Submission on the

Redrafted General Insurance Code of Practice

CLAIMSHERO®

1300 219 469 | www.claimshero.au | claims@claimshero.au

CLAIMSHERO

Level 6, 301 Coronation Drive
Milton Qld 4064
1300 219 469
[redacted]

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Insurance Council of Australia
Email: codeofpractice2026@insurancecouncil.com.au

Submission on the Draft General Insurance Code of Practice

Dear Insurance Council of Australia,

Thank you for the opportunity to provide feedback on the Redraft of the General Insurance Code of Practice.

Hero Group Services, trading as Claims Hero, is an insurance advocacy business that supports consumers navigating claims and complaints in the home and contents insurance sector. We operate under an Australian Financial Services Licence (AFSL) and assist clients with home insurance property claims, including internal dispute resolution processes and complaints to AFCA. As Claims Hero does not lodge insurance claims on behalf of consumers, the vast majority of clients who engage us are already experiencing significant difficulties with their insurer. Consequently, many of the consumers we assist would be considered vulnerable under the proposed Code.

Claims Hero supports the objective of a clearer, stronger and contractually enforceable Code. A modernised Code has the potential to improve claims handling, reduce avoidable disputes and strengthen consumer confidence in the general insurance sector. However, in Claims Hero's respectful view, the redrafted Code does not translate those objectives into clear, enforceable and practically effective consumer rights.

Our submission focuses on five key themes:

- **Replace Subjective Wording** - Replace subjective terms with clear, objective and measurable requirements. The Code uses subjective language more than 100 times, including "reasonable", "appropriate", "relevant" and "necessary" etc., allowing obligations to be interpreted and implemented differently across insurers. This will increase implementation complexity and materially undermine the consistency, enforceability and consumer protections the redrafted Code is intended to deliver.
- **Independently Verifiable Obligations** - Ensure all obligations are drafted so consumers, AFCA, regulators and courts can independently determine whether an insurer has complied. Phrases such as "we will have processes in place to consider", "if we believe we need it" and "if we are satisfied" rely on internal processes, beliefs or information controlled by the insurer. Obligations should instead require clear, observable outcomes, such as "if it is determined" instead of "if we determine", and should apply when objectively determined criteria are met, rather than when the insurer itself makes that determination. Otherwise, consumers may be unable to identify or establish non-compliance, while AFCA and the courts may have limited ability to determine what specific outcome the insurer must deliver. This would materially weaken the practical enforceability of the Code.

- **Enforceable Protections** - Remove unnecessary exceptions, qualifications and clarifications that allow insurers to avoid otherwise enforceable obligations. For example, the Code provides that policy wording will prevail over Code obligations (23 (a)). The Code should instead establish universal minimum standards, narrowly defined exceptions and meaningful consequences so contractual enforceability delivers consistent and practical consumer protection universally, rather than creating the appearance of enforceable rights that vary between Code subscribers.
- **Transparency and Accountability** - Require insurers to disclose the information, evidence and reasons supporting decisions and Code compliance. Greater transparency in insurer decisions, expert evidence, governance and breach reporting is necessary to allow meaningful scrutiny, strengthen accountability and improve consumer and regulatory confidence. Greater disclosure reduces disputes by ensuring all parties have access to the same information.
- **Exclude external reference material** - Include all substantive consumer protections and minimum standards within the Code, rather than relying on external guides referenced by the Code, including the ICA's *Use of Expert Reports: Industry Best Practice Standard* and *Guidance on Vulnerability*. Important consumer rights should not depend on external documents that may be amended, replaced or weakened without public consultation, independent oversight or ASIC approval. The incorporation of these external references effectively circumvents the ASIC approval process and undermines consumer protection.

Accordingly, Claims Hero has made principle-based recommendations to guide the significant redrafting required across the Code. The recommendations draw on Claims Hero's practical experience working at insurers to promote drafting obligations that are easier for insurers to implement, monitor and demonstrate compliance with, while improving consumer outcomes and strengthening regulatory oversight.

We consider these recommendations consistent with the findings of the Independent Code Review and Parliamentary Inquiry, including recommendations that have not been implemented in the redrafted Code. Having regard to the commitments made in the Industry Action Plan, the ICA should clearly explain why those recommendations have not been adopted or have been implemented only in a materially narrower form.

Without significant improvements to the drafting, Claims Hero considers that the Code is highly unlikely to deliver the benefits identified in the media release or adequately address the concerns raised through recent reviews and parliamentary inquiries. If those shortcomings are not addressed, confidence in industry self-regulation will continue to diminish, increasing the likelihood that legislative intervention is the only viable solution to protect consumers.

Claims Hero appreciates the opportunity to contribute to this consultation and would welcome ongoing engagement with the ICA to continue to improve the Code.

Note: Claims Hero acknowledges the use of artificial intelligence tools in preparing aspects of this document, including visualisations. These tools were used solely to improve readability, presentation and visual communication. All opinions, analysis, recommendations and proposed drafting contained in this document were developed solely by Claims Hero and not these tools.

Luke Dugdell
Managing Director
Claims Hero

Summary of Recommendations

Claims Hero recommends the following amendments to the proposed General Insurance Code of Practice. Collectively, these recommendations are intended to improve the clarity, consistency and enforceability of the Code by reducing unnecessary subjectivity, establishing objective minimum standards, strengthening transparency and accountability, and providing consumers with meaningful rights and effective remedies.

Given the extent of redrafting required, Claims Hero has developed principle-based recommendations to guide broader reform of the Code, rather than proposing replacement wording for every affected provision. Each recommendation is discussed in further detail throughout the remainder of this submission. The Code examples included in the table are illustrative only and are not intended to be exhaustive.

Clarity and accessibility of language

Ref	Principle Recommendation	Problem in Current Draft	Code Examples
1.	**Plain English:** Use plain English and minimise unnecessary legalistic language so the Code is clear, accessible and easily understood by consumers. The Code should be written so an average Australian consumer can understand their rights, the insurer's obligations and the consequences of non-compliance without requiring legal or insurance expertise.	The Code uses technical legal and contractual language that the average Australian may not understand without legal advice. This makes it difficult for consumers to identify their rights, understand when an insurer is exempt from compliance and determine what remedies are available following a breach.	Terms such as 'arise naturally', 'not a condition or warranty of the policy', 'liable to you', 'without fault or negligence on our part', 'indirect or consequential loss' and 'duty to mitigate loss' (paragraph 23).
2.	**Objective Obligations:** Significantly reduce subjective language with clear, objective and measurable requirements wherever practicable. Obligations should be capable of consistent application and independent assessment, rather than depending on how each insurer interprets subjective terms.	The Code relies extensively on subjective terms that permit different interpretations and practices across insurers. This creates uncertainty for consumers, increases implementation complexity and makes compliance more difficult to independently assess and enforce.	Terms such as 'if we believe we need it' (paragraph 58), 'if we are satisfied' (paragraph 84), 'reasonably believe it is relevant' (paragraph 98(d)), 'relevant information' (paragraph 134) and 'if appropriate' (paragraph 159(b)).
3.	**Defined Timeframes:** Use clear Business Day or Calendar Day timeframes instead of subjective wording (i.e. regularly, monthly) wherever practicable to improve certainty and consistency. Consumers and insurers should be able to identify the exact date by which an obligation must be completed.	The Code uses imprecise timeframes that do not establish a clear deadline or minimum frequency for compliance. This creates inconsistent expectations and makes it difficult to determine when a breach has occurred.	Terms such as 'regularly monitor and review' (paragraph 128) and 'as quickly as possible' (paragraph 165(b)).
4.	**Defined Thresholds:** Increase the use of defined terms, thresholds and objective criteria to reduce ambiguity and inconsistent interpretation. The Code should	The Code uses undefined thresholds and qualitative concepts to determine when obligations, exceptions or protections apply. Insurers may	Terms such as 'sufficient reason' (paragraph 126), 'outside of our control' (paragraph 76(a)),

	clearly identify when each obligation, protection or exception applies.	interpret these thresholds differently, resulting in inconsistent consumer outcomes and disputes about whether the relevant threshold has been met.	'reasonably suspect it is fraudulent' (paragraph 76(b)) and 'more appropriate' (paragraph 161).

Contractual enforceability of the redrafted Code

Ref	Principle Recommendation	Problem in Current Draft	Code Examples
5.	**Outcome-Focused Obligations:** Draft enforceable obligations that require insurers to deliver defined consumer outcomes, rather than merely maintaining internal processes, considering matters or expressing intentions. Compliance should be measured by the outcome achieved, not simply by whether an internal process exists.	Many enforceable provisions focus on insurer processes or internal decision-making without requiring a defined consumer outcome. This allows obligations to be technically satisfied even where the intended consumer protection is not delivered, making compliance more difficult to assess and enforce.	Terms such as *'we will consider the evolving needs of customers'* (Industry Principle (g)), *'we will have processes in place to consider'* (paragraph 87), *'we will have processes in place'* (paragraphs 14, 87, 140 and 150), and *'have processes in place to monitor'* (paragraph 138(c)).
6.	**Meaningful Remedies:** Include meaningful consequences and effective remedies where insurers fail to comply with Code obligations. Contractual enforceability will have limited practical value if consumers cannot obtain an effective remedy for non-compliance.	The Code provides that some obligations form part of the insurance contract but substantially limits insurer liability without clearly identifying the remedies available for different forms of non-compliance.	Terms such as 'we will not be liable to you' and exclusions for loss that does not 'arise naturally' (paragraph 23(c)).
7.	**Narrow Exceptions:** Remove or substantially narrow provisions that limit contractual enforceability, including broad exclusions and qualifications. Any retained exception should be objectively defined, supported by evidence and incapable of being relied upon where the relevant circumstances arose from the insurer's own conduct.	Broad exceptions and qualifications may allow insurers to avoid otherwise enforceable obligations while remaining technically compliant. Some exceptions depend on subjective or broadly expressed circumstances.	Terms such as 'beyond our control', 'not reasonably foreseeable or preventable' and 'without fault or negligence on our part' (paragraph 23(c)(ii)).
8.	**Recoverable Loss:** Permit recovery of reasonably foreseeable loss caused by Code non-compliance, instead of naturally arising. Remove legalistic language to improve stakeholder understanding. Consumers should be able to understand the losses for which compensation may be available without requiring legal advice.	The proposed limitation on recoverable loss uses an undefined legal test and may exclude foreseeable financial or non-financial harm caused by a Code breach.	Terms such as loss that does not 'arise naturally' and 'indirect or consequential loss' (paragraph 23(c)(iii)).

