FACTSHEET

consumer action law centre

Claims handling

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Claims handling in the wake of a climate disaster

After a catastrophic event, like a bushfire, storm or flood, a policyholder (**client**) may need to make a claim on their policy of insurance (**policy**), for example on their home insurance policy.

Lodging an insurance claim following an extreme weather event can be a complex and challenging process to navigate. Clients often report that the experience is emotionally draining, especially as they are trying to juggle the claim process during a time when their life has been upended.

There can be lengthy delays if a client's property has been damaged in a large scale natural disaster where damage and loss is widespread generating large number of claims.

Climate change and pollution are exacerbating factors driving increasingly extreme and erratic weather patterns globally. For example, more than 9,000 claims were lodged following Tropical Cyclone Alfred in early 2025, which left thousands in South East Queensland and the North Coast of New South Wales having to repair their property.

However, clients should be reassured that there are statutory and industry-implmented consumer protections in place. These are standards which insurers must meet when providing services to clients, such as being open, fair, honest and timely.

Clients' rights when making a claim on their insurer

Insurers are subject to statutory obligations (that is, legislated rules written by Parliament) and industry codes (that is, rules which insurers write and enforce themselves), to protect their clients' rights.

Statutory obligations

The *Insurance Contracts Act 1984* (Cth) (**the ICA**) is Federal legislation that provides the basic framework governing all consumer insurance contracts, as well as setting out both clients' and insurers' rights under a contract of insurance. It is legislation that was designed to strike a fair balance between insurers, policyholders and the public in general.

There are specific provisions in the ICA which impose an onus on insurers to take steps to ensure consumers' rights are protected when a claim is lodged under an insurance policy. A key provision is section 13, which is known as the duty of utmost good faith. Relevantly it states that:

(a) In every contract of insurance there is an implied term that each party, so the insurer and the insured, will act towards each other in relation to any matter in relation to that insurance contract with the utmost good faith;

(b) If an Insurer fails to comply with the provision of utmost good faith then they can be subject to civil penalties in a prosecution brought by the Australian Securities & investments Commission.

Clients are entitled under section 13 to expect that their insurers will:

(a) handle their claims promptly;

(b) promptly and properly investigate claims;

(c) provide clear and transparent communication about a claim;

(d) act reasonably, fairly and in good faith when assessing a claim

(e) act in a manner that is consistent with commercial and community standards of decency and fairness

If an insurer unreasonably delays in assessing and paying out a claim under a policy then the client may be entitled to seek interest on the sum of money owed to them in accordance with section 57 of the ICA.

How the ICA applies to the factual scenario presented by a client can be hotly contested with each claim depending on the facts in that individual case. If an issue arises about the application of the ICA to a client's claim following an extreme weather event, they should obtain advice from a qualified legal practitioner.

Statutory obligations – *cont'd.*

In Australia, most insurers are also required to hold a financial services license because they offer insurance policies, a type of financial product, and because they handle and settle insurance claims which is a kind of financial service[1]. As the holder of a financial services licence, this imposes on an insurer a further obligation under section 912a (1)(a) of the *Corporations Act 2001* (Cth) to do all things necessary to ensure that when handling a claim it does so efficiently, honestly and fairly. This means that they ought to:

(a) assess and resolve claims in a timely way without undue delay;

(b) handle claims in the least onerous and intrusive way;

(c) be fair and transparent providing consumers with information regarding:

   a. the claims handling process;

   b. if an insurer requires more information, the reason that more information is being sought;

   c. if an insurer makes a decision, the reasons for the decision

(d) handle claims in a manner that ensures adequate support is provided to consumers, in particular those experiencing vulnerability such as financial hardship. This is particularly crucial for clients who are trying to have a claim assessed in the aftermath of a natural disaster.

Industry Codes

The *General Insurance Code of Practice* (**the Code**) is a voluntary code which is written by the Insurance Council of Australia. The Insurance Council is a representative body of the general insurance industry in Australia. It provides policy recommendations for the insurance industry and is proactive in coordinating industry and governmental responses to human induced climate change.

The Code applies to all insurers who adhere to it (including the most common insurers). It covers most policies that consumers will purchase, including home and contents insurance. There are some notable exceptions, like domestic building insurance and workers' compensation insurance.

The Code provides a standardised system for how a client makes a claim.

When a client makes a claim, the insurer must inform them:

1. about their claims processes,
2. about their excess or deductible (the amount a client has to pay before the insurer will pay the rest of a claim),
3. about the time period for settling their claim,
4. about the ways to contact the insurer to discuss the claim.

Because of the prevalence of extreme weather events in Australia, clients can now request insurers to fast-track their claims, where an event (like a bushfire, flood or cyclone) causes the client to be in urgent financial need. Clients might also be able to request an early payment of money under the policy, provided that they can establish they have an urgent financial need.

Clients are entitled to have a decision made about their claim between 10 business days from when the insurer has completed its investigations (which may not be 10 days from the date the claim is lodged) and 4 months from the date the claim is received.

The reasons why a claim decision might be delayed longer than 4 months include where it arises from an 'extraordinary catastrophe', such as a widespread extreme weather event. Clients should understand that they are entitled to communications from their insurer, providing an explanation for when they can expect a decision or information about their insurer's complaints process.

Clients should also understand that their insurers must respond to catastrophes efficiently, professionally, practically and compassionately. Clients should know that they can sometimes request an internal review of a claim decision within 12 months of that decision, if they believe the assessment of their claim was incomplete or inaccurate. This applies even if a client has signed an agreement for the early payment.

1 Since 1 January 2021 claims handling and settling services have been a kind of financial service as defined under s766A(1)(eb) of the Corporations Act 2001 (Cth)

Clients' options for breach of claims handling standards

For significant breaches of the statutory obligations, insurers can sometimes be subject to investigation and enforcement by ASIC. This may include civil penalties for failures in claims handling.

Generally speaking, clients should ensure that they have read their policy and understand its terms before lodging a complaint. If they do not understand the terms, they can either contact their insurer for an explanation or seek the advice of a qualified legal practitioner. Clients should also understand that lodging insurance claims can be complicated. They should not rely on generative AI tools to inform themselves about their rights or protections.

The Code also sets out a standardised, tiered system for clients to complain about the experience of lodging a claim:

A.

Internal Review

A client can lodge a complaint with their insurer themselves. The client can contact their claims manager or the customer relations team to inform them that they would like to lodge a complaint. The contact details of the insurer's customer relations team can be found in their policy, or their product disclosure statement (**PDS**). The complaint will be reviewed by the insurer. The insurer may require additional information from the client to process or understand the complaint. Once the complaint is reviewed, the insurer will inform the client of the outcome of the complaint in writing.

B.

External Review

If the client is not happy with the outcome of the internal review, they can lodge a dispute with the Australian Financial Complaints Authority (**AFCA**). Clients should understand that AFCA has a limited jurisdiction, which means that it can only assist in certain types of complaints. AFCA may review the insurer's decision and has authority to make a binding decision on both the insurer and client (if the client accepts AFCA's determination). Prior to this, AFCA will often attempt to reach a favourable settlement which both parties can agree to.

C.

Litigation

A client can seek legal representation to bring a claim against their insurer for breach of contract or breach of specific statutory duties. This option can be expensive and time-consuming for both client and insurer. Clients should seek formal legal advice before embarking on litigation.