Submission by the

Financial Rights Legal Centre
CHOICE
Consumer Action Law Centre,

Senate Economics References Committee

Scrutiny of Financial Advice Inquiry: Additional terms of reference on the life insurance industry

April 2016

About the Financial Rights Legal Centre

The Financial Rights Legal Centre (Financial Rights) is a community legal centre that specialises in helping consumer's understand and enforce their financial rights, especially low income and otherwise marginalised or vulnerable consumers. We provide free and independent financial counselling, legal advice and representation to individuals about a broad range of financial issues. Financial Rights operates the Credit & Debt Hotline, which helps NSW consumers experiencing financial difficulties. We also operate the Insurance Law Service which provides advice nationally to consumers about insurance claims and debts to insurance companies. Financial Rights took over 25,000 calls for advice or assistance during the 2014/2015 financial year.

About CHOICE

Set up by consumers for consumers, CHOICE is the consumer advocate that provides Australians with information and advice, free from commercial bias. By mobilising Australia's largest and loudest consumer movement, CHOICE fights to hold industry and government accountable and achieve real change on the issues that matter most. To find out more about CHOICE's campaign work visit www.choice.com.au/campaigns

About Consumer Action

Consumer Action is an independent, not-for-profit, campaign-focused casework and policy organisation. Consumer Action offers free legal advice, pursues consumer litigation and provides financial counselling to vulnerable and disadvantaged consumers across Victoria. Consumer Action is also a nationally-recognised and influential policy and research body, pursuing a law reform agenda across a range of important consumer issues at a governmental level, in the media, and in the community directly.

Senate Economics References Committee
Scrutiny of Financial Advice Inquiry
By email: economics.sen@aph.gov.au

Dear Doctor Dermody,

Re: Scrutiny of Financial Advice, Inquiry into the Insurance Industry

Financial Rights Legal Centre, CHOICE, and Consumer Action Law Centre welcome the opportunity to submit comment about the life insurance industry to the Senate Economics References Committee.

This submission deals with problems with the sale of life insurance, with the claims and investigations process and with the level of funding and powers the financial regulator needs to properly regulate the life insurance sector.

Our organisations have raised concerns about life insurance for decades. There are ongoing issues with the industry that mean consumers are sold complex, expensive and, far too often, dud products. Consumers face delays and difficulties when claiming on policies and the regulator responsible for keeping the industry accountable, the Australian Securities and Investment Commission (ASIC), is underfunded and needs additional powers. The good news is that there are well developed policy solutions to improve life insurance. What's needed is action.

We recommend that the following actions are taken to address the ongoing problems with life insurance:

- That ASIC publishes bi-annual information about specific insurance policy's claim ratio, claim ratio plus claims acceptance rates, claims acceptance rates, claims frequencies and average claims payouts. Information should also be released about product category averages.
- That the *Corporations Amendment (Life Insurance Remunerations Arrangements) Bill (2015)* is passed as soon as possible without amendment.
- That the Federal Government sets a clear date for the removal of all commissions in life insurance advice, starting by phasing out up-front commissions shown to lead to the worst consumer outcomes.
- That insurance policies are not allowed to include unfair contract terms.
- The Federal Government should amend the *Insurance Contracts Act 1984 (Cth)* to codify consumer rights in relation to investigations.
- That Federal and State Governments through the Council of Australian Governments develop uniform private investigator licensing regulations with an enforceable code of conduct.
- That the Government should convene an industry and community consultation process to develop a fair standard definition for common terms for use in all life insurance policies.
- In the short-term the Federal Government should provide additional funds to restore ASIC's funding to pre-2013-14 levels plus reasonable growth for wages and costs. The

case for additional funding should consider, at a minimum, funds necessary to restore staffing levels to 2013-14 capacity (as staffing reductions occurred proactively in the lead up to the 2014-15 budget) and conduct increased surveillance activity.
- In the medium-to-long-term the Federal Government should establish an industry-pays funding model for ASIC that leads to secure, increased and non-conflicted funding.
- That all financial service providers are required to meet targeted and principles-based product design and distribution obligations. ASIC should be responsible for monitoring and enforcing these new obligations.
- That ASIC is given a proactive product intervention power that will allow broad action to prevent consumer harm.

Recommendations for a Life Insurance Industry Code of Practice

- That a Life Insurance Code is established as soon as possible. The Code must:
    - be a best practice code and hold insurers to a higher standard than is currently required under the law.
    - be legally enforceable, that is the Code be binding on, and enforceable against life insurer subscribers through contractual arrangements with consumers.
    - be registered with ASIC under Regulatory Guide 183 as a marker that consumers can trust the code operates in their interests.[1]
    - address the underlying problems of mis-selling and churn that drove earlier inquiries.
    - address significant issues with the claims process by outlining timelines consumers should expect and standards that insurers must adhere to.
    - commit to limits on unreasonable documentation requests
    - commit insurers to using independent medical examinations.
    - address issues with variable, out-of-date and other problematic definitions.
    - commit to strict limitations on surveillance to ensure that an investigator:
        - does not conduct surveillance on business premises;
        - does not communicate with a neighbour, work colleague or other acquaintance of a policyholder, in a way which might directly or indirectly reveal that surveillance is being, will be, or has been conducted or imply that the policyholder is involved in dishonest conduct;
        - does not record or film inside any court, tribunal, conciliation or mediation service or centre, or any other quasi-judicial facility;
        - does not record film inside any medical or health service or centre;
        - avoid any act or behaviour which might unreasonably interfere with a person's legitimate expectation of, or right to, privacy including but not limited to the recording of family or friends, the recording of someone within their residential premises, within change rooms, showers, toilets

[1] As per requirements established in ASIC (2013) *Regulatory Guide 183: Approval of Financial Sector Codes of Conduct*, http://download.asic.gov.au/media/1241015/rg183-published-1-march-2013.pdf?_ga=1.175469355.84513953.1449719296

bedrooms, lactation rooms, swimming pools, gyms, educational facilities or at religious or ceremonial occasions;

- develop a set of best practice standards of practice with respect to claims handling and investigation practices similar to the Victoria Workcover Authority Code of Practice for Private investigators[2] and the NSW Motor Accidents Authority Code of Conduct for Claims Assessors[3] and Claims Handling Guidelines for CTP insurers.[4]
- commits insurers to addressing the high lapse rate of funeral insurance products by:
  - capping premiums at the benefit amount, and applying the caps retrospectively;
  - providing real responses for consumers who buy funeral insurance and later struggle to make payments because of financial hardship;
  - not selling funeral insurance cover without first making a proper assessment of whether the customer can afford the cover over the long term;
  - giving a proper explanation of how the cost of a funeral insurance premium will change over the life of a policy. This should involve customers having access to standard, interactive modelling software that shows them how much their product will cost over the life of the policy;
- requiring insurers immediately stop sales of funeral cover for people aged under 18.
- requiring insurers stop allowing any life cover to be sold through the 'add-on' sales technique
- address the underlying problems of mis-selling and churn that drove earlier inquiries

- require insurers not allow products to be sold through pressure sales techniques, by preying on guilt and anxiety or any other sales tactics that are legally or ethically questionable. Insurers should make their sales scripts publicly available to prove that they are making an effort to improve sales processes.

[2] Victorian WorkCover Authority, Code of Practice for Private Investigators Version 2.0, Effective 1 November 2014, https://www.worksafe.vic.gov.au/__data/assets/pdf_file/0004/8707/VWA-Code-of-Practice-for-PIs-Final-Authorised-2014.pdf

[3] http://www.maa.nsw.gov.au/media/publications/for-professionals/Claims-Assessor-Code-of-Conduct-2013-to-2016MAA292.pdf

[4] http://www.maa.nsw.gov.au/media/publications/about-us/maa-claims-handling-guidelines

Problems with the sale of life insurance

Life insurance refers to a range of life, income protection, trauma and disability insurance products. These may be sold individually either directly or through financial advisors, as add-on products or as group products through superannuation. Products are complicated, and consumers may be unaware what they are buying, what its purpose and life span ought to be.

This is a large and growing industry. As at December 2014, the gross insurance amount for life insurance products in Australia was $7.2 trillion.[5] This is also a highly profitable industry. In the year ended December 2015, net profit after tax was $3.2 billion, up 30.9 per cent from the previous 12 months.[6]

For consumers, the price of life insurance can vary significantly but price isn't necessarily a good guide of quality or product suitability. A CHOICE investigation from September 2015 found that life insurance purchased from the ten largest industry superannuation funds costs between $156-500 for a 30-year-old to $1132-4848 for a 60-year-old. Retail life insurance from 15 major insurers could cost between $240-423 for a 30-year-old female to $4069-5349 for a 60-year-old male.[7]

It is extremely difficult for consumers to assess the quality of life insurance products. Policies have complicated wording and there's no information usually provided at the point of sale about how many consumers have been able to make a successful claim.

Poor value products are a feature of the life-insurance market, particularly products sold as add-ons to car loans, credit cards or other kinds of finance (known as consumer credit insurance). A recent ASIC investigation found that life insurance sold through car-dealers was consistently poor value. In one case, add-on life insurance sold through a car yard would cost a consumer 18 times more than a similar level of cover under a term life policy available direct from the same insurer. Life insurance companies distributing products through car-dealers paid just $6.6 million in claims over five years for all car yard life insurance products sold over five years. That is just 6.6% of the total gross premium amount of $90 million, making it a great value product for the insurer and a particularly terrible option for consumers.[8]

Improving comparability: requiring disclosure of claims payouts

Further steps must be taken to assist consumers in understanding and comparing policies and to give them confidence that all insurance providers will treat them fairly.

The United Kingdom's finance regulator, the Financial Conduct Authority (FCA), has taken a new approach to giving consumers information to better compare insurance products and firms. After finding that consumers were paying too much for poor value general insurance and

[5] APRA, Life insurance supplementary statistical table, issued 10 June 2015.
http://www.apra.gov.au/lifs/Publications/Pages/Life-Insurance-Supplementary-Statistical-Tables.aspx
[6] APRA, Quarterly Life Insurance Performance Statistics, 16 February 2016:
http://www.apra.gov.au/lifs/Publications/Pages/quarterly-life-insurance-statistics.aspx
[7] https://www.choice.com.au/money/insurance/life/articles/life-insurance-review-and-comparison
[8] ASIC (2016), *Report 471: The sale of life insurance through car dealers, taking consumers for a ride:*
http://download.asic.gov.au/media/3549384/rep471-published-29-february-2016.pdf

add-on products[9], the FCA has developed an insurance 'scorecard' system.[10] Starting later in 2016, the FCA will publish the following information about individual general insurance products:

- Claims ratio as a stand-alone value measure
- Claims ratio plus claims acceptance rates
- Claims acceptance rates (stand-alone), claims frequencies and average claims payouts.[11]

It is expected that information about payout ratios will see insurers compete on the value of policies and give consumers a simple measure to assess value.[12] The pilot scorecard project will publish information about claims twice a year.

Australia could easily adopt a similar approach to address consumer confusion for all insurance products, including life insurance.

Recommendation:

- *That ASIC publishes bi-annual information about specific insurance policy's claim ratio, claim ratio plus claims acceptance rates, claims acceptance rates, claims frequencies and average claims payouts. Information should also be released about product category averages.*

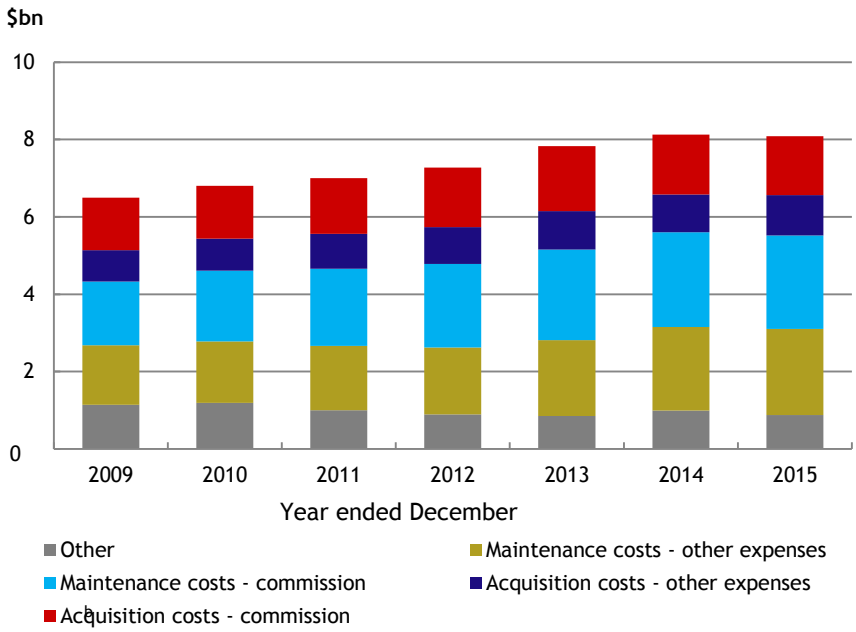
Insurance sales and conflicts of interest

Consumers buying life insurance directly will often use a financial adviser to make the arrangements. These financial advisers are still able to receive high upfront and ongoing commissions for selling life insurance, even though commissions are banned for all other kinds of personal advice.

The cost to insurers for life insurance distribution through adviser channels is significant, with ongoing and upfront commissions costing the life insurance industry billions each year.

[9] Financial Conduct Authority (2014), *MS14/1 General Insurance Add-ons Final Report – Confirmed Findings of the Market Study* https://www.fca.org.uk/your-fca/documents/market-studies/ms14-01-final-report
[10] https://www.fca.org.uk/news/fca-to-publish-claims-scorecards
[11] Ibid.
[12] Financial Conduct Authority (2016), *FS16/1: Feedback Statement on DP15/4 – general insurance value measures* https://www.fca.org.uk/your-fca/documents/feedback-statements/fs16-01

Graph: Life Insurer Operating Expenses[13]



Despite the high costs to insurers, there has been significant resistance from all sections of industry to removing commissions from life insurance advice.

Commissions give an adviser a strong incentive to place consumers in the policy that attracts the biggest payment for them, not necessarily the policy that's best for the client. There is clear evidence that advisers who receive commissions are more likely to recommend inappropriate products for their client and are more likely to switch a client into a new product unnecessarily. A 2014 ASIC review of retail life insurance advice found high levels of churn across the industry, where clients are placed into new products. 37% of advice failed to prioritise the needs of the client and comply with the law. High upfront commissions are strongly correlated with poor advice; 45% of advisers who were paid through up front commissions failed to comply with the law.[14]

The ASIC report clearly found that high upfront commissions led to the worst consumer outcomes. The report concluded that:

"High upfront commissions give advisers an incentive to write new business. The more premium they write, the more they earn. There is no incentive to provide advice that does not result in a product sale or to provide advice to a client that they retain an existing policy unless the advice is to purchase additional covers or increase the sum insured."[15]

Current remuneration arrangements encourage advisers to sell products rather than provide quality personal advice. Being sold an inappropriate life insurance product causes long-term financial and personal harm to consumers. It means consumers waste money on a product they

[13] Australian Prudential Regulation Authority Quarterly Life Insurance Performance Statistics, issued 16 February 2016 http://www.apra.gov.au/lifs/Publications/Pages/quarterly-life-insurance-statistics.aspx
[14] ASIC (2014), *Report 413: Review of retail life insurance advice*, pp. 5-7.
[15] Ibid para 147.

can't use, and should something go wrong, they or their families are not covered as expected. Over time, widespread mis-selling and poor behaviour from advisers means consumers will lose trust in the financial system.

The Federal Government has introduced a legislative package to reduce toxic upfront commissions and decrease the likelihood of inappropriate product churn.[16] The *Corporations Amendment (Life Insurance Remunerations Arrangements) Bill (2015)* and associated regulations place limits on how financial advisers arranging life insurance can be remunerated. It does this by removing the current exemption that allows advisers to receive commissions for life insurance products and enabling ASIC to determine acceptable remuneration arrangements. In the short-term ASIC will cap upfront and trail commissions and introduce a two-year clawback requirement to reduce the risk of inappropriate product churn.[17]

This suite of reforms is an important step in the right direction but needs to be taken much further. Given the harm that commissions cause consumers they should be banned in life insurance advice, just as they are for other kinds of advice.

