GENERAL INSURANCE
Code Governance Committee

Submission on the redrafted Code

Introduction

The General Insurance Code Governance Committee (Committee) independently monitors and enforces compliance with the General Insurance Code of Practice.

The Committee welcomes the opportunity to comment on the redrafted General Insurance Code of Practice and draft Code Governance Committee (CGC) Charter.

Financial services industry codes help lift standards, improve customer outcomes and maintain confidence in industry self-regulation.

The Committee plays a central role in the operation of the Code by:

- monitoring insurers' compliance with the Code
- investigating alleged and reported Code breaches
- deciding whether breaches have occurred and what corrective action is required
- imposing sanctions where appropriate
- identifying systemic and emerging issues, and
- promoting better industry practice.

Executive summary

The Committee recommends significant changes to the redrafted Code and draft CGC Charter ahead of finalisation by the Insurance Council of Australia (ICA).

At a minimum, the ICA should adopt the Committee's priority recommendations. Without these changes, the Code would not meet community expectations or reflect best practice and will be a step back from current commitments.

The proposed governance arrangements may not meet the Australian Securities and Investments Commission's (ASIC) requirements for an approved code, placing approval of the Code at risk.

The Committee supports contractual enforceability and welcomes several important new commitments. These include broader recognition of vulnerability, the new Vulnerability Framework, stronger protections for customers experiencing family and domestic violence, trauma-informed care and higher standards for expert reports.

Many other proposed changes would however weaken existing customer protections, reduce insurer accountability and limit the independent oversight that makes the Code effective.

In particular, the redrafted Code and draft CGC Charter in their current state would:

- limit support for customers experiencing vulnerability to what an insurer is "able to provide", rather than require support appropriate to the customer's individual circumstances
- restrict independent oversight by limiting the ability of the Committee to investigate breaches, impose sanctions, interpret the Code objectively and monitor compliance
- remove the current enforceable commitment for insurers to act honestly, efficiently, fairly, transparently and in a timely manner
- allow insurers to meet certain obligations by instructing a third party, without requiring them to ensure the third party delivers the promised outcome, and
- delay important customer protections through a proposed 24-month transition period.

Together, these changes would undermine the effectiveness of the Code and weaken industry self-regulation.

Contractual enforceability should not reduce existing protections or weaken independent monitoring and enforcement.

A revised Code should strengthen the commitments insurers make to customers and the framework that holds them accountable.

The Committee has made **ten Priority Recommendations** to address the most significant issues in the redrafted Code and draft CGC Charter.

The Committee recommends that the redrafted Code and draft CGC Charter:

- require insurers to provide appropriate support to customers experiencing vulnerability
- preserve effective and independent monitoring and enforcement
- maintain clear and enforceable standards for customer treatment
- hold insurers accountable for services delivered on their behalf
- introduce stronger customer protections without unnecessary delay, and
- maintain standards and accountability consistent with comparable financial services industry codes of practice.

These priority recommendations represent the minimum changes needed to preserve effective customer protection and accountability under the Code.

The Committee's recommendations extend beyond the priority issues outlined above. The **Further Recommendations** would improve the clarity and operation of the Code, address gaps and inconsistencies, support effective compliance and help industry respond to emerging risks and changing community expectations.

The Committee recommends that its Priority and Further Recommendations be adopted in full to strengthen the Code, lift industry standards, improve accountability and build confidence that insurers will meet their commitments.

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Summary of Priority Recommendations

The Committee recommends that the ICA make **ten priority changes** before finalising the Code and Charter. In addition, we have included a list of Further Recommendations on page 13.

Recommendations	Change required
1.Strengthen support for customers experiencing vulnerability	Revise paragraph 139 of the Code and the definition of Extra Care to require insurers to provide appropriate and reasonable support based on each customer's circumstances.
2. Increase First Nations protections	Include requirements for insurers to better identify First Nations customers, to follow Australian Transaction Reports and Analysis Centre (AUSTRAC) guidance on flexible identification procedures, and to provide dedicated resources including information about available support.
3. Preserve the Committee's investigation powers	Revise clause 5.3(a) of the CGC Charter so reporting a matter to a regulator or court does not automatically prevent the Committee from investigating or deciding whether an insurer has breached the Code.
4. Preserve effective sanctions	Remove the restrictions on sanctions where another body has "considered" a matter, and to only imposing sanctions for Significant Breaches of the Code.
5. Preserve independent interpretation of the Code	Remove provisions that require the Committee to give effect to the ICA's drafting intent. Any consultation on interpretation should occur only where appropriate and should not bind the Committee.
6. Require systems that support compliance monitoring and continue reporting all Code breaches	Reinstate the requirement for insurers to maintain systems and processes that enable the Committee to monitor compliance with the Code. Limit the exclusion in clauses 1.4(c) and 4.1(c) of the CGC Charter to complaints data that ASIC already collects and publishes. Insurers should continue to report on Code commitments that go beyond those requirements.
7. Retain enforceable standards of conduct	Retain an enforceable obligation requiring insurers to act honestly, efficiently, fairly, transparently and in a timely way in all dealings with customers.

Recommendations	Change required
8. Strengthen accountability for third parties	Amend all relevant third-party provisions to require insurers to deliver services to a particular standard, in addition to any instruction provided to third parties.
9. Provide greater protection for small businesses	Remove all restrictions based on wholesale insurance products from the Code and make all relevant protections under the Code available to small business customers.
10. Reduce the transition period	Commence the new Code as soon as reasonably practicable. Allow more time only for specific amendments to the Code where industry provides clear evidence it is needed.

Detailed recommendations

This section explains the Committee's priority recommendations and identifies the provisions the ICA should amend before finalising the Code and Charter.

Recommendations 1: Strengthen support for customers experiencing vulnerability

We are concerned that, despite introducing a range of positive amendments for customers experiencing vulnerability, the redrafted Code weakens the central enforceable obligation requiring insurers to provide additional support to those customers.

As drafted, the Code would limit support to what an insurer is *able* to provide, rather than requiring insurers to provide support that is appropriate to a customer's individual circumstances (see our analysis of paragraph 139).

This represents a significant shift in the purpose of the Code. Supporting customers experiencing vulnerability is not an additional customer service offering that insurers may provide where they are able. It is a fundamental consumer protection.

A Code of Practice should set a clear minimum standard that every insurer must meet and support continual improvement across the industry. Customer protections should not depend on an individual insurer's operational capability or discretion.

The redrafted Code in its current state, will undermine many of its positive improvements unless it includes a strong, enforceable commitment requiring insurers to provide appropriate support to customers experiencing vulnerability.

While the proposed Vulnerability Framework, broader definition of vulnerability, enhanced family and domestic violence protections and commitments to trauma-informed care are all welcome, they ultimately depend on an enforceable obligation that requires insurers to respond appropriately to customers' needs. Without that foundation, the practical value of these amendments is diminished.

Limiting the support insurers are required to provide would represent a significant step back from existing protections and is inconsistent with other comparable financial service industry

Codes of Practice. Both the Banking Code of Practice (2025) and Life Code of Practice (2025) include broad commitments to support customers experiencing vulnerability without an equivalent restriction.

The proposed definition of 'Extra Care' risks undermining the positive improvements the redrafted Code introduces to protect and support customers experiencing vulnerability. The ICA's Vulnerability Framework cannot achieve its purpose without an overarching and enforceable commitment to provide support based on customers' needs.

For these reasons, paragraph 139 and the definition of extra care must be revised to guarantee appropriate and reasonable support for customers experiencing vulnerability, consistent with the guidance set out in the Vulnerability Framework.

Recommendation 1

The Committee recommends that the ICA revise paragraph 139 and the definition of Extra Care to require insurers to provide appropriate and reasonable support based on each customer's circumstances.

The protection available to a customer should not depend on the capability or discretion of their insurer.

Recommendation 2: Increase First Nations protections

The redrafted Code does not go far enough in its commitments to support First Nations customers.

The redrafted Code includes important commitments to require employees to receive cultural awareness training, and to have policies to provide culturally appropriate support to First Nations customers. These new commitments are welcomed.

However, we are concerned that customers will not be able to access this support if they are not identified. Insurers should be required to ask customers if they identify as Aboriginal and/or Torres Strait Islander, consistent with AUSTRAC guidance and recommendations by the Code Review. Doing so in an appropriate and culturally sensitive way, and seeking consent to retain this information, helps insurers identify when greater flexibility is required and enables these customers to receive tailored supports.

The redrafted Code commits to having processes in place to reduce barriers that First Nations customers may face in obtaining standard forms of identification by supporting non-standard identification methods.