9.	**Binding Industry Principles:** Incorporate Industry Principles as enforceable Code obligations or make them binding interpretive principles for all Code obligations. Insurers should not be able to comply narrowly with an individual provision while acting inconsistently with the Code's overarching consumer protection principles.	Important consumer commitments are contained in non-binding Industry Principles. This allows an insurer to comply with the technical wording of an individual provision while acting inconsistently with the broader purpose of the Code.	Commitments such as providing services 'efficiently, honestly and fairly', supporting customers experiencing Vulnerability and using technology responsibly are contained in the Industry Principles.
10.	**Protections Within the Code:** Include substantive consumer protections and minimum standards directly in the Code, rather than relying on external guidance or reference documents (i.e. in relation to expert reports). Consumers should be able to identify their enforceable rights by reading the Code alone.	Substantive consumer protections are contained in external guides that may be amended, replaced or weakened without the same public consultation, independent oversight or ASIC approval applying to the Code.	References to the *Use of Expert Reports: Industry Best Practice Standard* (paragraph 71) and the ICA's *Guidance on Vulnerability* (paragraph 141).
11.	**Code Protections Must Prevail:** Remove paragraph 23(a), which allows policy terms to override the Code, as it fundamentally undermines contractual enforceability and subscribing to the Code. The Code should establish universal minimum protections that cannot be reduced or displaced by individual policy wording.	Allowing policy terms to prevail means Code protections may be displaced and may vary between insurers depending on their individual policy wording.	The policy term 'will prevail to the extent of that conflict or inconsistency' (paragraph 23(a)).
12.	**Separate Operational Guidance:** Improve the readability of the Code by moving practical guidance into a separately governed Operational Guideline, similar to AFCA's Operational Guidelines, while ensuring all enforceable obligations remain within the Code. Guidance should explain how obligations operate without defining, qualifying or changing consumer rights.	The Code appears to contain significant clarification material which can increase the length. The Code should have the clear obligations and the operational guideline could provide the interpretation guidance on the obligations.	Notes, examples and explanatory material appear throughout the Code, including the guidance following the claim and complaint provisions.

Consumer protections in the redrafted Code

Ref	Principle Recommendation	Problem in Current Draft	Code Examples
13.	**12 Month Automatic Coverage:** Strengthen the automatic acceptance of claims by narrowly and objectively defining the circumstances in which the provision does not apply. Where a claim is automatically accepted, the Code should confirm that acceptance is final and identify the	Paragraph 75 automatically covers the loss or damage claimed, subject to policy coverage and limits, where a Decision has not been made within 12 months. However, broad or subjective exceptions will likely prevent this in practice. Delays by	Terms such as 'outside of our control', reports delayed despite 'best endeavours', 'reasonably suspect it is fraudulent' and a complaint that 'impacts our ability' to make a Decision (paragraph

	limited circumstances, if any, in which it may subsequently be withdrawn, narrowed or qualified. If an exception is to apply this should be communicated prior to the 12-month period or the exception should not apply.	insurer-appointed experts should not be an exception. The Code also does not expressly confirm the finality or subsequent effect of automatic coverage.	76).
14.	**Complete Claim Disclosure:** The Code should expand disclosure obligations to include all claim information obtained, created, reviewed or considered during the claim, irrespective of claim decision or complaint outcome. Consumers should have access to the same material information available to the insurer, subject only to narrow and legally necessary exceptions.	Disclosure is focused on information and reports relied upon in the final decision. This may exclude information that influenced the investigation, assessment or handling of the claim but was not expressly relied upon.	Terms such as information 'used to make a Decision' (paragraph 80(d)) and External Experts' reports 'we relied on' (paragraph 81).
15.	**Expert Evidence Standards:** Strengthen expert report obligations, including independence, qualifications, conflicts of interest and disclosure requirements. These should be included within the Code itself. Expert evidence that materially affects claim outcomes should be subject to clear, consistent and enforceable minimum standards.	The Code does not comprehensively prescribe the qualifications, independence, instructions, evidence, methodology, conflicts and disclosure requirements applying to expert evidence. Having this information in a separate document undermines enforceability of critical obligations.	Reliance on the external *Use of Expert Reports: Industry Best Practice Standard* for substantive expert requirements (paragraph 71).
16.	**Cash Settlement Safeguards:** Require objective actions to occur before offering a Cash Settlement to ensure settlements are appropriate and sufficient. The Code has fallen materially short of the recommendations of the parliamentary inquiry. Increased minimum requirements on insurers should be implemented to safeguard consumers. This is consistent with in principle agreement outlined in the General Insurance Industry Action Plan.	The Cash Settlement obligation requires an insurer to maintain a process and consider appropriateness but does not prescribe the mandatory assessment steps or minimum conditions that must be satisfied. This was identified in recent industry reviews and inquiries.	Terms such as 'we will have processes in place to consider whether a Cash Settlement may be appropriate' (paragraph 87).
17.	**Cash Settlement Review Rights:** Remove 12-month limit on reviewing cash settlements and allow review where deficiencies could not reasonably have been identified earlier. Consumers should not lose their right to review merely because a deficiency became apparent after the prescribed period.	The fixed review period may expire before defects, omissions or insufficient allowances in a Cash Settlement could reasonably be identified.	The right to request a review of the Cash Settlement amount 'within 12 months' (paragraph 92).
18.	**Right to Representation:** Protect consumers' right to be assisted by an authorised representative or	Exceptions permitting direct insurer contact may undermine consumer choice	Provisions allowing insurers to contact consumers directly

	nominated person by limiting exceptions that permit direct insurer contact. Any direct contact should be necessary, documented and communicated to the appointed representative. Insurers should not be making conclusions on 'best interests' as this would amount to personal advice and likely breach their license conditions.	and create barriers for consumers who depend on a representative because of vulnerability, disability or the complexity of their claim.	despite the appointment of a Nominee or representative (paragraph 9).
19.	**Standard Authority Process:** Implement a consistent, industry-wide authority process with prescribed minimum requirements to eliminate unnecessary insurer-specific forms and administrative barriers. A valid authority should be recognised consistently across all Code subscribers.	The Code does not prescribe a consistent authority process across insurers. Consumers and representatives may therefore encounter insurer specific forms, requirements and administrative barriers.	References to authority being granted through 'any standard third-party authorisation form' containing 'all the necessary information' (Nominee definition).
20.	**All Opinion Providers:** Apply the Code's expert report requirements to all providers who prepare reports or opinions relied upon in claims handling, not just limited to experts (i.e. builders, loss adjusters etc.). The applicable standard should depend on how the report or opinion is used, rather than the title given to its author.	Providers whose reports and opinions materially influence claim outcomes may fall outside the definition of External Expert and the associated expert report requirements.	The definition of 'External Expert' excludes Service Suppliers, which may include builders, leak detection providers, restoration companies who undertake reports on causation and scope.
21.	**Temporary Accommodation Protections:** Require insurers to regularly assess continuing accommodation needs and provide at least three months' written notice before making a substantive adverse change. The notice should include reasons, supporting evidence, alternative assistance and an effective right of review. It should also mandate that accommodation limits are extended for any insurer delays.	The Code does not establish minimum requirements for assessing continuing accommodation needs or for reducing, withdrawing or materially changing accommodation arrangements. This was a key finding in recent industry reviews.	The Code contains no general obligation for governing temporary accommodation.
22.	**Informed Consent for Contractor Works:** Require insurers and their contractors to obtain and document informed consumer consent before entering a property or undertaking stripping, removal, destructive work or repairs. Any urgent make-safe exception should be narrowly defined and followed by prompt written notification.	The Code does not expressly require informed consumer consent before a contractor enters a property or undertakes destructive or substantive work. This was identified as a key issue in recent industry reviews.	The Code does not expressly require informed consumer consent before entry, stripping, removal, destructive work or repairs.