Recommendations:

- *That the* Corporations Amendment (Life Insurance Remunerations Arrangements) Bill (2015) *is passed as soon as possible without amendment.*
- *That the Federal Government sets a clear date for the removal of all commissions in life insurance advice, starting by phasing out up-front commissions shown to lead to the worst consumer outcomes.*

Direct Insurance

Issues with commissions and poor sales practices in life insurance are not limited to financial advisors and planners. Mis-aligned commissions can also affect direct sales.

For example, the recent ACE/Combined Insurance scandal is a good example of where the commission structure leads to insurers selling products directly inappropriately. Specific cases included:

- *"A NSW couple subjected to "false and misleading conduct" when advised to buy a policy that was useless because they were on a disability pension.*
- *A NSW man who Combined found was subjected to "twisting" when he was sold a new policy he did not need "in contravention of the rules".*
- *A Melbourne couple whose previous serious medical history was omitted by an agent in disclosure forms, meaning the policy they bought was worthless.*
- *A family which was charged for insurance they never bought after an agent fraudulently submitted their bank account to pay for a policy."*[18]

[16] http://kmo.ministers.treasury.gov.au/media-release/024-2015/
[17] Ibid.
[18] http://www.smh.com.au/business/vulnerable-duped-in-combined-insurance-fraud-affecting-thousands-20150405-1mez95.html#ixzz46QoO5692

Aggressive sales tactics

The Financial Rights Legal Centre provides free and independent advice on its national Insurance Law Service. In examining queries and complaints relating to life insurance on its phone and email advice a large proportion of the issues raised centre on:

- the general mis-selling of life insurance products by the insurer in the first place;
- bad or incorrect advice from advisors and other sales agents at the time of purchase;
- the mis-selling of problem products most particularly funeral insurance;
- the mis-selling of replacement policies by financial advisors leading to issues of non-disclosure or the loss of accrued benefits.

Financial Rights Legal Centre Case Study 1 - Abbie and Alan – CLISIS 130009

Abbie had an existing funeral insurance with an insurer covering her and her husband. She took this out as she was concerned Alan's veterans benefits would not be enough to cover his funeral expenses if something happened.

In 2006 Abbie spoke to her insurer about taking out life insurance as well, because they had an outstanding loan that she would not be able to afford herself. After speaking with family, she decided to put her money into paying off the loan faster rather than on life insurance premiums. then rang her back to try to persuade her into the policy again. The salesperson encouraged her to cancel her funeral insurance and take out life insurance in its place for an amount to include both the loan and the original funeral insurance. He said it would be *"larger cover, which is going to cover both the loan and also your funerals"*. He never mentioned the policy would end at age 70, but did check she received the PDS (that had a guarantee of renewal to age 70 hidden towards the end of a badly worded policy). She agreed to $50,000 life cover for $50.01 a fortnight, to replace the existing $7000 funeral cover for $40.04 a month

Abbie cancelled the policy last year after being told Alan would no longer be covered as he reached aged 70. After raising a dispute, the insurer greed to refund $22,646.52 which is all the premiums on the life policy – on a confidential basis and with a non-disparagement clause

Financial Rights Legal Centre Case Study 2 –Chris – CLSIS 130884

Chris was sent a brochure on life insurance then received a phone call from an insurance representative. Chris has a bank account with the vertically integrated insurer. Chris agreed to have the contract read out and discussed the price however said he didn't agree to be signed up and would seek advice from his financial planner. However, the salesman said he had agreed to the contract and the policy would commence in a few days. Chris submitted a complaint to the insurer's Internal Dispute Resolution and the policy was cancelled.

Financial Rights Legal Centre Case Study 3 – David – CLSIS 106506

David's father has funeral insurance. They called his father and somehow managed to sell his father another funeral plan even though he already had funeral insurance with the same insurer. David found out and complained to the insurer. The insurer refused to give a refund.

Financial Rights Legal Centre Case Study 4 – Erica– CLSIS119950

Erica went to a free lunch presentation at work and was asked to put her phone number down, early 2013. Since then, Erica has received regularly phone calls wanting to sign her up for insurance. Her phone number was passed to different company who were more persistent, and insisted they meet with her face to face. At the meeting, she was told to sign for an insurance plan, or be charged $250 for the consultation.

Financial Rights Legal Centre Case Study 5 –James- CLSIS 100510

James suffers from Asperger disorder, an autism spectrum disorder. He relies on a low income. His father came across a monthly withdrawal of $47.95 from my client's bank account. James was unaware what this was for, so he authorised his father to make enquiries. This is when he became aware that it was for an insurance policy. The policy was then cancelled straight away. James's father on his behalf requested a refund of all premiums since the start of the policy. The insurer declined. The policy was set up via a verbal telephone agreement. After initially refusing to provide a copy of the voice recording, the insurer subsequently provided a copy of it. It was evident in the voice recording that my client was not able to understand what was been told to him by the sales representative. The sales person used fast talk and pressure to push the sale and it was clearly confusing for the client. An ILS solicitor wrote to IDR and they immediately agreed to a full refund of premiums, the same day they received the complaint.

Claims handling

Life insurance claims processes including assessments and investigations can take months or even years. To consumers and consumer advocates, the processes often appear non-transparent, slow and bureaucratic. There are well documented cases where life insurance providers have relied on hidden terms or protracted investigations processes to delay or deny a claim.[19]

As mentioned above Financial Rights provides free and independent advice on its national Insurance Law Service. In examining queries and complaints relating to life insurance on its phone and email advice the most significant categories of concern relate to:

- Delays in claims handling and financial hardship brought about or exacerbated by claims delays
- Unreasonable requests for information or piecemeal evidence gathering;
- Concerns with surveillance tactics;
- Concerns with investigation tactics;
- Impossible to meet definitions and out of date medical terminology;
- Disputes over whether a policyholder is capable of working;
- Disputes centred on non-disclosure or mis-representation;
- Complaints relating to problematic products.

Other issues that policyholders face include poor internal dispute handling processes and disputes over whether a policyholder is capable of working.

Delays in claims handling

Delays in processing of a claim are by far the most common complaint with respect to life insurance products. While claims assessment by its very nature can take some time to conduct and some policyholders expectations can be unrealistic, Financial Rights regularly hears of delays that are well beyond what could be considered reasonable.

Financial Rights Legal Centre Case Study 6 – Kevin - CLSIS 131852

Kevin became sick in 2011 and stopped working in July that same year. Kevin made an income protection claim in august 2011, which was granted. In February 2014, Kevin applied for the TPD option and was still waiting for an answer in October to see if it is approved. Kevin has followed through with medical reports and their investigation and has yet another appointment with one of their assessors in late October.

Financial Rights Legal Centre Case Study 7 – Charlene CLSIS 121184

Charlene's called the ILS in October 2014 when her total and permanent disability benefit was

[19] For example, http://www.theaustralian.com.au/news/nation/greigs-wife-in-600000-insurance-battle/news-story/ad481ccba4b583102b16fe5645815532

recently accepted. However, Charlene lodged her claim in January 2012. Three case managers went through the single claim. Charlene had promptly provided her insurer will all paperwork in early 2012. Charlene believes that the claim should have been settled within 6 months and wants to know if she can complain about the length of time and claim interest on the payout due to the excessive delay.

Financial Rights Legal Centre Case Study 8 – Murray - CLSIS 110807

Murray lodged a TPD claim 18 months ago. His insurer keeps asking him for same information over and over. He called the ILS as he wants to know if there is time limit for insurer to make decision.

With no Code of Practice in place outlining time limits on claims processing, nor any other regulations, there is little policyholders can do in a situation like this other than complain to the internal dispute resolution of the insurer involved.

It is also common to hear that the delays involved in the claims process impacting significantly on the finances of the claimant policyholders involved, leading to substantial hardship

Financial Rights Legal Centre Case Study 9 – Aravind - CLSIS 110807

Aravind is a self employed builder who took out income protection. Aravind had a grave accident injuring his neck and being in a coma for a number of weeks. Aravind is not well still and his partner is caring for him. They have 2 dependent children. Aravind made a claim on his income protection in September 2012. His insurer has so far taken 7 months to consider the claim, asking for a huge amount of documents, which they have supplied with some difficulty as they also have a civil case on foot. The couple have no income at the moment, apart from some casual work that Aravind's partner does. They are about to apply for Centrelink and they have hardship variations in place for all their loan contracts including their mortgage. However at the time they called ILS they were about to run out and are in "dire straits".

Unreasonable requests for information or piecemeal evidence gathering

A key strategy used by life insurers to delay claims is by requesting excessive amounts of information or small pieces of information intermittently over a lengthy period of time to delay the claims process.

Financial Rights Legal Centre Case Study 10 – Jackie - CLSIS 130006

Jackie has been receiving income protection payments since 1998 – approximately 17 years and is continues to receive it. CPI increases were not applied correctly and Jackie provided her

Tax Notice of Assessment. However, her insurer wants her Income Tax Returns. They haven't paid CPI for the last two years but the insurer are asking Jackie for 17 years of tax returns (that is her tax return for every year since 1998) and wanting her to consent to them accessing full ATO records.

The extent of the information and documentation requested in the above case study and the following case study is suggestive of fishing exercises for any material that may be used against a claimant.

Financial Rights Legal Centre Case Study 11 – Kenneth - CLSIS 112240

Kenneth obtained an income protection policy in 2010. 10 months later Kenneth had workplace accident. After his workers compensation benefits ran out, Kenneth made an income protection insurance claim in late 2012. After 12 months there was still no resolution to his claim.

In November 2012, Kenneth signed authorisation for his insurer to access his Medicare and PBS records for the previous five years. A year later Kenneth was asked by his insurer to sign a new form authorising release of information from 1984. When he asked why his insurer told him that it is because he hadn't dated the authorisation form he signed in November 2012, which according to Kenneth was not true – he had dated it. When queried further the claims officer stated that the reason they are asking Kenneth to sign release for full medical record going back 20 years to 1984 is that they were looking further into Kenneth's medical history. This, a year after the claim was made.

Financial Rights hear from many clients who are asked to provide excessive amounts of information to maintain their claims. This drip feed of information requests can not only delay claims but in the following case can exacerbate the problems for which they are receiving benefit payments in the first place.

Financial Rights Legal Centre Case Study 12 – Karolina - CLSIS 106041

Karolina has Income Protection Insurance a life insurer. Karolina has been unable to work for a number of years and has been receiving insurance payments from his insurer. Karolina has a number of issues with her insurer including the fact that her Claims Manager and Rehab Manager and other staff have been rude to her and made her cry; her benefit payments are always paid late and the insurer didn't want to pay money toward her fitness programme, which Karolina says she was entitled to under her policy. The insurer eventually paid for the fitness programme. Karolina reports also that the Claims Manager would keep telling her she was better and that she should go back to work, in face of all medical evidence to the contrary.

However Karolina is most affected by the amount of information that she needs to provide her

insurer. Her insurer used to make Karolina keep an Activity Diary where every 2 hours she'd have to write down her symptoms. Karolina reports she has medical evidence to show this process of noticing and recording her symptoms was actually making her worse because it made her think about her illness constantly.

The insurer also requests that Karolina go to her GP to fill in paperwork every month. Her GPs say that she needs to only go once every 3 months as it is not likely for Karolina to recover any time soon.

The insurer also makes Karolina go to Independent Medical Examinations (IMEs). Lately it has been every two months. But in the past it was once a year. Karolina says the Independent Medical Examinations are exhausting and unnecessary. Karolina says she has Doctors', Physios and Psychologists' reports all saying that the insurer's treatment of her is making her medical condition worse.

Another aspect to the unreasonable requests for information is that sometimes the burden placed upon a claimant to gather the information can be overly burdensome.

Financial Rights Legal Centre Case Study 13 – Jaunnie - CLSIS 136131

Jaunnie took out life insurance policy in 1993 with her insurer. In 2010/2011 C started having mental health problems. Jaunnie lodged a claim in about January 2015 for TPD due to her mental health problem. She's had to provide medical information to them however they're now requesting that she attend an appointment with one of their psychiatrists whose office is approx. 110km away.

Concerns with surveillance tactics

Claims handling, assessment and investigation practices have a significant impact upon consumers – issues with investigation tactics are explored further below, however one of the key elements complained about to the ILS involves surveillance. In Australia there is no statutory action for invasion of privacy, in addition there is no current appellate recognition of the tort of invasion of privacy. What this means is that any person can without your consent take photographs, still pictures and videography of you in a public place. In addition, any information that is publically available can be sourced. Insurers also will sometimes allow themselves the right to undertake surveillance of their insured's in the contract of insurance. This contractual right does not extend to non-parties to the insurance. But, as stated, there is no restriction on the practice of still photography, and filming or monitoring of third parties in public places.

Surveillance device laws theoretically provide a level of protection against the unwarranted, intrusive or inappropriate surveillance of Australians, including insurance claimants. While laws are in place in each state and territory to regulate the use of surveillance devices, their complexity, inconsistency and failure to keep up with technological progress provide irregular

protection and little comfort to parties subject to intrusive and unwarranted surveillance. See further information in the Financial Right's Legal Centre Report *Guilty Until Proven Innocent: Insurance Investigations in Australia*[20] included in this submission as Appendix B. In the end though while much of the surveillance undertaken by life insurance investigators is legal, the conduct of the surveillance does veer into ethically murky territory.

Financial Rights Legal Centre Case Study 14 - Tara - CLSIS 119543

Tara has been receiving payments because of severe mental illness caused by trauma. The illness involves a significant paranoia and more specifically being afraid of male strangers. Tara found out that her insurance company has been conducting intrusive surveillance and now has stopped payments after sending her surveillance footage and saying there are inconsistencies to her story. In contacting the ILS Tara was very upset by the surveillance which seems to have followed people that were not actually her and accused her of seeing men, one of which was a woman that they mistaken for a man.

Financial Rights Legal Centre Case Study 15 – Peter - CLSIS 134975

Peter had income protection from his insurer since 2004. Insurer began investigating him in 2012. He noticed a man following him around town – when he turns around, the man runs away. He has become depressed/anxious/stress because of this and doesn't want to leave the house. When his son spotted the surveillance he followed him and the investigator turned around and told the son that if he did not stop folllowing him the investigator would "kill him"

Financial Rights Legal Centre Case Study 16 – Nelum - CLSIS 129588

Nelum has an income protection claim. She has a chronic back injury and the claim is being paid monthly - this has been ongoing for over 2 years. Nelum received 9 DVDs in the mail from her insurer of surveillance footage a private investigator has taken of her. For some time she had felt like she was being watched, in her home, at the shops, when she takes her son to daycare, at the beach with her husband - and now that has all been confirmed. She is also worried her phone has been tapped. The insurer sent the footage with a letter saying they are not sure she still meets the criteria for her insurance claim - they think she is not as in pain as she claims she is. They are giving her an opportunity to comment before they make an official decision. She still sees their medical examiner regularly and fills out forms monthly which they approve monthly. She is worried that she doesn't go to physio often because it hurts her too much and she cannot take care of her son after treatment - it is a criteria of her policy that she undergoes the treatment recommended by her doctor. She says sometimes she can bend and twist - on good days, and on others she is in too much pain - they have filmed her bending and twisting a

[20] Financial Rights Legal Centre (2016), *Guilty until proven innocent, insurance investigations in Australia*, http://financialrights.org.au/wp-content/uploads/2016/03/Guilty-until-proven-innocent.pdf

few times though. She says she has always been honest with them about going to the shops and about the inconsistency of her pain - but her doctors all say she still cannot work full time.

Issues with insurance investigations

We have significant concerns with the way insurers conduct investigations, especially with the use of private investigators and the time insurers can take to assess claims.

While we note the need for reasonable investigation to establish the facts of a claim and prevent fraud, investigations must be proportionate and based on the likelihood of fraud. The claim made by the insurance industry including general insurers, life insurers and the CTP sector is that fraud costs the industry $2.1 billion annually are inflated - this figure being based on a 20-year-old estimated percentage of claims insurers "believed to be fraudulent" rather than on any actual data of proven fraudulent claims.[21] The definition of fraud can also include claims that don't fit the definition. The insurance industry's willingness to overstate the cost of insurance fraud by including suspected yet wholly unproven case of fraud in their statistical analysis belies a "guilty-until-proven-innocent" approach that appears to feed into the investigation process itself. Insurers often take an aggressive approach to investigations and consumers have little protection against unscrupulous practices.

