mourning protocols, time frames and communal activities, including rituals, ceremonies and burial, after someone dies – has exacerbated widespread distrust of life insurers and by extension the entire financial services sector. The decades-long systemic misrepresentation to First Nations people by ACBF/Youpla is but one example of exploitation that we see. The mis-selling and overselling of funeral insurance products continues to this day.

[60] Particularly Target 17 re: people having access to information and services enabling participation in informed decision-making regarding their own lives. See Closing the Gap Targets and Outcomes
[61] LCCC, Supporting Aboriginal and Torres Strait islander customers: Good practice guidance for life insurers, November 2025

Case study 4. Lina's story

Lina is a First Nations single mother living in remote Australia. She did not finish high school and has below average reading and writing, has worked in different administrative jobs through her life and survives on Centrelink benefits. Sometimes she says yes to things believing she would be looked after.

Lina saw a TV ad for a life insurer offering life and funeral insurance. She wanted life insurance to look after her children when she goes.

The insurer offered her funeral insurance and she listened to a four minute disclaimer she did not understand.

The insurer told Lina she was not successful in her application for life insurance but congratulated her for having accidental death and injury insurance. Lina did not understand this nuance and though she was covered for life insurance. The insurer read out a two minute disclaimer very quickly and asked if she understood. She said yes as she was tired and wanted it over and done with.

The premiums were unaffordable. She would miss premiums and the insurer would follow up on over 25 occasions. She told them she was struggling financially, she wanted to cancel. She was advised she could only cancel via email where she correctly identified herself and the policy number. She was not able to do this.

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First Nations people in regional and remote communities face particularly unique issues.[62] It means problems with digital connectivity. It can mean limited access to devices and the internet. It can mean generally having to deal with a poor communications environment and digital divide. This can lead to difficulties in the claims process with the need to upload and send multiple documents via dedicated insurance portals. This assumes that everyone has access to a digital device and the internet and know how to use it.[63] The most recent Australian Digital Inclusion Index released in July 2023, found that there was an overall Index Score of 73.4 for non-First Nations Australians but only 65.9 for First Nations Australians, reflecting a national gap of 7.5 points for First Nations people.

[62] Note that while it is clearly the case that not all First Nations people are vulnerable, it is equally true that not all vulnerable First Nations people are remote. 37.1 per cent of First Nations people lived in capital city areas, while the remaining 62.9 per cent lived outside of capital cities.

[63] Measuring Australia's Digital Divide. Australian Digital Inclusion Index 2023

First Nations households may also share one device, meaning the customer has limited opportunities to make calls and use websites. When a First Nations person needs to rely on other people to access a device to navigate technology, there is an increased risk of financial abuse – particularly if they are entitled to a payout. Further, if the device is lost and a new device is needed, the customer usually has to get a new phone number and email address as they aren't able to access their last contact details. This can then lead to the insurer closing the claim as there has been no further contact.

Living in regional or remote areas also means long distances, which has an impact on engagement with insurance products and services. For example, many people in remote and regional areas may find it difficult, if not impossible to reach medical appointments that may be many hundreds of kilometres away.[64]

Other factors that can intersect with the experience of First Nations customers include generational trauma, language, literacy, and financial literacy. While culture is not a vulnerability in itself (in fact quite the opposite) there are cross-cultural differences which mean that First Nations people may find it particularly difficult to navigate some insurance products, services and processes. Cultural differences, including communications styles, can mean that customer needs are not clearly understood.

The LCCC's recently released report into subscribers' approach to supporting Aboriginal and Torres Strait Islander Customers is well timed.[65] The LCCC reported that First Nations people with life insurance are disproportionately represented in AFCA complaint numbers with complaints relating to unmet financial hardship requests, cultural misunderstanding and difficulties in meeting identification requirements. It outlines a series of both poor and good practices with respect to meeting the current commitments in the Life Code. In summary the review found that:

- *Insurers do not routinely ask customers if they identify as an Aboriginal or Torres Strait Islander person or record this information systematically.*

Life insurers pointed to privacy concerns, anti-discrimination laws amongst other reasons for not asking and recording this information. Our view is that these issues are not insurmountable. They reflect similar concerns that were previously held by those in the banking sector. That sector has done much work to change their approach to be more proactive and culturally safe in their engagement with First Nations consumers. There are many examples (referenced in the report) where banks are now creating opportunities for

[64] See for example, the issues highlighted in Super Consumers, Backflip on mental health claim highlights problem with insurance in super, 16 July 2025

[65] LCCC, Supporting Aboriginal and Torres Strait Islander Customers, 8 December 2025

customers to share their cultural identity voluntarily, in an environment of trust and consent. Importantly banks explain why the information is being collected – they reassure the customer that the information is there to help those customers. Many banks also provide specific teams and dedicated phone lines to promote trust – to allow customers to speak to people that they may be more comfortable in sharing sensitive information with. These lessons from the banking sector should be adopted wholeheartedly by the life insurance sector, with strengthened code commitments that will assist life insurers to better serve First Nations consumers.

- *The depth of understanding and application of the concept of gratuitous concurrence varies widely.*

Given this variance, more specific industry guidance may be required to lift practice with respect to consent in this area.

- *The availability of accessible information and support for First nations people was often limited in visibility, scope, or prominence.*

The Life Code should be more specific in terms of its expectations of life insurers in ensuring resources are accessible.

- *Implementation of solid, flexible identification measures was not across the board*

The Life Code should require insurers maintain uniform policies that embed AUSTRAC guidance in identification and verification. Industry guidance should be considered to lift standards.

- *The detail and relevance of cultural training varied across insurers*

All staff from the board down should be trained in cultural competency with:

- a specific focus on the interaction of life insurance practices regarding sales and claims handling vis a vis First Nations practices such as Sorry Business and kinship systems, and
- specific additional training for specific roles.

This training should be designed with direct engagement with First Nations people and organisations.

- *No insurer provided services in First Nations languages.*

While there is a commitment to providing interpreter services, it is important that that First Nations people specifically who speak English as an additional language are provided with the language support they need. It may be difficult to easily find and engage these services but it is far from impossible and should not be used as an excuse to not meet this commitment. It requires subscribers to be actively looking for solutions to the language barriers and working with First Nations communities to improve language support.

A new Life Code needs to include strengthened commitments that take into account and address these issues.

Recommendations | First Nations consumers

36. **Proactively ask all customers whether they wish to disclose that they identify as First Nations and record and use this information with consent to develop and deliver tailored support and hold this information under NIAA Indigenous Data Sovereignty Standards. Develop Life Code related guidance to support subscribers to lift standards here and help surmount the misgivings held.**
37. **Identify communities which have a high proportion of First Nations peoples through ABS data and match this data against who has the aggregate number of current insureds within those communities to better identify and address the needs and geographical barriers of the member's customer base.**
38. **Develop Life Code related guidance to assist the sector to better understand and address the issue of gratuitous concurrence and consent issues more broadly.**
39. **Amend Clause 6.8(e) to be more specific in terms of its expectations of life insurers in ensuring distinct resources are accessible and the nature of the prominence expected.**
40. **Life Code related industry guidance regarding identification and verification should be developed to lift standards across the industry.**
41. **Ensure all life insurer and third party employees are appropriately trained in cultural competency with specific training – developed with First Nations people and organisations - relevant to life insurance practices, and additional training specific to particular roles: Clause 6.1. See also recommendations under Question 4.1.**
42. **Explicitly offer access to interpreters in First Nations languages (where a consumer or their financial counsellor asks for an interpreter, or the fund identifies that one is needed) in commitments made at Clauses 5.26, 5.35, 6.8 and 6.13.**

43. **Commit to developing, implementing and publishing a First Nations customer service policy which sets out how the life insurer will support First Nations customers to receive the best possible outcomes including:**

    a. **establishing a dedicated phone number for First Nations peoples**

    b. **employing First Nations staff and establishing First Nations customer service teams to solve problems for First Nations customers and resolve disputes on the spot as often as possible**

    c. **undertaking outreach to First Nations peoples, such as by visiting remote communities.**

44. **Commit to specific improved customer service standards including:**

    a. **meeting minimum operating hours for call centres (not solely centred on EST) and prescribed limits on waiting times to speak to an operator**

    b. **calling a consumer back if the phone call cuts out**

    c. **explaining at the outset the likely timelines involved in processing a claim, as well as any information consumers may be asked to provide throughout the process and how they can get help**

    d. **reassuring customers that an investigation is not a criminal process, but an inquiry the insurer needs to undertake to substantiate a claim**

    e. **using standardised forms for certain transactions, with standardised documentation requirements and prescribed processing time limits.**

45. **Monitor and report on outcomes received by First Nations customers.**

46. **Engage First Nations specialist teams to advise on how to explain the complex terms of insurance through different means (for example, via the use of multimedia) and undertake consumer testing of communications materials (including First Nations customers) and monitor their impacts once delivered to consumers.**

Claims handling

3.14. Does Section 5 of the Code provide adequate protection for consumers making a claim? Are there any areas where it could be improved?

No, Section 5 does not provide adequate protections and yes it can be improved.

Financial Rights data analysis found that poor claims handling (and the collection of issues this captures) was the number one issue raised in 29.7% of their life insurance services. The key issues that arose involved:

- unreasonable information requests (38.8%)
- delays (31.7%)
- documents not being provided by the insurer (20.2%), and
- issues with medical examination requests and reports (17.4%).

Life Code commitments on claims handling therefore need to be strengthened.

Claims handling is the key area where an insurer's approach to vulnerability (particularly family violence/abuse) and First Nations customers needs to be embedded to ensure unnecessary barriers are removed and appropriate support is provided to customers.

We provide the further details with respect to the following specific issues consumers face in dealing with life insurers:

- Timeframes
- Medical Examinations
- Investigations/Surveillance
- Information requests

Timeframes

Delays are one of the most common complained about issues in life insurance complaints at AFCA, coming in third in 2024-25.[66] A number of timeframes set in the current Life Code were 'loosened up' in the previous code review and re-draft. These included increasing the timeframe for a written decision from 10 to 15 days (at Clause 5.50) and introducing a "claim reopen" concept (Clause 5.57), which has allowed life insurers to reset the timeframes significantly delaying outcomes for customers. These need to be amended or removed altogether.

There are also a number of ambiguities that need removing and elements that need to be added to bring further clarity to the expectations of these commitments. For example:

- the date the subscriber makes the decision is not transparent to the customer
- Clauses 5.48-50 essentially extend the 2 month and 6 month cap by three weeks, and
- the process of closing a claim for outstanding information at Clause 5.56 does not commit life insurers to providing the claimant with written information outlining what

[66] Page 98, AFCA, Annual Review 2024-25, October 2025

information may be missing, and how the life insurer may be able to assist the claimant in obtaining that information.

Claims handling timeframes were also fundamentally undermined during the past Life Code re-draft with the broadening of the definition of "circumstances beyond our control." This concept and its overly broad definition acts as a get-out-of-gaol clause enabling life insurers to avoid the Life Code timeframes. The definition was expanded in the last review to include concepts that, in various combinations:

- are subjective in nature: for example, "reasonable time to assess reports"
- are duplicative e.g. both sub-clause (a) and (b) refer to insureds not providing requested information
- fully within the control of the life insurer "reasonable opportunity to complete our assessment of your claim"
- subject to poor processes and delays of related third parties that life insurers should proactively minimise and be incentivised to address (e.g. group policy owners, with whom life insurers have ongoing contractual arrangements) and
- actively deny any responsibility of life insurers to actively assist customers to meet disclosure, information or other requirements despite the presence of structural and other vulnerabilities.

Finally, it is critical that life insurers be incentivised to prevent delays through a bright line upper limit for a claims decision. The same issue has been raised in general insurance with the government recommending insurers automatically accept claims after 12 months where delays were not the fault of the insured.[67] The issue however is arguably more widespread and endemic in life insurance and requires urgent addressing.

Recommendations | Claims timeframes

47. Clause 5.50 should be amended to:

a. tell claimants in writing within 5 business days of the decision being made and the date it was made

b. introduce a requirement to proactively assist life insureds who are having difficulties obtaining the information required due to a form of vulnerability or otherwise

[67] See Recommendation 57 at 7.176 of the House of Representatives Standing Committee on Economics *Flood failure to future fairness*, October 2024

c. **clarify that the additional 5 days (currently 15 days) is inclusive of the 2 and 6 month timeframes outlined in clauses 5.47 and 5.48, rather than in addition to those timeframes.**

48. **Remove clause 5.57 that allows a subscriber to restart the clock with respect to claims timeframes if they reopen a claim.**

49. **Amend clauses 5.56 and 5.58 to ensure that:**

    a. **claimants are provided with written information that sets out the information that is missing and how the life insurer may be able to assist the claimant in obtaining that information**

    b. **that the details provided in writing are provided to those with a closed claim based on those with outstanding information.**

50. **With respect to superannuation trustee complaint timeframes (at clauses 7.16-19) – this needs to align with the proposed super services standards and include end-to-end timeframes for claims in super (and public reporting on these).**

51. **Tighten the definition of "circumstances beyond our control" to be applied at clauses 5.59-60 as well as at clause 7.15 in complaints by either**

    a. **removing the concept altogether or, at a minimum,**

    b. **removing from the definition**

        i. **subclause (a) where we have not received or had a reasonable time to assess reports, records, evidence or other information we reasonably requested from you**

        ii. **subclause (c) where we have not had a reasonable opportunity to complete our assessment of your claim and make a decision after we issue a Show Cause or Procedural Fairness letter.**

        iii. **all references to "the Group Policy Owners," and "Independent Service Provider"**

    c. **amending**

        i. **subclause (b) to require that this only be able to be relied upon after the insurer has proactively offered to provide specific assistance to help a consumer respond to enquiries or requests for documents (including identification documents etc) including assistance to obtain certified copies of their documents**

ii. **subclause (d) to include a specific number of attempts, a specific number of communications channels in line with a consumer's communications preferences.**

52. **Where a life insurer has not made a decision on the claim within 12 months, and the delay is not due to the consumer or other reasons beyond the control of the insurer (such as a complaint having been lodged with AFCA), the Life Code should require the claim to be accepted.**

Medical examinations

In 2017 Life Insurance Report the PJC recommended[68] that the life insurance sector:

> "mandate through the Life Insurance Code of Practice … an upper limit on the number of medical assessments that can be requested of a policyholder and the specific circumstances in which this upper limit could be deviated from."

This has yet to be fully enacted despite ongoing need for it. The issue with Clause 5.22 is that it that:

- the commitment is caveated by the use of the phrase "where possible"
- the clause avoids detailing "the specific circumstances in which this upper limit could be deviated from" instead providing an example of a circumstance in an unlimited and unconstrained manner, and
- that the circumstances detailed are broad and non-specific i.e. "such as for a claim for terminal illness or where superannuation law requires".

Finally, the current commitment to merely ask for an independent medical examiner to give us a report within 20 Business Days under clause 5.23 is far too weak. This commitment frames the life insurer in a passive way and fails to acknowledge that the life insurer has the ability to do more than merely ask for a report in that time, and the life insurer can be more proactive in ensuring a report is provided in a more timely manner, and keeping life insured in the loop on any potential delays. Further the length of time allowed is far too long.

[68] Recommendation 10.10 at para 10.130 of the Parliamentary Joint Committee on Corporations and Financial Services, Life Insurance Inquiry Report, March 2018

Recommendations | Medical examinations

53. **Amend Clause 5.22 to establish a genuine upper limit to the number of medical examinations detailing a limited list of specific circumstances life insurers can rely on to avoid this limit.**

54. **Amend clause 5.23 to:**

    a. **require an independent medical examiner give the life insurer a report within 10 Business Days and**

    b. **where there is a delay, commit to:**

        i. **proactively pursue the report and**

        ii. **inform the life insured of the delay and every proactive step taken to obtain the report, and**

        iii. **outline the consequences of that delay for the medical examiner under any arrangement.**

Investigations/Surveillance

Investigations and surveillance are processes that can add significant delays to a claim. While life insurers are well within their rights to conduct investigations and surveillance this should be done so within a framework that seeks to avoid harm.