Protections for customers experiencing vulnerability

Ref	Principle Recommendation	Problem in Current Draft	Code Examples
23.	**Minimum Extra Care Protections:** Establish mandatory minimum Extra Care measures to ensure consistent support for customers experiencing vulnerability across all insurers. The support received should not depend solely on an insurer's internal processes, discretion or operating model.	Extra Care protections focus on internal systems and processes without prescribing a consistent set of minimum support measures that every insurer must provide.	Terms such as 'we will have processes in place to identify signs you might need Extra Care' (paragraph 140).
24.	**Documented Support Arrangements:** Require insurers to assess, implement, document and regularly review support arrangements throughout the lifecycle of a claim. Support should remain responsive to changes in the consumer's circumstances and the demands of the claim. This could include regularly asking the customer if further support is required.	The Code does not clearly require insurers to document agreed support, confirm responsibility for implementation or review whether the support remains effective throughout the claim.	General requirements to identify signs that a consumer 'might need Extra Care' and recognise that circumstances 'may change over time' (paragraph 140).
25.	**Access to Independent Evidence:** Ensure consumers are not disadvantaged by the cost of independent expert evidence where it is reasonably required due to the insurer's conduct or position. There should be an explicit obligation for insurers to fund consumer reports if they change the insurer's decision or assessment. Limited exceptions could apply (i.e. reasonable cost).	The Code does not require insurers to obtain or fund independent evidence where it is needed to address deficiencies in the insurer's investigation, evidence or claim position.	No corresponding obligation requires an insurer to fund reasonably necessary independent evidence where the consumer cannot afford it or the need arose from the insurer's conduct.

Governance and accountability

Ref	Principle Recommendation	Problem in Current Draft	Code Examples
26.	**Identified Breach Findings:** Publish substantiated Significant Breach findings identifying the relevant insurer, except where prohibited by law. Consumers and regulators should be able to identify recurring compliance issues and compare the conduct of Code subscribers. This was agreed to in principle in the General Insurance Industry Action Plan.	De-identified breach findings reduce transparency, prevent consumers from identifying recurring compliance concerns and weaken the reputational incentive for insurers to comply.	Significant Breach findings may be published without identifying the Code subscriber responsible.
27.	**Systemic Remediation:** Require insurers to identify, notify and	The Code does not impose a sufficiently clear obligation to	The Significant Breach framework focuses on

	appropriately remediate consumers affected by systemic failures to comply with the Code. Remediation should extend to every affected consumer, not only those who made a complaint.	identify every affected consumer and provide complete remediation following systemic non-compliance.	reporting and governance without clearly prescribing identification, notification and remediation of every affected consumer.
28.	**Disclosure of Errors:** Require insurers to promptly acknowledge and notify consumers in writing when errors or mistakes are identified during the handling of a claim and how these have been rectified. Consumers should be informed of the effect of the error and any corrective or remedial action taken.	Insurers are not expressly required to disclose material errors identified during claim handling, explain their effect or confirm the corrective action taken.	No general obligation requires written disclosure when an insurer or Service Supplier identifies a material error affecting a claim.
29.	**Serious Individual Breaches:** Empower the Code Governance Committee to investigate serious individual breaches, as well as systemic non-compliance with the Code. Serious consumer harm should be capable of attracting oversight before a broader pattern of misconduct has been established.	The governance framework places substantial emphasis on systemic non-compliance. A serious failure affecting one consumer may receive insufficient scrutiny even where it reveals a practice capable of recurring.	The Code Governance Committee framework prioritises matters characterised as serious or systemic and broader industry issues.

Future readiness of the Code

Ref	Principle Recommendation	Problem in Current Draft	Code Examples
30.	**Three-Year Independent Review:** Require an independent review of the Code at least every three years to ensure it remains effective, relevant and fit for purpose. Review frequency should reflect the pace of change in technology, claims handling and consumer expectations.	A five-year review cycle, combined with the implementation period, may allow ineffective or harmful practices to remain embedded for an extended period before formal review.	A formal independent review is required only 'at least every five years' (paragraph 210).
31.	**Targeted Interim Reviews:** Introduce targeted interim reviews where emerging risks, systemic issues or significant industry changes arise. The Code should be capable of responding to identified consumer harm without waiting for the next scheduled review.	The Code does not establish clear triggers or a process for reviewing particular provisions when emerging risks or systemic consumer harm arise between formal reviews.	No express interim review mechanism applies where technology, catastrophe events, claims practices or systemic issues expose deficiencies in the Code.
32.	**Artificial Intelligence Standards:** Establish enforceable standards governing the use of artificial intelligence and automated decision-making in claims handling. These standards should address transparency, accountability, accuracy, human oversight and the	The responsible use of technology is addressed through a non-binding principle and does not establish enforceable minimum standards for artificial intelligence or automated decision-making.	The commitment to 'use technology responsibly' is contained in Industry Principle (e), which is excluded from contractual enforceability.

	consumer's ability to challenge an automated or AI influenced decision.		
33.	**Oversight of External Materials:** If reference to external material remains in the Code, require any external documents referenced by the Code to be subject to public consultation, independent oversight and ASIC approval before substantive changes take effect. External documents should not provide a mechanism for changing consumer protections outside the Code approval process.	External materials containing substantive protections may be amended, replaced or weakened without undergoing the consultation, independent oversight and ASIC approval applying to the Code.	The Expert Reports Standard applies 'as amended, updated or replaced from time to time' (paragraph 71).

Implementation of the new Code

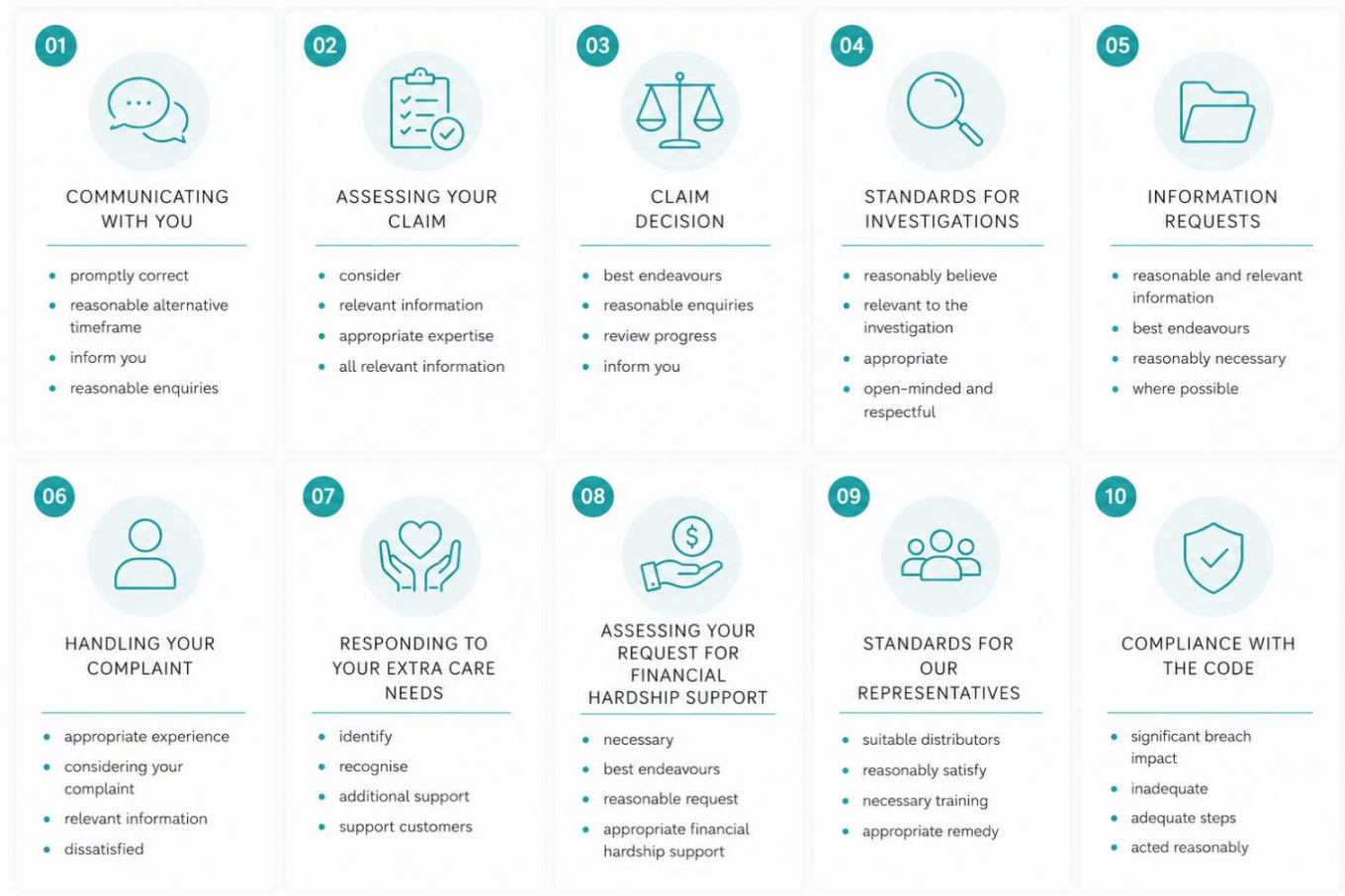
Ref	Principle Recommendation	Problem in Current Draft	Code Examples
34.	**Independent Consumer Testing:** Before the Code is finalised, undertake an independent consumer-focused review, including practical scenario testing with consumers, insurers and other stakeholders. The review should assess whether an average Australian consumer can understand, apply and rely on the Code without legal or insurance expertise, and whether the obligations produce clear, consistent and enforceable outcomes when applied to real claims. The findings and resulting amendments should be published before the Code is submitted to ASIC.	The Code continues to use subjective, legalistic and process-based drafting that consumers may struggle to understand or apply. Obligations that appear effective in isolation may also produce unclear, inconsistent or unintended outcomes when applied across the lifecycle of an actual claim.	See recommendations regarding subjective language and legalistic drafting. Examples include the interaction between claim timeframes and exceptions (paragraphs 59–77), Cash Settlement protections (paragraphs 87–92) and Investigation obligations (paragraphs 94–128).
35.	**Phased Implementation:** Adopt a phased implementation model, with most obligations commencing within 12 months and full implementation within 18 months, unless a longer period is objectively justified. Any extended implementation period should be limited to specific obligations and supported by published reasons.	The proposed 24-month implementation period delays important consumer protections, including obligations that reflect existing regulatory expectations and industry practices.	The proposed implementation model allows a 24-month transition period before the redrafted Code takes full effect.