Financial Rights' Insurance Law Service found that close to one in four calls (22.6%) to the Insurance Law Service are from policyholders with concerns relating to insurance investigations.

The Financial Rights Legal Centre recently released a major report into the claims investigation process.[22] While the report focused on issues with general insurance, Financial Rights notes that similar issues arise with life insurance and that similar solutions are needed.

Financial Rights Legal Centre Case Study 17 - Dilini - CLSIS 121175

Dilini is subject to a long-term ongoing income protection claim. Dilini was recently contacted "out of the blue" by her insurer and was told that there was a "claims support" person travelling through her city in three days time who wanted to interview her about her claim. The representative asked that the interview be in her house but since Dilini is not well she requested that they simply ask the questions that they wished to ask over the phone. Dilini was informed that this was not possible and an interview was required.

The investigator was polite but when Dilini tried to explain case her, the investigator asserted his own version in a strong and persistent manner. Dilini felt that the interviewer was attempting to trick her into admitting to things that were not true and that she knew that she was about to lose her job at the time she took out the policy. As a part of her injuries Dilini had significant memory problems and had verified the date of the closing of her company before

[21] Financial Rights Legal Centre (2016), *Guilty until proven innocent, insurance investigations in Australia*, http://financialrights.org.au/wp-content/uploads/2016/03/Guilty-until-proven-innocent.pdf
[22] Ibid.

the interview started so that she was certain of the dates. Nevertheless the interview persisted for well over an hour on the timing of her company's closure. The interview would use lines such as "how come you remember that but not this" making her feel stupid and unsure.

The report found major problems with the investigations process. Consumers reported:

- being subject to incredibly long interviews up to five hours, sometimes repeated over months.
- being bullied, harassed and intimidated by investigators.
- being "treated like a criminal" and that the investigator has prejudged their guilt with little or no basis, putting forward theories that bear scant resemblance to reality.
- being grilled with repetitive and seemingly irrelevant questions about highly personal and sensitive issues like past relationships and medical conditions.
- that investigators threatened to reject claims and or initiate serious repercussions (such as the reporting of relatives to immigration) if consumers did not act in the way the investigator demanded.
- racial profiling.
- failure to provide people with poor English skills access to appropriate translators and failure to provide consumers with mental health problems the use of a support person
- being given little or no explanation of the investigation process and no mention of any rights or standards.
- being asked to sign documents that are not explained, asked to hand over personal and sensitive documents without warning and with no reasons given, and have had their neighbours, family, friends and business associates or clients questioned without the policyholder being notified.

Financial Rights Legal Centre found that the onerous demands placed on consumers by an investigation led many to withdraw their claim, not due to any admission of fraudulent behaviour but simply because the process is too burdensome or invasive for many consumers to bear.

Investigations can often involve externally engaged private investigators. Private investigator licensing however varies significantly between states. The threshold requirements to become a private investigator, for example, vary greatly from state to state as do the training and competency standards. There is also vast variability in the offences applying in each state.[23] It

[23] Most jurisdictions make it an offence not to display credentials, place restrictions on advertising, or require investigators identify themselves to others. There is a variety of offences that apply in one or two jurisdictions only, including intoxication (Tas, Vic), failing a medical exam (WA), breaching the code of conduct (WA) not purporting to have powers outside the licence (SA, NT), and harassment (NSW, NT, Tas, Vic). Many states also list a variety of

should also be noted that private investigators do not have to be licensed in the ACT. More significantly, the various licensing schemes in place offer few, if any, consumer protections.[24] Only one state, WA, has an enforceable Code of Conduct outlining the responsibilities of licensees including promoting the public interest, acting with integrity and avoiding conflicts of interest. There is an urgent need to clarify and lift standards for investigators operating in the life insurance industry. We note that the Australian Law Reform Commission examined this issue and recommended that the Council of Australian Governments consider models for the regulation of private investigators.[25]

Recommendations

- *The Federal Government should amend the* Insurance Contracts Act 1984 (Cth) *to codify consumer rights in relation to investigations.*
- *That Federal and State Governments through the Council of Australian Governments develop uniform private investigator licensing regulations with an enforceable code of conduct.*

For more information and the full suite of recommendations, see the Financial Right's Legal Centre Report *Guilty Until Proven Innocent: Insurance Investigations in Australia* submitted as Appendix B in this submission.

Impossible to meet definitions and out of date medical terminology

Recently there have been a series of high profile cases involving life insurance companies denying claims on the basis of definitional gaming and out of date terminology. These include claims denied because a stem cell treatment used the patient's own cells rather than someone else's,[26] because insurers were relying on an outdated medical definition of a heart attack[27] and because insurers were relying on an outdated medical understanding of arthritis treatments.[28] This is a common issue faced by Insurance Law Service callers.

Financial Rights Legal Centre Case Study 18 – Jerry - CLSIS133409

Jerry was refused a claim on his life insurance after a heart attack 3 1/2 years ago. The claim was refused on a technical definition of heart attack. The definition has subsequently been updated, which he believes would fit his original circumstance. He saw the Four Corners report and contacted the ILS to know whether it is worth challenging this decision? His claim was declined in about Sept 2012 and didn't go through with a complaint at that time as he just accepted their decision.

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prescribed offences relating to state and commonwealth criminal codes or privacy laws that disqualify the licensee from holding a licence but this too is far from uniform.

[24] Ibid pp 71-72.

[25] Recommendation 44-3, ALRC, For Your Information: Australian Privacy Law and Practice (ALRC Report 108) http://www.alrc.gov.au/publications/44.%20New%20Exemptions%20or%20Exceptions/private-investigators .

[26] http://www.abc.net.au/news/2015-11-25/sick-mother-denied-transplant-over-technicality-in-policy/6970656

[27] http://www.abc.net.au/news/2016-03-05/comminsure-denying-heart-attack-claims/7218818

[28] http://www.smh.com.au/business/banking-and-finance/arthritis-sufferers-denied-payouts-due-to-antiquated-medical-js-20160311-gngu5q.html

Financial Rights Legal Centre Case Study 19 – Stephen - CLSIS109293

Stephen was injured in a car accident and claimed for whiplash and post traumatic stress under his income protection policy. The insurer rejected PTSD as they don't cover mental illness, and rejected whiplash because they claimed it was caused by mental illness, not the accident. Stephen has a letter from a doctor saying that the whiplash was from the accident.

Financial Rights Legal Centre Case Study 20 – Luigi – CLSIS 25299

Luigi took out income protection insurance through his superannuation fund to cover loss of income in the events of sickness and injury. A year later he experienced pain in his left wrist. He sought medical attention, and discovered that his left scaphoid bone was not healed from an injury in ten years previous. Because of his wrist pain, he was unable to work as a chef. He lodged a claim with the insurer and was rejected on the basis that the injury occurred prior to the policy's commencement.

We raised a dispute that, as the policy did not provide definitions of "sickness" and "injury", Luigi's wrist pain came within the meaning of "sickness" rather than "injury" because (a) dictionary definitions provide that "sickness" means a disordered, weakened and unsound condition, and this applies to Luigi's wrist pain (b) Luigi first became aware of it while the policy was in force. The insurer rejected this argument without providing any explanation.

The claim was eventually paid.

We believe that there is significant justification for the government to consider introducing fair and easily understood standard definitions for common concepts in life insurance including but not limited to heart attack, sickness, injury and illness, that would be used in all Australian life insurance policies.

Firstly, there are varied definitions used by insurers, which make it difficult for consumers to compare policies and understand exactly what cover is extended to them under their policy. Secondly, not all insurers provide cover for particular events. Thirdly, where certain events are excluded or limited, consumers may be unaware of this.

Consumers should be able to understand what they are agreeing to if they are offered coverage and exclusions in their policy, and should be able to be confident when shopping around that they are comparing like policies with like. The Government should convene an industry and community consultation process to develop a fair standard definition for common terms for use in all life insurance policies. If the industry cannot implement this proposal within 12 months, the Government should amend the *Insurance Contracts Act 1984 (Cth)* to implement it.

The government has already acted to introduce standard definitions in other areas of insurance where variance in definitions has acted to the significant detriment of the

community. In 2012 the *Insurance Contracts Amendment Regulation 2012 (No. 1) (Cth)* was enacted to introduce a standard definition of flood home building, home contents, strata title and small business insurance after significant community concern arose following a series of major floods in 2011 and 2012.

We believe that there is significant scope for the government to examine standard definitions for common terms in the life insurance space.

Disputes centred on non-disclosure or misrepresentation

One of the most common complaints Insurance Law Service solicitors hear are those relating to claims processes that involve non-disclosure or misrepresentation. Policyholders can find themselves denied their claim or in a dispute over innocent non-disclosure of an illness or injury, or simply being unaware of their medical history.

Financial Rights Legal Centre Case Study 21 – Barry – CLSIS 132718

Barry lodged a claim in mid 2015 for income protection for depression/anxiety. His claim was approved in September but then the insurer started to raise the issue of non-disclosure of depression and stopped his payments. They said the GP mental health plan stated he was being referred to a psychologist for 'depression' but on his insurance application he didn't disclose he had depression.

Barry's however did not know he was being referred for depression and he completed his insurance application with what he knew i.e. disclosed there had been a referral to a psychologist to help deal with work and life issues and also provided the contact numbers of his GP and psychologist.

Financial Rights wrote a letter to the super fund and insurer and provided 2 letters of support from Barry's GP and Psychologist both confirming that Barry would not have "known" that he was being referred by GP to Psychologist for depression. The GP stated Barry had been having a stressful time due to work and family issues, she had referred him to psychologist for support, she did not specifically advise him he had a diagnosis of depression, ad he responded well to the psychologist support. Psychologist stated that while the mental health care plan mentioned he was depressed, she did not give him a diagnosis or give him cause to believe he had been categorised in that way.

Ultimately the insurer accepted his income protection claim.

Complaints relating to problematic products

There is ample evidence about consumer problems with poor value life insurance products sold to vulnerable consumers, including funeral insurance[29] and consumer credit insurance.[30]

[29] Most recently, see ASIC Report 454, *Funeral Insurance: A Snapshot*, 29 October 2015 http://asic.gov.au/regulatory-resources/find-a-document/reports/rep-454-funeral-insurance-a-snapshot/

In our view there are other insurance products that may equally be of low value and have problematic sales techniques, for example, some income protection and accident insurance. The requirement for insurers to publicise their claims pay-out ratios would be signal to a regulator whether these products are a problem before a scandal or consumer detriment is suffered.

A 2015 ASIC report into funeral insurance found major problems with the design and distribution of these products. The report found that premiums increased steeply with age, with the structure of the policies creating the very real possibility that a consumer would pay more in premiums than the policy is worth. While 51.2% of consumers with funeral insurance were aged between 50-74, 50% of indigenous consumers with funeral insurance were under 20. Young people are extremely unlikely to need to rely on funeral insurance. This is also a product that becomes less valuable for consumers the longer they have the policy, with sales to young indigenous consumers indicating significant issues with the distribution of products. Funeral insurance companies are preying on communities and selling products that are poor value, especially when compared with funeral bonds, pre-paid funeral options, some life insurance products or simple savings.[31] Consumers often do not understand key features of the product including in particular, the increasing of premiums. Unfair sales tactics and unfair pressure are placed on vulnerable consumers, exploiting genuine concerns for the financial future of their families in the name of increasing sales.

Funeral Insurance

Funeral insurance is regularly sold not "fit for purpose" and the increases on the benefit for the funeral insurance policy were unconscionable.

Financial Rights Legal Centre Case Study 22 – Aaron – CLSIS 112600

Aaron is 64 years old and in receipt of a Disability Support Pension. He has a mental illness as well as a physical impairment. He heard an advertisement on the television 6 years ago about funeral insurance for $2.60 a day. He rang up and took out the insurance, as well as another 'special' insurance that he was persuaded to buy when he was on the phone.

He is now being Direct Debited $48.50 per fortnight for the funeral insurance and a further $38 per fortnight for the other insurance. He can no longer afford it.

To his recollection he did not ask whether the premiums would rise and he could not remember if he was told they would verbally. He had never taken insurance of any sort out before. At the time the insurance was arranged he worked as a low income labourer. He never finished school, and he has a history of mental health problems including been treated chronic

[30] See ASIC reports 256: *Consumer credit insurance: A review of sales practice by authorised deposit taking institutions*, 19 October 2011 http://asic.gov.au/regulatory-resources/find-a-document/reports/rep-256-consumer-credit-insurance-a-review-of-sales-practices-by-authorised-deposit-taking-institutions/ and ASIC Report 361: *Consumer credit insurance policies: Consumers' claims experiences*, 31 July 2013, http://asic.gov.au/regulatory-resources/find-a-document/reports/rep-361-consumer-credit-insurance-policies-consumers-claims-experiences/ and Consumer Action Law Centre's *Junk Merchants* report, December 2015 http://consumeraction.org.au/junk-merchants-report-how-australians-are-being-sold-rubbish-insurance-and-what-we-can-do-about-it/

[31] ASIC (2015), *Report 454*.

depression, schizophrenia and attempted suicide.

He recalls that a year into policy the insurer called him and offered an extension of his policy - from $6,000 cover to $7,000 cover. He could not remember whether they told him his premiums would change, and it was not until he saw his next bank statement he realised his premiums had risen.

Funeral insurance is regularly sold not "fit for purpose" and the increases on the benefit for the funeral insurance policy were unconscionable.

Financial Rights Legal Centre Case Study 23 – Larry and Beryl

Larry and Beryl have had some form of funeral insurance or life insurance for at least 8 years. Beryl had been suffering from non-Hodgkin's Lymphoma (cancer) over a long period.

After seeing an advertisement on television Larry contacted the insurer. He was concerned as the premiums on his current policy were increasing. He spoke to someone at the relevant insurer who appeared to have some of his details, including telephone numbers on file. When questioned he was advised that Larry may have "called before".

During the course of the discussion Larry inquired about obtaining insurance only for $5,000. It appears from the recording he was doing this because his premiums with his existing insurer were $56.16 per fortnight each. He indicated he was looking at an alternative product as his existing insurer "charged like the light brigade".

In the course of the conversation, the new prospective insurer convinced him to take his new product which turned out to be the same price ($56.16 per fortnight each for himself and his wife). However, it had a limitation that it would only cover "accidental death" (and not illness) in the first 12 months. The insurer indicated Larry should cancel the first policy. He indicated the Product Disclosure Statement (PDS) would be sent within 5 days

Larry indicates a number of times in the conversation he is having difficulty hearing. Larry never received the PDS. Unfortunately Beryl passed away within 12 months of taking out the policy and Larry made a claim. The claim was rejected as Beryl passed away from cancer and not an "accident". Larry received the PDS and other relevant documents *only after* he contacted the insurer in respect of making a claim on Beryl's policy (including a will kit for his wife who was by then already dead). The matter was ultimately settled to our client's satisfaction after raising a dispute in the Financial Ombudsman Service

Financial Rights Legal Centre Case Study 24 – Ingrid - CLSIS 124703

Ingrid has very limited financial acumen and understanding. Since 1994 her income has been

solely based on the pension, namely disability support pension. Until recently, she was caring for her daughter with autism. She entered into two insurance policies with her insurer: a funeral insurance policy obtained in June 2005 and a life insurance policy obtained in October 2008.

Her insurer misrepresented information to Ingrid at the point of sale for the life insurance policy, by deliberately omitting that the policy would be cancelled at age 70 and advertising the policy as "full life cover." Ingrid was also not advised at the inception of the life insurance policy that "inflation protection" had been selected on her insurance cover, and that it would periodically increase the benefit payable.

Her insurer was never advised by the telephone representatives that the premiums on the life insurance policy will be stepped. Rather, similarities were drawn with the funeral insurance policy, whose premiums are level.

The policy documents provided are also poorly worded and do not offset the information presented to Ingrid on the telephone. The policy does not clearly outline that it will be cancelled at age 70, and leaves it open to the insurer to decide what to do thereafter. Further, the premium increases are unclear as to when they will increase. With stepped premiums, as with Ingrid's policy, it was guaranteed that premiums will increase due to age and inflation factors.

Her insurer's representatives made a couple of unsolicited invitations to Ingrid to increase her policy cover on her funeral insurance policy, and accordingly, her premium. This is despite having sold Ingrid a life insurance policy, so that her funeral would be covered, and financial support provided to her children.