However, insurers should act in accordance with AUSTRAC's guidance on alternative identification procedures for First Nations customers. The Code should commit insurers to follow this guidance, consistent with recommendations from the Code Review and other comparable financial service industry Codes of Practice. Both the Banking Code of Practice (2025) and Life Code of Practice (2025) commit to following the AUSTRAC guidance in providing flexibility.

To improve access to support, and to relevant information, the Code should require insurers to provide dedicated resources which are easy to find and address the needs of First Nations customers.

Recommendation 2

The Committee recommends that the Code should require insurers to:

- ask customers whether they identify as First Nations people, in a respectful, sensitive and culturally appropriate manner, and to seek their consent to record this information, so that appropriate support measures can be made available
- follow the AUSTRAC guidance on alternative identification procedures for First Nations customers
- provide dedicated resources for First Nations customers, including information about available support, that is easy to find, understand and apply.

Recommendations 3–6: Preserve the independent accountability framework that underpins the Code

The Code establishes the standards of conduct insurers commit to upholding. Independent oversight and monitoring of that Code ensure that industry is held accountable to its commitments and that action is taken where insurers fall short of those standards.

The Committee recommends that the ICA revise the redrafted Code and draft CGC Charter to preserve the current independent oversight, monitoring powers and access to information.

In particular, the ICA should:

- allow the Committee to investigate matters reported to a regulator or raised in another proceeding where it remains reasonable and appropriate to do so (see our analysis of clause 5.3(a) of the CGC Charter)
- remove the restrictions that limit sanctions to Significant Breaches and prevent sanctions where a regulator or court has "considered" a matter (see our analysis of paragraph 204 of the Code)
- preserve the Committee's authority to interpret and apply the Code independently (see our analysis of clause 5.4(d) of the CGC Charter)
- retain reporting requirements for Code obligations that extend beyond the information ASIC collects and publishes (see our analysis of clauses 1.4(c) and 4.1(c) of the CGC Charter)
- require insurers to maintain systems and processes that enable effective compliance monitoring (see our analysis of paragraph 199 of the Code).

These changes are necessary because the proposed provisions would substantially weaken the Committee's ability to enforce the Code.

The draft CGC Charter would automatically prevent investigation of a matter once it has been reported to a regulator or becomes subject to another proceeding. This would apply even if the regulator does not investigate, takes no action or does not consider whether the insurer breached the Code.

The Committee supports avoiding unnecessary duplication. However, the current framework already allows for consideration as to whether another body is better placed to deal with a matter and whether further action is reasonable.

The proposed restrictions on sanctions are also unworkable as written. The redrafted Code would only allow sanctions for Significant Breaches and would prevent sanctions where a regulator or court has considered the matter. As the Committee must report every Significant Breach to ASIC, these provisions could effectively prevent any sanctions being imposed.

The redrafted Code and draft CGC Charter would require the ICA's drafting intent to guide interpretation of the Code. While the ICA's views may provide useful context, they should not determine the outcome. Decision-makers should interpret the Code objectively, based on its wording, purpose and the commitments it makes to customers. This would support consistent decisions and maintain confidence in the independence of the oversight framework.

In addition, the Code is part of the agreement between customers and insurers so must be sufficiently clear so that customers understand what the agreement means in practice.

The proposed reporting and monitoring changes would also create gaps in oversight. Limiting information about complaint-related breaches and removing the requirement for insurers to maintain systems that support compliance monitoring would make it harder to identify repeated breaches, emerging risks and areas where industry practice needs to improve.

Taken together, the proposed changes could allow breaches to go undetected or unresolved. Affected customers may not receive appropriate remediation, and broader industry issues may continue until a regulator, court or individual customer takes action.

The proposed arrangements may also fall short of ASIC's expectation that the independent body responsible for an approved code is adequately empowered to administer and enforce it, as set out in RG 183.47.

ASIC approval and contractual enforceability should strengthen the Code, consistent with the recommendations of the Parliamentary Flood Inquiry. They should not come at the cost of the independent monitoring and enforcement framework that gives the Code practical effect.

A reduction to the independent accountability framework would be a substantial step backwards in consumer protections and place a greater burden on customers to hold insurers accountable. The changes are also inconsistent with the oversight and monitoring arrangements for other comparable financial service industry Codes of Practice, including the Banking Code of Practice (2025) which is also contractually enforceable.

For the reasons outlined above, the limitations introduced in the redrafted Code and draft CGC Charter must be removed to ensure effective independent oversight and enforcement of the Code.

Recommendation 3

The Committee recommends that the ICA revise clause 5.3(a) of the CGC Charter to require the Committee to consider what is reasonable and appropriate when a matter has been reported to a regulator or is subject to another proceeding.

The clause should not automatically prevent the Committee from investigating or deciding whether an insurer has breached the Code.

Recommendation 4

The Committee recommends that the ICA revise paragraph 204 of the Code to:

- remove the restriction to only impose sanctions for a Significant Breach of the Code
- remove the restriction preventing imposing sanctions for breaches considered by a regulatory body or court
- ensure consistency on the factors that the Committee must consider between the Code and clause 6.1(b) of the draft CGC Charter.

The Charter should instead require the Committee to consider any active regulatory investigation or court proceeding when deciding whether and how to act, consistent with clauses 5.2(c) and (f).

Recommendation 5

The Committee recommends that the ICA remove the provisions that require the Committee to give effect to the ICA's drafting intent. The Code should be written such that this intent is sufficiently clear so that its meaning is understood by customers.

Any requirement to consult on interpretation should apply only "as appropriate" and should preserve the Committee's authority to decide independently whether an insurer has complied with the Code.

Recommendation 6

The Committee recommends that the ICA:

- revise paragraph 199 of the Code to reinstate the current requirement for insurers to maintain systems and processes that enable the Committee to monitor compliance
- limit the exclusion in clauses 1.4(c) and 4.1(c) of the CGC Charter to complaints data that ASIC already collects and publishes.

Insurers should continue to maintain appropriate systems and processes to enable effective monitoring and report on compliance with all Code commitments.

Recommendation 7: Retain enforceable standards of conduct

The Committee recommends that the ICA retain an enforceable obligation requiring insurers to act honestly, efficiently, fairly, transparently and in a timely manner in all dealings with customers.

Paragraph 21 of the current 2020 Code requires insurers to meet these standards. This overarching obligation sets a clear baseline for customer treatment and allows the Code to continue to meet evolving community expectations of fairness. It also helps clarify for customers what insurers needs to do to comply with legislation, consistent with ASIC's expectations of an effective code (RG 183.4(c))

The redrafted Code moves many of these standards into the Industry Principles. However, the draft states that the principles are guidance only and cannot be enforced.

This would reduce accountability and create gaps in the Code. Conduct could fall short of the standards insurers have committed to uphold, and of what customers reasonably expect, without amounting to a breach.

These standards are not simply aspirations. They describe the basic conduct customers should expect from every insurer. Making them enforceable also helps identify and address emerging problems that may not yet be covered by a detailed Code obligation.

Comparable financial services codes retain enforceable overarching standards. For example, the Banking Code of Practice requires banks to provide banking services efficiently, honestly and fairly.

Insurers are already required to meet these standards under the current Code. The introduction of a new Code should not reduce that obligation. If the Industry Principles describe how insurers intend to treat customers, the Code should make them enforceable.

The ICA should retain the existing overarching commitment and ensure the Industry Principles can be enforced.

Recommendation 7

The Committee recommends that the ICA retain an enforceable overarching obligation requiring insurers to act honestly, efficiently, fairly, transparently and in a timely way in all dealings with customers.

The ICA should also consider making other Industry Principles enforceable where they describe standards that insurers publicly promise to meet.

Recommendation 8: Strengthen accountability for third parties

The Committee supports paragraph 25, which states that insurers are responsible when third parties acting on their behalf breach the Code.

This is important because customers contract with their insurer, not with the investigators, builders, assessors, repairers or other suppliers the insurer appoints. Customers should receive the same protections under the Code regardless of who delivers the service.

However, many of the individual commitments in the redrafted Code do not support this principle.

In several places, the Code only requires insurers to instruct, tell or require a third party to do something (including paragraphs 69, 98, 101, 116, 117, 124, 178, 182, 184-186, and 191).

Once the insurer gives that instruction, it may have met its obligation, even if the third party does not follow it and the customer does not receive the intended protection.

For example, paragraph 117(a) requires an insurer to instruct an investigator to limit an interview to 90 minutes. As drafted, the insurer may comply by giving the instruction, even if the interview lasts longer.