Subjective Language Undermines Every Objective of the Code

The most significant issue identified during our review of the Redrafted General Insurance Code of Practice ("the Code") is its extensive reliance on subjective language. While some degree of discretion is unavoidable in any principles-based framework, the volume and frequency of subjective terms used throughout the draft materially undermines the Code's effectiveness.

The ICA has stated that the redrafted Code is intended to deliver stronger consumer protections, improve claims experiences and, for the first time, become contractually enforceable. These are important and worthwhile objectives. However, the drafting adopted throughout the Code makes many of these objectives significantly more difficult to achieve in practice.

The image below demonstrates the scale of use of subjective words contained in the redrafted Code:



Over-reliance on subjective language has the following practical implications:

- **Inconsistent application:** Insurers will interpret subjective terms individually, increasing the likelihood of inconsistent implementation and customer outcomes
- **Reduced accountability:** The absence of clear, objective obligations creates scope for insurers to adopt narrower interpretations that fall short of the intended consumer protections while remaining arguable under the Code.
- **Interpretation disputes:** Without measurable standards, obligations are harder to understand and apply consistently, increasing confusion and disputes regarding interpretation.
- **More AFCA complaints:** Consumers are more likely to challenge whether insurers have complied with the Code, resulting in an increase in complaints, Code breach allegations and AFCA disputes.
- **Weakened enforceability:** The effectiveness of the Code is significantly undermined where

obligations are expressed in subjective or ambiguous terms, making it more difficult for consumers, insurers, AFCA and the Code Governance Committee to determine whether a breach has occurred.

- **Regulatory uncertainty:** Greater reliance on subjective obligations reduces certainty for all stakeholders and weakens the Code's ability to establish clear, consistent and enforceable minimum standards across the general insurance industry.

Importantly, Claims Hero is not suggesting that all subjective language should be removed. Some flexibility is appropriate where insurers are responding to individual customer circumstances, particularly when supporting customers experiencing vulnerability. However, subjective language should be the exception rather than the rule. Where discretion is necessary, the Code should establish clear minimum standards that apply in every case, while allowing insurers to exceed those standards where appropriate. As currently drafted, subjective language is the primary mechanism for many protections, creating unnecessary ambiguity, reducing consistency, increasing the likelihood of disputes, and weakening the practical enforceability of the Code.

For these reasons, Claims Hero considers that reducing unnecessary subjectivity should be a foundational drafting principle before the Code is finalised. Doing so would improve implementation by insurers, strengthen consumer understanding, reduce interpretive disputes before AFCA, and ultimately better achieve the objectives the Insurance Council has identified for the redrafted Code.

The subjective language can be summarised in the following broad categories:

Practical improvement examples

Cognitive Subjectivity

The following examples demonstrate current obligations are drafted based on an insurer's internal judgement or beliefs and how they can be replaced with objective and measurable requirements without reducing the intended consumer protection:

SECTION	CURRENT DRAFT WORDING	IMPROVED DRAFTED OBLIGATION
 **Investigations** *Paragraph 98(d)*	“...collect information only if they **reasonably believe** it is relevant to the Investigation	Investigators must collect information only **where it has a direct, documented causal link** to establishing the factual circumstances of the claim. Investigators **must advise** a customer why they are requesting the information.
 **Surveillance** *Paragraph 121*	“Before **we authorise** any surveillance of you, we: (a) will make sure that alternative methods of verifying the relevant information have **been considered**; (b) must **record** the reasons why **we believe** your claim appears to be inconsistent with the information available to us; and (c) will arrange for a **suitably experienced** Employee to review and approve the request for surveillance.	Before we **undertake** any surveillance of you, we must: a) **exhaust all alternative methods** of verifying the relevant information; b) document in writing **the objective evidence** demonstrating a material inconsistency between your claim and the information available to us, including the alternative methods used to verify the information and **the outcome of those enquiries**; c) ensure the surveillance request is reviewed and approved for compliance with this Code **by a senior employee** who was not directly involved in the investigation. d) **identify and document** any personal circumstances or vulnerabilities relevant to the surveillance and **document in writing** actions that **must be taken** to minimise any adverse impact on you. If we do not comply with this paragraph, we **cannot rely on any surveillance** or information obtained through the surveillance.
 **Information Requests** *Paragraph 58*	“We will use our **best endeavours** to limit the number of requests we make and explain why we need the information. Paragraph 57 does not prevent us from asking for more information if **we believe** we need it to make our Decision.	We will **only request** information required to determine your claim. We will request this information **within 10 business days** of lodgment of your claim. **For all requests** for information, we must **in writing**: a) advise the **information required**; b) **explain the reason** why the information is required; and c) **provide options** for how the information can be provided. If **we do not comply** with this paragraph, you are **not required to provide** the information. This paragraph **does not prevent us** from making subsequent requests for information, provided we comply with this paragraph and explain why the information could not have been requested earlier **in writing.**

Cognitive subjectivity allows for significant discretion in how all stakeholders interpret the obligations which results in inconsistent practices, weakens accountability, and makes Code compliance difficult to independently assess or enforce. Replacing subjective concepts with clear, evidence-based obligations improves consistency, transparency and consumer protection. Where cognitive subjectivity is necessary, the Code should prescribe minimum objective criteria and require insurers to document and communicate the reasons supporting their subjective assessment to enable consumer understanding and regulatory oversight.

Qualitative Subjectivity

The following examples demonstrate how the current drafting of the Code relies on subjective standards and how those obligations can be replaced with clear, objective and measurable requirements:

SECTION	CURRENT DRAFT WORDING	IMPROVED DRAFTED OBLIGATION
Expert Reports *Paragraph 69*	“External Experts will have **appropriate expertise** and **be instructed to meet** their rules and regulations relevant to their expertise.	We will only appoint an External Expert who has **demonstrated qualifications, experience or expertise** relevant to the opinion they have been engaged to provide. If you request this information, **we will provide it to you within two business days**. If the appointed External Expert does not meet this requirement or we do not provide the information requested, we **cannot rely on their opinion** when making, maintaining or defending our Decision.
Cash Settlements *Paragraph 87*	“Before offering a Cash Settlement, and where a scope of works is available, we will have processes in place to **consider whether** a Cash Settlement **may be appropriate** in the circumstances.	**Before** offering a Cash Settlement, **we must complete and document** a Cash Settlement assessment. **At a minimum**, the assessment must include: a) whether you have disclosed, or we have recorded on your claim file, any vulnerability that may affect your ability to arrange, manage or complete the repairs; b) whether the Cash Settlement amount is equal to or greater than the total value that it will likely cost you to complete the works; c) that we have **exhausted all options for Us to undertake the repairs**; d) whether there is a **detailed scope of works** for the likely repairs **from all trades**; and e) confirmation from the builder that the scope of works includes **all identified repair work, together with independent validation of the scope and pricing.** Otherwise, we will have the scope of works **independently reviewed** to ensure it is accurate.

Reducing qualitative subjectivity improves the Code by replacing discretionary and value-based judgements with clear, objective and measurable obligations. This promotes consistent application across insurers, improves transparency for consumers, reduces disputes about interpretation, and enables AFCA and the courts to independently assess compliance. Where appropriate, the inclusion of meaningful consequences for non-compliance further strengthens accountability, provides consumers with effective recourse, and creates a genuine incentive for insurers to comply with their obligations.

Temporal Subjectivity

The following examples demonstrate how these obligations create an unclear timeframe and how they can be replaced with objective and measurable requirements without reducing the intended consumer protection:

SECTION	CURRENT DRAFT WORDING	IMPROVED DRAFTED OBLIGATION
Correcting Mistakes *Paragraph 54*	“We will take action to **promptly correct** any known mistakes we make in handling your claim.	We **must correct** any known mistake in handling your claim **within 5 Business Days** after becoming aware of the mistake. We will **confirm the mistake in writing** with you and **advise the actions** we have taken to rectify the mistake or error. If we do not comply with the timeframe specified in this section, **we will compensate you** for any loss caused by the delay.
Investigation Communications *Paragraph 101*	“If you have asked us to communicate through a Nominee, then we will tell the Investigator to contact the Nominee **first**. If they cannot make contact with the Nominee within a **reasonable time**, they will contact you.	If you have nominated a Nominee to communicate with us on your behalf, the Investigator **must contact the Nominee** before contacting you. The Investigator **must, at a minimum,** make one telephone call and send one email to the Nominee and allow **5 business days for a response**. If the Investigator has not received a response from your Nominee after this time, the Investigator **will contact you directly** and **must notify the Nominee in writing** that direct contact has occurred.

Reducing temporal subjectivity improves the Code by replacing vague timeframes with clear, measurable deadlines that establish consistent expectations for insurers and consumers. Objective timeframes improve transparency, reduce disputes about whether obligations have been met, enable independent assessment of compliance by AFCA and the courts, and strengthen accountability by ensuring obligations are capable of consistent enforcement.

