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Submission on the redrafted General Insurance Code of Practice

Insurance Council of Australia consultation – July 2026

Submitted to: Insurance Council of Australia (**ICA**)
Consultation: Redrafted General Insurance Code of Practice
Submitted by: Elkington Bishop Molineaux Insurance Brokers Pty Ltd (**EBM Group**)
Date: 21 July 2026
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Introduction

EBM Group welcomes the opportunity to comment on the Insurance Council of Australia's consultation draft of the redrafted General Insurance Code of Practice.

Our submission focuses on provisions that may be unclear, open to different interpretations or difficult to apply consistently in practice, especially where obligations may become enforceable as part of an insurance contract.

About EBM Group

EBM Group is an Australian financial services licence holder. Our business includes general insurance broking, wholesale broker operations and underwriting agency operations.

The proposed Code changes are expected to affect our underwriting agency operations most directly, particularly where obligations apply across the policy lifecycle, including new business, renewals, claims, vulnerable customers, complaints and cancellations.

Our wholesale broker operations may also be affected where they operate under insurer binder arrangements or provide services on behalf of insurers.

Our general insurance broking teams may also be affected where they interact with insurers and need to understand how insurers apply the Code.

Overall comments

We support clear, practical and customer-focused standards for general insurance. We also recognise the value of clearer drafting and a more accessible Code.

However, where Code provisions are intended to become contractually enforceable, clarity becomes especially important. Broad or subjective expressions may create uncertainty for customers, insurers and organisations acting on behalf of insurers.

We ask the ICA to consider whether further clarification, examples or drafting refinements are needed for the areas below. This includes open-ended terms such as 'where possible', 'if your claim requires one', 'appropriate to Employees' roles', 'principles' and 'information about you', as well as provisions where the intended scope, timing or practical operation is unclear.

Issues and clarification sought

Issue 1: Contractual enforceability and open-ended terms

Relevant draft Code paragraphs: 21 to 24

Issue: Paragraphs 21 to 24 are a significant structural change. They would make applicable paragraphs in sections 1 to 9 part of the customer's contract and give customers contractual enforcement rights.

This increases the need for clear, certain and workable drafting. Some draft Code provisions use broad or subjective language that may be difficult to apply consistently, particularly where compliance depends on judgement, system capability, third-party conduct, service availability or customer circumstances.

Contractual enforceability may also change the risk profile for insurers and organisations acting on their behalf. Ambiguous obligations may increase disputes, legal costs, compliance costs and uncertainty in pricing and reserving.

Clarification sought:

- ICA to provide guidance on how broad or subjective obligations are intended to operate, particularly where compliance depends on judgement, customer circumstances, operational capability or service availability.
- Open-ended terms such as 'where possible', 'appropriate', 'if required' and 'principles' to be supported by examples or implementation guidance.
- ICA to consider tightening provisions intended to become contractual obligations, particularly where non-compliance may give rise to contractual remedies.

Issue 2: Electronic renewal reminders and nominated contacts

Relevant draft Code paragraph: 39

Issue: Paragraph 39 requires an insurer offering renewal on an annual policy to send a renewal notice at least 14 calendar days before expiry and a further electronic reminder before expiry, where possible and where an email address or mobile number is recorded for the policy.

The phrase 'where it is possible to do so' is open-ended. It is unclear when it would be considered not possible to send an electronic reminder if an email address or mobile number is recorded.

The phrase 'we have an email address or mobile number recorded for your policy' is also unclear. It is unclear whether the insurer is expected to send the electronic reminder to another policy contact who has an email address or mobile number recorded, even though they would not normally receive policy communications.

Clarification sought:

- Where a customer has appointed an agent, nominee or other authorised contact to receive policy communications, does sending the renewal notice and electronic reminder to that person satisfy paragraph 39?
- Where an agent, nominee or other authorised contact has been appointed to receive policy communications, but an email address or mobile number has not been recorded for that person, is the insurer expected to send the electronic reminder to another contact recorded on the policy, even though they would not normally receive policy communications?

- What circumstances would make it not possible to send an electronic reminder where an email address or mobile number is recorded?
- ICA to provide examples or guidance on how paragraph 39 is intended to operate under different communication and authorisation arrangements.

Issue 3: When a claim requires a primary contact

Relevant draft Code paragraphs: 62 and 63

Issue: Paragraphs 62 and 63 require a primary contact to be provided if the claim requires one, but the draft does not explain when a claim 'requires' a primary contact.

Because the obligation is conditional, clearer guidance is needed to avoid inconsistent interpretation, and customer confusion and disputes.

Clarification sought:

- What factors determine whether a claim 'requires' a primary contact?
- ICA to identify the factors relevant to whether a claim requires a primary contact, such as claim complexity, expected duration, number of suppliers, severity of loss, vulnerability or the customer's stated support needs.
- ICA to provide examples or guidance on claims that do and do not require a primary contact.

