

FINAL REPORT

Review of the General Insurance Code of Practice

Insurance Council of Australia

June 2018

CEO'S MESSAGE

I am pleased to present the Final Report of the Review of the General Insurance Code of Practice by the Insurance Council of Australia (ICA).

The Code is reviewed regularly to ensure the industry's commitment to consumer outcomes remains relevant and up to date. This Review was launched in 2017 at the request of the ICA Board. As it progressed, its focus widened to anticipate regulatory developments affecting the industry, as well as to address changing community needs and expectations.

The review consulted widely with the industry, regulators, and consumer and community organisations. The issues raised by stakeholders were broad but were focused on improving consumer outcomes. Importantly, they also addressed the growing awareness of complex social issues facing consumers experiencing vulnerability when dealing with insurance, including in the areas of mental health, financial hardship and family violence.

The revised Code will reflect the general insurance industry's commitment to positive outcomes for consumers and its determination to provide best practice in conduct and customer service. The industry understands the essential role it plays in the community and the economy and its responsibility to treat customers with respect and compassion.

The industry has made big strides in the current Review. Though the ICA could not deliver on all issues raised during the consultation process, the ICA supports the recommendations proposed to improve the Code.

The Final Report recognises the diverse needs of consumers experiencing vulnerability and commits members to assisting them with new principles and greater flexibility. New mental health principles will provide guidance to members addressing the rights and the needs of people with a mental health condition. Similarly, guidance on family violence will provide additional assistance to affected consumers, while also focusing on training and assistance to staff in the industry.

The recommendations also include product design and disclosure obligations, claims investigation standards and financial hardship provisions.

The General Insurance Code of Practice was one of the first of its kind in Australia and the industry treats it with utmost respect and seriousness. It has long been regarded as the benchmark for self-regulation in the financial services sector, and I believe the revised Code will again meet this test.

A strong Code provides confidence to consumers and trust in the industry. The ICA and its Board welcome an updated Code. However, the significant revisions in this version do not preclude further changes as required. The industry does not think of the Code as a static document, but rather as a living document subject to ongoing improvements to benefit general insurance consumers.

I would like to thank all stakeholders for their significant contribution to the Review and in assisting with the development of a modern new Code.

Robert Whelan, Executive Director & CEO

Table of Contents

1. EXECUTIVE SUMMARY	4
2. SUMMARY OF RECOMMENDATIONS & NEXT STEPS	6
3. BACKGROUND	13
4. CUSTOMER COMMITMENTS	14
5. CONSUMERS EXPERIENCING VULNERABILITY	16
5.1. New Code Obligations on Consumers Experiencing Vulnerability	16
5.2. New Code Obligations on Financial Hardship	20
5.3. New Requirements on Family Violence	27
5.4. New Guidance on Mental Health	28
6. EFFECTIVE DISCLOSURE & ACCESS TO INFORMATION	32
6.1. Effective Disclosure & Enhancing Transparency	32
6.2. Access to Information	38
7. PRODUCT DESIGN & DISTRIBUTION	41
7.1. New Code Obligations on Product Design and Distribution	41
7.2. New Code Obligations for Third Party Distributors & Employees	43
7.3. New Guidance for Add-on Insurance	48
8. INVESTIGATORS & SERVICE SUPPLIERS	50
8.1. New Standards for the Use of Investigators	50
8.2. New Obligations for Service Suppliers	52
9. CLAIMS	57
10. COMPLAINTS PROCESS	65
11. MONITORING, ENFORCEMENT AND SANCTIONS	68
12. ASIC APPROVAL	73
13. OTHER ISSUES	76
Appendix 1: Draft Guidance on Family Violence	81
Appendix 2: Draft Guidance on Mental Health	91
Appendix 3: Draft Guidance on Best Practice Disclosure	96
Appendix 4: Draft Guidance for the Design and Distribution of Add-on Insurance Distributed through Motor Dealer Intermediaries	101
Appendix 5: Draft Standards on the Use of Investigators	105
Appendix 6: Details of stakeholder workshops	109

1. EXECUTIVE SUMMARY

In developing the recommendations for this Final Report of the Review of the General Insurance Code of Practice (the Code), the ICA has taken into account detailed submissions and discussions with the ICA's Consumer Liaison Forum (CLF),¹ ICA member committees, submissions received from a range of consumer representatives, the Code Governance Committee (CGC), Financial Ombudsman Service (FOS), and the Australian Securities and Investments Commission (ASIC).

Based on the feedback received, the ICA has identified a number of priority areas, reflected in the 30 recommendations made. These include matters such as assisting consumers experiencing vulnerability (including family violence, financial hardship and mental health conditions), more effective disclosure, standards on claims investigations, and strong governance of product design and distribution. The ICA strongly believes that these amendments to the Code will place the industry in a good position to meet the expectations of consumers and the community.

In addition to this, the ICA proposes to amend the Code so that it opens with a set of core commitments. These commitments reflect, at its very basic, the industry's purpose. The ICA believes it is more important than ever, in an increasingly fast-paced and innovation-driven environment, for the industry to be able to articulate in simple terms its value proposition.

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 is not so prescriptive that it restricts insurer competition and innovation.

In some cases the ICA has not adopted changes to the Code where we consider the change as either not coming within the ambit of the Code, or not within the scope of this Review. This is not to underplay the importance of these issues; indeed, many of these issues are being dealt with outside of the Code mechanism, such as the ICA's ongoing work with members to improve the effectiveness of disclosure.

In determining the changes to the Code where there would be greatest impact on achieving good consumer outcomes, the ICA has used the following criteria of assessment:

- The change would improve treatment of customers;
- The change would improve product design;
- The change would improve claims experience;
- The change would improve the provision of information and processes to ensure customers are kept adequately informed during and after the point of sale.

The ICA has sought to balance this criteria with the expected length of time required for implementation, systems changes and costs involved, any gaps in the formal regulatory regime and the impact on smaller insurers in the market and the competitive landscape.

¹ 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 ICA's recommendations will introduce new layers to the existing Code in the form of standards and guidance. This is necessary to reflect the need for industry self-regulation to commit, at times, to more than just minimum standards and create momentum for leadership in certain areas. This certainly is the case for the best practice guidance proposed by the ICA on the topics of family violence, mental health, disclosure, and the sale of add-on insurance.

These are areas where minimum standards may not be appropriate, particularly as the industry continues to learn through research and consumer co-design. These best practice principles, while not mandatory, aim to set higher standards than could be achieved through binding minimum Code obligations. For family violence, the guidance will also be accompanied by a new Code obligation for insurers to have policies in place; this will ensure that all Code Subscribers will have appropriate policies, while providing sufficient flexibility for individual insurers to benchmark the content of their policies against agreed industry best practice contained in the guidance.

On the other hand, the ICA proposes mandatory standards for the use of investigators, given the significant consumer benefits expected from a uniform industry approach.

It should be noted that many of the Code recommendations intersect with a range of legislative changes or proposals currently under way. As a result, these reforms have precluded the industry from making certain changes to the Code where there is a risk of Code obligations becoming inconsistent with the law.

Many of the areas of guidance and standards, including add-on insurance and investigations standards, have reforms under consideration by the regulators. As such, while the ICA has published these as an indication of where the ICA would like to head, some of the detail may require adjustment when drafting the amended Code, as regulatory, legislative and other developments occur.

Given the number of recommendations made in this report, it was thought helpful to provide a brief description of the issues concerned. A more detailed explanation of the background of each issue can be found in the Interim Report on the ICA's Code Review website.²

² <http://www.codeofpracticereview.com.au/>

2. SUMMARY OF RECOMMENDATIONS & NEXT STEPS

2.1. Outline of Recommendations

Core Commitments	
1	The Code should be amended to state upfront the key commitments of the Code, as well as articulate the spirit, intent and objectives of the Code. This section will express the industry's commitment to creating an ethical corporate culture through best practice conduct and customer service.
Consumers Experiencing Vulnerability	
2	<p>The Code should be amended to include a new principles-based section on consumers experiencing vulnerability, which includes:</p> <ul style="list-style-type: none"> • A statement acknowledging the diverse needs of consumers experiencing vulnerability. • A commitment to accommodating the needs of consumers experiencing vulnerability where they tell insurers they need particular support or assistance in relation to their vulnerability. • Accommodation of requests from consumers experiencing vulnerability for formal or informal assistance from third parties where they tell insurers they need particular support or assistance from third parties in relation to their vulnerability. • A requirement for staff to be trained to help to identify consumers experiencing vulnerability, and engage with them with sensitivity, respect and compassion, and to take appropriate steps for additional support. • A requirement for insurers to provide assistance to those who have trouble meeting identification requirements. • Best practice standards for the use of interpreters.
3	<p>The Code should include enhanced protections for consumers experiencing Financial Hardship, including the following amendments to the Code:</p> <ul style="list-style-type: none"> • An obligation for timeframes for Financial Hardship applications to be in line with the National Credit Code. • Require insurers to have internal policies and train relevant employees to help with the identification of consumers who may be experiencing financial hardship. • Clarification that the Financial Hardship section applies to situations where a customer cannot pay their excess, and include in the list of options for

	<p>financial hardship assistance “<i>deduction of the excess from the claim payment</i>”.³</p> <ul style="list-style-type: none"> • Where an insurer is aware that a customer who has applied for Financial Hardship assistance has a nominated representative, an obligation for the insurer to ask if they want their representative to be kept updated. • An obligation for Employees and agents involved in debt collection to be trained on the Financial Hardship requirements of the Code, and on how to help identify someone who might be experiencing Financial Hardship. • An obligation for insurers to make requests for further information, when assessing Financial Hardship, as early as possible so that the request does not unreasonably or unnecessarily delay the application. • An obligation for reasonable requests to pay a debt in full in instalments not to be refused. • An obligation for an insurer to provide written reasons where they have determined that someone is not entitled to Financial Hardship assistance. • An obligation for any communications about debt recovery to provide sufficient information to enable the consumer to determine whether the amount being recovered is fair and reasonable and to include information about the Financial Hardship process. • Clarification that uninsured third parties seeking Financial Hardship assistance can access an insurer’s Complaints process.
4	The Code should be amended to require insurers to have a family violence policy in place. The Code should be accompanied by family violence guidance, attached at Appendix 1, to provide insurers with guidance on developing their own family violence policies.
5	The ICA proposes to continue to work with members, family violence experts, Financial Ombudsman Service (FOS) and legal expert Dr Ian Enright to address the complex legal issues raised in situations of family violence. ⁴
6	The Code should be accompanied by best practice guidance on mental health, attached at Appendix 2.
<i>Effective Disclosure and Access to Information</i>	
7	The Code should be accompanied by best practice disclosure guidance, attached at Appendix 3.

³ Words italicized and in bold refer to amendments to existing Code obligations.

⁴ FOS will be replaced by the Australian Financial Complaints Authority (AFCA) on 1 November 2018. All references to FOS in this report are references to AFCA following its commencement.

8	The Code should be amended to require insurers to effectively disclose how promoted benefits could be realised in practice where incentives are used to influence decision-making.
9	The Code should be amended to require consumers applying for home building insurance to be given access to a sum insured calculator which insurers will regularly review to ensure accuracy.
10	The Code should contain a new obligation for insurers to disclose the previous year's premium at renewal for home insurance policies.
11	<p>The Code should be amended to:</p> <ul style="list-style-type: none"> • Require the insurer to ensure that the automatic renewal is made clear where a customer purchases a policy that automatically renews each year. • Require information about the automatic renewal, including the ability to opt-out, to be included on the annual renewal notice.
12	The Code should be amended to require an insurer, if they are unable to provide cover when an application is made, to <i>inform the consumer of their right to ask for the information relied on.</i>
13	<p>The Code should be amended to clarify that a customer can have access, at no cost, to the following information if requested:</p> <ul style="list-style-type: none"> • Information and documents relied on to deny a claim. • Copies of the PDS and insurance certificate. • Copies of any expert or assessment reports relied on. • Copies of any recordings or available transcripts from any interaction the insurer has had with the consumer, where these exist.
<i>Product Design and Distribution</i>	
14	The Code should be amended to require insurers to have policies in place documenting their processes and governance arrangements for designing and distributing products so that insurance products are designed for, and distributed to, an appropriate target market.
15	<p>The Code should be amended to:</p> <ul style="list-style-type: none"> • Clarify that all third parties operating under an insurer's Australian Financial Services Licence (AFSL) are subject to the standards of the Code by changing the references to "Authorised Representative" to "Distributor". • Require insurers to have policies and procedures for Employees and Distributors to conduct sales appropriately and prevent unacceptable sales practices.

	<ul style="list-style-type: none"> • Require insurers to make it clear to Employees and Distributors selling their products that pressure selling is not permitted. • Require Distributors to notify insurers of any Complaints made within two business days, so that insurers can commence the Complaints process as early as possible. Also require Distributors to notify insurers of any Code breaches when acting on the insurer's behalf. • Require insurers to monitor the sales practices of its Employees or Distributors, and investigate concerns raised or identified.
16	<p>The Code should be amended to provide a non-exhaustive list of remedies available to consumers where poor conduct has been identified, including:</p> <ul style="list-style-type: none"> • Arranging a refund of premiums paid • Payment of interest on the refunded premium • Adjusting the cover • Correcting information • Honouring a claim
17	<p>The Code should be accompanied by best practice product design and distribution guidance, which would apply to add-on insurance sold through motor dealer intermediaries, attached at Appendix 4.</p>
<i>Investigators, Service Suppliers & External Experts</i>	
18	<p>The Code should be accompanied by mandatory standards on the use of investigators, attached at Appendix 5.</p>
19	<p>The existing Code requirement for insurers to notify claimants within five business days of appointing an investigator should be amended to include an explanation of the investigator's role.</p>
20	<p>The ICA proposes to discuss with members and ANZIIF the possibility of developing a course to assist members to undertake investigation activity in a manner that complies with the Code and that meets community expectations.</p>
21	<p>The Code should be amended to:</p> <ul style="list-style-type: none"> • Require insurers to put in place measures to ensure that suitable Service Suppliers are appointed. • Require Service Suppliers to notify the insurer within two business days if they receive a Complaint, so that the insurer can address this through their Complaints process as early as possible. They must also notify the insurer of any Code breach that they identify. • Require insurers to address identified performance shortcomings in their Service Suppliers' services, such as a requirement for further training.

- Require insurers to only engage External Experts where the insurer is satisfied that they have the expertise to provide the requested opinion, and where the insurer believes they are compliant with the rules and regulations relevant to their area of expertise.

Claims

22 The Code should be amended to reflect the following:

- When a claim is made, require insurers to provide the claimant with an overview of the claim process, along with any excesses and waiting periods applicable. They will also provide the claimant with contact details to get information about their claim.
- Enhance transparency for uninsured third party claims against a customer's insurance policy; including the provision of information about the insurer's claims process and the Complaints process.
- When assessing a claim, require insurers to only ask for relevant information, and explain why it is relevant. Insurers should use best endeavours to request all information early and, if possible, in one request.
- In situations of total loss, require claims to be treated with sensitivity. Claimants will be provided with support, and assisted to determine the amount of their claim. Insurers will not require proof of ownership or an inventory assessment where it is clear that the loss exceeds the sum insured or any sub-limit within it.
- To provide to claimants ***in writing*** the following if a claim is denied or ***partially accepted***:
 - ***Which aspects of the claim have not been accepted and the reasons for the insurer's decision;***
 - The consumer's right to ask for the information relied on in assessing the claim;
 - The consumer's right to ask for copies of any Service Suppliers' or External Experts' reports relied on in assessing the claim; and
 - Details of the Complaints process.
- Where a decision has not been made within four months, or within twelve months in exceptional circumstances, require insurers to provide details of their Complaints process ***in writing***.
- Where an insurer's appointed repairer does a faulty or poor repair, require insurers to cover the reasonable costs of hire car and accommodation above what the insured is covered for.

23 The ICA proposes to work with the CGC and insurers to agree on consistent categories and definitions on withdrawn claims, to complement the work of CGC and ASIC on data collection.

Complaints Process

- 24** The Code should be amended to require insurers to inform consumers *in writing*, where an insurer has been unable to provide a decision within 45 calendar days, for the reasons for the delay and the consumer's right to take their Complaint to FOS.
- 25** The ICA proposes to continue to work with insurers to determine suitable changes that address stakeholder concerns with the current two-stage complaints process.

Monitoring, Enforcement & Sanctions

- 26** The Code should be amended to:
- Clarify that **anyone** can report alleged breaches to the CGC **at any time**.
 - Clarify that the sanctions in the Code enable compensation for any direct financial loss or damage cause to an individual, in line with ASIC Regulatory Guide (RG) 183.
 - Provide that the principles of honesty, fairness, efficiency, transparency and timeliness have broad application as standalone provisions by removing the words "in accordance with this section" at sections 4.4, 6.2, 7.2 and 10.4.
 - Enable the CGC to publish its decisions on a de-identified basis on the Code website, to assist Code subscribers to understand the CGC's interpretation of the Code's requirements.

ASIC Approval

- 27** In order to meet the requirements for ASIC approval of the Code, the Code should be amended to:
- Clarify that the Code is enforceable through CGC oversight and sanction powers, and through FOS taking Code breaches into account when determining disputes.
 - Enable the CGC to report systemic code breaches and serious misconduct to ASIC, and require the CGC to notify an insurer's Chief Executive that it intends to do so. The ICA will work closely with the CGC to ensure there is a common understanding of the meaning of "systemic breach" or "serious misconduct", to provide insurers with clarity.
 - Include a maximum timeframe for independent reviews in line with RG 183.

Other Issues

- 28** The Code should be amended to elaborate on the role of the CGC. Specifically, the CGC is responsible for:
- Monitoring and enforcing insurer compliance with the Code, in accordance with section 13 of the Code, including through investigations and analysis of data and evidence;

	<ul style="list-style-type: none"> • Providing leadership to industry and helping insurers to understand and comply with their Code obligations and seeking continuous improvement of insurance practices; • Liaising with the ICA on relevant matters.
29	The ICA proposes to relaunch the Code website with the revised Code, to provide more information about the CGC and the enhanced provisions on reporting of a Code breach.
30	The ICA website should promote the rights of residential strata consumers under the Code.

2.2. Next Steps

The ICA will now commence work to revise the Code, as per the recommendations in this report, by November 2018.

There are some matters raised that require further work. In particular, the ICA has advanced on work with insurers to determine suitable changes to the Complaints process to address stakeholder concerns. Refinements to draft guidance and the standards to reflect ongoing work by ASIC and legislative developments will occur prior to the finalisation of the revised Code in November. We will also take into account Mr Phil Khoury's final oversight report, which will be published on the Code Review's website shortly.

Other related work streams are either under way or will commence shortly and continue beyond November 2018, including:

- Discussions between industry, family violence experts, FOS and legal expert Dr Ian Enright to address the complex legal issues raised in situations of family violence;
- Liaison between CGC and insurers, including on consistent categories and definitions on withdrawn claims, to complement the work of CGC and ASIC on data collection;
- Discussions with the Australian and New Zealand Institute of Insurance and Finance (ANZIIF) on the possibility of developing a course to assist members to undertake investigation activity in a manner that complies with the Code; and
- Discussion with stakeholders on the development of an industry training program on consumers experiencing vulnerability that can be accessed by code subscribers.

Some recommendations made by the ICA will require substantial changes to insurer systems. Notwithstanding the longer transition period required for these recommendations, the ICA has pursued change where substantial consumer benefit is anticipated. The ICA expects a phased transition period would be appropriate, so that many revised Code obligations could commence sooner, and others requiring systems changes are provided with a longer transition period. The ICA will consult with stakeholders where appropriate to determine transition arrangements.

For all of these work streams, the ICA will undertake targeted consultation as required.

3. BACKGROUND

On 17 February 2017, the ICA launched an internal, targeted review of the Code, at the request of the ICA Board. The objective was to ensure the Code remains relevant and a benchmark of industry self-regulation, amidst recent external developments impacting the general insurance industry.