Threshold Subjectivity

The following examples demonstrate how these obligations can be replaced with objective and measurable requirements without reducing the intended consumer protection:

SECTION	CURRENT DRAFT WORDING	IMPROVED DRAFTED OBLIGATION
Harm Caused by Employees or Distributors *Paragraph 192*	“If we identify that any of our Employees or Distributors have engaged in poor conduct in breach of our policies or procedures and that has caused you **material harm,** then we will contact you to discuss an **appropriate remedy**.	If it is determined or we identify that an Employee, Distributor, Supplier or Expert has caused you harm, we must notify you in writing **within 5 Business Days** of becoming aware. **We must compensate you** for the harm caused and **undertake actions to address any ongoing harm immediately.** For the purposes of this paragraph, **harm includes, but is not limited to,** financial loss, delays in the handling or settlement of your claim, inconvenience, and any other identifiable adverse consequence resulting from the conduct.
Making a Decision *Paragraph 76*	“(a) something happens **that is outside of our control,** which means that we **cannot** make a Decision in the **relevant timeframe.**	(a) Something occurs that **directly prevents us** from complying with the timeframe and **could not have been prevented or mitigated by us.**
	“(b) your claim is fraudulent, or we **reasonably suspect** it is fraudulent	(b) There is **objective and documented evidence** indicating that your claim is fraudulent, or only where **we have commenced a formal investigation** in accordance with this Code.

Reducing threshold subjectivity improves the Code by replacing undefined triggering thresholds with clear, objective criteria that specify when an obligation or exception applies. This promotes consistent decision-making across insurers, improves transparency for consumers, reduces disputes about whether a threshold has been met, and enables AFCA and the courts to independently assess compliance and enforce the Code consistently.

Contractually enforceable nature of the Code

Claims Hero supports, in principle, the proposal to make the Code contractually enforceable. Incorporating Code obligations into consumer insurance contracts has the potential to strengthen accountability and provide consumers with a direct means of enforcing the standards insurers have publicly committed to meet.

However, contractual enforceability will only improve consumer outcomes if the obligations themselves are capable of meaningful enforcement and there are appropriate consequences when insurers fail to comply. The current drafting significantly undermines this objective by qualifying, limiting or excluding many of the provisions intended to be contractually enforceable, meaning consumers may be given the impression they have enforceable rights when, in practice, those rights are substantially diminished or unavailable.

The ICA has defined contractual enforceability as a "significant enhancement to consumer protection". In Claims Hero's view, the proposed wording does little to provide consumer protection. This objective will only be achieved if the Code establishes clear and actionable obligations, preserves minimum protections notwithstanding inconsistent policy terms, limits the scope of exceptions and provides effective remedies for non-compliance.

Claims Hero considers that the proposed framework requires substantial amendment in each of these areas outlined below.

The Code must prevail the policy

A contractually enforceable Code is intended to establish minimum consumer protection standards that apply consistently across the general insurance industry. Claims Hero is very concerned with the current exception under Paragraph 23(a) of the proposed Code that states:

> 23. Where a paragraph of the Code forms part of your policy, it applies on the following basis:
>
> (a) If there is a conflict or inconsistency between what is in the Code and other provisions of your policy, the term of the policy will prevail to the extent of that conflict or inconsistency.
>
> (b) What is in the Code is not a condition or warranty of the policy.

Claims Hero considers that this exception fundamentally undermines the purpose of contractual enforceability. It effectively allows insurers to support a contractually enforceable Code while drafting policy terms that displace the very protections the Code is intended to guarantee. We therefore cannot reconcile this against the statements of the ICA in the accompanying media release [1]:

- "legally enforceable as part of an insurance contract for the first time"
- "significant uplift in protections for consumers"
- "strengthen consumer protections by providing consumers with additional avenues for enforcement"
- "insurers' key commitments under the Code will be legally enforceable"

[1] https://insurancecouncil.com.au/wp-content/uploads/2026/06/20260612-Media-Release-Insurance-industry-opens-consultation-on-strengthened-Code-of-Practice-1.pdf

- “real practical changes that put the customer first”

However, Paragraph 23(a) materially qualifies those statements by providing that policy terms prevail where there is any inconsistency with the Code. It is difficult to reconcile these two positions. If insurers may rely on policy wording to override Code obligations, the Code cannot operate as a mandatory minimum consumer protection standard.

This approach also requires insurers to comprehensively review and amend their policy wording to remove any inconsistencies with the Code if they genuinely intend to comply with its obligations. If this is not done effectively, consumers are likely to face unnecessary disputes over whether the policy or the Code applies, undermining certainty and increasing the complexity of enforcement.

The exception should be reversed so that, where there is any inconsistency, the Code prevails over the policy. This would ensure the Code operates as a genuine minimum consumer protection standard and the Code is guaranteed to provide protection to all relevant consumers.

Obligations must be clear and actionable

As discussed in the Subjectivity paragraph above, many provisions of the proposed Code rely on subjective concepts, broad discretion and procedural obligations rather than clear, objectively measurable standards. These drafting issues do not only create uncertainty regarding compliance and undermine the practical value of contractual enforceability.

A contractually enforceable obligation should clearly identify:

- what the insurer must do;
- when it must do it;
- the minimum standard that must be met;
- the limited circumstances in which an exception applies; and
- the consequences of non-compliance.

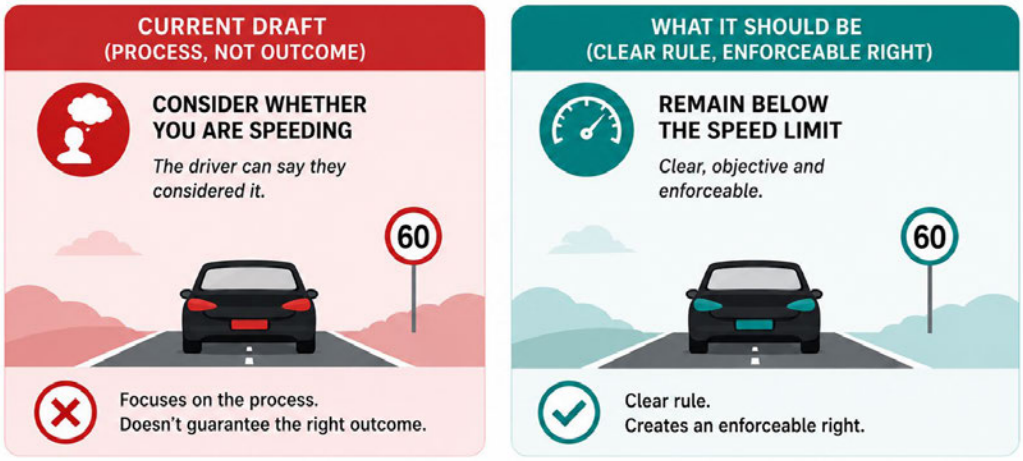
The effectiveness of contractual enforceability should therefore be assessed by a simple question:

- Can a consumer, insurer, AFCA or a court determine objectively, using the wording of the Code alone, whether the obligation has been complied with?

Where the answer is no, the provision should be redrafted to include an objective minimum standard, clearly defined exceptions and meaningful consequences for non-compliance.

A contractually enforceable Code should establish clear consumer rights, rather than merely requiring insurers to demonstrate that they considered, assessed or followed a process. The current Code drafting falls significantly short of providing any meaningful consumer protection and appears to have been drafted to give the illusion of protection.

Many obligations in the proposed Code require insurers to merely consider an issue or maintain a process, rather than achieve a defined outcome. The illustration below demonstrates why process-based obligations do not create meaningful contractual rights or effective enforceability:



Contractual incorporation requires obligations to be actionable and enforceable. The current wording undermines enforceability.

Exceptions must be narrow and objectively defined

Exceptions to contractually enforceable obligations should be limited to circumstances that are necessary, clearly defined and capable of objective assessment. Broad exclusions, qualifications and carve-outs risk displacing the obligation itself and substantially reducing the consumer protection it is intended to provide.

Where an exception is retained, the Code should specify the circumstances in which it applies, the evidence required to establish those circumstances and any procedural requirements that must be satisfied before the insurer may rely upon it. An insurer should not be permitted to rely on an exception where the relevant circumstances arose from its own conduct or the conduct of a Service Supplier for which it is responsible.

Without these safeguards, broad exceptions may allow insurers to avoid otherwise enforceable obligations while remaining technically compliant with the Code, undermining consistency and increasing disputes about whether an exception applies.

Important obligations must be included in the Code

A contractually enforceable Code should contain all substantive consumer protections within the ASIC-approved document incorporated into the insurance contract. Consumers should be able to identify their rights, determine whether an insurer has complied, and understand the consequences of non-compliance by reference to the Code itself.

We consider there are two primary issues with the current draft Code, namely:

- **Industry principles are not contractually enforceable** - Many of the Code's fundamental consumer protection commitments, including the obligation to provide services efficiently, honestly and fairly, are contained in non-binding Industry Principles rather than the enforceable Code.
- **Key consumer protections are contained in external guides** - Important obligations and minimum standards are incorporated by reference to external guidance documents that sit outside the ASIC-approved Code, creating uncertainty as to the content, stability and enforceability of consumers' contractual rights.

Claims Hero considers that all substantive consumer protections, minimum standards and overarching principles should be incorporated into the contractually enforceable Code. External guidance (for example an Operational Guideline similar to AFCA) should be limited to explanatory material, examples and implementation assistance, rather than defining or altering consumers' contractual rights.

The exclusion of industry principles is particularly significant because many operative provisions rely heavily on insurer judgment and discretion. The Code frequently requires insurers to determine what is reasonable, appropriate, necessary or practicable in the circumstances. In that context, binding overarching principles are essential to ensure that discretionary powers are exercised consistently with the Code's consumer protection purpose.

