# INTERIM REPORT

*Review of the General Insurance Code of Practice*

Insurance Council of Australia

November 2017

## CEO's Message

The Insurance Council of Australia (ICA) is pleased to present the Interim Report of the Review of the General Insurance Code of Practice (Code) 2017 for consultation.

This targeted review, conducted by the ICA, was launched in February 2017 at the request of the ICA Board. It is intended to ensure the Code remains relevant and a benchmark of industry self-regulation amidst recent external developments impacting the general insurance industry. This is not the first time the ICA has updated the Code in response to external factors. In 2012, the industry promptly addressed key stakeholder issues arising from natural disasters through Code amendments.

The Code represents the general insurance industry's strong commitment to improving consumer outcomes. It commits insurers to mandatory standards of service above and beyond their statutory obligations, and all ICA members offering products covered by the Code must be signatories.

The ICA considers the Code should allow flexibility to adapt beyond regulatory requirements. To this end, the ICA proposes the inclusion of principles and the development of ICA guidance for a number of prioritised areas. The ICA guidance will serve as best-practice examples of how the industry can better serve consumers in many areas.

In developing this Interim Report, the ICA has taken into account detailed stakeholder issues from the ICA's Consumer Liaison Forum, ICA member committees, submissions received from a range of consumer representatives, the Code Governance Committee and the Australian Securities and Investments Commission. The input of all stakeholders was invaluable and the feedback was significant in its breadth. This report addresses the key issues raised, rather than incorporating every detail of every submission.

Based on the feedback received, the ICA has identified a number of priority areas that we believe a revised Code should respond to. These include matters such as disclosure, claims investigations, family violence, how insurers interact with vulnerable customers, and amendments directed at facilitating ASIC's approval of the Code. We are seeking feedback on these priority areas, and ask stakeholders to advise if the ICA has correctly identified the key issues.

In addition to this, a number of other matters have been identified. Due to the volume of suggestions received, we have provided a matrix that seeks to prioritise suggestions based on consumer outcomes and implementation considerations for industry. We ask stakeholders to consider all matters raised. We also propose an extensive consultation period to ensure there is time for proper consideration.

It is important to emphasise that this is an Interim Report only. The ICA encourages further submissions and remains open to revisions and changes. Other inquiries and reviews, such as the Treasury Review of Industry Codes, may create a level of uncertainty or provide additional insights into Code improvements.

Alongside a call for further submissions, the ICA will conduct issue-specific workshops with stakeholders to further discuss the practical impacts of the proposals raised in this Interim Report.

The ICA appreciates your input and looks forward to working collaboratively with stakeholders to enhance consumer outcomes under the Code.

Robert Whelan, Executive Director & CEO

INSURANCE COUNCIL OF AUSTRALIA

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# 1. Executive Summary

***ICA proposals***

Following review of stakeholder submissions and discussions with industry, the ICA has identified key areas that we consider to be priority matters for consumers of general insurance products. The ICA suggests that the Code Review prioritises these key areas.

We have provided more detail under section 3 as to why we have identified each area as a priority. For some issues, in addition to a Code response, further industry initiatives will be needed. We welcome your feedback on these priority areas and the best method for their implementation.

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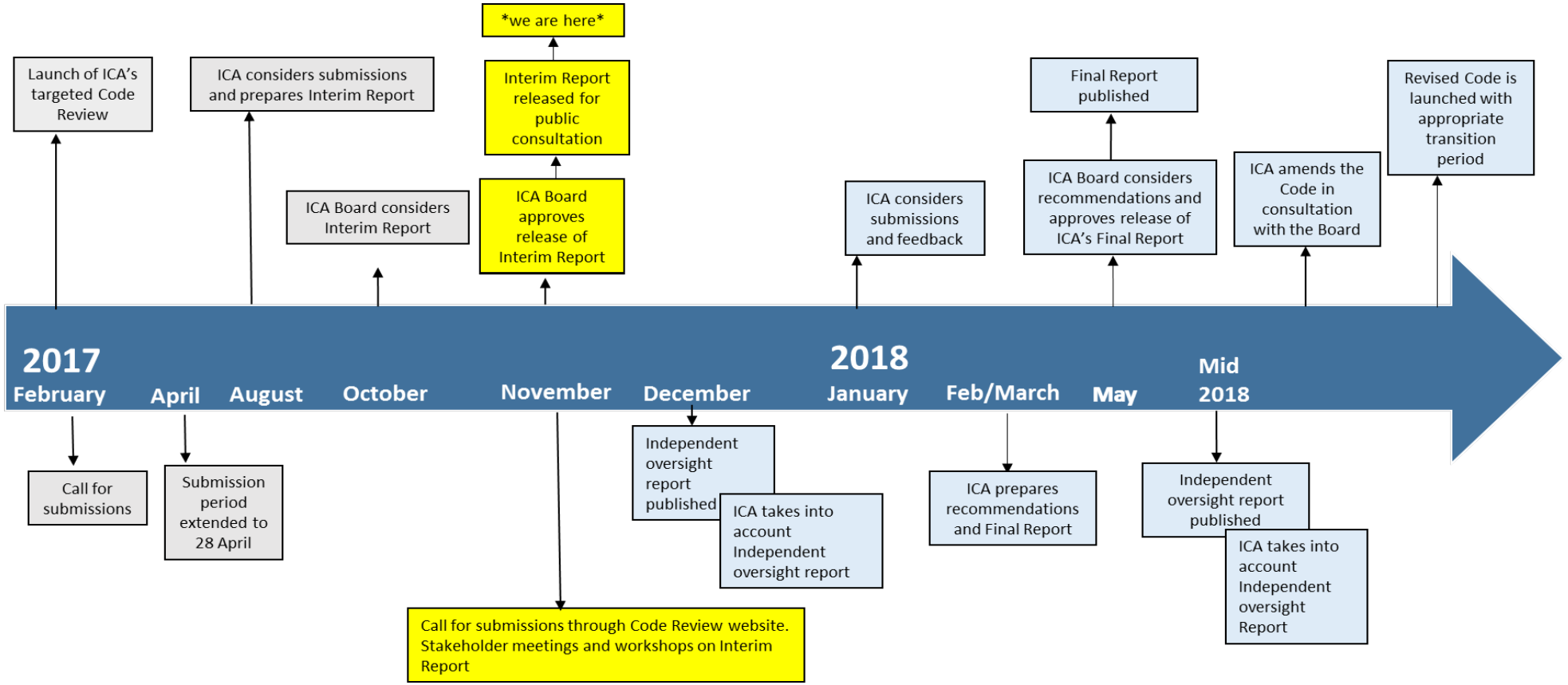
| Proposal 1 | **The Code should strengthen standards relating to vulnerable consumers including:**<br>• **A new Code section on vulnerable consumers**<br>• **The provision of guidance on best practice mental health principles**<br>• **The provision of guidance on recognising and responding to instances of family violence**<br>• **Stronger Code standards on financial hardship** |
| Proposal 2 | **The Code should provide guidance on best practice disclosure principles** |
| Proposal 3 | **The Code should include product design and distribution principles and provide guidance to insurers** |
| Proposal 4 | **The Code should provide product design and distribution guidance specific to add-on insurance products** |
| Proposal 5 | **The Code should strengthen standards relating to third-party distributors** |
| Proposal 6 | **The Code should strengthen standards relating to Service Suppliers** |
| Proposal 7 | **The Code should include mandatory standards for Investigations** |
| Proposal 8 | **The revised Code should meet the requirements for ASIC approval** |

***Additional Code Review Themes***

In addition to these priority areas, a number of other issues have been identified by stakeholders. We have categorised these into 11 different themes. A summary can be found at section 8 of this Report.

## 2. Review Pathway



## 3. ICA Priority Code Review Proposals

**Proposal 1: The Code should strengthen standards relating to vulnerable consumers**

**Specifically, the ICA proposes that the Code should:**

a. **include a new section on vulnerable consumers**
b. **provide guidance on best practice mental health principles**
c. **provide guidance on recognising and responding to instances of family violence**
d. **include stronger standards on financial hardship**

***(1A) Including a new section in the Code on vulnerable consumers***

The ICA agrees with submissions that the Code Review is an opportunity to improve standards for how industry interacts with vulnerable consumers. We propose that the revised Code includes a new section to detail this.

Many of the submissions focused on the needs of vulnerable people, and highlighted community expectations that insurers could do more to support and protect their customers.

Submitters noted that consumers may have a degree of vulnerability when interacting with an insurer, due to factors and circumstances including age, disability, mental health, living in a remote Indigenous community, coming from a non-English speaking background, or experiencing trauma, abuse or disadvantage including family violence. This vulnerability may impact on their ability to communicate with an insurer, access insurance, or make a claim or complaint.

ASIC suggested that the Code could clarify the role of formal and informal third parties, especially for customers who may require additional support. As an example, ASIC submitted that processes to recognise a third party authority to act on behalf of a consumer should not be an impediment to fair and practical support for consumers.

Question 1: The ICA suggests that the Code could include a new section on vulnerable consumers. The section would begin with a statement acknowledging the diverse needs of vulnerable people and committing to supporting the particular needs of customers where these are identified. Please identify any concerns or suggestions for improvements with this approach.

Question 1.1: It seems reasonable that the Code should require insurers to accommodate vulnerable consumers' requirements for formal or informal assistance from third parties. Please detail any concerns with this suggestion.

a. Staff training:

The ICA acknowledges that in order to identify and engage with vulnerable consumers, staff are required to be appropriately trained. The ICA's view is that the Code cannot be overly prescriptive, as the level and type of training will depend on the employee's role. However, while we do not expect call centre staff to be counsellors or advisers, they should recognise when (for

example) someone requires an interpreter, or how to identify when a customer's issue requires escalation to someone equipped to respond appropriately.

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| Question 1.2: The ICA suggests that the Code should require staff to be trained to identify and engage appropriately with vulnerable consumers, and to escalate requirements for additional support. Are there any implementation factors that need to be considered? |

b. Improving insurance access

Some of the submissions suggested that the Code could require insurers to provide more tailored policy options to ensure all consumers can access products that meet their needs in an affordable manner. As an example, ASIC suggested that the Code contain a commitment to developing suitable products that cater to the needs of older Australians (i.e. travel and volunteer insurance).

Broadly, it is the ICA's view that the role of the Code is not to determine the products that insurers must offer, as product development is a commercial decision. The industry will respond where it sees a market for a product. As an example, the ICA's Find an Insurer website lists a number of insurers who provide Seniors Travel Insurance.[1]

Submitters also suggested that the Code should consider consumer needs for flexible payment options, such as payment through Centrepay as well as fortnightly instalment payments "*without penalties*".

Payment through Centrepay is offered for at least one low-income product on the market. Insurers that offer payment through Centrepay have advised that it can be an administratively burdensome process, and may not be an appropriate requirement for all products.

The ICA is aware of at least one insurer who offers fortnightly payments, and whose website makes it clear that paying by instalments will attract a higher total premium. Other insurers have provided feedback that their systems are not currently set up for fortnightly payments, and this would require a new system build.

The ICA understands that fortnightly premiums will need to take into account the associated risk, the likelihood of default, and the additional administration of processing twice as many payments. Insurers have noted that this pricing of premiums is not a "penalty" but a part of underwriting.

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| Question 1.3: The ICA suggests that the Code should not prescribe specific products or payment arrangements, such as through Centrepay. However, Proposal 3 sets out product design principles for the Code. How could these principles improve product design for vulnerable consumers? |

[1] http://www.findaninsurer.com.au/category/12014.

c. Identification requirements

The Code of Banking Practice and the Life Code provide for assistance to be given to those who have difficulty meeting identification requirements. This may apply to people who have been raised in remote communities or in countries that did not provide legal identification documents.

Question 1.4: The ICA suggests that the Code should require insurers to provide assistance to those who have trouble meeting identification requirements. Please identify any concerns you may have with this approach.

d. Use of interpreters

The Financial Rights Legal Centre (Financial Rights) submission has suggested referring to the Commonwealth Ombudsman best-practice principles for the use of interpreters.[2] The key points are included below:

- Provide fair, accessible and responsive services. Provide an interpreter to facilitate communication wherever necessary. This includes whenever one is requested by a client, or whenever the staff member needs one to communicate effectively with a client (whether formally or informally).
- Maintain good records. Staff should record clients' interpreter needs in the agency's system and plan ahead to meet client needs. Where an interpreter is offered but declined by the client, this should also be recorded. Staff should be flexible enough to arrange an interpreter if it becomes apparent that assistance is required.
- Promote access to interpreter services. Provide a direct link on the website home page to information on interpreter services and other relevant information for non-English speakers, including information translated into other languages.

The Commonwealth Ombudsman best-practice principles note that the use of friends and family members as interpreters should be avoided. Some insurers have advised that in situations in which a customer wishes to use a friend or family member as an interpreter, and the staff member is comfortable with this, then it should be accommodated.

Question 1.5: Noting the Commonwealth Ombudsman best-practice principles, and the point raised by some insurers, would the following principles satisfactorily reflect best practice standards for the use of interpreters?

a) Insurers must provide access to an interpreter, either when one is requested by the customer or when a staff member needs one to communicate effectively with a customer (whether formally or informally).
b) Staff must make a record of a customer's interpretation needs and plan ahead to meet these needs. Where an interpreter is offered but declined, staff must also record this.
c) Insurers must provide a direct link on their website to information on interpretation services and any other relevant information for non-English speakers. This includes any product information that insurers have translated into other languages.

Do you have any concerns with this approach or suggestions for improvement?

[2] http://www.ombudsman.gov.au/__data/assets/pdf_file/0014/35600/Use-of-interpreters.pdf.

### *(1B) Providing Code guidance on best practice mental health principles*

a. Principles to inform best practice

The ICA has developed a draft document of best-practice mental health principles. This draft document is designed to encourage continuous progress by industry in expanding access to general insurance for consumers with mental illness. We suggest that this document could be used to provide guidance on best practice mental health principles to Code Subscribers.

The principles address the issues raised in this section and by submitters, including:

- risk assessment of mental illnesses should be centred on reliable, evidence-based data and objective assessment
- where possible, insurers should seek to provide cover and manage risk through pricing, exclusions, limits and caps, rather than not provide cover at all
- as data becomes more available over time, insurers should move away from blanket exclusions and apply narrower exclusions
- exclusions for pre-existing mental illnesses should only be applied where there is evidence that an applicant has, or is at risk of a recurrence of, a mental illness and the covered event relates to the pre-existing mental illness
- staff training should increase awareness and understanding of common mental illnesses, and develop communication skills for interacting with consumers who have, or show signs of having, a mental illness.

The principles have been detailed in Appendix 1, and the ICA welcomes your feedback on this document.

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| Question 1.6: The ICA proposes that the mental health best-practice principles (detailed in Appendix 1) should be developed into an ICA guidance document. Do the principles adequately respond to the issues raised by stakeholders? Are there any matters that have not been addressed? |

b. Discrimination

The Disability Discrimination Act 1992 (DDA) prohibits insurers from discriminating against a person on the basis of their mental health condition unless the discrimination is reasonable having regard to:[3]

a) actuarial or statistical data that is reasonable for the insurance provider to rely on and all other relevant factors; or

b) in a case where no such actuarial or statistical data is available, and cannot reasonably be obtained, any other relevant factors.

The Public Interest Advocacy Centre (PIAC) has recommended that the Code contain details of insurers' obligations under the DDA and guidelines on what is required for insurers to lawfully rely on the exemption above. The ICA's view is that, ideally the Code should not undertake the

[3] Section 46, Disability Discrimination Act 1992 (Cth).

role of legal interpretation. We believe the relevant regulator is best placed to provide instruction on this. We discuss this view further in Section 4(x), Code scope, and we welcome stakeholder feedback on this perspective.

However, the Code could contain a statement explaining how underwriting decisions are made. PIAC has also suggested some relevant factors that insurers may take into account when considering the risk of someone's mental health condition:

- medical opinions
- information which is relevant to the particular individual seeking insurance cover, including:
    - the type of disability the person has
    - the severity of the disability
    - the function impact of the disability
    - treatment plans
    - the person's employment records
- the practice of others in the insurance industry
- actuarial advice

Question 1.7: The ICA's view is that the Code should not contain guidelines for complying with the DDA. However, the Code could include a statement explaining how underwriting decisions will be made. For example:

a) Decisions will be evidenced based;
b) Underwriting decisions will be regularly reviewed to ensure decision making is not relying on out-of-date information.

Is this a suitable alternative? Are there any issues or concerns with this approach?

c. Provision of data

Where an insurer relies on the DDA in order to make a decision in relation to a person with a mental health condition, many of the submitters pointed out that it can be difficult for that person to gain access to the data or information relied on by the insurer. PIAC has pointed out that the "*lack of transparency can at times operate to reinforce discrimination against people with mental illness and limits the ability of applicants to seek review of an insurer's decision to deny their claim*."

The ICA acknowledges that while the actuarial or statistical data insurers rely on might be complex, and possibly commercial-in-confidence, insurers could provide a summary in plain language that specifies the type of data relied on and why that data is relevant to the decision.

Question 1.8: Should the Code require insurers to provide, on request, a summary of the type of data or a description of the relevant factors relied upon, and why that data or those factors are relevant, when they rely on the DDA to make a decision about the provision of insurance or about a claim? What are the strengths or weaknesses of this approach?

d. Mental health exclusions

PIAC has noted its concern that "*insurance products which include broad mental health exclusions are being designed based on outdated understandings of mental health conditions which lump unrelated mental health conditions in one category. This approach fails to recognise that mental illness occurs on a spectrum from the very mild to the very serious...*"

The ICA considers that the ultimate position when taking into account mental health in underwriting is for an exclusion to be sufficiently granular. This will ensure that the exclusion reflects the actual risk represented by the particular condition.

The ICA is currently evaluating whether an ICA-led program of data collection and analysis for mental health claims in travel insurance is necessary in order to facilitate improved access for people with a mental illness. Whether undertaken individually by members, or collectively by the ICA, as data becomes available over time, insurers will be in a position to provide narrower exclusions.

It is worth noting that two travel insurers who are ICA members have recently announced that they have removed blanket exclusions for mental health conditions from their travel insurance policies.[4]

### *(1C) Providing Code guidance on recognising and responding to instances of family violence*

The ICA has received submissions from the Economic Abuse Reference Group and WEstjustice. These detail a number of complex insurance issues created by situations of family violence and economic abuse. Family violence is not limited to physical instances of violence. It may also include psychological and financial abuse, and damage to property.

The issue of family violence was also raised as a key priority area by the ICA's Consumer Liaison Forum (CLF) [5]. The CLF recommended that the ICA should develop industry guidelines for recognising and responding to instances of family violence for inclusion in the Code Review. When developing these guidelines, the ICA should draw from guidelines and initiatives underway in other sectors

The ICA has developed a draft family violence guidance document which is detailed in Appendix 2, in consultation with members and a number of parties with expertise in this area. This outlines the issues and areas that insurers could consider in developing their own family violence policies.

If a co-insured or joint owner of a property is found to have intentionally caused property damage, current Australian law precludes the victim from recovering even a portion of any payout. The ability to purchase insurance via telephone can result in scenarios where a

[4] http://www.smh.com.au/business/consumer-affairs/travel-insurance-providers-remove-mental-health-illness exclusions-20170704-gx4514.html.

[5] The CLF was formed in early 2017, and is made up of consumer representatives and an independent chair. It acts as a conduit for key consumer issues to be raised with the ICA Board, with a view to collaboratively designing practical industry responses. The CLF recommended that the Code include standards relating to family violence as well as add-on insurance and claims investigations (discussed in later sections of this report).

perpetrator of family violence is able to insure a jointly owned property in their name alone (allowing them to be the sole recipient of any claim payment), and can also cancel a joint policy without the victim's knowledge. Generally, this is a matter of convenience; however, in a situation of family violence the impact can be disastrous.

Many of the issues and case studies raised by submitters involve complex, difficult legal questions about the intersection of insurance law, family law, property law and privacy. The ICA has engaged the assistance of insurance law expert, and former independent reviewer of the Code, Ian Enright, to facilitate discussions between insurers, experts working in family violence services, and legal services. These discussions aim to determine how the industry can appropriately deal with issues such as:

- The impact of a party's non-disclosure on an innocent co-insured
- The impact of someone deliberately causing damage to a partner or ex-partner's property, and the ability to make an insurance claim
- The ability for a perpetrator to cancel an insurance policy without the victim's knowledge
- Whether a valid claim may be paid to the perpetrator alone if the insurance is in their name
- Whether a policy can be taken out in one party's name, even if multiple names are on the property title

The ICA considers that many of these issues will not have short-term solutions, and will require insurers to alter the terms and conditions of their policy documents. The ICA and members will continue to work with family violence experts to address the complex legal issues raised in situations of family violence and will report back to the CLF on our progress. While the ICA continues to work through the difficult areas of law contemplated above, we suggest that insurers acknowledge the fact that cases involving family violence require particular care and flexibility. Staff should be trained to recognise and appropriately respond to these cases.

Question 1.9: The ICA proposes that the family violence document attached in Appendix 2 be developed into an ICA guidance document. Does the document adequately respond to the issues raised by stakeholders?

Question 1.10: Does it appropriately capture the areas that an insurer should include in their family violence policy?

### *(1D) Including stronger Code standards on Financial Hardship*

Consumers experiencing financial hardship are often vulnerable individuals. The ICA recognises that processes for dealing with financial hardship assistance requests should be responsive, flexible and fair.

a. Awareness and identification

The ICA's view is that insurers must ensure their staff and Service Suppliers understand their Code obligations in relation to people experiencing financial hardship. This is particularly important for front-line staff who are usually a customer's first point of contact when lodging a claim and are likely to inform them that an excess is payable.

A number of submitters asserted that the onus should not just be on the consumer to raise financial hardship. Submitters suggested that the industry can work with experts to determine a non-exclusive list of identifiers for staff to be aware of, such as where Centrelink is the consumer's sole source of income. Suggestions also included for the Code to require training of employees, and relevant Service Suppliers (such as collection agents and claims management services) to identify and respond to financial hardship.

It was suggested that insurers should be required to inform individuals from whom they are seeking recovery about the availability of financial hardship assistance. Information about the ability to request financial hardship assistance could be included on debt recovery letters.

The ICA understands that this may be challenging for insurers on the basis that it could be seen as nudging someone towards requesting assistance in order to not be required to pay their debt. However, the individual would still need to provide evidence that they are actually in financial hardship as part of the process.

The Code Governance Committee (CGC) noted that it is not unusual for a consumer in hardship to independently contact a Code Subscriber even though they have a representative who is actively involved in the management of their case.

The CGC's position is that if a represented consumer in hardship initiates contact with a Code Subscriber about their matter, it should always notify the representative that such contact has occurred. This ensures that the representative is aware of the contact and in particular the nature of the discussions. The ICA notes that this may have privacy implications, as an insurer is likely to need the consumer's approval before sharing any information with a third party.

Question 1.11: The ICA suggests that the Code should require insurers and Service Suppliers to receive training on their obligations with regard to consumers in financial hardship, and to identify signs of financial hardship when engaging with individuals who owe money to an insurer. Are there any implementation factors to consider with this approach?

Question 1.12: Noting that an individual will still have to provide evidence of actual financial hardship, are there any practical implications to consider, if the Code were to require debt recovery letters to include information about the financial hardship process?

Question 1.13: Should an insurer who is contacted directly by a consumer in hardship, who is aware that the consumer has a representative, always be required to notify the representative that such contact has occurred? If there are any privacy implications, please detail them. Are there any alternative solutions?

b. Timeframes

The Code expects insurers to respond quickly and appropriately to consumers who have requested financial hardship assistance. In order to provide flexibility, the Code standard is for assessments to be made "*as soon as reasonably practicable*".

The Code does not define what "reasonably practicable" means, or specify a timeframe for assessing a hardship request. The CGC has noted that this can cause timeframes to vary dramatically between insurers. Submitters also identified a need to clarify how long an insurer

should wait to receive requested information from a consumer before making a determination about financial hardship.