The ICA appointed former ASIC General Manager and Managing Director of Cameron Ralph Khoury, Phil Khoury, to provide independent oversight of the Review. Mr Khoury's role is to ensure the Review appropriately considers the submissions received and recent external developments.

The Review commenced with a six-week consultation period, during which time feedback was sought from external stakeholders and ICA members. Fourteen written submissions were received, ten of which are available to view and download on the Code Review website.⁵

The ICA followed up with submitters to discuss their feedback. ICA member committees also provided verbal and written feedback on key issues raised by submitters, as well as the draft guidance and standards documents included as appendices to this report.

The ICA then released an Interim Report in November 2017, which identified priority areas for a revised Code to address, and sought feedback on whether the ICA had correctly captured the key issues. Of the sixteen submissions received in response to the Interim Report, thirteen are available on the Code Review website.

The ICA held several workshops with submitters to discuss practical solutions to specific issues where there were diverging views. Workshops were held on the topics of mental health, product design and distribution, third party distributors, the internal complaints process and industry data collection (Appendix 6 outlines the workshops held).

The ICA has taken into account all of the feedback received from stakeholders, in formulating this Final Report, which has been approved for release by the ICA Board.

⁵ www.codeofpracticereview.com.au

4. CUSTOMER COMMITMENTS

ICA Recommendation 1

The Code should be amended to state upfront the key commitments of the Code, as well as articulate the spirit, intent and objectives of the Code. This section will express the industry's commitment to creating an ethical corporate culture through best practice conduct and customer service.

4.1. *Background*

The ICA has considered the merit of the inclusion of some key commitments at the front of the Code to provide an overarching framework that conveys the intent and objectives of the Code. While the Code had always been drafted to contain simple to read commitments that would be engaging for consumers, it has been recognised that simplifying the Code's intent into a concise set of commitments may be beneficial. Such commitments could also set the standard for good corporate culture.

4.2. *Stakeholder feedback*

FOS considered that an industry code should contain strong, prominent statements of guiding principles such as the 'Key Code Promises' in the Life Insurance Code of Practice (the Life Code).⁶

The Joint Consumer submission also suggested that the Code should contain specific provisions with a view to fostering a culture of customer service.⁷ Both ASIC and the Public Interest Advocacy Centre (PIAC) felt it was important for the Code to acknowledge the importance of corporate culture and to outline steps insurers should take to improve culture.

However, the Joint Consumer submission suggested that such commitments should be included in the Code, rather than a separate charter. Insurers agreed that the Code should be maintained as the primary reference document for consumers.

Insurers noted that both APRA and ASIC have clearly communicated expectations in relation to matters of corporate and risk governance. Insurers noted that the Code obligations, by setting standards above the law, already provides an indicator of what good corporate culture looks like, without the need to duplicate the regulators' work.

The CGC agreed that the Code should not contain a specific provision relating to corporate culture.

⁶ <https://fsc.org.au/policy/life-insurance/code-of-practice/life-code-of-practice.pdf>.

⁷ Joint submission from Consumers' Federation of Australia, Community Legal Centres Queensland, Consumer Action Law Centre, Consumer Credit Law Centre SA, Consumer Credit Law Service WA, Economic Abuse Reference Group, Financial Counselling Australia, Financial Rights Legal Centre, Good Shepherd Microfinance, and WEStjustice.

4.3. ICA position

The ICA proposes that the Code begin with a statement of its key commitments, which would articulate the spirit of the Code. This concise statement would provide the overarching framework that conveys the objective of the Code to meet high standards of conduct. These commitments should reflect the industry's purpose and value proposition.

The ICA considers that it is unnecessary to specifically address corporate culture in the Code, which would be difficult in the context of a consumer-facing document. However, we agree with the industry submission that the key commitments made would, in itself, set expectations around what good corporate culture looks like.

5. CONSUMERS EXPERIENCING VULNERABILITY

5.1. New Code Obligations on Consumers Experiencing Vulnerability

ICA Recommendation 2

The Code should be amended to include a new principles-based section on consumers experiencing vulnerability, which includes:

- A statement acknowledging the diverse needs of consumers experiencing vulnerability.
- A commitment to accommodating the needs of consumers experiencing vulnerability where they tell insurers they need particular support or assistance in relation to their vulnerability.
- Accommodation of requests from consumers experiencing vulnerability for formal or informal assistance from third parties where they tell insurers they need particular support or assistance from third parties in relation to their vulnerability.
- A requirement for staff to be trained to help to identify consumers experiencing vulnerability, and engage with them with sensitivity, respect and compassion, and to take appropriate steps for additional support.
- A requirement for insurers to provide assistance to those who have trouble meeting identification requirements.
- Best practice standards for the use of interpreters.

5.1.1. Background

Many submissions to the Review touched on the role the Code could play in the setting of high standards for the support of consumers experiencing vulnerability. There are equivalent sections in the Life Code and the Insurance in Superannuation Voluntary Code of Practice.⁸

These codes focus on a commitment to taking extra care with customers who are identified as experiencing vulnerability, a need for staff training to identify and act with sensitivity towards someone who is vulnerable, and the need for an internal policy to escalate sensitive matters.

The Interim Report suggested that the Code contain a new section on consumers experiencing vulnerability, which was broadly supported by stakeholders.

⁸https://www.superannuation.asn.au/ArticleDocuments/498/Insurance_in_Superannuation_Voluntary_Code.pdf.aspx?Embed=Y

5.1.2. Scope of section

5.1.2.1. Stakeholder feedback

The Joint Consumer submission suggested that the ICA not reinvent the wheel and instead base its statements on similar statements found in other codes.

Legal Aid NSW pointed out that any defining criteria for vulnerability should not be exhaustive, as vulnerability is not a fixed trait and that some consumers may become vulnerable at specific times during their lives.

PIAC suggested that the Code require insurers to identify as early as practicable whether assistance is required and, if it is, the nature of the assistance required and to take all reasonable steps to accommodate the consumer.

ASIC has also recently suggested issues of 'gratuitous concurrence' when selling insurance products to Indigenous consumers be considered for guidance under the Code.

Insurers suggested the section should be principles-based and designed to apply in a flexible way.

5.1.2.2. ICA position

The ICA agrees that the revised Code should draw from the best of other financial services codes, as well as feedback from stakeholders. It is also agreed that the section on consumers experiencing vulnerability should be principles-based and enable flexibility in implementation, rather than prescriptive procedures.

It may be difficult for insurer staff to identify vulnerability unless a consumer raises this themselves; particularly with much general insurance being sold online. Asking staff to proactively identify customers affected by circumstances that have rendered them vulnerable may be beyond the professional capabilities of front-line staff. Furthermore, an individual may not wish to be treated any differently on the basis that an insurance employee has determined that they are experiencing vulnerability. Therefore, the ICA's position is that the Code's standards should focus on customers who self-identify as vulnerable for a particular reason. The ICA agrees with the Industry submission that the ICA and members should work with relevant stakeholders in developing the text of the new section.

The ICA recommends a new section on the Code on customers experiencing vulnerability, including a statement acknowledging the diverse needs of consumers experiencing vulnerability. This section will also contain a commitment to accommodating the needs of consumers experiencing vulnerability where they tell insurers they need particular support or assistance in relation to their vulnerability.

5.1.3. Assistance from third parties

5.1.3.1. Stakeholder feedback

Legal Aid NSW suggested that a balance must be struck when a customer wants to appoint a third party to act on their behalf, so that the process required for appointment does not introduce unnecessary obstacles.

Insurers pointed out that any Code obligations regarding assistance from third parties must not cause an insurer to breach the requirements under the *Privacy Act 1988* (Cth) or State-based privacy legislation.

5.1.3.2. ICA position

Where a consumer wants the assistance of a third party, it will be important for insurers to be able to identify that the third party has the appropriate authority; however, insurers are encouraged to be flexible in their requirements for authority, to ensure this is not a barrier for a consumer seeking assistance.

The ICA recommends that the Code is revised to require insurers to accommodate requests from consumers experiencing vulnerability for formal or informal assistance from third parties where they tell insurers they need particular support or assistance from third parties in relation to their vulnerability.

5.1.4. Employee training

5.1.4.1. Stakeholder feedback

The Joint Consumer submission recommended that all staff should receive training on consumers experiencing vulnerability, and that different cohorts, such as front-line staff and management/senior executives receive specific training, according to their role.

Insurers noted that new training requirements will have a larger cost impact on smaller insurance businesses, and that an industry-based training programme should be developed in consultation with stakeholders.

PIAC suggested that training programs should be reviewed annually by insurers to ensure the programs' effectiveness in achieving their objectives and Code subscribers should be required to report annually to the ICA on the outcomes of the review.

5.1.4.2. ICA position

The ICA will continue to work with insurers on the possible development of an industry-wide training program that can be accessed by all Code subscribers. This will be of particular importance to smaller insurers, who may not have the resources to develop their own training program.

The ICA is satisfied that the CGC will have sufficient oversight of the insurers' requirements for training, without the need for this to also be reported directly to the ICA.

The ICA recommends that the Code is revised to require staff to be trained to identify consumers experiencing vulnerability, and engage with them with sensitivity, respect and compassion, and to take appropriate steps for additional support.

5.1.5. Accessibility of insurance

5.1.5.1. Stakeholder feedback

Legal Aid NSW considered that more attention should be given to ensuring product accessibility and affordability. The Joint Consumer submission recommended that insurers commit to more flexible payment arrangements under the Code, including, where appropriate, Centrepay deductions and fortnightly payment options.

The CGC suggested that the provision of more tailored payment options is an important issue worthy of further consideration, and supported a full study and cost-benefit analysis into how payment arrangements, such as Centrepay, would work in practice.

The Law Council suggested that consumers experiencing vulnerability could be seen as a “target market” within the context of the impending product design and distribution legislative obligation, and insurers should design products that take into account the specific requirements and limitations of consumers experiencing vulnerability.

5.1.5.2. ICA position

The ICA agrees with submitters that access to insurance is vital for all Australians. However, it is not the role of the Code to mandate the products that insurers offer. More accessible payment options, including the use of Centrepay and fortnightly payment options, are open to insurers to utilise, and at least one insurer offers each of these.

In relation to the suggestion that insurers treat consumers experiencing vulnerability as a target market when designing and distributing products, we note that the best practice guidance on mental health (Appendix 2) suggests that insurers should, when designing products, consider the needs of consumers with a current or past mental health condition.

5.1.6. Interpretation standards

5.1.6.1. Stakeholder feedback

The Interim Report sought feedback on best practice standards for the use of interpreters. While submitters were supportive of these standards, it was suggested that family and friends should not be allowed to be used as interpreters as this can sometimes result in misinformation about insurance products and can encourage non-disclosure of certain information when signing up for insurance products.

Insurers suggested the Code require subscribers to use “best endeavours” to provide access to an interpreter, taking into account languages and dialects that are not common.

5.1.6.2. ICA position

To provide additional assistance to consumers and insurers, the identification requirements should refer to the flexible approach taken by the Australian Transaction Reports and Analysis Centre (AUSTRAC).

The ICA maintains that the interpretation standards suggested in the Interim Report are best practice and should be contained in the revised Code:

- 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).
- 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.
- 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.

The ICA believes that the industry standard should be that access to an independent interpreter is provided when requested or needed. However, this shouldn't be forced on someone who wishes to use a friend and family member for interpretation support and assistance. This is in line with the earlier discussion on accommodating requests from consumers experiencing vulnerability for informal or formal assistance.

5.2. New Code Obligations on Financial Hardship

ICA recommendation 3

The Code should include enhanced protections for consumers experiencing Financial Hardship, including the following amendments to the Code:

- An obligation for timeframes for Financial Hardship applications to be in line with the National Credit Code.
- Require insurers to have internal policies and train relevant employees to help with the identification of consumers who may be experiencing financial hardship.
- Clarification that the Financial Hardship section applies to situations where a customer cannot pay their excess, and include in the list of options for financial hardship assistance “**deduction of the excess from the claim payment**”.
- Where an insurer is aware that a customer who has applied for Financial Hardship assistance has a nominated representative, an obligation for the insurer to ask if they want their representative to be kept updated.
- An obligation for Employees and agents involved in debt collection to be trained on the Financial Hardship requirements of the Code, and on how to help identify someone who might be experiencing Financial Hardship.

- An obligation for insurers to make requests for further information, when assessing Financial Hardship, as early as possible so that the request does not unreasonably or unnecessarily delay the application.
- An obligation for reasonable requests to pay a debt in full in instalments not to be refused.
- An obligation for an insurer to provide written reasons where they have determined that someone is not entitled to Financial Hardship assistance.
- An obligation for any communications about debt recovery to provide sufficient information to enable the consumer to determine whether the amount being recovered is fair and reasonable and to include information about the Financial Hardship process.
- Clarification that uninsured third parties seeking Financial Hardship assistance can access an insurer's Complaints process.

5.2.1. Background

The Interim Report made a number of suggestions for improvements to the Financial Hardship provisions of the Code. The ICA has considered the range of feedback received and recommends the above additional obligations and clarifications to the Financial Hardship section of the Code.

5.2.2. Awareness and identification

5.2.2.1. Stakeholder feedback

Submitters were supportive of the Code including training requirements on Financial Hardship obligations for Employees and Service Suppliers; however, insurers pointed out that the training only needs to apply to Service Suppliers involved in debt collection. Insurers cautioned about the extent to which Employees could be relied on to identify Financial Hardship, as they are not financial counsellors.

Submitters were supportive of insurers including information about the Financial Hardship process in debt recovery letters, on the basis that it is a simple, fair and good-faith step to take to ensure that those who may require assistance are informed of their ability to request it. It was also suggested that the Complaints process and contact details should be included as part of this information.

The CGC believed that an insurer should always notify a consumer's representative when contacted by a consumer in hardship. The Joint Consumer submission and Legal Aid services suggested that appropriate authority and consent would have to be obtained from the consumer first, and the notification would have to be within the scope of the authority given by the consumer. Insurers agreed that to the extent that a consumer has formal representation, such as a legal or financial representative, this would enable insurers to manage any privacy implications.

The CGC also suggested that where an insurer determines that someone is not entitled to Financial Hardship assistance, the reasons for this should be provided in writing. The CGC

extended this suggestion to cover many of the communications required by the Code, suggesting that insurers should be providing more of these in writing.

5.2.2.2. ICA position

It is the ICA's view that the parties that need to be trained to help identify possible Financial Hardship are Employees dealing with customers directly, and any agents of insurers involved in debt collection. The ICA recommends a new Code obligation for Employees and agents involved in debt collection to be trained on the Financial Hardship requirements of the Code, and how to help identify someone who might be experiencing Financial Hardship.

The ICA is supportive of including information about the Financial Hardship process in debt recovery letters. An individual will still have to provide evidence of genuine financial hardship, so raising awareness of the rights available to them will not "open the floodgates", as a gateway to false allegations of hardship. Genuine claims for Financial Hardship will be encouraged by insurers outlining the information they require to support claims for assistance.

Where a customer has previously nominated a representative, and the insurer is aware of this when they later apply for Financial Hardship assistance, the ICA's position is that the insurer should ask the customer whether they want the insurer to notify the representative. This protects the customer's privacy, if for any reason they do not want their nominated representative contacted.

In relation to the CGC's suggestion that more of the communications in the Code are provided in writing, the ICA supports the suggested changes to sections 7.17, 7.18, 7.19, 8.6, 8.8(e), 8.11, 9.3 and 10.10.

5.2.3. Timeframes

5.2.3.1. Stakeholder feedback

Submitters were supportive of the inclusion of the National Credit Code timeframes in the financial hardship process. The Joint Consumer submission suggested that consumers or third parties should be allowed 45 calendar days to provide information requested (rather than 21 calendar days), with the ability to extend the timeframe further in special circumstances. This is on the basis that consumers may get discouraged when provided with short timeframes, which is exacerbated by the use of communications by post, and the time taken to see a financial counsellor.

Legal Aid NSW suggested there should be provision for urgent decisions where a claim needs to be prioritised and a consumer is unable to pay an excess due to Financial Hardship.

Submitters were supportive of insurers only asking consumers for information that is genuinely necessary to assess their application for Financial Hardship assistance, and that any request for information should not unreasonably or unnecessarily delay the assessment of the hardship request. The commitment should also ensure that insurers identify what further information is needed as soon as possible and request it. The Law Council suggested

the use of the phrase “*reasonably necessary*” rather than “*genuinely necessary*”, as this is a phrase that insurers are familiar with and is unlikely to cause confusion.

5.2.3.2. ICA position

The ICA supports the suggestion to incorporate timeframes for Financial Hardship requests in line with the National Credit Code. This ensures that consumers receive timely responses when they are in a vulnerable situation. The timeframes provided are intended to be maximums, and insurers are encouraged to make decisions about Financial Hardship as early as possible.

It is the ICA’s view that there is a need to balance the consumer’s window of time to collate and provide information, with their need for timely assistance in situations of Financial Hardship, and providing a deadline can be motivation to turn around requests quickly. Of course, if a consumer could not meet the timeframe provided by the National Credit Code, this would not preclude them from having their circumstances assessed on the information available to the insurer, which would then be reassessed on the basis of new information once provided.

5.2.4. Excesses

5.2.4.1. Stakeholder feedback

Submitters were supportive of clarity around the application of the Financial Hardship section to consumers who are having difficulty paying an excess. The Joint Consumer submission referenced the FOS, which has previously stated that consumers experiencing financial difficulty may be unable to pay a policy excess, but this should not mean the claim cannot progress.⁹

It was suggested that those who cannot pay their excess upfront should be provided with an option to pay the excess in affordable instalments. The Law Council did not agree with this, on the basis that each situation is different and there may be other factors which mean the particular offer to pay in instalments is not reasonable. The Law Council did point out that when an insurer seeks to enforce a judgment debt and a reasonable offer has been made by a debtor, a court would be likely to sanction the offer. It suggested that the Code could require an insurer to consider all offers to pay by instalments which are reasonable having regard to the extent of the policyholder’s financial hardship which is known, or which reasonably ought to be known, by the insurer.

5.2.4.2. ICA position

The ICA agrees that it is not currently clear to consumers that they can apply for Financial Hardship in a situation in which they cannot pay their excess, and that the revised Code should refer to this specifically. Customers who qualify for financial hardship assistance could be given the option of deducting the excess from the claim payment, where this is possible (noting that in situations where a claim results in repair or replacement rather than a payment, the deduction would not be an option).

⁹ FOS Circular, Issue 3, July 2010 https://www.fos.org.au/custom/files/docs/the_circular_issue_3_july_2010_pdf.pdf.

5.2.5. Premiums

5.2.5.1. Stakeholder feedback

The Joint Consumer submission raised the need for financial hardship assistance to be extended to the payment of premiums; something that clause 8.2 currently excludes. They argued that opportunity should be given for consumers who are paying their premiums in instalments to enter into a Financial Hardship arrangement to avoid cancellation of their policy.

It was suggested that consideration be given to the following options:

- changing the coverage in an appropriate and ethical manner;
- reducing or stopping payments for a short period with consequences for coverage;
- part payment of a premium with the remainder of the premium and the usual premium to be paid the following month;
- delaying payment of a premium with a double premium to be paid the following month;
- part payment of premiums for a few months then full payment of the outstanding value of the insurance premium in full; and
- notices about non-payment inviting the consumer to call the insurer to discuss their options if payment is not possible in the period required.

The CGC also recommended that the proposed options for retaining a policy for those in Financial Hardship who are in a situation of family violence (contained in the family violence guidance document in Appendix 1), should be extended to all consumers experiencing vulnerability and should form part of the Code rather than guidance.

The Law Council recommended that guidelines are developed for dealing with payment of premiums in circumstances of financial hardship, which could include reviewing policy terms, the excess and applicable limits, as well as maintaining the right to cancellation of the policy as a “last resort” if agreement cannot be reached. The guidelines would be triggered only in the event that a consumer has sought Financial Hardship assistance; otherwise, the insurer could be left second-guessing whether it could cancel a policy.