Issue 4: Meaning of 'up to the policy coverage and limits'

Relevant draft Code paragraph: 75

Issue: Paragraph 75 provides that, for certain home building, home contents and motor vehicle claims, if a Decision has not been made within 12 months of receiving the claim, the insurer will automatically cover the loss or damage claimed 'up to the policy coverage and limits', unless paragraph 76 applies.

The phrase 'up to the policy coverage and limits' is unclear.

It is unclear whether 'up to the policy coverage' is intended to mean 'to the extent covered under the policy'.

The reference to 'up to the policy limits' could also be interpreted as requiring payment up to the full applicable policy limit, even where the claimed or likely loss is clearly much lower than the policy limit. Without clearer drafting, paragraph 75 may

produce outcomes inconsistent with the indemnity principle by allowing recovery beyond the loss actually suffered or otherwise payable under the policy.

Clarification sought:

- Confirm whether any amount payable under paragraph 75 is limited to the loss or damage claimed that is otherwise payable under the policy, subject to the relevant policy limit?
- If 'loss or damage claimed' is clearly speculative, exaggerated or unsupported by objective evidence, is the insurer nevertheless required to pay more than the amount otherwise payable under the policy?

Issue 5: Partial claim resolution before the 12-month trigger

Relevant draft Code paragraph: 75

Issue: Paragraph 75 is unclear where some aspects of a claim have been resolved or decided within 12 months based on objective evidence, but other aspects remain unresolved.

An insurer may have accepted and paid part of a claim, declined another part, or resolved all but a narrow issue relating to quantum, causation, ownership, entitlement, competing information, fraud indicators, customer-related delay, a complaint or catastrophe constraints.

The drafting should clarify that automatic cover under paragraph 75 is limited to the unresolved portion of the claim, rather than applying to the claim as a whole.

Clarification sought:

- Confirm that, where only part of a claim remains unresolved after 12 months, paragraph 75 applies only to that unresolved part of the claim.

Issue 6: Calculating the 12-month period where exceptions apply

Relevant draft Code paragraphs: 75 to 76

Issue: Paragraph 75 is also unclear as to how the 12-month period is calculated where a paragraph 76 exception applies for part of the claim lifecycle.

The draft does not specify whether the 12-month period continues to run, is paused, or is extended during periods where a paragraph 76 exception applies.

It is also unclear how paragraph 75 is intended to operate where a paragraph 76 exception ends shortly before the 12-month period expires. In those circumstances, an insurer may have insufficient time to reasonably assess and decide the claim before paragraph 75 is triggered.

Further guidance is also needed for claims that have been closed and later reopened after 12 months. It is unclear whether paragraph 75 applies by reference to the original claim receipt date, the reopening date or another point in the claim lifecycle.

Insurers need clear rules for calculating the 12-month period in these scenarios.

Clarification sought:

- How should insurers calculate the 12-month period where a paragraph 76 exception applies for part of the claim lifecycle?
- How is paragraph 75 intended to operate where a paragraph 76 exception ends shortly before the 12-month period expires, potentially leaving insufficient time for the insurer to assess and decide the claim before paragraph 75 applies?
- How is paragraph 75 intended to operate where a claim has been reopened after 12 months?

Issue 7: External expert reports and declined claims

Relevant draft Code paragraph: 79, 80 and 81

Issue: Paragraph 79 provides for the insurer Decision to be made In Writing. Paragraph 80 applies where a claim is declined or not covered in full. Paragraph 81 then states that the insurer will 'also provide a copy of any External Experts' reports it relied on'.

The Current Code gives customers a right to request copies of External Experts' reports relied upon by the insurer. Paragraph 81 moves beyond this by requiring External Experts' reports to be provided automatically, regardless of whether the customer has requested them.

It is also unclear whether paragraph 81 applies only where the claim is declined or not covered in full, or whether it creates a broader obligation to provide External Experts' reports with all claim Decisions.

If External Experts' reports are required to be provided automatically and with all claim Decisions, this will create additional review requirements to determine whether reports were relied upon, as well as privacy assessment requirements before reports can be provided to customers.

Clarification sought:

- Is paragraph 81 intended to require External Experts' reports relied on by the insurer to be provided automatically, regardless of whether the customer has requested them?
- Confirm whether paragraph 81 is intended to apply only where a claim is declined or not covered in full, and the Decision relied on an External Expert's report.
- If so, would the ICA consider incorporating paragraph 81 into paragraph 80 as an additional item, to make this clear?

Issue 8: Meaning of 'information about you'

Relevant draft Code paragraphs: 80(d) and 82

Issue: Paragraph 80(d) refers to the customer's right to ask for 'the information about you that we used to make a Decision on your claim'. This phrase is broad, open-ended and undefined.