Consumer Credit Insurance

Consumer Credit Insurance (CCI) is another low value insurance product sold through exploitative sales practices. CCI is regulated as a type of general insurance, but in most cases it is a bundle of products including life cover. CCI is a demonstrably poor value product—a loss ratio of 23% indicates that it pays far less in claims as a proportion of premiums than any other type of insurance for which APRA records are available. CCI also receives fewer claims, and rejects a higher proportion of the claims it receives, than any other line of insurance.[32]But the bigger problem with CCI is the 'add-on' sales technique that is used to upsell it to people when they are buying car loans, personal loans or credit cards. Work done by consumer advocates and regulators in Australia and the UK show that the add-on sales technique leads to consumers buying insurance that they don't understand and is unsuitable for their needs. The add-on sales process, together with commission-based remuneration for sales staff, also encourages mis-selling. Consumer Action and Financial RIghts solicitors have provided advice in many cases where consumers have been sold insurance without their knowledge or consent and where insurance sold is clearly inappropriate for the consumer.

[32] Data on loss ratios is from APRA, data on claims is from FOS. More explanation and full references are in Consumer Action Law Centre's report *Junk Merchants: How Australians are being sold rubbish insurance and what we can do about it*, December 2015, pp 8-10.

Consumer Action Case Study 1– Jessica

Jessica signed up for car finance to buy a car in 2014. The finance, provided through a broker, covered the car for approximately $18,000, over $1,000 of fees, over $2,000 of Consumer Credit Insurance (CCI) and a discretionary risk product which also cost around $2,000.

At the time of signing up for the finance, Jessica was in 'fairly dire straits' and needed a car urgently. Jessica states that she was told that she had to buy the warranty and the CCI to get the car loan. The representative produced the warranty and said that it was the only warranty the representative carried.

Jessica thinks the adviser probably 'had the feeling I had no idea' as the process of buying a car was new to her. However, the adviser was very friendly, which helped reassure Jessica that he cared about her interests. It was only later when Jessica's mother looked over the documents and questioned the add-ons that she began to doubt what had happened.

Consumer Action Case Study 2– Steve

Steve (not his real name) applied for a credit card with a major bank in 2013. Steve is a full time carer for his wife, who has a disability. Both are solely reliant on Centrelink income.

During the application process, the bank staff added CCI (including an unemployment benefit) to the credit card. Steve did not ask to buy insurance and the CCI he ended up with was not explained to him. It should have been clear to the bank staff that both Steve and his wife—who did all their banking with this bank—were solely reliant on social security and neither could have claimed the unemployment benefit.

Steve paid around $90 per month on CCI premiums for two years. By the time the two years had passed, his wife's medical condition worsened and Steve needed to spend more money on renovations to make the home suitable to a person with limited mobility. This extra expense caused financial strain and Steve rang the bank to ask if the insurance policy we had would cover the period of financial difficulty. The bank staff told Steve that his policy would only cover him if he became unemployed. Steve responded that he wasn't working when he was sold the policy. According to Steve, the bank staff 'didn't have any real answers' about why he had been sold the policy.

ASIC's recent report 471 *The Sale of Life Insurance through car dealers: taking consumers for a ride*, provided further evidence that life insurance sold as an add-on (usually through CCI) in car yards was being sold inappropriately and presented poor value for consumers. Report 471 found, among other things, that:

- life insurance sold through car yards paid out only 6.6% of premiums back in claims;[33]

[33] ASIC Report 471, paragraph 4.

- insurance sold through car yards could be 18 times more expensive than equivalent products from the same insurer bought online;[34] and
- high volumes of life insurance is being sold to young consumers who are unlikely to need it.[35]

It is time for the life insurance industry to acknowledge those problems and commit to either improving the value of these products or stop selling them. One relatively straight forward way to deal with these issues is to address them in the life insurance Code, as discussed in detail in the following section.

Issues with the claims process and the need for a life insurance code of practice

To address issues in claims handling, a Life Insurance Code of Practice should be established as soon as possible and specific measures should be taken to introduce protections into the insurance investigations process.

The General Insurance Code of Practice provides industry guidelines on complaints and claims handling for general insurance. This code includes claims timeframes and requires notification of when it will take further time. The timeframes and the right to documents provide consumers some guidance and certainty about claims handling and industry standards. However, life insurance products are not covered by the GICOP, and there is currently no industry code or best practice guidelines for these products. We believe this needs to be rectified as a matter of priority.

A code for life insurance was a recommendation of John Trowbridge's *Review of Retail Life Insurance Advice*,[36] and has since been commissioned by the Financial Services Council (FSC) and the Association of Financial Advisors (AFA) as a response to ASIC's report 413, *Review of Retail Life Insurance Advice.*[37] Work to finalise a code is ongoing.

At a minimum, we maintain that a code must:

- be a best practice code and hold insurers to a higher standard than is currently required under the law.
- be legally enforceable, that is the Code be binding on, and enforceable against life insurer subscribers through contractual arrangements with consumers.
- be registered with ASIC under Regulatory Guide 183 as a marker that consumers can trust the code operates in their interests.[38]
- address significant issues with the claims process by outlining timelines consumers should expect and standards that insurers must adhere to.
- commit to limits on unreasonable documentation requests
- commit insurers to using independent medical examinations.

[34] ASIC Report 471, paragraph 4.
[35] ASIC Report 471, table 1 (page 8).
[36] Trowbridge Report, Policy Recommendation 6.
[37] ASIC, *Report 143: Review of retail life insurance advice*, October 2014 http://asic.gov.au/regulatory-resources/find-a-document/reports/rep-413-review-of-retail-life-insurance-advice/
[38] As per requirements established in ASIC (2013) *Regulatory Guide 183: Approval of Financial Sector Codes of Conduct*, http://download.asic.gov.au/media/1241015/rg183-published-1-march-2013.pdf?_ga=1.175469355.84513953.1449719296

- address issues with variable, out-of-date and other problematic definitions.
- commit to strict limitations on surveillance to ensure that an investigator:
    - does not conduct surveillance on business premises;
    - does not communicate with a neighbour, work colleague or other acquaintance of a policyholder, in a way which might directly or indirectly reveal that surveillance is being, will be, or has been conducted or imply that the policyholder is involved in dishonest conduct;
    - does not record or film inside any court, tribunal, conciliation or mediation service or centre, or any other quasi-judicial facility;
    - does not record film inside any medical or health service or centre;
    - avoid any act or behaviour which might unreasonably interfere with a person's legitimate expectation of, or right to, privacy including but not limited to the recording of family or friends, the recording of someone within their residential premises, within change rooms, showers, toilets bedrooms, lactation rooms, swimming pools, gyms, educational facilities or at religious or ceremonial occasions;
- develop a set of best practice standards of practice with respect to claims handling and investigation practices similar to the Victoria Workcover Authority Code of Practice for Private investigators[39] and the NSW Motor Accidents Authority Code of Conduct for Claims Assessors[40] and Claims Handling Guidelines for CTP insurers.[41]
- commits insurers to addressing the high lapse rate of funeral insurance products by:
    - capping premiums at the benefit amount, and applying the caps retrospectively;
    - providing real responses for consumers who buy funeral insurance and later struggle to make payments because of financial hardship;
    - not selling funeral insurance cover without first making a proper assessment of whether the customer can afford the cover over the long term;
    - giving a proper explanation of how the cost of a funeral insurance premium will change over the life of a policy. This should involve customers having access to standard, interactive modelling software that shows them how much their product will cost over the life of the policy;
- requiring insurers immediately stop sales of funeral cover for people aged under 18.
- requiring insurers stop allowing any life cover to be sold through the 'add-on' sales technique
- address the underlying problems of mis-selling and churn that drove earlier inquiries
- require insurers not allow products to be sold through pressure sales techniques, by preying on guilt and anxiety or any other sales tactics that are legally or ethically questionable. Insurers should make their sales scripts publicly available to prove that they are making an effort to improve sales processes.

[39] Victorian WorkCover Authority, Code of Practice for Private Investigators Version 2.0, Effective 1 November 2014, https://www.worksafe.vic.gov.au/__data/assets/pdf_file/0004/8707/VWA-Code-of-Practice-for-PIs-Final-Authorised-2014.pdf

[40] http://www.maa.nsw.gov.au/media/publications/for-professionals/Claims-Assessor-Code-of-Conduct-2013-to-2016MAA292.pdf

[41] http://www.maa.nsw.gov.au/media/publications/about-us/maa-claims-handling-guidelines

Consumer groups including Consumer Action and Financial Rights Legal Centre have been involved in consultations with industry about the Life Insurance Code of Practice (LICOP or the Code) and have raised serious problems with drafting. The key problem is that if the Code simply restates the law and does not require life insurers to meet any standard that is not already required of them it will be manifestly inadequate. This falls far short of a best practice code recommended by the Trowbridge Report and required by the Retail Life Industry Reforms announced by the Assistant Treasurer in November 2015 which sough that a:

"Life Insurance Code of Conduct …be developed by the FSC by 1 July 2016. Similar to existing codes for Banking and General Insurance, the Code would set out best practice standards for insurers, including in relation to underwriting and claims management."[42]

The draft Code also includes a number of sections dictating how consumers should behave rather than self-regulating the industry's own conduct addressing consumer issues, concerns and problems with industry practice. Further the current draft makes no attempt to address the problems with churn and poor sales practices.

While the Code will apply to life insurance providers it can and should bind the whole industry through contracts with advisers and other distributors. John Trowbridge's review of retail life insurance, which proposed the development of a code of practice, did not support the code explicitly dealing with the adviser-consumer or the insurer-adviser relationships. However, Trowbridge's final report was clear that a code should be designed to lift the standards of all involved in retail life insurance, including advisers and licensees.

Trowbridge considered that

> …a focus on how insurers interact with licensees or advisers would lack a consumer focus. This relationship could still be covered in a Life Insurance Code of Practice but with a view to how these interactions impact on consumer outcomes. Commercial dealings between life insurers, licensees and advisers are generally a matter for the marketplace to determine but inserting behavioural or conduct principles around these practices would assist.

…for a code of conduct to be effective it will require broad industry support and membership. Aiming this at life insurers would effectively mean capturing a smaller group than licensees and advisers. However, lifting life insurer standards will have flow on effects on licensees and advisers and seems the quickest and most effective way for change to be implemented through the industry. This approach has been successful in banking and general insurance.[43]

One way insurers could encourage improved sales practices would be to conduct random audits of how its products are being sold, and assess sales against a standard set out in the Code. The Code standard could be based on the 'Warning signs of poor advice'[44] and the Life Insurance Advice Checklist[45] in ASIC's Report 143, and any other standards life insurers

[42] The Hon. Kelly O'Dwyer MP, Minister for Small Business, Assistant Treasurer, *Government announces significant improvements to life insurance industry*, 6 November 2015 http://kmo.ministers.treasury.gov.au/media-release/024-2015/
[43] John Trowbridge, *Review of Retail Life Insurance Advice: Final Report*, 26 March 2015, page 64.
[44] ASIC Report 143, pp62-64
[45] Ibid, pp68-71.

choose to include. Life insurers should require parties they contract with to submit to audits as a term of their agreement.

In addition, the code should commit life insurers to vigorously investigating credible reports that their products are being mis-sold, report detected wrongdoing to ASIC, terminate relationships with licensees or advisers that repeatedly mis-sell their products, and compensate consumers who have suffered loss. Insurers know that commission-based sales raise the risk of mis-selling but continue to use this sales channel because it drives sales. They cannot then turn a blind eye when mis-selling occurs.

Recommendations:

- *That a Life Insurance Code is established as soon as possible. The Code must:*
    - *be a best practice code and hold insurers to a higher standard than is currently required under the law.*
    - *be legally enforceable, that is the Code be binding on, and enforceable against life insurer subscribers through contractual arrangements with consumers.*
    - *be registered with ASIC under Regulatory Guide 183 as a marker that consumers can trust the code operates in their interests.*[46]
    - *address the underlying problems of mis-selling and churn that drove earlier inquiries.*
    - *address significant issues with the claims process by outlining timelines consumers should expect and standards that insurers must adhere to.*
    - *commit to limits on unreasonable documentation requests*
    - *commit insurers to using independent medical examinations.*
    - *address issues with variable, out-of-date and other problematic definitions.*
    - *commit to strict limitations on surveillance to ensure that an investigator:*
        - *does not conduct surveillance on business premises;*
        - *does not communicate with a neighbour, work colleague or other acquaintance of a policyholder, in a way which might directly or indirectly reveal that surveillance is being, will be, or has been conducted or imply that the policyholder is involved in dishonest conduct;*
        - *does not record or film inside any court, tribunal, conciliation or mediation service or centre, or any other quasi-judicial facility;*
        - *does not record film inside any medical or health service or centre;*
        - *avoid any act or behaviour which might unreasonably interfere with a person's legitimate expectation of, or right to, privacy including but not limited to the recording of family or friends, the recording of someone within their residential premises, within change rooms, showers, toilets bedrooms, lactation rooms, swimming pools, gyms, educational facilities or at religious or ceremonial occasions;*
    - *develop a set of best practice standards of practice with respect to claims handling and investigation practices similar to the Victoria Workcover Authority Code of*

[46] As per requirements established in ASIC (2013) *Regulatory Guide 183: Approval of Financial Sector Codes of Conduct*, http://download.asic.gov.au/media/1241015/rg183-published-1-march-2013.pdf?_ga=1.175469355.84513953.1449719296

Practice for Private investigators[47] *and the NSW Motor Accidents Authority Code of Conduct for Claims Assessors*[48] *and Claims Handling Guidelines for CTP insurers.*[49]

- *commits insurers to addressing the high lapse rate of funeral insurance products by:*
  - *capping premiums at the benefit amount, and applying the caps retrospectively;*
  - *providing real responses for consumers who buy funeral insurance and later struggle to make payments because of financial hardship;*
  - *not selling funeral insurance cover without first making a proper assessment of whether the customer can afford the cover over the long term;*
  - *giving a proper explanation of how the cost of a funeral insurance premium will change over the life of a policy. This should involve customers having access to standard, interactive modelling software that shows them how much their product will cost over the life of the policy;*
- *requiring insurers immediately stop sales of funeral cover for people aged under 18.*
- *requiring insurers stop allowing any life cover to be sold through the 'add-on' sales technique*
- *address the underlying problems of mis-selling and churn that drove earlier inquiries*
- *require insurers not allow products to be sold through pressure sales techniques, by preying on guilt and anxiety or any other sales tactics that are legally or ethically questionable. Insurers should make their sales scripts publicly available to prove that they are making an effort to improve sales processes.*

- *That the Government should convene an industry and community consultation process to develop a fair standard definition for common terms for use in all life insurance policies.*

For more information and to see all consumer recommended changes to the draft Code see the Submission by the Financial Rights Legal Centre, Consumer Action Law Centre and Financial Counselling Australia on the Draft Life Insurance Code of Practice which is included as an attachment to this submission.

A ban on unfair contract terms will improve the claims process

It is our view that life insurance providers are engaging in unethical practices to deny or delay paying reasonable claims. Unfortunately, this behaviour does not necessarily breach the current law. Insurers have a duty to act in good faith but are exempt from unfair contract terms law.

Unfair contract terms protections currently apply to most contracts between Australian consumers and businesses. The ban on unfair contract terms can be found in the *Competition and Consumer Act (2010)* and the associated clauses in the *Australian Securities and Investments*

[47] Victorian WorkCover Authority, Code of Practice for Private Investigators Version 2.0, Effective 1 November 2014, https://www.worksafe.vic.gov.au/__data/assets/pdf_file/0004/8707/VWA-Code-of-Practice-for-PIs-Final-Authorised-2014.pdf

[48] http://www.maa.nsw.gov.au/media/publications/for-professionals/Claims-Assessor-Code-of-Conduct-2013-to-2016MAA292.pdf

[49] http://www.maa.nsw.gov.au/media/publications/about-us/maa-claims-handling-guidelines

Commission Act (2001). Terms may be considered unfair if they are part of a standard form contract (where one party is unable to negotiate amendments) and a term:

-
- causes a significant imbalance of rights and obligations between parties,
- is not reasonably necessary to protect the legitimate interests of the party that would benefit from its inclusion or,
- would cause detriment if it were to be applied.