5.2.5.2. ICA position

Entering into a Financial Hardship arrangement where a customer has not paid their premium has been included in a limited way, through the family violence guidance document in Appendix 1. Extending this further to anyone who identifies themselves as a consumer experiencing vulnerability could be difficult, as it would mean that an insurer is making an assessment about someone’s vulnerability as well as their more objective assessment of Financial Hardship.

Taking into account the high numbers of existing general insurance policies, requiring general insurers to enter into arrangements with customers who request premium holidays or

to make up their premium the following month would be administratively burdensome and costly.

5.2.6. Debt waiver

5.2.6.1. Stakeholder feedback

The Joint Consumer submission supported the inclusion of information about the factors that insurers would take into account when considering a debt waiver, in order to promote greater consistency in the provision of debt waivers. Factors that could be referred to include:

- the debtor's sole source of income is Centrelink;
- the debtor has no income;
- the debtor is likely to remain on Centrelink as their sole source of income for the foreseeable future;
- the debtor has no significant assets;
- the debtor is subject to family violence;
- the debtor is experiencing a serious illness or disability; and
- other compassionate grounds.

It was noted that this criteria should not be exhaustive and flexibility and discretion for insurers in determining when debt waivers are appropriate should be maintained.

Legal Aid QLD welcomed recognition that an insurer may agree to waive a debt, but pointed out that specifying criteria could diminish the autonomy of insurers to make what is essentially a commercial decision, and risks a more robotic approach to debt waiver that could make it harder to take into account the nuances of individual cases.

Insurers agreed that debt waiver assessments should be conducted on a case-by-case basis. They highlighted the need for discretion and flexibility, and felt that ASIC and ACCC regulatory guidance is comprehensive and provides sufficient guidance.¹⁰

5.2.6.2. ICA position

The ICA believes that a list of criteria for a debt waiver runs the risk of prescribing the circumstances in which an insurer must waive a debt; the ICA believes that this should be left for individual insurers to determine.

However, the ICA recommends a new Code obligation for reasonable requests to pay a debt in full in instalments to not be refused.

¹⁰ Debt collection guideline for collectors & creditors <https://www.accc.gov.au/publications/debt-collection-guideline-for-collectors-creditors>.

5.2.7. Complaints

5.2.7.1. Stakeholder feedback

Consumer advocates were supportive of a shorter timeframe for complaints about Financial Hardship.

Insurers pointed out that shortening timeframes would increase resourcing pressures and costs, and that issues may arise in terms of prioritisation if there are dual timeframes and processes to be followed. Additional criteria for a relatively small category of complaints would create complexity and would be costly to implement. Insurers indicated that in practice, they give priority to Financial Hardship complaints, without the need for a separate timeframe.

Submitters wanted the Code to make it clear that uninsured third parties have access to both Financial Hardship assistance and the complaints process where they are not satisfied with the outcome of their Financial Hardship application.

The CGC requested clarity that any individual who comes within the scope of the Financial Hardship section have access to an insurer's complaints process, and that this access is not limited to recovery of money owed in connection with retail insurance products. That is, the Complaints process should be extended to wholesale insurance. The Law Council pointed out that section 8.6 refers to providing information about the insurer's complaints process where hardship has not been agreed. It would be inconsistent if the complaints process referred to is different depending on whether the person is seeking assistance for a retail product or a wholesale product.

Insurers felt that the complaints process should be consistent with the obligations contained in ASIC RG 165; amending the complaints process to include wholesale insurance will require systems changes and be administratively burdensome.¹¹

5.2.7.2. ICA position

The ICA believes that the new timeframes for determining a Financial Hardship request will assist to keep the process moving quickly, without the need for a shorter Complaints process as well. Insurers should endeavour to settle Complaints early, during the first 15 business days. A different process for Financial Hardship will cause confusion and complexity at a time when the industry is seeking to simplify the Complaints process.

The ICA supports an expanded definition of "you" in the Complaints section of the revised Code, to ensure it is clear that it covers uninsured third parties making a complaint about their Financial Hardship request. The ICA does not support expanding the Complaints section to cover wholesale products, as the process was not designed with wholesale products in mind. The ICA also notes the industry submission that this could have a negative impact on retail customers by diverting resources to wholesale products.

¹¹ ASIC Regulatory Guide 165, Licensing: Internal and external dispute resolution

5.3. New Requirements on Family Violence

ICA recommendation 4

The Code should be amended to include a requirement for insurers to have a family violence policy. The Code should be accompanied by family violence guidance, attached at Appendix 1, to provide insurers with guidance on developing their own family violence policies.

ICA recommendation 5

The ICA proposes to continue to work with members, family violence experts, FOS and legal expert Dr Ian Enright to address the complex legal issues raised in situations of family violence.

5.3.4. Background

The issue of family violence was raised as a key priority area by the ICA's CLF. The CLF recommended that the ICA develop industry guidelines for recognising and responding to instances of family violence, drawing from guidelines and initiatives underway in other sectors.

The ICA developed a draft family violence guidance document in consultation with members and a number of parties with expertise in this area. The guidance outlines the issues and areas that insurers should consider in developing their own family violence policies.

5.3.5. Stakeholder feedback

The Joint Consumer submission supported the development of a family violence guidance document, and the recognition in the draft that family violence issues require flexible decision making by senior employees. They noted that there are a number of issues with respect to family violence situations which do not have short-term solutions and would require insurers to alter the terms and conditions of their policy documents.

Submitters suggested additions and amendments to the drafting of the guidance document, many of which are reflected in Appendix 1.

In relation to referring to external agencies, the Joint Consumer submission recommended that the ICA base this on the Economic Abuse Reference Group (EARG) Good Practice Guide regarding referral options for staff.¹² The EARG guide recommends that the list of referral options needs to be concise with a minimum range of referral options, with additional referral options only if staff can differentiate between the services based on the customer's circumstances.

¹² EARP, Good practice for industry family violence guidelines – Referral Options, 19 September 2017, <https://eargorgau.files.wordpress.com/2017/03/referrals-good-practice-190917.pdf>

The CGC suggested that some of the guidance should come into the Code as mandatory standards.

5.3.6. ICA position

The ICA supports the provision of a best practice guidance document, to assist insurers to put in place their own internal family violence policies. However, the ICA considers that, at a minimum, insurers should have a family violence policy in place. The ICA recommends that the Code is amended to include a requirement for insurers to have a family violence policy in place. Supplementing this requirement with guidance will provide insurers with flexibility in designing their own policies.

The ICA received submissions on a number of complex insurance issues created by situations of family violence and economic abuse. 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, and will require insurers to alter the terms and conditions of their policy documents. The ICA has engaged the assistance of insurance law expert, and former independent reviewer of the Code, Dr Ian Enright, to facilitate discussions between insurers, FOS, experts working in family violence services, and legal services. This work will continue in addition to the proposed improvements to the Code on family violence.

5.4. New Guidance on Mental Health

ICA recommendation 6

The Code should be accompanied by best practice guidance on mental health, attached at Appendix 2.

5.4.1. Background

Throughout 2017, the ICA worked with its Anti-Discrimination Working Group to develop a set of best-practice mental health principles, to encourage continuous progress by industry in expanding access to general insurance for consumers with mental illness.

These principles were included in draft in the Interim Report of the Code Review, with the intention that they would become guidance for Code Subscribers.

The Interim Report sought feedback on whether the Code could also contain a statement, in addition to the proposed guidance, explaining how underwriting decisions are made. For example:

- i) decisions will be evidence-based; and
- ii) regularly reviewed to ensure decision making is not relying on out-of-date information.

The Life Code also contains a statement on underwriting, as well as a framework for insurers to monitor compliance with sales requirements:

“Our decisions on applications for insurance will comply with the requirements of anti-discrimination law. Our decisions will be evidence-based, involving

relevant sources of information where this is available, and having regard to any other relevant factors where no data is available and cannot reasonably be obtained. We will regularly review our underwriting decision-making processes to ensure we are not relying on out-of-date or irrelevant sources of information.”

5.4.2. Binding vs non-binding standards

5.4.2.1. Stakeholder feedback

There was broad support for the principles, though some submitters suggested they should be mandatory Code standards, rather than best-practice guidance. PIAC’s view was that a separate, non-binding document setting out the principles will not adequately address the issues of concern to them, and that the principles should be binding and enforceable, with breaches subject to the same monitoring, enforcement and sanction provisions as apply to any other breaches of the Code. Beyondblue suggested the ICA co-design a set of mandatory minimum standards with consumers and mental health sector stakeholders, through a dedicated consultation process.

It was also noted that the principles should make it clear that mental health conditions cannot be treated as a single group. Submitters suggested that the Code could take a stronger stance on blanket exclusions covering all mental health conditions.

At workshops with stakeholders, the guidance document attached at Appendix 2 was discussed in detail, with the aim to express best industry practice over and above the legal requirements of anti-discrimination law.¹³

5.4.2.2. ICA position

The ICA considered the option of incorporating minimum binding standards in the Code, as opposed to best practice non-binding guidance. We acknowledge the preference of mental health advocates for minimum binding standards. The intent of creating best practice standards was to leverage off recent strides made by the industry in widening coverage for mental health conditions, and to provide a mechanism through which insurers could set and benchmark themselves against aspirational standards.

On balance, the ICA sees best practice standards that set a higher benchmark as having a greater impact over minimum binding standards. As such, the ICA recommends that the guidance remain as non-binding best practice standards. As the market continues to make improvements in the underwriting of mental health conditions, the ICA will reconsider the feasibility of binding minimum standards.

¹³ A list of workshops can be found at Appendix 6.

5.4.3. Anti-discrimination law

5.4.3.1. Stakeholder feedback

Some submitters recommended that the Code should contain details of insurers' obligations under the *Disability Discrimination Act 1992* (DDA) and to promote industry awareness of their obligations under the DDA. PIAC suggested the ICA develop its own guidance on the DDA drawing from the Australian Human Rights Commission's DDA Guidelines on insurance and superannuation.

Submitters were concerned that the Interim Report's suggestion that the Code contain a statement on how underwriting decisions will be made does not appropriately summarise the legal requirements of the DDA. PIAC did not agree that this was a suitable alternative; while the statement seeks to address some of the requirements of the DDA, there was a concern that it introduces new language which does not accurately reflect the language of section 46 of the DDA and which could be confusing for consumers and insurers.

Legal Aid NSW pointed out that the application of the DDA is not limited to mental health exclusions, and by including a statement such as "*our decisions on applications for insurance will comply with the requirements of anti-discrimination law*" would also protect consumers with other health conditions.

5.4.3.2. ICA position

While the ICA believes that guidance on mental health would have the greatest impact by focusing on areas that go above the law (rather than restating or interpreting the law), the ICA acknowledges the preference of mental health advocates for the guidance to reference the obligations of insurers under the DDA. The revised guidance at Appendix 2 has incorporated a statement that insurers must, as a minimum standard, comply with anti-discrimination legislation.

5.4.4. Information relied upon

5.4.4.1. Stakeholder feedback

Submitters supported insurers providing a plain-language summary of the data and relevant factors relied upon in making a decision, and why that data or those factors are relevant. Providing information early may resolve a matter before it goes to External Dispute Resolution (EDR). Legal Aid QLD was concerned that providing a summary risked the information being too general to be of any use to a consumer in understanding the decision that has been made. Legal Aid NSW said that the Code should mandate that the information is provided in a way that is accessible and easily understood by consumers and their advocates.

Submitters also suggested the insurer provide copies of the data relied on, unless it can demonstrate that such data is commercial-in-confidence.

5.4.4.2. ICA position

The workshops resulted in a number of other improvements to the guidance, particularly in relation to transparency of the underwriting decision. The guidance suggests that where cover is not offered or is provided on terms deviating from the standard policy, insurers should provide the applicant with a statement of written reasons explaining why they cannot offer cover or why they have offered cover on non-standard terms. The guidance also suggests that applications for insurance should not be automatically declined where the consumer discloses a past or current mental health condition, but that the insurer should obtain further information to enable a proper assessment of the application.

6. EFFECTIVE DISCLOSURE & ACCESS TO INFORMATION

6.1. Effective Disclosure & Enhancing Transparency

ICA recommendation 7

The Code should be accompanied by best practice disclosure guidance, attached at Appendix 3.

ICA recommendation 8

The Code should be amended to require insurers to effectively disclose how promoted benefits could be realised in practice where incentives are used to influence decision-making.

ICA recommendation 9

The Code should be amended to require consumers applying for home building insurance to be given access to a sum insured calculator which insurers will regularly review to ensure accuracy.

ICA recommendation 10

The Code should contain a new obligation for insurers to disclose the previous year's premium at renewal for home insurance policies.

ICA recommendation 11

The Code should be amended to:

- Require the insurer to ensure that the automatic renewal is made clear where a customer purchases a policy that automatically renews each year.
- Require information about the automatic renewal, including the ability to opt-out, to be included on the annual renewal notice.

6.1.1. Background

Since 2015, the ICA has been working with industry leaders and independent experts on ways to better align the provision of policy information with customers' needs. The industry has recognised the need to shift from a minimum mandated disclosure approach to best practice transparency. This was the key finding from the report of the Effective Disclosure Taskforce, an independent taskforce established by the ICA's Board to enhance the effectiveness of disclosure.¹⁴

¹⁴ Effective Disclosure Taskforce (October 2015), *Too Long; Didn't Read. Enhancing General Insurance Disclosure*, Report to the ICA Board, <http://www.insurancecouncil.com.au/assets/Effective%20Disclosure%20Report.pdf>

The Interim Report consulted on draft best practice disclosure guidance for incorporation into the Code. The best practice has been developed based on the findings of consumer research conducted by the ICA to better understand the impact of information on decision-making.¹⁵ The guidance was framed as best practice to provide flexibility for insurers to continuously improve their practices, and to be updated to reflect learnings from the trialling of innovative disclosure techniques.

As part of the ICA's work on effective disclosure, insurers have also agreed in-principle to disclosing changes to the year-on-year premium at renewal. The ICA recommends this commitment is reflected as an obligation in the Code.

The Interim Report also sought feedback on whether the Code should require insurers to provide access to an accurate and informative sum insured calculator as part of the home building insurance application process, in order to improve the guidance provided to consumers on selecting a sum insured amount.

Consumer advocates have raised concerns about consumers not being clearly informed that an insurance policy will automatically renew unless they advise otherwise. The Financial Rights Legal Centre (FRLC) has previously proposed that automatic insurance renewals be banned.

The Interim Report suggested that in order to address concerns raised about automatic renewals, the Code could 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.

The Interim Report also considered whether the following provisions would provide adequate restrictions on advertising and marketing:

- consider the target audience for the advertisement or marketing communication and whether it provides adequate information for that audience; and
- ensure statements in advertisements or marketing communications are consistent with the features of the relevant policy and the disclosures in any corresponding PDS.

Finally, the Interim Report sought feedback on whether the Code should require key information to be provided by insurers in plain language. This would strengthen the existing Code requirement that insurers take "reasonable steps" to communicate in plain language.

6.1.2. Best practice guidance

6.1.2.1. Stakeholder feedback

Submitters were supportive of best practice guidance on effective disclosure and continual progress by industry in implementing more innovative disclosure over time.

¹⁵ ICA (February 2017), *Consumer research on general insurance product disclosures*, research findings report, http://www.insurancecouncil.com.au/assets/report/2017_02_Effective%20Disclosure%20Research%20Report.pdf

The Joint Consumer submission suggested that there should be an acknowledgement in the guidance that enhanced disclosure, while helpful, is not a comprehensive solution to better consumer outcomes. They also suggested the following additions to the guidance:

- there should be a standard PDS format and structure
- the guidance should encourage good website design
- the guidance should apply not just to key product features but also disclosures such as consents
- disclosure should promote consumer understanding of deviations from standard cover
- a commitment to improving and testing the Key Facts Sheet (KFS)
- best practice disclosure on automatic renewals
- a commitment to not use opt-out mechanisms
- a focus on advertising and ensuring such information is not misleading
- a commitment to standard definitions
- a commitment to disclosing the previous year's premium at renewal
- the provision of premium component pricing
- more information on natural hazard risks
- more targeted guidance on mental health clauses

ASIC also suggested that there should be transparency around no claims discounts (NCDs) and insurers should effectively disclose how such promoted benefits could be realised in practice. For example, where NCD schemes are offered, insurers should inform consumers about the effect of a claim on a policyholder's NCD rating and underlying premium.

6.1.2.2. ICA position

Reflecting the feedback received, the ICA has made some amendments to the best practice guidance, including:

- an acknowledgement that disclosure should not be the only tool used to promote consumer comprehension;
- the guidance applies to all forms of communications, including advertising and consents;
- clear disclosure where automatic renewals are offered.

Regarding ASIC's suggestions around disclosure accompanying promoted NCD benefits, the ICA agrees that where incentives are used to influence decision-making, insurers must effectively disclose how promoted benefits could be realised in practice. The ICA will amend the Code to make this a mandatory obligation (rather than incorporating this in best practice guidance).

While the ICA also agrees with other suggestions, such as the use of standard definitions, more prominent disclosure of deviations from standard cover, and more engagement with consumers about natural hazard risks, we note these are already areas which the ICA is developing industry initiatives. We note Treasury has also been tasked with exploring reforms in relation to component pricing, and will be reviewing the effectiveness of the Key Facts Sheet (KFS) for home policies.

6.1.3. Disclosure of year-on-year changes to premium

The Effective Disclosure Taskforce had recognised the merits of insurers disclosing the previous years' premium at renewal to enhance transparency and encourage informed decision-making at renewal. Through the ICA's work on disclosure, insurers have agreed that such disclosures are likely to be beneficial for consumers, although the requirement to make systems changes to disclose the previous year's premium has presented a barrier to quick implementation across the industry.

The ICA believes the Code should play a strong role in encouraging a voluntary move towards this disclosure, and recommends a new Code obligation to require the disclosure of the previous year's premium at renewal. At the same time, the ICA will continue to work with members to ensure the methodology used in disclosing this information is consistent across the industry.

6.1.4. Sum insured calculator

6.1.4.1. Stakeholder feedback

Submitters were supportive of insurers providing access to an accurate and informative sum insured calculator as part of the home building insurance application process, as well as committing to regular reviews of the calculators.

It was suggested that the calculators should record the information that is input into the calculators, as well as the result, and keep this on a policyholder's file. This would assist to determine whether there are any errors identified, and whose responsibility this is.

6.1.4.2. ICA position

The ICA agrees with submitters that sum insured calculators provide essential guidance at the point of sale for home building insurance policies, and recommends the Code is amended to require insurers to provide access to a calculator. In addition, the guidance document encourages insurers to build the calculator into the sales process for more streamlined access by consumers.

6.1.5. Automatic renewals

6.1.5.1. Stakeholder feedback

The Joint Consumer submission suggested that automatic renewal should not be a standard term of the policy and should require specific consent at the time of purchase. Further, information about automatic renewal should be expressed in plain language and readily available to any party affected by the term.

The Joint Consumer submission also suggested that the Code should ensure that automatic renewal is only used where:

- the term is transparent or effectively disclosed to the policyholder;
- sufficient notice is given that a contract is about to renew, including that the information in the renewal notice is prominent, consumer-tested and unambiguous;
- a long window of opportunity is provided to opt out of the term; and
- no additional fees will be incurred if they cancel after the contract is automatically renewed.

The CGC suggested that insurers should provide 30 days' prior notice of an automatic renewal to prompt consumers to review their insurance arrangements.

Insurers suggested they could clearly inform at or before inception of the contract that an automatic renewal will occur and notify consumers prior to renewal via their renewal notice that they can opt out. Insurers did not want to leave customers uninsured, with continuity of cover the primary concern, balanced against ensuring the customer is aware that their cover is being automatically renewed.

6.1.5.2. ICA position

The ICA is of the view that automatic insurance renewals are 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.