It may mean personal information under the Privacy Act 1988, or any information concerning the customer used in the claim Decision. This could include file notes, call recordings, internal assessments, opinions, service supplier material, underwriting records or other claim file information.

Although similar language appears in the Current Code, the concern is greater under the draft because the obligation will become contractually enforceable and is linked to a shorter 10-business-day timeframe.

Clarification sought:

- Is 'information about you' intended to mean personal information under the Privacy Act 1988?

- If not, what categories of information are intended to be captured?
- Would the ICA consider defining 'information about you' in the Code to remove uncertainty regarding its scope and application?

Issue 9: Refusal grounds for 'information about you'

Relevant draft Code paragraphs: 30, 80(d) and 82

Issue: Paragraph 30 sets out circumstances where an insurer may refuse access to information. Paragraph 82 sets out more limited refusal grounds for information requested under paragraph 80(d), being where the law prohibits disclosure or there is a legal basis not to provide the information.

If 'information about you' means only personal information under the Privacy Act 1988, the narrower refusal grounds are understandable. However, if it captures broader claim information, paragraph 82 may not clearly preserve the ability to refuse information that is commercially sensitive, prejudicial to a complaint or dispute, or otherwise within paragraph 30.

Clarification sought:

- If 'information about you' is intended to mean personal information under the Privacy Act 1988, would the ICA consider defining the term in the Code to remove uncertainty?
- If 'information about you' is intended to capture broader claim information, why are the refusal grounds in paragraph 82 narrower than the refusal grounds in paragraph 30?

Issue 10: Reduced timeframe for information requests under paragraph 80(d)

Relevant draft Code paragraphs: 27, 28, 80(d) and 82

Issue: Paragraph 28 sets a 20-business-day timeframe for providing information under paragraph 27. Paragraph 82 sets a shorter 10-business-day timeframe for information requested under paragraph 80(d).

If 'information about you' means personal information under the Privacy Act 1988, paragraph 82 appears shorter than the Privacy Act framework, which requires an organisation to respond within a reasonable period. Guidance published by the

Office of the Australian Information Commissioner states that, generally, a reasonable period should not exceed 30 calendar days.

If it captures broader claim information, the shorter timeframe may be difficult to meet for large or complex claims, third-party information, privilege review, privacy assessment or redaction.

Clarification sought:

- Why has a 10-business-day timeframe been proposed for paragraph 80(d) requests?
- Has the ICA considered aligning paragraph 82 with the 20-business-day timeframe in paragraph 28?
- Will the ICA clarify whether an extension process is available where a paragraph 80(d) request cannot reasonably be completed within 10 business days?

Issue 11: Proof of ownership for total loss claims

Relevant draft Code paragraph: 86

Issue: Paragraph 86 provides that, where a total loss claim under a home building or home contents policy is accepted and the customer cannot provide proof of ownership because it was lost or damaged in the insured event, the insurer will not require proof of ownership or a list of insured property lost or damaged.

The Current Code includes the additional concept that 'ownership must be clear'. The draft does not appear to retain that qualifier. While it may not be reasonable to require detailed proof in many total loss situations, ownership, entitlement or competing interests may be unclear in some cases.

Clarification sought:

- Can an insurer request reasonable information where ownership, entitlement or competing interests are unclear?
- Would the ICA consider wording that protects customers who genuinely cannot provide documents, while allowing reasonable verification where ownership or entitlement is uncertain?

Issue 12: Cash settlement information where no repair or rebuild option exists

Relevant draft Code paragraph: 88

Issue: Paragraph 88 applies where an insurer offers a Cash Settlement or is Cash Settling a claim.

It is unclear how paragraph 88 operates where cash settlement is the only available settlement option under the policy or in the circumstances of the claim. If that is the case, some of the prescribed information in paragraph 88(b) and 88(c) may be confusing because it is framed as though the customer has a choice between cash settlement and insurer-managed repair or rebuild.

The Cash Settlement Fact Sheet requirements in the Corporations Act 2001 apply where both cash settlement and insurer-managed repair or rebuild are available settlement options. Paragraph 88 does not appear to make the same distinction.

Clarification sought:

- What information must be provided where cash settlement is the insurer's only available settlement option under the policy wording or in the circumstances of the claim?
- Would the ICA consider tailoring paragraph 88 to distinguish between these scenarios and align more closely with the Cash Settlement Fact Sheet framework?

Issue 13: Vulnerability Guidance principles incorporated into an enforceable obligation

Relevant draft Code paragraphs: 33, 141 and 148

Issue: Paragraph 141 requires systems, processes and training to be developed in accordance with the principles from the ICA's Guidance on Vulnerability. Paragraph 148 requires policies and role-appropriate training to support several Extra Care-related obligations. Paragraph 33 states that non-binding industry guides do not form part of the Code, and the Vulnerability Guidance describes itself as voluntary and not legally binding.