The ban on unfair contract terms provides two important protections. First, it allows for a relatively straight forward remedy for a consumer if a business relies on an unfair contract term. Second, they prevent consumer harm by encouraging businesses to draft contracts with fairness in mind.

Insurance contracts are exempt from the unfair contract terms requirements under Australian Consumer Law. We believe that there is no justification for this exception. Allowing insurance contracts to include provisions that are unfair leaves consumers open to exploitation. Recent investigations into Comminsure highlight that consumers experience extreme detriment when insurers rely on unfair terms or interpret broad terms in an unfair manner.[50]

Expanding unfair contract terms provisions to insurance policies will provide a much needed broad protection for consumers. It will give consumers the confidence to purchase life insurance, knowing that terms in complex and long policies cannot be unfair. It will also make the claims process easier for consumers to navigate, reducing incidents where insurers creatively interpret clauses to deny reasonable claims. Furthermore it would create an incentive for insurers to draft their contracts with an eye to fairness, review their existing contracts and remove terms that may be unfair, rather than face enforcement later. It would ensure that terms, for example those requiring the provision of any and all documents, or the cost of an investigation be borne by the consumer, would be removed.

Extending unfair contract terms provisions to life insurance contracts is not a new idea. A number of inquiries and reviews have recommended extending unfair contract terms protections to insurance contracts.[51] In fact, the previous government announced in 2012 that the unfair contract terms regime be extended to insurance contracts with a Bill drafted, however the Bill never entered into law. A ban on unfair contract terms in insurance contracts has also been in place in the United Kingdom for a number of years, demonstrating that this is a feasible reform.[52]

Recommendation:

- *That insurance policies are not allowed to include unfair contract terms.*

[50] See http://www.smh.com.au/interactive/2016/comminsure-exposed/mental-health/
[51] See Senate Economics Legislation Committee (2009), *Report into the Trade Practices Amendment (Australian Consumer Law) Bill 2009*, para 10.12-10.14 and House of Representatives Committee on Social Policy and Legal Affairs (2012), *Inquiry into the operation of the insurance industry during disaster events*, Recommendation 4.
[52] Unfair terms were first being capable of being challenged by individuals in the United Kingdom under the *Unfair Terms in Consumer Contracts Regulations (1999)* and are now banned for insurance policies under the *Consumer Rights Act (2015)*

This could be achieved by amending section 15 of the Insurance Contracts Act (1984) *so that the provision which currently excludes insurance contracts from the operation of any other Commonwealth, State or Territory Act allows the unfair contract terms provisions in the* Australian Securities and Investments Commission Act (2001) *to apply.*[53]

Australian Securities and Investments Commissions' role

ASIC plays an essential role in regulating life insurance providers and distributors. Our view is that ASIC is constrained by limited resources and needs additional powers to protect consumers.

ASIC funding

In 2014-15, ASIC's budget was reduced by $120 million over four years, in addition to an efficiency dividend reduction of $47 million over the same period.[54]

ASIC needs adequate funds that will allow it to be proactive (able to uncover and investigate suspected misconduct rather than waiting for a crisis), independent (accountable to the Federal Government and Parliament, but able to set its own agenda), flexible (able to keep up with rapid change in the industries it regulates) and able to offer salaries in line with the financial services industry.

In its response to the Financial System Inquiry, the Federal Government has committed to consider three-year funding arrangements and an industry-pays funding model for ASIC. This offers a more reliable funding option for ASIC however, we don't know when this will be implemented. The initial funding proposal put forward by Treasury would not lead to increased funding for ASIC and some aspects of the proposal pose risks to ASIC's independence. [55]

What's needed is an industry-pays funding model for ASIC that leads to secure, increased and non-conflicted funding in the long-term. Until future funding arrangements are confirmed and take effect, ASIC requires additional funds to properly fulfil its mandate and protect consumers.

Recommendations:

- *In the short-term the Federal Government should provide additional funds to restore ASIC's funding to pre-2013-14 levels plus reasonable growth for wages and costs. The case for additional funding should consider, at a minimum, funds necessary to restore staffing levels to 2013-14 capacity (as staffing reductions occurred proactively in the lead up to the 2014-15 budget) and conduct increased surveillance activity.*
- *In the medium-to-long-term the Federal Government should establish an industry-pays funding model for ASIC that leads to secure, increased and non-conflicted funding.*

Additional powers for ASIC

[53] S 15, Insurance Contracts Act 1984 https://www.legislation.gov.au/Details/C2016C00037/Html/Text#_Toc440549001
[54] ASIC (2015), *Annual Report*. ASIC (2014), *Annual Report*.
[55] The problems with the proposed industry funding model are explained in detail in the joint consumer advocate submission to the proposal, available here: http://consumeraction.org.au/proposed-industry-funding-model-for-the-australian-securities-and-investments-commission-joint-submission/

Currently ASIC has limited proactive powers to prevent harm to consumers and act in cases where products are being sold inappropriately, like in the case of funeral insurance sold to young, indigenous consumers.

The Final Report of the Financial System Inquiry recommended two new powers for ASIC. These were:

- a targeted and principles-based product design and distribution obligation.
- a proactive product intervention power (PIP) that would enhance the regulatory toolkit available where there is risk of significant consumer detriment.[56]

The Federal Government has supported these recommendations in principle and has committed to consulting further on the detail of reform.

Giving ASIC oversight of product design and distribution and providing new PIP powers will help consumers of life insurance in Australia. The new powers will allow ASIC to encourage insurers to promote fair treatment of consumers, intervene where necessary to prevent harmful marketing or sales practices or the sale of harmful products and reduce the number of consumers buying products that do not match their needs.

However, it's important to note that the Financial System Inquiry has recommended that PIP powers should not extend to "large numbers of consumers have incurred a small detriment".[57] These exclusions are not justified and would limits ASIC's ability to take action in the life insurance market, particularly against dodgy sales practices. It is our view that ASIC needs the ability to use PIPs across the entirety of the financial products and services it regulates.

Recommendations:

- *That all financial service providers are required to meet targeted and principles-based product design and distribution obligations. ASIC should be responsible for monitoring and enforcing these new obligations.*
- *That ASIC is given a proactive product intervention power that will allow broad action to prevent consumer harm.*

[56] Financial System Inquiry (2015), *Final Report*, recommendations 21-22.
[57] FSI, *Final Report*, pp. 206-207.

APPENDIX A

Submission by the

Consumer Action Law Centre, Financial Counselling Australia, and the Financial Rights Legal Centre

Financial Services Council

Draft Life Insurance Code of Practice

January 2016

About Consumer Action

Consumer Action is an independent, not-for-profit, campaign-focused casework and policy organisation. Consumer Action offers free legal advice, pursues consumer litigation and provides financial counselling to vulnerable and disadvantaged consumers across Victoria. Consumer Action is also a nationally-recognised and influential policy and research body, pursuing a law reform agenda across a range of important consumer issues at a governmental level, in the media, and in the community directly.

About Financial Counselling Australia

Financial Counselling Australia (FCA) is the peak body for financial counsellors. Financial counsellors provide information, support and advocacy for people in financial difficulty. They work in not-for-profit community organisations and their services are free, independent and confidential. FCA is the national voice for the financial counselling profession, providing resources and support for financial counsellors and advocating for people who are financially vulnerable.

About the Financial Rights Legal Centre

The Financial Rights Legal Centre (Financial Rights) is a community legal centre that specialises in helping consumer's understand and enforce their financial rights, especially low income and otherwise marginalised or vulnerable consumers. We provide free and independent financial counselling, legal advice and representation to individuals about a broad range of financial issues. Financial Rights operates the Credit & Debt Hotline, which helps NSW consumers experiencing financial difficulties. We also operate the Insurance Law Service which provides advice nationally to consumers about insurance claims and debts to insurance companies. Financial Rights took over 25,000 calls for advice or assistance during the 2014/2015 financial year.

Introduction

Thank you for the opportunity for the Consumer Action Legal Centre and the Financial Rights Legal Centre to comment on the Financial Services Council's Draft Life Insurance Code of Practice. We will provide both general comments regarding the approach taken to the Code as well as specific comments on the drafting of the Code.

Summary and key recommendations

This joint consumer submission argues that the Life Insurance Code of Practice (LICOP) as currently drafted is not a best practice standard and has not fulfilled the expectations and obligations set by Government. The current draft does not require life insurers to meet any standard that is not already required of them by the law. It does not meet the minimum standards of enforceability set by ASIC. The draft Code includes a number of sections dictating how consumers should be behave rather than self-regulating the industry's own conduct addressing consumer issues, concerns and problems with industry practice. The current draft also makes no attempt to address the problems with churn and poor sales practices, issues that initiated the process that ultimately led to the development of this draft LICOP.

Unless substantial changes and additions are made, consumers will have minimal confidence in the Code and our organisations will not be able to support it.

We expect the final version of the LICOP to be registered with ASIC in accordance with ASIC's *Regulatory Guidance 183*. However for registration to occur, considerable improvements would need to be made to bring it up to the standard expected by ASIC for Code approval. Adherence to the Code must be a term of the contracts of all life insurance policies and adherence to the Code should be compulsory for membership of the FSC. It is not appropriate, nor practical, for a code to dictate how consumers should behave. The relevant sections in the Code - "General Information" and "How you can assist with your application" should therefore be removed. The final Code should also set enforceable, best practice standards for advisers and licensees.

In addition to these general expectations for a final LICOP, we believe that life insurers should make the following specific commitments to improve consumer confidence in the industry:

1. Life insurers should commit to providing specific details of how they will address consumer concerns about someone selling or distributing life insurance products.

2. The Code should include additional advertising and marketing commitments specific to the life risk product industry that are not currently included in the ASIC good practice guidelines.

3. Life insurers should commit to providing greater transparency for beneficiaries of group policies and provide copies of policies to beneficiaries and take steps to improve disclosure generally.

4. Life insurers should commit to provide to policyholders:

    a. projections of likely costs of the premium
    b. information and contact details of the subscriber's internal dispute resolution and complaints process;
    c. in the case of replacement policies, information on what a consumer may potentially be losing and specific information on pre-existing conditions
    d. clear disclosure on the impact of offsets.

5. Where an insurer cannot provide insurance to a consumer they should commit to providing the reasons for their decision (in all cases), details of the subscribers complaints process and alternative insurance options.

6. If there is a need to increase the price of a policyholder's policy outside of the annual anniversary life insurers should commit to providing reasons as to why the price increase is warranted. Life insurers should also commit to providing the previous year's premium on the annual renewal notice.

7. Contact via a letter, email or text message should be sent on the same day that a cancellation occurs. The Code should also require life insurers to offer financial hardship assistance if a customer misses a payment, and be prepared to offer reasonable assistance if it is requested.

8. The life insurance industry should:

    a. commit to improving the prominence of warnings and the risks and consequences of replacing a policy
    b. commit signatories to investigate reported or suspected mis-selling of replacement policies
    c. report where they uncover wrongdoing; and
    d. ensure any customers who have suffered a loss are compensated.

9. The Code should include directions to the IDR and Complaints process on making a decision. For those policyholders experiencing financial difficulty whilst an investigation is taking place life insurers should commit to paying a portion of the income protection payments.

10. Life insurers need to commit to training staff on how to engage appropriately with vulnerable consumers. They should also put in place appropriate processes and procedures to accommodate consumer needs and work closely with vulnerable

consumers to only provide insurance products that are suitable to their particular circumstances.

11. To assist life insurers to identify those consumers who require additional support, insurers should commit to including voluntary demographic questions on their application forms.

12. Insurers should commit to providing consumers with reasons why documents and information sought in a claim are relevant and including a referral to the dispute process where there is an issue. Insurers should also commit to correcting errors or mistakes that they have identified and not discourage a policyholder from lodging a claim.

13. We recommend that life insurers meet a 12 week minimum standard timeframe similarly met by general insurers in gathering third party service providers reports or if this deadline cannot be met a commitment be made to keep consumers informed of the progress in obtaining the report. Furthermore specific timeframes should be instituted when keeping claimants informed about the assessment and investigation of their claim.

14. Life insurers should commit to including more specific timeframes within the Code including a four month time limit from receipt of the claim.

15. The Code needs to include a commitment to fully inform consumers of the tax and legal implications of a lump sum payment and to ensure that consumers are provided with enough time before the end of the financial year to receive appropriate advice.

16. The Code should include specific timeframes limiting the frequency of ongoing contact to reasonable levels that do not impede upon the lives of policyholders experiencing hardship.

17. A specific timeframe needs to be included to require life insurers to contact a policyholder to let them know when an ongoing claim is coming to an end or their claim is expiring.

18. The Code should commit life insurers to using only licensed investigators and require them to abide by the requirements of the Privacy Act 1998 and relevant state surveillance legislation. It is the life insurer's responsibility to deal with all complaints regarding that service that is being provided on their behalf. We recommend that broader, more specific standards be set for investigators to address our concerns with respect to investigations including poor communication practices, aggressive or unethical investigator behaviour and unreasonable requests for documentation.

19. Reviews of the Code should be conducted by an independent party. The FSC should be empowered to develop the Code on an ongoing basis in consultation with consumer groups and other stakeholders.

20. The Code must include a section addressing issues of financial hardship including paying a portion of an income protection payment to assist those experiencing financial

difficulty whilst an investigation is taking place, fast-tracking assessments for those claimants who have urgent financial need, and informing policyholders of options available if hard times hit.

21. The Code should commit insurers to addressing the high lapse rate of funeral insurance products; immediately stop sales of funeral cover for people under 18 years old; stop allowing CCI to be sold through the 'add-on' sales technique; and not allow products to be sold through pressure sales techniques.

Further suggestions and recommendations are detailed throughout the submission.

General Comments

ASIC Code Registration

We maintain that the final version of the Life Insurance Code of Practice ("LICOP" or "the Code") must be registered with ASIC in accordance with ASIC's *Regulatory Guidance 183: Approval of financial sector codes of conduct, March 2013*.[58] RG183 establishes the minimum benchmark for the development, content, enforceability, administration and review of industry Codes of Conduct. The Guide states that

> *"It is not mandatory for any industry in the financial services sector to develop a code. Where a code exists, that code does not have to be approved by ASIC.* ***However, where approval by ASIC is sought and obtained, it is a signal to consumers that this is a code they can have confidence in.*** *An approved code responds to identified and emerging consumer issues and delivers substantial benefits to consumers."*[59] ***(our emphasis)***

We agree with ASIC that registering the Code is a signal to consumers that they can have confidence in the Code. Conversely, choosing not to register the Code would send a public signal that the life insurance industry's unwillingness to meet the minimum standards set out by ASIC. This submission details how this current draft does not meet these minimum standards for ASIC approval including the fact that the draft Code is not enforceable and does not include any commitments beyond the current legislative requirements. It also outlines our concerns with respect to the current wording of the draft.

It is our strong view that it is incumbent upon the Financial Services Council (FSC) to register the Code, but to do this substantial changes are required to bring it up to the standard expected by ASIC for Code approval. If the FSC chooses not to register the Code it then should detail explicitly and publicly why the it has chosen not to meet the minimum standards set down by RG183.

Enforceable and binding

It is critical that the final version of this Code be binding on, and enforceable against, subscribers through contractual arrangements with consumers: RG 183.20(a) and RG183.25(a). In other words, adherence to the Code must be a term of the contracts of all life insurance policies. This is strongly encouraged by ASIC under RG 183.27.