Without a binding overarching standard, an insurer may comply narrowly with the technical wording of an individual provision while acting in a manner that is inconsistent with the broader purpose of the Code.

Claims Hero is particularly concerned that the draft Code requires compliance with the ICA's *Expert Report Best Practice Standard*[2], rather than incorporating the minimum standards directly into the Code itself. The use of external experts has been a recurring issue in numerous independent reviews, AFCA disputes and the Parliamentary Inquiry into Insurers' Responses to 2022 major flood claims[3], making it one of the most significant areas of consumer protection addressed by the Code.

Despite its importance, the Guide has not been subject to public consultation and contains many of the same subjective drafting issues identified throughout the redrafted Code. Rather than providing clear, objective and enforceable obligations, it relies heavily on discretionary concepts that create uncertainty about the standards insurers and experts are expected to meet. Given its significance, these minimum requirements should be incorporated into the ASIC-approved, contractually enforceable Code, rather than being contained in an external document that can be amended or replaced over time (as expressly contemplated by Paragraph 71 of the redrafted Code).

Remedies must be available and not limited

Paragraphs 21 and 22 appropriately provide that applicable provisions of the Code will form part of the insurance contract and may be legally enforced. However, Paragraph 23 significantly limits the practical value of those rights through a series of broad qualifications and exclusions, including:

> (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.

Taken together, these qualifications substantially limit the circumstances in which consumers may obtain meaningful remedies for breaches of the Code. In practical terms, the proposed framework appears to require a consumer to satisfy each of the following elements before a remedy will be available:

1. **Prove the insurer breached the Code** - Establish that the insurer failed to comply with a contractually enforceable obligation.
2. **Prove the breach caused a loss** - Demonstrate that the consumer suffered financial loss or damage because of the breach.
3. **Prove the loss arose naturally from the breach** - Demonstrate that the loss was the ordinary or reasonably foreseeable consequence of the insurer's failure to comply.
4. **Demonstrate reasonable mitigation** - Show that the consumer took reasonable steps to minimise their loss where they were able to do so.

The phrase "arise naturally" is not defined within the Code and is unlikely to be readily understood by consumers. Its legal meaning is also uncertain in the context of the Code. In practice, it appears intended

[2] https://insurancecouncil.com.au/wp-content/uploads/2024/08/Use-of-Expert-Reports_Industry-Best-Practice-Standard_Aug_2024-1.pdf

[3] https://www.aph.gov.au/Parliamentary_Business/Committees/House/Economics/FloodInsuranceInquiry/Report

to confine recovery to losses that are the ordinary or reasonably foreseeable consequence of a breach, while excluding indirect or consequential losses. This imposes a more restrictive threshold than simply requiring a causal connection between the breach and the consumer's loss.

When combined with the Code's extensive use of subjective and process-based obligations, these limitations are likely to significantly reduce the circumstances in which consumers can obtain meaningful compensation for breaches of the Code.

The existence of a legal cause of action does not, of itself, provide an effective consumer remedy. A consumer considering enforcement must also weigh the likely legal costs, delay, evidentiary burden and financial risk of commencing proceedings against the compensation that may ultimately be recovered. Where recoverable loss is narrowly confined, enforcement may not be commercially or practically viable, even where non-compliance can be established.

This would substantially diminish the practical value of contractual enforceability. It may leave consumers with rights that exist formally but cannot reasonably be pursued, while also reducing the incentive for insurers to comply with the Code where the consequences of non-compliance are limited.

The Code should therefore ensure that consumers have access to effective remedies for loss caused by a breach, including compensation for reasonably foreseeable financial and non-financial harm. Any exclusions or limitations on recovery should be narrow, objectively justified and expressed in language that consumers can readily understand.

Consumer protections in the redrafted Code

Claims Hero supports measures that genuinely strengthen consumer protection. However, consumer protection should be measured by the practical rights the Code creates, rather than the number of new provisions or the way they are described.

As discussed throughout this submission, effective consumer protection requires clear obligations, objective minimum standards, meaningful consequences for non-compliance and effective remedies. While the draft introduces several new consumer protections, many are limited by the same drafting issues identified elsewhere in this submission, particularly subjective obligations, broad insurer discretion and extensive qualifications.

We respectfully consider that the current version of the Code offers little additional consumer protection, and significant redrafting is required to achieve this objective.

Automatic claim coverage after 12 months requires review

Automatic claim coverage has the potential to provide an important protection where an insurer has not made a claim decision within 12 months. Paragraph 75 provides that, subject to policy coverage and limits, the insurer will automatically cover the loss or damage claimed unless an exception in paragraph 76 applies.

However, the practical value of automatic claim coverage is materially reduced by the breadth and subjectivity of the exceptions. These include circumstances described as outside the insurer's control, delays by insurer-appointed experts despite the insurer's "best endeavours", alleged non-cooperation, suspected fraud, complaints to the insurer or AFCA, court or tribunal proceedings, and alternative timeframes agreed with the consumer.

The exceptions should be narrowed and objectively defined. Each exception should apply only where the relevant circumstance directly and materially prevented the insurer from making a decision within 12 months. The insurer should be required to demonstrate that it took all prescribed reasonable steps to avoid or address the delay. Circumstances arising from the conduct or delay of an insurer-appointed expert or Service Supplier should not ordinarily be treated as outside the insurer's control.

Exercising a complaint or review right should not, by itself, prevent automatic claim coverage. Paragraph 76(c) should apply only where a particular issue raised in the complaint genuinely prevents the insurer from determining coverage and cannot reasonably be resolved within the applicable timeframe. A consumer should not lose this protection merely because they complained about the insurer's failure to progress or decide the claim.

The Code should require the insurer to notify the consumer in writing before the 12-month period expires if it intends to rely on an exception.

The Code should also clearly define the effect of automatic claim coverage. It should confirm that the loss or damage claimed is covered, subject to the policy coverage and limits, and identify the limited circumstances in which that coverage may subsequently be withdrawn, narrowed or qualified. Automatic claim coverage will not necessarily determine the scope of covered damage, repair methodology, settlement amount or form of claim fulfilment. However, it should ensure that the insurer has accepted coverage for the claimed loss or damage.

Uplift in information access and transparency required

Meaningful consumer protection requires meaningful transparency. Consumers cannot properly understand, challenge or enforce an insurer's decision without access to the information used to make it.

Paragraphs 27 to 30 require insurers to provide only the information they *relied on* when assessing an application, handling a claim or responding to a complaint. Paragraph 81 similarly requires disclosure only of external expert reports relied upon when declining or partially declining a claim.

Claims Hero considers this threshold is fundamentally inadequate. It allows the insurer to determine what information is disclosed by simply asserting that documents were not relied upon. An insurer may obtain, review or consider reports, file notes, emails or technical opinions, yet a consumer may never know those documents exist if the insurer later says they were not relied upon. This ambiguity creates confusion for all stakeholders.

This creates a disclosure regime controlled by the insurer. The insurer decides what information it considers relevant, what it says it relied upon and, ultimately, what will be disclosed to the consumer. The consumer has no way of knowing whether important evidence has been omitted. It also fails to reflect the reality of decision-making, where conclusions are typically informed by the totality of the information available, making it difficult to objectively distinguish between material that was merely considered and material that was relied upon.

The ICA has not explained why this restriction is necessary. Given that it materially reduces transparency and consumer protection, the onus should rest with the ICA to demonstrate why limiting access to information is justified and why any commercial interests outweigh the resultant detriment to consumers.

The disclosure obligation should instead extend to all material obtained, created, reviewed or considered in connection with the claim or complaint, subject only to clearly defined and limited exceptions. This would allow consumers, AFCA and the courts to assess decisions on the complete evidentiary record rather than the insurer's characterisation of it. This reflects a similar approach in personal injury schemes, which assists in resolution of claims.

The proposed approach is also narrower than Australian Privacy Principle 12, [4] which generally provides individuals with access to personal information an organisation holds, subject to limited statutory exceptions. The Code should strengthen existing transparency rights, not create a narrower disclosure framework. This is a key point of clarification required if the wording does not change.

[4] https://www.oaic.gov.au/privacy/australian-privacy-principles/australian-privacy-principles-guidelines/chapter-12-app-12-access-to-personal-information

At a minimum, the Code should require disclosure of:

- expert and assessment reports (including drafts);
- scopes of work, quotes and costings;
- photographs, testing results and site records;
- instructions provided to experts and assessors;
- relevant call recordings and factual file notes; and
- correspondence relating to causation, scope or quantum.

General claims of commercial sensitivity should not justify withholding information necessary for a consumer to understand or challenge a claim decision. Without meaningful access to information, consumers are expected to enforce their rights without access to the evidence needed to do so. AFCA is also unable to oversight this obligation, because AFCA does not have access to insurer processes or systems. Where an insurer withholds information, it should be required to provide the consumer with a schedule of all withheld documents, identifying each document, the specific reason it has been withheld, and the legislative or Code provision relied upon.

Cash settlement protections should be strengthened

The redrafted Code presents the new cash settlement review provisions as an enhancement to consumer protection. However, Paragraph 92 significantly limits that protection by restricting a consumer's right to request a review of a cash settlement to just 12 months after it is received.

Consumers should not lose their right to seek a review before they could reasonably identify that the settlement was insufficient. The proposed limitation risks preventing legitimate claims from being reviewed while leaving consumers with no practical remedy. The ICA has not explained why such a restriction is required and this has not been recommended by any of the reviews and inquiries.