The ICA recommends that, where a customer purchases a policy that automatically renews each year, the Code should require the insurer to make clear disclosures about the automatic renewal. The Code should also be amended to require information about the automatic renewal, including the ability to opt-out, to be included on the annual renewal notice.

The ICA's research on effective disclosure suggests that consumers are more engaged with renewal notices than other disclosure documents, so we anticipate the proposed additional disclosure at renewal should achieve this objective.

6.1.6. Plain language

6.1.6.1. Stakeholder feedback

The Joint Consumer submission supported the use of plain language in all disclosure, sales and policy information communications.

Insurers noted that they are currently subject to a range of disclosure obligations, including under the existing Code, the *Corporations Act 2001* (Corporations Act) and *Insurance Contracts Act 1984* (Insurance Contracts Act). There was a concern that an additional Code requirement on plain language for key information would unnecessarily complicate insurers' compliance with their obligations.

6.1.6.2. ICA position

While the ICA believes that information should be provided in plain language, we acknowledge this may not always be possible. Some technical language cannot be avoided to ensure clarity in explaining the circumstances in which cover is provided or not provided. Simplification of product information needs to be balanced with the need for sufficient policy clarity.

The ICA has carefully considered whether the existing Code requirement for insurers to take reasonable steps to ensure that communications are in plain language could be bolstered. On balance, the ICA's view is that introducing a new concept of "key information" would over-complicate insurers' existing obligations under the law. Whether certain information would be considered to be "key information" would be dependent on a number of factors, including factors subjective to an individual consumer's circumstances.

Rather than a prescriptive Code requirement, the ICA has made amendments to the Guidance (attached at Appendix 3) to encourage the use of plain language where possible, and to utilise consumer testing to ensure disclosure is clear and concise in language and tone.

6.1.7. Advertising and Marketing

6.1.7.1. Stakeholder feedback

The Joint Consumer submission also supported the inclusion of the following commitments:

- ensure that any images used do not contradict, detract from or reduce the prominence of any statements used;
- if price or premium are referred to, ensure that these are consistent with the price or premium likely to be offered to the target audience for the advertisement or marketing communication;
- make clear if a benefit depends on a certain set of circumstances;
- ensure any use of phrases such as "free" or "guaranteed" are not likely to mislead;
- ensure that advertising does not solely focus on premium savings and provides balanced information regarding the loss of cover for lower premiums; and
- comply with the ASIC's guidance for advertising financial products and services and guidance regarding unsolicited sales.

Insurers felt that current law and regulatory guidance provided adequate protection to consumers, including the *Australian Securities and Investments Commission Act 2001* (ASIC Act), the Corporations Act and ASIC RG 234.¹⁶ In addition, the proposed product design and distribution obligation is likely to include requirements for product issuers to describe the target market in advertising.

¹⁶ ASIC Regulatory Guide 234, *Advertising financial products and services (including credit): Good practice guidance*

6.1.7.2. ICA position

The ICA's view is that the Code does not need to duplicate material from existing legislation and regulation.

6.2. Access to Information

ICA recommendation 12

The Code should be amended to require an insurer, if they are unable to provide cover when an application is made, to ***inform the consumer of their right to ask for the information relied on.***

ICA recommendation 13

The Code should be amended to clarify that a customer can have access to the following information, at no cost, if requested:

- Information and documents relied on to deny a claim.
- Copies of the PDS and insurance certificate.
- Copies of any expert or assessment reports relied on.
- Copies of any recordings or available transcripts from any interaction the insurer has had with the consumer, where these exist.

6.2.1. Background

Clause 4.8 of the Code sets out the obligations on insurers if they do not offer insurance cover. Legal Aid NSW had suggested that for clarity and transparency, insurers should provide their reasons for not providing cover in writing. They 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 Interim Report sought feedback on whether clause 4.8 could be expanded to say “*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.*”

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

The Interim Report also sought feedback on whether the Code should list the following documents:

- information and documents relied on to deny a claim;
- copies of the PDS and insurance certificate;

- copies of any expert or assessment reports relied on; and
- copies of any recordings or available transcripts of the sale of insurance.

6.2.2. When insurance not offered

6.2.2.1. Stakeholder feedback

Submitters supported the expansion of clause 4.8. Insurers suggested that to reduce the administrative burden, only material information relied upon should be provided.

6.2.2.2. ICA position

The ICA supports the insurer informing a consumer that they can request the information relied on, when insurance is not offered. However, it may not be appropriate to require this information to be provided in writing in all cases; for instance, many consumers apply for insurance over the phone or on an insurer's website, and are told in real time whether or not their application has been approved. It would seem an unnecessary administrative burden to also require the insurer to write to them (and they may not have their contact details at that point, as the applicant is not yet a customer).

6.2.3. When claim denied

6.2.3.1. Stakeholder feedback

The Joint Consumer submission was generally supportive of amending the Code to clarify the information that should be provided by insurers. They suggested that copies of any recordings or available transcripts for any interaction between the insured and the insurer should also be provided upon request.

The Joint Consumer submission also suggested that the Code should require insurers to be transparent about actuarial or statistical data that has been relied on to deny a claim, unless the data is commercial-in-confidence. PIAC suggested that the section should provide for a detailed summary of the type of data or the relevant factors relied on and an explanation as to why that data or those factors were considered relevant.

PIAC suggested that the Access to Information section should be prefaced with the following:

"Where we:

- i. refuse to enter into a contract of insurance with you*
- ii. deny your claim on a contract of insurance*
- iii. cancel your contract of insurance*
- iv. indicate to you that we do not propose to renew your cover under your insurance contract*
- v. offer you insurance cover on non-standard terms,*

we will provide the following information on request:"

Finally, it was suggested that this information is provided for free.

6.2.3.2. ICA position

The ICA is supportive of clarifying the information that will be provided by insurers upon request, at no cost.

The ICA suggests that the Access to Information section remains drafted in broad terms; the preface information suggested by PIAC is not a necessary qualifier, and reframes the section in a negative way, suggesting consumers will only receive information when they are unhappy with an outcome. The ICA instead supports open and transparent access to information at all times.

7. PRODUCT DESIGN & DISTRIBUTION

7.1. New Code Obligations on Product Design and Distribution

ICA recommendation 14

The Code should be amended to require insurers to have policies in place documenting their processes and governance arrangements, for designing and distributing products, so that insurance products are designed for, and distributed to, an appropriate target market.

7.1.1. Background

On 20 October 2015, the Government accepted the recommendation of the Financial System Inquiry (FSI) to introduce a targeted and principles-based statutory product design and distribution obligation. Since 2016, the ICA, members and ASIC have been working to improve product design and sales processes specifically in relation to add-on products sold through the motor dealer channel. This work, which focussed on addressing the issues identified by ASIC through its Reports 470 and 492, culminated in the development of product design and distribution principles for add-on insurance.^{17,18}

The Interim Report asked for feedback as to whether the principles outlined by ASIC should be included in the Code. While the principles developed by ASIC was designed to address concerns with the sale of add-on insurance through car dealerships, the ICA sought feedback in the Interim Report about whether the principles could apply to general insurance products more broadly.

After the Interim Report was released, Treasury released exposure draft legislation for the introduction of legislative product design and distribution obligations on 21 December 2017.¹⁹ While the industry is supportive of these obligations being enshrined in law, there is uncertainty around how the obligations will apply in practice, and Treasury has advised that it is amending the proposed legislation to reflect stakeholder feedback.

7.1.2. Stakeholder feedback

While some submitters suggested the role of the Code could be to provide some practical guidance or more concrete obligations as to how insurers are to comply with the new legislative requirements, insurers were concerned that the Code should not prematurely anticipate the final form of the legislation. This would likely lead to considerable operational inefficiencies and duplicated costs for insurers who would need to update computer systems, train staff and amend procedures multiple times.

Insurers expressed a concern about developing any principles for the Code that would ultimately conflict with the legislative obligations, or with ASIC's guidance materials. Even if

¹⁷ ASIC (February 2016), *Buying add-on insurance in car yards: Why it can be hard to say no*, Report 470.

¹⁸ ASIC (September 2016), *A market that is failing consumers: The sale of add-on insurance through car dealers*, Report 492.

¹⁹ Treasury Laws Amendment (Design and Distribution Obligations and Product Intervention Powers) Bill 2017.

there were duplication as opposed to conflicting standards, this could lead to complexity in complying and reporting, unless the standards were absolutely identical.

There were also concerns that specific issues with add-on insurance addressed in the principles, such as over insurance and negative value products, were not applicable to general insurance products more broadly.

The ICA workshopped with stakeholders the possibility of incorporating into the Code two areas in the principles that are not covered in the Treasury's exposure draft legislation:

- insurers must set clear expectations about what constitutes good sales practices, and equally what conduct is not acceptable
- insurers must provide the necessary training and information to their distributors to enable them to sell the product in line with their stated policies

The Law Council agreed in its submission that all distributors of products should be trained to ensure they are familiar with the product being offered and any limitations of the product. The Law Council also agreed that insurers should set clear standards for a good sales process, reflected in processes and manuals and monitored compliance with these standards, and that such manuals should be provided to distributors.

It was also suggested that the Code could provide some statements reflecting the industry's commitment to good practices for product design and distribution, by requiring insurers to have a policy in place for product design and distribution, which could for example explain:

- how the insurer designs its products
- how it ensures the design meets consumer needs, and the metrics used to assess this occurs in practice
- how it distributes its products
- its controls over the design and distribution process, taking into account a product's particular risk profile
- what the insurer considers to be good sales practices, and what constitutes unacceptable sales practices
- how it makes clear to customers who the product has been designed for.

7.1.3. ICA position

The Code states at clause 3.9 that where there is any conflict or inconsistency between the Code and any law, the law will prevail. The ICA is reluctant to include any standards in the Code as a result of this review, if those standards will almost immediately be superseded by legislation. There is limited consumer benefit in repeating in the Code obligations that will be contained in law as this will cause operational inefficiencies and duplication of costs.

The discussions at the workshop regarding challenges of identifying the target market for a product and ensuring the product is reaching the target market made it clear that further work on these issues need to occur while the legislation and associated guidance are being developed. The ICA intends to work closely with ASIC as it develops its guidance on product design and distribution.

However, there is an ability for the Code to step in where there are gaps in legislation. The ICA suggests that the Code require insurers to document and clearly explain their processes for product design and distribution, so that the products of insurers are designed with an appropriate target market in mind and distributed to the appropriate target market. This will provide insurers with flexibility in developing policies that can be amended to reflect the legislative obligation and ASIC guidance as they are developed and finalised. Regardless of this, the ICA sees some of the principles developed by ASIC on add-on insurance as reflecting broad regulator and industry expectations specific to those products. As such, the ICA proposes specific product design and distribution guidance on add-on insurance as discussed at section 7.3 of this report.

The ICA considers that this enhanced governance of product design and distribution, in conjunction with the proposed strengthening of conduct and consumer redress (discussed at section 7.2 of this report) would provide robust protections for consumers. Once the legislation and guidance are in place and insurers have had an opportunity to reflect the requirements in their businesses, the ICA can look again at whether there is a role for the Code to play in going beyond the law.

7.2. New Code Obligations for Third Party Distributors & Employees

ICA recommendation 15

The Code should be amended to:

- Clarify that all third parties operating under an insurer's AFSL are subject to the standards of the Code by changing the references to "Authorised Representative" to "Distributor".
- Require insurers to have policies and procedures for Employees and Distributors to conduct sales appropriately and prevent unacceptable sales practices.
- Require insurers to make it clear to Employees and Distributors selling their products that pressure selling is not permitted.
- Require Distributors to notify insurers of any Complaints made within two business days, so that insurers can commence the Complaints process as early as possible. Also require Distributors to notify insurers of any Code breaches when acting on the insurers behalf.
- Require insurers to monitor the sales practices of its Employees or Distributors, and investigate concerns raised or identified.

ICA recommendation 16

The Code should be amended to provide a non-exhaustive list of remedies available to consumers where poor conduct has been identified, including:

- Arranging a refund of premiums paid
- Payment of interest on the refunded premium
- Adjusting the cover

- Correcting information
- Honouring a claim

7.2.1. Sales conduct and monitoring of employees and distributors

7.2.1.1. Background

Under the current Code, 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.

However, when insurers' products are sold by a third-party entity, under their own AFSL rather than the insurer's AFSL, the Code Subscriber is not currently held responsible for the third-party seller's compliance with the Code, in accordance with the exemption in section 5.5. These third-party distributors include insurance brokers or banks, which operate under their own AFSL.

At the outset of the Code Review, a number of parties suggested that the Code should be broadened to cover all such third-party distributors. Insurers raised concerns about their ability to monitor third parties who are not operating under the insurer's AFSL.

In the Interim Report, the ICA suggested that where an insurer has a formal agreement in place with a third party to sell its product, 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; and
- distributors will notify insurers of any complaints and tell customers the identity of the relevant insurer.

The Interim Report also sought 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, such as:
 - a) cancelling the cover;
 - b) arranging a refund of premiums and interest;
 - c) arranging more suitable cover; and
 - d) honouring a claim.

This is similar to requirements in the Life Code.

Where relevant, the ICA has proposed strengthening the Code's oversight of Employees as well as distributors in this section.

7.2.1.2. Stakeholder feedback

While some submitters welcomed the suggested strengthening of standards through third-party agreements, others were not supportive on the basis that having different requirements for different categories of third parties would add complexity and confusion. There was also concern that the suggested proposals were more limited than the full spectrum of relevant commitments within the Code.

At a stakeholder workshop, participants discussed whether a distinction needed to be made between third parties that were operating under their own AFSL, and those that operated under the insurer's AFSL.²⁰ Parties operating under their own AFSL are already subject to their own licence conditions, and in the case of banks and insurance brokers, their own codes of practice. It was also noted that insurance brokers are usually acting on behalf of the consumer, rather than the insurer.

In terms of third parties operating under an insurer's AFSL, workshop participants felt it was important that all such distributors are treated in the same way Authorised Representatives are currently treated in the Code; with requirements for Code compliance, appropriate training, and notifying the insurer of any complaints or breaches.

As the Code does not currently contain detailed requirements as to how products should be sold, it was suggested that the Code make it clear that pressure selling is not permitted.

In relation to pressure selling, the Joint Consumer submission suggested that the Code should contain similar requirements to the Life Code at clause 4.3, which commits insurers to implement sales rules for staff to conduct sales appropriately and prevent pressure selling or other unacceptable sales practices, including:

- how to identify if someone is unlikely to ever be eligible to claim the benefits under a policy;
- having clear rules on when staff must stop selling if a consumer indicates they do not want a policy or the consumer is unlikely to be eligible to claim under the policy;
- how to record and keep adequate evidence that the consumer has genuinely consented to purchase a policy;
- the minimum information that must be disclosed about the premium, features, benefits, exclusions, limits and cooling-off period of the policy; and
- compliance performance measures included in staff incentive programs including consequences if the insurer identifies they have engaged in pressure selling, incentivisation of financial advisers contrary to law or other unacceptable sales practices.

²⁰ A list of workshop can be found in Appendix 6.

The Joint Consumer submission also suggested that the Code prohibit unacceptable practices described in ASIC Reports 256 and 470.^{21,22}

- persistent pitches;
- keeping consumers ‘captive’;
- using the cooling off period as a selling point;
- unfairly highlighting the benefits of insurance over cheaper more responsible alternatives;
- masking the cost of loans;
- pre-filling forms; and
- sales scripts not allowing customer to say no.

At the stakeholder workshop, it was also suggested that the Code require third parties to notify insurers of any complaints within a particular timeframe, to ensure that an insurer can make contact with the customer and get the complaints process underway as soon as possible. Insurer representatives at the workshop committed to providing further input as to an appropriate timeframe for requiring notification of any complaints.

Finally, the question was raised at the workshop of whether entities engaging in activities covered by an approved code should be required to subscribe to that code, as had been suggested by the ASIC Enforcement Review Taskforce. This would mean that any third party distributing an insurance product would have to become a Code Subscriber in their own right, rather than the insurer being responsible for their Code conduct. Insurers felt that this would be an impractical solution; the Code has been written to apply to an insurer, so it would be largely irrelevant to third parties, and the cost of compliance would be extremely high relative to any consumer benefit.

7.2.1.3. ICA position

It is the ICA’s view that those distributors that operate under their own AFSL are subject to ample regulation, through the law as well as self-regulation, without requiring duplication in the Code. Potential breaches of licence conditions can be reported to ASIC. For banks and brokers distributing insurance products, there are codes of practice in place that determine their standards of conduct. The Insurance Brokers Code of Practice makes this explicit: *“When we act for an insurer and not on your behalf we will... comply with any obligation that the insurer has under any law or code of practice the insurer subscribes to, where relevant to our conduct and subject to our agreement with the insurer.”*²³

²¹ ASIC (October 2011), *Consumer credit insurance: A review of sales practices of Authorised Deposit-taking Institutions*, Report 256.

²² ASIC (February 2016), *Buying add-on insurance in car yards: Why it can be hard to say no*, Report 470.

²³ Service Standard 5 <https://www.niba.com.au/codeofpractice/c3-service-standards-3.cfm>.

In relation to other third party distributors operating under the insurer's AFSL, the Code definition of Authorised Representative already has broad coverage of third parties authorised by an insurer to sell insurance to consumers:

***Authorised Representative** means a person, company or other entity authorised by **us** to provide financial services on **our** behalf under **our** Australian Financial Services licence, in accordance with the Corporations Act 2001.*

The ICA's view is that this definition includes not only Authorised Representatives as defined in the Corporations Act, but also general insurance Product Distributors exempt from the need to be an Authorised Representative.²⁴ From submissions received, the ICA understands that there is some misunderstanding about the status of the Code with regard to such third party distributors.

It is the ICA's position that the Code should make it clear to insurers and to consumers that third parties operating under an insurer's AFSL are all subject to the relevant standards of the Code, by changing the references to "Authorised Representative" to "Distributor". The definition of Distributor can remain the same as the current Code definition of Authorised Representative. This will ensure that it is clear the Code applies to Authorised Representatives as well as general insurance Product Distributors.

The ICA agrees that the Code should set standards in relation to sales conduct, which would apply to both Distributors and Employees. The ICA recommends that the Code require insurers to have policies and procedures for Employees and Distributors to conduct sales appropriately and prevent unacceptable sales practices. There will be a Code obligation for insurers to make it clear to Distributors selling their products that pressure selling is not permitted. Distributors will also be required to notify insurers of any Complaints made within two business days, notify of Code breaches and insurers will be required to monitor the sales practices of its Employees or Distributors, and investigate concerns raised or identified.

The ICA will work with the CGC as part of a broader project to define what constitutes "pressure selling".

7.2.2. Consumer Redress

7.2.2.1. Background

The Interim Report sought feedback on whether the Code should require insurers to discuss a remedy with a customer if a policy is found to have been sold inappropriately. This would complement the proposed enhanced monitoring of conduct discussed at 7.2.1 in this report.

7.2.2.2. Stakeholder feedback

The Joint Consumer submission suggested that the Code mirror the clauses found in the Life Code.

²⁴ Relief is provided under ASIC Corporations (Basic Deposit and General Insurance Product Distribution) Instrument 2015/682.

7.2.2.3. ICA position

Where inappropriate sales have been identified, the ICA's view is that the Code should require insurers to discuss possible remedies with the consumer, such as:

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

The Joint Consumer submission suggested the Code go further than this and provide for compensation for a consumer or fines to encourage compliance. The ICA's view is that including a consumer redress requirement in the Code is intended to be a straight-forward way for an insurer and a consumer to directly and efficiently right a wrong in the sale of an insurance product. A refund may not always provide the best outcome for a consumer, and introducing a concept like "reasonable compensation" as suggested by the Joint Consumer submission may over-complicate the process.

7.3. New Guidance for Add-on Insurance

ICA recommendation 17

The Code should be accompanied by best practice product design and distribution guidance, which would apply to add-on insurance sold through motor dealer intermediaries, attached at Appendix 4.