The life insurance sector has come a long way with respect to investigations and surveillance – as evidenced by significant drops in surveillance usage following the original Life Code.[69] And while we continue to speak to clients who are subject to investigations,[70] surveillance and the delays and stress that arise, these are not at levels that we have seen previously.

There are however always improvements and clarifications that can be made that can assist the sector to reach best practice.

Firstly, there remain outstanding recommendations made by the consumer movement from the previous review that were not taken up by the Financial Services Council including the need to develop a standard interview consent form.

[69] Financial Services Royal Commission Transcript of Proceedings 14 September 2018 R2 P-5787-9
[70] Investigations and surveillance were issues seen in only 1.5% of life insurance services in the Financial Rights analysis

Further, Clauses 5.30(a) and 5.38 should include the provision of a transcript or record of the interview[71] in addition to a summary. While a summary is useful, a full transcript is also useful. This is easily implemented through AI transcription tools – an example of a pro-consumer use of AI, when done so with consent and with appropriately secure products capable of confidentially handling Australian Privacy Principle protected information.

We also note that the General Insurance Code has introduced commitments on the monitoring and continual improvement of investigations and surveillance practices that should be taken up by life insurers.

Finally, the consumer movement is aware of an issue that has emerged with respect to the sector's interpretation and application of Clause 5.42(h) of the Life Code. The requirement that investigators "do not continue … surveillance for longer than 4 months" has been subject to different interpretations:

The first is that the obligation is a **single discrete period** to be completed within 4 months from the commencement of surveillance, which subsequently cannot resume following this 4-month period, regardless of gaps or pauses.

The second is that the obligation allows **multiple discrete periods** where each individual surveillance period must not exceed 4 months, with no limit on the number of surveillance periods, so long as they do not exceed 4 months continuously.

The third is that the obligation is a **cumulative total**, where the total duration of all surveillance activity must not exceed 4 months. In this scenario the surveillance may be conducted in multiple activities and periods, but the cumulative total must be tracked and limited.

The original intent of the clause was to ensure that there was an upper limit placed on the use of surveillance to limit the impact surveillance can have on insureds – particularly those with mental health issues. Surveillance and the awareness that one is being surveyed can exacerbate some mental illnesses through increased paranoia and/or increased stress levels.

This limit was set at 4 months and was always intended to be a single discrete period. This is clear from the natural reading of the text.

Firstly subclause (h) is drafted as a series of explicit limits on excessive or poor investigator behaviour. It not only places an upper time limit on the use of surveillance but also prohibits investigators engaged by life insurers:

[71] as was previously the case in the 2017 Life Code Clause 8.11(j)

- using illegal methods
- threatening anyone
- making any promise or offer, or cause anyone to do anything they wouldn't have done otherwise during the Surveillance.

Secondly, if the intent was that a life insurer or investigator could subsequently begin another, distinct period of surveillance so that multiple discrete periods of surveillance could take place, the 4-month period concept would be rendered meaningless, with little if any work to do. There would in effect be no practical limit to the surveillance. Why then include any reference to a 4-month period at all?

Fourth, the 4-month period was never considered a cumulative total. This is clear from a plain reading of the text. If this had been the intent then the drafting would have and should have made been made explicit in the words of the subclause. A cumulative clause would allow insurers to "drip feed" its investigations. That is, insurers would have been allowed to conduct surveillance for one week here or one week there, spread out over an unreasonably extended periods of time longer than 4 months. This too would render the specific reference to 4-month period meaningless. It would also render any attempt to protect consumers from the worst harms arising from unreasonably prolonged surveillance, worthless.

We accept that there may be edge cases where a 4 month upper limit may not be practical. However, we do not support re-interpreting or re-drafting this clause to allow multiple discrete periods of surveillance to be conducted or enable the 4 months to be used as a cumulative total. If there is a genuine need to deal with circumstances that render the 4 month upper limit impractical, these need to be spelled out specifically in the Life Code with constraints put in place to ensure that life insurers cannot exploit this to render the upper limit meaningless.

Recommendations | Investigations and surveillance

55. A standard interview consent form should be developed and introduced

56. Life insurers should specifically commit to

- **a. conduct quality assurance programs,**
- **b. review investigations that have gone on too long**
- **c. ensure investigations are appropriately focused**
- **d. keep insureds up to date with an investigation.**

57. Clauses 5.30(a) and 5.38 should be updated to include the provision of a transcript or record of the interview

58. **Clause 5.42(h) should maintain a strict 4 month limit on the duration of surveillance. If there is any consideration of an exception this needs to be strictly defined and not undermine the notion of an upper limit.**

Information requests

Life insurers' approach to information requests are at the heart of many of the delays in the claims handling process. Unreasonable information requests were the issue raised most often by Financial Rights clients making up 38% of all clams handling issues.

Case study 5. Nicola's story

Nicola has been on claim for income protection for many years. She is usually asked every year to provide permission for her medical information, normally she is given 2 options – the relevant notes or the whole file. This year, she been asked to provide an authority to her insurer to provide her entire medical record. No reason was stated for the change in practice.

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Case study 6. Jessica's story

Jessica is on claim for income protection insurance and has been providing the requested documentation and signing the necessary authorities when required. However, she was recently requested to provide information about a medical examination she had as a child, and all psychological notes. She has medical advice it is unrelated to her claimed condition. She has not been provided reasons.

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Many clients are provided with information requests they don't understand and find themselves unable to obtain or action the requests.

Case study 7. Neville's story

Neville has income protection insurance and was recently injured leading to a claim. He has provided the information requested but the insurer has asked for further information from

his doctor. However, they did not specify what the information was that they need, nor why they need it. This is leading to delays and he is now experiencing financial hardship.

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Clause 5.13 remains unspecific, overly vague and contributes to delays. Firstly, Clause 5.13 commits life insurers merely to minimise multiple information requests. This was previously a commitment to avoid multiple information requests. Second consumers will be asked for this information "as soon as possible" which is a subjective, impossible to enforce and can lead to significant delays. Third, there is no timeframe placed on life insurers for follow-up with the claimant if any further information is required.

Finally, there is no requirement to assist consumers in obtaining this information. There are many reasons people are not able to obtain this information easily. They can be expensive to obtain, involve digital access which can be difficult for those on the other side of the digital divide, they can involve digital literacy skills that not everybody has and can involve significant costs arising from travel to apply for and collect documents.

Recommendations | Information requests

59. Amend Clause 5.13 to:

- **a. ensure the commitment from insurers is to avoid multiple information requests rather than minimising multiple information requests**
- **b. provide reasons for the information needed**
- **c. replace "as soon as possible" with a strict time frame of 5 business days.**
- **d. add a requirement that where a claimant has provided information requested of them, the insurer should follow up with the claimant if any further information is required within 5 business days**
- **e. provide assistance to consumers who need help in obtaining the information required.**

3.15. What are the causes of delayed claim decisions? How could the Code contribute to reducing these?

Causes include:

- difficulties with the application process of making a claim
- a lack of proactive assistance to address issues relating to vulnerabilities impacting on the process of making a claim (see for example, First Nations and regional experience)
- unreasonable information requests
- unreasonable number of medical examination requests
- documents not being provided by the insurer
- a lack of information about why, and curiousness to any barriers a consumer may be facing
- poor claims handling with the LCCC noting in many of its determinations that poor claims handling was caused by individual claims managers.[72] The training, resourcing and supervising of claims managers must be improved. Insurer should recognise that a poor claims manager is a reflection on poor training and systems.

For life insurance claims through super, further specific causes include

- no end-to-end claims timeframes commitment
- a lack of clarity for claimants whether the life insurer or group policy owner (including the super trustee) is responsible for a particular communication/action and
- the double handling and duplication of requests by super trustees and life insurers.

See above with respect to recommendations.

3.16. Are the grounds for insurers to rely on 'Circumstances Beyond our Control' reasonable? How do insurers apply these in practice? Should any changes be made to help support timely claims processing?

No. This clause needs to be either removed altogether and/or amended to remove loopholes as outlined above.

3.17. How effectively does the Code ensure people receive useful and timely communication about their claim? How could this be improved?

Clause 5.5(d) commits subscribers to tell a claimant about the claims process and how to contact the insurer for more information within 10 Business Days of the Claim Received Date. This needs to be spelled out more with a standard set of information to be provided in a standard form as discussed further below at **Question 4.11**.

[72] See LCCC, Notice of Determination – CX18075, and Notice of Determination – CX15952 as two examples of many.

Further, standard pre-claim information and a claims handling policy should be made available, as similarly discussed further below at **Question 4.11**

Medical definitions

3.18. Are the Code's requirements in relation to the review of medical definitions adequate and appropriate? If not, how could they be improved?

Clause 2.7's commitment to review medical definitions is limited to policies available to new customers only. This needs to be expanded to legacy products with these definitions.

Furthermore Clause 2.7 does not fully implement the recommendation of the 2018 Life Insurance Inquiry Report that medical definitions be updated in consultation with independent medical experts.[73] The use of the word "relevant" does not itself imply independence, as is subject to the selection of the subscriber.

Finally, the carve-out of group insurance at Clause 2.10 should be removed in line with our recommendations under **Questions 4.5 and 4.6.**

Recommendations | Review of medical definitions

60. Amend Clause 2.7 to

- **a. extend the commitment to review all medical definitions to legacy products and**
- **b. replace "help from relevant medical specialists" with "based on the views of a panel of independent relevant medical experts".**

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[73] Para 10.58, Parliamentary Joint Committee on Corporations and Financial Services, Life Insurance Inquiry Report, March 2018.

3.19. How effective are the Code commitments relating to claims where a policy has an outdated definition?

and

3.20. Is it still useful for the Code to include specific medical definitions for trauma and critical illness cover? What is the role of the Code definitions relative to definitions contained in insurers' policy terms, particularly in light of AFCA's observations? If they should remain, do the definitions need to be updated?

The key aim of introducing standard definitions is to ensure that consumers have a better understanding of the risks that they are covered for and the risks that they are not covered for. Standard definitions also increase comparability between products, choice and reduce disputes based on unwelcome surprises at claims time.

The Life Code's approach to standardising medical definitions, does little to achieve these aims.

AFCA Case 607118[74] establishes that the use of technical and medical jargon can obfuscate and mislead consumers in the meaning of a definition used. That decision provided the complex technical definition and then states:

> The policy document does not say that only more severe heart attacks are covered. It does not say that only heart attacks with evidence of severe muscle damage are covered. The effect of the definition is that not all heart attacks are covered. Only more severe heart attacks are covered. The definition contains a lot of medical jargon, and no plain language about the limitation to severe attacks. The result is that, to anyone other than a medical expert, the limitation to severe heart attacks is unlikely to be noticeable.
>
> By contrast, another of the conditions covered is 'Severe burns'. For that condition, it is obvious from the name of the condition that not any burns will be covered, but only severe burns.

This is made even more confusing with the establishment of definitions in the Life Code that are similarly filled with technicalities and jargon. Further, as the consultation paper outlines,

[74] AFCA, Determination: case number 607118, TAL Life Ltd, 16 October 2019

AFCA Cases 607118 and 989722[75] demonstrate that – at least with respect to the definition of heart attack – the Life Code's definition is not considered the minimum standard and does little to assist insureds in terms of claiming and comprehension – especially those with legacy products.

> The Code does not have a minimum standard medical definition of 'heart attack'. Instead, it has a definition of 'Heart attack – with evidence of severe heart muscle damage'

In line with the approach taken by the Royal Commission, AFCA assert that the 4th Universal definition of heart attack is good industry practice[76] – not the LICOP definition. This suggests that the existence of a Life Code definition which is not a minimum standard is just not very useful and can obfuscate and confuse matters by referencing "heart attack" at Clause 5.67 when in fact that is referring to "severe heart attack." Consumers are either then faced with an out-of-date definition in their legacy product that could be for "heart attack" or "severe heart attack," which may not at all be clear to them or a definition that sets the standard too high to be able to be relied on.

There remains a large number of legacy and on-sale products that have inconsistent, out of date definitions that are complex, technical, difficult to understand, and limit the ability for insureds to claim on leading to detrimental outcomes for insureds. In theory establishing standard definitions for medical terms can and should assist comprehension and comparability.

To be useful, the Life Code needs to change its approach to standard definitions. It needs to establish standard definitions that are the minimum benchmark[77], be updated independently and align with good industry practice and the universal definition. In the case of heart attack this should be the Fourth Universal Definition of Myocardial Infarction (2018) and should be automatically updated as this universal definition is updated.

Where there is the need to differentiate on the basis of severity (say between an ordinary heart attack and a severe heart attack) this differentiation should be a distinct addition to the

[75] AFCA, Determination: case number 989722, TAL Life Ltd, 26 April 2024
[76] Fourth Universal Definition of Myocardial Infarction (2018) Kristian Thygesen, Joseph S. Alpert, Allan S. Jaffe, Bernard R. Chaitman, Jeroen J. Bax, David A. Morrow, and Harvey D. White The Executive Group on behalf of the Joint European Society of Cardiology (ESC)/American College of Cardiology (ACC)/American Heart Association (AHA)/World Heart Federation (WHF) Task Force for the Universal Definition of Myocardial Infarction
[77] In line with recommendations of Financial Ombudsman Service's submission to the 2018 Life Insurance Inquiry available on the Submission Page of the inquiry. See page 164 of the Report

minimum definition, made clear to consumers in plain English[78] and set out clearly which associated conditions arising from the initial condition are covered.[79] This way the consumer will be made aware of the risks that they are paying to be covered for and which ones they are not.

The Life Code should also require plain English be applied to medical definitions in all subscriber PDSs (current and legacy documents) so that people can understand what is the severity of risk covered or what the restrictions placed on coverage.[80]

If this approach is rejected, then it may be necessary to support legislative reform to standardise the use of medical terms in the same way standard terms plan to be introduced in general insurance.

Recommendation | Medical definitions

61. The approach to standard medical definitions at Clauses 2.7-2.10 and Clauses 5.66 and 5.67 needs to change to:

- **a. establish standard definitions that are minimum benchmarks**
- **b. be updated independently by medical experts including engagement with Aboriginal Controlled Health Organisations such as the National AboriginalCommunity Controlled Health Organisation (NACCHO)**
- **c. align with good industry practice and universal definitions**
- **d. make clear to consumer any differentiation based on severity, in plain English in the Life Code and PDSs**

Medical definitions and group insurance

Commissioner Hayne in the Financial Services Royal Commission suggested

[78] "us[ing] clear and simple language" as recommended by the 2018 Life Insurance Inquiry Report at Recommendation 10.3
[79] Again see Recommendation 10.3 of the 2018 Life Insurance Inquiry Report
[80] Also in line with Recommendation 10.3 of the 2018 Life Insurance Inquiry Report

> "...there is merit in considering the extent to which insurance within MySuper funds can be standardised, or at least standardised in key respects."[81]

Accordingly, he recommended that Treasury determine the practicability, and likely pricing effects, of legislating universal key definitions, terms and exclusions for default MySuper group life policies.[82] This consultation took place but was never acted upon.[83] The Life Code could assist in achieving the goal set by Commissioner Hayne.

We note that there is carve-out of group insurance at Clause 2.10. There is no rationale for this carve-out, and it creates significant uncertainty for people with insurance in their super. This should be removed in line with our recommendations under **Questions 4.5 and 4.6**.