More fundamentally, the Code should require insurers to ensure that any cash settlement is reasonably sufficient to enable the consumer to complete the insured repairs. This should include an obligation to independently validate the scope of works, repair methodology and pricing, rather than relying solely on estimates or scopes prepared by the insurer's own builder or supplier. A cash settlement should reflect the reasonable cost of completing the insured repairs, not simply the insurer's preferred repair cost. Insurers should be required to explicitly tell consumers to obtain their own quotes and the reviews that are available to them if they accept or are forced to accept a cash settlement.

Insurers should also be required to assess whether a customer is reasonably capable of managing the repair or rebuild themselves, taking into account their vulnerability and Extra Care needs. Where the insurer identifies that the customer is unlikely to be able to effectively manage the works, it should either undertake the repairs or fund appropriate support services, such as independent project management, to enable the customer to complete the repairs safely and effectively.

The 12-month limitation should be removed and instead rely on the existing AFCA and legislative timeframes. At a minimum, consumers should remain entitled to request a review where they can reasonably demonstrate that the settlement was insufficient to complete the insured repairs, including where additional costs arise from omitted work, latent damage or inaccurate pricing. The insurer should also clearly explain the review process, evidence requirements and applicable time limits when making a cash settlement offer.

These changes would ensure the proposed review right provides a genuine consumer protection rather than one that expires before many consumers could reasonably identify a problem. Alternatively, the proposed limitation may create an incentive for insurers to make inadequate cash settlement offers, knowing that consumers may not discover omitted damage or the true cost of repairs until after the 12-month review period has expired.

Protections for Customers Experiencing Vulnerability

Claims Hero welcomes the broader definition of vulnerability and the introduction of an Extra Care framework. Recognising that vulnerability can arise from a wide range of circumstances is a positive step.

However, recognising vulnerability alone does not protect consumers. As discussed throughout this submission, effective consumer protection requires clear obligations, minimum standards and meaningful remedies. The current framework relies heavily on insurer discretion and external guidance, leaving vulnerable customers without certainty as to the support they are entitled to receive or whether those protections can be effectively enforced.

Authorised representatives should be respected

The clearer recognition of authorised representatives is a welcome improvement. Many vulnerable customers appoint a representative because they are unable to manage the claims process themselves.

Claims Hero is concerned, however, that Paragraph 9 as drafted allows an insurer to bypass a customer's chosen representative where it believes the representative is not acting in the customer's best interests. The insurer is not an independent arbiter of the relationship between the customer and their representative. It is a party to the claim and may have a direct commercial interest in the outcome of the dispute. It is therefore inappropriate for the insurer to determine, without objective criteria or external oversight, that the customer's chosen representative is not acting in their best interests.

That expression is not objectively defined. An insurer may disagree with a representative's position, strategy or request, but disagreement does not establish that the representative is acting contrary to the customer's interests. An insurer is also unlikely to have sufficient knowledge of the customer's personal circumstances, instructions and relationship with the representatives to make that assessment without further safeguards.

An insurer may disagree with a representative's interpretation of the policy, challenge expert evidence, request for further information, rejection of a settlement offer or decision to escalate a complaint. None of those circumstances establishes that the representative is acting contrary to the customer's interests. There is a material risk that the provision could be used to bypass representatives who challenge the insurer's position or advocate firmly for the customer's entitlements.

The "best interest" test should instead be replaced with objective criteria for when an insurer may contact a customer directly.

Claims Hero has observed a recurring industry issue where insurers refuse to accept valid authorities or impose different authorisation processes and forms. This creates unnecessary inconsistency, delays and confusion for consumers and their representatives. The ICA should strengthen paragraphs 10–12 by prescribing the mandatory requirements of a valid authority. Once those requirements are met, all insurers should be required to accept authority without imposing additional or insurer-specific processes. These authorities establish the scope of the Nominee's authority and permit the insurer to communicate, disclose relevant information and act on instructions. The essential requirements should be capable of consistent definition across insurers.

Minimum support measures should be prescribed

Claims Hero supports this broader vulnerability definition and needs-based approach.

However, the definition does not establish what support a customer is entitled to receive. The definition of Extra Care refers to the additional support or flexibility the insurer is "able to provide". Paragraph 139 requires the insurer to provide Extra Care it has agreed with the customer, while Paragraph 140 requires the insurer to have processes to identify signs that Extra Care may be needed. These provisions do not set the minimum standard or options available.

The current drafting risks defining vulnerability broadly while defining the insurer's response narrowly. The consumer's entitlement is effectively limited to the support the insurer has available and is prepared to

agree to provide with no clear boundaries. While some insurers may choose to provide additional support or services, the ICA and the industry should clearly define the minimum assistance that every insurer must provide to customers experiencing vulnerability or requiring extra care. This could include:

- a dedicated claims manager, consistent point of contact or specialist vulnerability team;
- use of the customer's preferred and safe communication channel;
- accessible formats, interpreter services or simplified communications;
- additional time to provide information or make decisions;
- flexible identification and documentation requirements;
- priority or expedited claims handling where delay may create health, safety, housing or financial risks;
- proactive consideration of temporary accommodation and urgent financial needs;
- change of claims manager or service supplier if this would assist the customer's vulnerability; and
- a written record of the support measures agreed, including responsibility for implementing them.

The Code should instead establish a core set of mandatory protections that apply once the insurer knows, or reasonably ought to know, that a customer is experiencing vulnerability. Insurers should remain free to provide additional support beyond those minimum requirements, but the baseline protection should not vary according to each insurer's internal operating model or discretion.

The insurer should also be required to explain in writing where a requested support measure cannot be provided, identify the reason and propose a reasonable alternative.

Financial hardship and the cost of expert evidence

Customers experiencing vulnerability or financial hardship are often least able to obtain independent expert evidence, yet they may be the most affected by incorrect insurer decisions.

The Code should require insurers to take reasonable steps to ensure customers are not disadvantaged because they cannot afford the evidence needed to properly assess or progress their claim. Where further expert evidence is reasonably required, insurers should obtain that evidence themselves or fund it where it is necessary to fairly determine the claim. Consumers should not be required to incur significant expert costs simply to address deficiencies in an insurer's investigation or assessment.

Claims Hero considers that reimbursement should follow where consumer-funded evidence causes or contributes to:

- a change in the insurer's decision;
- an increase in the settlement offer;
- withdrawal or correction of a flawed insurer report;
- further investigation;
- acceptance of additional damage;
- resolution of a complaint; or
- a materially different assessment of causation, scope or quantum.

The need for reform is particularly acute for customers experiencing vulnerability or financial hardship. Those customers are often least able to fund expert evidence yet may suffer the greatest harm if they cannot challenge an incorrect decision. The present imbalance means that the insurer can appoint multiple experts while the consumer may be unable to obtain even one independent opinion.

Consequences for failing to provide Extra Care to vulnerable customers

The Code contains limited practical consequences where an insurer fails to identify or provide Extra Care to a consumer.

This is a significant omission. A failure to provide appropriate support can directly affect the customer's

ability to effectively and meaningfully participate in the claims process. The Code should specify that, where an insurer fails to provide agreed or reasonably required Extra Care, the insurer may be required to:

- immediately implement the support measure;
- extend any affected deadline;
- reconsider any decision made without the agreed support;
- restore or extend policy benefits depleted because of the failure;
- reimburse reasonable expert, advocacy, accommodation or other costs caused by the failure;
- pay interest on delayed amounts;
- compensate the customer for reasonably foreseeable financial and non-financial loss; and
- refer to the matter for broader remediation where the failure reflects a systemic issue.

A customer should not be disadvantaged for failing to navigate a process that the insurer knew, or reasonably should have known, was inaccessible to them. This should be reflected in the redrafted Code.

The applicability of the redrafted Code in the future

The Code should not only address today's claims-handling practices, but also remain effective as technology, insurance products and claims processes evolve. This requires regular review, enforceable protection for emerging risks and governance arrangements that ensure important consumer protections cannot be weakened outside the formal Code approval process.

Proposed review cycle timeframe is not justified

Paragraph 210 proposes that the ICA commission a formal independent review of the Code at least every five years, extending the current review period of three years. The consultation paper also anticipates a 24-month transition period following approval to enable insurers to update policies, systems and processes.

The combined effect of this provision is that the first formal review of the new Code may not commence until approximately seven years after it is approved. Once the time required to conduct the review, consult on recommendations, obtain approval and implement any subsequent reforms is taken into account, close to a decade may pass before material deficiencies in the Code are substantively corrected.

That timeframe is not appropriate for an industry undergoing rapid operational and technological change and the importance of the Code as a consumer protection framework. A five-year formal review cycle may allow ineffective, outdated or potentially harmful practices to become embedded well before the Code is reconsidered.

Claims Hero acknowledges that insurers require a reasonable period to implement the new Code. However, the time required by insurers to implement the Code does not justify reducing the frequency with which the Code's effectiveness is independently assessed. Implementation and review serve different purposes. The former allows insurers to make operational changes; the latter tests whether those changes have delivered the intended consumer outcomes.

Claims Hero recommends retaining a formal independent review at least every three years. The Code should also provide for targeted interim reviews where:

- significant changes in technology or claims-management practices occur;
- evidence of systemic or emerging consumer harm is identified;
- AFCA, ASIC or the CGC identifies recurring interpretive or compliance issues;
- major catastrophe events expose deficiencies in the Code; or
- a substantive external standard incorporated into the Code requires amendment.

The Code should be reviewed at a frequency that reflects the pace of industry change and allows emerging deficiencies to be addressed before they become entrenched. A five-year review cycle is unlikely to provide sufficiently timely oversight, particularly given the consequences of ineffective claims-handling

protections.