Paragraph 182 creates a similar problem. It requires certain third parties to tell customers that they are acting on the insurer's behalf. However, the Code does not directly bind those third parties and does not clearly require the insurer to ensure this happens.

This creates a gap between what the Code promises and what customers receive.

The Code includes broader requirements for insurers to oversee third-party performance, but these do not fix the problem in the individual commitments. Customers may still be affected before poor performance is identified or addressed.

This matters because insurers use third parties to deliver many important services, including investigations, repairs, expert reports, assessments and claims fulfilment.

Insurers may outsource services, but they should not be able to outsource responsibility. This is consistent with ASIC's guidance (RG 104) and the findings of the Parliamentary Flood Inquiry.

The ICA should revise all relevant provisions so insurers must ensure that third parties deliver the standards and outcomes required by the Code. Insurers should remain responsible for monitoring performance and addressing failures.

This would give effect to paragraph 25 and ensure customers receive the same protection, regardless of who performs the work.

Recommendation 8

The Committee recommends that the ICA amend all relevant third-party provisions so that insurers commit to deliver services to a particular standard, in addition to any instruction provided to third parties.

Recommendation 9: Provide greater protection for small businesses

The redrafted Code remains extremely limited in the protections it provides for small businesses.

The Committee is concerned that the redrafted Code provides limited protection for small business customers. Small businesses often lack the expertise and resources to navigate complex insurance arrangements and operate much closer to retail consumers, especially when purchasing policies directly from an insurer or underwriting agency.

The protections afforded by the Code are determined by product type (retail versus wholesale), not based on the customers circumstances and needs.

The redrafted Code excludes small businesses with wholesale insurance products from all protections relating to buying insurance (Section 2), cancelling an insurance policy (Section 3), making a claim (Section 4), and vulnerability (Section 7). These sections of the Code offer important consumer protections that should be available to small businesses, irrespective of the type of insurance product.

The Code should apply to individuals and small businesses irrespective of product types, consistent with recommendations by the Code Review. We recommend removing restrictions based on wholesale insurance products and making all relevant protections under the Code available to small business customers.

Recommendation 9

The Committee recommends that the ICA remove all restrictions based on wholesale insurance products from the Code, and to make all relevant protections under the Code available to small business customers.

Recommendation 10: Reduce the transition period

The Committee recommends that the ICA shorten the proposed 24-month implementation period.

Many of the proposed changes respond to longstanding issues identified through the Committee's inquiries and compliance monitoring, ASIC's regulatory work and the Parliamentary Flood Inquiry following the 2022 floods. These issues have already been examined through years of investigation, consultation and public scrutiny. The priority should now be implementation.

The current Code commenced in July 2021 and requires an independent review at least every three years to support continual improvement. If the new Code does not commence until late 2028 or early 2029, some amendments may not take effect until almost eight years after the current Code began and at least four years after the underlying problems were widely and publicly identified.

This would undermine the purpose of the review process. Code reviews should ensure industry standards respond promptly to emerging risks, evidence of customer harm and changing community expectations. Once stronger protections have been identified and agreed, industry should introduce them without unnecessary delay.

The Committee recognises that some complex amendments may require more time to implement. However, the ICA has not provided sufficient evidence to justify a blanket 24-month transition period for the entire Code.

A more targeted approach would allow additional time for amendments that can be demonstrated as involving significant operational change while bringing other protections into effect sooner. This would avoid unnecessarily delaying benefits for customers and would be more consistent with the implementation of comparable financial services codes, including those that introduced contractual enforceability.

Recommendation 10

The Committee recommends that the new Code commence as soon as reasonably practicable, with straightforward amendments implemented immediately, and all others within 12 months.

Where specific amendments genuinely require additional implementation time, insurers should provide a clear evidence-based justification, and those amendments should be supported by targeted transitional arrangements rather than delaying the commencement of the Code as a whole.

Further Recommendations

This section explains the Committee's Further Recommendations and identifies provisions requiring further consideration, amendment and improvement before the Code and Charter are finalised.

These recommendations are not optional refinements. They address substantive gaps and weaknesses that could affect the clarity, operation and effectiveness of the Code, and the industry's ability to demonstrate meaningful compliance.

Further Recommendations	
11.	Revise paragraph 15 to commit to using "best endeavours" to use a customers preferred communication channel
12.	Revise paragraphs 23(c) and 32 to make it clear to customers when the insurer is liable
13.	Reinstate the commitment by insurers to comply with obligations and binding standards introduced to the Code by the ICA
14.	Revise paragraph 39(a) to require renewal notices to be provided at least 28 calendar days before policy expiry
15.	Revise the Code to provide clarity on the support insurers can provide to customers who require assistance maintaining premium payments
16.	Revise paragraph 62 to remove the qualification "if your claim requires one" or otherwise narrow this exception
17.	Revise paragraph 72 to require insurers to monitor external experts' compliance with all relevant obligations
18.	Revise paragraph 76(a) to clarify that it cannot be applied in cases of operational delays and introduce a commitment by insurers to take reasonable steps to reduce the likelihood of delays
19.	Revise paragraph 60 to include a commitment by insurers to explain in writing how agreeing to an alternative timeframe may affect the customer's right to automatic acceptance of their claim
20.	Reinstate the commitment by insurers to allow customers to request a reassessment of their loss where the claim is finalised within 1 month of a Catastrophe event
21.	Revise paragraphs 96 and 97 to clarify when exceptions can be relied upon and how their use will be assessed
22.	Revise paragraph 118 to avoid implying that the independent interpreter is a support for the customer
23.	Revise paragraph 129 to require insurers to review non-genuine claim indicators at least annually

Further Recommendations	
24.	Revise paragraph 130 to clarify what the commitment to comply with RG 271 means for customers and what they can expect
25.	Revise paragraph 135 to specify the timeframe that customers can expect to be informed about the progress of their complaint in the first 30 days
26.	Revise paragraph 136 to include a commitment requiring insurers to tell customers when they can expect to receive an outcome for their complaint
27.	Revise paragraph 141 to require insurers to provide support in accordance with the principles of the ICA's Guidance on Vulnerability, and to develop systems, processes and training to enable this
28.	Revise paragraph 167 to include a commitment by insurers to encourage customers to seek additional time if required and to work flexibly with customers applying for financial hardship
29.	Revise paragraph 171 to require insurers to work collaboratively with customers in agreeing to the debt owed as part of the bankruptcy process
30.	Introduce a commitment that requires insurers to regularly review the effectiveness of their support for customers experiencing vulnerability and financial hardship
31.	Revise the introduction to Section 9 to remove the reference to insurers' preferred network in relation to skilled trades
32.	Revise paragraph 180 to require insurers to have policies, procedures and effective systems to monitor the compliance, conduct and performance of representatives
33.	Revise paragraph 197(b) and (f), and the equivalent clauses 1.2(b) and (g), to remove the restriction to alleged breaches that are serious and systemic
34.	Revise the definition of Significant Breach to clarify that not all factors need to be present for a breach to be considered significant
35.	Revise clause 1.2 and paragraph 197 of the redrafted Code so that the CGC's responsibilities remain consistent between the two documents
36.	Revise clause 5.1(a) to make clear that the Committee may commence an investigation when a subscriber reports a Significant Breach of the Code
37.	Revise all relevant parts of clauses 5.2-5.5 and 11.1 to clarify they apply to actual or alleged breaches of the Code, not just alleged breaches
38.	Revise paragraph 6.2(c) to make clear whether the information shared with the ICA should identify the Code Subscriber
39.	Revise clause 8.1(b) to specify that the ICA's CEO and AFCA's Chief Ombudsman will determine whether a complaint concerning the CGC should be referred to an independent party, and if so, to then appoint that independent party for this purpose.

Further Recommendations	
40.	Develop a clear framework for regular reviews of the CGC, in accordance with clause 11.5
41.	Correct the errors in the definitions included in clause 12
42.	Introduce a clause into the draft CGC Charter that clarifies how decisions will be made on the CGC budget, and how consumer representatives will be involved in this process.

Appendix A: Supporting analysis for Priority Recommendations

This section provides further analysis and evidence supporting the Priority Recommendations. It examines specific provisions, explains their implications and sets out the basis for the recommendations above.