New medical definitions

We note that the Parliamentary Joint Committee on Corporations and Financial Services was

> firmly of the view that **all definitions** should be up-to-date and standardised across all types of life insurance policies. This would provide certainty to consumers and policyholders about what they are covered for ...[84]

We agree with this view. We also note that Life Code 2.0 did not investigate or introduce standard medical definitions as previously promised by the Financial Services Council:

> Building on the work done to date on draft minimum standard medical definitions, the FSC will investigate whether further standardisation or updating of definitions is required.
>
> The industry will discuss the possibility of putting in place a standardised process for policy upgrades for existing customers. [85]

[81] Page 322 Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, Final Report Volume 1, 2019
[82] Recommendation 4.13, Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, Final Report Volume 1, 2019
[83] Treasury, Universal terms for insurance within MySuper, 26 April 2019
[84] Para 10.57 of the 2018 Life Insurance Inquiry Report
[85] FSC, Media Release, Life Insurance Code of Practice, 11 October, 2016 see: Financial Services Council releases life insurance code of practice, Professional Planner

If the sector agrees to amend their approach to medical definitions in line with the above recommendations, CALI should establish a process to begin standardising more definitions including:

- "mental health conditions'
- "Activities of daily living" test if this is not removed altogether, which would be our preference
- "Endometriosis"

To take a look at one of these "mental health conditions" there are a wide range of mental health tests, definitions used in life insurance policies with varying degrees of quality, and capturing varying aspects of what would collectively be understood as a "mental health condition." This lack of standardisation, clarity and nuance is having genuine impacts on consumers. See **Veronika's story** above at **Question 3.2**.

The Life Code currently has a broad, unhelpful definition:

> 'A broad range of disorders, illnesses, and syndromes including mood or anxiety disorders, bipolar disorder, schizophrenia, and personality disorders.'

As mentioned above, CALI are currently working on a new assessment framework for mental health claims. This review with an expert panel to provide technical advice on the framework will inevitably have to examine the definition and range of "mental health conditions." This is an opportune time to examine a potential definition or definitions to provide greater certainty for consumers.

Recommendation | New medical definitions

62. Life insurers should establish a process to begin standardising more definitions including "mental health conditions"

3.21. Would there be benefit in having a separate guide on medical definitions that allowed for more regular updates or a greater level of detail than the Code, or is it preferable to continue to include these definitions in the Code?

To promote comprehension and understanding insurers should commit to providing consumer-tested, plain English information about the standard definitions in the Life Code.

Recommendation | Medical definition guide

63. CALI should develop consumer-tested, plain English information about the standard definitions in the Life Code.

Other issues

Training

4.1. Should there be a more explicit overarching commitment that staff and authorised representatives are appropriately trained on the Code itself?

Yes, noting that the Life Code currently only requires that "Authorised Representatives", and "Staff and the staff of our Authorised representatives who sell our policies" are trained on the Life Code itself.

In line with recommendations outlined below under **Question 6.3** for life insurers to perform tasks with due, care, competence and diligence, and be trained to perform duties to a high level of professionalism, life insurers should commit explicit commit to training *all* employees and all authorised representatives on the requirements of the Life Code itself.

It is critical that all employees – again from Board and Executive downwards - receive this training in addition to customer facing staff, since it the board, the executive team, management , claims assessors, even IT departments and administration that make the decisions that can impact consumers in ways that may not meet the spirit or the letter of the Life Code.

4.2. Are the various Code commitments to train staff and authorised representatives in relation to particular areas of insurance or particular customers adequate?

No, the commitments in the Life Code to training are piecemeal and complex and have produced significant gaps. Insurers currently commit to various forms of training to various internal and external staff members in a complex web of requirements.

- **Clause 2.16:** Insurers need to agree with **Authorised Representatives** on staff training requirements to meet agreed commitments, sales rules and Life Code requirements
- **Clause 2.18-19: 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 and will cover the customer perspective, Life Insurance Policies and the characteristics of customers in the target audience, acceptable and unacceptable sales practices, the legal duties owed to customers that they have when they provide personal advice and the Life Code's relevant standards

- **Clause 2.24:** Corrective training for **our staff, Authorised representatives or Distributors** engaged in (attempted to engage in) an unacceptable sales practice
- **Clause 4.18: Underwriters** have the appropriate skills and training, including for Mental Health Conditions
- **Clause 5.27: Interviewers** who life insurers are satisfied has the appropriate training and experience to discuss a claim involving a Mental Health Condition
- **Clause 5.45:** Ensuring **claims assessors** have the appropriate skills and training (including for mental health where applicable) to make objective decisions
- **Clause 6.7:** Arrange for relevant training for **our staff who are likely to be involved in communications requiring an interpreter**
- **Clause 6.15: role-appropriate training to help staff** identify and understand if a consumer is vulnerable, consider unique needs or vulnerability … engage with empathy, compassion, and respect, not least to avoid exacerbating any Mental Health Condition
- **Clause 6.16:** provide cultural awareness training to **staff who regularly help customers in remote Indigenous communities**

This approach needs to be reconsidered to consolidate and simplify, making clear what is expected of life insurers, and what consumers can expect.

Life insurers should commit to the principle of performing tasks with due care, competence and diligence, and be trained to perform duties to high level of professionalism as outlined at **Question 6.3**. This would re-establish a principle that life insurers previously set themselves under FSC Standard 1.

This high-level commitment should then be supplemented with specific commitments to receive specific forms of training for *all staff* including:

- the Life Code itself
- vulnerability[86]
- trauma informed practice
- working sensitively with customers with a past or current mental health condition
- LGBTIQA+ awareness and inclusion
- cultural awareness and safety training to support First Nations people and other culturally and linguistically diverse (CALD) customers

[86] In line with the expectations of 6.2.3.1 of ISO 22458:2022, Consumer vulnerability — Requirements and guidelines for the design and delivery of inclusive service, Edition 1, 2022

- anti-discrimination, and
- empathy and/or Emotional Intelligence training.

Finally, there should be specific commitments that relate to specific roles. This should acknowledge the higher risks of consumer harm that can arise through the performance of their role. This is not to argue that all staff should have some awareness of the nature of the training involved here but that it is critical that specific roles at a minimum be trained in these practices. These include, for all customer-facing staff:

- working with interpreters
- training and education for staff to implement payment difficulty assistance measures with compassion and consistency, and
- training to elicit information in a supportive and compassionate way, in line with the requirements of the *Privacy Act*.

Specific training for defined roles and responsibilities should include:

- unacceptable sales practice for all sales staff and management
- appropriate skills and training for underwriting, including for Mental Health Conditions
- objective decision-making for claims assessors.

Recommendation | Training

64. Consolidate and simplify training requirements in the Life Code to ensure that all employees from Board and Executive downwards, and all third parties:

a. are required to perform tasks with due, care, competence and diligence, and be trained to perform duties to high level of professionalism

b. are trained in the Life Code itself

c. receive specific forms of training including those related to vulnerability, trauma-informed practice, cultural awareness training and others, and

d. receive additional specific forms of training relevant to their role – including unacceptable sales practices, and objective decision making amongst others.

Application of the Code - Third parties

4.3. Are any changes required to insurers' commitments in the Code to help ensure that the conduct of third parties is consistent with Code obligations?

The Life Code refers to a multitude of different internal and external parties and entities with varying naming conventions. This is complex and confusing. In alphabetical order, the Life Code refers to:

- Allied health professionals
- Authorised Representatives
- Claims assessors
- Distributors
- Financial advice companies, financial advisers, planners
- Group Policy Owner, superannuation fund trustees, superannuation trustee, and/or trustee
- Independent medical examiners
- Independent Service Providers who help underwrite, administer policies and manage claims including registered doctors
- Interviewers
- Investigators
- Licensed private investigators
- Other industry participants
- Reinsurers
- Sales staff
- Treating doctors, and
- Underwriters.

Different Life Code commitments apply to these different parties in different ways that are not always clear.

In reality, consumers deal with 'third parties' engaged by life insurers on the basis that they are dealing with the insurer itself. The distinctions between the types of arrangements means nought to someone seeking to have their claim decided, managed or paid.

All internal and external actors - i.e. all-of-the-above entities listed – must be equally subject to the Life Code via a commitment from life insurers. The Life Code should be redrafted to provide clarity and simplicity in this regard.

Specific commitments – regarding say interviewers – should apply equally to internal and external parties as if there were no distinction. Consumers should be able to rely on a commitment regardless of the arrangements between a life insurer and a third party,

This would also align with recommendation 3.1 of the 2018 Life Insurance inquiry that:

> *consumer protections for life insurance uniformly cover:*
>
> - *all life insurance industry sectors, including direct, retail and group*
> - *all life insurance industry participants, including but not limited to insurers, distributors, licensees, advice licensees, advisers, superannuation trustees and employees of such organisations and*
> - *all forms of life insurance, including but not limited to life, trauma, disability, income protection; funeral insurance*

Insurers can negotiate formal service level agreements that bring the third party in line with all the relevant commitments under the Life Code.

Commitments to monitoring compliance should be extended to all third parties including Distributors – not just Authorised Representatives and Investigators.[87] This should include the provision of additional data to the LCCC to ensure compliance with commitments regarding "appropriately dealing with actions by service provides that breach service level agreements". This would align with the requirements of ASIC RG 271.48.[88]

Recommendation | Third parties

65. **All Life Code requirements should apply equally to both employees and external third parties as if there were no distinction. The Life Code should be redrafted to provide clarity and simplicity in this regard and ensure that the obligation is centred on the life insurer.**
66. **Life insurers should be required to the monitor and report on the monitoring of all third parties – not simply Authorised Representatives and Investigators.**
67. **Data should be provided annually to the LCCC to ensure compliance of third parties with the requirements of the Life Code in line with ASIC RG 271.48.**

[87] At Clauses 2.16, 2.17, 5.25, and 5.44

[88] ASIC RG 271 Internal Dispute Resolution

Application of the Code – Reinsurers

4.4. Are any changes required to the Code to clarify reinsurers' obligations?

Whether a reinsurer member of CALI is required to comply with the Life Code is unclear since the drafting of clause 1.16 is far from straightforward.

Clause 1.16 states that reinsurers are bound to comply with clause 1.6 - the high-level principles clause – but *also* will comply with the Life Code if they either comply with Clause 1.6 or help other life insurers meet their commitments. This is circular, confusing and needs to be cleared up.

For example, in developing the desktop audit of life insurer family violence policies it was not immediately clear to Financial Rights whether Munich re or SCOR were required to have a family violence policy as per clause 6.6.[89] This is because it is not prima facie clear from the list on the LCCC website differentiates reinsurers for the purpose of clarifying the extent of their subscription to the code.

Consumers engaging with subscribers of the life insurance code – be they life insurers or reinsurers in certain circumstances where they assist other life insurer subscribers in meeting their Life Code obligations – expect to be able to rely on the protections in the Life Code, without distinction.

Clarity is required in the Life Code to make clear the exact obligations that reinsurers are accountable for, including demarcating more precisely how their compliance is met, and when they are liable for a breach. Reinsurers, for example, can and do play a role in claims handling processes that may not be direct customer service facing, which can contribute to delays.

Further the LCCC subscriber page should make clear what those obligations are for those reinsurer subscribers if it is deemed necessary to maintain distinctions in the Life Code itself.

Recommendations | Reinsurers

68. Clarify Clause 1.16 to detail the exact obligations reinsurers commit to under the Life Code.

[89] Financial Rights, Family Violence and Life Insurance: Desktop audit of family violence policies, May 2024

69. **The LCCC subscriber page should make clear what obligations reinsurer subscribers are subject to under the Life Code.**

Application of the Code -Group policies

4.5. Do you have any feedback on the way in which the Code applies to group policies?

4.6. Could the Code's application to group policies be clarified? If so, how?

The application of the Life Code in relation to group policies is complex, ambiguous and needs clarifying. There are carve outs for group policy owners in the following sections:

- **Policy design commitments** at Clauses 2.1-2.5 including not incorporating blanket mental health exclusions, reviewing target markets at least every three years, obligations to Plain English and consumer text sales and policy information and indexing benefits. [90]
- **Updating medical definitions** at Clauses 2.7-2.9[91]
- **Regular contact** under Clause 5.6 which enables Group Policy owners to agree to a different timeframe
- **Financial hardship obligations** under Clauses 6.18 and 6.22[92]

There is also ambiguous application of the Life Code to group policy owners under the following sections:

- **Communication with the insured** depending on the policy type under Clauses 3.1-3
- **No obligation to send the insured their policy documents** under Clause 3.8, only to the "Policy Owner" i.e. the group policy owner, who will not always or routinely provide it, even on request
- **Regular contact** under Clause 5.11 which suggests the group policy owner or insurer will be the contact
- **'Circumstances Beyond Our Control'** impacting timeframes under Clauses 5.59 and 5.60 where the group policy owner *or* insurer will communicate with the insured

[90] As per Clause 2.6
[91] As per Clause 2.10
[92] As per Clause 6.23

- **Responding to complaints** under Clause 7.16-19 which suggests an insured can complain to the life insurer or the trustee

We note too that the obligations relating to the design and introduction of new life insurance policies do not apply to group policies, which was a backward step from the previous code that did apply these principles.

All of this patchwork of obligations and carveouts will be made infinitely more complex and confusing with the introduction of mandatory service standards for superannuation trustees.[93]

The key principle however remains – consumers should be able to expect and rely on the same set of consumer protections and minimum standards whether they have obtained life insurance directly or via a group policy.

We see no strong argument for exceptions to remain.

All Life Code clauses should be expressed as commitments to life insureds equally, irrespective of whether they obtained the product directly, via their employer, their superannuation trustee, an advisor or any other entity.

This review is a chance for super trustees and insurers to actively work with each other to ensure commitments in the Life Code are clear and upheld for the millions of people with insurance in super. We note there remains no impediment for super trustees to voluntarily making the same commitments under the Life Code.

Ultimately the Life Code needs to work seamlessly and in tandem with the Super Service standards, to ensure that there are no gaps and few differences. Appropriate cross references to expectations under the expected mandatory superannuation service standards are likely to be necessary.

Recommendations | Group owners

70. The Life Code's application to group policies need to be clarified to ensure that consumer protections are equally applied irrespective of how they obtained coverage. This should include:

a. remove the carve out from product design obligations at Clause 2.6

[93] See: The Hon Jim Chalmers MP, Mandatory service standards for the superannuation industry, 28 January 2025

b. **remove the carve out from medical definitions obligations at Clause 2.10**

c. **amend Clauses 3.2-3 to clarify who the "contact for the policy" is and explain the respective roles of the subscriber and group policy owner**

d. **amend Clause 3.8 to provide that subscribers will send copies of policy documents to the insured, not just to the Policy Owner**

e. **ensure the Group Policy owners meet the same timeframe detailed at Clause 5.6 – be it in this code or in Super Service Standards**

f. **amend Clause 5.11 to clarify who will be the contact organisation or person**

g. **ensure Group Policy Owners are subject to the same hardship provisions outlined in Clause 6.18-22 – be it in this code or in Super Service Standards**

h. **amend Clauses 5.59 and 5.60 to ensure that it is clear when and where the group policy owner or insurer will communicate with the insured with respect to Circumstances Beyond Our Control – in the event that the concept remains in the Life Code – noting our recommendation to remove it altogether**

i. **introduce an overarching commitment to require that Life Code subscribers will work with group policy owners to ensure they meet all substantive commitments under the Life Code.**

Advertising and sales practices

4.7. Does the Code provide adequate protections for consumers from poor direct sales practices, including pressure selling? Could it be improved, in particular, to address issues raised in ASIC's letter to life insurers?