7.3.1. Background

ASIC has identified concerns with the design and distribution of add-on products sold through the motor dealer channel, including consumer credit insurance (CCI); guaranteed asset protection (GAP) insurance; loan termination insurance; tyre and rim insurance; and mechanical breakdown/extended warranty insurance.²⁵

As well as the ASIC work on product design and distribution principles discussed at 7.1 above, ASIC has consulted on the implementation of a deferred sales model (DSM) for add-on insurance sold through motor dealer intermediaries.²⁶ The ICA is in-principle supportive of the introduction of a DSM for add-on products sold through the motor dealer channel, which will insert a pause into the sales process to better enable consumers to consider their needs.

The Interim Report queried whether the Code could play a role in supporting the implementation of a DSM. ASIC has not concluded its consultation; while the detail of the DSM is yet to be announced, ASIC has indicated its intention to implement a DSM by way of a legislative instrument.

²⁵ ASIC (September 2016), A market that is failing consumers: The sale of add-on insurance through car dealers, Report 492.

²⁶ ASIC (August 2017), *The sale of add on insurance and warranties through caryard intermediaries*, Report 294.

7.3.2. Stakeholder feedback

Consistent with their concerns about the application of product design and distribution principles in the Code in relation to other general insurance products, insurers were concerned about the risk of conflicting Code obligations with developing legislation in relation to add-on insurance.

7.3.3. ICA position

While the concerns about duplicating and conflicting guidance in the Code are also applicable to add-on insurance, the ICA recognises the seriousness of the poor conduct identified by ASIC. We acknowledge that some insurers do not favour targeting specific products (the Code currently broadly applies to all products within scope), and others do not favour incorporating principles that may duplicate/conflict with developing legislation. On balance, the ICA considers that there is sufficient merit to incorporate some of the principles developed by ASIC into guidance that would apply to add-on products that are distributed through the motor dealer channel.

The guidance attached at Appendix 4 reflects a modified version of the ASIC principles, amended to reduce the risk that they would duplicate or conflict with the developing legislative obligation and impending ASIC guidance. As guidance material, the ICA could update them if necessary to remove any areas of inconsistency with the law at a later stage. The ICA acknowledges, given time constraints, that no consultation has been undertaken on the modified version of the ASIC principles. The ICA will undertake targeted consultation on this guidance document before the revised Code is published.

The DSM being developed by ASIC is not at a sufficiently advanced stage for the ICA to make specific recommendations as to how the Code could support its implementation.

The ICA is exploring with ASIC potential further obligations in relation to CCI.

8. INVESTIGATORS, SERVICE SUPPLIERS & EXTERNAL EXPERTS

8.1. New Standards for the Use of Investigators

ICA recommendation 18

The Code should be accompanied by mandatory standards on the use of investigators, attached at Appendix 5.

ICA recommendation 19

The existing Code requirement for insurers to notify claimants within five business days of appointing an investigator should be amended to include an explanation of the investigator's role.

ICA recommendation 20

The ICA proposes to discuss with members and ANZIIF the possibility of developing a course to assist members to undertake investigation activity in a manner that complies with the Code and that meets community expectations.

8.1.1. Background

The ICA's Consumer Liaison Forum (CLF) identified claims investigations as a priority area. 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.

A draft set of standards were included in the Interim Report, which built on the work undertaken by the CGC in 2017 in its Own Motion Inquiry on the use of investigators and outsourced providers.

8.1.2. Stakeholder feedback

The Joint Consumer submission suggested that the standards should inform a consumer that their claim is being investigated at the outset.

It was also recommended that when a formal interview is to take place, that the information the standards require an insurer to provide to the consumer should be provided in writing. This is on the basis that providing the information in writing will give consumers the chance to refer back to this after the fact, with less likelihood of misunderstanding.

The Joint Consumer submission also suggested a high level of additional prescription in the standards, in the following areas:

- contracts with external investigators and written instructions to external investigators should include a requirement to obtain an insurer's express and written authority before putting a fraud allegation to a claimant;
- interviewers should provide a business card and license details;

- interview transcripts should be provided automatically, without the need for the consumer to request one;
- more prescription around interview length and monitoring interview duration;
- more prescription around vulnerable consumers and interviews with minors;
- more prescription about surveillance; and
- more prescription about requests for information and the scope of authority requested.

Finally, the Joint Consumer submission recommended that surveillance is discontinued if it is negatively impacting the claimant's recovery, rather than the suggestion in the Interim Report that discontinuation is triggered by a negative impact on a pre-existing mental health condition.

Insurers were concerned about the need to align standards with the requirements in life insurance and/or State statutory schemes, and thus suggested the standards are not mandatory to provide flexibility.

8.1.3. ICA position

The ICA has worked with its members to take into account existing standards to develop a set of best practice requirements. The ICA has attempted to raise minimum standards without creating unnecessary duplication or additional obligations that do not result in additional consumer benefit.

Some of the additional standards suggested by submitters have been incorporated into the standards contained in Appendix 5, such as an interviewer offering breaks every half hour, and information about the interview process being provided in writing.

However other suggestions, in the view of the ICA, tip too far into overly detailed prescription, and give very little room for insurers to conduct investigations when justified. These standards, combined with the new Code requirements on consumers experiencing vulnerability, will provide ample consumer protection.

The requirement for an interviewer to provide a business card and license details assumes that in all cases the interviewer will be a licensed investigator. This is not necessarily the case, and the standards have been drafted in such a way that an interview could be carried out by an insurer's employee or an expert where appropriate.

The claims section of the Code already requires requests for information to be reasonable, and the consent form template included with the investigation standards will record the scope of authority and information requested, which the insurer can keep on file.

The reason the surveillance standards do not refer to the impact on a claimant's recovery is that general insurance claims are usually not related to an individual's injury or illness, so their recovery is not a major focus of an investigation. Therefore, it is appropriate to discontinue the surveillance when it impacts on a pre-existing mental health condition. The Joint Consumer submission has suggested that "independent medical examiner" in the context of assessing a claimant's mental health requires defining. The ICA is of the opinion

that the meaning is clear; an independent medical examiner is someone who is not the claimant's treating doctor.

It is the ICA's view that the investigation standards must be mandatory. Not all general insurers are subject to the standards in the Life Code nor the State statutory schemes – very few insurers provide statutory insurance – so posing these as guidance would not achieve consistency across the industry. The standards have been based on the life insurance standards, with insurers' experts involved in making any required amendments and improvements to ensure they reflect best practice. Insurers exposed to multiple sets of standards are encouraged to implement the highest of the standards across their business.

We are aware of and have participated in ASIC's review on fraud investigations including its stakeholder workshop. We will continue to engage with ASIC on the issues raised at the workshop, which remain ongoing, as we finalise the standards for the use of investigations.

8.2. New Obligations for Service Suppliers

ICA recommendation 21

The Code should be amended to:

- Require insurers to put in place measures to ensure that suitable Service Suppliers are appointed.
- Require Service Suppliers to notify the insurer within two business days if they receive a Complaint, so that the insurer can address this through their Complaints process as early as possible. They must also notify the insurer of any Code breach that they identify.
- Require insurers to address identified performance shortcomings in their Service Suppliers' services, such as a requirement for further training.
- Require insurers to only engage External Experts where the insurer is satisfied that they have the expertise to provide the requested opinion, and where the insurer believes they are compliant with the rules and regulations relevant to their area of expertise.

8.2.1. Service suppliers

8.2.1.1. Background

In 2017, the CGC released the report of its Own Motion Inquiry into the investigation of claims and outsourced services.²⁷ The CGC found that once claim-related functions are outsourced to Service Suppliers, compliance with the requirements of the Code can be unpredictable. It found considerable variability in the degree of oversight that insurers

²⁷

<http://codeofpractice.com.au/assets/documents/GICGC%20OMI%20on%20Investigation%20of%20Claims%20&%20Outsourced%20Services%20May%202017.pdf>.

exercise over Service Suppliers and stated a concern that in some cases oversight may be inadequate, particularly in relation to claims handling.

The Interim Report suggested that while insurers will currently be found to be in breach of the Code if a Service Supplier fails to comply with the Code, the following requirements could be made explicit:

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

The Interim Report also considered whether the Code should 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.

8.2.1.2. Stakeholder feedback

The Joint Consumer submission supported the inclusion of strengthened standards relating to Service Suppliers, but suggested that the Code could go further, by adopting the following recommendations from the CGC's 2017 Own Motion Inquiry on Investigations of Claims and Outsourced Service:

- the Service Supplier's arrangements with a subcontractor or agent are in writing and reflect the Code standards that apply to the services provided by the subcontractor or agent;
- the Service Supplier's arrangements require a subcontractor or agent to report to the Service Supplier complaints about them or the matters they are dealing with, by the next business day;
- the Service Supplier does not engage the services of an agent or subcontractor in the investigation of a 'sensitive claim' – for instance, where the claim includes death or serious injury. If this is not practical, the Code Subscriber should increase its oversight of such matters;
- contracts with Service Suppliers must include a requirement to develop their own systems and processes to ensure compliance with applicable Code obligations. This includes prompt reporting of actual or possible Code breaches and corrective actions.

Submitters strongly supported Service Suppliers being required to be trained on the requirements of the Code.

Insurers considered that there is already appropriate consumer protection and regulatory oversight in relation to Service Suppliers, and that extending these obligations further would not provide additional consumer benefit. Insurers indicated that in practice, Service Suppliers are bound by their contracts to meet certain standards, and where these standards are not

met, insurers would typically refuse to renew contracts. This process ultimately achieves greater protections for consumers without the additional training and compliance costs associated with the Interim Report's proposed additional standards.

Insurers also noted that they are bound by APRA's Prudential Standard CPS 231 to approach outsourcing their business activities with caution and due diligence.²⁸

In addition, insurers pointed out that there are circumstances where insurers do not use their usual Service Suppliers, such as when responding to a catastrophe. In such instances, the benefits to consumers in providing speedy access to service suppliers is paramount, and to apply a requirement to be up to date with the Code would not be practical and may slow down the process.

The Law Council considered that to impose an obligation on insurers to be involved in a Service Supplier's training would be unreasonable and unnecessary. Insurers could include in tender requirements that service providers remain up to date with industry developments and the requirements of the Code.

8.2.1.3. ICA position

The ICA accepts the concerns of insurers regarding the potential unintended consequences of further Code requirements for Service Suppliers or their approved subcontractors particularly during catastrophes.

However, the ICA suggests in order to address the concerns raised by submitters regarding insurers' responsibility for their Service Suppliers, that Service Suppliers should be required to notify an insurer about any Complaint received within two business days, as is recommended for Distributors. The Code will also require the Service Supplier to notify the insurer of any identified Code breaches; this will remove the need for the Code to be prescriptive about a Service Supplier's compliance framework, while ensuring that they put one in place.

Insurers should also address identified performance shortcomings in the Service Suppliers services, such as a requirement for further training.

The ICA does not believe that specific training on the Code is required, as long as Service Suppliers understand the obligations under the Code that relate to them; for example, that they need to conduct their services in an honest, fair, transparent and timely manner. The Code website contains example information that an insurer can provide to its Service Suppliers about its Code requirements.²⁹

With regard to the additional prescription suggested by the Joint Consumer submission, the ICA does not believe it is necessary to prescribe a Service Supplier's subcontracting arrangement.

²⁸ APRA (July 2017), *Outsourcing*, Prudential Standard CPS 231.

²⁹ <http://codeofpractice.com.au/for-service-suppliers>.

Such prescriptive standards may also diminish the flexibility and timeliness in which insurers can engage with their Service Suppliers. This is of particular importance where there may be a large number of claims, such as within the context of natural catastrophes, or in remote areas where the choice of local suppliers may be limited. The flexibility for insurers to appoint their Service Suppliers is therefore critical to ensure they are able to respond to claims in a timely manner, while preserving ultimate responsibility for their work.

Any additional prescription in the Code for Service Suppliers may perversely result in an unintended increase in the cost of claims and insurance premiums, where capacity constraints due to the location or nature of the catastrophe may affect the local labour market. Furthermore, any additional prescription would be impractical in travel insurance cases where, for example, an insurer may require to engage a Service Supplier overseas.

Regarding the suggestion that sensitive claims involving death or serious injury should not be subcontracted, within the general insurance industry, the types of claim that are likely to involve death or serious injury are typically travel claims occurring overseas. In the ICA's view, it would not be practical to prevent a Service Supplier from engaging an agent in the country in which the claim has arisen to manage the claim.

8.2.2. External experts

8.2.2.1. Background

In response to a stakeholder suggestion 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 took the position in the Interim Report that this was not supported, as it could compromise an expert's independence.

8.2.2.2. Stakeholder feedback

The Joint Consumer submission did not accept that external experts' independence would be compromised through the imposition of insurer oversight and expectations. It instead suggested that the Code mirror the Life Code, which requires independent medical examiners to comply with the American Medical Association's Ethical Guidelines on Independent Medical Assessment.

Legal Aid NSW suggested that a commitment to act in a manner that is honest, efficient, fair and transparent is unlikely to compromise an external expert, and that in some cases it may strengthen an expert's independence because it clarifies that experts have obligations to the insured as well as to the insurer who is engaging them.

Insurers submitted that External Experts are engaged to provide an independent expert opinion in a subject area. Their performance as professionals in that subject area is governed by industry-specific rules and regulations, and they are typically members of an industry association. There was a concern that attempting to bind External Experts to insurer service standards could impair their ability to comply with Expert Witness Codes of Conduct. The Law Council endorsed the ICA's view that expanding the definition of Service Supplier to cover External Experts could compromise their independence. They instead suggested that it could be made a requirement of engagement of any External Expert that they agree to some aspect of the Code that is necessary to ensure the insurer's compliance.

8.2.2.3. ICA position

The ICA maintains its view that External Experts should not be subject to the same level of prescription within the requirements of the Code as Service Suppliers, so that they can maintain their independence. Stakeholders have equated External Experts with Independent Service Providers in the Life Code, which are the outsourced parties that life insurers use for underwriting and claims management. In general insurance, the External Expert is more likely to be, for example, a hydrologist engaged after a catastrophe.

The ICA believes that it is appropriate to acknowledge that an External Expert will deal with an insurer's customer in a way that is honest, fair, transparent and timely. Also, that an insurer will only engage someone if satisfied they have the appropriate expertise, who is compliant with the rules and regulations relevant to their area of expertise.

9. CLAIMS

ICA recommendation 22

The Code should be amended to reflect the following:

- When a claim is made, require insurers to provide the claimant with an overview of the claim process, along with any excesses and waiting periods applicable. They will also provide the claimant with contact details to get information about their claim.
- Enhance transparency for uninsured third party claims against a customer's insurance policy; including the provision of information about the insurer's claims process and the Complaints process.
- When assessing a claim, require insurers to only ask for relevant information, and explain why it is relevant. Insurers should use best endeavours to request all information early and in one request if possible.
- In situations of total loss, require claims to be treated with sensitivity. Claimants will be provided with support, and assisted to determine the amount of their claim. Insurers will not require proof of ownership or an inventory assessment where it is clear that the loss exceeds the sum insured or any sub-limit within it.
- To provide to claimants **in writing** the following if a claim is denied or **partially accepted**:
 - Which aspects of the claim have not been accepted and the reasons for the insurer's decision;
 - The consumer's right to ask for the information relied on in assessing the claim;
 - The consumer's right to ask for copies of any Service Suppliers' or External Experts' reports relied on in assessing the claim; and
 - Details of the Complaints process.
- Where a decision has not been made within four months, or within twelve months in exceptional circumstances, require insurers to provide details of their Complaints process **in writing**.
- Where an insurer's appointed repairer does a faulty or poor repair, require insurers to cover the reasonable costs of hire car and accommodation above what the insured is covered for.

ICA recommendation 23

The ICA proposes to work with the CGC and insurers to agree on consistent categories and definitions on withdrawn claims, to complement the work of CGC and ASIC on data collection.

9.1. Background

While the Interim Report did not identify the claims process as one of the priority areas for review, there were a number of changes presented for discussion, and many submitters felt that the claims section of the Code could benefit from further work.

9.2. Communications and Timeframes

9.2.1. Stakeholder feedback

The Joint Consumer submission was supportive of the Code requiring insurers to give claimants contact details for a primary contact, explanations for why particular information is being requested as part of the claims process, and for all information to be requested early and in one request where possible. Submitters also suggested that insurers explain to the claimant the cover that the claimant holds, the claim process and any waiting periods, excesses and other relevant information.

The Joint Consumer submission was supportive of regular updates on claims being provided every 10 business days, with responses to routine queries given within five business days. They pointed out that for those who don't have access to the internet, the Code should provide the ability for communications to be given via letter.

Insurers felt that the current 20-day timeframe provides a reasonable balance between meeting the claimants' need to be kept informed and administrative burden. Insurers requested that the Code recognise technology where the claimant could access the status of their claim at any time through a mobile application or other online media, and that this should satisfy the customer contact requirement.

The Joint Consumer submission suggested that where an External Expert's report cannot be provided within 12 weeks, insurers should provide an update to the consumer every 10 business days, and after 30 days give them the details of the Complaints process, to complain about the delay. Legal Aid QLD stated that in a catastrophe context, the majority of consumers are unlikely to complain about a delay while the key piece of evidence from an External Expert is still to be provided, but that in non-catastrophe contexts, it is important that consumers are given information about the Complaints process when an expert's report is delayed, to keep them fully informed and to encourage oversight of experts by insurers.

9.2.2. ICA position

The ICA supports the claims process being more transparent, timely and easier to navigate, to aid consumer understanding about what can be an unfamiliar process and makes a number of recommendations including requiring insurers to provide the claimant with an overview of the claims process, along with any excesses and waiting periods applicable and contact details to get information about their claim.

Having considered stakeholder feedback, the ICA does not believe that the Code's timeframes for providing regular updates to claimants need to be reduced; the existing timeframes balance a consumer's need for up-to-date information with the administrative cost to insurers of providing updates, particularly when there may not be any new information for the insurer to give to the consumer. These regular updates would continue to apply where

there is a delay in receiving an External Expert's report, so there is no need for the Code to make this a specific requirement for expert reports.

Insurers are also increasingly making technology available for claimants to access the status of their claim online or via a mobile application. The ICA agrees that the provision of real-time updates through mobile applications should meet the Code's requirements for regular updates and will consult the CGC as part of future work on consistent definitions and data collection.

The ICA does not support putting a hard deadline of 30 business days on expert reports. As stated in the Interim Report, insurers have advised that the situations in which External Experts have difficulty providing a report in the required timeframe 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.

9.3. Withdrawn Claims

9.3.1. Stakeholder feedback

The Joint Consumer submission supported extending the current commitment under clause 7.8 to include not encouraging a withdrawal.

Insurers considered that the Code currently provides adequate protection, and that there may be instances in which there is a genuine reason for an insurer to provide the insured with the option to withdraw their claim so as not to impact the insured's insurance history (for example, where the cost of the claim is below the policy excess).

Some submitters were supportive of better recording of withdrawn claims, in a consistent manner that can be made available to the CGC. However, insurers pointed out that recording the reasons for withdrawing claims may not be possible where there has been no contact from the customer. Insurers also noted the extensive systems changes that would be required to record this information and submitted that for some insurers it was not a viable option.

PIAC suggested that where the claim appears to have been abandoned, insurers should follow up with the claimant to determine whether the claim has in fact been withdrawn and if so, to ask the claimant the reasons for this.

9.3.2. ICA position

The ICA accepts the industry submission in relation to withdrawn claims that there may be unintended consequences for the consumer if insurers are required to not encourage a withdrawal, so does not propose to extend clause 7.8. The customer can also make a Complaint if they are withdrawing because they are not satisfied with the claim process.

At its workshop with stakeholders on data collection, the ICA committed to working further with insurers and the CGC to improve standardisation of definitions, data capture and reporting. This work will include withdrawn claims.