Paragraph 139 – Commit to providing support based on the needs of customers experiencing vulnerability

> ***Paragraph 139 of the redrafted Code***
>
> *We will provide you with Extra Care that we have agreed with you, if you tell us or we have identified that you are experiencing Vulnerability.*

Currently, all insurers commit to taking extra care with customers experiencing vulnerability (paragraph 91 of the 2020 Code), without qualifying or limiting what additional support will be provided., The redrafted Code does not include an equivalent broad obligation. Instead, paragraph 139 requires insurers to provide *Extra Care* agreed with the customer:

The redrafted Code defines *Extra Care* as:

> *The additional support or flexibility we are able to provide, if you are an individual, to assist you while you are experiencing Vulnerability.*

In combination, these would mean that the support that is offered is determined by what the insurer is able to provide, not what the customer needs. In effect, some customers experiencing vulnerability may receive less support than they are guaranteed under the current Code. If an insurer is not set up to provide certain kinds of support, irrespective of customers' actual needs, it may still comply with its obligations in the Code.

Clause 5.3(a) – Remove restrictions on investigating matters reported to another regulator

> ***5.3 Matters outside the scope of CGC's investigation powers***
>
> *(a) If a Code Subscriber notifies the CGC that:*
>
> *(i) the alleged conduct has been subject to a breach report to another regulator (e.g. ASIC, APRA, ACCC, OAIC);*
>
> *(ii) a regulator has commenced an investigation; or*
>
> *(iii) there are alternative proceeding underway, such as court proceedings,*
>
> *the CGC will not, or cease to, investigate or make a determination on the alleged breach.*

Clause 5.3(a) of the draft CGC Charter requires the Committee to stop, or not commence, an investigation when the alleged conduct has been reported to a regulator, a regulator is investigating, or alternative proceedings are underway.

However, reporting a matter to a regulatory body does not mean that action has or will be taken by that regulator, or that the matter has been considered with respect to Code

obligations. By introducing this requirement, the Committee is prevented from investigating and acting where serious issues have occurred, as these will almost always result in reporting to a regulator.

A similar issue currently exists in the Life Code Compliance Committee Charter, where the Life Code Compliance Committee cannot apply one of its sanction powers (Community Benefit Payment) in circumstances where the subscriber has reported the matter to ASIC (clause 8.4(b)). For this reason, the power has never been used, as any situation sufficiently serious to warrant the use of the sanction power has already been reported to a regulator. Appropriately, the recent Life Code independent review recommended removing this restriction.

There is also ambiguity as to how this obligation would interact with clause 5.6 of the CGC Charter which requires the Committee to report all Significant Breaches and serious misconduct to ASIC. Interpreted broadly, the CGC could not investigate any Significant Breach of the Code, as these are automatically reported to a regulator.

Given the restriction applies to all Committee investigations, it has the potential to significantly undermine the Committee's ability to enforce the Code and for industry to self-regulate by managing and addressing serious failures through the Code.

It is reasonable to require the Committee to cease investigating matters currently under investigation by a regulator or where alternative proceedings are underway. However, the Committee must still be able to consider these matters after the conclusion of any regulatory investigation or alternative proceeding, taking the outcome of these into account, to ensure all Code obligations have been sufficiently met and Code breaches addressed.

We recommend revising clause 5.3(a) to require the Committee to consider what is reasonable and appropriate when a matter has been reported to a regulator, consistent with its responsibilities in clause 1.2(c), and to not investigate matters currently under investigation by another forum, such as a regulator or court.

In addition, we recommend introducing a requirement in the draft CGC Charter, equivalent to 5.1(c) of the Banking Code Compliance Committee, that would allow the Committee to investigate allegations heard by another forum, without reopening the finding of fact made by another forum:

- if the other forum has not determined whether a Code breach has occurred, inquire whether a breach of Code has occurred; or
- if the other forum has determined a breach of Code has occurred, inquire on the severity, seriousness and systemic nature of the allegation and the adequacy of the Subscriber's rectification and remediation actions, so as to avoid repeat occurrences.

Paragraph 204 – Remove new restrictions on imposing sanctions

Paragraph 204 of the Redrafted Code

The Code Governance Committee may impose sanctions on us for a Significant Breach of the Code unless that breach is being, or has been, considered by another regulatory body or court. When determining any sanctions to be imposed, the Code Governance Committee will consider:

(a) the intent of the Insurance Council of Australia in drafting and including the Code provisions;

(b) the appropriateness of the sanction;

(c) if we have not acted on – or have taken too long to act on – a request from the Code Governance Committee to remedy a breach;

(d) if we have breached an undertaking we gave to the Code Governance Committee;

(e) if we have not taken adequate steps to prevent a Significant Breach from reoccurring;

(f) if we have not acted reasonably.

Paragraph 204 of the redrafted Code restricts sanction to only be imposed for Significant Breaches of the Code. This would be a step back from existing commitments, and conflicts with paragraph 206, which distinguishes which sanctions may be applied for any breach of the Code, and which may only be applied for Significant Breaches.

Paragraph 204(a) of the redrafted Code prevents sanctions from being imposed where the breach is "considered" by a regulatory body or court.

However, the consideration of a matter by a regulatory body does not mean that action has been taken, or that the matter has been considered with respect to Code obligations. Further, the meaning of "considered" is unclear, and could be interpreted to apply to any matter reported to a regulator.

Finally, it is expected that ASIC or another regulatory agency would assess a matter as to whether it amounted to a breach of a legislative obligation, and if the regulatory agency is not satisfied that the legislative obligation has been breached it should still be open to the CGC to determine whether there has been a breach of a Code obligation.

In effect, paragraph 204 of the redrafted Code would prevent sanctions from being imposed for any matter reported to a regulator, including all Significant Breaches, as these are reported to ASIC by the Committee in accordance with clause 5.6 of the draft CGC Charter.

In combination with the limitation to only impose sanctions for Significant Breaches, this requirement would effectively mean no insurer could ever be sanctioned for any breach of the Code.

For these reasons, we recommend removing the restriction to only impose sanctions for a Significant Breach of the Code to maintain the existing accountability framework and to ensure consistency with other parts of the Code.

In addition, we recommend removing the restriction in paragraph 204(a), and instead applying our recommendations on clause 5.3(a) to introduce new commitments in the Charter outlining how the Committee considers matters heard by another forum.

Lastly, the factors the Committee must consider, as set out in paragraph 204, differ from those in clause 6.1(b) of the draft CGC Charter. We recommend revising these factors to ensure consistency between the Code and Charter.

Clause 5.4(d) and other related provisions – Remove requirements to conform to the ICA's intent in drafting Code provisions

> ***5.4 Process for considering alleged Code breaches***
>
> *(d) A Code Subscriber may request, or the CGC may determine, that engagement with the Insurance Council is warranted on interpretation of Code provision(s) subject to the investigation. Where a Code Subscriber requests such engagement, the CGC must reasonably consider this request and provide sufficient time for this engagement prior to reaching any determination on the interpretation of a Code provision. In making a decision, the CGC must take into account evidence presented by the Code Subscriber and/or the Insurance Council of the intent of the Insurance Council in drafting and including the Code provision in the Code. The CGC must ensure that any interpretation adopted, and any resulting determination, is consistent with and gives effect to that intent.*

Clause 5.4(d) of the draft CGC Charter allows insurers to engage with the Committee on the interpretation of Code provisions, and to present evidence of the "intent of the Insurance Council of Australia in drafting and including the Code provision". Further, it requires the Committee to ensure any determination it makes is consistent with this intent.

Paragraph 197(c) of the Code also require the Committee to consult with the ICA to understand this intent, and paragraph 204(a) requires the Committee to consider this intent when imposing sanctions.

In combination, these requirements have the potential to significantly undermine the independent accountability framework that underpins the Code.

The Code forms part of the agreement insurers have with customers and must be used and understood by those customers. If evidence of the intent of the ICA is required to clarify how the Code provision should be interpreted, then that Code provision is not sufficiently clear to customers.

When courts consider consumer contracts, they aim to give effect to the presumed intention of all parties to the contract and consider how a reasonable person would interpret and understand any language in the contract. By allowing insurers to present evidence of their intent to the Committee, the Committee may be required to interpret Code provisions differently than the courts. This creates a situation where customers may only be able to enforce certain requirements under the Code through the courts, as opposed to being enforceable by the Committee.

These requirements also undermine the efficacy of the current public consultation on the Code. If the intent of Code provisions is not sufficiently clear to stakeholders, it is not possible to provide effective feedback on the implications of those provisions taking effect.

We recommend removing all requirements that give effect to the ICA's drafting intent. In addition, any consultation on interpretation of the Code should occur only where appropriate and should not bind the Committee.