The National Credit Code sets out timeframes that apply to credit providers' consideration of consumer requests for hardship assistance.

The CGC also suggested that insurers must:

- only ask consumers to provide information genuinely necessary to assess their application for assistance
- identify as soon as possible what further information is needed and request it
- ensure that any request for information does not unreasonably or unnecessarily delay the assessment of the hardship request, if the information initially provided is insufficient.

Question 1.14: It has been identified that timeframes for assessing hardship requests vary among insurers. If the Code required that financial hardship applications should be processed in line with the National Credit Code, would this be a satisfactory solution? Is there another preferable way to address this matter? The timeframes would require that:

a) The insurer will assess an application for hardship assistance and inform the consumer of its hardship decision within 21 calendar days, or inform them that it needs more information.
b) If the insurer needs more information, the consumer has 21 calendar days to provide it.
c) Within 21 calendar days of the consumer providing the requested information, the insurer must make its hardship decision and inform the consumer of its decision.
d) If the consumer fails to provide the requested information, then the Code Subscriber must make its hardship decision on the information available within 28 calendar days of the date that information was requested, and inform the consumer of the decision.

Question 1.15: There appears to be sound reasons for the Code to require that consumers requesting financial hardship assistance are only asked to provide information that is genuinely necessary to assess their application. Also any request for information should not unreasonably or unnecessarily delay the assessment of the hardship request. Are there any issues that would have to be resolved in order for this to be implemented?

c. Payment of excesses

Consumer Action Law Centre (Consumer Action) has suggested that the hardship provisions of the Code should be expanded to include clear standards for payment of an excess where the customer has a valid claim, but is in financial hardship and cannot afford to pay their excess. Financial Rights submitted that customers experiencing difficulty paying their excess upfront should be given the option of deducting the excess from the claims amount, or being able to pay the excess in instalments.

Feedback from insurers suggests that it is not widespread practice to only accept payment of an excess as a lump sum. It may be that there have been cases in which an insurer has determined that the administrative cost of processing instalment payments outweighs the amount being paid by the consumer.

Question 1.16: To address the concerns noted above, should the financial hardship section of the Code make it clear that it applies to situations where a customer cannot pay their excess? Also, should the options for financial hardship assistance in clause 8.8 include "*deduction of the excess from the claim payment*"? Are there any practical implications with this approach?

d. Debt waiver

Financial Rights has suggested that the Code should set criteria upon which debt waiver may be considered, and should apply the same criteria to proactively identifying customers who may be eligible for debt waiver.

Insurers have advised that they seek to take a common-sense approach to waiving debt, particularly in cases where (for example):

- the debtor's sole source of income is Centrelink
- the debtor is a minor
- the debtor is a victim of family violence

The ICA welcomes stakeholder views as to whether it is more appropriate for these decisions to be left to the discretion of the insurer in response to particular circumstances, or if they should be prescribed in the Code.

Question 1.17: If a customer in financial hardship has the ability to pay their debt in instalments, should the Code specify that this option should not be refused by the insurer?

Question 1.18: What would the potential challenges or advantages be if the Code were to specify criteria for debt waiver?

e. Complaints about financial hardship

Financial Rights submitted that the Code does not allow consumers to access an insurer's complaints process where a request for financial hardship assistance is rejected, or to know the reasons for rejection.

This requirement is currently contained in clause 8.6 of the Code: "If we determine that you are not entitled to Financial Hardship assistance, we will provide you with the reasons for our decision, and information about our Complaints process."

It has been suggested that the ICA may want to consider shortening the timeframe for complaints relating to financial hardship so that these are dealt with in 21 days. This would align with the maximum timeframe for deciding credit disputes about hardship under ASIC's Regulatory Guide RG 165 (RG 165).[6]

[6] Regulatory Guide 165: Licensing: Internal and external dispute resolution (July 2015) http://download.asic.gov.au/media/3285121/rg165-published-2-july-2015.pdf.

In line with the earlier discussion point regarding timeframes for processing financial hardship requests, a complaint about financial hardship could be removed from the normal complaints track and dealt with in 21 days as part of the financial hardship process. The ICA would welcome feedback from members and other stakeholders as to whether this is practical, or whether this could cause administrative and resourcing issues that outweigh the benefit to consumers.

Question 1.19: Should the financial hardship process include a complaint handling timeframe of 21 days, in line with the timeframe for credit disputes about hardship in RG 165? Would this create any administrative or resourcing issues that would outweigh the benefit to consumers?

f. Uninsured third parties

Financial hardship assistance is available to uninsured third parties who owe a debt to an insurer (for example, after a motor vehicle accident in which the uninsured party was the at-fault driver).

The CGC has suggested that several insurers have taken a view that uninsured third parties, who request financial hardship assistance, are not entitled to access the insurer's internal complaints process.

The ICA's view is that the financial hardship section of the Code expands the definition of "you" to cover an individual from whom an insurer is seeking recovery for damage or loss caused by them to an insured.

The ICA suggests that the confusion arises because the expanded definition of "you" only applies to the financial hardship section of the Code. In the complaints section (Section 10), the definition of "you" is defined as an insured and third party beneficiary.

In its submission the CGC also recommends that access to an insurer's complaints process, with regards to financial hardship, should not be limited to complaints about financial hardship that only stem from a retail insurance product. The current complaints section of the Code applies to retail insurance only.

Question 1.20: There is confusion and varying interpretations about the interaction between section 8 and 10 of the Code. How can the obligations and rights of uninsured third parties be clarified? What factors need to be considered?

Question 1.21: Are there any practical implications with expanding access to an insurer's internal complaints process for those who have a financial hardship complaint that relates to wholesale insurance?

**Proposal 2: The Code should provide guidance on best practice disclosure principles**

In 2015 the ICA formed an Effective Disclosure Taskforce, comprised of industry leaders and non-industry experts, to provide recommendations to the ICA Board on ways to better align the provision of policy information with customers' needs.

One of the recommendations contained in the Taskforce's report was that the industry should shift from a minimum mandated disclosure approach to best practice transparency, to better assist consumers to choose a product that meets their needs.

a. Best practice principles

The ICA has developed a number of best practice product disclosure principles which are detailed in Appendix 3. They are intended to provide flexibility for insurers to continuously improve their standards of disclosure, and will be updated to reflect learnings from the trialling of innovative disclosure techniques.

The best practice principles consider opportunities for greater customer engagement through targeted information that is specific and relevant to the individual.

The principles also state that offering scenarios of the most commonly made claims may provide consumers with contextual information that is useful for decision-making. Legal Aid NSW noted in its submission that insurers could make use of "worked examples" of specific clauses to demonstrate how they work in practice, and infographics to aid customer comprehension.

| Question 2: Do the best practice principles detailed in Appendix 3 adequately address key concerns related to disclosure? Please identify any areas that have not been addressed. |
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b. Plain language

The current Code requires insurers to take "reasonable steps" to communicate in plain language. Legal Aid NSW suggested that the reasonableness qualification is not strong enough.

It has also been suggested that appropriate consumer testing through surveys and research should be undertaken to ascertain consumers' level of comprehension of insurance products.

The Life Code requires that insurers incorporate plain language into sales and policy information and consumer-test the plain-language information.

| Question 2.1: Would a new Code requirement that key information must be provided in plain language, and be consumer tested to ensure it is clear and informative enough for a consumer to reasonably assess the suitability of the policy for them, be a sufficient strengthening of the plain language provision? Please advise if you consider an alternative approach more appropriate. |
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c. Sum insured calculators/rebuilding costs

One of the recommendations of the Effective Disclosure Taskforce was that insurers should integrate sum insured calculators into the sales process for home building to provide consumers with guidance prior to selecting their sum insured.

Stakeholders would like to see calculators that are easily accessible, accurate and informative. Financial Rights suggested in its submission that the sales process should include general guidelines about rebuilding costs and the implications of valuing a building, and helping consumers to ask questions about the details of their property.

The ICA notes that many insurers have now made significant improvements to provide a more streamlined sales process and incorporate sum insured calculators into the quotation process in order to facilitate more informed decision-making around sum insured amounts.

This approach is consistent with the direction of the ICA's effective disclosure work, informed by consumer research. This work aims to make it easier for consumers by streamlining information - rather than producing more information which consumers are unlikely to engage with.

For this reason the ICA suggests that insurers continue to develop and improve effective sum insured decision-making by ensuring that either their websites contain their own calculators, or by providing a link to a common industry calculator. The ICA suggests that this would be a more effective approach than requiring the provision of more guidelines.

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| Question 2.2: In order to improve the guidance provided to consumers on selecting a sum insured amount, the ICA suggests that Code could require insurers to provide access to an accurate and informative sum insured calculator as part of the home building insurance application process. Would this adequately address the issues raised above and are there any additional factors to consider with this suggestion? |

**Proposal 3: The Code should include product design and distribution principles and provide guidance to insurers**

***Product design***

The CLF has identified product suitability as a key issue for consumers of general insurance products. This has also been indicated by ASIC, Treasury and in other submissions, including submissions from Financial Rights and Consumer Action. While the ICA will continue to work with members on improving product suitability, we consider that the Code has an important role to play in providing best practice product design principles that can form the foundation of general insurance product design going forward.

The ICA has already commenced working with ASIC on a set of comprehensive principles for product design and distribution. While these principles were developed in response to issues with the sale of add-on insurance through car dealerships, the ICA suggests they are also appropriate for the design and distribution of general insurance products more broadly.

The product design principles outlined by ASIC are:

- Cover should be designed with a clear target market in mind. Equally, it should be clear to insurers and distributors which consumers are not part of the target market.
- Cover should be designed to meet a genuine need and offer a tangible benefit at reasonable value.
- Insurers must not design products that offer (or are capable of offering) negative or very low value.
- Additional benefits should be subject to strict scrutiny in terms of product design.
- The product and its features and exclusions must be capable of being communicated to and understood by the target market.
- When designing products for bundling, insurers should consider how this impacts on the target and non-target market and product value.
- Insurers should regularly review product performance and act promptly on any identified concerns.

These principles echo the design and distribution proposals released by Treasury in December.[7] These principles are intended to make issuers and distributors of financial products more accountable for ensuring that products are designed with consumer needs in mind, and are marketed at appropriate sections of the population.

The Treasury commentary accompanying its product design obligations explains how the broad principles are intended to operate:

> *"Broadly speaking, issuers should seek to match products with target markets based on the needs the product satisfies and the target market's ability to understand the product. …*

[7] Design and Distribution Obligations and Product Intervention Power – Proposals Paper, The Treasury (December 2016) https://www.treasury.gov.au/~/media/Treasury/Consultations%20and%20Reviews/Consultations/2016/Design%20and%20distribution%20obligations/Key%20Documents/PDF/Design-and-distribution-obligations.ashx

*For insurance products, whether any significant terms or conditions could prevent a consumer from benefiting from the feature will be relevant. For example, a consumer is unlikely to derive benefit from:*

*insurance that overlaps with an existing right that the consumer has (for example, under a manufacturer's warranty); or*

*unemployment insurance with exclusions for self-employed individuals if the consumer is self-employed.*

*In both cases, these factors should influence the identified target market.*

*…*

*The focus will be on significant features. This would include features that consumers pay for, will be highlighted in marketing material or are unusual."*

Question 3: Would the inclusion of the following principles in the Code be an effective means of improving product suitability? Are there any other principles to add?

a) Cover must be designed with a clear target market in mind. Equally, it should be clear to insurers and distributors which consumers are not part of the target market.
b) Cover must be designed to meet a genuine need and offer a tangible benefit at reasonable value. This applies to additional as well as core benefits.
c) Insurers must not design products that offer (or are capable of offering) negative or very low value.
d) The product and its features and exclusions must be capable of being communicated to and understood by the target market.
e) When designing products for bundling, insurers must consider how this impacts on the target and non-target market and product value.
f) Insurers must regularly review product performance and act promptly on any identified concerns.

Along with the suggested principles noted above, ASIC has provided more detailed considerations to be taken into account by insurers when applying the principles. Some of the considerations apply to all general insurance products, while some are specific to add-on style products. These considerations have been detailed in Appendix 4 of this Report, and the ICA suggests, could form part of an ICA guidance document on product design and distribution.

Question 3.1: Do the product design considerations attached in Appendix 4 adequately respond to stakeholder concerns? Can the principles be applied to all general insurance products and does the material provide sufficient detail as to how the principles are to be applied?

***Product distribution***

a. Product distribution principles

Where products are sold under a general advice model, as general insurance largely is, a customer's particular circumstances are not taken into account in the sale of the product. The legal restrictions on providing personal advice mean that it is largely up to a consumer to assess whether a product is suitable for them, unless they engage a financial advisor or insurance broker.

Submitters provided a range of recommendations aimed at ensuring consumers purchase insurance that is suitable for them.

Consumer Action recommends in its submission that the Code include a basic commitment that insurers will not sell consumers insurance under which they are ineligible to claim a benefit. This should include bundled products (such as add-on CCI) under which a consumer may not be able to claim on one or more components.

The Financial Rights submission suggests insurers should be required to seek information from the consumer on what they need from their insurance and ensure the product sold is suitable. This would require a shift away from a no-advice model.

The ICA believes that if insurers were required to sell retail general insurance products solely under a personal advice model, the cost involved in training, education and authorisation of advisers is likely to be significant. This could have a serious impact on insurance affordability and availability.

Along with the product design principles discussed earlier, ASIC has developed a number of practical distribution principles with the ICA's Add-on Insurance Working Group. The ICA suggests these principles could ensure insurers have reasonable controls in place to make sure their product reaches the target market.

The principles are as follows:

Insurers should have reasonable controls in place to ensure that:

a) the product reaches the target market for whom it is intended
b) the product does not reach those outside the target market
c) the product does not offer low or negative value
d) the risk of over-insurance is managed
e) they set clear expectations about what constitutes good sales practices, and equally what conduct is not acceptable
f) they provide the necessary training and information to their distributors to enable them to sell the product in line with their stated policies
g) they regularly review distribution and promptly address any identified concerns

These principles cover similar ground to the Life Code. The Life Code requires insurers to have documented internal sales rules to ensure sales are conducted appropriately and compliance is monitored.

The ICA has worked with ASIC to create material to provide further guidance to insurers as to how to put these principles into practice. This material is also part of Appendix 4. It echoes

the details of the Treasury's proposed obligations on design and distribution; for instance, when determining an appropriate distribution channel and marketing approach, insurers must have regard to the complexity of the product and whether the distribution channel or marketing approach will enable the target customers to understand the product.

We note that the Code Review does not yet have the benefit of the final product design and distribution Treasury legislation. The ICA will endeavour to work closely with Government to ensure there are no inconsistencies between the principles provided in Appendix 4 and the final legislation.

Question 3.2: Would the inclusion of the following principles in the Code effectively help consumers to purchase insurance that is suitable for them? Are there any other principles to add?

Insurers must have reasonable controls in place to ensure that:

a) the product reaches the target market for whom it is intended
b) the product does not reach those outside the target market
c) the product does not offer low or negative value
d) they set clear expectations about what constitutes good sales practices, and equally what conduct is not acceptable
e) they must provide the necessary training and information to their distributors to enable them to sell the product in line with their stated policies
f) they regularly review distribution and promptly address any identified concerns

Question 3.3: Do the distribution considerations attached in Appendix 4 adequately respond to stakeholder concerns? Can the principles be applied to all general insurance products covered by the Code and does the material provide sufficient detail as to how the principles are to be applied?

b. Consumer redress

The product design and distribution principles require insurers to regularly review distribution and act promptly on any identified concerns. This may include remediating the customer if necessary.

The ICA seeks feedback on whether the Code should require insurers to:

- investigate potentially inappropriate sales
- discuss a remedy with the customer if a policy is found to have been sold inappropriately

Question 3.4: Are there any issues that would have to be considered if the Code were to include options for consumer redress in circumstances where an insurer identifies issues with the distribution of its products? Examples could include:

a) cancelling the cover
b) arranging a refund of premiums and interest
c) arranging more suitable cover
d) honouring a claim

**Proposal 4: The Code should provide product design and distribution guidance specific to add-on insurance products**

Add-on insurance purchased from a car dealership covers risks relating to the car or to the loan taken out to purchase the car. These products include Consumer Credit Insurance (CCI), Guarantee Asset Protection insurance (GAP), mechanical breakdown insurance and tyre and rim insurance.

In 2016, ASIC released a report on add-on insurance sold through car yards which found that many add-on products were poorly designed, so that consumers may be paying for something they did not need or that offered poor value. ASIC also found that the sales process lacked adequate controls and inhibited good or informed decision-making.

The ICA's CLF has echoed these views, and recommended that the ICA work with members to develop standards relating to sales practices, oversight of third parties and product design of add-on products to be incorporated into the Code Review. Similar suggestions were made in submissions received from Financial Rights, Consumer Action and Legal Aid NSW.

a. Product design, distribution and sales practices

The product design and distribution principles, under proposal 3, will apply to all general insurance products covered by the Code. In developing these principles, the ICA and ASIC also identified a number of product-specific considerations relevant to add-on products (see Appendix 4). These product-specific considerations could be developed into ICA guidance specific to add-on insurance products.

The ICA and members offering add-on products through the motor dealer channel have been working with ASIC to identify a range of improvements, other than in relation to product design and distribution already mentioned above.

In August 2016, members committed to a range of non-price initiatives to improve consumer outcomes. These initiatives were intended to complement the industry's application to the Australian Competition and Consumer Commission to authorise a uniform cap on commissions. While the industry's application was unsuccessful, the industry remains committed to the non-price initiatives. These initiatives include:

- insurers that offer a single premium loan financed premium will also offer a non-financed payment option;
- insurers will ensure consumers are given clear information about the payment options, including a comparison of the indicative costs of the premium at the point of sale;
- insurers will ensure that consumers paying for a policy through a single loan financed premium are required to acknowledge they have selected a finance option and they understand interest will be payable on the finance premium;
- insurers will, as soon as practicable following a purchase, make available to the consumer a confirmation of the purchase and provide a reminder of cooling off rights; and
- insurers will provide annual reminders to consumers who have purchased multi-year policies through a motor dealer.

The Life Code has also responded to ASIC's findings on add-on insurance by including a number of provisions specific to the sale of CCI. Provisions include:

- evidence of consent to purchase;
- provision of information about the purchase being optional, the eligibility criteria, the main exclusions and the cooling off period;
- a minimum cooling off period of 30 days.

If the Code were to include guidance specific to add-on insurance products, these additional consumer protections and sales process improvements could also be incorporated.

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| Question 4: Would it be appropriate to develop product-specific guidance in the Code around product design and distribution for add-on insurance products? Are the product-specific considerations relevant to add-on products in Appendix 4 adequate, or is further detail needed? |

b. Deferred sales model

ASIC has communicated to the ICA and its members its expectation that the ICA take a leadership role in the implementation of a deferred sales mechanism in order to lead the industry to better consumer-centric practices. This position was echoed by other submitters to the Review, who suggested that if the insurers were to continue allowing their products to be sold as add-ons, there should be an appropriately formulated delay between the introduction and conclusion of the sale of the add-on insurance.

The ICA and members have commenced assessing the practicality of a deferred sales model for all add-on products sold through the motor dealer channel, excluding comprehensive motor and compulsory third party insurance. ASIC has also released a consultation paper proposing a deferred sales model that would require a yet to be determined period of between four to thirty days to elapse before car dealership intermediaries could sell an add-on insurance product.[8]

A deferred sale model could be implemented through regulation (through ASIC's modification powers) or through the Code. While implementation through regulation would capture a broader range of products and establish a more competitively neutral regulatory landscape, implementation through the Code could provide greater flexibility for adjustments to improve the model over time.

If a deferred sales model is implemented through regulation, other aspects of the model could still be incorporated through the Code, such as common standards around consumer communications that would be required.

The ICA would welcome stakeholder views as to the role that the Code should play in the implementation of a deferred sales model for add-on products.

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| Question 4.1: What role, if any, should the Code play in the implementation of a deferred sales model for add-on products sold through the motor dealer channel? |

[8] ASIC Consultation Paper 294, The sale of add-on insurance and warranties through caryard intermediaries http://asic.gov.au/regulatory-resources/find-a-document/consultation-papers/cp-294-the-sale-of-add-on-insurance-and-warranties-through-caryard-intermediaries/

**Proposal 5: The Code should strengthen standards relating to third-party distributors**

Currently, a Code Subscriber will be in breach of the Code if its employees, Authorised Representatives or Service Suppliers fail to comply with the Code while acting on its behalf.

ASIC noted that the current Code provides broad commitments for employees and Authorised Representatives in section 5 of the Code. However, they suggested that these commitments could be enhanced by providing more detailed commitments in specific areas, such as for people experiencing financial hardship or with mental health issues.

The ICA suggests that the proposals relating to vulnerable consumers, along with a strengthening of the distribution requirements as discussed earlier, will assist with concerns over standards for employees and Authorised Representatives.

However, as noted by both ASIC and the CGC, where an insurer's products are sold by a third party entity under its own Australian Financial Services Licence (AFSL), subsection 5.5 exempts such third-party sellers from the scope of the Code. This means that they are not required to comply with section 4 or section 5 of the Code.

Third party distributors include entities with their own AFSL (such as brokers and banks) and also distributors who have been appointed under the Subscriber's AFSL but have not been appointed an Authorised Representative (such as real estate agents and travel agents).

A number of submissions have suggested that the Code should be broadened to cover all such third-party distributors.

ASIC has submitted that the Code should make clear the monitoring and oversight to be undertaken by insurers where outsourced third parties are making direct contact with customers.

There has been concern from Code Subscribers as to their ability to monitor third parties who are not operating under the insurer's AFSL. This was echoed in the commentary accompanying the Treasury design and distribution proposals:

> "*Some product issuers have expressed concerns about any expectation that they will be indirectly accountable for the conduct of external distributors under the reforms. In general, distributors will have direct responsibility for putting in place controls to ensure products are distributed in line with the issuer's expectations… However, product issuers cannot be wilfully blind if distributors are acting in a manner that is inconsistent with their expectations*."[9]

Where an insurer has a formal agreement in place with a third party to sell its product, the ICA suggests that this agreement could be bolstered by requiring the following:

- Sales must be conducted in an efficient, honest, fair and transparent manner
- All salespeople must be appropriately trained and educated, their conduct monitored by their employer and problems with conduct addressed
- Insurers will notify their distributors of the identified target and non-target market for the product
- Pressure selling is not permitted

[9] Design and Distribution Obligations and Product Intervention Power, Proposals Paper, December 2016

- Distributors will notify insurers of any complaints and tell customers the identity of the relevant insurer

Another option, suggested by the ASIC Enforcement Review Taskforce[10], is to have entities engaging in activities covered by the Code to subscribe to the Code directly. The argument being that bringing more parties under the umbrella of the Code's standards may be more effective than expecting insurers to have a high level of oversight over parties that are at arm's length.

The ICA's view is that such an exercise will be particularly challenging for those parties already covered by a financial services code (i.e. insurance brokers and banks), and would require extensive engagement with the parties involved. We suggest that in the first instance, the agreements insurers have in place with a third-party distributor are strengthened.

Question 5: The ICA has identified obstacles with requiring all entities, engaged in an activity covered by the Code, to subscribe to the Code directly. We suggest that as an alternative, the Code should require that when an insurer enters into a formal agreement with a third party to sell its product, the agreement should include the following:

a) Sales to be conducted in an efficient, honest, fair and transparent manner
b) All salespeople to be appropriately trained and educated, their conduct monitored by their employer and problems with conduct addressed
c) Insurers to notify their distributors of the identified target and non-target market for the product
d) Pressure selling is not permitted
e) Distributors to notify insurers of any complaints and tell customers the identity of the relevant insurer

Is this a suitable option for strengthening the standards relating to third-party distributors? Please identify any concerns with this approach.

Question 5.1: Industry has noted the operational challenges of requiring insurers to monitor the sales practices of third parties. Is there an alternative approach that would allow for the effective monitoring of outsourced third parties?