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

The role of Codes of Practice

Industry codes are a set of enforceable rules that set the standard for expected conduct by signatories to that code. An industry code is therefore first and foremost about self-regulating

[58] http://download.asic.gov.au/media/1241015/rg183-published-1-march-2013.pdf?_ga=1.175469355.84513953.1449719296
[59] *Regulatory Guidance 183: Approval of financial sector codes of conduct, March 2013*, RG 183.3

an industry's own conduct. We are therefore concerned that the current draft of the LICOP includes a number of statements outlining the industry's expectations of consumers. These are outlined in the draft Code's "General Information" and "How you can assist with your application" sections. For example, under *Section 3. When You Buy Insurance* the draft Code states:

> *"To support us to assess your application correctly and charge you the correct price, we require you to tell us anything that you know might affect our decision to insure you. The law provides us with a number of options if we find out that information relevant to your policy is incorrect or incomplete after the policy has been issued.*
>
> *"You should ensure the policy you are buying suits your needs, including whether it provides cover that is right for you, whether you will be able to afford the payments, and whether you are already covered under any existing policies. If you have a Representative, they may be able to assist.*
>
> *If we request information from you or ask you to have an assessment such as a medical examination as part of the underwriting process, the sooner you can provide these, the quicker we can make a decision on your application.*

Under section *4. Replacement Polices* the draft Code states:

> *If you wish to replace your existing life insurance policy with a policy from another insurer, you may need to go through the application and underwriting process again. Under your new policy, you may not get coverage for any health issues that have come up during the term of the existing policy. You may also be subject to waiting periods before you can make a claim on the replacement policy.*
>
> *If you apply for a replacement policy, it is important that you don't cancel your existing policy until your replacement application has been accepted, and any additional terms and conditions have been accepted by you, and your policy has commenced.*

Section *5. Non-disclosure and misrepresentation* the draft code states that:

> *"Before you enter into a contract with us, it is important that you answer any questions we ask you correctly and tell us anything that you know might affect our decision to insure you. This is called your "duty of disclosure"."*

Similar expectations and obligations are detailed under section 7.

A Code is fundamentally about addressing consumer issues, concerns and problems with industry practice through the imposition of self-regulating obligations and commitments to raising the standards of industry behavior. A code is not about dictating how consumers should behave or adjusting their expectations.

The Code should therefore be drafted to improve consumer confidence in the industry, not tell consumers how they can assist their own application nor detail the expectations the industry has of them. To do otherwise would demonstrate a fundamental misunderstanding of what a code of practice is designed to achieve.

To pick one example detailed above regarding buying suitable insurance products, a LICOP should detail how and what steps the industry itself will take to only sell life insurance products that are suitable to an individual's personal circumstances. As currently drafted though, the obligation to buy a suitable life insurance product falls wholly on the shoulders of the consumer. This is not appropriate for a code of practice.

Furthermore Section 4 of the Code regarding Replacement Policies is only about the industry's expectations of consumers and a description of how the industry currently acts, all of which serves to lower consumer expectation of what life insurance can do. There are no commitments, standards or obligations set for the industry to address consumer concerns around replacement policies. This too is not appropriate for a code of practice.

We note that the General Insurance Code of Practice does not include any equivalent wording or framing and only addresses the industry's obligations to consumers and the rights of consumers.

Consequently it is our strong view that the "General Information" and "How you can assist with your application" sections outlined above should be removed. If there are parts of these sections that provide important background information or deal with industry obligations or commitments, then these should be detailed and numbered in the Code. For example the Code should detail the standards the industry will set for itself with respect to the full and clear disclosure of "stepped premiums" and "level premiums" under section 3.

We acknowledge that at the FSC consultation it was suggested that these statements could be a separate set of information available from the FSC as "explanation tools" sitting outside the Code, similar to the general information provided by the Insurance Council of Australia through its "Understanding Insurance" website. We do not oppose the FSC producing materials targeted at consumers explaining life insurance products and processes as long as it sits outside of the Code and does not form part of the Code.

Expectations of Codes of Practice

One of our biggest concerns with the draft code is that, as it stands, the draft does not seem to require life insurers to meet any standard that is not already required of them by the law. If the draft Code does in fact improve on the law, it still only sets a standard which the minimum required of a decent life insurer. This falls far short of the 'best practice' code recommended by the Trowbridge report which stated:

> *Policy Recommendation 6: That a Life Insurance Code of Practice be developed that is modelled on the General Insurance Code of Practice and aimed at setting standards of best practice for life insurers, licensees and advisers for the delivery of effective life insurance outcomes for consumers.*[60]

A 'best practice' code is also required by the Retail Life Insurance Industry Reforms announced by the Assistant Treasurer in November 2015 which states that:

[60] John Trowbridge, Review of Retail Life Insurance Advice: Final Report, 26 March 2015, http://www.fsc.org.au/downloads/file/MediaReleaseFile/FinalReport-ReviewofRetailLifeInsuranceAdvice-FinalCopy(CLEAN).pdf

9. *Life Insurance Code of Conduct to be developed by the FSC by 1 July 2016. Similar to existing codes for Banking and General Insurance, the Code would set out best practice standards for insurers, including in relation to underwriting and claims management.*[61]

The draft also fails to meet the standard set by ASIC Regulatory Guide 183,[62] that is:

> *"effective codes should deliver stronger consumer protection outcomes because …they set standards that elaborate on, exceed or clarify the law…"*[63]

and

> *"It is essential that core rules address existing and/or emerging problems in the marketplace, rather than merely restating the law."*[64]

The draft Code also fails to meet its own objectives as described at cl. 1.6:

> *"The objectives of the Code are:*
>
> *a. To seek continuous improvement within the life insurance industry;*
>
> *b. To commit us to high standards of customer service. "*

We are of the strong view that life insurers are obligated to create a code that sets out best practice for the life insurance industry. As it currently stands this draft does not meet this objective and has not fulfilled what the Government has required of the industry. Unless substantial changes and additions are made, consumers would have little confidence in the Code and we would not be able to support it.

Addressing the problems that prompted development of the Code

Further to the above, we are disappointed that the current draft makes no attempt to address (nor even acknowledge) the problems with churn and poor sales practices that drove the FSC to write the Code in the first place. As mentioned above, this Code was a recommendation of John Trowbridge's *Review of Retail Life Insurance Advice*,[65] in turn commissioned by the FSC and the Association of Financial Advisors as a response to ASIC's report 413, *Review of Retail Life Insurance Advice.*[66] A code written in this context that does not discuss sales practices is at best a missed opportunity. At worst it suggests life insurers are still not willing to face up to the sales and churn problems.

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[61] The Hon. Kelly O'Dwyer MP, Minister for Small Business, Assistant Treasurer, *Government announces significant improvements to life insurance industry*, 6 November 2015 http://kmo.ministers.treasury.gov.au/media-release/024-2015/

[62] ASIC, *Regulatory Guide 183: Approval of financial services sector codes of conduct*, March 2013, http://asic.gov.au/regulatory-resources/find-a-document/regulatory-guides/rg-183-approval-of-financial-services-sector-codes-of-conduct/

[63] RG 183.22

[64] RG 183.60

[65] Policy Recommendation 6.

[66] ASIC, *Report 143: Review of retail life insurance advice*, October 2014 http://asic.gov.au/regulatory-resources/find-a-document/reports/rep-413-review-of-retail-life-insurance-advice/

At recent consultation sessions held by the FSC it was suggested that the LICOP cannot set standards for advisers and licensees as they are not bound by the Code and insurers cannot control the conduct of advisers. This is not true. Insurers can set enforceable sales standards through their contracts with advisers and licensees, and require that those parties hold any subcontracted party to the same standard. This would be similar to the enforcement of standards set under Section 9 of the draft Code applying to "third parties dealing with underwriting or claims."

If standards are set down in an industry Code, this will be easy for life insurers to implement – life insurers would simply refer to the Code in their contracts. If all (or most) life insurers are signatories to the Code, then licensees and advisers will be held to the Code standard if they wish to contract with insurers. We think this is the kind of impact John Trowbridge had in mind when he proposed a Code that would raise the standard of the whole industry even though it only bound insurers. For example the Trowbridge report stated that:

> *'… lifting life insurer standards will have flow on effects on licensees and advisers and seems the quickest and most effective way for change to be implemented through the industry. This approach has been successful in banking and general insurance."*[67]

Moreover, insurers should want to take an interest in how their products are sold if they care about their reputation, the reputation of their industry, and the welfare of their customers.

One way insurers could encourage improved sales practices would be to conduct random audits of how its products are being sold, and assess sales against a standard set out in the Code. This kind of standard was envisaged by the Financial System Inquiry's recommendation for a product design and distribution obligation.[68] Life insurers have an opportunity to lead the financial services industry in introducing this kind of standard for members, as well as getting the opportunity to test how this recommendation would work in practice in their industry. The Code standard could be based on the 'Warning signs of poor advice'[69] and the Life Insurance Advice Checklist[70] in ASIC's Report 143, and any other standards life insurers choose to include. Life insurers would require parties they contract with to submit to audits as a term of their agreement.

We have also made further related recommendations below under 'Who does the code apply to' and 'Replacement Policies'.

[67] *The Trowbridge Report* at page 64
[68] *Financial Services Inquiry: Final Report*, November 2014 http://fsi.gov.au/files/2014/12/FSI_Final_Report_Consolidated20141210.pdf The obligations proposed by Recommendation 21 include that "issuers should agree with distributors on how a product should be distributed to consumers. Where applicable, distributors should have controls in place to act in accordance with the issuer's expectations for distribution to target markets."
[69] ASIC Report 143, pp62-64
[70] ASIC Report 143, pp68-71

Detailed comments

The following comments detail our view on the current drafting of the Code and provide recommended corrections, amendments and changes.

Introduction and Objectives

Under Clause 1.7 the draft Code refers to "utmost good faith" rather than the "duty of utmost good faith." This should be corrected.

Scope of the Code

Who does the Code apply to?

Clause 2.1b references "other industry participants … who can adopt the Code…" It seems that this should reference those "who adopt" the Code rather than those who can adopt the Code. As we understand it the Code will only apply to those who adopt it.

Clause 2.4 states that

> *"If you tell us that you have a concern about someone selling or distributing our products, we can tell you how you can have the matter addressed."*

We do not believe this is a sufficient response. Concerns about sales of life insurance were, as mentioned above, the driving force behind ASIC report 413, the Trowbridge report and the current draft Code. Clause 2.4 is an opportunity to acknowledge and respond to those concerns. Where someone raises concerns about how a life insurer's products are being sold, that insurer should take the report seriously and take responsibility for investigating whether misconduct has occurred. This is consistent with the Trowbridge report's vision of a Code that raises standards of not only the signatory insurers, but licensees and advisers as well. It would also be more likely to promote trust and confidence in the life insurance industry. At a minimum, we believe this to be too vague and should be more specific and directed. The clause should be expanded to provide specific details of how subscribers will address these concerns. It should also state "we will tell you" rather than "we can tell you" to ensure that this will actually take place. An investigation by the insurer shouldn't prevent a consumer making their own complaint to the relevant bodies.

When you buy insurance

Advertising and marketing

We note that industry codes should improve consumer protection outcomes and set standards that elaborate on, exceed or clarify the law, as per RG 183.22 and RG 183.60. Clause 3.1 as currently drafted simply states that subscribers will comply with the ASIC good practice guidance. The LICOP should improve consumer protections available through advertising and marketing commitments specific to the life risk product industry that are not currently included in the ASIC good practice guidelines. For example,

- making explicit the nature of stepped premiums and level premiums and not simply giving "a realistic impression of the overall level of fees and costs a consumer is likely to pay"
- prohibiting the use of terms such as "free," "no cost," "without cost," "no additional cost" or "at no extra cost"
- not promoting products to customers in situations where it is evident that the product is worthless or of very low value to that customer; and
- not engaging in high pressure sales practices, practices based on exploiting anxiety or guilt, or other ethically or legally questionable selling techniques.

Application

We note that the standards in this section do not apply to cover under a Group Policy. We understand that under the current law it is the policyholder to whom disclosure rules apply and not beneficiaries, but we question why this should necessarily be the case. We are regularly contacted by clients who are beneficiaries under a Group Policy but are unable to access the disclosure documents or policy. This is particularly problematic in the case of denials. There is a substantial gap here and the formulation of the LICOP provides a real opportunity for life insurers to make group policies more transparent.

We note that in other cases of group insurance – for example travel insurance available via a credit card – the policies are available on the web. It is unclear why this does not similarly occur for life insurance.

We therefore recommend that life insurers at the very least commit to providing greater transparency for beneficiaries of group policies and provide copies of policies to beneficiaries and take steps to improve disclosure generally in this regard.

Underwriting

We note that cl. 3.5 is already a part of the law and does not further address consumer concerns in this area – that is the lack of independent medical assessments. Again we believe that the Code should improve consumer protection outcomes and set standards that elaborate on, exceed or clarify the law, as per RG 183.22 and 183.60. For example, the Code provides an opportunity for the industry to develop standards for the provision of genuinely independent medical assessment – that is, independent of the policyholder and the life insurer.

Our decision

Clause 3.7(g) states that a subscriber to the Code will provide to a policyholder a description of how the price you pay is structured, including whether the policy has "stepped premiums." We believe that this should be expanded to include projections of likely costs of the premium. It is critical that pricing information is spelt out clearly to consumers for the sake of transparency. Consumers have great difficulty with fully comprehending the financial implications of life insurance products and this leads to a large number of complaints.

Furthermore on the list of information to be provided with policy documentation Clause 3.7 should include

- information and contact details of the subscriber's internal dispute resolution and complaints process;
- in the case of replacement policies, information on what a consumer may potentially be losing and specific information on pre-existing conditions; and
- clear disclosure on the impact of offsets.

With respect to clause 3.8 we note that the draft code states that if the subscriber cannot provide insurance to a consumer they will provide "the reasons for our decision where possible for us to do so." It is unclear to us what circumstances exist that would cause the subscriber to be unable to provide reasons. The obligation arises under s75(4) of the Insurance Contracts Act 1980 that an insured must provide reasons when it relates to the state of health of the life insured. There is no exception. What are the circumstances that would make it not possible to provide reasons? Under the GICOP subscribers to that Code have committed to simply providing the reasons full stop: cl. 4.8. We recommend that life insurers commit to providing the reasons for their decision, with no qualifier. This will promote transparency and understanding in the community.

We further note that this draft Code also differs from the GICOP with respect to what information will be provided on refusal to insure. The draft LICOP does not refer refused consumers to the FSC for information about alternative insurance options or another insurer as GICOP 4.8(c) does. Rather than providing details of the complaints process (as GICOP 4.8(d) does) the draft Code merely states that "you can discuss this with us, and request a review." We do not agree with this approach. Customers should not only be entitled to request a review, they are entitled to have that request heard and to receive a response. We recommend that the draft Code clearly state that consumers who have had their request for insurance refused be provided with details of the subscribers complaints process as well as alternative insurance options.

Ongoing communication

In notifying a policyholder in writing if there is a need to increase the price of their policy outside of the annual policy anniversary under cl. 3.9, subscribers to the Code should provide reasons as to why an extraordinary price increase is warranted.

We also believe that life insurer subscribers to the Code should commit to providing the previous year's premium on the annual renewal notice. Such a move would be an important step in improving price transparency and assist consumers in making more informed decisions. The information at renewal is an important opportunity for consumers to consider their financial situation and make appropriate decisions. Information about (a) the risks of switching and (b) any premium hardship options available under their existing policy may be of benefit to consumers. The industry should consider what best practice may apply at the point of renewal to prevent lapses, unnecessary churning, and other consumer harms. This would be our preference to the "General Information" statements included in the Code.

Cancellation rights

We note that the standards in this section do not apply to cover under a Group Policy. Again we question why this should be the case. Providing information on what the expected standards are for Group Policies and cancellation procedures would be of great benefit so that all life insured consumers can be aware of their rights.

We welcome that customers will be given 20 business days notice before a policy will be cancelled for non-payment of premium: cl. 3.12. This gives consumers two pay cycles to catch up with a missed payment, which will assist people in short term financial hardship. We also note it exceeds the notice required under the GICOP.

However, clauses 3.12 still needs improvement. Providing notice of policy cancellation as late as 28 days after the cancellation is far too slow. We do not see why a letter, email or text message (depending on what contact details the insurer has) cannot be sent on the same day that the cancellation occurs. The Code should also require insurers to offer financial hardship assistance if a customer misses a payment, and be prepared to offer reasonable assistance if it is requested. This is discussed further in our "Financial Hardship" section below.

Replacement Policies

As argued above, we do not believe that the wording in this section is appropriate for a code of practice. However as it currently stands there is no information or commitments made under the replacement policy section. This Code provides an opportunity for life insurers to commit to improving information and disclosure with respect to replacing policies. Rather than providing general information in the Code on what consumers should expect, at a minimum the industry could commit to improving the prominence of warnings and the risks and consequences of replacing a policy.