Clauses 1.4(c) and 4.1(c) – Continue reporting Code compliance relating to complaints not otherwise published by ASIC

Clause 1.4(c) of the draft CGC Charter

The CGC is also responsible for:

(c) publishing an annual public report containing aggregate industry data and consolidated analysis on Code compliance (with the exception of Section 6 of the Code on complaints); and

Clause 4.1(c) of the redrafted Charter

Monitoring and information gathering

The CGC is responsible for monitoring and enforcing compliance with the Code in the manner set out in this Charter. Without limiting the CGC's Code functions and powers, the CGC may for the purposes of monitoring compliance with the Code:

(c) request each Code Subscriber to lodge an annual data return and survey reporting on their compliance with the Code (excluding compliance with Section 6 of the Code on complaints)

Clauses 1.4(c) and 4.1(c) of the draft CGC Charter relate to the Committee's responsibility to collect compliance data from subscribers annually and publish this in a public report. These clauses now include an exception for reporting compliance with Section 6 of the redrafted Code on complaints.

We recognise the need to avoid duplicating ASIC's collection and publication of insurer complaints data, in relation to compliance with RG 271. However, by excluding all of Section 6, insurers would not be required to report on their compliance with paragraphs 131-137 of the redrafted Code, which include commitments that go above and beyond the law relating to complaints handling, outcomes, and management by service suppliers. This information is not otherwise collected or published by ASIC.

For this reason, we recommend limiting the exemption in clauses 1.4(c) and 4.1(c) to only include information about complaints breaches that is otherwise collected and published by ASIC.

Paragraph 199 – Maintain commitments to have systems and processes to enable the monitoring of Code compliance

Paragraph 199 of the redrafted Code

We will prepare an annual compliance report to the Code Governance Committee on our compliance with the Code.

Paragraph 199 of the redrafted Code removes the previous requirement, under paragraph 180 of the current 2020 Code, to:

> *have appropriate systems and processes in place to enable the Code Governance Committee to monitor our compliance with the Code*

This commitment is essential to allow for effective independent compliance monitoring and to maintain trust in the integrity of the Code. Without appropriate systems and processes to enable monitoring of compliance, it is unclear how insurers will be held accountable for their commitments under the Code.

For these reasons, we recommend reinstating the commitment, as set out in paragraph 180 of the 2020 Code.

Appendix B: Supporting analysis for Further Recommendations

This section provides further analysis and evidence supporting the Further Recommendations. It examines specific provisions, explains their implications and sets out the basis for the recommendations above.

Section 1 – Code overview

Paragraph 15 – Commit to using customers preferred communication channels

> ***Paragraph 15 of the redrafted Code***
>
> *We will communicate with you in plain language using various communication channels, which may include the following:*
>
> *(a) in person, by telephone or video conference;*
>
> *(b) In Writing; or*
>
> *(c) by any other method agreed with you.*

Paragraph 15 commits insurers to using various communication channels, but does not commit to using the customer's preferred communication channel(s), except for customers experiencing vulnerability or financial hardship (paragraphs 145 and 161 of the redrafted Code)

The Parliamentary Flood Inquiry recommended "insurers be required to accommodate the preferred communication channel nominated by a policyholder" (PFI-34) during the claims processing period for claims during major natural disasters, not just for customers experiencing vulnerability or financial hardship. While it is not always possible to use a customer's preferred communication channel, insurers should endeavour to communicate with customers in the customer's preferred communication channel, not just when the customer experiences vulnerability.

We recommend revising paragraph 15 to include a commitment by insurers to "use our best endeavours to communicate with you using your preferred communication channel".

Paragraphs 23(c) & 32 – Clearly explain exceptions to insurer liability

Paragraph 23(c) of the redrafted Code

Where a paragraph of the Code forms part of your policy, it applies on the following basis:

(c) If we fail to comply with the Code paragraph, we will not be liable to you:

- *(i) for breaches of timeframes for the period that an Extraordinary Event declaration is in place;*
- *(ii) to the extent the failure was affected by some other event or circumstance that:*
  - *was beyond our control,*
  - *was not reasonably foreseeable or preventable, or*
  - *occurred without fault or negligence on our part;*
- *(iii) for any loss that does not arise naturally, including any indirect or consequential loss;*
- *(iv) to the extent that any loss was caused by your failure to comply with your obligations and responsibilities under your policy, the law, or the Code including your duty to mitigate loss; or*
- *(v) for breaches of the relevant timeframe, if we have agreed an alternative timeframe with you.*

Paragraph 32 of the redrafted Code

If we report a breach of a paragraph of the Code to the Code Governance Committee or any other regulator, this will not be an admission of liability to you.

Paragraph 23(c)(iii) creates an exception for insurers liability to customers for "any loss that does not arise naturally". However, this language is unclear and will not be easily understood by consumers.

Paragraph 32 states that reporting a breach of the Code to the CGC or a regulator is not an admission of liability to the customer. The meaning and purpose of this statement is unclear and requires clarification. A breach of the Code is necessarily a breach of the contract with the customer, except in the instances outlined in paragraph 23(c).

We recommend revising these paragraphs to ensure their intent is clear and to support customer understanding.

Paragraph 33 – Require insurers to comply with binding standards introduced by the ICA

Paragraph 33 of the redrafted Code

The Insurance Council of Australia may issue non-binding industry guides to promote good customer outcomes. These guides do not form part of the Code.

Paragraph 33 allows the ICA to issue non-binding industry guidance, equivalent to paragraph 192 of the 2020 Code.

However, the redrafted Code does not include a provision that requires insurers to comply with any additional obligations and binding standards that the ICA introduces to the Code, equivalent to paragraph 191 of the 2020 Code.

Removing this commitment limits the Code's ability to respond quickly to emerging issues between formal Code reviews, which will now take place every 5 years.

We recommend reinstating a commitment by insurers to comply with obligations and binding standards introduced to the Code by the ICA.

Section 2 – Buying insurance

Paragraph 39 – Provide sufficient time for customers to consider renewal notices

> ***Paragraph 39 of the redrafted Code***
>
> *If we are offering you a renewal on your annual policy, then we will:*
>
> *(a) give you a Renewal Notice In Writing at least 14 Calendar Days before your policy expires;*
>
> *(b) send you a further electronic reminder before your policy expires - unless you have already renewed your policy - where it is possible to do so and we have an email address or mobile number recorded for your policy.*

Paragraph 39 requires insurers to provide renewal notices at least 14 calendar days prior to renewal, half the 28 days recommended by the Code Review (Recommendation 58).

Providing renewal notices only 14 days before renewal does not give customers sufficient time to adequately review their cover, compare alternative options, or arrange payment before making a renewal decision. Further,

We recommend amending paragraph 39(a) to require renewal notices to be provided at least 28 calendar days before policy expiry to give customers a meaningful opportunity to assess their insurance needs.

Paragraph 42 – Clarify what support is available to customers having trouble paying premiums

> ***Paragraph 42 of the redrafted Code***
>
> *If you are an existing customer and having trouble paying your premium, support may be available to you. We will provide you with information on our website and on payment reminder notices, except for final cancellation notices, about support that may be available.*
>
> ***Section 8 – Financial hardship of the redrafted Code***
>
> *This section does not apply to support with paying premiums under a policy we have issued. If you are experiencing Financial Hardship, we encourage you to tell us so that we can discuss your situation and the options available to support you.*

Paragraph 42 states that support may be available to customers having trouble paying premiums. However, in Section 8 – Financial hardship, it states that the section does not apply to support with paying premiums.

This creates uncertainty about whether there is support available to customers having trouble paying premiums.

Customers are likely to be unclear about whether support is available to maintain their insurance cover during periods of financial hardship, and whether they are entitled to ask for such support. Where support is available, customers may be unclear on what type of support is available, and how they can apply for support.

Further, the Code Review recommended that financial hardship support should apply to "all customers who require it, including people who need help maintaining premium payments"

We recommend that the Code be drafted with greater clarity and consistency regarding the support that insurers can provide to customers who require assistance maintaining premium payments.

Section 4 – Making a claim

Paragraph 62 – Commit to providing a primary contact person for home building claims

Paragraph 62 of the redrafted Code

If you make a claim under your home building policy, but not a Strata Insurance Policy, we will provide you with a primary contact if your claim requires one.

Paragraph 62 commits insurers to providing customers with a primary contact person for home building claims "if your claim requires one". This qualification gives insurers broad discretion to decide whether a claim "requires" a primary contact.

It is unclear what criteria would be used to assess this need and how an insurer's assessment could be challenged. Without this clarity, it will be difficult for customers to know whether they are entitled to a primary contact, and difficult to effectively monitor and enforce. It may also lead to inconsistent application across different insurers.