[10]ASIC Enforcement Review, Position Paper 4 – Industry Codes in the Financial Sector, June 2017

**Proposal 6: The Code should strengthen standards relating to Service Suppliers**

a. Insurer responsibility and oversight

Clause 13.4 of the Code stipulates that a Code Subscriber is in breach of the Code if one of its Service Suppliers fails to comply with the Code. Nevertheless, submitters suggested that more could be done to provide clarity that an insurer is responsible for the conduct of Service Suppliers they engage, and their subcontractors. This feedback follows the CGC's Own Motion Inquiry on Investigation of Claims and Outsourced Services.[11]

Particular reference was made to the responsibility of insurers who use offshore or outsourced claims management services to have good oversight, systems and training of outsourced teams.

Question 6: Would making the following requirements explicit help to strengthen insurers' responsibility for the conduct of their Service Suppliers:

a) Insurers are responsible for the conduct of their Service Suppliers and their approved subcontractors
b) Insurers must have measures in place to ensure that due skill and care is taken in choosing suitable Service Suppliers
c) Service Suppliers should notify the insurer of a customer complaint by the next business day
d) Insurers will appropriately address any actions by Service Suppliers that breach the Code, Service Level Agreements or licence obligations

Are there any further provisions to be considered?

b. Service Supplier training

The Code currently requires a Code Subscriber to be satisfied that a Service Supplier:

- is qualified by education, training or experience to provide the required service competently and to deal with customers professionally (including but not limited to whether they hold membership with any relevant professional body)
- holds a current licence, if required by law.

Contracts with Service Suppliers must also reflect the standards of the Code.

The CGC's Own Motion Inquiry recommended that Service Suppliers should receive training on the requirements of the Code, focusing on the standards that apply to their services.

A submission was also received from the Australasian Institute of Chartered Loss Adjusters (AICLA), which pointed out that as there is no licensing or registration process for loss adjusters in Australia, there are no restrictions on who can operate and purport to be a loss adjustor. Insurers may use Service Suppliers who are trade-qualified, such as builders or carpet layers, to assess loss. However, it is AICLA's position that no one should be holding themselves out as a loss adjuster unless they are appropriately qualified and trained.

[11] General Insurance Code Governance Committee's Own Motion Inquiry on Investigation of Claims and Outsourced Services (1 May 2017) http://codeofpractice.com.au/assets/documents/GICGC%20OMI%20on%20Investigation%20of%20Claims%20&%20Outsourced%20Services%20May%202017.pdf.

AICLA recommended that the Code should require minimum training requirements for Service Suppliers (for example, for loss adjusters, completion of a number of modules from the Diploma of Loss Adjusting offered by ANZIIF).

The Motor Traders' Association (MTA) reported in its submission that motor vehicle assessors may not be up-to-date with technological advances and repair techniques.

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| Question 6.1: Are there any issues to consider if the Code were to require insurers to ensure that Service Suppliers are appropriately skilled and qualified to carry out their duties and remain up-to-date with industry developments as well as the requirements of the Code? |

c. External Experts

Consumer Action suggested that External Experts, who an insurer may call on to provide an independent report for a claim, should be brought within the scope of the definition of Service Suppliers.

The ICA considers the relationship with External Experts to be materially different to Service Suppliers. The relationship it is more likely to be transactional and without an underlying, ongoing contract.

The ICA believes that External Experts are distinct from Service Suppliers as they are independently providing an opinion. We would not want their independence compromised through the imposition of insurer oversight and expectations. We welcome stakeholder feedback on this perspective.

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| Question 6.2: The ICA does not believe that the definition of Service Suppliers should be expanded to include External Experts. Do you agree with the concerns we have raised with this proposal? How can the standards of External Experts be improved without compromising their independence? |

**Proposal 7: The Code should include mandatory standards for Investigations**

A key plank of the Financial Rights submission to the Code Review was standards for the use of investigators as part of the claims process. This follows a major report produced by Financial Rights in 2016 titled *Guilty until proven innocent: Insurance investigations in Australia*.[12]

The ICA's CLF has also identified claims investigations as a priority area for industry. The CLF recommended that, as part of the Review of the Code, the ICA should develop standards for investigators and interviews to be included in the revised Code.

In 2017 the CGC published an Own Motion Inquiry on the use of investigators and outsourced providers.

A draft set of standards are attached in Appendix 5. These standards have received input from some ICA members.

It has been suggested that, as investigated claims make up such a small proportion of claims overall, incorporating a number of pages of detailed standards regarding investigations, interviews and surveillance into the main Code document may lead consumers to believe investigations are much more prevalent than they are.

The ICA suggests that the investigation standards be an appendix to the Code. However, it should be made clear that the standards are mandatory Code standards and not guidance.

As part of the consultation on this Review, we propose that the ICA will engage with investigation licensing bodies to provide feedback on these standards. The ICA will also seek to raise awareness that concerns or complaints about insurance investigations should be passed onto the insurer to be dealt with as part of the complaints process.

Question 7: Do the investigation and interview standards attached in Appendix 5 adequately respond to stakeholder concerns regarding investigations? Please advise if any areas have not been covered.

Question 7.1: Are there any practical implications if these standards were to be included in the Code as mandatory?

Question 7.2: Are there any other practical issues with these requirements?

[12] http://financialrights.org.au/wp-content/uploads/2016/03/Guilty-until-proven-innocent.pdf.

**Proposal 8: The revised Code should meet the requirements for ASIC approval**

ASIC has the power to approve financial services codes of conduct upon application. However, it is not a legal requirement to obtain ASIC consent for a Code. ASIC's Regulatory Guide 183[13] (RG 183) gives guidance on its approach to approving codes, the criteria for code approval and how to obtain and retain approval.

As ASIC points out in RG 183, "*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*."

A number of submitters have recommended ASIC approval of the Code. This is on the basis that it would increase public confidence in the sector and ensure the Code is meeting best practice standards.

The ASIC Enforcement Review Taskforce has recently released a consultation paper on industry codes in the financial sector.[14] This paper considers a "co-regulatory model", under which industry participants would be required to subscribe to an ASIC-approved code. In the event of non-compliance with the code, an individual customer would be entitled to seek appropriate redress through the participant's internal (IDR) and external (EDR) dispute resolution arrangements. The ICA will take into account any developments from this consultation into the Code Review Final Report.

The ICA has developed the Code with a view to meeting the requirements of RG 183 where possible, on the basis that this would demonstrate that the Code is the "gold standard" of financial services codes.

To date, the ICA has not sought ASIC approval of the Code, on the basis that the standards of the Code require further development in the areas of enforceability, breach reporting and independent reviews.

a. Enforceability of the Code

ASIC requires enforceability of a code as one of the key threshold criteria for approval. This allows Code breaches to be dealt with effectively and independently. This requires that:

a) subscribers must agree to be contractually bound by the code.

b) there is an independent person or body that is empowered to administer and enforce the code, including imposing any appropriate sanctions.

c) the code provisions provide that consumers have access to internal dispute resolution (IDR) processes and an appropriate external dispute resolution (EDR) scheme for any code breaches resulting in direct financial loss.

d) there is broad standing to complain about any other code breach to the independent body.

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[13] Regulatory Guide 183: Approval of financial services sector codes of conduct (March 2013) http://download.asic.gov.au/media/1241015/rg183-published-1-march-2013.pdf.

[14] ASIC Enforcement Review Position and Consultation Paper 4: Industry Codes in the Financial Sector (28 June 2017) http://www.treasury.gov.au/~/media/Treasury/Consultations%20and%20Reviews/Reviews%20and%20Inquiries/2016/ASIC%20Enforcement%20Review/Key%20Documents/PDF/Industry_Codes_Paper.ashx.

ASIC notes in RG 183 that:

> "*In most cases, subscribers will incorporate their agreement to abide by a code by contracting directly with the independent person or body that has the power to administer and enforce that code. In some cases, subscribers will also incorporate their agreement in individual contracts with consumers (e.g. written directly into the terms and conditions of a particular product). We strongly encourage code owners to consider this approach*."

The ICA agrees that enforceability of the Code is key. Subscribers are bound by the Code through entering into a deed of adoption, through which they give the CGC power to monitor and enforce their compliance with the Code.

Further to this, the Code is enforceable by FOS in its capacity as the EDR scheme for the Code. The FOS Terms of Reference provide that FOS will have regard to "*applicable industry codes or guidance as to practice*" when deciding a dispute.

The ICA notes that the Australian Financial Complaints Authority (AFCA) - a new EDR scheme for financial service providers - is due to commence from 1 July 2018.[15] The ICA anticipates that AFCA will also have regard to industry codes. While the specific operational details of AFCA are currently unknown, the ICA will consider any developments in the Code Review Final Report.

ASIC's suggestion, that subscribers will also incorporate their agreement to abide by the Code into individual contracts with consumers, causes concern for the ICA.

The ICA has sought independent legal advice on the requirements and impact of RG 183 from Radford Lawyers, an excerpt of which is below:

> *"[I]f the ICA were to agree to require members as a term of the Code to incorporate compliance with the Code into policy terms…*
>
> *We would not recommend this without careful consideration. By doing this, a customer could seek to bring an action against a member directly for a breach of the Code based on breach of contract, breach of the duty of utmost good faith under the IC Act, misleading or deceptive conduct under the Corporations Act 2001 (Cth) or ASIC Act 2001(Cth)."*

The ICA considers the benefit of keeping the Code standards part of a standalone self-regulatory model is that it allows the Code to contain principles and flexibility. This means that members can determine how they will comply and will seek to be constantly improving and innovating.

If Code Subscribers are required to make the Code enforceable at law, that flexibility could well end up being stripped out and the Code reduced to base-level, prescriptive service standards. If the Code were to become a brief, base level document, it would weaken its ability to respond to emerging issues and to deliver evolving and improved outcomes for consumers. In this regard, the ICA would not support ASIC approval if it required the Code to be incorporated into individual contracts with consumers.

[15] http://sjm.ministers.treasury.gov.au/media-release/044-2017/

The ICA suggests that providing enforceability through CGC oversight and sanction powers, as well as through EDR, is appropriate to meet the requirements of RG 183.

| Question 8: What issues should be taken into account if the Code were to make it explicitly clear that Code standards are enforceable through the Code Subscribers' EDR scheme? |
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b. Breach reporting to ASIC

RG 183 requires the code administrator (in the case of the Code, the CGC), to report systemic code breaches and serious misconduct to ASIC.

| Question 8.1: Are there any factors to consider if the Code required the CGC to report systemic code breaches and serious misconduct to ASIC? |
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c. Regular independent reviews

RG 183 requires that a code must be independently reviewed at intervals of no more than three years.

The ICA agrees with the requirement for regular independent reviews, to ensure that a code remains current and continues to deliver real benefits to consumers and subscribers. However, it can take a significant amount of time to carry out an independent review, including developing and adopting new Code standards.

To use the last independent review of the Code as an example, the review was announced in May 2012, with the final report of the review released in August 2013. The ICA and its members then worked on significant changes to the Code, which were finalised in February 2014 for a 1 July start date. Subscribers then had 12 months to transition to the revised Code, with a final adoption date of 30 June 2015 – three years after the review commenced.

The ICA's view is that industry should have time to bed down the standards in the code before the next independent review commences. For this reason, the ICA suggests that the Code requires an independent review no later than three years after the adoption date of the last round of changes. As this is a minimum standard, the ICA could announce a review earlier where required, in consultation with the CGC, ASIC, the EDR scheme and members.

| Question 8.2: Noting the issues raised above, in order to meet the requirements for ASIC approval, would it be satisfactory if the Code required an independent review no later than three years after the adoption date of any previous changes to the Code? Are there any alternative approaches to consider? |
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d. Remedies and sanctions

It is the ICA's view that the current remedies and sanctions in the Code meet RG 183 requirements. However, the ICA believes there is a separate issue regarding the clarity of the operation of the current requirements for corrective action and sanctions in the Code.

ASIC commented that the Code does not include provisions for compensating direct financial loss caused to a consumer as a result of the Code breach.

The ICA has been of the view that the Code requirements to implement corrective measures after a Code breach, and the requirement that "particular rectification steps be taken", include compensation where appropriate. The CGC's annual reports indicate that corrective actions by insurers have previously included payment made to customers.

Financial Rights has suggested that the current Code sanction of "publication of our non-compliance" is not the same as publicly naming an insurer who breaches the Code. As brand reputation is so important, the ICA has viewed the public naming of an insurer who does not rectify a Code breach as one of the most severe sanctions afforded to the CGC. Code breaches are published by the CGC on a de-identified basis, so for the sanction to have teeth, an insurer would need to be publicly named.

Due to the confusion about the operation of the remedies and sanctions included in the Code, the ICA suggests that the wording of the available sanctions mirror the options suggested by ASIC in RG 183.

One of the sanctions listed in RG 183 is the ability to fine a Code Subscriber. It is currently unclear who would collect fines and how they would be used. The Insurance Council of New Zealand (ICNZ) has included in its Fair Insurance Code the ability for the ICNZ Board to award up to $100,000 against a member, as well as reprimand the member or expel them from membership. The ICA Board could determine whether it wanted to hold the same power, and the basis on which it would require fines to be paid.

It is important to note that the sanctions listed in RG 183 are examples only. The ICA would welcome stakeholder feedback on whether the Code should mirror the options suggested in RG 183.

Question 8.3: Given the apparent lack of clarity around the operation of the remedies and sanctions in the Code, would this be addressed if the available Code sanctions mirrored those recommended by ASIC RG 183:

a) Compensation for any direct financial loss or damage caused to an individual
b) Binding non-monetary orders obliging the subscriber to take (or not take) a particular course of action to resolve the breach
c) Formal warnings
d) Public naming of the non-complying organisations
e) Corrective advertising orders
f) Fines
g) Suspension or expulsion from the ICA
h) Suspension or termination of Code subscription

Are there any other factors that need to be considered with this approach?

## 4. Additional Code Review Themes

As noted at the start of this Report, there are a number of other matters raised by submitters that warrant stakeholder consideration and feedback.

We have sought to address each theme according to an approximate order of priority, noting that some suggestions may be of equal importance. With reference to the Review Pathway in section 2 of this Report, and the Rating Matrix in section 6, we seek feedback on these further suggestions and their priority for inclusion into a revised Code.

### i. Claims

a. Making a claim

Submitters suggested that the following standards from the Life Code could be brought into the claims section of the Code:

- When a claim is made, the insurer should provide the claimant with contact details they can use to get information about the claim.
- When requesting information from a claimant, the insurer should advise them why the requested information is considered relevant.
- Where possible, insurers should request all required information early and in one request, rather than asking for different documents on an ad-hoc basis as the claim proceeds.

Discussion Point 1: What issues should be taken into account if the Code were to require the following:

a) provide a claimant with contact details they can use to get information about the claim
b) explain to the claimant why particular information is being requested
c) where possible, request all required information early and in one request, rather than in multiple information requests.

b. Withdrawn claims

Submitters suggested that the Code should include a broader commitment to neither discourage a claim nor encourage a withdrawal.

One example given was that insurers should encourage customers to claim on their own insurance policy after a motor vehicle accident where the policyholder is not at fault. This would give the claimant a contact within their insurer to handle their claim with the at-fault driver's insurer directly, and they could potentially have the use of a replacement car.

The view of one of the submitters was that it is not for the insurer to give advice to a claimant about whether they have a valid claim or should withdraw – the insurer should refer the claimant to a lawyer if there is any question as to validity or coverage of the claimant's insurance policy, rather than suggesting a withdrawal.

Discussion Point 1.1: Some stakeholders have suggested that the Code should make it clear that insurers will neither discourage a claim nor encourage a withdrawal. Is this a sensible Code requirement or are there any problems with this approach?

Unlike the requirements that apply to declined claims, Code Subscribers are not under any obligation to provide consumers with written notification of a claim withdrawal.

The CGC's General Insurance Industry Data report 2015-2016 found that the number of withdrawn claims for retail insurance has continued to rise in the past two years. The report noted that:[16]

> *"We know that some of this increase was due to enhancements Code Subscribers have made to their systems and reporting frameworks. However, few other underpinning reasons for these increases were provided, raising concerns that:*
>
> • *There may still be gaps in consumers' understanding of how some of these products operate in practice.*
>
> • *Some withdrawn retail insurance claims may represent claims that would otherwise have been declined."*

The ICA agrees that better data collection of withdrawn claims is required. We note that Subscribers are working with the CGC in this regard, some Subscribers will need extensive system changes to fully capture this information.

When a claimant tells an insurer that they want to withdraw their claim, the ICA suggests it would be useful if the insurer asked the claimant for their reasons. These reasons could be recorded if systems allow. The reasons could assist insurers in determining whether there are issues with their claims handling procedures that require addressing.

Discussion Point 1.2: There is strong support for better data collection of withdrawn claims. The ICA notes that this could involve extensive system changes for some insurers. Taking this into consideration, would an appropriate middle ground be for the Code to require that when a claim is withdrawn, insurers should endeavour to record the reasons for this (if known) and ensure the customer is aware that they can make a complaint if they wish? Please identify any concerns with this approach or alternative options.

c. Claims decisions

Legal Aid NSW has suggested that the timeframe for deciding a claim should be reduced from four months to two months before a claimant is referred to an insurer's complaints process. Insurers are of the view that the full four months is needed, however they seek to decide claims as early as possible rather than waiting until the deadline.

[16] Code Governance Committee GI Industry Data Report 2015–16 http://codeofpractice.com.au/assets/documents/March%202017%20General%20Insurance%20Code%20Governance%20Committee%20-%202015-16%20Industry%20Data%20Report%20FINAL.pdf

The ICA acknowledges that claimants need to understand how their claim is progressing. The Code currently requires an update to be given at least every 20 business days, and responses to routine queries to be provided within ten business days.

The enormous volume of claims received by insurers means that every communication requirement is costly and resource-heavy. However, the standards of the Code should keep pace with customer expectations, and the ICA understands that a claimant may find it unreasonable to receive an update once a month and to wait two weeks to receive a response about a routine query.

The ICA would welcome stakeholder feedback as to whether these timeframes should be shortened by half, with more regular communications given via digital methods where possible (as opposed to letter or phone call), and what the practical implications of this would be.

Discussion Point 1.3: What factors should be taken into account if the Code were to require regular updates to be given to a claimant every 10 business days (which can be provided via text, email or mobile phone), with responses to routine queries given within five business days?

d. Claims denials and partial denials

The CGC has suggested that better recording and reporting of partially accepted claims data is required. The CGC has also strongly encouraged Code Subscribers to accurately and consistently record the reasons why claims are declined, and to review declined claims data on a quarterly basis, to enable insurers to better identify and analyse the causes underlying emerging trends.

It has been noted by the CGC that clause 7.19 of the Code needs to be amended to make it clear that all of the information is required to be provided in writing, not just the reasons for the denial in (a). Similarly, the obligation to notify a claimant after a catastrophe contained in clause 9.3 should be provided in writing.

Discussion Point 1.4: Are there any matters that would have to be resolved if the Code were to require that, where a claim is partially accepted, this should be confirmed in writing? The written confirmation could include:

a) which aspects of the claim have not been accepted and the reasons for this
b) the consumer's right to access information relied on to make the decision
c) information about the insurer's complaints process

Discussion Point 1.5: Would a satisfactory Code improvement be for clause 7.19 to make it clear that all of the information provided when a claim is denied is required to be in writing, not just the reasons for the denial in (a)? Is there an alternative approach?

Discussion Point 1.6: Are there any issues to be considered if the Code required insurers to record the reasons for claim denials?

Discussion Point 1.7: What factors should be taken into account if clause 9.3 of the Code were amended so that, after a catastrophe, there was an obligation to notify a claimant, in writing, about their entitlement to have their claim reviewed within 12 months?

e. External Expert reports

Financial Rights has suggested that if an expert report cannot be provided within 12 weeks, insurers should update the policyholder every 10 days. If, after 30 days, the report has not been provided, insurers should provide the policyholder with details of the complaints process.

Insurers have advised that the situations in which External Experts have difficulty providing a report in 12 weeks are usually after a major event, when there is a limited number of experts who can be engaged to produce a large number of reports (for instance, hydrology reports after a flood).

While a claimant is free to make a complaint at any time, the ICA questions whether the Code should explicitly encourage this in catastrophe situations, during which resources are focussed on processing claims as quickly as possible.

Discussion Point 1.8: We have noted a number of issues with providing a policyholder with the details of the complaints process when an external report is not received within 30 days. Do you agree with our concerns? If not, is there an alternative solution that could be considered?

f. Home building and vehicle repairs

Financial Rights notes that a large number of disputes brought to its attention are about the extent of repairs required, the adequacy of repairs completed and poor workmanship.

The Code currently requires insurers to accept responsibility for the quality of the workmanship and materials. However, Financial Rights believes there is a need to address a situation in which poor repair work results in the insured having to pay hire car or accommodation expenses over and above their insurance cover.

Discussion Point 1.9: What would be the advantages or disadvantages if the Code were to require that, where an insurer engages someone to carry out repairs on a customer's building, contents or motor vehicle, a written summary of the scope of the work is to be provided to the customer?

Discussion Point 1.10: Are there any issues that need to be taken into account if the Code were to require that where a repairer, organised by the insurer, has done a faulty or poor repair of a vehicle or building, and this requires the use of a hire car or accommodation over and above what is in a customer's insurance cover, the insurer will arrange these for the customer and cover any costs for the arrangements?

g. Total loss claims protocol

Legal Aid NSW has raised a concern about insurers' handling of total loss claims, particularly in the context of major events. For example, if a family home is completely destroyed by fire, it is inappropriate and unnecessary to require a list of contents and evidence of their value.

The ICA agrees that insurers and their Service Suppliers must handle total loss claims, and claims after major events, with great sensitivity. Under such circumstances, and where possible, insurers should make efforts to ease the burden on the claimant. However, the ICA also suggests that there needs to be some obligation on the customer to assist in reasonably quantifying the loss suffered. For property claims, this is important as the sum insured can exceed the value of the property.

Discussion Point 1.11: Given the concerns noted above, would it be a suitable improvement if the Code required that, when a claimant's loss is equal to or greater than the full sum insured, or a sub-limit within this, the insurer and its Service Suppliers will help them to assess their loss, and any inventory assessment required will only have to be provided up to the limit or sub-limit of the cover? What are the advantages or disadvantages with this approach?

h. Uninsured third-party claims

Financial Rights has raised a concern about the rights of uninsured not-at-fault drivers who make a claim through the insurance of the at-fault driver.

The FOS Terms of Reference cover "*a claim under another person's motor vehicle insurance policy for property damage to an Uninsured Motor Vehicle caused by a driver of the insured motor vehicle – but only where a valid claim has been lodged by the owner of the insured motor vehicle*".

However, in order to access FOS, the cap for a claim by an uninsured third party is $5,000.

As noted earlier, AFCA, a new external dispute resolution service for financial service providers is expected to be in place from 1 July 2018. Currently, it is unclear if AFCA will adopt the same cap for a claim by an uninsured third party.

Discussion Point 1.12: The Code could clarify the rights of an uninsured third-party driver making a claim with an at-fault driver's insurer by including:

a) principles for claims handling
b) an explanation of the claims process
c) access to the insurer's complaints process for a claim up to $5000
d) access to EDR for a claim up to $5000.

Would this be a satisfactory solution or is there a more appropriate alternative?

i. Debt recovery

A number of submitters raised concerns about the lack of information provided to a third party from whom an insurer is seeking payment of a debt. An example provided by Legal Aid NSW is where, after a car accident, an uninsured driver receives a debt recovery letter from an insurer, where the amount claimed appears to be beyond the scope of the damage caused, and issues of liability are contested, but the letter asserts liability is resolved in favour of the insured. Legal Aid NSW has observed that third parties should be able to question the sum that the insurer is seeking to recover, before the matter ends up in court.

Discussion Point 1.13: Would a Code requirement, that insurers should treat individuals from whom they are seeking recovery of a debt in an honest, fair, transparent and timely manner, be a satisfactory improvement and address stakeholder concerns noted above?