It is unclear what 'principles' means in paragraph 141. It may refer only to section 2 of the guidance, titled 'Principles for supporting customers experiencing vulnerability', or to broader concepts throughout the guidance. It is also unclear which principles require systems, processes or training.

Clarification sought:

- Which specific principles from the Vulnerability Guidance are incorporated into paragraph 141, and would the ICA consider listing those principles in the Code itself?
- If only part of the guidance is intended to be enforceable through paragraph 141, how should insurers distinguish that content from guidance that remains voluntary?
- Does the ICA consider there is a contractual certainty risk in making paragraph 141 enforceable by reference to broad principles from external guidance that is described as voluntary and not legally binding, and is this consistent with the decision not to make the General Insurance Code of Practice Industry Principles contractually enforceable?

Issue 14: Interpreter services and 'where possible'

Relevant draft Code paragraphs: 112 and 147

Issue: Paragraph 147 requires insurers, where possible, to provide access to an interpreter if requested or needed to communicate effectively. Paragraph 112 uses similar language in the investigation context.

The phrase 'where possible' may create uncertainty, especially in an enforceable Code provision. Interpreter services may be technically possible, but not immediately available or reasonably practicable in the circumstances. The Current Code uses 'where practicable', which may better recognise operational and availability constraints.

Clarification sought:

- How should 'where possible' be interpreted where interpreter services are technically available, but not reasonably available within the timeframe needed for the customer interaction?
- Would 'where reasonably practicable' better reflect the intended standard?

- Will the ICA provide examples of circumstances where arranging an interpreter may not be possible, despite reasonable steps being taken?

Issue 15: Trauma-informed care and role-based training

Relevant draft Code paragraphs: 148 and 181

Issue: Paragraph 148 requires internal policies and role-appropriate training to help employees identify Extra Care needs, apply Trauma-informed Care, support Financial Hardship and Family and Domestic Violence needs, assist First Nations customers, assist customers who may require an interpreter and engage with sensitivity, dignity, respect and compassion.

We support role-appropriate training and customer care. However, Trauma-informed Care is specialised and subjective. The definition refers to recognising trauma symptoms and acknowledging the role trauma may play in a person's life, but the draft does not clearly explain what level of recognition, response or escalation is expected from financial services staff who are not specialist support workers.

This is important because paragraph 148 will become contractually enforceable. A failure to identify Extra Care needs or apply Trauma-informed Care in a particular case may be alleged to have contractual consequences, even where staff have received reasonable role-based training.

Financial services staff are not trained support workers. Training can improve awareness and sensitivity, but it cannot guarantee that every instance of trauma, vulnerability or family and domestic violence will be identified in every interaction.

More guidance is needed on what reasonable compliance looks like in practice, including training, scripting, escalation pathways and staff judgement. This would help insurers implement proportionate controls without excessive or defensive processes that increase cost without necessarily improving customer outcomes.

Clarification sought:

- What level of recognition, response and escalation is expected from employees who are not specialist support workers?
- Will the ICA provide examples of proportionate training, escalation and support models for different roles?

- How should insurers demonstrate reasonable compliance where staff have received appropriate training but a customer's Extra Care needs were not identified in a particular interaction?

Issue 16: Family and Domestic Violence training scope

Relevant draft Code paragraphs: 150 and 181

Issue: Paragraph 150 requires systems and processes designed to protect customers experiencing Family and Domestic Violence and reduce potential harm from interactions. It includes training to help employees identify, support and avoid harm to affected customers.

Unlike paragraph 148, paragraph 150 does not expressly state that training is to be appropriate to Employees' roles. It is unclear whether all employees must receive the same level of training, or whether training may be tailored by role, customer contact and decision-making responsibility.

Clarification sought:

- Can Family and Domestic Violence training under paragraph 150 be role-based?
- What level of training is expected for employees with limited or no customer interaction?
- Would the ICA consider aligning paragraph 150 with paragraph 148 by referring to training appropriate to Employees' roles?

Use of AI tools

Microsoft Copilot was the only AI tool used to assist with drafting and editing this submission. The issues raised, interpretation of the redrafted Code, and clarification sought from the ICA were identified and reviewed by EBM Group personnel, with legal and compliance input. Copilot was used to help organise those issues into a clear submission structure, refine wording into plain English, reduce repetition, and improve readability and consistency. Copilot was not used to determine EBM Group's position or to make legal or compliance decisions.

Closing statement

EBM Group appreciates the opportunity to provide feedback on the consultation draft. We would welcome any further guidance from the ICA on the matters raised in this submission.