9.4. Claims Decisions

9.4.1. Stakeholder feedback

The Joint Consumer submission suggested that the timeframe to decide a claim should be reduced to two months, with an ability to extend to four months or further in exceptional circumstances. The Code would then require insurers to notify a claimant of their right to seek Internal Dispute Resolution (IDR) and EDR if a decision has not been made within two months.

Beyondblue stated that insurers should focus on transparency and enforceability of claims timeframes in the Code. ASIC suggested that the Code include independent monitoring of insurers' compliance with timeframes for the consideration of claims.

Most submissions were supportive of information about a claim denial being provided in writing, as well as detailed information provided in writing where a claim is only partially accepted, although the industry submission agreed that such information be provided only if the customer requested it and if it was possible to do so.

The Joint Consumer submission supported insurers recording the reasons for claim denials, but raised concern about the impact on a consumer's insurance report when the denial includes an accusation of fraud. They suggested that the Code outline consumer rights and insurer responsibilities in using insurance reports, and that insurers commit to improving the insurance reporting system.

It was further suggested that the catastrophes section of the Code should be expanded so that all claims finalised after a catastrophe should be notified in writing that they can have their claim reviewed within 12 months.

9.4.2. ICA position

The ICA does not support reducing the claims decision timeframe by half at this time, on the basis that it would be better for insurers to focus first on improving their servicing of claims in line with the discussion in this section of the Report, rather than potentially creating more customer complaints where the two-month timeframe for a decision cannot be met. Moving a claim into a Complaint when the insurer has been communicative but needs more time to investigate or seek information may not result in the best consumer outcome.

The ICA supports insurers recording the reasons for claim denials, as well as partial acceptances, but acknowledges that care will have to be taken in recording fraud accusations. This recommendation will require system changes. The ICA and members will continue to work with the CGC to define 'partial acceptance' and those matters that will therefore require a written response.

With respect to the suggestion that insurers commit to improving the insurance reporting system, the ICA notes that insurance reports are generated by third party providers. There is

not a standard framework for these and there is not a standard requirement for insurance reports to be accessed. Therefore, the ICA does not believe that it is appropriate for the Code to mandate the use or content of a report that is created by a party that is not a Code Subscriber.

Where a claimant has had their claim finalised within one month after a catastrophe, the ICA supports claimants being notified in writing under clause 9.3 that they can have their claim reviewed within 12 months, but does not support the suggestion that this is extended to every claim finalised after a catastrophe. This clause is intended to operate in circumstances where claims have been finalised very quickly after a major event, when there are large numbers of claims, if a claimant believes that the insurer should reconsider its decision and/or take additional information into account. Opening up this review to all claims after a catastrophe would be impractical for insurers, as resources would be focussed on supporting the large number of claimants after an event.

9.5. Repairs

9.5.1. Stakeholder feedback

The Joint Consumer submission supported claimants being given a summary of the scope of work to be carried out by someone engaged by the insurer to undertake repairs to the claimant's building, contents or vehicle.

Legal Aid QLD stated that a downside of this approach is that many consumers believe that the more expensive something is, the higher the quality, and suggested that this new process could be used as an opportunity to change consumers' current perception around this issue.

Insurers felt that written quotes could be problematic where the insurer provides repairs as an in-house service. A summary of the scope of work is usual in large or complex claims, however should not be a requirement for all claims due to the administrative burden this would create. It was suggested that this would hinder the ability for insurers to use small businesses or sole traders for repair work.

Submitters also supported the Code requiring insurers to arrange and pay for hire cars or accommodation where required as a result of faulty or poor repairs done by the insurer's repairer. Insurers suggested that the requirement be to pay reasonable costs only.

9.5.2. ICA position

The ICA supports the Code committing insurers to cover the reasonable costs of hire cars and accommodation that are required as a result of poor repair work by the insurer's repairer.

9.6. Total Loss Claims

9.6.1. Stakeholder feedback

In relation to total loss claims, the Joint Consumer submission stated that providing a detailed inventory with evidence of value after a total loss event is a difficult process. Legal Aid NSW suggested that where a customer has suffered a total loss in relation to a contents

claim, unless exceptions apply, insurers should not require the insured to complete a list of their contents and provide evidence. The agreed sum should be paid. Exceptions may include situations where there is a reasonable basis for suspicion of fraud, or where there is a reasonable basis for forming a belief that the actual loss is less than the agreed sum. Where there is disagreement over the actual loss, insurers should make an assessment on loss within 10 days of gaining access to the property. Payment should then be made immediately without requiring the insured to commit to this as a full and final settlement.

The Joint Consumer submission suggested that in the alternative, insurers should allow claimants to recover losses up to an average sum insured (taking into account the number of occupants and rooms etc), without having to quantify the loss or provide an inventory assessment and evidence of value.

The CGC agreed with the statement in the Interim Report that insurers and Service Suppliers must handle total loss claims with great sensitivity. The CGC suggested that if a claimant's loss is equal to or greater than the full sum insured (or a sub-limit within this), the insurer should pay the full sum insured unless it has a reasonable belief that the sum insured is greater than the value of the property being claimed. Where the insurer has such a reasonable belief then it should assist the claimant to ascertain the extent of the loss.

Legal Aid QLD suggested that it is appropriate for insurers to help consumers assess their loss up to the full sum insured or any sub-limit within it. It would be inappropriate for an insurer to require a claimant to provide a full list of all contents in these circumstances. Insurers felt this would be cumbersome to implement, but that it was appropriate to not require proof of ownership in total loss scenarios.

Insurers agreed that treating total loss claims differently would support good consumer outcomes.

9.6.2. ICA position

The ICA recommends that in situations of total loss, the Code should require claims to be treated with sensitivity. Claimants should also be provided with support, and assisted to determine the amount of their claim. Insurers will not require proof of ownership or an inventory assessment where it is clear that the loss exceeds the sum insured or any sub-limit within it.

9.7. Uninsured Third-party Claims

9.7.1. Stakeholder feedback

The Joint Consumer submission supported clarifying the rights of an uninsured third-party driver making a claim with an at-fault driver's insurer. In relation to the query in the Interim Report about whether the Code could clarify consumers have access to IDR and EDR for a claim up to \$5000, they suggested that the monetary limit of \$5000 is too low given the rising costs of car repair, and there should be no limit for an uninsured driver to access an insurer's Complaints process, with an increased limit of \$15,000 for EDR.

FOS clarified that there is a \$5000 cap on the compensation FOS can award for these claims. This compensation cap does not prevent FOS considering claims involving losses of

over \$5000. Statements that a consumer can access EDR for a claim up to \$5000 could therefore create confusion. As part of the transition to AFCA, measures to increase access to EDR will include raising the compensation cap for uninsured motor vehicle claims from \$5000 to \$15,000.

The Joint Consumer submission was concerned about the situation in which an uninsured driver is unable to make a claim because the at-fault driver has not paid their excess. It was suggested that a claim should be considered valid once lodged, irrespective of whether the excess has been paid.

9.7.2. ICA position

The ICA supports greater transparency being provided to uninsured third parties, as a subset of the claims process. The ICA recommends that the Code require the provision of information about the insurer's claims process and the Complaints process to uninsured third-party claimants. These measures are intended to demonstrate insurers' commitment to treat uninsured third-parties in an honest, fair and transparent manner.

The ICA accepts FOS' submission that disclosing claims limits in the Code would cause confusion, and recommends not pursuing with this.

9.8. Debt Recovery

9.8.1. Stakeholder feedback

The Joint Consumer submission supported insurers extending the Code principles of customer service to individuals from whom they are seeking debt recovery, and recommended that this requirement should be placed on debt collectors also.

They supported the suggestion that insurers should provide sufficient information in writing to third parties from whom a debt is being recovered so that they can determine whether the amount being recovered is fair and reasonable. Insurers considered that the industry currently acts in a manner consistent with these proposals, so agreed that they could be reflected in the Code. They felt that the principles of customer service should not create any right to compensatory damages for third parties.

The Consumer submission also suggested that insurers should inform third parties of their right to question the sum that the insurer is seeking to recover.

9.8.2. ICA position

The ICA supports insurers and Service Suppliers treating individuals in debt recovery situations in the same manner as any other individual under the Code – that is, in an honest, fair, transparent and timely manner.

The ICA supports greater transparency being provided to third parties, including sufficient information in writing so that a debtor can determine that the amount being recovered is fair and reasonable. This would assist with a timely debt recovery process, with less likelihood of dispute.

The ICA questions the need for insurers to tell third parties that they can challenge the amount of the debt, as this could encourage greater delay to the debt recovery process. If the insurer is providing a sufficient breakdown of the debt, then this will give the debtor ample information to determine whether the debt is appropriate, and if they believe it is inflated then they can respond on this basis.

10. COMPLAINTS PROCESS

ICA recommendation 24

The Code should be amended to require insurers to inform consumers *in writing*, where an insurer has been unable to provide a decision on a complaint within 45 calendar days, for the reasons for the delay and the consumer's right to take their Complaint to FOS.

ICA recommendation 25

The ICA proposes to continue to work with insurers to determine suitable changes that address stakeholder concerns with the current two-stage complaints process.

10.1. Background

The Code currently provides a two-stage internal complaint resolution process, after which time a customer may access EDR through FOS if they are not satisfied with the outcome. When the Code Review was launched, consumer advocates expressed concern about the use of a multi-tier complaints process, due to 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 consumers essentially giving up on their complaint before all avenues are explored.

ASIC RG 165 does not take a position on multi-tiered complaints processes, other than to note that the maximum complaint handling timeframe of 45 days applies even if a financial service provider operates IDR procedures that include internal appeals or escalation mechanisms.

In the Interim Report, the ICA did not propose to change the complaints process due to the substantial systems changes and costs involved. In addition, with the transition to AFCA, we are aware that ASIC will be consulting on RG 165, which may affect regulatory requirements around complaints handling.

10.2. Stakeholder Feedback

Many submitters felt that a two-stage system is too long, difficult and confusing, particularly for consumers experiencing vulnerability; many consumers do not know what stage they are at and what to do at a particular point. It was suggested that this deters legitimate complaints from progressing because the process is laborious.

To improve the system, it was suggested that insurers could train people at the frontline who can quickly triage complaints and deal with minor complaints themselves, while directing more complex or serious complaints appropriately and immediately. The Complaint should always be dealt with by someone different from the person(s) whose conduct is the subject of the Complaint, with an independent internal review as part of the IDR process, and the consumer should be given a single point of contact throughout the process. Complainants would be provided with a single decision that is final in response to their Complaint, with no letter closing Stage One and no requirement for the consumer to make a new request for a Stage Two review.

It was suggested that the Complaint process should be 15 business days unless more information or investigation is required, in which case a new timetable up to a maximum of 45 calendar days is instituted.

With respect to complainants who have nominated a representative, it was the view of the Joint Consumer submission that insurers and their Service Suppliers should contact a customer through their representative when this has been requested by the customer. PIAC stated that vulnerable consumers should be able to appoint a non-legal representative to act on their behalf (which was discussed in the section of this Report on consumers experiencing vulnerability). This can assist in reducing a consumer's distress and facilitate the early resolution of a matter.

Insurers were of the view that a two-tier process provides better outcomes for most consumers compared to a one-tier system. A two-tier process enables staff resourcing to be appropriately managed ensuring access to senior staff for Complaints. For large insurers with proportionately larger Complaints numbers, it was felt that a single-stage process would be difficult to manage and very expensive to run. Insurers were of the view that there may be a lack of understanding and transparency of the two-tier system and wished to explore this further with stakeholders.

A workshop was held with stakeholders to discuss possible improvements to the Complaints process.³⁰ At the workshop, participants discussed the importance of early acknowledgement of Complaints, including Complaints to third parties being sent to insurers as a matter of urgency, and the need to record the date the Complaint is made. Insurance employees and third parties need to be trained to recognise Complaints, and how these can be triaged. Finally, the workshop looked at whether there was an ability to adapt the current process so that a consumer would not be required to pursue the complaint from Stage One to Stage Two in order to get the insurer's final decision.

The CGC requested that the existing requirement to provide a final decision in response to a Complaint within 45 calendar days should be provided in writing.

10.3. ICA Position

While the Complaints process was not identified by the ICA as a priority area for review, we accept the concerns expressed by multiple stakeholders that the Code requirements should be changed to ensure the best consumer outcomes are achieved. The ICA proposes to continue to work with insurers and other stakeholders to determine suitable changes to the Complaints process that address stakeholder concerns with the current process. The ICA will also ensure that any changes to the Complaints process do not fall below current timeframe standards, but go beyond minimum regulatory requirements and deliver best practice standards. The ICA also proposes that the date of the complaint should be included in all written communications to the complainant.

³⁰ A list of workshops can be found at Appendix 6.

In response to the CGC's request for certain information to be provided in writing, the ICA agrees to amend the Code so that an insurer is required to inform consumers in writing where they are unable to provide a decision about a Complaint within 45 calendar days.

11. MONITORING, ENFORCEMENT AND SANCTIONS

ICA recommendation 26

The Code should be amended to:

- Clarify that *anyone* can report alleged breaches to the CGC *at any time*.
- Clarify that the sanctions in the Code enable compensation for any direct financial loss or damage cause to an individual, in line with Regulatory Guide (RG) 183.
- Provide that the principles of honesty, fairness, efficiency, transparency and timeliness have broad application as standalone provisions by removing the words “in accordance with this section” at sections 4.4, 6.2, 7.2 and 10.4.
- Enable the CGC to publish its decisions on a de-identified basis on the Code website, to assist Code subscribers to understand the CGC’s interpretation of the Code’s requirements.

11.1. Reporting of Breaches

11.1.1. Background

The Interim Report suggested that the intention of the monitoring and enforcement provisions in the Code is that *anyone* should be able to report an alleged Code breach to the CGC. This includes FOS, consumer advocates and legal professionals.

11.1.2. Stakeholder feedback

Submitters supported clause 13.1 to read “*Anyone can report alleged breaches of this Code to the CGC.*” PIAC suggested it should also be made clear that a breach can be reported “*at any time*”.

11.1.3. ICA position

The ICA agrees that the Code should make it clear that *anyone* can report a breach *at any time*.

11.2. Sanctions

11.2.1. Background

The Interim Report queried whether there is sufficient clarity in the operation of the current requirements for corrective action and sanctions in the Code. This was in response to various stakeholder feedback that the sanctions did not include compensation for direct financial loss caused to a consumer as a result of the Code breach, nor publicly naming an insurer who breaches the Code, both of which the ICA views as being captured by the existing sanction regime.

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

11.2.2. Stakeholder feedback

Some submitters supported the inclusion of sanctions in the Code which mirror the recommendations of ASIC in RG183. The Joint Consumer submission suggested that in order to avoid moral hazard through the imposition of fines imposed by the CGC, the money collected could be used to provide specific rectification or redress for a class of harmed consumers or support better consumer outcomes.

Insurers viewed this as unnecessarily repeating existing provisions and obligations. There was an unwillingness to commit to fines or corrective advertising orders being issued by any authority other than ASIC.

11.2.3. ICA position

It is the ICA's view that the sanctions in the Code meet RG 183 requirements. However, the ICA believes there is a separate issue around 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. To provide clarity, the ICA recommends that existing clause 13.15(a) be amended to mirror the consumer compensation wording reflected in RG 183.

Although it has been a long-held position by the ICA that there is no need for fines to be used for rectification or compensation, there is already an ability for the Code to impose specific rectification or consumer compensation.

Moreover, the ICA Board has the ability under its Constitution by resolution to censure, fine, suspend or expel a member from the ICA, "where a member wilfully refuses or neglects to comply with the provisions of the constitution...or is guilty of any conduct which in the opinion of the board is unbecoming of a member."

11.3. Interpretation of Code standards and process for appeal

11.3.1. Background

The Code Review highlighted that there are some Code standards that the CGC and Code Subscribers are interpreting differently. A number of the sections of the Code begin with the principles of honesty, efficiency, 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 Interim Report sought feedback as to whether the establishment of a formal appeal process would be appropriate, where a CGC decision has a significant and/or broad industry impact.

The Interim Report also suggested improved transparency of CGC decision-making so that insurers can better understand CGC expectations, through the publication of CGC decisions on a de-identified basis.

11.3.2. Stakeholder feedback

The Joint Consumer submission strongly opposed the suggestion that principles such as honesty and fairness should operate only in relation to the standards set in each section. They suggested that this interpretation would mean that any significant dishonesty or unfairness from a Service Supplier that isn't explicitly covered under the Code would not be captured. Insurers supported the principles being an overarching Code obligation at the front of the Code, rather than being repeated in each section.

The CGC and the Joint Consumer submission were supportive of regular publishing of CGC decisions. The Joint Consumer submission wanted these to identify the insurers involved in order to incentivise compliance with the Code.

Submitters strongly opposed the introduction of any appeals process, on the basis that this would undermine the independence and enforceability of the CGC's decisions. It was pointed out that the Charter for the CGC allows for complaints to be raised concerning the CGC not acting in accordance with the Code or the Charter.

11.3.3. ICA position

The ICA has accepted the CGC and insurer submissions that the principles of honesty, fairness, efficiency, transparency and timeliness should have broad application as standalone provisions. For clarity, the references to "in accordance with this section" that follows these principles at sections 4.4, 6.2, 7.2 and 10.4 will be removed.

The ICA agrees that the CGC should publish its decisions on a de-identified basis on the Code website, to assist Code subscribers to understand the CGC's interpretation of the Code's requirements. The suggestion of the Joint Consumer submission that the decision names the insurer is not supported, as publicly naming a breaching insurer is the most serious sanction open to the CGC to use.

The ICA agrees with submitters that an appeal process for CGC decisions is unnecessary.

11.4. Reporting of Significant Breaches

11.4.1. Background

The Interim Report suggested that the current definition of Significant Breach creates confusion, on the basis that its reference to “likely breaches” may be interpreted to mean likely Significant Breaches should be reported to the CGC. The ICA in the Interim Report considered that the intention is only for actual Significant Breaches to be reported, and incorporation of the words “likely breach” are unnecessary.

11.4.2. Stakeholder feedback

The CGC stated that Code subscribers need clarity around the interpretation of the words “likely breach” in the definition of Significant Breach and the CGC’s approach to this is consistent with ASIC’s approach – that a subscriber is likely to breach a Code obligation if, and only if, the subscriber is no longer able to comply with a relevant obligation. The CGC proposed that it could publish a guidance note to provide clarity on the interpretation.

The Joint Consumer submission strongly opposed the removal of the words “likely breach” from the definition of Significant Breach, on the basis that the breach would have to be so clear and discrete for the insurer to be confident that it was an actual breach.

11.4.3. ICA position

The ICA supports the CGC’s submission that the phrase “likely breach” in the definition of Significant Breach means that a subscriber is likely to breach a Code obligation if, and only if, the subscriber is no longer able to comply with a relevant obligation.

On this basis, there is no need to amend the definition of Significant Breach, and the ICA will work with the CGC to ensure insurers understand what is expected of them.

11.5. Relationship between Code breaches and EDR

11.5.1. Background

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 Interim Report suggested the monitoring process in the Code could include the following:

- 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.
- If a breach allegation is currently being heard at EDR, then the CGC should await the outcome of this before investigating.
- EDR should provide details of possible Code breaches to the CGC once a determination is made.

11.5.2. Stakeholder feedback

The CGC stated that it already has in place processes to determine how its work interacts with EDR, and that the proposal to require the CGC to await the outcome of an EDR determination would not always be appropriate.

The Joint Consumer submission did not support the introduction of a rule to limit the power of the CGC, through awaiting the outcome of an EDR dispute before investigating an alleged breach of the Code. EDR and Code breach investigations are mutually exclusive tasks that can occur distinctly and in parallel.

Insurers suggested that the CGC should notify the relevant insurers that they are awaiting the EDR outcome prior to investigating.

11.5.3. ICA position

The ICA supports the CGC's submission on the interplay between its work and the EDR process, and suggests that the Code does not need to provide greater clarity. In the alternative, the ICA will provide more information about the roles of the CGC and EDR on the Code website, once the revised Code is launched.