Discussion Point 1.14: To improve the provision of information to third parties, where an insurer is seeking recovery from an uninsured third party, the Code could require the insurer to provide sufficient information in writing for the individual to determine that the amount being recovered is fair and reasonable, such as:

a) details of the damage and the claim
b) the repair estimate or completed repairs
c) evidence relied on for making an assessment of liability

Would this help to address the concerns raised? Would there be any challenges with implementing this provision?

j. Provision of documents

Financial Rights has advised that their clients often do not have adequate information about their claim in order to advance a complaint through the insurer's complaints process and then on to EDR.

The Code requires insurers to inform customers after a claim is denied about their right to ask for the information relied on to assess the claim, and to supply it, if requested, in accordance with the Access to Information section of the Code. Financial Rights has suggested that it would assist both consumers and insurers if the Code specifically mentioned the documents that can be provided.

Discussion Point 1.15: The Access to Information section of the Code could be updated to clarify that insurers will provide the following information on request (subject to any special circumstances where information cannot be provided under clause 14.4):

a) information and documents relied on to deny a claim
b) copies of the PDS and insurance certificate
c) copies of any expert or assessment reports relied on
d) copies of any recordings or available transcripts of the sale of insurance

Would this be a suitable improvement or are there alternative documents that should be specified?

### ii. Automatic Renewals

ASIC has suggested in its submission that, when first purchasing a policy, consumers are not always clearly informed that it will automatically renew unless they advise otherwise. It recommends that the Code should require insurers to effectively inform consumers about automatic renewal when they first purchase any policy, including obtaining express consent to allow this.

Financial Rights proposes that automatic insurance renewals be banned.

The ICA's view is that automatic insurance renewals can be important for ensuring customers are not at risk of losing cover if they do not actively renew their policies. However, this protection should be balanced with adequate customer awareness, both at the point of sale and at renewal time.

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| Discussion Point 2: In order to address concerns raised about automatic renewals, would a practical option be for the Code to require insurers to effectively inform consumers about automatic renewal when they first purchase a policy and at renewal time? This would include obtaining a customer's express consent to allow this and providing the ability to opt out. Is this a sensible balance? |

### iii. Cancellation of policy

Where instalment payments are unpaid and the insurer intends to cancel the policy, the Code currently contains a requirement to provide a customer with two notices in writing.

Financial Rights provided a number of suggestions for improving cancellation procedures to ensure consumers are not unnecessarily losing their insurance cover:

- Any notice of cancellation for non-payment of instalments should mention the availability of hardship arrangements.
- The cancellation procedures in the Code should be amended to provide notice in writing at least 14 days before cancellation through two different channels of communication (SMS, email, post).
- Insurers should be required to always give the second notice of cancellation within 14 days after the policy has been cancelled.

The ICA would welcome feedback on these suggestions. For example, if a customer has stated a preference to be given notice by a particular channel (for example, email), is consent required before utilising an additional channel?

Would confirmation that a policy has been cancelled be the most effective means of motivating the customer to take action before an insurable event takes place? Or, would a second notice provided before the policy is cancelled motivate the customer to speak to their insurer, rather than risk losing their cover?

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| Discussion Point 3: How can we improve the cancellation procedures in the Code to assist with customer engagement and prevent unnecessary cancellation? Are there any practical implications with changing the cancellation procedures? |

## iv. Complaints and disputes

### a. Multi-tier complaints process

Consumer advocates have expressed concern about the use of a multi-tier complaints process within the general insurance industry. The issues raised with the ICA include the risk of consumer confusion (with consumers not aware of the point in time at which they are eligible to escalate a complaint to the second stage) or fatigue, with customers essentially giving up on their complaint before all avenues are explored.

Submitters have proposed that insurers could determine how complaints are dealt with internally within one complaint timetable. This could be either 45 days as provided by RG165 or a shorter prescribed period. For example, insurers may provide a provisional response to discuss with the customer, escalating straight to the IDR team for more serious complaints, or coming to a final decision more quickly.

Insurers are of the view that this would be difficult to manage, particularly for large insurers who handle very large numbers of complaints, the bulk of which are resolved without issue.

Some of the additional feedback insurers provided includes:

- Having a two-stage system means that, in the first instance, someone close to the complaint reviews it and does not have to spend a significant amount of time familiarising themselves with the file. Sending a matter straight to an independent team will build time into the initial review as someone will have to review the entire file to assess the complaint.
- Requiring large insurers to have sufficiently large complaint and dispute management departments to deal with all complaints would be a significant financial burden.
- If the Code only included one 45-day timeframe for deciding on a complaint, this would lead to insurers having differing processes and practices, leading to customer uncertainty. Consistency in communication and processes would be preferred.

Insurers have also suggested that it would be prudent to wait until the details of AFCA are in place before making any changes to the standard industry complaint process.

| Discussion Point 4: Insurers have suggested that moving to a one-tier complaints process would be difficult to manage. Noting the issues outlined above, are there other suggestions for improving the internal complaints process? Are there any concerns with waiting until after AFCA is established before implementing changes? |
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### b. Customer representatives

Consumer Action has suggested that, where an insurer has been informed that a customer has legal representation, the insurer, and any Service Suppliers, should be required to contact the customer's representative rather than the customer directly. The insurer should only contact the customer directly where there is good reason and the representative agrees. The ICA has referenced a similar discussion under the Financial Hardship section of the Report.

| Discussion Point 4.1: Would a satisfactory improvement be for the Code to require that insurers and Service Suppliers contact a customer through their representative when this has been requested by the customer? |
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### v. Advertising and marketing

The submission from Financial Rights suggested that the Code enforce advertising and marketing restrictions. For example, prohibiting the use of terms such as "free" in advertising or marketing, on the basis that it may not be appropriate to offer free gifts or bonuses with insurance products, when considering the likely audience.

The Life Code contains a number of restrictions on the advertising and marketing of life insurance products, based on work done by ASIC and in overseas jurisdictions.

> Discussion Point 5: Would the following provisions provide adequate restrictions on advertising and marketing?
>
> a) Consider the target audience for the advertisement or marketing communication and whether it provides adequate information for that audience
> b) Ensure statements in advertisements or marketing communications are consistent with the features of the relevant policy and the disclosures in any corresponding PDS.
>
> Are there other factors to consider?

### vi. Pressure selling

In 2011, ASIC issued a report that contained details of "*pressure tactics and harassment being used to induce consumers to purchase*".[17] ASIC's report expressed concern about:

- staff persisting with an insurance sales pitch to a consumer who has clearly indicated they do not wish to purchase the product
- the practice of keeping consumers 'captive' until after the insurance sales pitch has been completed
- using the insurance cooling-off period as a selling point
- highlighting the risks of not having insurance if the consumer became sick or unemployed, without providing information about other alternatives such as financial hardship variations
- deliberately masking the cost of the insurance in the loan repayment (in reference to consumer credit insurance).

The ICA has proposed that the Code should strengthen standards relating to third-party distributors and we welcome feedback on whether formal agreements with distributors should prohibit pressure selling. We also welcome feedback on whether the Code should more broadly include standards on pressure selling.

> Discussion Point 6: What issues need to be taken into account if the Code were to explicitly state that pressure selling practices are prohibited?

[17] Report 256 *Consumer credit insurance: A review of sales practices by authorised deposit-taking institutions* (19 October 2011) http://www.asic.gov.au/media/1343720/rep256-issued-19-October-2011.pdf.

## vii. Customer communications

a. When insurance is not offered

Clause 4.8 of the Code sets out the obligations on insurers if they do not offer insurance cover. Legal Aid NSW has provided a number of recommendations to improve this process.

Legal Aid NSW has suggested that for clarity and transparency, the insurers should provide their reasons for not providing insurance in writing.

Insurers have identified some immediate and practical concerns with this. A large proportion of general insurance is purchased online or over the phone. At the point at which an insurer determines that insurance cannot be offered, it may be able to provide this information to the consumer as part of the initial phone call, or onscreen if they have made the enquiry online. However, some insurers have advised it would be an onerous requirement to expect the insurer to also write to the consumer with this information.

The ICA suggests that reasons in writing could be provided on request, which would assist those consumers who would like to take their application further, either through an insurer's complaints process, or by seeking alternative insurance options.

Legal Aid NSW has also suggested that many consumers would not know that they can ask for the information relied upon by an insurer, and that insurers should be required to inform consumers of this right. The ICA's view is that this is consistent with the obligation on insurers where a claim is denied, and would therefore appear to be an appropriate extension of this section.

Finally, Legal Aid NSW recommends that the Code should require insurers to refer consumers for legal advice where coverage is refused. The current requirement is to refer consumers to the ICA or NIBA or another insurer for information about alternative insurance options, and also to provide details of the insurer's complaints process.

It is the ICA's view that assisting a consumer to make a complaint would then allow them to avail themselves of the EDR scheme which consumers can access for free. We suggest that this is preferable to referring consumers for legal advice in a situation which is not necessarily litigious.

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| Discussion Point 7: To address the concerns raised above, is a satisfactory solution for clause 4.8(b) in the current Code to be amended to state "*we will inform you of your right to ask for the information that we have relied on in assessing your application and, if you request it, we will supply it in accordance with Section 14 of this Code*." Please identify any concerns with this approach. |

b. Verification of a customer's disclosure

Financial Rights has submitted that there should be a greater onus on insurers at the point of sale to verify customers' disclosures. The examples given in the Financial Rights submission are that insurers have access to information such as a consumer's insurance report, driver history and criminal record, and should verify their disclosures against these documents.

A number of insurers have advised that they do not have easy access to this data and that access to consumer information through a third party insurance report service can be ambiguous. For example, withdrawn claims may be shown as declined, which could lead to an insurer believing a customer may have failed to disclose a previously declined claim. Insurers have also noted that it could be costly to have to generate an external insurance report for every sale.

In addition to this, insurers have noted that accessing a consumer's driver history and criminal record are not processes that happen in real time, and there are privacy concerns involved that would require the individual's consent. This could cause major delays in the sales process, as it can take significant time to receive this information.

Based on the above, the ICA suggests that it may not be practical to request these documents in all cases. The ICA considers that as a principle, insurers should be able to rely on their customers' duty of disclosure in order to make decisions about their risk and the cover offered.

There may be instances in which an insurer becomes aware of a failure to disclose, or of information inconsistent with the customer's disclosures, after the policy is taken out. In these cases, the insurer should have an obligation to act upon this information and raise it with the customer as early as possible. The ICA agrees that it is not appropriate to continue to collect premiums in a situation where the insurer knows that if the customer made a claim, it would be denied due to failure to disclose.

The Life Code has a provision for this scenario:

> *"Should we become aware after the cover is issued that information you provided in your application for insurance was incorrect or incomplete at the time the Life Insurance Policy was issued:*
>
> *a) if we consider the information to be important for your cover, we will ask you to provide an explanation, including giving you an opportunity to review any relevant documents about you, before we make any decision such as changing the terms or cancelling your cover; and*
> *b) once we have made a decision, we will advise you of our decision and any actions we will be taking, and the process to have this reviewed or make a Complaint if you disagree with our decision."*

| Discussion Point 7.1: Given the obstacles noted above regarding verifying disclosure at the point of sale, would a satisfactory alternative be for the Code to require that a customer is contacted as soon as an insurer becomes aware of an issue with their disclosures? What are the advantages and disadvantages of this approach? |
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c. Policies with no-claim discounts (NCDs)

In 2015, ASIC released a report on motor vehicle policies with NCDs which found that disclosure could be improved to ensure consumers understood how the premium was structured and the impact of a claim on the premium.

ASIC has recommended the Code contain a number of measures aimed at increasing understanding of NCDs.

ASIC is currently doing a review of the extent to which the recommendations in its report on NCDs have been taken up by insurers. The ICA understands that many insurers have implemented ASIC's recommendations in the past two years.

The ICA would welcome stakeholder feedback as to whether the Code needs to respond to this, or whether the ICA should await the results of this review before determining whether a Code response is required.

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| Discussion Point 7.2: Should the Code contain measures aimed at increasing consumer understanding of NCDs or, have insurers taken reasonable steps to improve this? If the Code were to include measures, please provide examples. |

### viii. Monitoring, enforcement and sanctions

a. Reporting of Code breaches

The CGC has suggested that the current wording of clause 13.1, which allows "you" to report alleged Code breaches, is too narrow. This is because "you" only encompasses an insured and third-party beneficiary.

The ICA agrees that the intention has been that anyone should be able to report an alleged Code breach to the CGC. This includes FOS, consumer advocates and legal professionals.

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| Discussion Point 8: Would a redrafting of Clause 13.1 of the Code to read "*Anyone can report alleged breaches of this Code to the CGC*" sufficiently address the issue noted above? Is an alternative solution needed? |

b. Interpretation of Code standards and process for appeal

The Code Review has highlighted that there are some Code standards that the CGC and Code Subscribers are interpreting differently, and differently from the ICA's intention in drafting the standards.

A number of the sections of the Code begin with the principles of honesty, fairness, transparency and timeliness. They state that insurers will comply with these principles when carrying out their activities in accordance with the relevant section.

The CGC views those principles as standalone and capable of being assessed for compliance or breach. The ICA intended for the rest of the standards in the section to provide the measure for whether the principles have been complied with.

As an example, an insurer must handle claims in a timely fashion. The ICA's view is that if the insurer complies with the timeframes in the claims section, then it has met the requirement to be timely. The ICA considers concepts such as "fairness" and "timeliness" may not provide sufficient clarity for insurers unless they are read against the subsequent standards.

This example of a difference in Code interpretation potentially has an enormous impact on the industry in determining its compliance with the Code. It has been suggested that there should be

an ability to appeal a decision of the CGC, or for the industry to provide a collective submission, in those cases where there is likely to be a significant impact on the industry broadly.

The ICA would welcome feedback as to whether the establishment of a formal appeal process would be appropriate. The ICA and its members would need to work with the CGC to discuss how this might operate in practice.

The ICA also suggests improved transparency of CGC decision making so that insurers can better understand CGC expectations.

Discussion Point 8.1: The ICA suggest that provisions such as honest, fair and timely should operate in relation to the standards in each section. Is there a way for these terms to be appropriately defined if this approach is not taken?

Discussion Point 8.2: What would be the advantages or challenges if the CGC were to regularly publish its decisions on a de-identified basis?

Discussion Point 8.3: Are there any issues that need to be taken into account if the Code were to require that, where a CGC decision has a significant and/or broad industry impact, there is an ability to appeal? Should the industry be able to provide a collective submission on Code interpretation?

c. Reporting of Significant Breaches

An insurer has pointed out that the current definition of Significant Breach has created confusion. This is because its reference to "*likely breaches*" suggests that likely Significant Breaches should be reported to the CGC. The ICA considers that the intention is only for actual Significant Breaches to be reported, and incorporation of the words "*likely breach*" are unnecessary.

Discussion Point 8.4: Would the issue identified above be appropriately resolved if the definition of Significant Breach in the Code was amended to remove the words "*likely breach*". Do you have any concerns with this proposed change?

d. Relationship between Code breaches and EDR

Comments by submitters have made it clear that the relationship between the Code breach process through the CGC, and the EDR process through FOS, is not well understood. The ICA agrees that to aid understanding by consumers, their representatives, and insurers, the Code could make this relationship more explicit.

Discussion Point 8.5: To address the confusion noted above, is an appropriate solution for the monitoring process in the Code to include the following:

a) The CGC should determine whether a breach allegation has also gone to IDR/EDR, and if the issue is more appropriate for an insurer's complaints process, then it can be referred there.
b) If a breach allegation is currently being heard at EDR, then the CGC should await the outcome of this before investigating.
c) EDR should provide details of possible Code breaches to the CGC once a determination is made.

Do you have any concerns with this approach or an alternative suggestion?

### ix. Promotion of the Code

The ICA observes that consumer engagement with the Code and the CGC is not high. More can be done to promote the Code and improve awareness of Code standards and the role of the CGC.

ASIC has suggested that the Code should involve some form of external or independent monitoring or auditing, rather than relying solely on self-monitoring by Subscribers. The ICA notes that the CGC carries out desktop audits and own motion inquiries. However, the Code and/or its website could provide more information about the powers of the CGC.

The ICA would also welcome feedback on the usefulness of a 'customer charter'. The charter could summarise key Code commitments at the beginning of the Code. It may be a more engaging and useful summary for consumers.

Discussion Point 9: Would it be beneficial if the Code included more information about the CGC's role and its areas of focus, such as:

a) to monitor and enforce the Code through investigations and analysis of data and evidence
b) to provide leadership to industry and help subscribers understand and comply with their obligations and seek continuous improvement of insurance practices
c) to liaise with the ICA

Is there any other additional information that could be provided?

Discussion Point 9.1: The Code website could be expanded to include:

a) promotion of the CGC and its role and areas of focus
b) de-identified decisions of the CGC
c) guidance to insurers through the use of scenarios and FAQs
d) online annotations, explanations and examples to aid consumer understanding of the Code

Is there any other information that could be included on the Code website?

Discussion Point 9.2: Would a summary of the key consumer commitments in the form of a "customer charter" be useful for consumers? Please advise if a more engaging tool could be adopted or if you have any concerns with this proposal.

## x. Code scope

a. Corporate culture

ASIC's submission recommended that the Code refer to culture: "*how an organisation sets its values and priorities, how it ensures that these values are expressed in formal policies, supported by monitoring and governance and flow through to business practices and staff conduct*."

The ICA is concerned that a Code reference to corporate culture would not be sufficiently clear for insurers to ensure compliance, nor for the CGC to monitor and determine whether an insurer has exhibited "good" culture. The ICA's view is that proposals and suggestions in this Review will have an impact on internal culture – such as the proposal for insurers to set clear expectations about good sales practices and unacceptable conduct.

| Discussion Point 10: The ICA's view is that the Code should not contain a specific provision relating to corporate culture. Please advise any concerns with this perspective. How can culture be adequately monitored and measured? |
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b. Residential strata

In its submission the CGC has noted that it is unclear whether the definition of retail insurance in the Code includes residential strata products.

The Code definition of retail insurance includes "*a home building insurance product*", with reference to Regulation 7.1.12 of the Corporations Regulations 2001. The regulation includes in the definition of "*home building*" the building and any out-buildings; fixtures, including fixed wall, ceiling and floor coverings; services; fences and gates. The ICA website explains that strata insurance covers "*common or shared property… This might include common areas, lifts, pools, car parks, gardens, wiring, balconies, walls, windows, ceilings and floors*."[18]

It is the ICA's view that the coverage of residential strata insurance would appear to fit within the description of a "home building insurance product" for the purposes of the Corporations Regulations 2001.

Residential strata title insurance products are covered by the FOS Terms of Reference, which defines them as "*an insurance policy insuring the body corporate of a strata title or company title building that is wholly occupied for residential or small business purposes.*"

It has been suggested that the definition of residential strata, that would appropriately fit within the Code's definition of retail insurance, would exclude mixed-use strata and high-value residential buildings. The Australian Reinsurance Pool Corporation defines mixed-use and high-value buildings as having a floor space of at least 20% used for commercial purposes, or a building sum insured of at least $50 million, whether used for commercial or other purposes.[19]

[18] http://www.insurancecouncil.com.au/assets/Consumer%20tips/Strata%20owners%20FAQ.pdf

[19] http://arpc.gov.au/qanda/mixed-use-and-high-value-buildings-qa/

Discussion Point 10.1: Should the definition of Retail Insurance explicitly state that this includes residential strata, excluding mixed-use and high value strata insurance?

c. Extension of the Code to business insurance

The CGC has recommended that the sections of the Code that currently only cover retail insurance should be extended to cover non-retail insurance products that are owned by small businesses. The sections that currently only cover retail insurance include:

- Buying insurance
- Service Suppliers
- Claims
- Catastrophes
- Complaints and disputes

The justification for this extension is to bring the Code definition in line with the FOS Terms of Reference.

This would extend the standards of the Code to cover business products such as general property, theft and loss of profits/business interruption.

During the previous review of the Code, it was determined that the intention of the Code was to largely focus on individual consumer protections. Ian Enright stated in the final report of his 2012-13 independent review of the Code:[20]

> "*The Code principles and objectives should apply to all Code Insurances, including Wholesale Code Insurances. It is critical in my view for the education and training standards to apply to all Code insurances, including Wholesale Code Insurances. The other sections, standards and guidelines should apply to Code Retail Insurances only. One aim of this recommendation is to unburden the general insurance industry from Code standards on buying insurance, claims, IDR and monitoring and sanctions for Wholesale Code Insurances so that it has more resources to devote to more effective aspects of the Code standards. The ethical principles and principles should apply to all Code Insurances*."

The ICA agrees with the perspective referenced above. Our view is that the distinction between retail insurance and wholesale insurance in the Code should remain as it is.

Discussion Point 10.2: Do you agree with the ICA's view that the current distinction between retail insurance and wholesale insurance should remain unchanged? What are the practical implications of extending sections of the Code to wholesale insurance?

[20] General Insurance Code of Practice Independent Review 2012–2013 Final Report (May 2013) http://www.insurancecouncil.com.au/assets/report/GI%20COP%20Independent%20Review%20Final%20Report%202012-13.pdf.

d. Application and guidance on the law

As discussed under Proposal 1 – Code guidance on mental health principles, the ICA's view is that as, far as possible, the Code should not seek to play a role in interpreting legal requirements.

The ICA sees the value of the Code in providing enhanced consumer outcomes over and above existing legislative requirements. Insurers are subject to a range of legal obligations that fall within the jurisdiction of various government authorities. These bodies are appropriately placed to monitor compliance and, where necessary, take action if legal obligations are not being met.

Submitters suggested that the Code should require that insurers must not provide policy wording or deny claims in contradiction with their legal requirements, particularly the Insurance Contracts Act 1984 and the DDA.

PIAC has recommended that the Code contain details of insurers' obligations under the DDA, as well as guidelines on what is required for insurers to lawfully rely on exemptions.

The ICA notes that Section 14 of the existing Code refers to the Privacy Act 1988. One insurer has advised that this provision creates overlap and ambiguity as to which obligations under the Privacy Act are under the remit of the Code.

The ICA suggests that the Australian Privacy Principles, their accompanying guidelines, and the role of the Office of the Australian Information Commissioner provide a comprehensive regime under which insurers' privacy obligations must be met, monitored and enforced. The Code should not cut-across this framework.

To avoid overlap and confusion, we therefore suggest that the Code does not take an active role in interpreting existing legal requirements.

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| Discussion Point 10.3: Do you agree with the ICA's view that the Code should not restate and provide guidelines on existing legal requirements? If not, noting the concerns raised, how could the Code effectively provide guidance on existing legal requirements without cutting across regulatory frameworks? |

## xi. Emerging technologies

A number of emerging technologies were raised by submitters as part of the Review. The ICA agrees that, ideally, the Code should be flexible enough to allow for the development of technological innovation by insurers, balancing consumer protection with ease of communication and efficiency.

Submitters provided the following examples:

- Robo advice - Insurers may look to offer robo-advice for sales of insurance products in the future.
- Robo contact - Insurers may seek to use robo-contact to communicate with customers and claimants.

- Self-managing apps - Some insurers are already allowing their customers to use apps to self-manage their claim. Having a client-driven claims process should meet the requirements of the Code for regular contact during claims handling.

| Discussion Point 11: How can the Code be flexible enough to allow for the use of emerging technologies in insurance sales, customer communication and claims handling? |
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## 5. What the Code does not cover

The ICA views the purpose of the Code as establishing valuable principles and standards of industry practice for the benefit of consumers. However, the ICA does not consider the Code to be a catch-all for every issue raised in relation to general insurance. It is also important that the Code does not become so prescriptive that it restricts insurer competition and innovation.

To these ends, we have noted some matters below which submitters have raised, but which the ICA either does not view as coming within the ambit of the Code, or does not view as appropriate for the scope of this Review. This is not to underplay the importance of these issues, but to note that they will be dealt with outside of the Code mechanism.