We recommend revising paragraph 62 to remove the qualification "if your claim requires one" or otherwise narrowing this exception.

Paragraph 72 – Monitor external experts' compliance with all relevant Code obligations

Paragraph 72 of the redrafted Code

We will monitor compliance of our External Experts with paragraph 70 and take action as required. This could include, for example:

(a) cancelling our contract with them;

(b) taking steps to ensure they are not assigned to our claims in future; or

(c) requiring them to go through further training.

Paragraph 72 requires insurers to monitor external expert's compliance with paragraph 70, requiring reports be provided within 60 business days.

However, there are no obligations to monitor external expert's compliance with paragraph 69, requiring them to meet their rules and regulations relevant to their expertise, and paragraph 71, requiring them to comply with the ICA's guide on expert reports. This risk is exacerbated as the commitments in Section 9 relating to insurer's representatives do not include external experts.

We recommend revising paragraph 72 to require insurers to monitor external experts' compliance with all relevant obligations (paragraph 69, 70, and 71).

Paragraphs 76(a) – Narrow the exceptions to automatic acceptance of claims after 12 months

> ***Paragraph 76(a) of the redrafted Code***
>
> *The circumstances referred to in paragraphs 74 and 75 are:*
>
> *(a) something happens that is outside of our control, which means that we cannot make a Decision in the relevant timeframe.*

Paragraph 75 states that if the insurer has not made a decision on a claim within 12 months, it will automatically cover the loss unless the circumstances in paragraph 76 apply.

Paragraph 76(a) provides an exception for when something happens outside the insurer's control that means they cannot make a decision. This exception must only be applied when there are genuinely uncontrollable events that mean a decision cannot be made within 12 months. Insurers should not be able to apply this exception on the basis of operational delays, such as unexpected staff departures, that are reasonably within the insurers control.

Further, insurers should be required to take actions to reduce the likelihood of delays, such as supporting customers in providing necessary information and taking proactive steps to follow up when information has not been received, either from customers or third parties.

We recommend revising paragraph 76(a) to clarify that it cannot be applied in cases of operational delays and introducing a commitment by insurers to take reasonable steps to reduce the likelihood of delays.

Paragraphs 76(e) – Explain to customers the consequences of agreeing to alternative timeframes

> ***Paragraph 76(e) of the redrafted Code***
>
> *The circumstances referred to in paragraphs 74 and 75 are:*
>
> *(e) we have complied with an alternative timeframe that we have agreed to with you, which prevents us from making a Decision within the relevant timeframe.*

Paragraph 76(e) exempts the insurer from automatically covering a claim after 12 months if it has complied with an alternative timeframe agreed to with the customer.

However, we are concerned that it is not sufficiently clear to the customer that, by agreeing to an alternative timeframe, it may exclude them from having their claim automatically accepted under paragraph 75.

The Code should ensure customers understand this consequence before agreeing to an alternative timeframe.

We recommend revising paragraph 60 to include a commitment by insurers to explain in writing how agreeing to an alternative timeframe may affect the customer's right to automatic acceptance of their claim, when proposing an alternative timeframe.

Paragraph 90 of the 2020 Code – Restore the commitment to review Catastrophe claims

> ***Paragraph 90 of the 2020 Code***
>
> *If you have a property claim resulting from a Catastrophe and we have finalised your claim within 1 month after the Catastrophe event causing your loss, you can request a review of your claim if you think that assessment of your loss was not complete or accurate, even though you may have signed a release. We will give you 12 months from the date of finalisation of your claim to ask for a review of your claim. We will inform you in writing about this entitlement and our Complaints process when we finalise your claim.*

Currently, the Code requires insurers to allow customers to request a review of property claims resulting from a Catastrophe (paragraph 90 of the 2020 Code). The redrafted Code has removed this commitment, with no equivalent.

The protection supports the swift resolution of claims following a Catastrophe, which is in the interest of both the customer and insurers. It recognises that the full extent of damage may not be immediately apparent following a Catastrophe. Importantly, it provides the customer with assurance that, if the initial assessment of the loss was not complete, there is an opportunity to have this reassessed.

Removing this commitment would be a significant step back from the 2020 Code.

We recommend that the redrafted Code reinstate the commitment to allow customers to request a reassessment of their loss where the claim is finalised within 1 month of the Catastrophe event (paragraph 90 of the 2020 Code).

Section 5 – Standards for Investigations

Paragraphs 96 and 97 – Clarify the exceptions to notifying customers of an investigation

> ***Paragraph 96 of the redrafted Code***
>
> *Before we start an Investigation, we will tell you In Writing:*
>
> *(a) about our decision to commence an Investigation;*
>
> *(b) about our Investigation process;*
>
> *(c) who your primary contact is for the Investigation;*
>
> *(d) the role and responsibility of the Investigator;*
>
> *(e) when to expect to hear from the Investigator, and what to do if you do not hear from them within that timeframe;*
>
> *(f) that once we have determined we have all relevant information, we will inform you of our decision within 10 Business Days, unless an exception in the Code applies;*
>
> *(g) about your rights and responsibilities under your policy during the Investigation; and*
>
> *(h) about our Complaints process;*

except in circumstances where it would prejudice our Investigation or this could lead to a serious or imminent threat to a person.

Paragraph 97 of the redrafted Code

If we appoint an Investigator, within 5 Business Days of the Investigation commencing, we will tell you:

(a) that we have appointed them;

(b) what their role is; and

(c) if applicable, when they plan to contact you or visit your property;

except in circumstances where it would prejudice our Investigation or this could lead to a serious or imminent threat to a person.

Paragraphs 96 and 97 require insurers to notify customers when deciding to commence an Investigation and when appointing an Investigator, except when doing so would prejudice the investigation or lead to a serious or imminent threat to a person.

We are concerned that these exceptions are broad and could reduce transparency for customers, who may not be informed they are subject to an investigation or have an opportunity to understand the process, respond to concerns or seek support.

It is unclear what criteria would be used to assess whether notification would prejudice an investigation or pose a threat to a person. Equally, it is unclear how an insurer's assessment could be challenged, and thus how this commitment could be effectively enforced.

It is essential for insurers to protect against serious or imminent threats to persons, however there must be clear criteria as to how this exception is applied to ensure customers are treated fairly and transparently.

We recommend revising paragraphs 96 and 97 to clarify when exceptions can be relied upon and how their use will be assessed.

Paragraph 118 – Clarify that independent interpreters are not a customer support

Paragraph 118 of the redrafted Code

If during the interview an independent interpreter or other support (for example a lawyer, or support person) is needed, (even though one had not previously been requested or arranged), then the Investigator will:

(a) pause the interview; and

(b) restart it at a later time, or date, once the interpreter or support person is present.

Paragraph 118 refers to an "independent interpreter or other support person", which may imply that an interpreter is solely a support for the customer rather than an independent party required to facilitate communication during the interview.

We recommend revising paragraph 118 to avoid implying that the independent interpreter is a support for the customer to avoid any ambiguity this may create about the role of an interpreter.

Paragraph 129 – Reviewing non-genuine claim indicators annually

> ***Paragraph 129 of the redrafted Code***
>
> *Our quality assurance program will include reviews of our non-genuine claims indicators to make sure they remain relevant, appropriate and do not discriminate.*

Paragraph 129 requires insurers to review their non-genuine claim indicators but does not specify the frequency that these reviews must occur. In comparison, paragraph 195 of the 2020 Code requires these to be reviewed "at least once a year".

Without a prescribed review period, insurers may apply the requirement inconsistently, increasing the risk that non-genuine claim indicators are not reviewed regularly.

We recommend revising paragraph 129 to require insurers to review non-genuine claim indicators at least annually, consistent with paragraph 195 of the 2020 Code.

Section 6 – Complaints

Paragraph 130 – Explain what customers can expect when making a complaint

> ***Paragraph 130 of the redrafted Code***
>
> *(a) You can make a Complaint to us, our Distributors or Service Suppliers at any time.*
>
> *(b) Our Complaints resolution process will comply with the enforceable provisions of ASIC Regulatory Guide RG 271: Internal dispute resolution. If that Regulatory Guide does not apply to you, we will act as though it does.*
>
> *Note: ASIC Regulatory Guide RG 271 is available on ASIC's website and can be accessed via this link: RG 271 Internal dispute resolution \| ASIC*

The Code should set out, in plain English, what customers can expect when they make a complaint. Paragraph 130 of the redrafted Code does not support customers in understanding what they can expect from their insurer in relation to complaints, instead requiring them to review ASIC's RG 271 and understand what 'enforceable provisions' are.