Responsible use of artificial intelligence (AI) must be enforceable

The redrafted Code states that insurers will use technology responsibly, but this commitment is contained in the non-binding Industry Principle (e) and excluded from enforceability.

Claims Hero considers that this approach is inadequate given the increasing use of artificial intelligence by insurers in claims triage, fraud detection, document review, customer communications, assessment processes and decision support. The use of AI may improve efficiency and consistency, but it may also introduce or amplify risks relating to accuracy, bias, transparency, explainability, accountability and procedural fairness.

These concerns are consistent with ASIC's findings in Report 798, *Beware the gap: Governance arrangements in the face of AI innovation*[5]. ASIC found AI adoption was outpacing governance arrangements in some financial services firms and identified gaps in consumer-focused risk assessment, transparency, contestability and meaningful human oversight, creating an increased risk of consumer harm.

These findings demonstrate that a general and non-binding commitment to responsible technology use is insufficient. At a minimum, insurers should:

- remain accountable for decisions and outcomes made or materially influenced by AI;
- disclose where AI has been used in a manner that materially affects a customer or their claim;
- disclose where substantive customer-facing material has been generated wholly or partly by AI;
- provide meaningful human oversight and review of significant or adverse decisions; and
- provide customers with sufficient information to understand and challenge AI-assisted outcomes.

Claims Hero therefore recommends that responsible use of AI be included as a contractually enforceable obligation within the Code, supported by clear minimum standards concerning transparency, accountability, human oversight and contestability. Leaving these matters solely within non-binding principles would not provide an adequate response to the pace of technological change or the consumer risks already identified by ASIC.

Changes to the significant breach threshold may conceal emerging harm

Changes to the threshold for what constitutes a Significant Breach have important implications for oversight, reporting, accountability and consumer remediation.

The redrafted definition of Significant Breach requires all listed factors to be considered "holistically and in combination". This will create confusion and likely lead to under-reporting of breaches.

Claims Hero considers that the proposed change appears primarily directed at reducing the administrative burden on insurers. However, this is achieved at the expense of consumer protection.

The existing factors already require consideration of:

- the number and frequency of similar breaches;
- the impact on the insurer's ability to provide services;
- the adequacy of the insurer's compliance arrangements;
- actual or potential financial loss; and
- the duration of the breach.

Requiring all factors to be considered together may mean that a breach causing severe harm does not

[5] https://download.asic.gov.au/media/mtllqjo0/rep-798-published-29-october-2024.pdfhttps://download.asic.gov.au/media/mtllqjo0/rep-798-published-29-october-2024.pdf

qualify as significant because it affected a small number of consumers, was detected quickly or did not cause readily quantifiable financial loss.

This is particularly concerning for emerging risks. Harm associated with artificial intelligence, new claims platforms or outsourcing arrangements may initially appear in a small number of cases before a broader pattern becomes visible. A high cumulative threshold may delay escalation until the practice has become widespread.

The proposed definition also focuses on financial loss without expressly recognising broader non-financial harms.

To strengthen consistency and ensure significant breaches are identified and reported appropriately, the Code should:

- remove the requirement to assess all factors "in combination";
- clarify that a single sufficiently serious breach is capable of constituting a Significant Breach;
- expressly recognise both financial and non-financial harm;
- require consideration of the impact on customers experiencing vulnerability;
- retain the current 10-business-day reporting timeframe; and
- require uncertainty about whether a breach is significant to be resolved in favour of reporting.

The general insurance Significant Breach framework should operate as an early-warning mechanism. It should not require harm to become widespread before it attracts scrutiny or in a manner that will trigger internal debates about whether the threshold is met and reporting is required.

Other recommendations

In addition to the matters addressed above, Claims Hero considers that several further amendments are necessary to ensure the redrafted Code operates as a credible, transparent and effective consumer protection framework.

Expert report obligations should extend to service suppliers

The proposed expert report protections should apply not only to the External Expert who prepares the report, but also to any Service Supplier involved in commissioning, instructing, managing, reviewing or materially influencing that evidence.

The redrafted Code expressly excludes Service Suppliers from the definition of External Expert. At the same time, Service Suppliers include Loss Assessors and Insurance Claims Managers, including approved subcontractors that may manage claims or make decisions on an insurer's behalf. The specific expert report obligations in paragraphs 69 to 72 are, however, directed principally to insurers and External Experts.

This creates a material accountability gap. In practice, assessors, loss adjusters and outsourced claims or expert-management platforms may:

- identify the issues to be investigated;
- select or recommend the expert;
- prepare or transmit the instructions;
- determine what information is provided to the expert;
- decide whether consumer-obtained evidence is included;
- authorise or restrict further testing;
- review draft reports;
- manage costs and timeframes; and
- make recommendations to the insurer based on the resulting report.

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The independence and reliability of an expert report therefore depend not only on the conduct of the person

who signs it, but also on the integrity of the process through which the expert was selected, instructed and managed.

Claims Hero have raised concerns regarding incomplete or outcome-oriented briefs, failure to provide experts with relevant factual material and competing causation hypotheses, and the influence of outsourced platforms and vendor panels over expert selection, instructions and performance measures. These arrangements are often not transparent to the consumer, despite their potential to materially affect the resulting opinion.

Temporary accommodation protections

Temporary accommodation is essential where a consumer's home remains unsafe or uninhabitable. The Independent Code Review recommended that accommodation not be subject to rigid 12-month limits. The Parliamentary Inquiry into insurers' responses to the 2022 major floods also recommended at least three months' notice before any substantive change to temporary accommodation.

The redrafted Code does not prescribe minimum requirements for reviewing, reducing or withdrawing accommodation. Insurers should regularly assess habitability, repair progress, vulnerability and the availability of suitable alternatives.

At least three months' written notice should be required before accommodation is withdrawn, reduced or materially changed. The notice should explain the decision, evidence relied upon, effective date, alternative support and review rights. A shorter period should apply only where urgent action is necessary, the accommodation becomes unavailable or the consumer requests the change.

Informed consent for contractor works

The Parliamentary Inquiry identified concerns about contractors entering properties or commencing stripping, removal and repair work without adequate consumer consent.

The redrafted Code makes insurers responsible for their representatives but does not expressly require informed consent before destructive or substantive work begins. Consumers should be told who will attend, the purpose and scope of the work, what will be removed or altered, any material risks and how relevant evidence will be preserved.

An exception should apply only where urgent make-safe work is necessary to protect people or property and prior consent cannot reasonably be obtained.

CGC oversight should recognise serious individual harm

Claims Hero supports a strong focus by the Code Governance Committee on serious and systemic non-compliance. However, the proposed framework places considerable emphasis on matters that are already systemic or affect the industry more broadly.

The CGC Charter states that its investigations will focus on matters that may be serious or systemic, and that its stewardship role will be informed by serious and systemic breaches.

Systemic issues are frequently first identified through individual claims. A serious failure affecting one consumer may reveal:

- an incorrect interpretation of a Code obligation;
- inadequate systems or controls;
- a flawed expert methodology;
- a failure to respond to vulnerability; or
- conduct capable of recurring across other claims.

An individual matter should not be disregarded merely because the broader pattern has not yet been

established. This is particularly important where the breach results in severe financial or non-financial harm, including prolonged displacement from their home, unsafe living conditions or significant disadvantage to a customer experiencing vulnerability.

Claims Hero recommends that the Charter expressly confirm that:

- a serious individual breach may warrant CGC investigation;
- individual complaints may be used to identify emerging or systemic risks;
- the CGC may require a review of other potentially affected claims;
- affected consumers should be remediated where non-compliance is established; and
- the existence of an AFCA complaint should not prevent the CGC from considering the broader compliance implications.

Published breach outcomes should identify the insurer

Claims Hero supports the publication of serious and systemic breach decisions but does not support routinely de-identifying the insurer. While consumers' identities and sensitive claim information should remain protected, there is no equivalent justification for concealing the identity of an insurer responsible for a substantiated breach.

Identifying the insurer would improve transparency, strengthen accountability, enable consumers and regulators to identify recurring compliance issues, and create a stronger incentive for insurers to invest in effective compliance systems.

The default position should be that insurers are identified where a serious, systemic or significant breach has been substantiated, unless prohibited by law.
Where an insurer is not identified, the CGC should publish its reasons.

Transparency should be a meaningful consequence of serious non-compliance, not merely a mechanism for publishing anonymous case studies. This will also support consumer choice based on compliance outcomes.

Independent consumer-focused drafting review

Claims Hero welcomes the plain English review undertaken during drafting. However, we respectfully note that we consider this review was inadequate. The extensive use of subjective language means many consumers are still unlikely to understand what an insurer must do, when obligations apply, whether the Code has been breached, or what remedies are available.

Legalistic language should be removed and replaced with clear objective obligations. Reducing subjectivity benefits all stakeholders and improves customer protections.

Before the Code is finalised, it should undergo an independent, consumer-focused review involving scenario-based testing with a diverse range of consumers to ensure the Code is genuinely understandable and can be applied in practice. The findings, and any resulting amendments, should be published before the Code is submitted to ASIC.

The proposed 24-month implementation period is excessive

Claims Hero considers that a 24-month implementation period is unnecessarily long and delays important consumer protections. While some reforms may require additional time to implement, many of the proposed obligations reflect existing regulatory expectations and could be introduced much sooner.

Claims Hero recommends a phased implementation model, with obligations that do not require significant systems or policy changes commencing within twelve months of ASIC approval. This would deliver meaningful consumer protections sooner while allowing additional time for more complex operational reforms.