For example, there were many suggestions that relate to the improvement of disclosure. Improving disclosure is a core focus for the ICA and, as detailed earlier in the Report, the ICA believes it is a priority that best practice disclosure guidance be included in the Code. However' we also recognise that the project to improve disclosure is multi-faceted. Some aspects will require separate and more detailed discussions with consumer groups and other stakeholders, others may be addressed via legislative changes. Any disclosure developments that take place, and that fall within the timeframe of the Review, can be considered in the Review's Final Report.

a. Unfair contract terms

In April 2017, Consumer Affairs Australia and New Zealand provided consumer affairs ministers with its final report on its review of the Australian Consumer Law.[21]

One of the proposals was to apply unfair contract terms protections to contracts regulated by the Insurance Contracts Act 1984.

In their final report following the inquiry into the general insurance industry, the Senate Economics References Committee, also recommended that the Government introduce legislative changes to remove the exemption for general insurers to unfair contract terms laws.[22]

The ICA is currently exploring how unfair contract terms could be incorporated into the Insurance Contracts Act, and how to assist the Government and regulators to develop an appropriate solution, if a decision is made to accept the ACL Review proposal and/or the Senate Committee recommendation.

[21] Australian Consumer Law Review, Final Report, March 2017
https://cdn.tspace.gov.au/uploads/sites/86/2017/04/ACL_Review_Final_Report.pdf

[22] The Senate Economics References Committee, Australia's general insurance industry: sapping consumers of the will to compare, August 2017
http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Economics/Generalinsurance/Report

b. Addressing affordability and underinsurance

A number of submitters' recommendations touched on issues of insurance affordability and underinsurance. While this is a major priority for the ICA and its members, the ICA suggests that the Code focuses on customer service standards. Matters of insurance affordability and underinsurance will continue to be progressed via other work streams in consultation with the relevant stakeholders.

c. Written-off vehicles

Financial Rights has suggested that standards relating to the written-off vehicle register (WOVR) should be incorporated into the Code. For example, it is suggested that insurers be more flexible about giving options to car owners that want to organise repairs to their own vehicles.

The ICA considers that the Code should not intersect with the requirements and processes for insurers to put vehicles on the WOVR after an accident. The WOVR is regulated in each State and Territory and there could be safety issues when vehicles are badly damaged, even if they are still drivable.

d. Renewal notices

One of the recommendations of the Effective Disclosure Taskforce was for insurers to actively identify opportunities for constructive and useful interaction with consumers through the life of a product to enhance consumer engagement.

The ICA views a customer's renewal notice as a convenient regular channel for up-to-date information to be provided. It also provides an opportunity to nudge the customer to assess the ongoing suitability of the insurance they hold.

Financial Rights noted in its submission that insurers can introduce sub-limits at renewal time that did not exist before.

ASIC referenced research conducted by the Financial Conduct Authority in the United Kingdom which showed that the disclosure of last year's premium on renewal notices can promote better engagement, with more consumers considering whether the cover still meets their needs. This results in more shopping around or switching.

The Senate Economics References Committee also recommended that:

*…the government strengthen the transparency of general insurance pricing by amending the product disclosure regime in the Corporations Act 2001 to require insurers to:*

- *disclose the previous year's premium on insurance renewal notices; and*
- *explain premium increases when a request is received from a policyholder.*

The ICA is aware that many insurers' systems are not currently in a position to provide this information on every customer's renewal notice. For this reason, we regard this as industry best practice, and note that many insurers are progressing in this direction. For example, several

insurers have moved to provide year-on-year premium comparisons in the context of Emergency Services Levy reform in NSW.

We suggest that the Code is not used to prescribe insurers' renewal notices. However, as part of the ongoing work in improving disclosure, the ICA and members should work with Government and other stakeholders to consider how a customer's renewal notice can be more effective.

Options could include:

- Use of plain language
- A short, simple explanation for any increase in premium
- For home building policies, a suggestion that the customer reviews their sum insured, and an explanation that the cost of rebuilding can increase
- Information about contacting an insurer to discuss options if a policyholder wanted to change the terms of the policy or is having difficulty meeting premium payments.

e. Customer communication during the complaints process

It was recognised by insurers that improvements could be made to communications during the complaint process, in order to aid customer understanding about progress made and next steps.

The ICA suggests that insurers work with consumer advocates to determine how communications could be delivered more effectively while complaints are being decided. There is a flow chart of the complaints process on the Code website[23] which could serve as a starting point for more effective customer communication.

Some insurers raised issues with the requirement for the Stage One response to the customer to be in writing, and to include reference to the FOS EDR scheme, even though a customer's complaint would need to go through Stage Two within the insurer before being directed to EDR. The reason for requiring such a detailed written response at the completion of Stage One is so that, if this decision resolves the customer's complaint, or the customer chooses not to go to Stage Two, the response serves as a "final response" for the purposes of RG 165.

The ICA's view is that it would be challenging to design an alternative process that still satisfies the requirements specified in RG 165. As noted earlier in the Report, a new external dispute resolution body (AFCA) is due to commence from 1 July 2018. Under the section complaints and disputes, Discussion Point 6, we have asked stakeholders for feedback as to whether the complaints process in the Code should be left unchanged until AFCA is established. In the interim, we suggest that insurers consider ways in which communication during the complaints process can be improved within the parameters of RG 165 requirements.

f. Standardisation and comparability of cover

Submitters provided a number of suggestions for ways in which policies could be standardised and comparability improved. These included:

[23] http://codeofpractice.com.au/assets/documents/How%20to%20make%20a%20complaint.pdf.

- **Standard cover**. There is a standard cover regime in the Insurance Contracts Regulations 1985, of which there is little awareness. Insurers can use the PDS to detail any deviations from standard cover, which arguably does not provide sufficient clarity for consumers. Submitters suggested that policies should clearly show where they provide less than standard cover, or that standard cover should operate as a minimum standard or benchmark, with the only variation being additional benefits.
- **Standard definitions**. The industry could undertake consumer testing to identify which policy terms are not well understood. It may be appropriate to adopt industry-developed common definitions to facilitate consumer understanding. Legal advice would need to be obtained regarding the impact of standardising terms, as standard definitions may require ACCC approval.
- **Standard PDS order**. Insurers could agree on the development of a standard content order and standard headings in PDSs, which could be enshrined in the Code. This could assist consumers with comparability of different policies**.**

As well as these suggestions from submitters, the Senate Economics References Committee recommended that the Government initiate an independent review of the current standard cover regime with particular regard to the efficacy of current disclosure requirements. The Committee also recommended that the Government work closely with industry and consumer groups to develop and implement standardised definitions of key terms for general insurance.

The ICA is committed to working with Government and consumer groups on improving product comparability. We have commenced planning consultation with stakeholders as part of the disclosure project to enhance the comparability of polices. The ICA's work on product comparability will consider the use of standard cover, standard definitions, and standard order and headings for product disclosure statements. This work will progress under the auspices of the effective disclosure project. Any developments that occur within the timeframe of this Review can be considered in the Review's Final Report.

g. Key Facts Sheet (KFS)

Submitters suggested that KFSs could include an explanation of excesses and when they might apply, as well as disclosure of caps or sub-limits in policies.

For general insurance, there is a requirement in place for the provision of key information. The Insurance Contracts Regulations 1985 require an insurer to provide a consumer with a one-page KFS for home building and home contents insurance, with prescribed content. The aim of the KFS is to enable consumers to easily access key information about, and compare, similar insurance contracts.

Due to the level of prescription, the ICA notes that a KFS can end up looking generic, which may defeat the purpose of attempting to assist customers to easily access key information.

Submitters also suggested that KFSs be made available on insurer websites in a consistent and obvious manner.

The Senate Economics References Committee recommended that Government undertake a review of the utility of KFSs as a means of product disclosure, with particular regard to the

effectiveness of KFSs in improving consumer understanding of home building and contents policies.

As part of the disclosure project, the ICA will seek to work with consumer groups to assess how KFSs can be made more user-friendly and tailored with the bounds of the legal requirements. This work can consider whether the KFS could be improved while still meeting the prescribed requirements.

h. Key Facts Sheet for motor policies

One of the areas of focus for submitters was motor vehicle insurance. The Motor Trades Association (MTA) suggested that a KFS for motor insurance would assist consumers to make more informed choices as to the type of cover they require.

It was noted that the most commonly misunderstood terms of a motor insurance policy are whether the customer has the right to choose their repairer, and the type of spare parts used in the repair process.

Submitters also noted the confusion generated by the different types of motor vehicle insurance offered - for example comprehensive, third party property, uninsured motorist extension, compulsory third party personal injury (CTP) – with some customers unclear on their coverage.

The Senate Economics References Committee also suggested that Government consider the merit of extending the use of KFSs to other forms of general insurance.

The ICA does not consider KFSs for motor policies to be within the scope of this Code Review. However, as part of the ongoing work on improving disclosure, the ICA and members can consider whether there is value in an industry standard KFS for motor vehicle insurance products (excluding CTP).

i. Disclosure of component pricing

Financial Rights submitted that insurers should be required to provide information as to the components that make up their premium pricing; for example, where loadings have been included for particular weather risks.

The Senate Economics References Committee recommended that the Government initiate a review of component pricing to allow for component pricing of premiums to policyholders upon them taking out or renewing an insurance policy.

Insurers have raised concerns that this approach could have competition and pricing issues.

The ICA's view is that such an approach would require the disclosure of commercially sensitive pricing calculations that frequently change for insurers to remain competitive and commercial. Further, component pricing may not help consumers to better understand their risks and how to mitigate them.

Nonetheless, the ICA acknowledges that consumers need better awareness of the particular risks they are facing. One of the ICA's priorities is improving access to natural hazard information, including flood, earthquake, bushfire, storm surge and cyclone exposures, at an individual property level. The ICA and its members will continue to work on this as data is made available by local governments and councils, to allow insurers to accurately price risk and to engage with their customers as to the risks they face.

j. Provision of data/access to information

One of the responsibilities included in the charter for the CGC is the production of an annual industry data report.

The CGC requires insurers to provide data on policy numbers, claims, complaints and Code compliance at a product level.

The CGC has noted that there are inconsistencies in data collection and calculation approaches, both between and within insurers' businesses. This makes it difficult to make meaningful comparisons or to draw firm conclusions about the cause and meaning of any trends. As a result, the CGC has identified improving data quality as a priority.

ASIC has also made statements about the need for better quality, more consistent and more transparent data, to identify trends and issues within a product, an insurer or the industry as a whole.

As part of the Government's proposals to improve dispute resolution in the financial system, it has been proposed that members of AFCA will be required to report to ASIC in a standardised form (as determined by ASIC) on their IDR activity.

The ICA agrees that industry data collection, analysis and reporting could be improved. Options to be considered include:

- Consistent definitions of declined claims, partially declined/accepted claims and withdrawn claims
- Reasons for claim denials and withdrawals
- Public reporting regime on claims and disputes

There is scope for this work to be carried out by independent data experts, in order that it does not take up a large amount of the CGC's resourcing which could be used for Code investigations. Granular data could then be provided to the CGC, the ICA and insurers, and the CGC could use it to determine whether there are systemic issues to be addressed in Code compliance.

The ICA will seek to work with the CGC and Code Subscribers to ascertain the best mechanism for improving industry data collection and reporting once the requirements related to AFCA are known.

k. Governance of the Code

The CGC has suggested in its submission some changes to its governance arrangements. The ICA does not consider that this is within the scope of the Code Review, as they are decisions for the independent Code Governance Committee Association to determine through changes to the CGC's Charter. The ICA suggests that these matters are raised with the Association at its annual general meeting.

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| Discussion Point 12: Do you agree that the areas above are not in the scope of this Code Review? For those areas where non-Code initiatives are underway, are they responding to stakeholder concerns? |

## 6. Stakeholder Assessment

When reviewing the ICA priority proposals and the additional Code Review themes, we ask stakeholders to consider the rating matrix below and indicate the likely impact of the suggestions on consumer outcomes and implementation considerations for industry.

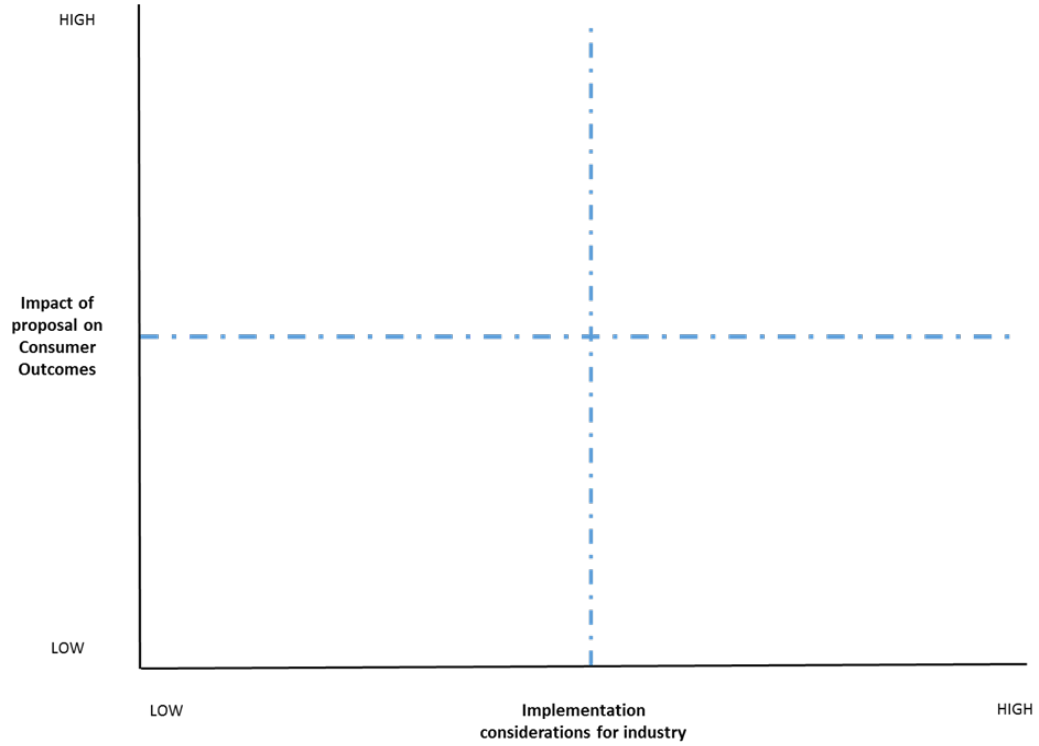
Impact of the proposal on consumer outcomes include, but are not limited to:

- Improved treatment of customers, for example greater fairness
- Improved product design
- Improved claims experience
- Improvement in the provision of information and processes to ensure customers are kept adequately informed during and after the point of sale

Implementation considerations for industry include, but are not limited to:

- The length of time required for implementation
- System changes and costs associated with implementation
- Any existing legislative requirements that may interact with the proposal
- Whether the proposal has a disproportionate impact on larger or smaller insurers

**Rating Matrix**




Question 9: Do the ICA Priority Proposals adequately reflect the priority matters to be addressed by the Code Review?

Question 10: Have the additional Code Review themes been appropriately prioritised for inclusion into a revised Code?

## 7. How to make a submission

The Consultation period for this Interim Report runs until Monday 8 January 2018. Anyone can provide written feedback by using the submission portal on the Review's website http://codeofpracticereview.com.au/

Alternatively, you can send your submission by email to the Code Review Secretariat at secretariat@codeofpractice.com.au

All submissions will be treated as public documents and published on the review website unless you request that your submission be treated as confidential. You can make it clear if you wish for your submission to be confidential by either selecting the appropriate box in the submission upload form on the Review website, or in writing via email.

## 8. Summary of Code Review Questions

| ICA Proposals | Questions |
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| **Proposal 1**<br>The Code should strengthen standards relating to vulnerable consumers:<br><br>• Including a new Code section on vulnerable consumers | **1**: The ICA suggests that the Code could include a new section on vulnerable consumers. The section would begin with a statement acknowledging the diverse needs of vulnerable people and committing to supporting the particular needs of customers where these are identified. Please identify any concerns or suggestions for improvements with this approach.<br><br>**1.1:** It seems reasonable that the Code should require insurers to accommodate vulnerable consumers' requirements for formal or informal assistance from third parties. Please detail any concerns with this suggestion.<br><br>**1.2:** The ICA suggests that the Code should require staff to be trained to identify and engage appropriately with vulnerable consumers, and to escalate requirements for additional support. Are there any implementation factors that need to be considered?<br><br>**1.3**: The ICA suggests that the Code should not prescribe specific products or payment arrangements, such as through Centrepay. However, Proposal 3 sets out product design principles for the Code. How could these principles improve product design for vulnerable consumers?<br><br>**1.4**: The ICA suggests that the Code should require assistance to be provided to those who have trouble meeting identification requirements. Please identify any concerns you may have with this approach.<br><br>**1.5**: Noting the Commonwealth Ombudsman best-practice principles, and the point raised by some insurers, would the following principles satisfactorily reflect best practice standards for the use of interpreters?<br>a) Insurers must provide access to an interpreter, either when one is requested by the customer or when a staff member needs one to communicate effectively with a customer (whether formally or informally).<br>b) Staff must make a record of a customer's interpretation needs and plan ahead to meet these needs. Where an interpreter is offered but declined, staff must also record this.<br>c) Insurers must provide a direct link on their website to information on interpretation services and any other relevant information for non-English speakers. This includes any product information that insurers have translated into other languages. |

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| | Do you have any concerns with this approach or suggestions for improvement? |
| • Providing Code guidance on best practice mental health principles | **1.6**: The ICA proposes that the mental health best-practice principles (detailed in Appendix 1) should be developed into an ICA guidance document. Do the principles adequately respond to the issues raised by stakeholders? Are there any matters that have not been addressed?<br><br>**1.7**: The ICA's view is that the Code should not contain guidelines for complying with the DDA. However, the Code could include a statement explaining how underwriting decisions will be made. For example:<br>a) Decisions will be evidenced based;<br>b) Underwriting decisions will be regularly reviewed to ensure decision making is not relying on out-of-date information.<br><br>Is this a suitable alternative? Are there any issues or concerns with this approach?<br><br>**1.8:** Should the Code require insurers to provide, on request, a summary of the type of data or a description of the relevant factors relied upon, and why that data or those factors are relevant, when they rely on the DDA to make a decision about the provision of insurance or about a claim? What are the strengths or weaknesses of this approach? |
| • Providing Code guidance on recognising and responding to instances of family violence | **1.9**: The ICA proposes that the family violence document attached in Appendix 2 be developed into an ICA guidance document. Does the document adequately respond to the issues raised by stakeholders?<br><br>**1.10**: Does it appropriately capture the areas that an insurer should include in their family violence policy? |
| • Including stronger Code standards on financial hardship | **1.11**: The ICA suggests that the Code should require insurers and Service Suppliers to receive training on their obligations with regard to consumers in financial hardship, and to identify signs of financial hardship when engaging with individuals who owe money to an insurer. Are there any implementation factors to consider with this approach?<br><br>**1.12**: Noting that an individual will still have to provide evidence of actual financial hardship, are there any practical implications to consider, if the Code were to require debt recovery letters to include information about the financial hardship process? |

**1.13**: Should an insurer who is contacted directly by a consumer in hardship, who is aware that the consumer has a representative, always be required to notify the representative that such contact has occurred? If there are any privacy implications, please detail them. Are there any alternative solutions?

**1.14**: It has been identified that timeframes for assessing hardship requests vary among insurers. If the Code required that financial hardship applications should be processed in line with the National Credit Code, would this be a satisfactory solution? Is there another preferable way to address this matter? The timeframes would require that:

a) The insurer will assess an application for hardship assistance and inform the consumer of its hardship decision within 21 calendar days, or inform them that it needs more information.
b) If the insurer needs more information, the consumer has 21 calendar days to provide it.
c) Within 21 calendar days of the consumer providing the requested information, the insurer must make its hardship decision and inform the consumer of its decision.
d) If the consumer fails to provide the requested information, then the Code Subscriber must make its hardship decision on the information available within 28 calendar days of the date that information was requested, and inform the consumer of the decision.

**1.15**: There appears to be sound reasons for the Code to require that consumers requesting financial hardship assistance are only asked to provide information that is genuinely necessary to assess their application. Also any request for information should not unreasonably or unnecessarily delay the assessment of the hardship request. Are there any issues that would have to be resolved in order for this to be implemented?

**1.16**: To address the concerns noted above, should the financial hardship section of the Code make it clear that it applies to situations where a customer cannot pay their excess? Also should the options for financial hardship assistance in clause 8.8 include “deduction of the excess from the claim payment”? Are there any practical implications with this approach?

**1.17**: If a customer in financial hardship has the ability to pay their debt in instalments, should the Code specify that this option should not be refused by the insurer?

**1.18**: What would the potential challenges or advantages be if the Code were to specify criteria for debt waiver?

**1.19**: Should the financial hardship process include a complaint handling timeframe of 21 days, in line with the timeframe for credit disputes about hardship in RG 165? Would this create any administrative or resourcing issues that would outweigh the benefit to consumers?