12. ASIC APPROVAL

ICA recommendation 27

In order to meet the requirements for ASIC approval of the Code, the Code should be amended to:

- Clarify that the Code is enforceable through CGC oversight and sanction powers, and through FOS taking Code breaches into account when determining disputes.
- Enable the CGC to report systemic code breaches and serious misconduct to ASIC, and require the CGC to notify an insurer's Chief Executive that it intends to do so. The ICA will work closely with the CGC to ensure there is a common understanding of the meaning of "systemic breach" or "serious misconduct", to provide insurers with clarity.
- Include a maximum timeframe for independent reviews in line with Regulatory Guide (RG) 183.

12.1. Background

The ICA's intention is to submit the revised Code for ASIC approval and has sought to meet the requirements of ASIC's Regulatory Guide 183 where possible.

Submitters were supportive of the Code being submitted to ASIC for approval, with the exception of the Law Council. The CGC noted in its submission that:

"A General Insurance Code of Practice has been in force since 1996. Subsequent revisions over the last 20 years have resulted in a mature and comprehensive document that now forms an important part of the Australian consumer protection framework and is defined by high levels of ... compliance in the industry. Accordingly, the CGC considers the time is right for the ICA to submit the Code to ASIC for approval under ASIC Regulatory Guideline 183 'Approval of financial services sector codes of conduct' (RG183)."³¹

The Law Council submitted that ASIC approval would lead to a reduced form of the Code, and diminish its ability to provide flexible guidance and assistance for Code Subscribers and consumers.

12.2. Enforceability

12.2.1. Background

ASIC requires enforceability of a code as a key criterion for approval.

The Interim Report suggested that providing enforceability through CGC oversight and sanction powers and through EDR should be sufficient to meet the requirements of RG 183,

³¹ CGC submission (30 May 2017), p. 25.

and that requiring subscribers to also incorporate their agreement to abide by the Code into individual contracts with consumers is unnecessary and not supported by the ICA and the industry.

12.2.2. Stakeholder feedback

The Joint Consumer submission and PIAC submitted that insurers should agree to being contractually bound by the Code. Legal Aid NSW suggested that incorporating the Code into consumer contracts would mean that breaches of the Code could be dealt with by FOS.

Insurers agreed with the ICA's view that RG 183 does not require Code standards to be incorporated as a term of the insurance contract, and that such an outcome would be problematic under the law in relation to the duty of utmost good faith and in relation to misleading and deceptive conduct.

12.2.3. ICA position

The ICA maintains its position that the Code should make it clear that it is enforceable through the CGC's oversight and powers of sanction, as well as through the EDR process. The current FOS Terms of Reference state that FOS can take into account industry codes when determining disputes, and it is expected that the AFCA Terms of Reference will provide for the same enforcement. It is the ICA's view that Code enforceability does not require incorporation of the Code in the customer contract.

12.3. CGC Reporting to ASIC

12.3.1. Background

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

12.3.2. Stakeholder feedback

Submissions supported the CGC being empowered to report to ASIC. Insurers suggested that the CGC be required to notify the insurer before reporting any breaches to ASIC, and provide a reasonable time for the insurer to respond to the allegation of a systemic breach or serious misconduct, to accord the insurer procedural fairness and the ability to appeal if it considered the issue was not systemic.

Insurers recommended that they work closely with the CGC to create a systemic breach test to provide clarity. PIAC suggested that systemic breaches should include Code breaches that have implications beyond the immediate parties affected by the breach; this would be consistent with the definition of "systemic issue" in the FOS Terms of Reference.

12.3.3. ICA position

The ICA supports the CGC having the ability to report systemic code breaches and serious misconduct to ASIC, as well as require the CGC to notify an insurer's Chief Executive that it intends to do so. The ICA will work closely with the CGC to ensure there is a common

understanding of the meaning of “systemic breach” or “serious misconduct”, to provide insurers with clarity.

12.4. Independent Reviews

12.4.1. Background

RG 183 requires that a code must be independently reviewed at intervals of no more than three years. To take into account the lead time required for revisions of the Code and for insurers to transition to new versions of the Code, the Interim Report suggested that the Code is independently reviewed no later than three years after the adoption date of any previous changes to the Code.

12.4.2. Stakeholder feedback

The Joint Consumer submission suggested the independent review timeframe is three years after the Code is approved by ASIC. It was concerned that the length of time taken to review the Code and then transition to it would mean that the three years would become substantially longer, if the clock started ticking once the Code is adopted.

Insurers supported the regular independent review suggestion, but noted that there should also be flexibility to allow for amendments where new issues resulting in material consumer detriment emerge. These amendments should not push the independent review out an additional three years.

12.4.3. ICA position

The ICA agrees with submitters that the process of reviewing and transition to versions of the Code should not unnecessarily delay the next independent review. We recommend that the clock should start ticking when the transition period starts, rather than when the Code is fully adopted. In other words, when the Code is amended, the first date of when the transition period commences will also be when the three year period for review commences.

13. OTHER ISSUES

13.1. Promotion of the Code

ICA recommendation 28

The Code should be amended to elaborate on the role of the CGC. Specifically, the CGC is responsible for:

- Monitoring and enforcing insurer compliance with the Code, in accordance with section 13 of the Code, including through investigations and analysis of data and evidence;
- Providing leadership to industry and helping insurers to understand and comply with their Code obligations and seeking continuous improvement of insurance practices;
- Liaising with the ICA on relevant matters.

ICA recommendation 29

The ICA proposes to relaunch the Code website with the revised Code, to provide more information about the CGC and the enhanced provisions on reporting of a Code breach.

13.1.1. *Background*

The Interim Report suggested that the Code could include more information about the CGC's role and its areas of focus, such as:

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

The Code website could also be expanded to include:

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

13.1.2. *Stakeholder feedback*

The CGC agreed that it would be beneficial if the Code contained more information about the CGC's role and its areas of focus, including collecting industry data and engaging with consumers about the Code.

The Joint Consumer submission suggested that the Code website have a bold and prominent “Report a Breach” button on the front page and on the Governance and Monitoring page, with a subsequent filtering and step-by-step reporting process, rather than simply providing an email address. It was also recommended that the CGC have a standalone webpage similar to the Code Compliance Monitoring Committee (CCMC) which oversees the Code of Banking Practice, or a more prominent page link on the Code page.

13.1.3. ICA position

The ICA supports the Code providing a greater explanation about the role of the CGC. The ICA will also improve the Code website once the revised Code is completed, to provide more information about the CGC and greater ability for someone to report a Code breach. Furthermore, the ICA has agreed with the CGC that it should have its own standalone website which would include information on how to report a concern regarding a Code breach.

13.2. Customer Disclosures

13.2.1. Background

The Interim Report considered whether there should be a greater onus on insurers at the point of sale to verify customers’ disclosures. The ICA suggested that it may not be practical to request documents for verification, such as a consumer’s insurance report, driver history or criminal record, in all cases.

Instead, the Interim Report suggested that the Code require that a customer is contacted as soon as an insurer becomes aware of an issue with their disclosures, as is required in the Life Code.

13.2.2. Stakeholder feedback

The Joint Consumer submission did not accept that the issues raised with respect to verification of a customer’s disclosure were insurmountable obstacles. They submitted that the insurance reports system should be addressed, if insurers cannot rely on them for information. For example, a guide could be developed by the ICA which would cover consumer rights and insurer responsibilities in using insurance reports.

The Joint Consumer submission also suggested that consumer driver history can be accessed in real time with consent, as it already does under a data sharing arrangement in compulsory third party (CTP) insurance in NSW.

Insurers suggested that the Insurance Contracts Act provides adequate consumer protection and remedies, and noted that to contact a customer about their disclosures across the board would be very costly to introduce.

13.2.3. ICA position

The ICA’s view is that requiring insurers to verify disclosures made at the point of sale is not feasible at this point in time.

As has been stated earlier in this report, insurance reports are created by external, independent bodies. The Code cannot bind organisations that are not subscribers to the Code, and thus the ICA does not believe there is a role for the Code to play in determining the content of insurance reports, or requiring insurers to hold these for every new customer.

At this point in time, insurer access to real time data is limited to Compulsory Third Party (CTP) insurance in NSW where the State Government has built a platform to enable verification of an individual's driving history in real time. The Code cannot commit insurers to build similar platforms across the country, without this work being led by the State Governments.

The ICA is of the view that the Code does not need to include a provision for addressing non-disclosure after a policy is taken out. This is a requirement of the Life Code because life insurance policies automatically renew each year, so a consumer's duty of disclosure has a long-term impact. In general insurance, policies generally renew annually where the risk of non-disclosure is limited by the short duration of the policy.

13.3. Policy Cancellation

13.3.1. Background

The Interim Report sought feedback on whether the cancellation procedures in the Code could be improved to assist with customer engagement and prevent unnecessary cancellation.

13.3.2. Stakeholder feedback

The Joint Consumer submission supported the following improvements to cancellation procedures:

- 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); and
- insurers should be required to always give the second notice of cancellation within 14 days after the policy has been cancelled.

It was suggested that insurers could ask customers for a secondary method of contact when a new policy is taken out, to be used only if required.

The Joint Consumer submission believed that notification that a consumer's policy has been cancelled would be the most effective means of motivating them to take action before an insurable event takes place. This notice should also include information about the date of cancellation and the options to reinstate the cover.

Insurers felt that the current cancellation obligations provide suitable consumer protection, and that any additional requirements should be considered in the standards protecting consumers experiencing vulnerability.

13.3.3. ICA position

On the basis of limited complaints received about cancellation procedures, the ICA has formed the view that the current cancellation process is adequate. Given any new procedures would impose a cost on insurers, it is not clear that any additional consumer benefit would outweigh such costs.

13.4. Extending the Scope of the Code

ICA recommendation 30

The ICA website should promote the rights of residential strata consumers under the Code.

13.4.1. Residential strata

13.4.1.1. Background

The CGC has noted that it is unclear whether the definition of retail insurance in the Code includes residential strata products. The Interim Report proposed that the definition of Retail Insurance could explicitly include residential strata, excluding mixed-use and high value strata insurance.

13.4.1.2. Stakeholder feedback

The Joint Consumer submission supported the definition of retail insurance capturing residential strata.

Insurers submitted that the Code definition of retail insurance should be consistent with the definition in the Corporations Act.

13.4.1.3. ICA position

The definition of retail insurance in the Code is currently aligned with the definition of retail general insurance under the Corporations Act. Section 761G(5)(a) limits the definition of retail general insurance to products provided to an individual or *small business*. In many circumstances, residential strata insurance would trigger the small business limb of the retail definition. In practice, insurers generally treat all residential strata as retail insurance rather than assessing each case on the basis of whether the small business limb of the definition has been met.

While the ICA's view is that in most circumstances, residential strata insurance should be captured as retail insurance under the Code, clarifying the definition as proposed in the interim report is likely to cause more confusion. Defining residential strata to exclude mixed-use and high value strata insurance would require these exclusions to be defined as well. We note the CGC's submission that they currently treat residential strata as retail insurance for the purposes of the Code, and as such, we do not see any gaps in the application of the Code.

Instead, the ICA recommends more work, through the ICA website, to promote the rights of residential strata consumers under the Code.

13.4.2. Extension of Code to business insurance

13.4.2.1. Background

The Interim Report suggested that the current distinction between retail insurance and wholesale insurance should remain unchanged, rather than extending the Code in line with the FOS Terms of Reference.

13.4.2.2. Stakeholder feedback

The Joint Consumer submission suggested that the Code should be extended to cover wholesale insurance, or a separate Code for wholesale insurance should be developed.

The CGC supported extending the application of the Code to small business consumers of products that currently fall outside the Code's definition of Retail Insurance, but which are covered by the FOS Terms of Reference, such as "general property", "theft" and "loss of profits/business interruption". The CGC believed that this would ensure small businesses, including farmers, would have access to the protections under the Code. The CGC was not however supportive of expanding the Code to all wholesale products.

Insurers' view was that the Code currently provides appropriate protections for wholesale consumers and does not need to be expanded. The practical implications of such a change would be additional costs, diverting resources from retail insurance and consumers with vulnerabilities towards large businesses and sophisticated consumers. This would create inconsistencies with the Corporations Act.

13.4.2.3. ICA position

The ICA maintains its position that the current distinctions of retail and wholesale insurance in the Code should remain. During the previous independent review of the Code by Dr Ian Enright, this distinction was put into the Code, as the intention of the Code is to largely focus on individual consumer protections.

Appendix 1: Draft Guidance on Family Violence

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 experiencing vulnerability.

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.

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.

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 member companies and other stakeholders. The ICA encourages Code Subscribers to use this industry guidance to develop their internal processes, procedures and policies.

1. Summary

Code Subscribers should have an effective family violence policy that provides for:

- training and assistance for Employees to help identify, support and avoid harm to customers affected by signs of family violence, and people seeking to purchase insurance
- 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
- options for referring customers to specialist family violence services
- support to Employees affected by family violence or who experience vicarious trauma after dealing with affected customers

2. 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/economic and sexual abuse. Family violence can also include damage to property.

3. Requirements for family violence policy

The Code requires Subscribers to have systems, processes and appropriate training in place to identify and support customers experiencing vulnerability.

The requirements are designed to be high-level and enabling, providing Subscribers with flexibility to decide on their specific approach while also allowing them to adapt their policies over time.

Where family violence is identified or suspected, the number one priority is 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, as the issues are often highly complex.

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

- i. Employee training to improve responses to customers affected by family violence
- ii. Protecting private and confidential information and minimising repeat disclosures
- iii. Early recognition of family violence
- iv. Sensitive claims handling
- v. Access to Financial Hardship
- vi. Collections arrangements
- vii. Providing customers and Employees with referrals to specialist services
- viii. Making customers aware of information and assistance available
- ix. Support provided to Employees

3.1. Employee training to improve responses to customers affected by family violence

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

All relevant Employees should have ongoing training to help them:

- identify customers affected by family violence
- deal appropriately and sensitively with customers affected by family violence
- 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. Code Subscribers should provide Employees with skills to help identify signs that may indicate customers are 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 Employees 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. Employees 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.

Employees are not expected to be experts or social workers in family violence. However, training programs can assist Employees with reducing the impact of family violence on customers. Training should be tailored to Employees' role within the business and level of contact with customers, and focus on developing their knowledge, skills, competencies and information.

Training can help Employees:

- be more aware of the prevalence and practical effects of family violence on a customer
- recognise potential or early signs of violence that may lead to future violence and have a carefully and sensitively handled conversation with a customer, without disclosure to the perpetrator
- 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
- with options to refer the customer to specialist services that can give further guidance

- understand the impact of trauma on customers affected by family violence; in particular, how trauma may affect their presentation and how Employees can engage with them in a supportive manner
- understand the potential impact (positive and negative) that an insurer's actions can have on a family violence situation
- 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, whose needs have to be managed appropriately, and that perpetrators may attempt to convince Code Subscribers to disbelieve or dismiss someone affected by family violence
- 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.

The training of specialised employees should also take into consideration that a female customer affected by family violence may prefer to speak to a female Employee.

A Code Subscriber's Service Suppliers who 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.

3.2. Protecting private and confidential information and minimising repeat disclosures

Customer safety must be protected as the number one priority, by providing for the secure and confidential handling of information about customers affected by family violence.

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.

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, or having their physical address and password protected, so that the Code Subscriber does not run the risk of providing it to someone who can answer alternative security questions.

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 Employees.

The Code requires Subscribers to ask customers experiencing vulnerability for permission to keep a record of the support or assistance they require and respect their right to confidentiality. Code Subscribers may consider establishing a flag in their systems for customers affected by family violence.

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.

In relation to privacy concerns, Code Subscribers should consider the following in developing their family violence policies:

- 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. 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 within a reasonable time, 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
- discussing safe ways to communicate with a customer experiencing violence and recording these communication methods on the customer's file; for example, asking 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
- facilitating requests from joint policyholders who ask for policy communications and information to be sent to two different addresses (either physical or email)
- understanding the legal requirements and internal processes where a victim and perpetrator of family violence are joint policyholders, and ensuring customers are informed about the circumstances and nature of information that has to be shared with the perpetrator so that they can make arrangements accordingly
- understanding legal reporting requirements in relation to children
- protecting the details of Employees in situations where they may have to contact the perpetrator of family violence

In relation to repeated disclosure, Code Subscribers should consider the following to make it easier for customers to communicate with them:

- minimising the information that a customer is required to provide and the number of times a customer has to disclose the same information, noting that they may not have access to records and documentation

- where possible, providing customers with consistency in speaking to one Employee, 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.

3.3. 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 potential customers, or they may be Employees.

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 appropriately experienced and qualified counsellors accompany claims Employees 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.

3.4. Sensitive 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 Employees 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 may be affected by family violence and/or going to the claimant's home needs to be appropriately trained, in accordance with claims investigation standards of the Code, and should also be aware that they may be putting themselves in danger
- before any claim payment is made, the Code Subscriber should endeavour to ensure they are paying the appropriate party or parties – this can be a particularly complex area in cases of family violence and/or where family law property disputes are involved.

3.5. 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 experiencing Financial Hardship.

In addition to the existing requirements for Financial Hardship assistance contained in the 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 should 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.

3.6. 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.

Clause 9.6 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.

3.7. Providing customers and Employees with referrals to specialist services

Code Subscribers should provide a means for referring customers or Employees to specialist family violence services, by including this information on the Code Subscriber's website, as well as having Employees provide this information to customers directly.

An insurer's Employees are not best placed to provide specific advice on family violence outside the scope of insurance or financial matters. They are not professional social workers or experts in identifying family violence and customers may not raise that they are victims. However, where possible, Employees should be in a position to suggest a customer contact an external legal and support organisation.

A list of recognised external specialist services should be kept up to date and to a minimum, in order to make the choice of referral simpler. An alternative referral option may be kept in case a lack of availability.

Code Subscribers may choose to add other referral options where they have an established relationship with particular services, or they have specialised Employees with a higher level training to enable them to distinguish between services.

3.8. 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.

Code Subscribers should:

- i. 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;
- ii. provide a copy of the family violence policy to a customer upon request; and
- iii. 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.

3.9. Support provided to Employees

Employees of Code Subscribers may also be affected by family violence and require support in the same way as customers do. Moreover, Employees may be adversely affected either by 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 may include providers such as:

- Kildonan UnitingCare (National)
- 1800 RESPECT (National)
- DV-alert Domestic Violence Response Training (National)
- Domestic Violence Resource Centre Victoria
- Education Centre Against Violence, NSW Health (NSW)
- Women's Domestic Violence Court Advocacy Services (NSW)
- Centre for Domestic and Family Violence Research, Queensland
- Women's Council for Domestic and Family Violence Services (WA)

- Gendered Violence Research Network, UNSW
- Ask LOIS (Women's Legal Service NSW)
- State Legal Aid Commissions
- LawAccess NSW

Appendix 2: Draft Guidance on Mental Health

Background

One in five Australians aged over 15 will be affected by a mental health condition in any 12-month period, and one in two will be affected across the span of a lifetime.³² Australia's National Mental Health Policy defines a mental illness as "a clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities".³³

Consumers with a past or current mental health condition have experienced challenges at times in accessing some general insurance products. Some products provide limited underwriting for mental health conditions. Some products also include blanket mental health exclusions which exclude claims arising from a mental health condition.

While it is unlawful under the *Disability Discrimination Act 1992 (Cth)* (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 is contained in section 46 of the DDA, and is **excerpted** below:

"(f) the discrimination:

(i) is based upon actuarial or statistical data on which it is reasonable for the first-mentioned person to rely; and

(ii) is reasonable having regard to the matter of the data and other relevant factors; or

(g) in a case where no such actuarial or statistical data is available and cannot reasonably be obtained--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 of which Australia is a signatory.³⁴ Insurance products and underwriting practices must evolve to better meet the needs of consumers with past or current mental health conditions.