Improvement is needed. Misrepresentation or misunderstanding of life insurance products was raised as an issue in 21.1% of Insurance Law Service life insurance services. The key issues that arose involved

- instances of mis-selling (28.7% of the category)
- difficulties with the application process (30.1%)
- accusations of misrepresentations of some sort by the insurer (16.9%), and

- consumers who have genuinely misunderstood the nature of life insurance products that they own (19.1%).[94]

Misleading product/service information is regularly in the top five reasons in AFCA life insurance complaints.[95]

We regularly speak to people who do not understand, for example, that "life" insurance is not for life. They have expiry dates when the insured reaches a specific age. Life insurance is also not a savings account to draw from when it matures. Much of people's understanding of life insurance is drawn from fear-based advertising strategies and broad platitudes of a promise to be there when tragedy strikes.

The following case studies demonstrate common misunderstandings of life insurance and the nature of the products. Noting many of the sales practices, pre date the introduction of the Life Code and more recent consumer protections.

These are examples presented not to highlight low levels of financial literary but of a fundamental failure of the life insurance sector to relay the most basic of life insurance concepts to their customers in their advertising, sales and product information and ongoing communications – customers who life insurers do not actively engage with but from whom they continue to reap significant financial rewards from.

Life insurers must both recognise what current financial literacy levels currently are, and work to improve literacy in their advertising and sales practices. Life insurers need to see that their role is to meet a consumer where they are at and not to expect consumers to understand incredibly complex financial products.

Life insurers must also recognise the impact of time, and potentially poor practices of the past, can exacerbate consumer misunderstanding. Life insurers have opportunities with their ongoing communication of annual notices, to assist consumers to understand and make decisions about how to proceed.

[94] This category is not to blame consumers who may be subject to poor behaviour from insurers and advisors but it is to note that three is clearly a systemic issue relating to people not understanding the nature of the product (an expensive financial product) they own, and that the issues needs to be addressed by life insurers in line with their commitment under Section 2 of the Code.
[95] Page 98, AFCA, Annual Review 2024-25, October 2025

Case study 8. Uli's story

Uli took out a life insurance policy 20 years ago through a broker. When he recently called his insurer to pay his monthly premium, he was told his policy had expired. He did not know that his policy would expire when he reached a certain age.

Financial Rights Legal Centre

Case study 9. Irene's story

Irene has had life insurance since 1978. Recently she received a letter stating that her policy had reached its expiry date. She did not do anything about it at the time but she decided to sort it out now. She called her insurer and asked where her money was sitting.

Financial Rights Legal Centre

Case study 10. Timothy's story

Timothy called the Insurance Law Service complaining that he had spent several years to get his life insurer to "cash out" two policies he had taken almost 40 years prior and which should have "matured" when he turned 65.

Financial Rights Legal Centre

Case study 11. Kerry's story

Kerry has held a life insurance policy since 2002. When she bought the product, she understood the product was like a savings account and that she could choose where she would allocate the funds later on when she knew what she wanted to do with them. Essentially Kerry believed the product was just a savings account that she could withdraw her money from at any time rather then a product that needs an insured event to trigger a claim.

Financial Rights Legal Centre

Case study 12. Gerald's story

Gerald has a life insurance policy and a funeral insurance policy since 2005. He is about to move into a nursing home and cannot afford his premiums. When he took out the policies he understood them to be level premiums – that they would be set at a certain amount that wouldn't change. He did not understand that they would increase with inflation without discussing it with him. He has also calculated that he has paid more in premiums than his family would receive on his death. He tried speaking with his insurer but they gave him no alternatives.

Financial Rights Legal Centre

Section 2 of the Life Code refers to developing policies that are "easy to understand" but there are no real commitments made to:

- benchmark the levels of consumer understanding of the products they have, report on this and act to improve those levels
- proactively assist new or existing customers to understand the products they have through education or financial literacy campaigns
- life insurers do not commit to consumer test any of the "Plain Language" information used in
    - communications with customers[96]
    - sales and policy information[97]
    - funeral insurance policy information[98]
    - alternative terms[99]
    - decision language.[100]

Even the commitments that are there are ambiguous and unclear with respect to their application and what is expected of the insurer.

[96] Clause 1.1
[97] Clause 2.3
[98] Clause 2.29
[99] Clause 4.22
[100] Clause 4.25

Recommendations | Advertising and sales practices

71. **Life insurers should benchmark the levels of consumer understanding of the products they have, publicly report on this, and act to improve these levels by at the very least feeding these insights into the design and distribution process.**

72. **Life insurers should explicitly commit to consumer-test sales, advertising, and significant event notices to ensure that premium increase information is clear, simple comprehensible and generally understood.**

Sales practices and pressure selling

In 2018, ASIC reviewed the direct sale practices of life insurance products and highlighted several areas of concern in ASIC Report 587.[101] ASIC subsequently reviewed documents and policies from a sample of life insurers and life insurance distributors covering the period between July 2021 and June 2024 to determine whether consumer outcomes had improved since its 2018 review.[102] While ASIC acknowledge there have been improvements made by some companies in recent years, there found "notable deficiencies" especially around product design, retention practices and consumer feedback. To address these, life insurers should commit to improved practices under the Life Code.

While the current Life Code improved its approach to 'pressure selling' by providing a definition it remains seriously limited. The Life Code needs to provide further guidance and examples of unacceptable sales practices, pressure selling and other poor sales techniques to make it clear as to what is unacceptable. It should, for example, be made explicit that the following predatory and coercive practices should be prohibited:

- techniques that reduce informed decision making, such as bundling cover into a quote without seeking explicit consent from the consumer upfront.
- misleading consumers with respect to the First Nations nature or suitability of a product
- running 'Refer a Friend' programs or programs of a similar nature that incentivise consumers to provide contact details for family and friends without their consent, and making suggestions that the referring customer had endorsed the policy
- speaking too quickly and rushing through the sales calls

[101] ASIC REP 587, The sale of direct life insurance, August 2018
[102] ASIC, Media Release 25-168MR, ASIC urges life insurers to spearhead improvements to direct sales practices, 19 August 2025

- ignoring repeated objections and requests for time by consumers to consider whether they wanted to buy the insurance
- making repeated contact and harassment
- making misrepresentations about the insurance product
- unsolicited marketing
- down selling low quality insurance after customer applies for life insurance and not explaining the difference
- selling additional policies (such as funeral insurance) where the insured already has a pre-existing policy
- relying on making contact with consumer on the basis of a competition or completed a survey, or they unknowingly agreed to terms and conditions that signed them up to receive marketing calls about life insurance
- inappropriate 'objection handling' and 'closing' techniques
- exploitation or ignorance of gratuitous concurrence, and
- the misuse of cooling off periods and deferred payments.

Case study 13. Ethel's story

Ethel is an older First Nations woman who came to ICAN in 2024 for assistance with a No Interest Loan (**NILS**). Her NILS loan had been rejected because her budget was too tight, prompting us to go through her current expenses. Through this assistance we identified that she had been paying for a funeral insurance policy and a separate life insurance policy, which included funeral insurance with the same company. The life insurance policy had been taken out in 2021.

It was apparent from the call recording for the sale of the life insurance policy that Ethel informed the sales representative early in the conversation that she already had a current funeral insurance policy with the company taken out many years earlier. However, no discussion was had as to whether she wanted to continue paying for the earlier policy given the second policy included funeral cover.

Also of concern was the failure of the representative to clearly explain that should the life insurance policy end on her 85th birthday, neither she nor her family will receive any payments back under the policy. It was assumed she understood the implications of the policy ending when she reached 85. When we talked to her about this provision, it was clear she did not know or understand this. At the time of the sale, Ethel's sole source of income was the aged pension. The combined policies meant she was paying more than $155 per fortnight out of her low income. Given the financial hardship it was causing her, there is a real risk she would have eventually defaulted on both policies and lost all amounts paid to date.

Indigenous Consumer Assistance Network

Case study 14. Sandra's story

While assisting Sandra, with a No Interest Loan (NILS) application, ICAN's financial counsellor identified significant expenditure on insurances within Sandra's bank account. On investigation, it became apparent that she had been paying significant sums of life insurance for herself and her children.

When ICAN reviewed the phone recordings from the time of sale, it was apparent that there had been significant wrongdoing in relation to all policies sold. In particular, the sale was unsolicited and misleading with the sales representative failing to mention that premiums would increase over time in response to a direct question by Sandra about this. Sandra advises the sale representative that she already has funeral insurance but the sales representative goes on to sell her additional funeral cover anyway. Finally, at the end of the call, the sales representative attempts to entice Sandra into providing the names and phone numbers of family and friends with the promise of receiving $50 gift voucher per person referred. Despite Sandra's sole income being parenting payment, no attempt was made to ensure she could afford the significant insurance premiums.

Indigenous Consumer Assistance Network

The emerging harms and use of lead generation, finfluencers and the evolving financial landscape must also be recognised by the Life Code. Insurers should be banned from using or having arrangements with unlicensed entities, such as lead generation businesses or finfluencers. We are aware that many life insurers use online presence, algorithms and notifications as a means to sell their products – moving away from traditional cold calling practices. The Life Code should be alive to the potential risks of these new methods, and consider ways to monitor, and curb poor selling practices causing consumer harm.

Recommendations | Pressure selling

73. **Require sales staff to end a sales call the first time a consumer states that they do not want to proceed'**

74. **Amend clause 4.30 to provide further details with respect to unacceptable retention practices to prohibit complex cancellation processes or unnecessary barriers to**

cancellation. Ensure cancellation processes are simple and not require customers to complete multiple steps or provide extensive paperwork to cancel their policies.

75. **The definitions of unacceptable sales practices and pressure selling needs to be expanded with further explicit guidance detailing techniques that are unacceptable. Ensure this definition extends to retention practices, referenced at Clause 4.30.**
76. **Introduce a deferred sales model for downgrades—If a consumer is not eligible for a policy and the firm offers a downgraded option, they should provide a clear warning upfront about the product's extra restrictions or limitations and whether it will meet their needs. Insurers should also provide the Product Disclosure Statement (PDS) and schedule a call back at a later date, after a set number of days have elapsed, rather than concluding the sale in the same call, so the consumer has time to consider whether the product meets their needs**
77. **Amend clause 2.14 to expand upon what information insurers will provide customers regarding explanations of key exclusions and future cost including not rely on including this information in lengthy pre-recorded or verbatim disclosures.**
78. **Strengthen 2.27(g) to**
    a. **spell out the protections for vulnerable consumers**
    b. **detail clear expectations how sales staff should behave when dealing with vulnerable consumers, including when it will be appropriate to end a call.**
79. **Extend the commitment to quality assurance programs under Clause 2.15 to capture retention and cancellation practices.**
80. **Ensure that automatic cover increases do not exceed what the consumer can claim.**
81. **Prohibit the use of lead generation, finfluencers, targeted advertising and other unfair trading practices. If a prohibition is not accepted, these practices and their use should at minimum be capable of monitoring by the LCCC.**

Legacy products

Many of the cases we see relate to consumers holding legacy products with the mis-selling and poor sales and marketing behaviour having occurred years ago. Yet there is no obligation on life insurers to proactively identify and work with those customers who may be stuck with inappropriate and mis-sold legacy products, and who are paying good money after bad.

We note that when the Australian Banking Association (**ABA**) sought authorisation from the Australian Competition and Consumer Commission (**ACCC**) for their approved Banking Code the ACCC imposed a number of increased commitments regarding banks proactively identifying eligible customers who do not access to basic bank accounts but may be eligible. These commitments have increased in nature over time and are currently being considered for further uplift following the Code's approval in 2024.[103]

In many ways the situation is equivalent. Significant numbers of customers of a financial service are holding products that were either mis-sold to them or have subsequently become inappropriate for their circumstances. And in many cases life insurers hold the information they need to identify them.

Case study 15. Sharelle's story

Sharelle bought a funeral insurance policy almost 20 years ago following a cold door to door sales pitch. She was originally pay $80 per month but after Sharelle's son intervened on her behalf and contacted the insurer to complain, the premium was knocked down to $30. The insured amount of $9000 remained. Sharelle has paid over $20,000 to date.

Financial Rights Legal Centre

As with the banks there is a moral and legal obligation on life insurers who earn money from these customers to proactively identify these customers using data analysis and other means (e.g. identifying those with multiple policies) to make amends and provide people with alternative options that may be more suitable for them, be provided with appropriate financial hardship and/or other support measures or simply be repaid their premiums if mis-selling has been identified. To maintain its social licence to continue selling life insurance products, it is incumbent on life insurers to act to address this problem.

Recommendation | Legacy products

82. Life insurance should commit to proactively identifying customers who may have been mis-sold products or who may be experiencing financial hardship.

[103] See ACCC, Interim approval to Banking Code changes following Royal Commission, 11 July 2019 and ACCC, Australian Banking Association - Basic bank accounts - minor variation, 1 February 2024

4.8. Are the commitments on the communication of funeral insurance and consumer credit insurance fulfilling their purpose? In particular, do the Code commitments on funeral insurance sufficiently deal with the issues experienced by First Nations customers?

4.9. If not, how might they be amended?

We continue to see issues with funeral insurance particularly in a First Nations context including:

- concerns have been raised about First Nations people being signed up to funeral insurance in the wake of ACBF remediation (using ACBF compensation) i.e. transferring the harm to a different business.
- excessive and ongoing sales calls encouraging people to increase their funeral insurance cover, potentially as a result of problematic sales scripts and inappropriate sales incentives.

Being prepared for one's own or a loved one's funeral is for many people, and for many cultures, essential. This is particularly the case for First Nations people because of the cultural importance of Sorry Business and the high costs involved. Despite the industry being on notice of the widescale exploitation and harm caused by ACBF, the sale of low value, complex funeral insurance products continues to impact First Nations peoples who are not made aware that the products involve significant financial risks, the impact of which can leave many people in hardship or without enough funds when the time comes.

Unless the policyholder dies in the 5–10 years after taking out a policy, people end up paying more in insurance premiums than the actual cost of the funeral. This is particularly the case the younger someone who is signed up to a funeral expenses policy is. Further, there are significant exclusions (including only covering accidental death) that usually apply in the first years that can deny a payout.

The current Life Code stripped out a number of commitments raised by previous drafts of the Life Code with respect to funeral insurance. These need to be reconsidered.

- Prohibit stepped premiums for funeral policies
- Do not sell to people under the age of 50
- Offer Capped Funeral Insurance Premiums
- Prohibit the selling of multiple funeral policies to the same person
- Make specific commitments with respect to marketing of funeral insurance products
- Provide specific options for those suffering financial hardship by allowing:

    - premiums to remain unpaid for at least 60 days before providing options to repaying arrears and
    - premium payments to be stopped for a fixed period, during which time you will not be eligible to make a claim
- Reference to a key fact sheet in funeral insurance at 2.30 should be a standardised fact sheet that:
    - explains a funeral insurance policy is a not a savings plan
    - that there are other ways to provide for a funeral
    - that an insured can cancel the insurance at any time and explaining what this means – that is, the insured will lose all the money paid
- Commit to a deferred sales model in line with the add-on insurance regime
- Take steps to ensure that engagement with First Nations peoples is conducted in a culturally appropriate manner taking into account the specific needs and cultural protocols of each community.
- Ensure that any insurance products promoted and sold to First Nations peoples are suitable to their specific needs, and
- Do not procure sales leads from remote First Nations communities by exploiting First Nations kinship ties.

Recommendation | Funeral Insurance

83. The Life Code should include specific rules constraining the worst excesses seen in funeral insurance sales, distribution and design.

Communication

4.10. How effectively do the Code commitments ensure consumers receive clear and effective communication, particularly in relation to premiums?

and

4.11. Are any changes required to ensure the Code reflects modern customer communication channels and preferences?

Poor communications practices and a lack of information are at the centre of most complaints that our organisations hear about life insurers. They are also at the heart of the

failures outlined above with respect to various aspects of vulnerability and the sector's approach to First Nations people. They include:

- life insurers not being clear about the nature of the life insurance products they own with poor advertising and sales practices, combined with long complicated PDSs riven with technical jargon, and complex definitions
- life insurers obfuscating the true cost of their products exacerbated by poor premium labelling and information
- consumer anger and frustration from the lack of contact from life insurers during a long ongoing claim process, the lack of available information about their claim and the process that they will be going though, the drip feeding of multiple information requests and medical examinations, etc
- life insurers mishandling interactions due to a lack of empathy and understanding of the customer's experience and the different types of vulnerabilities that can impact upon their lives – be it requiring people to repeat their stories and re-traumatise themselves or having to justify themselves and their circumstance to a life insurer who isn't flexible enough to work with them.

The Life Code can assist in making clear that insurers should be more proactive in their information provision leading to greater transparency and a more meaningful interaction with their customers

Pre-claim information

We note that despite a commitment to "tell" an insured "about the claims process[104]" and provide new insureds with documentation that includes information about "our claims and complaints processes"[105] includes no requirement for insurers to provide specific publicly accessible information that details what consumers can expect from the claims process. Such information would assist in managing expectations, empowering the consumer to assert their rights and minimising confusion. There also is no current commitment to publishing a transparent claims handling policy.

Improvements can also be made in the provision of information under Clause 5.5.

[104] Clause 5.5(d)
[105] Clause 3.5(g)

Recommendations | Pre-claim information

84. Publish general information on websites for insureds about what they can expect from an insurance claims process, reviewed and (where required) updated annually, This information should include:

- **a. the steps in the claim process and indicative timeframes for each step**
- **b. eligibility criteria**
- **c. the claims form(s)**
- **d. the PDS(s)**
- **e. the expected documentation required to be submitted by the claimant for different claims**
- **f. the process for the claimant to follow if they want to make a complaint about how their claim is handled including access to IDR, EDR and rights under the Life Code**
- **g. avenues of support for financial hardship**
- **h. any other information necessary for the claimant to understand the claims process.**

85. Amend clause 5.5(d) to provide written information about the claims process in line with the recommendation above, but specific to the claim being made. This should include:

- **a. outlining the specific information and relevant documentation required**
- **b. the claims form(s)**
- **c. the PDS(s)**
- **d. providing explanations for why each document is relevant and necessary to the assessment of the claim**
- **e. outlining the steps the claimant should take if the claimant is unable/unwilling to provide the required information, including how the insurer may be able to assist the claimant in obtaining that information**
- **f. within 3 business days not 10 business days**
- **g. in both digital and hard copy forms**
- **h. once responded to by the claimant the insurer should follow up with the claimant if any further information is required within 5 days.**

86. **Insurers should also publish a claims handling policy that outlines the insurers approach to claims handling and its ongoing improvement. This should be annually reviewed and updated. It should include commitments to:**

    a. **sets timeframes**

    b. **review claims that exceed certain timeframes**

    c. **regular reporting to the board.**

Updates every 20 business days

The commitment to update every 20 business days under clause 5.6 is not in writing and does not provide details with what they will be told including what has occurred recently and what are the next steps.

Recommendation | Updates

87. **Amend Clause 5.6 to ensure that the update is provided in writing and outlines what has occurred and what next steps will be taking place.**

Primary contact

Having dedicated claims managers to maintain direct contact with a claimant results in better management of consumer expectations and a better claims experience overall. Life insurers have already committed to ensure a claimant has a primary contact person throughout the claims process at Clause 5.4. However, this only applies to income-related claims. This should be expanded to include all other claim types.

Further the term "Primary Contact Person" is not defined and not explicitly linked to training and other capability frameworks committed to in the Life Code. This needs to be clarified. It is critical to ensure that "Primary Contact Person" be a human being and not be some form or AI, empathy bot or other artificial, digitally based contact: see further under Use of Technology and AI in consumer communications below.

Recommendation | Primary contacts

88. **Amend Clause 5.4 to ensure all claimants are provided a primary contact person (not just income-related claimants) and that this person is a human and cross-referenced to appropriate training and skills competencies.**

Record keeping of communications

This submission has already outlined the need to flag and record the needs of life insured customers with consent in ways that meet best practice: see **Question 3.5**. This should also extend to any recording of communications with customers. AI could be used to more quickly transcribe phone calls and be used to develop subsequent meaningful communications with customers (as opposed to the overuse of templates letters). Transcripts can also be kept on file and be made available on request. This should be done so only if the recommendations on AI with respect to meeting the government's ethical principles, below, are accepted, to ensure that the use of AI does not contribute to further harm.

Recommendation | Record keeping

89. **Commit to providing transcripts and recordings of verbal communications with consumers, on request.**

Claim payments

There is no requirement to ensure the timely disbursement for approved claims. There are also no standards set for the clawing back of over-payments of benefits and/or premiums or addressing underpayments of benefits. The following cases studies demonstrate the range of issues that arise:

Case study 16. Angela's story

Angela had an income protection claim accepted that involved mental health issues. Two years into the claim Angela received a letter claiming they had overpaid her $60,000. Angela was extremely distressed by this letter and the size of the clawback. Angela had made financial commitments based upon the claim's acceptance. The experience exacerbated her mental health condition.

Financial Rights Legal Centre

Case study 17. Steve's story

Steve was on claim on his income protection policy being paid at a higher than usual rate based on a higher premium he had been paying. Steve was then informed by his life insurer that due to a technicality the higher amount should not have been paid and that he owed $35,000 and starting *that day* he would not be receiving any payments until the overpayment was paid back. This had a significant impact on Steve's financial planning.

Financial Rights Legal Centre

Case study 18. Olga's story

Olga's husband passed away and made a claim on his life insurance policy. The claim was denied on the basis that the policy was in her husband's name and no payout was possible. The insurer continued to take premiums from Olga's husband's account after he deceased. Olga attempted to cancel it and obtain a refund of those overpaid premiums but the insurer will not return her calls or action the cancellation paperwork. The insurer then pushed back saying that no premium refund was due since the policy was still active.

Financial Rights Legal Centre

Case study 19. Cara's story

Cara's income protection claim was accepted and had been receiving payments for a few years. Cara's most recent payment was however less than she expected. Cara subsequently called the insurer who only then told her that they had been overpaying her, that it was a mistake and they will be paying a reduced amount moving forward – also covering the overpayment. She was offered $100 compensation from the insurer for their mistake. Cara can now no longer afford her kids education costs and is financially struggling.

Financial Rights Legal Centre

A more compassionate approach is required when dealing with overpayments of benefits. Life insurers need to take into account the financial reality somebody faces when a sudden financial shock hits due to no fault of their own as well as the emotional and mental health shock that can accompany this. A similarly compassionate approach should be extended to those who have overpaid premiums and those who may have been underpaid benefits. It is questionable, whether an insurer can in fact and in accordance with their duty of good faith, demand overpayments and whether consumers have a defence of estoppel in circumstances where it was not their error and they relied on it in good faith.

Recommendations | Claim payments

90. Establish a compassionate approach to overpayments of premiums and benefits and underpayment of benefits to reduce distress and financial hardship.

91. Process claims payments within two business days of receiving valid bank details or confirmation from the claimant.

Communication carve outs for group policies

As touched on above (at **Question 4.6**), several commitments do not apply to insurance in super or do not give the claimant clarity.

Clause 5.6 commits insurers to update an insured on their claim every 20 business days. But this commitment does not apply to group policies. Super funds and insurers must actively work together to ensure it does.

Clause 5.11 confusingly suggests the group policy owner *or* insurer will be the contact. This is unclear and unhelpful to a consumer. There should be a commitment to tell the claimant at the beginning of the claim who the contact is.

Clauses 5.59 and 5.60 asserts that if there are circumstances beyond our control, the policy owner *or* insurer will communicate this and the complaints process. While we have argued that this concept either be removed from the Life Code altogether or at least severely constrained (see **Questions 3.14 and 3.16**) at a minimum it should be clear from the beginning of the claim who the claimant can expect this communication from.

Premium communications

There remains a significant lack of clear information provided to consumer with respect to the nature of the premiums they need to pay and how they work over time.

Incorrect premiums are the second biggest cause of complaints to AFCA in life insurance, second only to denial of claims that recently jumped to number one in the most current data.[106] Since 2022 ASIC and the Australian Prudential Regulation Authority (**APRA**) have been examining life insurers approaches to premium increases, product design, and disclosure and marketing materials. While they have noted some progress has been made including life insurers adopting new premium labels, consumers continue to contact Financial Rights Insurance Law Service with complaints that evidence a sector that has systemically failed to appropriately inform their customers of the nature of their premiums nor communicate in a way that it empathetic or compassionate of their circumstances.

Premium issues were raised in 14.6% of life insurance services on the Insurance Law Service mainly relating to premium increase complaints at 61% of premium related issues, followed by complaints regarding premium overpayments at 33% of premium related services..

Case study 20. Killian's story

Killian bought a life insurance policy over 20 years ago which started out cheap at $10 a fortnight which has now increased to over $500 per fortnight. Killian and his wife are in financial hardship and only realised that they had a "stepped premium" policy and what that means when they spoke with the insurer recently.

Financial Rights Legal Centre

Case study 21. Oliver's story

Oliver bought a life insurance policy 15 years ago which began as a level premium of roughly $1000 a month. Oliver was recently informed that his premium was increasing to over $5000 and would now be age-stepped premium.

Financial Rights Legal Centre

Another issue that has arisen is the need for more empathetic and proactive management of premium increase matters due to premium increases relating to sustainability and the need to re-rate.

[106] Page 98, AFCA, Annual Review 2024-25, October 2025

Case study 22. Belinda's story

Belinda took out funeral insurance after watching a TV ad and thought it would be a good idea. Almost 15 years later she is paying the same amount month after month. Belinda thought she would pay the amount per month until she reached the benefit amount, after which she would stop paying but the insurance would pay out if she died. But this is not how the policy worked and she needed to continue paying it. She had contacted the insurer but this was not helpful. Belinda has now received a letter explaining that the premiums may increase to ensure that the policy is sustainable. Belinda is upset.

Financial Rights Legal Centre

Case study 23. Vince's story

Vince has had his life insurance policy for over 15 years which was a level premium policy – not a stepped policy. He understood that he would pay a higher amount for the level premium rather than a step premium which gets more expensive over time. He also understood it would not be fixed but that it would increase in line with inflation. However recently his premium was increased well above inflation close to 20% higher. His insurer has merely offered him to cancel the policy or reduce his benefits. Vince is upset that his "level premium" can be rendered unaffordable at will and believes that his insurer needed to advertise how much it would cost over his life from the start.

Financial Rights Legal Centre

There is also a clear nexus between substandard communications, a lack of understanding of vulnerability and poor consumer outcomes.

Case study 24. Samuel's story

Samuel purchased a life insurance policy over 10 years ago, in his mid-60s. He however has only just become aware of the financial implication of the policy, which is causing him severe financial hardship having paid close to $80,000 over the period. Samuel is illiterate and showed several clear signs of vulnerability at the time of purchase. He was unable to read or understand written documents, was dependent on a pension from the Department of Veterans Affairs and has been diagnosed with PTSD and industrial hearing loss, both of which affected his ability to take in information and communicate effectively over the phone.

The insurer's own records noted his hearing loss and that his wife (since passed away) and later his daughter, briefly assisted him. These details should have prompted the insurer to check whether he understood the product or needed further assistance. However, the insurer did not assess his understanding or provide any support during the sales process or at any other time despite being aware of his circumstances.

Salvation Army

There also remains ongoing issues related to the sale of "accidental death" and "accidental injury" products. Our organisations work with consumers who have been sold a low value accidental death or accidental injury insurance product, believing it is life insurance but discover later that it is a general insurance product.

Simply put, an accidental death could be a general insurance product or a life insurance product depending on whether it is guaranteed renewable. Accidental death is usually not a life insurance contract under the *Insurance Contracts Act* nor a life policy under the *Life Insurance Act*[107] but can be in APRA approved certain circumstances.

We generally see it sold not as an interim product but a form of 'life insurance lite' when customers are unable to afford life insurance and they are downgraded – see Lina's story above.

Alternatively, we see the product added or bundled on to other products such as health insurance, paying a lump sum in the event of a burn for example or a broken leg or a death.

Accidental insurance tends to be worthless with limited scope of coverage and expansive exclusions, including blanket mental health exclusions (see under mental health), strict definitions applied, and low payout rates.

Ultimately the products nature as a general or life insurance product and its value is confusing and the communications around the sale of these products do little to assist consumers who end up paying large amounts of money for what is essentially junk insurance.

[107] Page 71, para 4.4. "If the duration of the contract is to be not more than one year, and payment is only to be made in the event of death by accident or death resulting from a specified sickness, the contract is not life insurance or a life policy; it cannot be insured with a life insurance company without an APRA declaration to deem it to be life insurance business." Dr Ian Enright, Peter Mann et al, Life Insurance Background Paper, 28 August 2018 for the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry

There needs to be a significant improvement in the approach life insurers take to communicating about products, premium structures and increases. A fairer, more proactive, compassionate, and empathetic approach needs to be introduced to see life insureds as real people, with real lives, rather than as cost centres that need to be managed and exploited.

Work needs to be undertaken to identify best practice communication of the information that insurers currently commit to providing on premiums during the sales process[108] and before each policy anniversary.[109] In line with the observations from APRA and ASIC with respect to premium increases and ensure that minimum standards are met across the sector the Life Code should commit insurers to consumer-testing annual renewal letters and significant event notices. The Life Code Committee has found systemic and repeated non-compliance with insurers failing to send out renewal notices.[110]

The Life Code should update its references to level and stepped premiums. We note however that the new labels are still confusing, far from intuitive and complex:

- Variable premium (reviewed annually)
- Variable age-stepped premium (reviewed annually)
- Fixed premium (reviewed after fixed period of >1 year)
- Fixed age-stepped premium (reviewed after fixed period of >1 year)

See also recommendations under **Question 4.7.**

Recommendations | Premium communications

92. Strengthen commitments under Clause 2.11, 2.14, 3.6 and others to promoting improved information regarding premium labels and how premiums will increase throughout a policy's lifespan.

93. Proactively provide information on support and alternative options to keep premiums affordable.

94. Provide consumers with the CALI fact sheet on these naming conventions to all insureds whose product names have changed.

95. Update all references in the Life Code to level and stepped premiums.

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[108] Clause 2.27(d; 2.29(g), 2.30, 2.31, 2.32, 3.5(b) and (c), 3.6, 3.7.
[109] Clause 3.10
[110] LCCC, Compliance with section 6.3 of the Life Insurance Code of Practice, Jan 2022

96. **Commit to reviewing and testing the comprehensibility of the new premium labels now that they have been on the market for some time.**

Policy cancellations and changes in cover

Related to policy renewals, are communications about cancellations.

Communications from life insurers regarding policy cancellations is also a notable issue. Financial Rights found that cancellation-related services accounted for 5.2% of life insurance services. The key issues that arose regarding cancellation issues include cancellation for non-payment and low balances (almost 30%) and cancellation because of an insurer mistake (15.6%).

Insurers communication to consumers, in circumstances where these are long term policies, must be better in ensuring contact information is up to date and that they are utilising multiple communication channels.

Insurance held within super has its own issues, with policy owners being able to change insurers and terms. The obligations across the super standards and the Life Code ensuring plain language, consumer tested explanation of these changes must be considered.

Case study 25. Patricia's story

Patricia has held life insurance for close to 20 years paying monthly. Patricia missed a payment recently due to her being hospitalised. She subsequently was given an extension to make the payment but Patricia was hospitalised again, could not access a computer and did not see the email. The insurer did not contact her by any other method. Her policy was cancelled.

Financial Rights Legal Centre

Case study 26. Harold's story

Harold has a life insurance policy that he was paying monthly for via direct debit when he switched banks. Harold subsequently found out that he was not able to set up direct debits the same way he had previously and attempted to fix it. He attempted to provide payment details via the insurer's online portal but it produced errors. He then tried to call the insurer

but was put on hold for so long he hung up. Life subsequently got in the way when a month later he was sent a letter from his insurer that his policy was cancelled. He tried to re-instate the policy explaining his situation but they insisted on underwriting him.

Financial Rights Legal Centre

Case study 27. Terry's story

Terry has income protection through his super fund which was cancelled last year. However, he never received a cancellation letter and his premiums kept being taken out. Terry was recently injured and made a claim. This was when he first found out that his policy had been cancelled. The insurer admitted an error had taken place and merely offered a small goodwill payment with refund of his premiums paid from the cancellation date.

Financial Rights Legal Centre

We have also seen a number of cases relating to unilateral changes in cover. 4% of Financial Rights' ILS services touched on this issue.

Case study 28. Melanie's story

Melanie has been receiving income protection payments for many years now when her insurer informed her that her payments will cease when she turns 60, despite her original contract stating that payments cease at 65. When she complained asking for the contract that showed the age, she was not provided the contact and was told she told to prove the age cap was 65.

Financial Rights Legal Centre

Recommendation | Policy cancellations

97. **Bolster commitments to providing customers with information regarding cancellations including ensuring life insurers proactively make contact with customers via multiple channels, and provide information to consumers in the Life Code or in cancellation notices as to their legal right to reinstatement and greater flexibility for individual circumstances re: reinstatement.**

98. Ensure the LCCC can issue meaningful deterrent sanctions for breaches of annual renewal notice requirements.

Use of technology and AI in consumer communications

There is likely to be an increased use of AI in life insurance including in consumer communications. While we can see some positive use cases for AI to improve consumer outcomes – such as using AI to transcribe recordings, conversations and interviews to provide proactively with insureds – many of these use cases do not necessarily directly increase profits. Given the sensitive and protected nature of client health information the ethical treatment of this information must be central.

Moreover, we hold specific concerns with respect to the use and/or misuse of AI in life insurance including in:

- Automated underwriting
- communicating with customers especially replacing humans in call centres and claims handling primary contacts with so-called empathy bots or other AI based tools
- interacting with consumers experiencing vulnerability and identifying vulnerabilities in consumer conversations through voice interaction models,
- identifying potential fraud flag, and
- claims decision making.

These have a real potential to go wrong, mis-identify, and/or discriminate.

The Life Code needs to address these issues to ensure a fair and ethical approach to AI is embedded early on. ASIC's report on AI governance arrangements[111] found that not all licensees had adequate arrangements in place for managing AI risk. Where they were in place, AI governance arrangements varied widely, seeing weaknesses that create the potential for gaps as AI use accelerates. ASIC also saw that some licensees assessed risks through the lens of the business rather than the consumer. The Life Insurance sector needs to temper any rush into using AI with appropriate governance frameworks to ensure that they build and update appropriate risk management systems.

The Life Code should provide an avenue to ensure, via an obligation, that insurers are reviewing their systems and processes and notifying of any breach

[111] ASIC, Report 798 Beware the gap: Governance arrangements in the face of AI innovation, October 2024

Recommendations | Technology and AI

99. **Agree to either meet the Australian Government's AI Ethics Principles or embed the principles such as contestability, transparency, explainability and accountability in the Life Code.**

100. **Prohibit the use of AI to make decisions in underwriting or claims without the oversight and intervention of a human.**

101. **Publish individual data and AI ethics policies (reviewed and updated annually) that set out how life insurers address risks associated with artificial intelligence and discrimination. This should include a commitment to annually review systems and processes and notify of any breach to the LCCC.**

102. **Build in AI risk and impact assessments into the service and product design process.**

103. **Disclose to consumer when a subscriber is using AI, for example in reviewing information, decision making, etc., and provide information regarding complaints and queries with respect to its use.**

Complaints

4.12. Could improvements or clarifications be made to the practical operation of Section 7 of the Code and/or enhancements be made for the benefit of consumers. For example: Is the guidance around timeframes sufficient to ensure timely resolution of complaints? Is the guidance around communication with customers about complaints sufficiently clear?

4.13. Do the Code commitments relating to complaints need to be amended or clarified in light of ASIC's guidance on internal dispute resolution, including its imposition of enforceable standards?

Our organisations have seen significant problematic Internal Dispute Resolution conduct including amongst other things:

- failure to provide documents in timeframes under the Life Code, drip feeding requested documents.

- inappropriate suggestions during IDR negotiations e.g. suggesting the client's children take overpaying the parents' unsuitable life insurance product that they should never have been sold
- Breaches of clause 7.16 where insureds have been told they can't complain direct to the insurer, others have been told they need to go direct to the insurer
- Putting onerous identification requirements on consumers using financial counselling or community legal centre representation.

Case study 29. Jaiden's story

Jaiden is a young Aboriginal man who lives with intellectual disabilities and requires extra assistance in tasks. He lives with family and relies on the Disability Support Pension and part time employment.

Financial Rights assisted Jaiden with another matter where his sister who assists him with daily administrative tasks noted that Jaiden had life insurance premiums being deducted from his account fortnightly. Jaiden was not aware of the policy he held life insurance nor had any information or details about the policy. We requested documentation.

The life insurer was unable to locate any policies for Jaiden and eventually referred the matter for investigation. That investigation began around early 2024 when they requested a third party authority form to be completed to provide access on the policy, even though we had already sent through our signed authority. We then provided our signed authority in response again and were then advised that the insurer required certified Proof of ID. After this we were then contacted a month later to say our request has been passed on and an insurance representative would be in contact. After we followed up week later we were told the representative would be in contact by the end of the week.

After still receiving no contact, we reached out again a total of 9 weeks later notifying them that we still are yet to receive requested documentation.

Financial Rights Legal Centre

Case study 30. Wayne's story

Wayne, a First Nations man from a remote community contacted ICAN in 2021 wanting support to understand what was going on with his life insurance policies. He advised that he had been receiving calls from multiple insurance companies over the years harassing him

until he signed up and he was unsure what he had signed up to. The financial counsellor assisting him, recalls Wayne saying: "You know how they just call you and call you and call you. Even when I would tell them I already had life insurance they would keep calling."

It became apparent that Wayne had signed up for a policy with Freedom Insurance and therefore may be entitled to make a claim under its remediation program. Presenting as a man who was capable of self-advocacy, we provided Wayne with all relevant information about claiming through the remediation scheme which he then attempted to do himself. However, in response to his application, Genus Life Insurance (responsible for undertaking the remediation review of his policies) found that Wayne had not experienced any detriment from the sale of the policy.

As a result of this outcome, ICAN assisted Wayne to get a review of the remediation decision. Our initial attempts to obtain the relevant policy and call recordings were challenged by the company requiring Wayne to provide certified ID – something that was difficult to facilitate where the client lived remotely, further delaying resolution. Once this hurdle was overcome, we obtained the documents and call recordings. From these, it was immediately apparent that Wayne had been sold a funeral insurance policy through an unsolicited sale. The product was sold despite the fact he had a pre-existing funeral insurance product as well as having a policy with the Aboriginal Community Benefit Fund (ACBF/Youpla) which Wayne advised the sales representative about early in the conversation. In addition to funeral cover, the policy includes accidental death and injury cover, which were not needed or wanted by Wayne. When explaining the premiums, the sales representative fails to explain that they would be stepped up over time.

Based on all of these concerns, ICAN lodged a review of the remediation outcome and received an acknowledgement that Wayne was "impacted during the sale of the Freedom policy and detriment did occur." A full refund of the policy was therefore offered. However, it should not have taken the intervention of ICAN to point out what was clearly apparent in the call recordings held by Freedom, under a remediation scheme ostensibly set up to support unrepresented customers.

Indigenous Consumer Assistance Network

At a minimum the Life Code needs to fully align and comply with the expectations of ASIC RG 271.[112]

[112] ASIC, RG 271: Internal dispute resolution, September 2021

Recommendations | Complaints

104. The definition of complaint must incorporate RG 271.32 regarding what actions are considered complaints.

105. Clause 7.13(d) 7.15(c) and 7.17(d) should be amended to ensure life insurers explicitly provide AFCA contact details as per RG 271.53 and RG271.66(c), including hyperlinks.

106. Clarify clause 7.10 to ensure than an explanation can be verbally or in writing as per RG 271.71 and that the consumer should have the choice as to which they prefer and that this be recorded.

107. Commit to ensuring that the IDR process is easy to understand and use, including by people with disability or language difficulties in line with RG271.134. This should involve proactive offering of these support measures – not simply being directed to a website as per clause 6.6 and clarifying the application of clause 6.13.

108. Commit specifically to having a publicly available, readily accessible complaints policy and an internal complaint management procedure as per RG 271.172. and that this be easily accessible and visible.

109. Establish customer advocates within their businesses, and do so in line with RG 271.109-110.

110. Amend 7.18 to:

a. **commit the life insurer to ask the super fund to explain the delay in writing to both the insurer and claimant, and**

b. **explain that the claimant can complain to AFCA after 45 days.**

111. Amend 7.19 to commit life insurers to tell claimants at the start whether the life insurer or the super trustee will provide the final decision in writing.

Interaction with the law

5.1. How effectively does the Code interact with the law and how, and in what areas, could this be improved?

We remain concerned with the financial services sector's gambit to remove commitments from codes on the basis of 'duplication'.

A code which on balance goes well beyond the law, can and in some cases should also contain provisions which essentially restate the law. This is sensible for a number of reasons:

- Doing so commits an industry to proactively self-monitor itself particularly those crucial obligations to promote best practice rather than leaving all the heavy lifting to ASIC, including via proactive monitoring from the Life Code Committee.
- Including the details of obligations found, say in an ASIC regulatory guidance, should be included in a code to ensure that consumers (and their representatives) are made aware of these rights and protections in an easy, accessible and centralised form. An effective code should function as a central source of information on the consumer rights and protections afforded by codes and the statutory and regulatory requirements that inform and provide important context.
- In this way it would also alleviate the burden being placed on consumers of having to read through legislation and regulatory guidance, documents that are not written primarily for them.

If there are commitments that are reflections of the law or ASIC regulatory guidance, these should be reworded to be in line with the wording in the original source to ensure that insurer subscribers can simply cut and paste the information required of them to meet those obligations.

5.2. In which areas could the Code help insurers meet legal obligations by specifying what they will do to comply with the law?

Very broadly, the Life Code should provide further "meat on the bones" to the following laws:

- **Design and Distribution laws:** further details regarding life insurers approach to product design and distribution obligations would assist life insurers, for example. meet the expectations of RG 274.47 with respect to considering vulnerabilities.[113] Further specific commitments on inclusive and safety by design and specific

[113] ASIC RG 274: Product design and distribution obligations

processes these expect – such as consultation with actual consumers, including those from cohorts experiencing vulnerability - would be appropriate too.

- **Privacy laws:** Providing further to meet consent and confidentiality requirements in appropriate ways would assist in providing certainty to life insurer subscribers in asking for, recording and storing sensitive information on their customers in appropriate ways.
- **Anti-hawking, advertising and sales laws:** The Life Code already includes a number of commitments that go beyond the expectations of the anti-hawking regime, and ASIC RG 234: Advertising financial products and services (including credit): Good practice guide. This needs to be expanded in line with the recommendations under **Questions 4.7-4.9**
- **Advice laws:** It is also appropriate for the life insurance sector to make commitments regarding the information that they provide and communications they undertake that help them meet and move beyond advice obligations.
- **Use of adverse genetic tests:** This submission recommends life insurers making commitments beyond that expected of life insurers under the current prohibition of use of adverse genetic test exposure draft legislation: see **Question 6.2** below.
- **Mandatory superannuation service standards**: As referenced above, the Government has committed to legislating service standards for super fund members. These will include standards for insurance claims handling. When those standards are finalised, the Life Code must be reviewed and updated to reflect any new obligations on subscribers.

Code structure, governance and enforceability

Structure of the Code

6.1. Can the Code be improved to be more accessible to its intended audience or audiences? If so, how?

Yes. We put forward the following principles.

- **Embed inclusive design principles into the Life Code itself**

Central to improving outcomes for consumers is to build a Life Code that serves all people including those experiencing vulnerabilities. The problem though is to see these topics as somehow divorced from the entire journey of insurance. Addressing vulnerability means improving and adding to commitments in most of the sections of the Life Code.

Embedding an inclusive design approach to both the Life Code design, and the commitments within, will ensure that insurer service delivery and product design will better serve all who engage with life insurance.

- **Identifying the primary audience for the Life Code is not a fruitful exercise.**

The audiences of the Life Code are equally consumers, their representatives, insurers, related third parties, external dispute resolution, regulators. Re-designing the Life Code to appeal to one over the other can lead to poor outcomes for other just as relevant audiences. It can also significantly delay the process of redrafting a code and the introduction of new consumer protections. If inclusive or universal design principles are applied to the structure and drafting of the Life Code, with robust, clear and enforceable commitments – then the Life Code will be accessible to all.

- **The Life Code should be a "body of rules" in line with RG 183 and avoid placing obligations on consumers to act**

A body of rules should represent a commitment made by a subscriber to either an individual consumer or small business owner, or consumers and small businesses collectively. The Life Code should not impose inappropriate obligations or requirements on consumers that do not exist at law,[114] nor should rules be merely descriptive. For example, requiring consumers

[114] For example, "if you tell us" is a common phrase that shifts the onus to enliven a commitment on to the consumer rather than the subscriber taking on the onus themselves to proactively engage with a consumer to identify the issue that would enliven the right.

to disclose their own vulnerability or respond to a show clause letter. The onus needs to be placed on the Life Insurer to act since it is their commitment to the consumer, not the other way around.

- **The Life Code should be clear, in plain English, robust and unambiguous for enforceability purposes**

The use of vague or ambiguous words as may be considered by some to be plain English but are passive, subjective, suggestive voluntariness, unenforceable and far from robust, clear or effective. For example:

- "timely"[115]
- "periodically"[116]
- "try to"
- "reasonable"[117]
- "where practical"[118]
- "where possible"[119]
- "as soon as possible"[120]

- **The Life Code is not read like a novel from end to end – users search for protections and right relevant to their circumstance**

The length of Life Code is not an issue for consumers or consumer representatives. The Life Code simply needs to be easily searchable, presented in an intuitive manner, following the journey of the consumer's engagement, with few exceptions and complexities.

- **"Code related" documents currently deemed aspirational and effectively unable to be relied upon should be integrated into the Life Code**

CALI has taken the approach of placing key, substantive commitments outside of codes and in a variety of code-related guidance, protocols and standards.[121] These are generally considered unenforceable, are generally not monitored for compliance and are seen by subscribers as aspirational or best practice as opposed to minimum standards to meet. This

[115] Currently only used in the Guiding Principles and Service Promise but should be avoided elsewhere.
[116] Used at Clauses 2.27, 4.8 and 6.21
[117] Used in Clauses 2.13, 4.5 the definition of Circumstances Beyond our Control
[118] Clause 2.25, 3.1, 5.18
[119] Clauses 5.12, 5.22, 6.13, 7.17
[120] Clause 5.13
[121] For example, CALI, Best Practice Guidance Family and Domestic Violence Policies, February 2025

stratagem weakens the effectiveness, enforceability and reliability of codes, and undercuts the value of self-regulation.

Plain English consumer guidance and fact sheets are welcome but should be consumer tested and remain separate to and aimed at promoting the Life Code

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Recommendation | Structure of the Life Code

113. Apply inclusive design principles to the Life Code structure itself drafted with robust, clear and enforceable commitments that place the onus on the Life Insurer to act, rather than the consumer.

114. Remove vague or ambiguous words and phrases:

- **a. "try to" at Clauses 5.14 and 5.40 should be replaced with more robust language such as "take steps to"**
- **b. "periodically" at Clauses 2.27, 4.8 and 6.21 should be replaced with explicit timeframes**
- **c. the phrase "where practical" at Clauses 2.25, 3.1, 5.18 should be removed**
- **d. the phrase "where possible" at Clauses 5.12, 5.22, 6.13, 7.17 should be removed**
- **e. the phrase "as soon as possible" at Clause 5.13 should be replaced with a strict time frame of 5 business days**
- **f. the phrase "as soon as practicable" from Clause 7.2 should be removed.**

115. Remove any phrasing that solely relies on consumers to act.

116. 'Code related" documents currently deemed aspirational should be integrated into the Life Code.

6.2. Are there any areas where the Code drafting could be improved or simplified, for example to reduce uncertainty or modernise the commitments, without reducing consumer protections?

In addition to the recommendations above there are number of improvements that could be made to the Life Code.

Remove Appendix A: Use of adverse genetic tests

Once the ban on the use of adverse genetic tests is enacted,[122] Appendix A - which details the moratorium on the use of genetic tests - should be removed.

However, there is likely to be at least one issue that will not be addressed by the legislation that should be considered for addressing in the life code. That is, applying the spirit of the ban on the use of adverse genetic tests to existing life insureds and legacy products.

Under the current drafting in the exposure draft legislation, the ban will apply in relation to life insurance contract *decisions* made on or after the date of commencement.[123] A life insurance decision is defined to only apply to those decisions an insurer may make in relation to an insured's application for a contract of life insurance.[124] It thus does not capture those insureds who have ongoing long-term coverage whose only interaction is annual premium adjustments. Consequently, individuals who have been paying premiums for many years, with a loading attached because of legal discrimination on the basis of genetic results, would be faced with the unfair choice of retaining cover with discriminatory penalties or cancelling their current policy and being re-underwritten on very unfavourable terms (due to the passage of time). These are individuals who have done the right thing, have declared their adverse results to insurers, have accepted the discriminatory penalties and in many cases paid additional sums to insurers over a number of years.

Public trust in the reform may be damaged by the perception that the new law doesn't really protect everyone that it should i.e., those who have already provided genetic information to life insurers will be penalised for doing so. This may interfere with the broader policy aims of the reform, including reducing the deterrence that fears of genetic discrimination have on people's willingness to have genetic testing

In the CALI submission to Treasury in 2024,[125] they highlighted the extremely small number of applications that receive adverse underwriting outcomes on the basis of genetic results – reporting that less than 0.05% of their underwriting decisions in 2022 resulted in adverse outcomes for consumers on the basis of genetic test results (a total of 90 cases). On this basis, the impact of removing loadings or exclusions prospectively for insureds who have been discriminated against already should be negligible in the context of the entire insurance market. Given the additional premiums collected from many of these individuals by insurers in the past, it is not unreasonable to ask insurers to apply modest resources to

[122] *Treasury Laws Amendment Bill 2025: Limiting the use of genetic information by life insurers*
[123] Item 4; Explanatory Memorandum, 1.98 *Treasury Laws Amendment Bill 2025: Limiting the use of genetic information by life insurers*
[124] at item 1, section 11 of the *Insurance Contracts Act 1984*
[125] CALI, Use of genetic testing results in life insurance underwriting, 31 January 2024

rectify the discrimination applied and cease to discriminate prospectively against current clients in a way that is unlawful for new life insurance applications. There is no suggestion that insurers should retrospectively refund premiums, only that penalties should be removed prospectively.

If, as it seems likely, this issue is not addressed in the legislation, we recommend Life Insurers under the Life Code commit to identifying which customers have received adverse underwriting outcomes on the basis of genetic test results and remove the loadings/exclusions from each of them from the date of the ban's commencement.

This would not require completely new underwriting to be undertaken, merely for adverse terms applied on the basis of genetic results to be removed. We have seen numerous cases previously where loadings or exclusions that have been applied to policies due to genetic results have been subsequently removed.

Remove Appendix B re: Supporting customers experiencing a Mental Health Condition

As addressed at **Questions 3.4** Appendix B re: Supporting customers experiencing a Mental Health Condition was included to be a "consumer-friendly" one-stop shop for consumer. This should be removed and replaced with a consumer tested, easy to read and comprehend guide – separate to the Life Code – to inform consumers of their rights and protections with respect to mental health and life insurance.

Clarify and simply the scope and application of the Life Code

The consultation paper raises issues of complexity and inconsistency in application of the Life Code with respect to third parties including distributors, authorised representatives, reinsurers and group policy owners: see **Questions 4.3 to 4.6.**

Much of the difficulties in comprehending the application of the Life Code arise from this. However, it also arises out of limiting the scope of products covered and not covered by the sector at Clause 1.7 to 1.9. This also need to be clarified and simplified based on the principle referred to at Question 4.6 – life insurance consumers should be able to expect and rely on the same set of consumer protections and minimum standards, no matter the product, and no matter the how they obtained the product. The reviewer should examine these arrangements to seek simplicity and consistency.

Recommendation | Simplification

117. Remove Appendix A once the ban on the use of adverse genetic tests is enacted.

118. **Identify customers who have received adverse underwriting outcomes on the basis of genetic test results and remove the loadings/exclusions from each of them from the date of the ban's commencement.**

119. **Amend Clauses 1.7 to 1.9 with the aim of achieving consistency of application to all life insurance products.**

6.3. Do you have any feedback on the sections of the Code that provide overarching ethical principles to guide life insurers in their interactions with customers?

and

6.4. Are there any other sections of the Code where enhancements or clarifications could improve consumer understanding, suitability, accessibility and affordability of life insurance products?

The three different sections that outline high level principles and promises need to be:

- consolidated
- included as part of the Life Code and therefore part of the contract with the consumer as per **Question 6.8** and
- re-drafted to ensure that the commitments are robust

We further note that when life insurers left the FSC to form CALI they scrapped FSC Standard No. 1: Code of Ethics and Code of Conduct. A subsequent internal review of the Standard led to some changes to the principles in its 1 March 2025 version. However, this failed to incorporate many significant commitments previously found in FSC Standard No. 1. These include (amongst others):

- We will give primacy to the duty owed to our customers[126]
- We will conduct all affairs in a manner that merits the trust and good opinion of consumers[127]
- We will perform tasks with due care, competence and diligence[128]
- We will be trained to perform duties to high level of professionalism[129]

[126] FSC Standard No. 1: Code of Ethics and Code of Conduct Clause 12.1
[127] FSC 2.3
[128] FSC 2.4
[129] FSC 2.4

- We will have a publicly available policy acknowledging, avoiding and managing actual and perceived conflicts of interest[130]

Recommendation | Life Code principles

120. The Life Code principles need to:

a. be simplified, consolidated and made enforceable

b. incorporate commitments from FSC Standard No. 1: Code of Ethics and Code of Conduct, particularly a commitment to

i. performing tasks with due, care, competence and diligence,

ii. be trained to perform duties to high level of professionalism

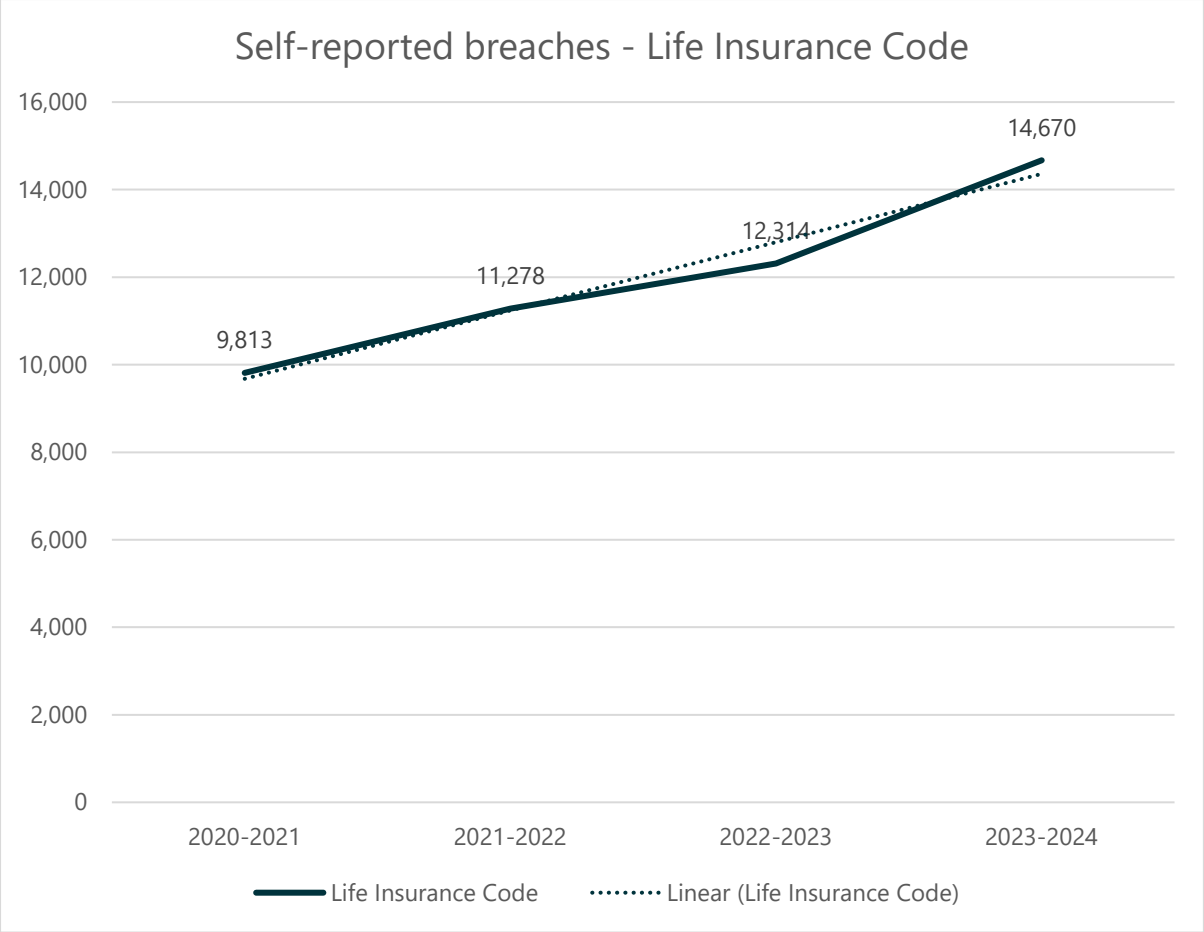
iii. avoiding and managing conflicts of interest.

Code governance and compliance

6.5. What measures could improve the governance of the Code and promote enhanced compliance with Code commitments?

We note that CALI's Life Insurance Code[131] is the only code committing subscribers to specifically having appropriate systems and processes in place to enable compliance with their code. Yet this has not seemingly led to improvements in meeting the Code requirements, with a steady increase year on year since 2020.

[130] FSC 2.5
[131] Clause 8.11



Another data point to consider is the results of the LCCC report into their mental health commitments under the Life Code.[132] This report found that insurers are in short not meeting their commitments.

> *Of the underwriting guidelines reviewed by the Life CCC, almost all relied solely on exclusions rather than exploring alternative ways to manage risk, such as higher premiums, limits, or caps.*
>
> *This approach can limit access to cover and may unintentionally reinforce stigma by treating all mental health disclosures in the same way.*
>
> *It risks undermining trust and could create the perception that people with experience of a mental health condition will face challenges in securing life insurance.*

[132] LCCC, Inquiry Report: Keeping the Promise: Mental Health and Life Insurance Commitment, September 2025

> *Ms McClelland said these practices do not align with the spirit of the Code.*[133]

To address this issue, we recommend that the LCCC undertake an own motion inquiry specifically into meeting Clause 8.11 to ensure that it is working as intended.

We also recommend that the language and enforceability of the Life Code is tightened up by removing loopholes and vague language: see Recommendations under **Question 6.1**. Further recommendations are made to strengthen the powers of the LCCC and enforceability of the Life Code under **Questions 6.6, 6.8 and 6.9**.

Finally, consideration needs to be given to establishing a mechanism to appropriately resource the LCCC. Under-resourcing of code monitoring is a key form of control to limit or constrain the ability of independent code compliance committees to fulfil their charter obligations. This needs to be addressed.

The General Insurance Code's current model for budgetary decision-making via the separate legal subsidiary of the ICA, Code Governance Committee Association[134] (**the Association**) is generally considered industry best practice. This is because resourcing decisions are made with significant input from consumer representatives in a committee distinct from the peak body – unlike any other Code arrangements. Membership of the Association is split between consumer representatives nominated by the Consumer Representatives on the AFCA Board and industry representatives determined by the ICA Board. The Chair is the ICA CEO. The CGC then develop a workplan and corresponding budget which is then provided to the Association to approve or amend.

The LCCC should also annually report to ASIC on its budgets, as well as metrics on how their resourced are subsequently allocated, the period of time taken to undertake each function and any other data point that may indicate whether a committee is being adequately resourced to fulfil its functions.

Recommendation | Governance

121. Commit to a mechanism to appropriately resource the LCCC.

122. Empower the LCCC to annually report to ASIC on its budget.

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[133] LCCC, The need for fairer treatment of customers who disclose mental health conditions, 16 September 2025
[134] See Constitution of Code Governance Committee Association Inc.

6.6. Are the sanctions in Section 8 of the Code and the LCCC Charter a sufficient deterrent to noncompliance? Are the measures the LCCC can use to publicly identify non-compliance with the Code sufficient? Should they be strengthened? If so, how?

The range of sanctions should be increased to the full complement of sanctions as outlined in the consumer submission to the review of ASIC RG 183.[135] This would mean for CALI to include:

- Formal warnings
- Suspension or expulsion from the industry association
- Suspension or termination of subscription to the code
- Compliance Review of Rectification
- Training
- Report to ASIC or another regulator

We also note that life insurers took a backward step in changes to clause 8.21(f) in 2024 by removing the ability for the LCCC to require a subscriber to publish its non-compliance on its Website *and the FSC Website*. The publishing on the FSC or CALI website is no longer in clause 8.21(f). Having the ability to require publication breach on the peak body's website is important to send the message to the entire membership that the peak body, as owner of the Code, it has *the* key role in promoting good practice and highlighting poor behaviour of its members.

Further, while the LCCC has a sanction power for a significant breach to publicly identify a subscriber the Life CCC does not have the power to identify subscribers in Determinations. This should be amended. The consumer movement's view is that naming a subscriber should be the default expectation for *all* code breaches and not be seen or used as a sanction for a select few "significant" breaches. This has been the limited – and ineffective approach - taken by all AFCA administered code compliance committees who have been either constrained by the charters or powers or by lack of resourcing. This places self-regulation outside of community expectations and industry norms. AFCA itself names virtually every firm in every

[135] See Table 1, page 12, Joint consumer submission, ASIC consultation on proposed update to RG 183 on approving codes of conduct, September 2025

decision it makes.[136] It also is a key reason that consumers remain cynical of self-regulatory codes and do not hold confidence in them.

Finally we are aware that some of the Charter clauses are causing issues with respect to the LCCC's ability to effectively apply community benefit payments. These need addressing

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Recommendation | Sanctions

123. Empower the LCCC with a full complement of sanctions.

124. Reinstate the previous version of Clause 8.21(f) to empower the LCCC to require publishing sanctions on the CALI website.

125. Amend the Life Code to enable the LCCC to name subscribers who breach the code in all circumstances.

126. Remove charter clauses 8.4(b), (c)ii and (c)iii from the LCCC charter to ensure that breaches reportable to ASIC can be subject to community benefit payments, and that the sanction is not linked to customer counts.

6.7. Is the definition of 'significant breach' appropriate given that sanctions are only available for such breaches? Is the requirement to report significant breaches of the Code to the LCCC working effectively in the light of reporting requirements to regulators?

We note that the LCCC recently consulted on the definition of significant breaches and Financial Rights raised the following issues with the definition:

- the definition in the Life Code does not include "duration of the breach" as the General Insurance Code of Practice does. It would be a positive move to align these definitions.
- there is an unnecessarily narrow focus on "financial loss", rather than the impact on consumers more broadly, especially vulnerable consumers
- the word "Determine" is capitalised in the Life Code definition but should not be since "Determine" in the Life Code is itself defined and means "When an External Dispute Resolution Body makes a final decision."

[136] The percentage of determinations not published each six month period since 1 October 2021 "due to compelling reasons to not name the financial firm" ranges from 0% to 0.18%: AFCA determinations public reporting

Putting these amendments to one side, the LCCC should be empowered to decide for itself where and when a sanction is appropriate and should not be pre-emptively constrained by artificial limits on its powers embedded in the Life Code. The ability to provide a sanction and any definition demarcating types of breaches – be they significant, serious, systemic, non-systemic or otherwise – should be left to the LCCC to develop itself.

Recommendation | Significant breaches

127. Remove the concept of 'significant breach' from the Life Code and empower the LCCC to decide when and where a sanction is warranted. If this is not taken up, at a minimum, the definition of significant breach should:

- **a. include "duration of the breach"**
- **b. shift the focus away solely from "financial loss" to the impact on consumers more broadly, especially vulnerable consumer**
- **c. amend the word "determine."**
- **d. allow sanctions for individual breach findings where serious misconduct is confirmed.**

Enforceability of the Code

6.8. Should any additional mechanisms be adopted to ensure the Code can be effectively enforced? If so, how should they be incorporated in the Code?

Individual consumers being able to enforce the rights and protections afforded them under a self-regulated code is key for a code to be effective, to be able to be relied upon and to provide the confidence needed that promises made in a code will be met.[137] The consumer movement considers the only way this can be practically implemented is by making the commitments in the code a term of the contract with individual customers. Anything less is not truly enforceable for individuals. This is because:

- a consumer is not a party to the contract between a subscriber and an administrator and cannot enforce a code breach via that agreement as a third party[138]

[137] See ASIC RG 183.6

[138] As contemplated at ASIC RG 183.46

- a consumer may be able to enforce some (even a majority of) code breaches at internal dispute resolution (**IDR**) and, if not there, at external dispute resolution (**EDR**) via AFCA. However, many disputes do not meet AFCA's limited eligibility, threshold requirements or monetary jurisdiction or may be otherwise excluded[139]
- AFCA's role is not enforcement of codes - its role is to make decisions in disputes that are "fair in all the circumstances" having regard to legal principles, good industry practice, previous determinations and codes,[140] and this can lead to decisions that do not strictly enforce a code commitment, and
- consumers cannot seek an individual remedy via the LCCC since its functions, roles and resources in this regard are constrained with only a small percentage of serious or systemic matters pursued.[141]

It is worth noting too that the enforceable code regime[142] is untenable as an enforceability option since it is not well designed and there are in-built incentives that encourage industries to be circumspect about both what provisions they are willing to put in their codes at all or which provisions they are willing to be made enforceable.

Being bound contractually to the terms of a code however is the simplest, most effective way to ensure that a code is enforceable by consumers and can be relied upon, giving consumers the confidence that subscribers will meet their commitments.

The ABA[143] and COBA[144] have long agreed to include their codes of practice in the terms and conditions of their contracts with their customers. The Insurance Council has recently announced that it will redraft its code to be contractually enforceable.[145]

Consequently, life insurers should take the same step and make the Life Code a term of the contract with consumers. Clause 8.10 should subsequently be deleted.

Contractual enforceability should also not simply extend to the Life Code's numbered commitments. It must also extend to the principles. Otherwise, they are mere words on a

[139] This is acknowledged by ASIC at draft ASIC RG 183.48.
[140] AFCA, How we make decisions
[141] While "enforcement" of the Life Code is literally listed a role of the at Clause 2.1 of the LCCC Charter, this has no practical effect since the Charter does not provide the LCCC with the powers to enforce a code breach outside of a limited ability to impose sanctions for a limited set of "significant" or "serious or systemic non-compliance."
[142] Outlined at Section 1101AE *Corporations Act 2001*
[143] ABA Banking Code of Practice 2025 Clause 2
[144] COBA Code of Practice 2022 v.2.0 Part A
[145] ICA, New insurance Code of Practice to deliver for consumers, 30 May 2025

page with little to no work to do other than providing a veneer of respectability and accountability.

The Life Code language should also be considered and if required re-drafted with an eye to enhance the clarity and robustness of the commitments to ensure that they meet the standards required to be enforceable.

Finally, we expect that the Life Code should be approved by ASIC. Anything less will place the sector out of step with consumer expectations and place life insurers well behind other financial services sectors who have or are seeking code approval.

Recommendation | Code enforceability

128. The Life Code – including the guiding principles - should be made a term of the contract, with clear, robust and enforceable language. Clause 8.10 should be deleted.

129. CALI should seek approval from ASIC for the Life Code.

6.9. Should any provisions of the Code be considered for designation as Enforceable Code Provisions and what changes to the Code would be needed to support that?

As referenced above, the enforceable code regime is confusing complex, piecemeal in its application and unlikely to achieve its stated objectives.

The consumer movement's position is that all codes should be made enforceable by including the code as a term of the contract with the consumer. This is the case with the ABA Code, the COBA Code and has been agreed to by the general insurers.

Future Code reviews

6.10. Should the Code be reviewed every five years?

If a code is to be approved by ASIC then it will need to be reviewed every five years in line with the law.

Our reading of the statutory requirement for an independent *review* of approved codes to occur every five years is that, in practice, this means that there will have to be on average, a

new amended code every five years,[146] such that the independent review, response, re-drafting, approval and implementation process is a five-year cycle. This is because the period of drafting and approval (be it one year or four years) is within the five-year review span for the next review following the triggering point of review submission to ASIC. If approval is not sought nor received, the Life Code review cycle should remain every 3 years.

Further, it is important to also ensure that the LCCC Charter is reviewed as a part of any review. Currently this is not the case. The lack of a guaranteed concurrent review risks misaligning the operational and administrative effectiveness of the LCCC when the Life Code is updated.

Recommendation | Life Code reviews

130. The Life Code should be reviewed every 5 years in line with the expectations of an ASIC-approved code.

131. Amend the Life Code to ensure that there is a formal Charter review whenever the Code is reviewed,

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6.11. How should the industry deal with amendments to the Code between reviews?

During any five-year cycle it is common for issues to arise that need to be addressed due to the introduction of new laws or specific problems identified in the community.[147] Code owners should be expected to act on these when the issue arises otherwise consumer harm may take place in the intervening period and/or consumers will need to wait for five years for needed protections. Without this expectation, there is a potential for the life insurance sector to take advantage of this gap and not act in a fashion nimble-enough to meet community expectations.

Recommendation | Life Code amendments

132. Amendments to the Life Code should be introduced to ensure that CALI:

[146] It is theoretically possible that a review could conclude that no changes to a code are required but this has never occurred and highly unlikely to ever occur given the ever-changing nature of the financial services industry.
[147] For example, the introduction (and update) of mandatory service standards for superannuation funds could fall out of the cycle. It is also conceivable that amendments to insurance laws to address financial abuse could arise between code reviews, necessitating an update.

a. **is empowered to conduct a review, and**

b. **are required to do so in a manner that meets best practice stakeholder consultation.**

Attachment A:
Life insurance service data summary 2024-25

Financial Rights examined the **life insurance-related services** it provided to clients between the 18-month period of 1 January 2024 to the 30 June 2025.

As a proportion of the services provided by the Insurance Law Service this makes up approximately 14.8% of services.

Funeral Insurance made up 40.3% of all life insurance-related services – by far the single biggest sub-product category. However, 86.1% of these were specifically related to the Youpla collapse.

In order to obtain a more accurate representation of the issues raised by consumers relating to life insurance the following totals are based upon the total of all non-Youpla related life insurance product services and clients (or **life insurance services or clients**).

Group life insurance products – variously IP, Life and/or TPD accounted - were raised by 42.5% of life insurance clients.

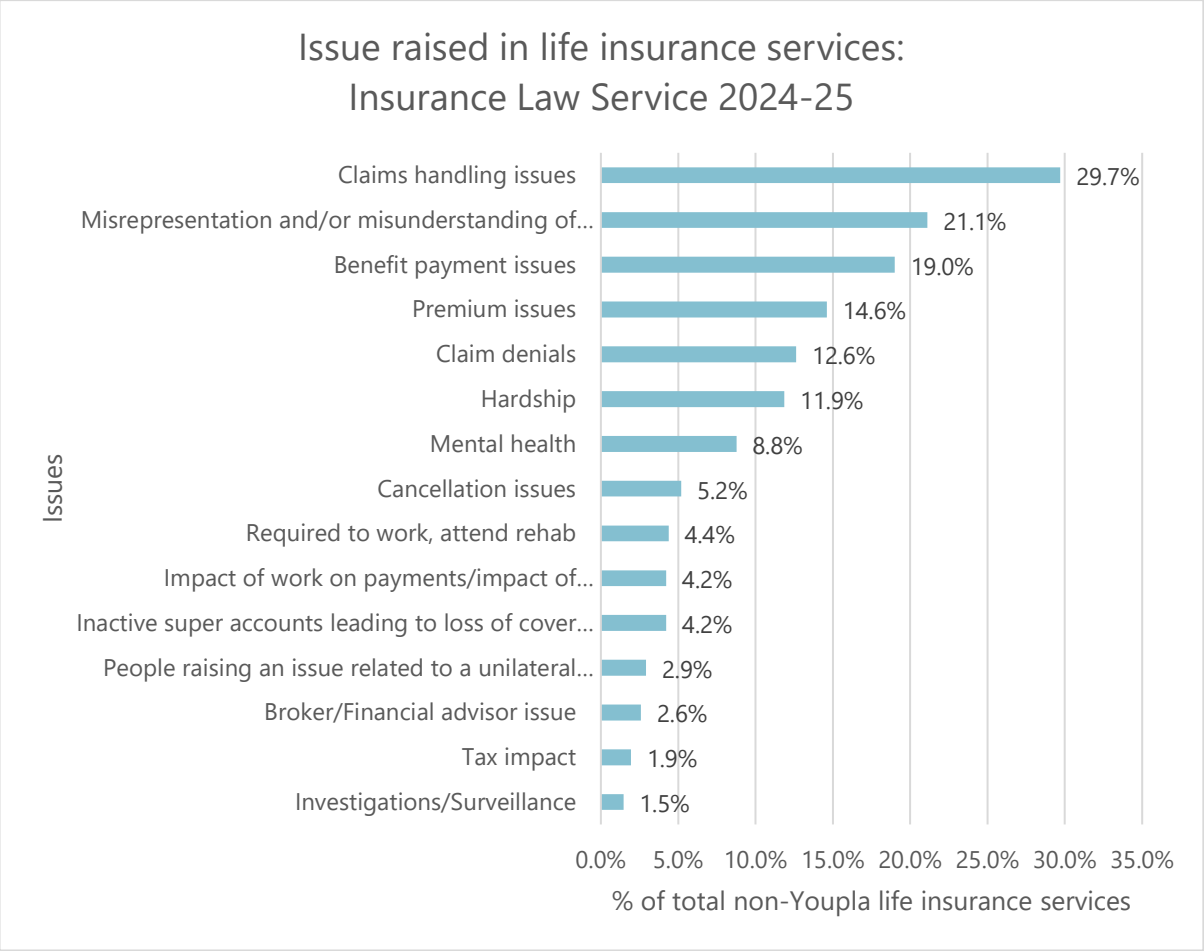
- Group Income Protection was the product most referenced with 13.1% of the total life insurance services or 45% of group insurance products raised.)
- This was followed by Group TPD at 10.9% of the total or 37.6% of group insurance products referenced, and
- Group -Life featured in 5% of the total or 17.6% of group life insurance products.

Direct life insurance products – including term life, whole of life, income protection, TPD and Accident - were raised 49.2% of life insurance clients.

- Life Insurance Protection was the product most referenced (12.9% of the total or 41.9% of direct life insurance products raised),
- This was followed by Term Life in (10% of the total or 32.5% of direct life insurance products raised),
- Direct TPD: 3.6% of the total or 11.7% of direct life insurance
- Direct Accident insurance: 3.2% of the total or 10% of direct life insurance.
- Others included Life- trauma and whole of life.

Issues

Taking a look at the issues raised in services provided by the ILS for all life insurance services during the 18 month period of 1 January 2024 to the 30 June 2025, we found the following:[148]



Somewhat related to the issue of misrepresentation and/or misunderstanding of life insurance is the role of definitions in exclusions or coverage. Services related to an issue specifically with a definition arose in 9.4% of services, with the definition of TPD, terminal, sickness or ADL (55.2% of definition-related services) and or work/regular occupation (41.3%).

[148] Note that some clients received multiple services over time as their situation progressed, and that some clients and services involved multiple issues identified.
[149] This category is not to blame consumers who may be subject to poor behaviour from insurers and advisors but it is to note that three is clearly a systemic issue relating to people not understanding the nature of the product (an expensive financial product) they own, and that the issues needs to be addressed by life insurers in line with their commitment under Section 2 of the Code.

Benefit payment issues

Services related to life insurance benefit payments accounted for almost one in five services or 19% of life insurance services. The main issues raised related to underpayment of benefits complaints at 74.4% of benefit-related issues, followed by the max benefit being reached at 13.7% and the clawing back of benefit over-payments at 12% of benefit-related services.

Premium issues

Premium issues raised in services accounted for 14.6% of life insurance services. The main issues raised related to premium increase complaints at 61% of premium related issues, followed by complaints regarding premium overpayments at 33% of premium related services.

Claim denials

Services related to claim denials accounted for 12.6% of life insurance services. Over half (55.2%) or these involved a disclosed or non-disclosed pre-existing condition or mental health exclusion. The other half included a variety of exclusions based upon definitions of TPD, medical terms, the date of disability or employment terms and or work requirements.

Cancellation issues

Cancellation-related services accounted for 5.2% of life insurance services. The key issues that arose regarding cancellation issues include cancellation for non-payment and low balances (almost 30%) and cancellation because of an insurer mistake (15.6%). This would be higher (9.8%) too if you were to combine the specific issue of on active super accounts leading to loss of cover or premium payments leading to super erosion: 4.2%.

Other issues of note

The following issues were also raised:

- Hardship 11.3%[150]
- Mental health 8.8%[151]

[150] This is likely underreported since arguably hardship is at the centre of many of the services including underpayment of benefits and overpayment of premiums amongst others. There may also be examples of hardship that may have been missed due to the volume of notes. This figure is based on those services where hardship was specifically mentioned and at the centre of why a caller has contacted the ILS.
[151] This is also likely underreported since mental health may be the issue upon which someone may have a claim or being provided a benefit but there was some other issue that they were calling the ILS about. There may also be examples of mental health issues that may have been missed due to the volume of notes. This figure is based

- Required to work, attend rehab etc: 4.4%
- Impact of work on payments/impact of termination/redundancy: 4.2%
- People raising an issue related to a unilateral change in cover: 3.9%[152]
- Broker/Financial advisor issue 2.6%[153]
- Tax impact 1.9%
- Investigations/Surveillance 1.5%

on those services where mental health was mentioned at the centre of why the caller has contacted the ILS. For example, they have had a claim denied, application for insurance knocked back, or have had their mental health impacted by poor claims handling behaviour.

[152] This involves both age limits significantly lowered and/or coverage restricted through changes of terms like employment.

[153] This covers a range of complaints specifically related to poor behaviour of insurance brokers or financial advisors including misrepresentation or not following disclosure instructions.