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| | **1.20**: There is confusion and varying interpretations about the interaction between section 8 and 10 of the Code. What factors need to be considered in order to clarify the obligations and rights under these sections for uninsured third parties?<br><br>**1.21**: Are there any practical implications with expanding access to an insurer's internal complaints process for those who have a financial hardship complaint that relates to wholesale insurance? |
| **Proposal 2**<br>The Code should provide guidance on best practice disclosure principles | **2:** Do the best practice principles detailed in Appendix 3 adequately address key concerns related to disclosure? Please identify any areas that have not been addressed.<br><br>**2.1**: Would a new Code requirement that key information must be provided in plain language, and be consumer tested to ensure it is clear and informative enough for a consumer to reasonably assess the suitability of the policy for them, be a sufficient strengthening of the plain language provision? Please advise if you consider an alternative approach more appropriate.<br><br>**2.2**: In order to improve the guidance provided to consumers on selecting a sum insured amount, the ICA suggests that Code could require insurers to provide access to an accurate and informative sum insured calculator as part of the home building insurance application process. Would this adequately address the issues raised above and are there any additional factors to consider with this suggestion? |
| **Proposal 3**<br>The Code should include product design and distribution principles and provide guidance to insurers<br><br>• Product design | **3:** Would the inclusion of the following principles in the Code be an effective means of improving product suitability? Are there any other principles to add?<br>a) Cover must be designed with a clear target market in mind. Equally, it should be clear to insurers and distributors which consumers are not part of the target market.<br>b) Cover must be designed to meet a genuine need and offer a tangible benefit at reasonable value. This applies to additional as well as core benefits.<br>c) Insurers must not design products that offer (or are capable of offering) negative or very low value.<br>d) The product and its features and exclusions must be capable of being communicated to and understood by the target market.<br>e) When designing products for bundling, insurers must consider how this impacts on the target and non-target market and product value.<br>f) Insurers must regularly review product performance and act promptly on any identified concerns.<br><br>**3.1:** Do the product design considerations attached in Appendix 4 adequately respond to stakeholder concerns? Can the principles be applied to all general insurance products and does the material provide sufficient detail as to how the principles are to be applied? |

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| • Product distribution | **3.2:** Would the inclusion of the following principles in the Code effectively help consumers to purchase insurance that is suitable for them? Are there any other principles to add?<br><br>Insurers must have reasonable controls in place to ensure that:<br>a) the product reaches the target market for whom it is intended<br>b) the product does not reach those outside the target market<br>c) the product does not offer low or negative value.<br>d) they set clear expectations about what constitutes good sales practices, and equally what conduct is not acceptable<br>e) they must provide the necessary training and information to their distributors to enable them to sell the product in line with their stated policies<br>f) they regularly review distribution and promptly address any identified concerns<br><br>**3.3:** Do the distribution considerations attached in Appendix 4 adequately respond to stakeholder concerns? Can the principles be applied to all general insurance products covered by the Code and does the material provide sufficient detail as to how the principles are to be applied?<br><br>**3.4:** Are there any issues that would have to be considered if the Code were to include options for consumer redress in circumstances where an insurer identifies issues with the distribution of its products? Examples could include:<br>a) cancelling the cover<br>b) arranging a refund of premiums and interest<br>c) arranging more suitable cover<br>d) honouring a claim |
| **Proposal 4**<br>The Code should provide product design and distribution guidance specific to add-on insurance products | **4:** Would it be appropriate to develop product-specific guidance in the Code around product design and distribution for add-on insurance products? Are the product-specific considerations relevant to add-on products in Appendix 4 adequate, or is further detail needed?<br><br>**4.1:** What role, if any, should the Code play in the implementation of a deferred sales model for add-on products sold through the motor dealer channel? |
| **Proposal 5**<br>The Code should strengthen standards relating to third party distributors | **5**: The ICA has identified obstacles with requiring all entities, engaged in an activity covered by the Code, to subscribe to the Code directly. We suggest that as an alternative, the Code should require that when an insurer enters into a formal agreement with a third party to sell its product, the agreement should include the following:<br>a) Sales to be conducted in an efficient, honest, fair and transparent manner<br>b) All salespeople to be appropriately trained and educated, their conduct monitored by their employer and problems with conduct addressed<br>c) Insurers to notify their distributors of the identified target and non-target market for the product<br>d) Pressure selling is not permitted |

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| | e) Distributors to notify insurers of any complaints and tell customers the identity of the relevant insurer<br><br>Is this a suitable option for strengthening the standards relating to Service Suppliers? Please identify any concerns with this approach.<br><br>**5.1**: Industry has noted the operational challenges of requiring insurers to monitor the sales practices of third parties. Is there an alternative approach that would allow for the effective monitoring of outsourced third parties? |
| **Proposal 6**<br>The Code should strengthen standards relating to Service Suppliers | **6:** Would making the following requirements explicit help to strengthen insurers' responsibility for the conduct of their Service Suppliers:<br>a) Insurers are responsible for the conduct of their Service Suppliers and their approved subcontractors<br>b) Insurers must have measures in place to ensure that due skill and care is taken in choosing suitable Service Suppliers<br>c) Service Suppliers should notify the insurer of a customer complaint by the next business day.<br>d) Insurers will appropriately address any actions by Service Suppliers that breach the Code, Service Level Agreements or licence obligations.<br>Are there any further provisions to be considered?<br><br>**6.1:** Are there any issues to consider if the Code were to require insurers to ensure that Service Suppliers are appropriately skilled and qualified to carry out their duties and remain up-to-date with industry developments as well as the requirements of the Code?<br><br>**6.2:** The ICA does not believe that the definition of Service Suppliers should be expanded to include External Experts. Do you agree with the concerns we have raised with this proposal? How can the standards of External Experts be improved without compromising their independence? |
| **Proposal 7**<br>The Code should include mandatory standards for Investigations | **7:** Do the investigation and interview standards attached in Appendix 5 adequately respond to stakeholder concerns regarding investigations? Please advise if any areas have not been covered.<br><br>**7.1**: Are there any practical implications if these standards were to be included in the Code as mandatory?<br><br>**7.2**: Are there any other practical issues with these requirements? |
| **Proposal 8**<br>The revised Code should meet the requirements for ASIC approval | **8:** What issues should be taken into account if the Code were to make it explicitly clear that Code standards are enforceable through the Code Subscribers' EDR scheme?<br><br>**8.1:** Are there any factors to consider if the Code required the CGC to report systemic code breaches and serious misconduct to ASIC?<br><br>**8.2:** Noting the issues raised above, in order to meet the requirements for ASIC approval, would it be satisfactory if the Code required an independent review no later than three years after the adoption date of any previous changes to the Code? Are there any alternative approaches to consider? |

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| | **8.3:** Given the apparent lack of clarity around the operation of the remedies and sanctions in the Code, would this be addressed if the available Code sanctions mirrored those recommended by ASIC RG 183:<br>a) Compensation for any direct financial loss or damage caused to an individual<br>b) Binding non-monetary orders obliging the subscriber to take (or not take) a particular course of action to resolve the breach<br>c) Formal warnings<br>d) Public naming of the non-complying organisations<br>e) Corrective advertising orders<br>f) Fines<br>g) Suspension or expulsion from the ICA<br>h) Suspension or termination of Code subscription<br><br>Are there any other factors that need to be considered with this approach? |

| **Additional Code Review Themes** | **Discussion Points** |
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| **i. Claims –**<br><br>a. Making a claim | **Discussion Point 1:** What issues should be taken into account if the Code were to require the following:<br><br>a) provide a claimant with contact details they can use to get information about the claim<br>b) explain to the claimant why particular information is being requested<br>c) where possible, request all required information early and in one request, rather than in multiple information requests? |
| **Claims –**<br><br>b. Withdrawn claims | **Discussion Point 1.1:** Some stakeholders have suggested that the Code should make it clear that insurers will neither discourage a claim nor encourage a withdrawal. Is this a sensible Code requirement or are there any problems with this approach? |
| | **Discussion Point 1.2:** There is strong support for better data collection of withdrawn claims. The ICA notes that this could involve extensive system changes for some insurers. Taking this into consideration, would an appropriate middle ground be for the Code to require that when a claim is withdrawn, insurers should endeavour to record the reasons for this (if known) and ensure the customer is aware that they can make a complaint if they wish? Please identify any concerns with this approach or alternative options. |
| **Claims –**<br><br>c. Claims decisions | **Discussion Point 1.3:** What factors should be taken into account if the Code were to require regular updates to be given to a claimant every 10 business days (which can be provided via text, email or mobile phone), with responses to routine queries given within five business days? |
| **Claims –**<br><br>d. Claims denials and partial denials | **Discussion Point 1.4:** Are there any matters that would have to be resolved if the Code were to require that, where a claim is partially accepted, this should be confirmed in writing? The written confirmation could include: |

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| | a) which aspects of the claim have not been accepted and the reasons for this<br>b) the consumer's right to access information relied on to make the decision<br>c) information about the insurer's complaints process |
| | **Discussion Point 1.5:** Would a satisfactory Code improvement be for clause 7.19 to make it clear that all of the information provided when a claim is denied is required to be in writing, not just the reasons for the denial in (a)? Is there an alternative approach?? |
| | **Discussion Point 1.6:** Are there any issues to be considered if the Code required insurers to record the reasons for claim denials? |
| | **Discussion Point 1.7:** What factors should be taken into account if clause 9.3 of the Code were amended so that, after a catastrophe, there was an obligation to notify a claimant, in writing, about their entitlement to have their claim reviewed within 12 months? |
| **Claims –**<br><br>e. External Expert reports | **Discussion Point 1.8:** We have noted a number of issues with providing a policyholder with the details of the complaints process when an external report is not received within 30 days. Do you agree with our concerns? If not, is there an alternative solution that could be considered? |
| **Claims –**<br><br>f. Home building and vehicle repairs | **Discussion Point 1.9:** What would be the advantages or disadvantages if the Code were to require that, where an insurer engages someone to carry out repairs on a customer's building, contents or motor vehicle, a written summary of the scope of the work is to be provided to the customer? |
| | **Discussion Point 1.10:** Are there any issues that need to be taken into account if the Code were to require that, where a repairer, organised by the insurer, has done a faulty or poor repair of a vehicle or building, and this requires the use of a hire car or accommodation over and above what is in a customer's insurance cover, the insurer will arrange these for the customer and cover any costs for the arrangements? |
| **Claims –**<br><br>g. Total loss claims protocol | **Discussion Point 1.11:** Given the concerns noted above, would it be a suitable improvement if the Code required that, when a claimant's loss is equal to or greater than the full sum insured, or a sub-limit within this, the insurer and its Service Suppliers will help them to assess their loss, and any inventory assessment required will only have to be provided up to the limit or sub-limit of the cover? What are the advantages or disadvantages with this approach? |
| **Claims –**<br><br>h. Uninsured third-party claims | **Discussion Point 1.12:** The Code could clarify the rights of an uninsured third-party driver making a claim with an at-fault driver's insurer, by including:<br><br>a) principles for claims handling<br>b) an explanation of the claims process<br>c) access to the insurer's complaints process for a claim up to $5000<br>d) access to EDR for a claim up to $5000<br>Would this be a satisfactory solution or is there a more appropriate alternative? |

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| **Claims –**<br><br>i. Debt Recovery | **Discussion Point 1.13:** Would a Code requirement, that insurers should treat individuals from whom they are seeking recovery of a debt in an honest, fair, transparent and timely manner, be a satisfactory improvement and address stakeholder concerns noted above? |
| | **Discussion Point 1.14:** To improve the provision of information to third parties, where an insurer is seeking recovery from an uninsured third party, the Code could require the insurer to provide sufficient information in writing for the individual to determine that the amount being recovered is fair and reasonable, such as:<br><br>a) details of the damage and the claim<br>b) the repair estimate or completed repairs<br>c) evidence relied on for making an assessment of liability<br><br>Would this help to address the concerns raised? Would there be any challenges with implementing this provision? |
| **Claims –**<br><br>j. Provision of documents | **Discussion Point 1.15:** The Access to Information section of the Code could be updated to clarify that insurers will provide the following information on request (subject to any special circumstances where information cannot be provided under clause 14.4):<br><br>a) information and documents relied on to deny a claim<br>b) copies of the PDS and insurance certificate<br>c) copies of any expert or assessment reports relied on<br>d) copies of any recordings or available transcripts of the sale of insurance<br><br>Would this be a suitable improvement or are there alternative documents that should be specified? |
| **ii. Automatic Renewals** | **Discussion Point 2:** In order to address concerns raised about automatic renewals, would a practical option be for the Code to require insurers to effectively inform consumers about automatic renewal when they first purchase a policy and at renewal time? This would include obtaining a customer's express consent to allow this and providing the ability to opt out. Is this a sensible balance? |
| **iii. Cancellation of policy** | **Discussion Point 3:** How can we improve the cancellation procedures in the Code to assist with customer engagement and prevent unnecessary cancellation? Are there any practical implications with changing the cancellation procedures? |
| **iv. Complaints and disputes –**<br><br>a. Multi-tier complaints process | **Discussion Point 4:** Insurers have suggested that moving to a one-tier complaints process would be difficult to manage. Noting the issues outlined above, are there other suggestions for improving the internal complaints process? Are there any concerns with waiting until after AFCA is established before implementing changes? |
| **Complaints and disputes –** | **Discussion Point 4.1:** Would a satisfactory improvement be for the Code to require that insurers and Service Suppliers contact a customer through their representative when this has been requested by the customer? |

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| b. Customer representatives | |
| **v. Advertising and marketing** | **Discussion Point 5:** Would the following provisions provide adequate restrictions on advertising and marketing?<br>a) Consider the target audience for the advertisement or marketing communication and whether it provides adequate information for that audience<br>b) Ensure statements in advertisements or marketing communications are consistent with the features of the relevant policy and the disclosures in any corresponding PDS.<br><br>Are there other factors to consider? |
| **vi. Pressure selling** | **Discussion Point 6:** What issues need to be taken into account if the Code were to explicitly state that pressure selling practices are prohibited? |
| **vii. Customer communications –**<br><br>a. When insurance is not offered | **Discussion Point 7:** To address the concerns raised above, is a satisfactory solution for clause 4.8(b) in the current Code to be amended to state "*we will inform you of your right to ask for the information that we have relied on in assessing your application and, if you request it, we will supply it in accordance with Section 14 of this Code.*" Please identify any concerns with this approach. |
| **Customer communications –**<br><br>b. Verification of a customer's disclosure | **Discussion Point 7.1:** Given the obstacles noted above regarding verifying disclosure at the point of sale, would a satisfactory alternative be for the Code to require that a customer is contacted as soon as an insurer becomes aware of an issue with their disclosures? What are the advantages and disadvantages of this approach? |
| **Customer communications –**<br><br>c. Policies with no-claim discounts (NCDs) | **Discussion Point 7.2:** Should the Code contain measures aimed at increasing consumer understanding of NCDs or have insurers taken reasonable steps to improve this? If the Code were to include measures, please provide examples. |
| **viii. Monitoring, enforcement and sanctions –**<br><br>a. Reporting of Code breaches | **Discussion Point 8:** Would a redrafting of Clause 13.1 of the Code to read "*Anyone can report alleged breaches of this Code to the CGC*" sufficiently address the issue noted above? Is an alternative solution needed? |
| **Monitoring, enforcement and sanctions –**<br><br>b. Interpretation of Code standards and process for appeal | **Discussion Point 8.1:** The ICA suggest that provisions such as honest, fair and timely should operate in relation to the standards in each section. Is there a way for these terms to be appropriately defined if this approach is not taken? |
| | **Discussion Point 8.2:** What would be the advantages or challenges if the CGC were to regularly publish its decisions on a de-identified basis? |

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| | **Discussion Point 8.3:** Are there any issues that need to be taken into account if the Code were to require that, where a CGC decision has a significant and/or broad industry impact, there is an ability to appeal? Should the industry be able to provide a collective submission on Code interpretation? |
| **Monitoring, enforcement and sanctions –**<br><br>c. Reporting of Significant Breaches | **Discussion Point 8.4:** Would the issue identified above be appropriately resolved if the definition of Significant Breach in the Code was amended to remove the words "*likely breach*". Do you have any concerns with this proposed change? |
| **Monitoring, enforcement and sanctions –**<br><br>d. Relationship between Code breaches and EDR | **Discussion Point 8.5:** To address the confusion noted above, is an appropriate solution for the monitoring process in the Code to include the following:<br><br>a) The CGC should determine whether a breach allegation has also gone to IDR/EDR, and if the issue is more appropriate for an insurer's complaints process, then it can be referred there.<br>b) If a breach allegation is currently being heard at EDR, then the CGC should await the outcome of this before investigating.<br>c) EDR should provide details of possible Code breaches to the CGC once a determination is made<br><br>Do you have any concerns with this approach or an alternative suggestion? |
| **ix. Promotion of the Code** | **Discussion Point 9:** Would it be beneficial if the Code included more information about the CGC's role and its areas of focus, such as:<br><br>a) to monitor and enforce the Code through investigations and analysis of data and evidence<br>b) to provide leadership to industry and help subscribers understand and comply with their obligations and seek continuous improvement of insurance practices<br>c) to liaise with the ICA<br><br>Is there any other additional information that could assist with improved understanding of the CGC? |
| | **Discussion Point 9.1:** The Code website could be expanded to include:<br><br>a) promotion of the CGC and its role and areas of focus<br>b) de-identified decisions of the CGC<br>c) guidance to insurers through the use of scenarios and FAQs<br>d) online annotations, explanations and examples to aid consumer understanding of the Code<br><br>Is there any other information that should be included on the Code website? |
| | **Discussion Point 9.2:** Would a summary of the key consumer commitments in the form of a "customer charter" be useful for consumers? Please advise if a more engaging tool could be adopted or if you have any concerns with this proposal. |
| **x. Extending the scope of the Code** | **Discussion Point 10:** The ICA's view is that the Code should not contain a specific provision relating to corporate culture. Please advise any concerns |

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| a. Corporate culture | with this perspective. How can culture be adequately monitored and measured? |
| **Extending the scope of the Code**<br><br>b. Residential strata | **Discussion Point 10.1:** Should the definition of Retail Insurance explicitly state that this includes residential strata, excluding mixed-use and high value strata insurance? |
| **Extending the scope of the Code**<br><br>c. Extension of code to business insurance | **Discussion Point 10.2:** Do you agree with the ICA's view that the current distinction between retail Insurance and wholesale Insurance should remain unchanged? What are the practical implications of extending sections of the Code to wholesale Insurance? |
| **Extending the scope of the Code**<br><br>d. Application and guidance on the law | **Discussion Point 10.3:** Do you agree with the ICA's view that the Code should not restate and provide guidelines on existing legal requirements? If not, noting the concerns raised, how can the Code effectively provide guidance on existing legal requirements without cutting across regulatory frameworks? |
| **xi. Emerging technologies** | **Discussion Point 11:** How can the Code be flexible enough to allow for the use of emerging technologies in insurance sales, customer communication and claims handling? |
| **x. What the Code does not cover** | **Discussion Point 12:** Do you agree that the areas above are not in the scope of this Code Review? For those areas where non-Code initiatives are underway, are they responding to stakeholder concerns? |

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| **Stakeholder assessment** | **9**: Do the ICA Priority Proposals adequately reflect the priority matters to be addressed by the Code Review? |
| | **10**: Have the additional Code Review themes been appropriately prioritised for inclusion into a revised Code? |

## 9. Terms of Reference

### i. Background

On 17 February 2017, the Insurance Council of Australia (ICA) launched an internal, targeted review of its General Insurance Code of Practice (Code).

The Code was first introduced in 1994 and has previously been independently reviewed four times.

The ICA is required to commission formal independent reviews of the Code from time to time. A thorough independent review of the Code was undertaken in 2012-2013 by Mr Ian Enright, with significant stakeholder consultation.

The Code was subsequently significantly amended to incorporate recommendations made by Mr Enright, and the current revised Code commenced on 1 July 2014, with a 12-month transition period.

In addition to formal independent reviews of the Code, the ICA can review the Code on an ad hoc basis in consultation with stakeholders.

### ii. Recent developments

Relevant recent and ongoing reviews, reports and developments include:

- The Federal Government's December 2016 Proposals Paper on product design and distribution obligations and ASIC's product intervention power, in response to recommendations of the Financial System Inquiry
- The Senate inquiry into the general insurance industry
- The Senate inquiry into consumer protection in the banking, insurance and financial sector
- The independent review of the financial system external dispute resolution framework
- ASIC's 2016 reports on the sale of add-on insurance through motor vehicle dealers
- ASIC's 2016 report on its industry-wide review of life insurance claims
- ASIC's Enforcement Review Taskforce's consideration of the adequacy of ASIC's enforcement regime in relation to industry codes of conduct
- The findings of the ICA's consumer research into effective disclosure of product information
- The commencement of the FSC's Life Insurance Code of Practice in October 2016, which includes provisions concerning product design and disclosure, vulnerable consumers, sales practices and advertising, CCI-specific sales and disclosure requirements, and restrictions on claimant interviews and surveillance
- The Australian Bankers' Association's independent review of the Code of Banking Practice
- The ICA's Effective Disclosure Taskforce's recommendation to develop guidance on the principles of transparency in fulfilling the Code's objectives of more informed relations between insurers and their customers, and the promotion of trust and confidence in the industry
- The General Insurance Code Governance Committee's own-motion inquiry into claims investigations and outsourced services

- Mental Health First Aid Australia's principles for working with people with mental health problems and financial difficulties

### iii. Terms of Reference

Taking into account the Code objectives, and the above recent developments, the review of the Code has considered the operation and effectiveness of:

- Section 4: Buying insurance
- Section 5: Standards for employees, authorised representatives and authorised financial services licensees acting on behalf of a Code subscriber
- Section 6: Standards for service suppliers
- Section 7: Claims
- Section 8: Financial hardship
- Section 10: Complaints and disputes
- Section 13: Monitoring, enforcement and sanctions

The review has also considered expansion of the scope of the Code. This is in response to the recent developments listed above, as well as priority issues raised through the ICA's Consumer Liaison Forum (CLF). The review has considered the extent to which the Code complies with the requirements of ASIC's *Regulatory Guide 183: Approval of financial sector codes of conduct* (RG 183) and the implications of seeking approval of the Code from ASIC.

The Terms of Reference also require that the review considers:

- any other matter relevant to the Code;
- changes in law and practice since the 2012-13 independent review; and
- any relevant recommendations or findings concerning the conduct of insurers from ASIC, the Financial Ombudsman Service and the Code Governance Committee.

### iv. Process

The ICA is responsible for carrying out the review.

The ICA must consult during the course of the review and in relation to any proposed findings or recommendations with:

- The ICA's National Code Committee
- The ICA's Consumer Liaison Forum
- The CGC
- ASIC
- FOS

The ICA may consult with any other organisation or individual as it sees fit. This includes seeking expert advice on specific matters.

The ICA must provide a quarterly report to the ICA Board on the progress of the review until its conclusion.

The review may be conducted in stages as appropriate in order to take account of forthcoming external reports or reviews.

### v. Stakeholder consultation

The review commenced with a six-week consultation period, during which time feedback was sought from external stakeholders and ICA members. Written submissions were received from the below parties, which are available to view and download on the Code Review website:[24]

- Australasian Institute of Chartered Loss Adjusters (AICLA)
- Australian Securities and Investments Commission (ASIC)
- Consumer Action Law Centre
- David Warner (individual)
- Financial Rights Legal Centre
- General Insurance Code Governance Committee (CGC)
- Legal Aid NSW
- Motor Traders' Association of NSW (MTA NSW)
- Public Interest Advocacy Centre
- WEstjustice

The ICA followed up with a number of submitters via telephone and/or face-to-face meeting, to discuss their feedback and ensure the ICA has properly captured and understood their concerns.

ICA member committees have provided verbal and written feedback on key issues raised by submitters, as well as the various draft documents included as appendices to this report.

The ICA has taken member feedback into account in drafting this interim report in order to take a balanced view. The ICA Board has considered and approved the release of this report for consultation.

### vi. Independent oversight

The ICA has appointed former ASIC General Manager and Managing Director of Cameron Ralph Khoury, Phil Khoury, to provide independent oversight of the review. Mr Khoury is a highly experienced independent reviewer of financial sector codes of practice who recently conducted the Australian Bankers' Association's review of its Banking Code of Practice.

Mr Khoury's role is to ensure the review appropriately considers the submissions received and recent external developments.

Mr Khoury will release his independent view following the release of the Interim Report and after some sampling of stakeholder reaction. His advice will focus on whether the Interim Report appropriately takes into account the submissions received and external developments.

[24] http://codeofpracticereview.com.au/.

### vii. Next steps

Once the consultation period is complete, the ICA will work on a Final Report. Once changes to the Code are finalised and approved, an appropriate transition period will be determined to give Code Subscribers ample time to make system and process changes and to train their employees.

## Appendix One: Mental Health – Principles to inform best practice

### Preamble

Around 45 per cent of Australians will have a mental illness at some time in their life, with a 12 month's prevalence over 20 per cent[25]. Australia's National Mental Health Policy[26] defines a mental illness as "A clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities".

Individuals with mental illness have experienced challenges at times in accessing some general insurance products. Some products provide limited underwriting of mental illness, due to the increased risk from higher levels of morbidity and mortality for consumers with a mental illness compared to consumers without a mental illness[27].

While it is unlawful under the *Disability Discrimination Act 1992* (Cth)[28] (the DDA) to discriminate against a person because of a disability, including a psychiatric or psychological disability, there is a partial exemption for insurance providers. This exemption recognises that some discrimination is necessary in the insurance business. The exemption only enables discrimination[29] if it is based on actuarial or statistical data, or if no actuarial or statistical data is available, the discrimination is reasonable having regard to any other relevant factors.

Notwithstanding the DDA exemption, there is a broader objective to promote the rights of people with a disability to participate equally in all areas of life under the DDA, Australia's National Mental Health Policy and international conventions[30] of which Australia is a signatory. With increasing awareness and better understanding of mental illness, there is a growing community expectation that insurance products should evolve to better meet the needs of consumers suffering from a mental illness.

One of the objectives of the General Insurance Code of Practice (the Code) is to maintain trust and confidence in the general insurance industry[31]. The Code also requires insurers to be open, fair and honest in their dealings with consumers[32]. These best practice principles (the Principles) have been developed[33] to enable signatories to the Code to benchmark their practices against industry-agreed best practice standards. The Principles are intended to be aspirational and

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[25] Slade, T., Johnston, A., Oakley Browne, M. A., Andrews, G. & Whiteford, H. (2009), "2007 National Survey of Mental Health and Wellbeing: methods and key findings", *Australian and New Zealand Journal of Psychiatry*, 43(7), 594 – 605.

[26] Commonwealth Department of Health and Aged Care (2008), *National Mental Health Policy.*

[27] Australian Government (2007), *Australia's welfare 2007*, retrieved from http://www.aihw.gov.au/publication-detail/?id=6442468047.