But moreover, it is unacceptable for this Code to contain no new commitment to prevent irresponsible sales of replacement policies (that is, 'churn') given that this problem has dominated all recent debates about consumer protection in life insurance. If the LICOP is going to promote trust and confidence in the industry, this problem needs to be acknowledged and addressed. We suggest that the Code should:

- commit signatories to investigate reported or suspected mis-selling of replacement policies. This investigation could use ASIC's Life Insurance Advice Checklist from report 413 as a way to determine whether replacement advice was appropriate
- report back (at least to ASIC) where they uncover wrongdoing and
- ensure any customers who have suffered a loss are compensated.

Non-disclosure and misrepresentation

We note that clause 5.1 is again simply repeating the law and we would encourage the FSC to elaborate on, exceed or clarify the law in this regard.

There are a number of issues relating to non-disclosure and misrepresentation that we believe should be addressed in the LICOP.

Investigations into non-disclosure and misrepresentation can take place when a claim has been made and is subsequently assessed as well as a random audit during the first 12-36 months of a policy. For those policyholders who have made a claim on income protection insurance it is important that during an investigation that they are not left in the cold through the withholding of payments. For many people, income protection payments are their only source of income. We understand that in a number of cases life insurers do pay a portion of the income protection payments to assist those experiencing financial difficulty whilst an investigation is taking place. This would meet an insurer's duty of utmost good faith. We believe that this should be acknowledged and should be included this in the Code.

It is also important that when a policyholder is subject to an investigation into non-disclosure or misrepresentation that they are given the opportunity to review the material that the insurer is relying on – be they application forms or other written or recorded material. Life insurers should commit to providing this material to policyholders – particularly in the case of a claim.

In order to further minimise existing or potential financial hardship non-disclosure and misrepresentation investigations should be prioritised and sped up.

We recommend that the Code include directions to the IDR and Complaints process on making a decision.

Consumers requiring additional support

We support the inclusion of a section that acknowledges the needs of particularly vulnerable consumers. Vulnerable consumers including Indigenous people, those from non-English speaking backgrounds, mature age Australians, those with a mental illness or mental health issues, people with a developmental disabilities, and those with a physical disability need to be identified in the text of the Code. All face considerable difficulties and disadvantages when seeking out life insurance and engaging with life insurers in the claims and complaints process. These needs should be generally acknowledged with specific obligations and commitments made.

The Australian Law Reform Commission has previously recommended that insurance codes:

> *"contain a diversity statement or objects clause that encourages consideration of the needs and circumstances of a diverse range of consumers. Such a statement should include reference to mature age persons, among other consumers."*[71]

We believe that this should be the aim of section 6. However, the draft clauses are far too limited in scope.

The education program proposed in cl. 6.1, for example, is limited *merely* to identifying consumers who are having particular difficulty engaging with life insurers. Once identified the

[71] http://www.alrc.gov.au/publications/6-insurance/insurance-codes-practice

draft Code does not commit insurers to actually doing anything about this difficulty. While cl. 6.2 is a positive step with respect to working with vulnerable consumers it is however unclear what it will mean in practice. As a minimum life insurers should commit to training staff on how to engage appropriately with vulnerable consumers at all stages of the life insurance relationship (buying, claims, assessment and investigation). For example, cultural sensitivity training should be a standard practice. Insurers should commit to having appropriate processes and procedures in place to accommodate consumer needs. For example, life insurers should commit to the use of interpreters or TTY services when and where appropriate. Life insurers should also commit to working closely with vulnerable consumers to only provide insurance products that are suitable to their particular circumstances.

To assist life insurers in identifying those consumers who require additional support, we suggest that life insurers commit to including demographic questions on their application forms. This would need to be implemented in a way that makes it clear that the information collected will not impact upon assessment and would need to be voluntary to meet the requirements of the National Privacy Principles (NPP). Under the NPP an organisation cannot require somebody to provide information, but an organisation can collect "sensitive information" including race/and or ethnicity with the consent of the individual.

Clause 6.3 as currently drafted merely recognises that "some groups of consumers … may require support in meeting identification requirements when buying insurance or making a claim or Complaint." This is far too limited in scope.

When you make a claim

Making a claim

It is our view that when a life insurer responds to a claim (under cl. 7.3) it should be done so in writing.

Clause 7.4 refers to only asking for and relying on information that the life insurer believes to be relevant to a claim, circumstances and policy. Disputes can arise over what is "relevant" and is an issue that arises with many of our clients. We therefore recommend insurers committing to providing consumers with reasons why the documents and information sought are relevant and include a referral to the internal dispute resolution process where there is an issue on this point.

Furthermore, we have seen authorities seeking medical information from decades before, sometimes over 30 years. This stretches the meaning of "relevancy" beyond what is reasonable and is tantamount to a fishing expedition. We recommend that these kind of practices are constrained and specifically addressed in the Code – particularly with respect to cll. 7.4 and 7.9

Under cl. 7.5 subscribers will only correct errors or mistakes when they are brought to their attention. We believe that this should be extended to include correcting errors or mistakes that subscribers have identified themselves. As it stands there would be no obligation on a life insurer subscriber to correct an error or mistake they discovered themselves. The GICOP cl. 7.4 does have such an obligation. It is therefore recommended that the wording found in GICOP cl. 7.4 should replace the current draft LICOP cl. 7.5:

> *"Where we identify, or you tell us about, an error or mistake in dealing with your claim, we will immediately initiate action to correct it."*

The GICOP also includes a statement that commits general insurers to not discouraging policyholders from lodging a claim. GICOP cl. 7.8 states:

> *"You are entitled to ask us if your insurance policy covers a particular loss before a claim is lodged. In answering, we will not discourage you from lodging a claim, and will inform you that the question of coverage will be fully assessed if a claim is lodged."*

We have had a number of clients who have said that they have been told not to bother lodging a claim or there is no point in lodging a claim, when there is an arguable case that the claim would meet the policy. We recommend a similarly phrased clause be included in the final LICOP.

Assessment and investigation

It is our view that the current wording of cl. 7.7 is unclear and potentially confusing. Specifically it is unclear whether the reference to an "*independent* assessment" in the second sentence is different to the "*assessment by Third Party Service Provider, who is selected by us*" in the first sentence. A truly *independent* assessment is one independent of the consumer *and* the life insurer. If the draft Code is referring to the same thing in the use of these two phrases then it needs to use the same phrase. At the very least this needs clarifying but we would ideally expect independent assessors – that is independent of the consumer and independent of the life insurer - in all cases.

We are concerned that there is currently no time limit placed upon the provision of a Third Party Service Provider report. This means that the investigation can continue for an unlimited amount of time with little or no recourse provided to policyholders. One of the key complaints Financial Rights receives in its Insurance Law Service is the lengthy timeframes that policyholders are faced with during assessments and investigations. This Code as currently draft does not improve this situation in a number of instances. We therefore recommend in this instance that life insurers meet a 12 week minimum standard timeframe similarly met by general insurers in gathering reports from third party service providers. Clause 7.15 of GICOP states:

> *If we engage a Third Party Service Provider to provide a report which is necessary to assess your claim, we will ask them to provide their report to us within 12 weeks of the date of their engagement. If the Third Party Service Provider cannot meet or fails to meet this timeframe, we will inform you of this, and keep you informed of our progress in obtaining the report."*

This clause should be included in the final version of the LICOP. Such a clause would provide significant benefits to consumers and insurers alike. One of the key factors in increasing stress levels of consumers is the sheer lack of information regarding how long an assessment will take. By letting consumers know that a report will be gathered in three months this will at the very least ease the stress brought on by the unknown. Consumers would similarly benefit from being told after three months that a report has not been completed, the reasons why and be provided with a timeline for it to be completed, in the situation where it has taken an expert

assessor longer than the three months. This decrease in consumer stress can have positive side effect for insurers in potentially decreasing the number of constructive denial claims. Finally introducing a three month timeframe could also lift standards in report writing by third party service providers.

Furthermore specific timeframes should be instituted when keeping claimants informed about the assessment and investigation of their claim. Clause 7.10 as currently drafts merely states that the insurer will make an arrangement for keeping the consumer regularly informed. This is not acceptable. We recommend that life insurers commit to keeping claimants informed of the progress of their claim at least every 20 days as general insurers do under cl 7.13 of the GICOP.

We support the recommendation made by the Australian Lawyers Alliance in its submission with respect to cl. 7.9, that is, that life insurers should commit to notifying the policyholder of their need to speak to the policyholder's doctor and seek the policyholder's signed authority before doing so.

Our decision

The current draft of the LICOP does not place a time limit of the total amount of time it will take to assess and investigate a claim. General insurers have committed to a four month time limit from receipt of the claim: GICOP cl. 7.17. We see no reason why life insurers could not make a similar commitment. We therefore recommend the inclusion of the following clause:

> *Our decision will be made within four months of receiving your claim. If we do not make a decision within four months, we will provide details of our Complaints process*

We note that the current draft cl. 7.12 commits subscribers to make a decision within 10 business days once they have all the information they need and have completed the investigation. The interaction of this clause with cl. 7.3 regarding responding to a claimant within 10 days is confusing. It is unclear whether this means that when a policyholder makes a claim and, at the time of making that claim they provide all the information that the insurer requires, the maximum amount of time a life insurer has to finalise the claim is 20 days or 10 days. We recommend to avoid confusion that the following sentence (drawn from GICOP cl. 7.9) should be included in the current draft 7.3:

> *If you make a claim and we do not require further information, assessment or investigation, we will decide to accept or deny your claim and notify you of our decision within ten business days of receiving your claim*

We are also concerned about the impact upon consumers when an insurer makes a lump sum payment. We are aware of a number of clients who have been provided with a lump sum payment days before the end of the financial year. This has significant detrimental tax implications for the policyholder. We believe that the Code needs to include a commitment to fully inform consumers of the tax and legal implications of a lump sum and to ensure that consumers are provided with enough time before the end of the financial year to receive appropriate financial advice.

Ongoing management

Clause 7.15 and 7.16 state the following:

> *If your claim requires ongoing management, we will make an arrangement with you for keeping in regular contact to review the progress of your claim.*
>
> *We will tell you what information we need you to provide and when it needs to be provided in order to assess your claim on an ongoing basis. This can include regular medical reports, although in some cases, we may determine that you do not require these.*

These clauses are too vague and unclear and lack any real commitment to improve the consumer experience of an ongoing claim. The Code should include actual timeframes, limiting the frequency of ongoing contact to reasonable levels that do not impede upon the lives of policyholders experiencing hardship. The most common complaint heard by solicitors in the Insurance Law Service from life insurance policyholders is the frequent, disruptive, highly bureaucratic and sometimes unwarranted ongoing management practices of life insurers. Financial Rights solicitors regularly hear from policyholders suffering from serious, debilitating health issues that are either not improving over time or are deteriorating, but where the policyholders are subjected to monthly reporting. It is our view that in many of these cases this level of reporting is excessive and burdensome on those experiencing from significant physical and/or mental health issues. We would expect this key consumer issue to be acknowledged and addressed in a constructive manner in the final Code. As it currently stands, the draft Code does little to assuage these concerns and provides no framework in which to limit inappropriate life insurer behaviour and poor industry practice.

Clause 7.19 requires signatories to contact a customer to let them know when an ongoing claim is coming to an end. This clause should include a timeline, for example, that the insurer will make the contact at least 90 days before the claim is coming to an end, or 'as early as possible'. Furthermore, the Code should include a commitment to providing policyholders with a warning a month before the expiration of a claim.

Compliance with timeframes

The requirement in cl. 7.21 that a life insurer must comply with timeframes is completely undermined by the qualifier 'unless our conduct and the timetable were reasonable in all the circumstances'. This allows a signatory to unilaterally decide that they need not adhere to a timeline imposed by the Code. These words should be removed.

We are also concerned that there is no clause under Section 7 that deals with claimants who have an urgent financial need. This is a common problem and needs to be addressed. The GICOP includes the following cl. 7.7:

> *"Where you reasonably demonstrate to us that you are in urgent financial need of the benefits you are entitled to under your insurance policy as a result of the event causing the claim, we will:*
>
> > *(a) fast-track the assessment and decision process of your claim; and/or*
> >
> > *(b) make an advance payment to assist in alleviating your immediate hardship within five business days of you demonstrating your urgent financial need; and*

(c) provide details of our Complaints process, if you are not happy with our decision."

We believe the same or similar clause should be included in the final Life Insurance Code of Practice as it is consistent with the duty of utmost good faith and current practice.

Complaints and Disputes

We note that a complaint about a life insurance product owned by a superannuation fund is twice as long at 90 days as one not owned by a superannuation fund. This is presumably because of s. 19 of the Superannuation (Resolution of Complaints) Act 1993. We believe that a total of three months to deal with a complaint is completely unreasonable and would have a severe impact upon policyholders suffering financial hardship, injury and/or illness. This Code provides the opportunity to improve this service and we recommend that a shorter timeframe be considered.

Standards for third parties dealing with underwriting or claims

We support the recommendation made by the Australian Lawyers Alliance in its submission with respect to cl. 9.3, that is that life insurers should require third party service providers act with honesty, fairness, transparency and timeliness to the policyholder claimant when providing their services..

Clause 9.4 states that subscribers will

> *"only enter into contracts with Third Party Service Providers who reasonably satisfy us of their expertise, experience or qualifications, and who hold any required Federal, State or industry licensing."*

We note that there is substantial ambiguity with respect to whether some insurance investigators need to be licensed at all. For example, there are no investigator licensing regulations or scheme in the ACT. All existing state licensing schemes exempt insurance companies, loss adjusters and their employees from the need to be licensed as a private investigator.[72] This means that some of the investigators working in insurance investigations will be licenced and others will not. The variability of regulations, dearth of minimum standards applying to private investigator behaviour and a lack of clear avenues of redress applying to the conduct of investigators is a disappointing feature of this broader regulatory framework.

We recommend that to remove any potential ambiguity and variability in whether a third party investigator needs to be licensed, life insurers should commit to using only licensed investigators. To ensure the highest quality of provider is used by the industry these providers

[72] Tasmania requires the loss adjuster to be a member of the Australian Institute of Chartered Loss Adjusters. Significantly South Australia exempts "a person employed under a contract of service by a [loss adjuster] while acting in the ordinary course of that business." This has the potential of including private investigators solely working in the fraud investigation field for loss adjusters under a contract of service. In its Code of Conduct the Australian Institute of Private Detectives refers to this potential ambiguity when it states:
it is contestable in the majority of the State based licensing regimes in relation to Commercial Investigations, as to whether a person requires a license at all in order to conduct investigations when engaged by insurance companies or authorised deposit taking institutions (ADI's) under the Commonwealth Banking Act 1959. (p14 http://www.aipd.com.au/pdf/COP_Adopted220908.pdf)

should demonstrate their expertise, experience, education, training *and* qualifications. As currently drafted providers do not have to demonstrate that they have been appropriately trained as an investigator. For example they simply have to demonstrate that they have "experience" in the area. This minimal standard could potentially mean anything and is a very low bar. We note that the GICOP cl. 6.3(a) refers to "education" and "training". We therefore recommend amending cl. 9.4 as follows:

> *"only enter into contracts with Third Party Service Providers who satisfy us of their expertise, experience, education, training and qualifications, and who hold Federal, State or industry licensing."*

We note and support the inclusion of cl. 9.5 which states that

> *"We will only rely on reports we request Third Party Service Providers to prepare in relation to your policy or claim that are impartial and objective."*

In order to bring further clarity to this objective approach, we recommend the inclusion of a subsequent sentence stating:

> *"All circumstances detected in the production of a Report, whether positive or negative for the parties involved, shall be taken into account with equal weight."*

Clause 9.6 of the draft Code asserts that subscribers will:

> *"require Third Party Service Providers to maintain confidentiality of your information, and only use that information for the purpose of the service they are providing."*

In order to clarify this further we recommend including the following sentence:

> *"Third Party Service Providers will meet requirements of the Privacy Act 1998 and all state surveillance legislation"*

Clause 9.7 deals with the complaints process with respect to Third Party Service Providers. We note that subscribers will handle the complaint if:

> *"It has not already been addressed by the Third Party Service Provider."*

We cannot accept this. The reason is that we have serious concerns with respect to the complaints processes of third party private investigator services. There are a large number of private investigator services engaged by the life insurance industry. Very few of them have complaints procedures in place. There are also over 12 private investigator associations in Australia and while a few of the associations have outlined disciplinary procedures in their codes, only a handful of associations include clear processes and information relating to the raising of complaints on their websites.[73]A particularly noteworthy example is the process of the Institute of Mercantile Agents who provide significant details of their complaints procedure on their website[74] include a lodgement fee of $220.00 (incl GST) for each complaint,

[73] The Australian Investigators and Security Professionals and National Security Association of Australia (Qld) Inc have somewhat difficult to find complaints policies on their websites. The Australian Security Industry Association has an online dispute resolution form on their website.
[74] http://www.imal.com.au/index.php?option=com_content&view=article&id=40&Itemid=51

payable by the complainant at the time the complaint is lodged. This is completely unacceptable.

Ultimately third party service providers are acting on behalf of a life insurer and representing that insurer to policyholders. It is therefore the life insurer's responsibility to deal with all complaints regarding the service being provided on their behalf. We also note that General Insurers have committed to dealing with all complaints about Service Providers in Section 6 of the GICOP. We therefore recommend removing the words:

> *"if has already been addressed by the Third Party Service Provider."*

Standards for Investigators

We recommend that the standards set for investigators be bolstered. Consumers hold serious concerns with respect to the process of investigation including poor communication practices, aggressive or unethical investigator behaviour or investigation processes, unreasonable requests for information and/or documentation and the ongoing pursuit of investigations with little or no evidence.

The Victoria Workcover Authority has developed a Code of Practice for Private investigators that seeks to address many of the issues policyholders have with investigator behaviour.[75] NSW Motor Accidents Authority too has a Code of Conduct for Claims Assessors[76] and Claims Handling Guidelines for CTP insurers.[77] Given the particular concerns in this area and the precedent set by the Victorian Workcover Authority and the NSW Motor Accidents Authority, cl. 9.8 of the LICOP should include the following:

- a commitment to standard, clear and thorough communication practices to policyholders subject to investigation including:
    - investigators fully identifying themselves and on whose behalf they are acting;
    - investigators explaining the exact reason for contacting the policyholder;
    - investigators leaving a business card if the policyholder is unavailable;
- setting standards and behaviours expected to be upheld in organising and conducting interviews including:
    - providing the policyholder with their choice of venue;
    - a limit on both the duration of an interview and the number of interviews, that is no more than two interviews of two hours each;
    - the right to request breaks;
    - the right to a shorter interview to meet responsibilities;
- the right of the policyholder to be accompanied by an independent support person;
- the right of the policyholder to an interpreter where appropriate;
- the right to being interviewed by an investigator of the same sex;
- only recording an interview with the permission and authorisation of the policyholder;

[75] Victorian WorkCover Authority, Code of Practice for Private Investigators Version 2.0, Effective 1 November 2014, https://www.worksafe.vic.gov.au/__data/assets/pdf_file/0004/8707/VWA-Code-of-Practice-for-PIs-Final-Authorised-2014.pdf

[76] http://www.maa.nsw.gov.au/media/publications/for-professionals/Claims-Assessor-Code-of-Conduct-2013-to-2016MAA292.pdf

[77] http://www.maa.nsw.gov.au/media/publications/about-us/maa-claims-handling-guidelines

- if an investigator knows that a policyholder is legally represented, it must make all reasonable efforts to contact the legal representative to obtain consent to interview the policyholder;
- ensure that if an investigator does not know whether a policyholder is legally represented, it must first ask the policyholder if they are legally represented;
- a commitment to comply with any reasonable restrictions placed on the interview by the interviewee and/or their legal representative;
- compliance with all state and federal surveillance and privacy laws;
- stricter surveillance commitments to ensure that an investigator:
    - does not conduct surveillance on business premises;
    - does not communicate with a neighbour, work colleague or other acquaintance of a policyholder, in a way which might directly or indirectly reveal that surveillance is being, will be, or has been conducted or imply that the policyholder is involved in dishonest conduct;
    - does not record film inside any court, tribunal, conciliation or mediation service or centre, or any other quasi-judicial facility;
    - does not record film inside any medical or health service or centre;
    - avoid any act or behaviour which might unreasonably interfere with a person's legitimate expectation of, or right to, privacy including but not limited to the recording of family or friends, the recording of someone within their residential premises, within change rooms, showers, toilets bedrooms, lactation rooms, swimming pools, gyms, educational facilities or at religious or ceremonial occasions;
- in mental injury claims, insurers commit to the use of only investigator with a minimum of 5 years relevant experience and who has completed appropriate training;
- a prohibition on any form of pretext activity, that is, any conduct or communication that conceals the true reason for that activity;
- a prohibition of entrapment or the use of dishonest or illegal means including any attempt to induce a policyholder to enter into a situation in which that person would not ordinarily enter;
- a prohibition on making any threat or promise, or offer any inducement to *any* person when conducting an investigation;
- a prohibition on seeking or accepting from, or offer to, any person any gifts, benefits or rewards in connection with an investigation, other than modest hospitality such as light refreshments; and
- maintaining and keeping written contemporaneous records of all investigation activities (including conversations held in person; telephone conversations, unanswered calls and messages left, letters and other correspondence; travel, statements obtained and electronic checks including on government and social media sites) and retained for 7 years.

We also support the recommendation made by the Australian Lawyers Alliance in its submission with respect to cl. 9.8 regarding the life insurer having a reasonable basis for believing that the policyholder has given inconsistent information to it on a claim. This

reasonable basis must be held prior to initiating surveillance and not be based on an unconfirmed suspicion which the life insurer hopes to later confirm though surveillance.

Information and Education

Clause 10.1 states that subscribers will:

> *make our customers aware of the Code, which may include providing information about the Code on our websites and in our product information where it is appropriate to do so.*

We cannot think of a time when it would be inappropriate to make customers aware of the Code. We therefore recommend the removal of the words "where it is appropriate to do so."

Clause 10.4 states that

> *The FSC may develop guidance documents from time to time, which are not binding on us but assist us in meeting our obligations under the Code.*

We believe there is no point to developing guidance documents that are not binding. It is therefore a meaningless clause with no commitment whatsoever. We also note that this non-binding nature is not included in the equivalent clause under the GICOP cl.11.3. We recommend replacing the words "which are not binding on us but" with the word "to".

The GICOP also includes clauses relating to the reporting of any recommendations on the Code (cl. 11.4) and initiating programmes to promote literacy and education (cll. 11.8 and 11.9). We cannot see any reason why these would not be supported by the life insurance industry. We note that ASIC RG 183.78 (f) and (g) state that:

> *The Code administrator should also be responsible for…*
>
> > *(f) recommending amendments to the code in response to emerging industry or consumer issues, or other issues identified in the monitoring process;*
> >
> > *(g) ensuring that the code is adequately promoted*

We therefore recommend the insertion of the following three clauses:

> *The Life CCC may include any recommendations on Code promotion in its quarterly reports to the FSC Board.*
>
> *We will work with the FSC to initiate programmes to promote insurance, financial literacy and the insurance industry, and we will support FSC initiatives aimed at education on general insurance.*
>
> *The Life CCC may include any recommendations on education relevant to the operation of this Code in its quarterly reports to the FSC Board.*

Code Governance

Role of FSC

Clause 11.2 asserts that the FSC is responsible for "commissioning formal reviews of the Code." It is important that these reviews are conducted by an independent party and not simply the FSC or related organisation. We note that the equivalent clause under the GICOP (cl. 12.7) does involve "independent reviews". There is no reason why this cannot be the same here. To do otherwise would not meet the minimum standard set by ASIC RG 183.82-85 which requires reviews of a Code to be independent. We therefore recommend amending this clause to ensure that reviews are conducted by independent parties.

Furthermore the Code should include the ability for the FSC to develop the Code on an ongoing basis in consultation with consumer groups and other stakeholders, similar to clause 12.8 of the GICOP. We recommend the inclusion of the following words in the Code:

> *In addition to formal independent reviews of this Code, the FSC will consult with the Life CCC, FOS, consumer and industry representatives, relevant regulators and other stakeholders to develop this Code on an ongoing basis*

Monitoring, enforcement and sanctions

Our responsibility

Clause 12.7 asserts that subscribers will:

> *apply fair and reasonable corrective measures within set timeframes, in consultation with the Life CCC, in response to a Code breach.*

We note that the equivalent GICOP cl. 13.6 ensures that corrective measures will be *agreed with* the CGC – not *in consultation*. By including the words "in consultation" there is no compulsion upon the subscriber to come to an agreement with the Life CCC when instituting corrective measures. This indirectly undermines the binding nature of the Code. We therefore strongly recommend that the words "in consultation" be removed and replaced with "as agreed."

Life CCC Responsibility

It is our view that there should be a statement in this section that explicitly states the following:

> *The Life CCC is responsible for monitoring and enforcing compliance with this Code*

We are also concerned with some of the wording found in this section. Firstly cl. 12.8(c) states that the Life CCC will "use its discretion to investigate alleged breaches in accordance with the Code." This should not be a sweeping discretion and should only be used in the case where the allegation is clearly frivolous. Otherwise the Life CCC should investigate every alleged breach in accordance with the Code.

Secondly, the Life CCC will "agree with [the subscriber] any fair and reasonable corrective measure(s) to be implemented by [the subscriber]". This suggests that the Life CCC would not be able to impose any sanction unless the life insurer agrees on the sanction. If this is a correct reading this should be re-worded to ensure that a life insurer cannot escape an appropriate sanction from an independent committee. We also note that the words "fair and reasonable"

are not found in the equivalent clause 13.9(c) in the GICOP and, when combined with the previous observation, looks to be a potential subjective judgement to further avoid potential corrective measures and relevant timings.

Thirdly, this same subclause includes the words "taking into account any corrective measures related to the breach agreed with us or imposed on us by any regulatory body." This too has the potential to lower or avoid a corrective measure on the basis that life insurers have been directed elsewhere. We recommend its removal.

Finally, we recommend that the Life CCC be empowered to provide recommendations on Code improvements to the FSC board, just as the CGC is empowered to do under GICOP cl. 13.10. This is an important power to ensure that the life insurance Code is a living document that responds to issues that arise. We therefore recommend the insertion of a cl. 12.10 that states:

> *The Life CCC may provide any recommendations on Code improvements as a response to its monitoring and enforcement, in its quarterly reports to the FSC Board.*

Sanctions

We note similar to cl. 12.8 the phrases:

> *"any measures related to the breach agreed with us or imposed on us by any regulatory body;"*

and

> *"taking into account any rectification related to the breach agreed with us or imposed on us by any regulatory body"*

appear in cll. 12.13 and 12.16 in relation to the determination of sanctions. Neither phrase appears in the equivalent GICOP clauses. We are concerned that these will be used to avoid the imposition of effective sanctions with claims that the life insurer has already had a sanction or recitation imposed upon them elsewhere. We therefore recommend their removal.

Access to information

Under cl. 13.4 the draft Code lists those special circumstances that subscribers may decline access to or disclosure of information. Included at 13.4(f) is:

> *"where we reasonably believe that the information is commercial-in-confidence."*

We do not support the inclusion of this subclause. Anything and everything can be deemed commercial-in-confidence from the way an investigation is conducted to a proprietary form of document storage or handling. It is unreasonable to deny access to information on this ground and denies consumers natural justice. We note that this clause does not appear in the equivalent clause in GICOP: cl. 14.4. There is no significant qualitative difference between the general insurance sector and the life insurance sector that would necessitate or justify its inclusion in a final LICOP. This should be removed.

At cl. 13.5 when a subscriber declines a claim the draft Code commits the subscriber to "provide details of our Complaints process if you are unsatisfied with our response." This unreasonably places the burden on the consumer to inform the life insurer that they are unsatisfied before they receive the information regarding their complaints process. We are of the view that this information should be provided in all circumstances as a matter of course. This is what occurs in the general insurance sector as per GICOP cl. 14.5. Again we see no reason why this should be any different in the life insurance sector.

Clause 13.6 states that if a consumer requests any of their policy documents from their life insurer, the subscriber will provide this to the policyholder "promptly and in an electronic form" if they request. "Promptly" is far too vague and subjective. We recommend that this be within one business day.

Furthermore life insurers should commit to providing policyholders with a copy of the applicable underwriting guidelines that were in operation at the time the insurance contract was entered into and a supporting statutory declaration as per the Australia Lawyers Alliance submission. This would be consistent from the FOS Circular regarding the Duty of Disclosure regarding insurance contracts.[78]

Financial Hardship

A major omission in the draft Code is any consideration of Financial Hardship. This is a key concern of our clients who generally face significant financial pressures and hardship. It is unclear why a Financial Hardship section has not been included in the draft. Addressing the financial hardship of customers in appropriate ways has become standard operating practice for the banking, utilities and general insurance industries. It is important that the life insurance industry also address this issue within its code of practice. While section 8 of the General Insurance Code deals largely with financial hardship issues with respect to monies owed to an insurer, it can act as an example of the type of commitment that the FSC should make in its own Financial Hardship section.

We recommend addressing a number of issues. Firstly, as outlined above, income protection insurance payments are often a policyholder's only source of income. Withholding these payments in the circumstances of a claims investigation can have a significant financial impact upon the policyholder. We understand that in a number of cases life insurers pay a portion of the income protection payments to assist those experiencing financial difficulty whilst an investigation is taking place. This would meet an insurer's duty of utmost good faith. We believe that this should be acknowledged and consideration should be included in the Code.

We also reiterate the need to consider the fast-tracking of assessments, where possible, for those claimants who have urgent financial need. Clause 7.7 of the GICOP provides a good basis from which this Code can draw.

Finally, any hardship section in a LICOP should apply to customers who are having difficulty paying premiums. We note that there are a significant proportion of policyholders who have a premium waiver option included in their policy. This is an important protection in times of

[78] https://www.fos.org.au/circular3/Nondisclosure.html

illness, injury and financial hardship. In many cases the policyholder is unaware that they have a premium waiver option and have subsequently sought a replacement policy when hard times have hit. Life insurers should commit to ensuring that these policyholders are aware of this option and any other options available before replacing their coverage. This could involve a commitment to providing this information on renewal notices and conducting semi-regular reviews of older policies.

Problem products and sales practices

There is now ample evidence about consumer problems with funeral insurance[79] and consumer credit insurance.[80] It is time for the life insurance industry to acknowledge those problems and commit to either improving the value of these products or stop selling them.

As a start, we recommend the Code commits insurers to:

- addressing the high lapse rate of funeral insurance products by
    - capping premiums at the benefit amount, and applying the caps retrospectively;
    - providing real responses for consumers who buy funeral insurance and later struggle to make payments because of financial hardship;
    - not selling funeral insurance cover without first making a proper assessment of whether the customer can afford the cover;
    - giving a proper explanation of how the cost of a funeral insurance premium will change over the life of a policy. This should involve customers having access to standard, interactive modelling software that shows them how much their product will cost over the life of the policy;
- immediately stop sales of funeral cover for people aged under 18; and
- stopping allowing any life cover to be sold through the 'add-on' sales technique;
- not allowing products to be sold through pressure sales techniques, by preying on guilt and anxiety or any other sales tactics that are legally or ethically questionable. Insurers should make their sales scripts publicly available to prove that they are making an effort to improve sales processes.

[79] Most recently, see ASIC Report 454, *Funeral Insurance: A Snapshot*, 29 October 2015 *http://asic.gov.au/regulatory-resources/find-a-document/reports/rep-454-funeral-insurance-a-snapshot/*

[80] See ASIC reports 256: *Consumer credit insurance: A review of sales practice by authorised deposit taking institutions*, 19 October 2011 http://asic.gov.au/regulatory-resources/find-a-document/reports/rep-256-consumer-credit-insurance-a-review-of-sales-practices-by-authorised-deposit-taking-institutions/ and ASIC Report 361: *Consumer credit insurance policies: Consumers' claims experiences*, 31 July 2013, http://asic.gov.au/regulatory-resources/find-a-document/reports/rep-361-consumer-credit-insurance-policies-consumers-claims-experiences/ and Consumer Action Law Centre's *Junk Merchants* report, December 2015 http://consumeraction.org.au/junk-merchants-report-how-australians-are-being-sold-rubbish-insurance-and-what-we-can-do-about-it/

Definitions

The definition of "Significant Breach" in this draft Code is almost exactly the same as that found in the GICOP except that the draft LICOP definition has removed "duration of the breach." We recommend including "duration of the breach" since this is an important factor in determining significance.

Concluding Remarks

Thank you again for the opportunity to comment. If you have any questions or concerns regarding this submission please do not hesitate to contact us on the details below.

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