Objectives

The General Insurance Code of Practice (the **Code**), at obligation (x) requires Code Subscribers to accommodate the needs of consumers experiencing vulnerability.³⁵ These best practice principles have been developed to enable subscribers to the Code to benchmark their practices against industry-agreed best practice standards. The Principles encourage continuous progress by industry in meeting the highest standards with regards to the provision of products to consumers with a mental health condition.

³² Australian Bureau of Statistics (2008), *National Survey of Mental Health and Wellbeing: Summary of Results*, 4326.0, Canberra.

³³ Commonwealth Department of Health and Aged Care (2008), *National Mental Health Policy*.

³⁴ Including the United Nation's *Universal Declaration of Human Rights* (10 December 1948).

³⁵ This is a proposed new Code obligation.

Status of Guidance Documents

This industry guidance document does not have legal force to prescribe binding obligations on individual insurers. While the ICA's guidance documents are voluntary, they are developed with input from member companies and other stakeholders. The ICA encourages Code Subscribers to use this industry guidance to develop their internal processes, procedures and policies.

Best Practice Principles

- 1. At a minimum, insurance product design, underwriting, exclusions, premiums and loadings must comply with the requirements of the DDA and/or any relevant State-based anti-discrimination requirements.**
- 2. Consumers who have a past or current mental health condition will be treated fairly and with dignity.**
 - 2.1. Through each stage of the life cycle for relevant insurance products, mental health conditions should be treated in the same way as any other medical condition, and have regard to available prognostic data and documented rates of prevalence, morbidity and mortality.
 - 2.2. Insurers and their Distributors and Service Suppliers should adopt a respectful and positive approach towards consumers with a past or current mental health condition in their sales and claims processes. Insurers should develop and implement policies and procedures that support this approach.
 - 2.3. Where an insurer is aware that a customer has a past or current mental health condition, they should determine whether they are a consumer experiencing vulnerability under the Code, and treat them accordingly.
 - 2.4. Claims involving mental health conditions should be processed sensitively having regard to the consumer's ongoing medical treatment needs using the least intrusive methods of investigation, in accordance with the claims investigation standards in the Code.
- 3. When designing general insurance products, the needs of those who have a past or current mental health condition should be considered.**
 - 3.1. Where possible, insurers should provide cover to persons with a past or current mental health condition and manage risk through policy pricing, exclusions, limits and caps based on actuarial and statistical data and other relevant factors, rather than not provide cover at all. The availability of insurance for persons with a past or current mental health condition should take account of the affordability of that insurance.
 - 3.2. As with all health conditions, when setting premiums for products that cover mental health conditions or for individual cover for a person with a past or current mental health condition, the pricing of the offered products or cover should reflect the risk.

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

- 3.3. Insurers should move away from the application of blanket exclusions for mental health conditions. Insurers should continuously seek to obtain better data to enable any exclusions to be narrowly designed. Any application of blanket exclusions of mental health conditions or broad categories of mental health conditions must be based on statistical or actuarial data or other relevant factors.
- 3.4. When designing products, insurers should seek to co-design with consumers.
- 3.5. The insurance industry 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 past or current mental health condition.
- 3.6. Insurers should co-operate with the Insurance Council of Australia in ongoing statistical research endeavours to get a better understanding of mental health conditions and proactively improve the availability of clinical data and claims experience data.
- 4. The risk assessment of people with past or current mental health conditions must be centred on available statistical or actuarial data on which it is reasonable for an insurer to rely, and the risk assessment must be reasonable having regard to the data and other relevant factors.**
 - 4.1. At the point of sale, insurers should act in a transparent manner in determining the risk of applicants with a past or current mental health condition.
 - 4.2. Mental health conditions should be categorised according to current commonly accepted professional standards.³⁶
 - 4.3. Insurers should ensure that questions asked at application for insurance:
 - 4.3.1. are simple, clear and specific;
 - 4.3.2. only ask questions that are relevant to the insurer's underwriting guidelines or its risk assessment of the applicant;
 - 4.3.3. do not ask questions requiring knowledge which the applicant could not reasonably be expected to possess;
 - 4.3.4. are accompanied by examples of the type of information that is sought where appropriate; and

³⁶ As at May 2017, commonly accepted professional standards include International Classification of Disease (ICD) or Diagnostic and Statistics Manual (DSM) systems.

- 4.3.5. provide sufficient opportunity for an applicant to provide more detailed answers.
- 4.4. When determining an individual's risk profile based on their past or current mental health condition, insurers should, where possible, take into account factors which may reduce a person's risk such as treatment plans and prescribed medication to give a holistic view.
- 4.5. If an application for insurance includes underwriting questions about medical history, insurers should not automatically decline an application where an applicant discloses a past or current mental health condition but rather should obtain further information from the applicant to assist in the assessment of their application.
- 4.6. Where cover is not offered or is provided on terms deviating from the standard policy, insurers should provide the applicant with a statement of written reasons in plain language, explaining why they cannot offer insurance or why they have offered cover on non-standard terms. Insurers should provide applicants the opportunity to discuss this with them further to get an understanding of the underwriting criteria, and reapply if their circumstances change.
- 4.7. Exclusions for pre-existing mental health conditions should only apply where there is evidence that an applicant has an existing mental health condition, or is at risk of a recurrence of a past mental health condition, and the covered event relates to the pre-existing mental illness.
- 4.8. Where a consumer makes a claim against an existing policy, the claim should not be denied on the basis of a pre-existing mental health condition where the covered event does not relate to the pre-existing mental health condition.
- 4.9. Where insurers rely on the exemption contained in section 46 of the DDA or a similar exemption in any relevant State-based legislation, they must keep accurate records of the actuarial or statistical data and/or other relevant factors they have relied upon to do so.
- 5. Insurer Employees, Distributors and Service Suppliers working with consumers with mental health conditions should be appropriately trained and supported.**
 - 5.1. Training should increase awareness and understanding of common causes, signs and symptoms of mental health conditions in the community.
 - 5.2. Training should develop communication skills for interacting with consumers who have, or show signs of having, a mental health condition.
 - 5.3. Training should cover the requirements of section 46 of the DDA and any relevant State-based anti-discrimination legislation.
 - 5.4. Training programmes should be reviewed regularly, and at a minimum every three years, by insurers to ensure the programmes are effective in achieving the objectives listed above. Insurers should include information on the outcome of any review as part of the annual reporting to the Code Governance Committee.

6. **The Principles should be reviewed and revised by the industry every two years, incorporating feedback from insurers, stakeholders and regulators.**
- 6.1. Insurers should regularly benchmark their practices against these Principles, and report on the outcome of these reviews to the Code Governance Committee.

Appendix 3: Draft Guidance on Best Practice Disclosure

Background

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 gap in expectations at claim time.

The industry acknowledges that disclosure should work alongside other measures, such as processes governing good product design, to drive consumer comprehension and engagement. 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.³⁷

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

Objectives

This guidance document contains best-practice principles that have been developed to enable subscribers 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 this guidance document to reflect learnings from members’ trialling of innovative disclosure techniques.

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 member companies and other stakeholders. The ICA encourages Code Subscribers to use this industry guidance document to develop their internal processes, procedures and policies.

This guidance document operates 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 subscribers to act outside their legal obligations or the conditions of their Australian Financial Services (AFS) licence.

³⁷ The Insurance Council’s Board has endorsed recommendation 3 of the Effective Disclosure Taskforce.

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.
- 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 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.³⁸ 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.
- 1.4. Advertising of insurance products may also be used by consumers to inform their purchase decisions, and insurers should ensure their advertising is clear and not misleading.

2. Disclosure is clear and concise in language and tone

- 2.1. Insurers should seek to use plain language wherever possible when communicating with consumers. Plain language uses elements such as personal pronouns, short words and sentences and active verbs.
- 2.2. Consumer testing and engagement of plain English experts should be utilised by insurers to ensure disclosure is as clear as possible to assist with consumer understanding.
- 2.3. Insurers should seek to continuously improve disclosure, including through the use of consumer testing.

3. Disclosure promotes consumer engagement

- 3.1. 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.
- 3.2. Insurers should build consumer trust by harnessing emerging technologies and the growing body of behavioural research to improve the way they communicate with consumers.

³⁸ 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).

- 3.3. 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.
- 3.4. 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.
- 3.5. Insurers should ensure that the disclosure design process is subject to whole-of-organisation input, including from customer-facing, customer insights and claims personnel.

4. Disclosure encourages informed decision-making

- 4.1. 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.
- 4.2. 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.
- 4.3. Insurers should consider initiatives to improve comprehension of policy exclusions to facilitate effective decision-making. Research suggests that consumers have very poor 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. Insurers should ensure they clearly bring all policy exclusions to a consumer's attention in a readily accessible and clear format, prior to the consumer entering into a contract.
- 4.4. 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".
- 4.5. 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.

- 4.6. Insurers should work towards improving the provision of calculator tools to assist consumers to estimate required coverage for home contents insurance.
- 4.7. 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.
- 4.8. 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.
- 4.9. If a policy automatically renews, this should be made clear to the customer at the time of purchase. The annual renewal letter should also make it clear that the policy will automatically renew unless the customer cancels the policy, and should encourage the customer to review whether the terms of the policy continues to meet their needs.
- 4.10. For renewing consumers, insurers should disclose the previous year's premium at renewal to enhance transparency around changes to the premium.
- 4.11. Insurers should consider best-practice disclosure within the context of a wide range of communications to consumers, such as requests for consent.

5. Disclosure is contextual

- 5.1. 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.
- 5.2. 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.
- 5.3. Scenarios explaining circumstances in which an exclusion is in operation could aid consumer comprehension of policy exclusions.
- 5.4. 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.
- 5.5. 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.

6. Disclosure is targeted, timely and accessible

- 6.1. 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.
- 6.2. 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.
- 6.3. 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.
- 6.4. 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 4: Draft Guidance for the Design and Distribution of Add-on Insurance Distributed through Motor Dealer Intermediaries

Background

General insurance products distributed through motor dealer intermediaries can play an important role in protecting the financial security of consumers. Distribution through such intermediaries allow consumers (individuals and small businesses) to consider and purchase these products at or soon after the same time as they purchase or finance their vehicles. The industry recognises the importance of sufficiently robust product design and distribution processes to ensure good consumer outcomes are achieved.

Most of these products are considered by the Australian Securities and Investments Commission (ASIC) to be “add-on” insurance, as the point of sale of the insurance coincides with the primary purpose of a consumer being at a motor dealership to buy (including the financing of) a motor vehicle or for its servicing.

The industry has worked with ASIC to improve product design and sales practices for “add-on” insurance products sold through motor dealer intermediaries, specifically:

- consumer credit insurance (CCI);
- guaranteed asset protection (GAP) insurance;
- loan termination insurance;
- tyre and rim insurance; and
- mechanical breakdown/extended warranty insurance.

Objectives

Code obligation (x)³⁹ requires insurers to have in place product design and distribution policies. These Best Practice Principles are intended to assist Code Subscribers that distribute add-on insurance through the motor dealer channel in meeting this Code obligation. The Principles reflect the industry’s work with ASIC in 2016 and 2017 to improve standards and address issues specific to this channel. As such, the Principles are only applicable to the products listed above, and distributed through the motor dealer intermediaries.

Status of Guidance Documents

This industry guidance document does not have legal force to prescribe binding obligations on individual insurers. While the ICA’s guidance documents are voluntary, they are developed with input from member companies and other stakeholders. The ICA encourages Code Subscribers to use this industry guidance to benchmark their internal processes, procedures and policies.

³⁹ This is a new Code obligation.

Best Practice Principles

- 1. Cover should be designed to meet the likely expectations of the target market(s)**
 - 1.1. Insurers should clearly document:
 - 1.1.1. The categories of consumers within the target market and their characteristics; and
 - 1.1.2. The types of persons, if any, who are outside the target market and their characteristics.
 - 1.2. The target and non-target market can be described in general terms. For example, the target market for a GAP product could be "consumers who are likely to face a shortfall which may be because they fall into a certain broad category – such as:
 - (a) having a large loan with long duration or a loan that has a significant balloon payment,
 - (b) having a deposit below a certain amount,
 - (c) having purchased a vehicle that depreciates rapidly, or
 - (d) a combination of these".Insurers may wish to set thresholds for any of these factors in order to delineate the target market.
 - 1.3. Insurers should articulate the primary benefit(s) that a product intends to deliver. Cover should be designed to meet a genuine need and take into consideration the target market's likely expectations.
 - 1.4. The eligibility of categories of consumers in making a claim on the primary benefit(s) should be considered in determining the target and non-target market(s).
 - 1.5. The product design process should prevent negative value products being offered (i.e. where the total cost to the consumer is more than the maximum amount claimable).
 - 1.6. Where the premium/excess is flexible and negative value could arise in some circumstances, the negative value threshold must be identified and safeguards put in place to prevent sales where it is clear that such circumstances could arise.
 - 1.7. Insurers should conduct testing, where possible, to understand a target market's likely expectations 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 during the sales process.
- 2. The product and its features and exclusions must be capable of being communicated to and understood by the target market**

- 2.1. In designing products, insurers should seek to limit, to the extent possible, the complexity of product features and exclusions.
- 2.2. If some complexity cannot be avoided, insurers should consider what additional steps, including digital and interactive tools, might be necessary to aid consumer comprehension.
- 2.3. Broad references to "peace of mind" should be avoided in sales scripts, focusing instead on concrete benefits and features.
- 3. Insurers should have reasonable controls in place to ensure that the product reaches the target market for whom it is intended**
- 3.1. Insurers should put in place controls to ensure that the product reaches the identified target market.
- 3.2. Insurers should translate the target market and any thresholds for negative value into safeguards to be applied during the sales process to prevent sales to consumers outside of the target market. For example, new systems rules could be created to make it impossible to process a sale where, based on the information provided by the customer, they are ineligible to claim on the primary benefit(s), do not meet any cover-to-premium ratios as determined by the insurer, or otherwise outside the target market.
- 3.3. Insurers should consider how their insurance products may interact when bought by the same consumer and avoid the occurrence of duplicate cover where possible.
- 3.4. Insurers should be aware of the impact of incentives, including commissions or non-remuneration benefits, on sales, and ensure they have adequate controls in place to minimise the risk of inappropriate sales.
- 4. Insurers should set clear expectations about what constitutes good sales practices, and equally what conduct is not acceptable**
- 4.1. Insurers should implement distribution conditions to take into account the behavioural and other factors that can undermine the consumer's ability to make rational or informed decisions.
- 4.2. 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.
- 4.3. Examples of poor conduct include:
 - 4.3.1. 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, and hiding insurance cover in finance contracts.
 - 4.3.2. Misleading or manipulating the consumer 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, or

giving only partial costs (for example, by presenting costs on a monthly basis rather than the total premium, or presenting costs without interest).

- 4.3.3. 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).
- 4.3.4. Poor disclosure such as not disclosing the price of the product at all, or only very late in the sales process, providing unclear descriptions of the product, using jargon and failure to provide Policy Documents.

5. Insurers should provide the necessary training and information to their distributors

- 5.1. Training and information should be designed to enable motor dealer intermediaries to distribute products in line with the insurer's expectations, with regard to any distribution conditions and good sales practices.
- 5.2. 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.

6. Insurers should review product performance and distribution and act promptly on any identified significant concerns

- 6.1. Insurers should have processes in place for monitoring/assessing product performance, such as:
 - 6.1.1. Whether a product is performing in line with objectives, is reaching the target market, and is not being sold to consumers who are not eligible; and
 - 6.1.2. Whether there is unacceptable conduct at the point of sale.
- 6.2. Periodically, insurers might also review a product more broadly against consumers' expectations and needs, and actual outcomes. Such reviews may prompt changes to product design, or indicate that further distribution conditions are required.
- 6.3. Insurers should be able to satisfy themselves that they have effective systems in place to prevent poor conduct at the point of sale, and how they can evidence these are working. Processes should go beyond training and or manuals and should involve insurers proactively monitoring actual adherence to good practices.
- 6.4. Any distribution safeguards should be tested and validated to ensure that they are effective.
- 6.5. Insurers should have processes in place for taking action where concerns are identified with particular distributors or individuals operating within the distributor.

Appendix 5: Draft Standards on the Use of Investigators

Overview

- 1) In a small number of claims, we will determine that further investigation by an internal or external investigator is required. To ensure that investigations are carried out when required and in an appropriate manner, we will:
 - a) explain why your claim is being investigated; provide you, in writing, details of our claims investigations process, how to make a complaint, or how to dispute a decision;
 - b) provide you, verbally and in writing, what our investigations process is and update you as we proceed through that process;
 - c) have your claim independently reviewed under our complaints and disputes process if it has been under investigation for 6 months, and supply you in writing why we have not been able to make a claim decision and what information is outstanding;
 - d) have a quality assurance program in place to review, regularly, investigations carried out, which may include a:
 - i) review of recordings, statements, affidavits 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
 - iv) review of our fraud investigation indicators at least once a year to ensure they remain relevant and appropriate.

Formal interviews

- 2) Where we require formal interviews to be carried out as part of a claim:
 - a) you will be advised before the interview of the following information:
 - i) the purpose of the interview;
 - ii) who will conduct the interview;
 - iii) the expected duration of the interview;
 - iv) that they are acting on our behalf;
 - v) our contact details if you would like to contact us with any questions about the interview or the interviewer;
 - vi) your right to have a legal representative or a support person, who may be a family member, friend or other person, to support you through the interview, including information on their role, such as they may not answer questions on your behalf; and
 - vii) your right to have an interpreter present who may assist you in translating any information conveyed to you and any answers you provide;
 - 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 one 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 as you may be experiencing vulnerability, we will only use an interviewer who we are satisfied has appropriate training or experience to conduct 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 digitally recorded, you will be asked to complete an interview consent form that contains the information contained in the Guide. In circumstances where the interview is digitally recorded, the interviewer will ask you a series of questions covering the information contained in the Guide as part of the interview, for the purpose of confirming your consent;
 - h) if we intend for a minor to be interviewed, or our investigators inform 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 who we are satisfied has appropriate training or experience to conduct 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 be of a maximum duration of two hours, unless both you and the insurer agree to an extension. Further interviews will be organised if it is reasonably required, with a 24-hour break between the interviews;
 - k) if you are identified as experiencing vulnerability, we will provide you with a five-minute break every 30 minutes during the interview; otherwise we will offer breaks every 30 minutes during the interview. You can request additional breaks, as well as stop the interview early and reschedule if needed; and
 - l) a transcript of the interview (or a digital copy of the recorded interview) can be provided to you if requested, although we will provide you with a copy of your interview prior to any further interviews that may need to be conducted.

External investigators

- 3) If we engage an external investigator to assist us with your claim, we will require that:
 - a) written instructions be provided to any external investigators that we engage, and we will confirm in writing any changes to our instructions
 - b) 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;
 - c) the investigator complies with any relevant State and Territory legislation;
 - d) the investigator must not exceed our written instructions without our prior consent;
 - e) 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;
 - f) the investigator only collects information relevant to their investigation;
 - g) the investigator does not make any threat, promise or inducement to any person when conducting an investigation on our behalf;
 - h) the investigator acts in accordance with the standards relating to interviews and surveillance below; and
 - i) records of all investigation activities are kept in accordance with the requirements of the Privacy Act 1988 (Cth).

Surveillance

- 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 will 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.

GUIDE

Interview consent form

Interviewer's name and contact details:

Insurer's details:

Interviewee's name and contact details:

Date:

Subject matter of interview:

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:

Appendix 6: Details of stakeholder workshops

Code Review Workshops

20 February 2018	Strengthening standards relating to Third Party distributors
20 February 2018	Internal complaints process
27 February 2018	Product design and distribution
13 March 2018	Mental health guidance
13 March 2018	Industry data collection
26 March 2018	Mental health guidance

ICA Working Group Workshops

4 April 2018	Vulnerable Consumers sub-working group
10 April 2018	National Code Committee
11 April 2018	National Code Committee
12 April 2018	Family Violence Working Group
18 April 2018	National Code Committee
7 June 2018	Family Violence Working Group
14 June 2018	IDR/EDR Working Group