[28] Section 46 of the *Disability Discrimination Act 1992* (Cth).

[29] By refusing to provide cover or by applying terms or conditions on which cover is provided.

[30] Including the United Nation's *Universal Declaration of Human Rights* (10 December 1948).

[31] Insurance Council of Australia (1 July 2014), *General Insurance Code of Practice*, paragraph 2.1.

[32] Insurance Council of Australia (1 July 2014), *General Insurance Code of Practice*, paragraph 1.3.

[33] Section 11 of the Code enables the Insurance Council of Australia to issue guidance to assist signatory insurers to meet their obligations under the Code.

encourage continuous progress by industry in meeting the highest standards with regards to the provision of products to consumers with a mental illness.

**Best Practice Principles**

**1. Through each stage of the life cycle for relevant insurance products, the recognition and management of mental illness should be commensurate with other medical conditions, with documented rates of prevalence, morbidity and mortality.**

1.1. Mental illnesses should be categorised according to current commonly accepted professional standards[34].

1.2. For some mental illnesses, the documented rates of prevalence, morbidity and mortality could be less than actual rates. When taking account of this, the risk assessment of mental illnesses should be centred on reliable evidence-based data and objective assessment.

**2. In designing general insurance products, the needs of those who have a mental illness should be considered.**

2.1. Premiums for covers related to mental health illness will be influenced by an insurer's risk appetite. Where possible, insurers should seek to provide cover and manage risk through policy pricing, exclusions, limits and caps rather than not provide cover at all.

2.2. When setting premiums for covers related to mental health illness, the pricing of the offered products should reflect the increased associated morbidity, mortality and other risks.

2.3. Insurers should aim to apply narrower exclusions as data becomes more available over time to reflect a better understanding of mental illness. Where possible, insurers should move away from the application of blanket-based exclusions.

2.4. Where exclusions and limits are applied, the pricing of the offered products should reflect the cover provided.

2.5. Insurers should work collaboratively with stakeholders such as consumers, mental health professionals and consumer advocates to improve the provision of products and services to consumers with a mental illness.

2.6. Insurers should co-operate with the Insurance Council in ongoing research endeavours that have the aim of improving the provision of products and services to individuals with a mental illness.

**3. Consumers who have a mental illness should be treated fairly and with dignity.**

3.1. At the point of sale, insurers should act in a transparent manner in determining the risk of applicants who have been previously diagnosed with a mental illness that is still part of the current commonly accepted professional standards.

[34] As at May 2017, commonly accepted professional standards include International Classification of Disease (ICD) or Diagnostic and Statistics Manual (DSM) systems.

3.2. Insurers should adopt a respectful and positive approach towards consumers with mental illness in their sales and claims processes. Insurers should develop and implement policies and procedures that support this approach.

3.3. Claims involving mental illness should be processed sensitively, and where possible, using the least intrusive methods of investigation.

3.4. Claims need to use standard diagnoses, established using evidence-based techniques and information.

**4. The risk assessment of mental illnesses should be centred on reliable, evidence-based data.**

4.1. Exclusions for pre-existing mental illnesses should only apply where there is evidence that an applicant has, or is at risk of a recurrence of, a mental illness and the covered event relates to the pre-existing mental illness.

4.2. Where loadings are applied to insurance products and services, these should be quantified based on reasonable data or opinions.

**5. Staff working with consumers with mental illness should be appropriately trained and supported.**

5.1. Training should increase awareness and understanding of common mental illnesses in the community.

5.2. Training should develop communication skills for interacting with consumers who have, or show signs of having, a mental illness.

**6. The Principles should be reviewed and revised by the industry every two years, incorporating feedback from members, stakeholders and regulators.**

6.1. Insurers should aim to regularly review their progress towards the effective implementation of these Principles.

## Appendix Two: Family violence guidance document

### Background

The General Insurance Code of Practice (Code) includes a requirement for Code Subscribers to have systems, processes and appropriate training in place to identify and support customers who require additional assistance.

One of the groups of people that this section of the Code contemplates is people affected by family violence.

This guidance document is intended to provide more detail about how Code Subscribers can identify and support people affected by family violence.

### Status of guidance documents

This industry guidance document does not have legal force or prescribe binding obligations on individual insurers. While the ICA's guidance documents are voluntary, they are developed with input from, and agreed support by, member companies. The ICA encourages members to use this industry guideline in their internal processes, procedures and policies.

### Summary

An effective family violence policy needs to provide for (at minimum):

- training for staff to identify and support customers affected by family violence
- the protection of private and confidential customer information
- minimising repeat disclosures of family violence by a customer
- assistance for claimants affected by family violence, including those suffering financial hardship
- referring customers to specialist family violence services
- providing support to staff affected by family violence or who experience vicarious trauma after dealing with affected customers

### Objectives

For Code Subscribers to put in place processes that help to minimise the risk of harm in their interactions with customers, and to help ensure they provide timely, consistent, and targeted assistance to people affected by family violence.

### Definition of family violence

Family violence is defined in the *Family Law Act 1975 (Cth)*, section 4AB as:

> *"violent, threatening or other behaviour by a person that coerces or controls a member of the person's family…, or causes the family member to be fearful."*

Family violence is not limited to physical instances of violence and may also include emotional, psychological, financial and sexual abuse. Family violence can also include damage to property.

**Requirements for family violence policy**

The relevant requirements in the Code are to have systems, processes and appropriate training in place to identify and support customers who require additional assistance.

The requirements are designed to be high-level and enabling, providing businesses with flexibility to decide on their specific approach. This also allows businesses to learn and adapt their policies and approach to family violence over time.

Code Subscribers should develop and implement a family violence policy which should include the following areas:

**1. Staff training to improve responses to customers affected by family violence**

All relevant staff should have ongoing training to help them:

a. identify customers affected by family violence;
b. deal appropriately with customers affected by family violence; and
c. apply the family violence policy and related policies and procedures to customers affected by family violence.

Customers may be reluctant or unable to disclose their circumstances, so training should provide staff with skills to help identify signs that may indicate customers may be affected by family violence, such as when someone:

- appears or sounds distressed or scared
- is seen or heard to be taking instruction/s from their partner
- remains silent while another party does all the talking
- does not understand or is not aware of cover taken out in their name or covering their property
- asks questions about a joint policyholder's behaviour or activities
- has concerns about protecting their personal privacy, safety or security of their policies
- expresses reluctance to involve the other joint policyholder when making changes to the policy, making a claim or seeking financial hardship assistance
- changes their address frequently or does not want their physical address on file
- is consistently late with premium payments
- discloses the existence of an intervention order or equivalent

The manner of staff dealing with a customer affected by family violence should facilitate, rather than act as a barrier to the identification of family violence, and improve the experience of customers affected by family violence. Staff should not require evidence of an intervention order in order to trigger the requirements of the family violence policy – someone self-identifying as being affected by family violence should be treated in accordance with the policy without further evidence being required.

Code Subscribers must make their staff aware of the policies and procedures in place when responding to family violence.

Training programs should focus on equipping appropriate employees with the knowledge, skills, competencies and information to help customers who may identify as being impacted by family violence. However, insurance staff are not expected to be experts or social workers.

Where family violence is identified or suspected, the number one priority should be the safety of the customer and their family.

Situations involving family violence require Code Subscribers and their employees to take particular care, and to be flexible with their processes. The issues are often highly complex and unchartered territory.

Training should include helping employees:

- Be more aware of the prevalence and practical effects of family violence on a customer.
- Recognise potential violence or early signs that may lead to future violence and have an appropriate conversation with a customer, or refer the customer to a specialised area who can give further guidance.
- Understand the potential impact (positive and negative) that an insurer's actions can have on a family violence situation.
- Appropriately triage matters that involve family violence, which may involve determining claims or Financial Hardship assistance as a matter of priority, as well as escalating to a sufficiently senior team.
- Understand the strict need for confidentiality and respecting their customer's privacy.
- Understand the significant safety risks for women and children and the heightened safety risks at, and following, separation.
- Understand that perpetrators of family violence are also customers, a fact that has to be managed appropriately.
- Understand the need for flexible arrangements and responses for customers impacted by family violence.
- Understand the legal and procedural implications of court issued family and domestic violence orders to the extent that these impact a claim or customer experience.
- Have knowledge of local referral pathways and contacts for local support services.

Training needs to be tailored to reflect the level of contact staff have with customers. For example:

- Frontline employees receive general information and instructions about internal procedures, and training on how to escalate to a team leader or manager where a matter is sensitive and may require immediate assistance or further review.
- Specialised employees (e.g. senior claims and IDR managers, financial hardship and collections teams), managers and supervisors receive more detailed information, support and training.

A Code Subscriber's Service Suppliers that deal directly with customers, such as loss assessors, investigators and claims management services, should also be required to carry out the same level of training before coming into contact with a customer who has been identified as being affected by family violence. Any Service Supplier engaged to contact someone who has been affected by family violence must handle the situation with the appropriate sensitivity.

There are external training programs available aimed at raising awareness, providing education on family violence policies for businesses, training frontline staff and equipping managers to support staff who are affected family violence. The ICA has included a list of service providers it is aware of as an Appendix to this document.

## 2. Protecting private and confidential information and minimising repeat disclosures

Customer safety must be protected by providing for the secure handling of information about customers affected by family violence, including in a manner that maintains confidentiality.

It is important for customers affected by family violence that businesses keep private their personal information, particularly when the perpetrator is or has been a joint account holder. In cases of family violence, particularly where there is a joint policy, abusive partners can use their current or ex-partner's personal information to pass privacy screening questions and obtain their new contact details in order to continue abusive behaviour.

It is equally important for customers to have confidence that information they share with their insurer about their family violence is not disclosed to the perpetrator(s), and that any information they provide is accessible only to authorised staff.

Customers affected by family violence need to have confidence that their personal information is secure and not at risk of deliberate or inadvertent disclosure. In particular, a customer's physical address must be protected. This could involve having only their email address accessible in the system; having their physical address password protected; or having the physical address as a mandatory ID/security requirement, in order that the Code Subscriber does not run the risk of providing it to someone who can answer alternative security questions.

Customers should not have to repeat disclosure of their family violence situation, which can have a traumatising effect, with people reliving their experiences. In addition, customers are not always able to provide details of their circumstances, as the perpetrator may be either present or monitoring the call, or monitoring web and mobile phone access.

Code Subscribers' family violence policies should consider the following:

- Ensuring there are systems in place to keep a customer's contact information secure and confidential, including treating all information about a customer affected by family violence as sensitive information. For example, if a customer changes their contact details, Code Subscribers should have processes in place that make sure that any communication with joint policy holders does not include the contact information for the customer experiencing family violence. Any protection should be extended across all policies held by the customer experiencing violence.
- Giving a customer affected by family violence access to personal information held about them and control over how it is shared with third parties.
- Asking a customer if they have more than one policy or account that requires amendment due to a situation of family violence, and proactively search for other policies that may be under their name
- Code Subscribers should discuss safe ways to communicate with a customer experiencing violence e.g. ask the customer whether it is a good time to talk or if it's safe to leave phone messages.
- Supporting customers to set up new insurance policies.
- If a joint policyholder asks for policy communications and information to be sent to two different addresses (either physical or email), this should be facilitated.
- Understanding the legal requirements and internal processes where a victim and perpetrator of family violence are joint policyholders. Inform customers about the circumstances and nature of information that has to be shared with the perpetrator. Customers will need to be aware and make arrangements accordingly.

- Understanding reporting requirements where there are minors involved. Where a customer tells a Code Subscriber that they are affected by family violence, if the Code Subscriber is aware that there are minors living in the same house, the customer should be asked if they want to Code Subscriber to make an online report to the State child protection agency
- Protecting the details of staff in situations where they may have to contact the perpetrator of family violence.
- Minimising the information that a customer is required to provide and the number of times a customer has to disclose the same information. Note: a customer may not have access to records and documentation.
- Where possible, customers should have consistency in speaking to one staff member, or a single pathway to an appropriately trained team.
- Providing copies of customer documents without charge to assist in resolving matters or for legal purposes.
- Working with a customer's agent or representative, such as a professional financial counsellor, lawyer, community services or social worker, legal aid officer or family violence specialist, and making it as simple as possible to appoint such an agent or representative while recognising privacy obligations.
- If required, referring a customer to a qualified, independent interpreter to assist with communication.

**3. Early recognition of family violence**

Code Subscribers can play a role in the early identification of possible family violence, in an effort to possibly mitigate the impact.

This can include not only identifying possible victims of family violence, but also potentially the perpetrators. Both may be customers, or they may be members of staff.

Early indicators of family violence may be apparent at claim time, and also after a major disaster event. As an indication of best practice, in the wake of a major event, Code Subscribers may wish to consider whether they are resourced to have counsellors accompany claims staff to recovery centres to interact with customers. They can be in a position to help identify not only issues of violence, but also of financial hardship and mental health.

Service Suppliers used by Code Subscribers to work with claimants should also be trained to recognise possible family violence, and to respond accordingly.

**4. Claims handling**

Where a customer affected by family violence makes an insurance claim, flexibility and care is required in a Code Subscriber's claims handling. This is particularly important if the perpetrator is a joint policyholder and/or has caused the claim (for example, through damage to the claimant's property).

Code Subscribers should consider the following in developing their family violence policies:

- The claims process and what is required of the claimant must be explained clearly and transparently
- Due to the complexity of the issues raised in family violence-related claims, it may be appropriate for specialist staff with adequate authority to be making the decisions.
- A survivor of violence may come across as incoherent or scattered; this is not necessarily an indication that their claim is not valid
- Traumatic events such as catastrophes that result in claims can trigger violence

- The claims process could also trigger further violence, particularly if the perpetrator has caused the damage
- Lack of contact from the claimant does not necessarily mean they have given up on their claim, nor is it an automatic indication of fraud; people affected by family violence may not have access to telephone or email communication
- A claimant experiencing family violence may not have access to their personal or financial records or other documents; a Code Subscriber's requests for information should take this into account
- The customer should not be required to make direct contact with the perpetrator, nor to make a police report about the perpetrator if they are not comfortable doing so.
- Anyone interviewing or investigating someone involved in a claim who is affected by family violence and/or going to the claimant's home needs to be appropriately trained, and should also be aware that they may be putting themselves in danger
- Before any claim payment is made, the Code Subscriber should ensure they are paying the appropriate party or parties – this can be a particularly complex area in cases of family violence

**5. Access to Financial Hardship**

Code Subscribers should recognise family violence as a potential cause of payment difficulties and as an eligibility criterion for access to Financial Hardship assistance.

Code Subscribers must work with an individual customer who is requesting assistance and discuss options for resolving their Financial Hardship. Furthermore, Code Subscribers should ask a customer who self-identifies as being affected by family violence what their financial situation is, to determine whether they are suffering from Financial Hardship.

In addition to the existing requirements for Financial Hardship assistance contained in the Code, Code Subscribers should:

- Fast-track hardship requests where family violence has been disclosed as an issue.
- Provide options for retaining the policy where a customer says they cannot meet their premium payments, such as:
  - changing the benefit structure or how much they are insured for
  - reducing the benefits and/or removing or altering benefit options in order to reduce the premium
  - stopping the payments for a short period without cancelling the policy.
- Ensure policies regarding the assessment of hardship assistance involving joint insureds are clear and appropriate. For example, a Financial Hardship application for a co-insured affected by family violence will be considered without requiring the consent of the other co-insured.
- Be aware that any reluctance to obtain consent from a co-insured in relation to hardship assistance may be the first indication of financial abuse, and take this into account when responding to any customer seeking hardship assistance
- Minimise the information and documentation that customers are required to provide.
- Not require an intervention order as evidence of family violence as part of assessing a Financial Hardship application. Disclosure by a customer should trigger the family violence policy and referral to the appropriate team.

**6. Collections arrangements**

Where a Code Subscriber is made aware that a customer's debt involves a situation of family violence, the debt must not be referred to or sold onto third-party debt collection agencies.

Where a debt has been referred to or sold to a third-party collection agency and the Code Subscriber becomes aware that this debt involved a situation of family violence, the Code Subscriber must work with the collections agency to provide the best outcome for the customer. This may include repurchasing an existing debt or taking back a referred debt from a collection agency. This should be assessed on a case by case basis.

Code Subscribers should also consider the risks involved in attempting to recover from the perpetrator of family violence. This may put the collection agent in danger and may also result in further violence towards the victim.

Note, Clause 8.12 of the Code requires that collection agents comply with the ACCC and ASIC debt collection guidelines. Code Subscribers should ensure that contracts with agents and debt purchasers include a requirement to comply with this guidance document.

**7. Providing customers with referrals to expertise**

Code Subscribers should provide a means for referring customers who may be affected by family violence to specialist family violence services, by including this information on the Code Subscriber's website.

An insurer's employees are not equipped to provide support for non-financial matters. Where possible, employees should be in a position to suggest a customer contact an external legal and support organisation. This referral information will need to be kept up-to-date.

**8. Making customers aware of information and assistance available**

It is important that customers affected by family violence are quickly able to access information, both on the policies that they hold, and on the support available to them. People will likely be more comfortable disclosing family violence if they are aware of the support their insurer has in place, and the existence of organisations offering specialist services. It is also important that a customer is aware that they will not be penalised for disclosing family violence.

A Code Subscriber should:

a. prominently publish on its website and in any branches, and keep up to date, the assistance and referrals available to customers affected by family violence and how customers may access such assistance;
b. provide a copy of the family violence policy to a customer upon request; and
c. provide for a periodic review mechanism of the policy and its associated procedures.

Code Subscribers should also consider publishing contact details for external specialist services.

Code Subscribers should promote their family violence policy and Financial Hardship assistance to employees, customers, financial counsellors, community legal services, legal aid, refuges and violence support services.

**9. Support provided to staff**

The staff of Code Subscribers may also be affected by family violence, who require support in the same way as customers do. Further, through their contact with customers experiencing family violence, staff can be adversely affected, either due to the impact of the customers' issues, or when their interactions cause them to relive their own experience of family violence.

Code Subscribers should articulate their policies and programs to employees in relation to how they support employees who are impacted by family and domestic violence, and manage known perpetrators of violence. This can include any training, leave, additional security measures, external referrals and counselling available.

Insurer employee assistance programs should ensure that support is provided to employees affected by family and domestic violence. The support arrangements should reflect the specific needs of the employee and take into account the nature of their role and the workplace environment.

## APPENDIX

**List of service providers to be developed as we speak to experts working in this area**

- Kildonan
- 1800RESPECT
- DV-alert Domestic Violence Response Training
- Domestic Violence Resource Centre Victoria
- Education Centre Against Violence (NSW)
- Centre for Domestic and Family Violence Research, Queensland
- Department for Child Protection (WA)
- WA Women's Council
- DV and Work (UNSW Centre for Gender Related Violence Studies)
- Ask LOIS (NSW Women's Legal Service)
- State Legal Aid Commissions
- LawAccess NSW

## Appendix Three: Product disclosure – Principles to inform best practice

### Preamble

Product disclosure, if done effectively, plays an important role through all stages of the product life cycle; from ensuring that consumers make an informed purchasing decision at the point of sale, to minimising any expectations gap come claims time[35].

The industry has recognised that compliance with the mandated disclosure requirements alone will not necessarily produce effective disclosure without a clear objective to engage consumers and aid decision-making. The industry has committed to shift from a minimum mandated disclosure approach to best practice transparency[36].

An important objective of the *General Insurance Code of Practice* (the Code) is to "…promote better, more informed relations"[37] between insurers and consumers. The terms of the Code requires signatory insurers to conduct the sales process in an efficient, honest, fair and transparent manner[38]. The Code also requires insurers to take reasonable steps to ensure their communications with consumers are in plain language[39].

These best practice principles (the Principles) have been developed[40] to enable signatories to the Code to benchmark their practices against industry-agreed best practice standards. The Principles are intended to be aspirational and encourage continuous progress by industry in meeting the highest standards of disclosure. The Insurance Council will continuously update the Principles to reflect learnings from members' trialling of innovative disclosure techniques.

These Principles operate within the formal regulatory regime created by the *Corporations Act 2001* (Cth) and the *Insurance Contracts Act 1984* (Cth). They are not to be taken to require Code signatories to act outside their legal obligations or the conditions of their Australian Financial Services (AFS) licence.

### Best Practice Principles

#### 1. Disclosure is clear in purpose

1.1. Disclosure should be clear about the information needs of consumers at various stages of the product life-cycle.

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[35] The *Corporations Act 2001* (Cth) and *Insurance Contracts Act 1984* (Cth) sets out content and other requirements in relation to mandated disclosure. Nevertheless, disclosure as mandated by law forms just one component of the range of information and tools provided by insurers to help consumers to purchase insurance that meets their needs.

[36] The Insurance Council's Board has endorsed recommendation 3 of the Effective Disclosure Taskforce.

[37] Insurance Council of Australia (1 July 2014), *General Insurance Code of Practice*, paragraph 2.1.

[38] Insurance Council of Australia (1 July 2014), *General Insurance Code of Practice*, paragraph 4.4.

[39] Insurance Council of Australia (1 July 2014), *General Insurance Code of Practice*, paragraph 4.5.

[40] Section 11 of the Code enables the Insurance Council of Australia to issue guidance to assist signatory insurers to meet their obligations under the Code.

1.2. At the point of sale, disclosure should aim to inform about the policy, particularly key exclusions and limits. Importantly, disclosure should also assist consumers to make informed decisions about the type and level of cover required.

1.3. Consumers use a range of disclosure sources to inform their purchase decisions. Research[41] indicates that sources of information other than the Product Disclosure Statement (PDS) may be more effective in engaging consumers at the pre-purchase stage of the product life-cycle. Insurers should consider how widely used sources, including the renewal letter, insurer websites, online quotes and call centres, could be used to provide targeted information pre-purchase.

**2. Disclosure promotes consumer engagement**

2.1. Disclosure should be designed to motivate consumers to use the information. Consumers are more likely to be engaged if information provided is actionable, i.e. consumers can use the information to make a choice or take a certain course of action.

2.2. Insurers should build consumer trust by harnessing emerging technologies and the growing body of behavioural research to improve the way they communicate with consumers.

2.3. There are varied consumer pathways to purchase and insurers should be nimble and innovative in engaging with a diverse range of consumers. Insurers should consider strategies to engage with specific segments of consumers, including but not limited to consumers with greater exposure to certain risks, new-to-market consumers, vulnerable or less financially literate consumers and renewal consumers. For example, research indicates that new-to-market consumers rely more on information provided through online quotes; a strategy could involve optimising the information presented through online quotes for these consumers.

2.4. Insurers should identify opportunities for constructive and useful engagement with consumers through the life of a product to enhance consumer engagement. For example, natural hazard events provide an opportunity for insurers to provide useful information to consumers about mitigation strategies to minimise risk. Proactive insurer prompts about the claims process following large scale weather events also provides a useful opportunity to deliver practical information.

2.5. Insurers should ensure that the disclosure design process is subject to whole-of-organisation input, including from customer-facing, customer insights and claims personnel.

**3. Disclosure encourages informed decision-making**

3.1. Disclosure should prompt consumers to consider and assess the types of risks that are relevant to them. Research indicates that very few consumers consider the risks to which they are exposed and which require cover.

3.2. Disclosure should encourage consumers to focus on selecting the type and level of cover appropriate to their circumstances, and not just the price. Research indicates that many consumers believe they have made an informed choice on the basis that they have considered the price alone.

3.3. Insurers should consider initiatives to improve comprehension of policy exclusions to facilitate effective decision-making. Research suggests that consumers have very poor

[41] Unless otherwise specified, references to research are in relation to consumer research conducted by the Insurance Council outlined in its report *Consumer Research on General Insurance Product Disclosures* (February 2017).

comprehension of common policy exclusions, including for wear and tear, failure to maintain asset, mechanical failure, pre-existing damage/medical conditions, risky behaviour and a consumer's obligation to avoid damage/loss.