We recommend revising paragraph 130 to clarify what the commitment to comply with RG 271 means for customers and what they can expect.

Paragraph 135 – Clarify when customers will be updated on the progress of their complaint

> ***Paragraph 135 of the redrafted Code***
>
> *We will keep you informed on the progress of your Complaint.*

Paragraph 135 of the redrafted Code requires insurers to keep customers informed on the progress of their complaint but does not specify timeframes for doing so. This is a step backwards from the current Code, which requires insurers to do so every 10 business days (paragraph 146 of the 2020 Code).

Without specifying a timeframe, it is unclear how this commitment will operate in practice. Paragraph 136(b) requires insurers to provide monthly updates if they are unable to resolve

the complaint after 30 days, but most complaints should be resolved by this point. It is unclear what updates, if any, insurers are required to provide in the first 30 days of receiving a complaint.

We recommend revising paragraph 135 to specify the timeframe that customers can expect to be informed about the progress of their complaint in the first 30 days.

Paragraph 136 – Advise customers when their complaint will have an outcome

> ***Paragraph 136 of the redrafted Code***
>
> *If we are unable to resolve your Complaint within 30 Calendar Days we will:*
>
> *(a) tell you, In Writing, the reasons for the delay;*
>
> *(b) give you monthly updates on the progress of the Complaint;*
>
> *(c) tell you, In Writing, about your right to complain to Australian Financial Complaints Authority if you are dissatisfied; and*
>
> *(d) provide you with contact details for Australian Financial Complaints Authority.*

Paragraph 136 of the redrafted Code outlines information that insurers will provide to customers where they are unable to resolve their complaint within 30 Calendar Days. However, it does not require insurers to tell customers when they can expect to receive an outcome for their complaint.

Customers should reasonably expect to be provided with information about when they should receive an outcome for a complaint when advised of the reasons for the delay. Without an expected outcome date, it may be harder to assess whether the insurer is managing delayed complaints appropriately.

We recommend revising paragraph 136 to include a commitment requiring insurers to tell customers when they can expect to receive an outcome for their complaint.

Section 7 – Taking Extra Care with customers experiencing Vulnerability

Paragraph 141 – Provide support in accordance with the Guidance on Vulnerability

> ***Paragraph 141 of the redrafted Code***
>
> *We will develop our systems, processes and training in accordance with the principles from the Insurance Council of Australia's Guidance on Vulnerability.*

Paragraph 141 requires insurers to develop systems, processes and training in accordance with the principles of the ICA's Guidance on Vulnerability. However, there is no commitment that requires insurers to ensure that the support they do provide is in accordance with the principles of the ICA's Guidance on Vulnerability.

If systems, processes and training are designed in accordance with the ICA's Guidance on Vulnerability, but are not followed when providing support, this should be a breach of the Code.

We recommend revising paragraph 141 to require insurers to provide support in accordance with the principles of the ICA's Guidance on Vulnerability, and to develop systems, processes and training to enable this.

Section 8 – Financial Hardship

Paragraph 167 – Offer flexibility on timeframes for customers to provide information

> ***Paragraph 167 of the redrafted Code***
>
> *The information we have requested under paragraph 166 must be provided within 20 Business Days from the date of our request.*

Paragraph 167 of the redrafted Code requires customers to provide information relating to financial hardship within 20 business days.

However, customers experiencing financial hardship may require additional flexibility and that this timeframe may not be appropriate in all circumstances.

We recommend revising paragraph 167 to include a commitment by insurers to encourage customers to seek additional time if required and to work flexibly with customers applying for financial hardship.

Paragraph 171(b) – Work collaboratively to agree on the amount the customer owes during the bankruptcy process

> ***Paragraph 171 of the redrafted Code***
>
> *If you tell us that you intend to declare bankruptcy, we will confirm In Writing:*
>
> *(a) the amount you owe us; or*
>
> *(b) any revised amount you owe us if we have agreed to provide you with debt relief, for example if we agree to release, discharge or waive a debt or excess payment.*

Paragraph 171(b) requires insurers to advise the customer of the amount the customer owes when providing debt relief. However, this is a step back from the collaborative process to negotiations required by paragraph 137 of the 2020 Code, which requires insurers to "work with you (or your representative) to agree on the amount owed".

Customers may be unaware that they (or their representative) can negotiate on the final sum owed to the subscriber during the bankruptcy process. This may lead to customers accepting revised debts which are not suitable for their circumstances or within their means.

We recommend revising paragraph 171 to require insurers to work collaboratively with customers in agreeing to the debt owed as part of the bankruptcy process

Regularly review the effectiveness of vulnerability and hardship support

The redrafted Code does not include any commitment by insurers to evaluate the effectiveness of the support they provide to customers experiencing vulnerability and financial hardship.

The Code Review recommended insurers should have quality assurance systems in place, overseen by management, for this purpose (Recommendation 17). The Parliamentary Flood

Inquiry recommended that insurers evaluate the assistance they provide after each declared event (Recommendation 38).

Failing to implement effective and suitable financial hardship support solutions can lead to prolonged financial difficulty and negative outcomes for customers and can risk increasing rates of customer vulnerability. Regular quality assurance reviews and senior oversight support early identification, and intervention to mitigate harm.

We recommend introducing a commitment that requires insurers to regularly review the effectiveness of their support for customers experiencing vulnerability and financial hardship, consistent with recommendations made by the Code Review and Parliamentary Flood Inquiry.

Section 9 – Standards for our representatives

Section 9 introduction – Remove implications that insurers are not responsible representatives outside their preferred network

> ***Section 9 of the redrafted Code***
>
> *When you engage with us, you may deal with an Employee or another representative acting on our behalf. For example, you may engage with a Loss Assessor we have appointed to help with your claim.*
>
> *Whether it is an Employee or another appointed representative you are dealing with, we are responsible for their conduct and they are required to meet the obligations in the Code. We also request skilled trades to undertake repairs. If they are part of our preferred network we require them to meet the obligations of the Code.*

The introduction to Section 9 states that the insurer will require skilled trades undertaking repairs to meet the obligations of the Code if they are part of the insurers preferred network. This implies that, if an insurer engages skilled trades outside its preferred network to undertake repairs, the commitments in the Code would not apply.

This implication creates a significant risk and must be removed to clarify that the insurer retains responsibility, irrespective of whether their representative is part of a preferred network or not. The insurer must be responsible for any representative it engages to act on its behalf.

We recommend revising the introduction to Section 9 to remove the reference to insurers' preferred network in relation to skilled trades.

Paragraph 180 – Monitoring compliance and conduct, not just performance of representatives

> ***Paragraph 180 of the redrafted Code***
>
> *We will have policies and procedures in place to monitor the performance of our Employees, Distributors, Service Suppliers and Claims Fulfilment Providers.*

Paragraph 180 requires insurers to have policies and procedures in place to monitor the performance of their Employees, Distributors, Service Suppliers and Claims Fulfilment Providers.

We are concerned monitoring performance is materially different from monitoring compliance and conduct. While performance monitoring is generally focused on service delivery, efficiency or outcomes, it may not identify whether employees and representatives are complying with their Code obligations or meeting appropriate standards of conduct.

This creates a significant risk. If the obligation is limited to monitoring performance, insurers may not have adequate systems to identify, address and prevent misconduct or non-compliance with the Code. This could create gaps in oversight and accountability, increase the likelihood that poor conduct or Code breaches go undetected, and ultimately result in poorer consumer outcomes.

The Code Review identified this as a concern and made several recommendations relating to insurers having effective systems to monitor and ensure compliance and conduct of their representatives (Recommendations 13, 51, and 53).

We recommend revising paragraph 180 to require insurers to have policies, procedures and effective systems to monitor the compliance, conduct and performance of representatives.

Section 10 – Enforcement, sanctions, compliance and reviewing the Code

Paragraph 197(b) and (f) – Remove limitations on investigating and determining breaches of the Code

> ***Paragraph 197 of the redrafted Code***
>
> *The Code Governance Committee is responsible for monitoring and enforcing compliance with the Code through:*
>
> *(b) receiving, investigating and making decisions about alleged serious and systematic breaches of the Code and giving us the opportunity to respond to any allegations that we have breach the Code;*
>
> *(f) publishing decisions in relation to serious and systemic breaches on a de-identified basis.*

Paragraph 197 outlines the responsibilities of the CGC. While these responsibilities are largely consistent with those set out in paragraph 169 of the 2020 Code, subparagraphs (b) and (f) include a restriction to only receive, investigate and make decisions about alleged "serious and systemic" breaches of the Code. These responsibilities are repeated in clauses 1.2(b) and 1.2(f) of the draft CGC Charter.

These restrictions would limit matters that the Committee could consider and investigate. It is unclear how this limitation would apply in practice, as the Committee may not be able to determine whether a breach is serious or systemic without investigating. Further, decisions on breaches of the Code, including those that are not serious or systemic, may be necessary to support agreement with insurers on corrective measures they are required to implement. Decisions on breaches can also support broader compliance with the Code and be part of guidance on areas for improved industry practice.

In addition, paragraph 197(b) limits the Committee to only receiving alleged breaches of the Code that are serious and systemic, which conflicts with paragraph 202 which enables any alleged breaches to be reported to the Committee, irrespective of whether it is serious or systemic.

Finally, the Committee is already required to "focus on matters that may be systemic or serious", in accordance with clause 5.1(b) of the draft CGC Charter.

On this basis, we recommend revising paragraph 197(b) and (f), and the equivalent clauses 1.2(b) and (g), to remove the restriction to alleged breaches that are serious and systemic.

Paragraph 197(b) also includes errors, including "serious and systematic [sic]" instead of systemic and "we have breach [sic] the Code" instead of we have breached the Code.

Clarify the definition of Significant Breach

> ***Significant Breach*** *means a breach that is determined to be significant by having regard to all of the following factors, considered holistically and in combination:*
>
> *(a) the number and frequency of similar previous breaches;*
>
> *(b) the impact of the breach, or likely breach, on our ability to provide our services;*
>
> *(c) the extent to which the breach, or likely breach, indicates that our arrangements to ensure compliance with the Code are inadequate;*
>
> *(d) the actual, or potential, financial loss caused by the breach; and*
>
> *(e) the duration of the breach.*
>
> *A breach will only be considered significant where, after considering all of these factors together, it is determined that the breach is significant in the context of our overall compliance with the Code.*

The definition of Significant Breach requires insurers to consider each of the listed factors "holistically and in combination". However, we are concerned that this may be interpreted as requiring all factors to be significant for the breach to be reported as a Significant Breach. A breach may still be significant even if the duration of the brief is short, or the breach does not impact the insurer's ability to provide its services and should be reported as such.

We recommend revising the definition of Significant Breach to clarify that, while all factors must be considered in combination, not all factors need to be present for a breach to be considered significant.

Draft CGC Charter

Clause 1.2 – Ensure the responsibilities of the CGC are consistent

> ***Clause 1.2(c) of the draft CGC Charter***
>
> *The CGC is responsible for monitoring and enforcing compliance with the Code through:*
>
> *(c) considering whether it is more appropriate for ASIC or another enforcement agency to investigate an alleged breach of the Code*

Clause 1.2 sets out the responsibilities of the CGC, including 1.2(c) which requires it to consider whether it is more appropriate for another enforcement agency to consider an alleged breach of the Code.

We recommend revising clause 1.2 and paragraph 197 of the redrafted Code so that the CGC's responsibilities remain consistent between the two documents.

Clause 5.1(a) – Commencing investigations of Significant Breaches

Clause 5.1(a) of the draft CGC Charter

(a) The CGC may commence an investigation of Code compliance in the following ways:

(i) in response to an allegation that a Code Subscriber may have breached the Code; or

(ii) in response to a referral or report from the Service Provider or the EDR Scheme that a Code Subscriber may have breached the Code; or

(iii) as an outcome of the CGC's monitoring and information gathering, if the CGC has reason to suspect that a Code Subscriber may have breached the Code.

Clause 5.1(a) outlines the ways in which the Committee may commence an investigation, including for allegations that a subscriber has breached the Code, referrals from AFCA, and as an outcome of the Committee's monitoring and information gathering.

For completeness, we recommend revising clause 5.1(a) to make clear that the Committee may commence an investigation when a subscriber reports a Significant Breach of the Code.

Clauses 5.2-5.5 and 11.1 – Clarify responsibilities when investigating actual or alleged breaches of the Code

Clauses 5.2-5.5 set out responsibilities for the CGC when conducting investigations. These clauses frequently refer to allegations, alleged conduct, and alleged breaches. However, there are instances where the CGC may investigate matters where a breach has been determined, such as when a subscriber reports a Significant Breach.

As drafted, clauses 5.2-5.5 do not apply to investigations where a breach has been determined by the CGC or reported by the subscriber. For example, clause 5.4(c) requires the CGC to provide Code Subscribers with an opportunity to respond to alleged breaches as part of its investigation. We consider it reasonable that this same opportunity should be provided when the Committee considers Significant Breaches reported by the Subscriber.

Clause 11.1 also sets out what the CGC will do when considering an alleged breach. We consider this should reasonably apply to any consideration by the CGC, whether in relation to an alleged breach or one that has already been determined.

The limitation to alleged breaches throughout these clauses appears to be an oversight and should be corrected.

We recommend revising all relevant parts of clauses 5.2-5.5 and 11.1 to clarify they apply to actual or alleged breaches of the Code, not just alleged breaches.

Clause 6.2(c) – Clarify notification requirements for imposing sanctions

> ***Clause 6.2(c) of the draft CGC Charter***
>
> *(c) The CGC will notify the Code Subscriber's Chief Executive Officer and ICA in writing of its decision regarding any Significant Breach of the Code and any sanctions to be imposed.*

Clause 6.2(c) requires the Committee to notify the ICA in writing of its decision regarding any sanctions to be imposed. However, it is unclear whether this notification requires identifying the Code Subscriber, even if the sanction would not do so.

We recommend revising paragraph 6.2(c) to make clear whether the information shared with the ICA should identify the Code Subscriber, even if the sanction would not do so publicly.

Clause 8.1(b) – Allow the ICA and AFCA to determine when to refer complaints concerning the CGC to an independent party

> ***Clause 8.1(b) of the draft CGC Charter***
>
> *(b) The CEO of the Insurance Council and the Chief Ombudsman of AFCA may jointly appoint an independent party for the purpose of this clause under appropriate terms of reference. If the complainant remains dissatisfied after receiving the CGC's response, they may refer the complaint to that independent party who must then consider the complaint in accordance with their terms of reference.*

Clause 8.1(b) allows complainants who are dissatisfied with the CGC's response to their complaint to refer the matter to an independent party who must consider the complaint. However, 8.1(b) states that the ICA's CEO and AFCA's Chief Ombudsman "may" jointly appoint an independent party for this purpose.

For clarity, we recommend revising clause 8.1(b) to specify that the ICA's CEO and AFCA's Chief Ombudsman will determine whether a complaint concerning the CGC should be referred to an independent party, and if so, to then appoint that independent party for this purpose.

Clause 11.5 – Clarify the process for regular reviews of the CGC's operational effectiveness and capabilities

> ***Clause 11.5 of the draft CGC Charter***
>
> *The CGC will cooperate with the Insurance Council in regular reviews of its operational effectiveness and capabilities, including in relation to its data collection requirements.*

Clause 11.5 requires the CGC to cooperate in reviews of its operational effectiveness and capability. We welcome this requirement and seek further clarification around this process.

We recommend developing a clear framework for regular reviews of the CGC that outlines who will conduct the review, the scope and process for this review, when they will occur, and how these will be funded.

Clause 12 – Correct errors in Definitions

> ***Clause 12 of the draft CGC charter***
>
> ***Service Provider*** *means the service provider appointed by the Association, through the CGC, from time to time, in accordance with the Code and this Charter, to monitor Code compliance on behalf of the Code Governance Committee.*
>
> ***Significant Breach*** *has the same meaning in the Code.*

Clause 12 includes two errors that should be corrected. The definition of Service Provider refers to "the Association". We understand the ICA plans to abolish the CGCA, so this reference should be removed.

In addition, the definition of Significant breach states that it has "the same meaning in the Code" and should be amended to "the same meaning as in the Code".

Abolition of the CGCA – Clarify how the budget approval process will maintain consumer representative involvement

The draft CGC Charter does not include provisions relating to the CGC's annual budget process. In particular, we are concerned as to how the ICA will ensure consumer representatives remain involved in decisions on the CGC budget, following the proposed abolishment of the Code Governance Committee Association, in accordance with recommendation 98 of the Code Review.

We recommend introducing a clause into the draft CGC Charter that clarifies how decisions will be made on the CGC budget, and how consumer representatives will be involved in this process.