3.4. Insurers should consider initiatives to improve awareness of and decision-making around the different types of policies available; for example, listed events compared to accidental damage home insurance policies. Research shows that consumers are particularly misinformed about the types of home insurance policies available, including confusion about terminology used such as "total replacement" and "sum insured".

3.5. Insurers should integrate sum insured calculators into the sales process for (sum insured) home building insurance policies so that consumers are provided free and automatic guidance prior to selecting their sum insured.

3.6. Insurers should work towards improving the provision of calculator tools to assist consumers to estimate required coverage for home contents insurance.

3.7. Insurers should explore the use of incentives to encourage greater use of sum insured calculators, particularly for renewing customers. Research suggests that greater consumer trust of sum insured calculators would encourage more informed decision-making.

3.8. Where a significant proportion of products are sold through third party distributors, particularly authorised representatives that are not themselves AFS licensees, insurers should monitor consumer outcomes to ensure the provision of information is appropriate and to the standards expected.

3.9. For renewing consumers, insurers should disclose the previous year's premium at renewal to enhance transparency around changes to the premium.

## 4. Disclosure is contextual

4.1. Disclosure that is specific and relevant to the consumer, rather than generic information, is more likely to be effective. Insurers should explore the possibilities of providing more specific information under the advice model in which they operate, particularly information provided by call centres.

4.2. Disclosure of scenarios of the most commonly made claims may provide consumers with contextual information that is useful for decision-making. Research suggests that consumers who had previously made a claim are more likely to consider policy details when purchasing a policy and have better comprehension of policy exclusions.

4.3. Scenarios explaining circumstances in which an exclusion is in operation could aid consumer comprehension of policy exclusions.

4.4. The provision of contextual information about the key expenses in a house rebuild at targeted points in the sales process may be useful. For example, providing an itemised list of key expenses that is used to derive the sum insured calculation can prompt consumers to consider the major costs associated with a rebuild and enhance confidence in the accuracy of these calculations.

4.5. Contextual information to help consumers understand why certain questions are being asked through the sales process may also assist consumers in responding in a more informed manner.

## 5. Disclosure is targeted, timely and accessible

5.1. Disclosure should be immediate to the decision-making needs of the individual consumer at a particular point in time, for example, specific claims scenarios when consumers are presented with policy options may assist consumers to decide on an appropriate option.

5.2. The PDS, while a trusted source, is seen by consumers as too detailed and inaccessible, reducing the likelihood that it will be used. Tools that enable the PDS to be searched and made more digestible would be beneficial.

5.3. Insurers should explore and adopt new forms of electronic disclosure that enable information to be delivered in more relevant and interactive ways. Information presented outside of the PDS may provide insurers with greater flexibility in their design and content to disclose in ways that would be engaging and user-friendly.

New disclosure should be consumer tested for usability before being implemented. Learnings from behavioural research suggests that even small friction costs, for example, additional steps required to access a document, can deter consumer engagement

## Appendix Four: Product design and distribution document

| PRINCIPLE | CONSIDERATIONS WHEN APPLYING THE PRINCIPLE |
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| **PRODUCT DESIGN** | |
| 1. **Cover should be designed with a clear target market in mind. Equally, it should be clear to insurers and distributors which consumers are not part of the target market.** | • Identification of the target market could include, amongst other things: the need the product is primarily designed to meet, the broad categories of consumers who are likely to have such a need and stand to benefit, and any exclusions or other features that may mean the product is not going to meet the needs of particular consumers who might otherwise be in the target market.<br>• By contrast, identifying consumers who are specifically outside the target market may include: those who have no need for the product or would not stand to benefit, or who have characteristics that mean they would not be able to claim at all or not able to claim a substantial benefit.<br>• The identification of target markets and non-target markets needs to be meaningful. For example, the target market for a GAP product cannot simply be "any buyer who finances a car through credit", given not all such consumers are likely to need or stand to benefit from GAP cover.<br>• Target markets can be described in general terms and with reference to particular characteristics. For example, a GAP insurance target market could be described as "consumers who are likely to face a shortfall which may be because they fall into a certain broad category – such as having a large loan with long duration or a loan that has a significant balloon payment, have a deposit below a certain amount, have purchased a vehicle that depreciates rapidly, or combination of these". Insurers may want to set thresholds for any of these factors in order to delineate the target market. The non-target market for a GAP product could be framed in relation to some of those same characteristics, but would likely also include consumers who hold comprehensive insurance that includes replacement vehicle cover.<br>• The identification of a product's target market should be driven by the primary benefit of the product. Consumers who do not stand to benefit from this cover should not be included in the target market even if they may benefit from secondary or additional benefits. |
| 2. **Cover should be designed to meet a genuine need and offer a tangible benefit at** | • Firms must be able to articulate and evidence the benefit consumers receive from the product, including why the consumer should not simply self-insure. As part of the add-on insurance review ASIC identified a number of products where it was questionable whether the products met a genuine need (Walkaway insurance) and/or provided a sufficiently tangible or substantial benefit |

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| **reasonable value.** | (Tyre and Rim insurance, MBI), suggesting that firms should consider redesigning the product and evaluate whether it should be sold as a standalone product.<br>• Consideration should be given to the outcomes a product delivers, and whether this is likely to genuinely benefit consumers and meet their needs and reasonable expectations. For example:<br>  ○ A CCI product for self-employed consumers where cover is only available once the consumer has declared bankruptcy or their business is in administration is not likely to help the consumer, nor is it likely to be in line with what they expected.<br>  ○ Walkaway cover means the consumer is paying significant amounts for a product that allows them to discharge the debt to the lender but on the basis that they will not retain possession of the vehicle. This product does not meet the needs of consumers who want cover that is more likely to enable them to keep the vehicle. Further, the cover may not discharge the debt to the lender if this is more than the maximum amount payable under the contract. There is therefore a significant risk that the product will also not meet consumers' expectations.<br>  ○ Similarly, the duration and level of payments for unemployment cover should take into account the average time taken by consumers to secure new employment. This is important in assessing whether the product is likely to genuinely help consumers. For example, the claims history may show that the majority of consumers are unemployed for either a short period (and able to obtain new employment during the waiting period) or for an extended period of time (that is longer than the period covered by the policy). If this was the case it would suggest that there is a need to redesign the way in which unemployment cover operates.<br>• ASIC does not expect firms to seek to meet all consumers' expectations all of the time - this would be unrealistic. However, ASIC would expect that firms conduct testing to understand what consumers expect before launching a product and either take that into account as part of the design process, or ensure that any identified significant departures are emphasised in disclosure documents and as part of the sales process.<br>• In this context, consideration must be given to how the sales process may influence expectations because of the language used to introduce the product to the customer. For example, the language used at point of sale may create an impression that a product offers a broad "safety net" |

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| | for when an insured event occurs, when it is in fact less broad.<br>• "Peace of mind" is frequently cited as a key benefit from add-on insurance. This is not sufficient to justify the sale of a policy, and is less likely to be relevant the higher the premium. Sale of the product would also need to be justified by the product offering a tangible benefit and having broad coverage against the identified risk (with few or narrow exclusions), and is purchased by consumers for whom it is suitable, and the claims performance shows that consumers make successful claims. |
| **3. Insurers must not design products that offer (or are capable of offering) negative or very low value.** | • The product design (and distribution) process must prevent negative value products being offered (i.e. the total cost to the consumer is more than they are able to claim), in any circumstances.<br>• Where the premium is flexible and negative value could arise in some circumstances, this threshold must be identified and safeguards put in place to prevent such sales (as per Principle 7 below).<br>• However, an emphasis on avoiding negative value does not mean that any product offering positive but low value is acceptable by default.<br>• Products should offer reasonable value to consumers. Where the line falls between low and reasonable value will depend on each product, and is a matter for the insurer to determine. However, ASIC expects the insurer to clearly articulate what constitutes reasonable value, for this to be supported by projected claims outcomes (and compared to past claims performance, if available) and monitored on an ongoing basis.<br>• Where multiple claims are needed for the product to not be considered negative or low value, the insurer should be able to evidence that, in fact, multiple claims regularly occur in practice, and that this is not simply a hypothetical proposition. If this is not borne out by actual claims experience, this suggests a need to redesign or reprice the product.<br>• Setting claims limits artificially high to suggest a product offers value when in reality the claims experience makes clear that consumers do not achieve such outcomes is not acceptable and not evidence of a product providing reasonable value. |
| **4. Additional benefits should be subject to strict scrutiny in terms of product design.** | • As with the primary benefit, any additional benefits should meet a genuine need and provide a tangible benefit to consumers.<br>• In designing cover, firms should consider the risk of additional benefits duplicating cover the consumer may already hold (including under other financial products or at law), and redesign the |

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| | product if there is a substantial risk of this happening. For example, ASIC observed that the additional benefits available under many GAP or MBI policies duplicated cover widely offered under comprehensive car insurance. This meant that the consumer paid twice for the same cover and was unable to claim under both products due to restrictions set out in the Insurance Contracts Act 1984.<br>• In general, the performance of additional benefits should be subject to the same scrutiny as the primary benefit. For example, poor claims performance of additional benefits should prompt a review and potentially require product redesign.<br>• There should be a reasonable link between additional benefits and the primary cover that the consumer is buying the product for. Insurers should avoid obscure and unrelated benefits, given the consumer is unlikely to expect such cover or indeed recall that they have it when they are entitled to claim. |
| **5. The product and its features and exclusions must be capable of being communicated to and understood by the target market.** | • The product, and its features and exclusions, must be capable of being communicated to, and understood by, the target market (noting that sales are currently made under either general advice or no advice models).<br>• This includes being able to explain clearly how a product interacts with the consumer's existing rights and what the cover will provide above and beyond those rights.<br>• If a product is so complex or difficult to explain that the consumer cannot reasonably be expected to make an informed decision at point of sale, the insurer should consider what additional steps might be necessary to ensure clearer communication.<br>• Additional steps could include:<br>  ○ The whole or part of the product to be redesigned;<br>  ○ Developing tools to be used at point of sale to help the consumer understand the product – this could be digital, interactive;<br>  ○ Other measures to help consumer decision-making, such as additional time;and<br>  ○ Consideration of whether the product should be sold under a personal advice model only.<br>• Examples ASIC has identified where this expectation has not been met include:<br>  ○ Pre-existing conditions (PECs) that are very broad, raising questions as to whether the consumer could form a clear view of whether the cover might meet their needs; and |

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| | ○ Mechanical Breakdown Cover where it is not necessarily clear how the product interacts with Australian Consumer Law (ACL) (including whether the product offers benefits or cover additional to that provided under the ACL, and, if so, the nature of those benefits) meaning that the consumer is likely to be unable to assess whether they need the product and whether it offers them good value. |
| **6. When designing products for bundling, insurers should consider how this impacts on the target and non-target market and product value.** | • Bundling of cover can be efficient and offer consumers cover they might not otherwise be able to access as a stand-alone product.<br>• However, bundling can also:<br>○ Increase the risk of consumers buying cover that they are not eligible for or cannot benefit from;<br>○ Can lead to them holding duplicate cover; and<br>○ Can contribute to poor value if consumers pay for two types of cover when they can only claim under one cover.<br>• ASIC expects that where products are bundled, the target and non-target market should be developed with the whole bundled product in mind, and reasonable controls put in place for distribution in line with this. For example, if a bundled product includes unemployment cover, then it is likely that the product's target market should not include consumers who do not meet the employment criteria, irrespective of whether they are able to claim under other components.<br>• In identifying the target market and distribution safeguards for a bundled product, ASIC expects insurers to apply judgement. For example, if a consumer is ineligible to claim under a component of a bundled product that covers a narrow or uncommon risk, and this is reflected in the price, this may be acceptable. However, ASIC expects that a firm would have evidence (especially through claims outcomes) to demonstrate that the risk is unlikely to arise, and consider the sale carefully. This might involve requiring representatives to record clear evidence that the consumer understood that there were aspects of cover they could not claim under, and made an active decision (not simply relying on the consumer signing a document that included a disclaimer to suggest that they understood). ASIC would also expect insurers to take action if a review of claims outcomes and complaints suggested concerns about consumer outcomes in this regard. |

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| PRODUCT DISTRIBUTION AND SALES | |
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| **7. Insurers should have reasonable controls in place to ensure that the product**<br>**a. Reaches the target market for whom it is intended**<br>**b. Does not reach those outside the target market**<br>**c. Does not offer low or negative value.**<br>**Reasonable controls should also manage the risk of over-insurance.** | • Firms should select distribution channels and market the product in a way most likely to result in the product reaching its target market. This selection may be influenced by the controls that can be put in place to ensure that the products reach the identified target market, or what best enables consumers to make an informed decision. Factors like product complexity should also inform selection including, for example, consideration of the appropriate advice model.<br>• Firms should translate the target market and any thresholds for negative or low value into safeguards to be applied during the sales process to prevent sales to consumers who are ineligible, do not stand to benefit or would derive low or no value from a product. For example, new systems rules could be created to make it impossible to process a sale where a customer is ineligible or otherwise outside the target market, or that does not meet the acceptable cover-to-premium ratios.<br>• Insurers should consider how their insurance products interact and ensure that the distribution strategy e.g. prevent the sale of GAP insurance and comprehensive car insurance with replacement vehicle benefit covering the same period of time.<br>• Similarly, sales processes should be geared to prevent over insurance - ensuring that consumers are not sold cover far in excess of what they could ever claim, especially where a lower and sufficient level of cover is available.<br>• The decision on how systems and processes might be calibrated to implement such safeguards is a matter for individual firms and will vary by product and firm.<br>• As noted above, the following points are important in designing an effective distribution strategy:<br>o Additional benefits should not be used to justify sales where the customer does not stand to benefit from the primary benefit.<br>o Insurers should consider whether bundling may affect their distribution strategy and its effectiveness.<br>• Insurers should be aware of the impact of different incentives (i.e. different commission levels) on sales, and ensure they have adequate controls in place around this.<br>• Training and information should be designed to enable distributors to sell products in line with the insurer's strategy, for example, relating to target market, and good sales practices. |

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| | Training and information should be regularly updated in line with product changes or in response to any concerns identified with distributor conduct or understanding. As such, training and information should also form part of the regular review (see Principle 10 below). |
| **8. Insurers should set clear expectations about what constitutes good sales practices, and equally what conduct is not acceptable.** | • Firms must take into account the behavioural and other factors that can undermine the consumer's ability to make rational or informed decisions, and take reasonable steps to address this in designing or approving sales processes.<br>• Factors such as a consumer's lack of familiarity, or focus, and a risk of decision fatigue should be taken into account in determining the content, format and timing of information given to consumers. Additional tools may be necessary to enable consumers to make an informed decision about a product. Insurers should consider whether consumers will require extra time to make an informed decision.<br>• Insurers should also consider what method of distribution is most conducive to consumers making an informed decision.<br>• Insurers should set clear standards for a good sales process, ensure that these are reflected in processes and manuals, and monitor compliance with these standards.<br>• Examples of unacceptable conduct include (but are not limited to):<br>o Pressure selling or other inappropriate sales tactics such as not giving the consumer any opportunity to refuse to consider/buy the product, opting consumers into products, hiding insurance cover in finance contracts, pre-filling application forms and upselling.<br>o Misleading or manipulating the customer by focusing on benefits at the expense of exclusions, presenting the insurance as mandatory to secure finance (or creating that impression), anchoring the price of insurance, price framing, or giving only partial costs (for example, by presenting costs on a monthly basis rather than the total premium, or presenting costs without interest).<br>o Overwhelming the consumer by presenting a large number of choices or only introducing add-on insurance late in the transaction, or on or near to delivery (when the consumer will be keen to complete the transaction and drive the car away).<br>o Poor disclosure such as not disclosing the price at the product at all, or only very late in the sales process, providing unclear descriptions of product, using jargon and failure to provide PDSs.<br>• Broad references to "peace of mind" should be avoided in sales scripts, focusing instead on |

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| | concrete benefits and features. If references to peace of mind are made, this should only be in the context of cover that offers a broad and tangible benefit, has been tested and found to be in line with consumer expectations, and has few or narrow exclusions. |
| **9. Insurers should provide the necessary training and information to their distributors to enable them to sell the product in line with their stated policies.** | • Training and information should be designed to enable distributors to sell products in line with the insurer's expectations, with regard to distribution and good sales practices.<br>• Training and information should be regularly updated in line with product changes or in response to any concerns identified with distributor conduct or understanding. As such, training and information should also form part of the regular review (see Principle 10 below). |
| **REVIEW** | |
| **10. Insurers should regularly review product performance and distribution and act promptly on any identified concerns.** | • Firms should have processes in place for monitoring/assessing product performance:<br>o Whether a product is performing in line with objectives, is reaching the target market, is not being sold to consumers who are not eligible or for whom it is not suitable; and<br>o Whether there is unacceptable conduct at point of sale.<br>• Product review should include an assessment of whether the product continues to meet consumers' needs.<br>• Firms should collect and evaluate relevant data to support the product reviews. Information considered as part of this should include, at a minimum, claims performance and complaints.<br>• Periodically, firms might also review a product more broadly against consumers' expectations and needs, and actual outcomes. This could include:<br>o Where products are linked to finance, firms might collect information from financiers to understand whether the product helped deliver the outcome for which it was intended. For example, a CCI product may indicate that many consumers claim, but consideration of ultimate consumer outcomes shows that limitations in cover mean that many claimants nevertheless had the vehicle repossessed, raising questions over whether the cover meets their needs.<br>o Firms could periodically review wider circumstances and economic and market conditions |

to assess whether the product continues to meet the need for which it was designed. For example, the increased casualisation of the workforce in Australia over time may suggest that there is a need to revisit the scope of exemptions for consumers in casual employment cover.

- A periodic review of consumer expectations might also prompt changes to product design, or indicate that further care needs to be taken during the sales process.

- Insurers must be able to satisfy themselves that they have effective systems in place to prevent poor conduct at point of sale, and how they can evidence these are working. It is expected that the processes themselves go beyond training and or manuals and should involve insurers proactively ensuring actual adherence to good practices.
- ASIC would expect that any safeguards are tested and validated to ensure that they are effective in preventing sales outside the target market or sales where there would be over-insurance. For example, firms might review a sample of files to validate controls and outcomes.
- Insurers should consider whether their monitoring and quality assurance processes meet appropriate standards (for example, in relation to sample sizing/statistically significant samples) to ensure that their products are being distributed appropriately.
- In conducting their review, licensees insurers should be aware of the impact of different incentives (i.e. different commission levels) on sales, and ensure they have adequate controls in place around this.
- Insurers should have processes in place for taking action where concerns are identified with particular distributors or individuals operating within the distributor. Action taken may include sanctions and, where appropriate, remediation to consumers. Where concerns are systemic and cannot be addressed through the above means, the insurer should consider whether the business relationship is sustainable.
- Insurers should also have clear procedures in place so that they actively remediate consumers financially disadvantaged by any such misconduct, and that they also report significant breaches of the law to ASIC.

## Appendix Five: Claims investigations standards

1) In a small amount of claims, we will determine that further investigation by an internal or external investigator is required. To ensure that investigations are being carried out when appropriate and in an appropriate manner, we will:
   a) review our fraud investigation indicators at least once a year to ensure they remain relevant and appropriate;
   b) provide written instructions to any external investigator that we engage, and we will confirm in writing any change to instructions;
   c) have a quality assurance program in place to regularly review investigations carried out, which may include:
      i) Review of recordings, statements, affidavits and/or transcripts of interviews;
      ii) Review of complaints about investigations, including disputes referred to FOS; and
      iii) Review of external investigators' records of investigation activities.

2) If we engage an external investigator to assist us with your claim, we will require that:
   a) a register of investigators' licences (including expiry dates) is maintained internally and kept up-to-date, to ensure the licences of any investigators we engage are current;
   b) the investigator complies with any relevant State and Territory legislation;
   c) the investigator must not exceed our written instructions without our prior consent;
   d) the investigator does not use illegal means to carry out the investigation, or induce someone to perform a task or activity that they would not have performed without the involvement of the investigator;
   e) the investigator only collects information relevant to their investigation;
   f) the investigator does not make any threat, promise or inducement to any person when conducting an investigation on our behalf;
   g) the investigator acts in accordance with the standards relating to interviews and surveillance below; and
   h) records of all investigation activities are kept in accordance with the requirements of the Privacy Act 1988.

3) Where we require formal interviews to be carried out as part of a claim:
   a) ahead of the interview being carried out, you will be advised of the following information:
      i) the purpose of the interview;
      ii) who will be carrying out the interview;
      iii) that they are acting on our behalf;
      iv) contact details if you want to contact us with any questions about the interview or the interviewer;
      v) your right to have an interpreter, legal representative or other person present to support you (although they cannot answer questions on your behalf);

b) if you have requested that we communicate through a representative, we will let the interviewer know to advise the representative before contacting you;
c) if an independent interpreter is required, we will arrange this at our cost. If it becomes apparent during the interview that an interpreter is required even though it had not previously been requested, the interviewer will terminate the interview and reconvene at a later date once an interpreter has been arranged;
d) where we are aware or you tell us that you require additional support due to mental health or family violence, we will only use an interviewer that we are satisfied has appropriate training or experience to carry out the interview;
e) if you request, we will arrange an interviewer of the same sex if one can reasonably be arranged;
f) you can choose to be interviewed somewhere other than your home, at a location acceptable to both parties;
g) if the interview is not being digitally recorded, you will be asked to complete an interview consent form that contains the information contained in the Appendix. In circumstances where the interview is being digitally recorded, the interviewer will ask you a series of questions covering the information contained in the Appendix as part of the interview, for the purpose of confirming your consent;
h) if we intend for a minor to be interviewed, or our investigator informs us that they wish to interview a minor, we will:
    i) assess whether the interview is necessary and whether the interviewee is capable of distinguishing truth from fiction;
    ii) only use an interviewer that we are satisfied has appropriate training or experience to carry out the interview;
    iii) ensure that any interview takes place only in the presence of a responsible adult; and
    iv) ensure that the interview is suspended if at any time the minor is distressed by the interview process or at the request of the responsible adult;
i) if the interview is to be digitally recorded, you will be advised before the interview starts;
j) interviews will be conducted respectfully and take a maximum time of two hours, unless you agree to an extension. Further interviews will be organised if it is reasonably required;
k) you can request breaks during the interview if you require and you can stop the interview early and reschedule if you needed; and
l) a transcript of the interview (or a digital copy of the recorded interview) can be provided to you if requested.

4) Where we require surveillance to be carried out:
a) alternative methods of verifying information will be sought prior to arranging surveillance;
b) surveillance will only be arranged where we reasonably believe prior to carrying out the surveillance that your claim appears to be inconsistent with information available to us, and our reasons for this will be documented;
c) requests for surveillance must be internally reviewed and approved by a suitably experienced employee who is senior to the claims handler;
d) surveillance will not be conducted inside any court or other judicial facility, in any medical or health facility, in any bathroom, change room, lactation room or inside your house;

e) we will discontinue surveillance where there is evidence from an independent medical examiner that it is negatively impacting a pre-existing mental health condition; and

f) surveillance investigators will not communicate with neighbours or work colleagues in ways which might directly or indirectly reveal that surveillance is being, will be or has been conducted.

## APPENDIX

### Interview consent form

Interviewer's name and contact details:

Insurer's details:

Interviewee's name and contact details:

Date:

Subject matter of interview:

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| You can have an interpreter, legal representative or other support person present during your interview. Please let the interviewer know as early as possible if you would like to arrange this, and confirm below in writing whether you require this: |

"I agree to be interviewed by the representative of [insurer] in relation to the above matter. Following discussion with the interviewer regarding the interview options available to me, I agree to participate in: (Please select)

- Digital audio interview
- Digital videotaped interview
- Provision of a typed statement
- Provision of a Q&A
- Provision of a handwritten statement
- Other"

Privacy statement, acknowledgement and consent:

Authority to access information from third parties:

- Scope of authority
- Type of information to be requested
- Period of information requested
- Impact on the claim if the information is not provided
- Date of issue and expiry of authority

Signature: