Submission to the Draft General Insurance Code of Practice

Date of submission: 20 July 2026

About FCVic

Financial Counselling Victoria (FCVic) is the peak body and professional association for Victoria's 300 practising financial counsellors. Our organisation was established in 1978 by Victorian financial counsellors to provide sector professionalisation, peer support, and undertake systemic advocacy.

FCVic's vision is *'a fairer and more equitable society with improved community wellbeing and better lives for vulnerable people'*. FCVic develops resources, builds sector capability, and advocates on behalf of financial counsellors and community members on systemic issues that cause and exacerbate poverty and financial hardship. We work with government, banks, utilities, insurers, debt collection agencies and other industries to improve approaches to consumer rights, financial hardship and vulnerability.

About this submission

FCVic welcomes the opportunity to provide a submission to the draft General Insurance Code of Practice (the Code).

Financial counselling is a free, confidential, and independent service. It provides vital help for people experiencing, or at risk of, financial hardship. Financial counsellors are uniquely qualified professionals, specially trained to deal with complex financial and consumer rights matters.

They work alongside consumers at some of the most difficult times in their lives. Whether assisting people recovering from floods, bushfires and storms, supporting victim-survivors of family violence, or helping households experiencing severe financial hardship, our members regularly observe how insurers implement the Code in practice. This provides FCVic with a unique perspective on where the Code succeeds, where it falls short, and where stronger consumer protections are required.

This submission is grounded in the direct experiences of Victorian financial counsellors working with people navigating the complexities of insurance claims in the aftermath of significant disaster events. They see firsthand the systemic barriers faced by their clients when trying to understand specialised insurance lingo and work constructively within bureaucratic power structures to reach a good outcome – all while grappling with significant personal and family trauma post-disaster. Our recommendations are informed by their frontline expertise and feedback through the FCVic Disaster Recovery Network.

The commentary and recommendations provided in this submission should be read in conjunction with a wide body of work already produced by FCVic in conjunction with our advocacy partners on issues relating to insurance and natural disasters including:

- Research Report - Unsettled: Climate risk and cash settlements in home insurance
- Submission to the Independent Review of the 2020 General Insurance Code of Practice
- Submission to the House Standing Committee on Economics Inquiry into insurers' responses to 2022 major floods claims
- Submission to AFCA's joint consultation on General Insurance Approaches
- Submission to AFCA's consultation on Approach to General Insurance Claims Handling
- Submission to the Insurance Brokers Code of Practice Review
- Submission to Treasury's consultation on Standard definitions and standard cover for insurance

We acknowledge and support the work of fellow consumer advocates throughout the consultation process of the draft Code. We support the recommendations made in the joint consumer submission to this consultation which is led by Financial Rights Legal Centre (FRLC), and the submission by the national financial counselling peak body Financial Counselling Australia (FCA) on Section 7 relating to Vulnerability. The recommendations and commentary in this submission are designed to complement the recommendations by FRLC, FCA and our consumer colleagues, and lend a Victorian financial counselling perspective.

Further questions on the content of this submission can be sent to Kellie Davis, FCVic Disaster Recovery Lead, at [redacted].

Disclaimer: The thoughts in this paper are those of Financial Counselling Victoria. AI was used to assist in drafting and editing this submission, but all content was reviewed by multiple human experts with subject matter expertise and policy experience before publication.

Full list of recommendations

Recommendation 1: Review and update discretionary language in the Code with mandatory obligations to reduce inconsistency of practice.

Recommendation 2: Require Code subscribers to communicate with customers using the nominated method of communication.

Recommendation 3: Amend prescribed timeframes in the Code to include expectations of communication content and quality.

Recommendation 4: All Code subscribers should accept a standard authority form.

Recommendation 5: Ensure that all sections of the Code are enforceable by the Code Governance Committee.

Recommendation 6: Consumer protections in the Code should be extended to eligible small businesses, with eligibility determined by a turnover of $10m or less, and fewer than 100 employees, a standard definition as used by the Australian Banking Association.

Recommendation 7: Extend the minimum period for automatic renewal notices from 14 days to 28 days.

Recommendation 8: Premiums should not be subject to higher charges for paying monthly rather than annually.

Recommendation 9: Protection from policy cancellation should be granted to consumers who engage with the insurer and request reasonable payment extensions.

Recommendation 10: A dedicated claims manager (primary contact) should be required for all claims.

Recommendation 11: A full section on temporary accommodation entitlements should be inserted into the Code.

Recommendation 12: The ICA should create and regularly review a standard claims management information sheet (similar to the current cash settlements information sheet) for insurers to provide to consumers once a claim is lodged.

Recommendation 13: Where an insurer relies upon an expert report to assess or determine a claim, that report should automatically be provided to the customer or their authorised representative within 14 days of being received by the insurer.

Recommendation 14: The Code should expressly comply with the Recommendations 75-78 of the Independent Review, and Recommendation 6 of the Parliamentary Inquiry, in relation to the use of expert reports.

Recommendation 15: Amend Code wording to require provision of an actionable Scope of Works for all cash settlement offers, even in cases of 'total loss'.

Recommendation 16: Amend the Code to ensure consumers are given sufficient time to consider the cash settlement offer, free from pressure or arbitrary deadlines, after having received qualified independent advice.

Recommendation 17: Requests for supporting information should be made only where reasonably necessary in the circumstances, with an obligation for Code subscribers to take a flexible and proportionate approach.

Recommendation 18: Where a hardship application has been made, or where hardship-related decisions are under review through internal or external dispute resolution, all debt recovery activity should cease until those processes have concluded.

Recommendation 19: The Code should require all representatives acting on behalf of Code Subscribers to comply with a consistent minimum standard of conduct.

Recommendation 20: All staff and representatives who engage directly with customers undertake regular training on vulnerability, family violence, financial hardship and trauma-informed practice. This training should be delivered or developed with appropriately qualified external experts rather than relying solely on internal training programs.

Our commentary

Overarching comments

Overuse of discretionary language

The Insurance Council has described the revised Code as an opportunity to modernise industry standards and improve consumer outcomes. FCVic supports that objective. However, we believe that **the current draft does not consistently strengthen consumer protections and, in some respects, represents a step backwards from the existing Code.**

Over the past two years since the Independent Review of the Code was conducted, consumer advocates have been working closely with insurers to improve practices. Several insurers have made significant positive progress, yet the revised Code sets minimum standards (in some cases, optional standards) that are less than current expectations and practices. The revisions fall short of addressing the recommendations of both the Independent Review, and the final report of the Parliamentary Inquiry into insurers' responses to 2022 major floods claims. As such, it fails as an effective guardrail against poor practice, and guideline for good practice.

Throughout the draft, mandatory obligations have frequently been replaced with broader principles or discretionary language. While flexibility has an important role in allowing insurers to respond to individual circumstances, it should not come at the expense of certainty for consumers. Where minimum standards exist to protect consumers during claims, complaints or hardship, those standards should be expressed clearly and enforced consistently across all Code Subscribers.

Financial counsellors frequently observe significant differences in practice between insurers despite their shared obligations under the existing Code. Consumers should not receive materially different standards of service depending upon which insurer they happen to hold a policy with. A revised Code should reduce inconsistency, not institutionalise it.

Recommendation 1: Review and update discretionary language in the Code with mandatory obligations to reduce inconsistency of practice.

Communication timelines, content and channel

The relationship between an insurer and a consumer is established well before a claim is made. The quality of information provided when a policy is purchased, renewed or cancelled influences customers' understanding of their cover, their confidence in engaging with their insurer, and ultimately their ability to recover when something goes wrong.

The draft Code contains welcome commitments to communicating with consumers clearly and in plain language. However, **effective communication is not simply about what is communicated, it is equally about the audience, and how and when the information is provided.**

Financial counsellors regularly support consumers who have explicitly advised their insurer that communication should occur through an authorised representative or via a particular communication channel, only for those preferences to be ignored. In many cases this creates inconvenience. In others, it creates genuine risk.

For some consumers, receiving unexpected telephone calls or correspondence directly from an insurer can be distressing and unsafe. Breaching a consumer's method of preferred contact can endanger family violence victim survivors. Following disasters, consumers may have limited access to reliable telecommunications or internet services, while others require support workers or interpreters to access and understand information.

The Code should therefore require insurers to communicate with customers using *only* their nominated method of communication, unless legislative requirements prescribe an alternative approach, in which case a dual approach using both the nominated method and legislatively-prescribed method should be adopted.

The draft also relies heavily on procedural compliance. Many obligations require insurers to communicate within specified timeframes but say comparatively little about the quality or usefulness of those communications.

Communication should be meaningful, not merely timely. Compliance with prescribed timeframes does not guarantee progress or good outcomes for customers.

Customers experiencing trauma, financial hardship or displacement following disasters require clear, practical information that assists them to make informed decisions and understand their rights. Compliance should therefore be assessed by the effectiveness of communication, not simply whether a communication occurred within the required timeframe.

Recommendation 2: Require Code subscribers to communicate with customers using the nominated method of communication.

Recommendation 3: Amend prescribed timeframes in the Code to include expectations of communication content and quality.

The role of authorised representatives

The revised Code should better recognise the role of independent consumer advocates. While we recognise that issue is included in the draft Vulnerability Guidance, we hold concerns that the Guidance as it stands is currently voluntary. As such, we believe that this issue in particular should be included in the mandatory Code. Financial counsellors regularly assist consumers who are overwhelmed by the claims process, experiencing significant psychological distress or otherwise unable to advocate effectively on their own behalf.

Financial counsellors continue to encounter situations where insurers refuse to accept a standard authority form or require unnecessary additional authorisations before engaging with an advocate. These practices create avoidable, sometimes purposeful, delays to claims processes, increase consumer frustration and undermine the role of independent advocacy.

Case study 1: Vulnerabilities and preferred method of communication

Client is a 50-year-old single parent impacted by family violence with multiple mental health co-morbidities. Her home was impacted by the January 2026 fires in Victoria.

Due to very ill mental health, she requested that her financial counsellor (FC) take over all communication with the insurer. The FC notified insurer of this preference, with provision of the appropriate authority form.

The insurer accepted the form, however continued to directly contact the client in emails and by phone, and only copying the FC into emails. The FC notified them three times to cease communication with the client as it resulted in further mental health crises for the client. The insurer demanded again that the client notify them directly that they didn't want to be contacted despite having done so previously. The client was unable to make contact with the insurer due to their poor mental health.

Further, this client was contacted by the claims handler late on a Friday before the claims handler commenced annual leave, in an attempt to cash settle the claim prior to their leave commencing. This caused significant distress to the client who had already notified the insurer they were obtaining their own quotes. The client expressed that the high-pressure tactics to accept cash settlement really impacted her mental health.

The matter was escalated to internal dispute resolution and a new claims handler appointed.

This case demonstrates that respecting communication preferences is not merely an administrative courtesy. **It is a critical component of trauma-informed and consumer-centred practice.**

As a point of comparison, for many years, financial institutions in the banking sector performed poorly when it came to acceptance a standard authority form. After much advocacy and collaboration, and the Hayne Royal Commission, it is now standard for all banks to accept standard authority forms, with no additional authorisations required. The insurance industry does not need a Royal Commission to make the same change – they can do this effectively in the Code.

Recommendation 4: All Code subscribers should accept a standard authority form.

Enforceability of all sections of the Code

FCVic is also concerned that important protections relating to vulnerability remain insufficiently enforceable. Section 7 contains many of the obligations most likely to affect consumers experiencing family violence, disability, mental ill-health or disaster-related trauma. These commitments should not operate merely as statements of good practice.

Every substantive consumer protection contained within the Code should be enforceable through AFCA and the Code Governance Committee. Consumers should have confidence that breaches of the Code will result in meaningful accountability regardless of which section contains the obligation.

Recommendation 5: Ensure that all sections of the Code are enforceable by the Code Governance Committee.

Small businesses

One of the most significant limitations of the draft Code is its continued exclusion of many small businesses from important consumer protections.

The rationale for distinguishing wholesale insurance from retail insurance has historically been that wholesale clients possess greater commercial sophistication and are better able to negotiate contractual arrangements. Financial counsellors' experience demonstrates that this assumption frequently does not reflect reality.

Many small business owners are sole traders, family businesses or owner-operated enterprises with limited financial resources and little bargaining power. Following disasters, these businesses experience the same practical and emotional challenges as individual consumers. They must navigate complex insurance claims while attempting to maintain income, support employees and rebuild their businesses. Often, they are managing multiple insurance claims for not only their business, but also claims for personal property that has experienced damage in the event.

Case study 2: small business supplementing rebuild with personal finances

A family-owned business suffered a total loss when floodwaters destroyed its premises.

At the time the insurance policy was taken out, the sum insured accurately reflected the replacement value of the property. However, rapid and significant increases in building materials and labour costs in the period leading up to the flood meant that the insured amount was no longer sufficient to cover the full cost of rebuilding. As a result, the business was materially underinsured at the time of the loss.

The owners were forced to draw on personal family finances to meet rebuilding and operational expenses, placing substantial strain on household finances and leaving the family in a significantly worse financial position. The use of personal finances will never be recouped, even if the business returns to previous levels of trade.

The Code should recognise that vulnerability is determined by circumstances, not legal structure. A family-operated business devastated by flood or fire may be no better equipped to negotiate with an insurer than a homeowner whose primary residence has been destroyed. Yet the protections available under the Code differ significantly depending on how the policy is categorised.

Expanding the Code in this way would better reflect the realities faced by small business owners and ensure that access to fair treatment is determined by need rather than by technical policy classification.

Recommendation 6: Consumer protections in the Code should be extended to eligible small businesses, with eligibility determined by a turnover of $10m or less, and fewer than 100 employees, a standard definition as used by the Australian Banking Association.

Section 2: Buying insurance

FCVic supports measures that improve transparency during policy purchase and renewal, including the $2.4 million announcement by the Federal Government in the 2026-27 Federal Budget for Treasury to legislate standard definitions of natural hazard terms used in property insurance contracts and improve clarity around how home and contents premiums are set.

We noted in our 2024 submission to Treasury's consultation on Standard definitions and standard cover for insurance that any work done on this issue should consider broader consumer understanding of the meanings of terms, rather than a strict insurance-only understanding. As an example, the term 'fire' should encapsulate not only actual fire damage, but related damage including smoke, ash, heat and melting. This broader definition is more in line with what consumers would anticipate 'fire' to cover, and will therefore prevent consumer misunderstandings around insurance cover.

Consumers should be provided with clear information explaining premium changes and the factors contributing to those increases. Greater transparency supports informed decision-making and enables consumers to compare products more effectively.

The proposed minimum period for automatic renewal notices should be extended from 14 days to 28 days. Many households require additional time to consider renewal options, seek advice or obtain alternative quotations, particularly where premiums have increased substantially. The process for opting out of automatic renewal should also be straightforward and free from unnecessary administrative barriers.

Feedback from a financial counsellor: insurers cancelling policies while fires were burning

As the January 2026 Fires were burning in Victoria, one insurer advised multiple policyholders living in areas surrounding the fires that their policies would not be renewed at the end of their 12-month term. This left affected consumers with only 14 days to obtain alternative insurance, an inadequate timeframe to properly assess, compare and secure replacement cover.

Given they resided in high bushfire risk areas, insurance options were already limited and difficult to compare. Allowing only 14 days to source alternative cover placed an unreasonable burden on consumers.

FCVic also remains concerned about the additional costs imposed on consumers who pay premiums by instalments. Charging higher effective premiums simply because consumers cannot afford annual payments disproportionately impacts lower-income households and contributes to the "poverty premium". While broader regulatory reform may be required, the

Code should recognise this issue and encourage practices that do not disadvantage consumers because of financial circumstances.

Recommendation 7: Extend the minimum period for automatic renewal notices from 14 days to 28 days.

Recommendation 8: Premiums should not be subject to higher charges for paying monthly rather than annually.

Section 3: Cancelling an insurance policy

The draft Code should also better recognise the financial realities faced by many consumers paying premiums by instalments. Cancelling policies after relatively short periods of missed payments may disproportionately affect people paid monthly or those experiencing temporary financial disruption.

Financial counsellors frequently observe consumers who have every intention of maintaining their insurance but require only a short extension until their next pay cycle. **The Code should encourage reasonable flexibility before cancellation occurs, particularly where consumers proactively engage with their insurer.**

Recommendation 9: Protection from policy cancellation should be granted to consumers who engage with the insurer and request reasonable payment extensions.

Section 4: Making a Claim

For most consumers, the true value of insurance is tested when they make a claim.

Financial counsellors consistently observe that the greatest sources of consumer harm do not arise solely from claim outcomes, but from the process itself. Delays, poor communication, incomplete information and inconsistent claims practices often compound the trauma associated with disasters and other insured events. The revised Code should establish stronger minimum standards that support transparency, informed decision-making and timely resolution.

For many consumers, navigating an insurance claim is made significantly more difficult by having to deal with multiple claims officers throughout the life of the claim, resulting in consumers having to repeatedly explain their circumstances and re-establish rapport, leading to unnecessary delays, confusion and inconsistent decision-making.

The Code should require insurers to appoint a dedicated claims manager (a primary contact) as the consumer's single point of contact for the duration of all claims wherever reasonably practicable. Where a change is unavoidable, insurers should ensure a comprehensive handover occurs and proactively introduce the new claims manager to minimise disruption and avoid duplication of requests for information.

Recommendation 10: A dedicated claims manager (primary contact) should be required for all claims.

Temporary accommodation

One of the most significant omissions from the draft Code is the absence of minimum standards relating to temporary accommodation.

Following major disasters, temporary accommodation is not simply another policy benefit. It provides consumers with stability while they rebuild their lives and recover from significant disruption. Yet financial counsellors regularly encounter situations where accommodation entitlements expire long before repairs or rebuilding can reasonably be completed.

This disconnect has become increasingly apparent following recent flood and fire events, where engineering assessments, planning approvals, labour shortages and material supply constraints have substantially extended rebuilding timeframes.

Temporary accommodation should continue for the reasonable duration of repairs or rebuilding, rather than being limited by arbitrary timeframes that bear little relationship to the realities of post-disaster recovery. Temporary accommodation entitlements should be for the full duration of the rebuild, or at least two years, recognising that rebuild often does not begin until well into the current 12 month entitlement period.

Case study 3: Temporary accommodation

Client is their 70s and was impacted by the October 2022 floods in Victoria.

Engineers attended the property in January 2023, delivering a report to the insurer in March 2023, indicating that the property required 6 months of soil drying time to review the damage to the stumps of property.

In July 2023, another engineer report was provided which indicated that there was no damage to the stumps of the property, however the client disagreed. A dispute with the report was opened, and the insurer declined to provide further accommodation while in dispute, which resulted in the client sleeping in their car.

The matter was not resolved until October 2024 in the client's favour.

The outcome demonstrated in this case study was entirely avoidable. Consumers should never lose safe accommodation because delays occur within the insurer's own assessment or dispute resolution processes.

Recommendation 11: A full section on temporary accommodation entitlements should be inserted into the Code.

Providing information that supports informed decisions

Consumers should receive sufficient information throughout the claims process to understand both the progress of their claim and the decisions being made.

FCVic recommends that insurers provide all customers with a claims management standardised information sheet immediately after a claim is lodged. This document should clearly explain expected claim timeframes, communication obligations under the Code,

available dispute resolution options and key consumer rights. A nationally consistent information sheet would improve transparency and reduce confusion.

Financial counsellors also strongly support greater transparency regarding expert reports.

At present, consumers often remain unaware that reports prepared by engineers, builders or other experts exist. Even where reports are requested, significant delays are common – and sometimes reports are not provided at all, even upon request. This prevents consumers from understanding the basis upon which decisions have been made and unnecessarily prolongs disputes.

Additionally, on occasion, redacted reports are provided citing 'commercial confidence'. Whilst the need to redact personal information of the report writer is acknowledged, the quantity of material, professionals needed to complete works, costs of materials and other price information should not be redacted.

In reports speaking to causation and extent of damage, there is no commercial reason to redact a report. This is not a commercially sensitive area, and where information of this type is redacted, consumers are estopped from being able to compare their own quotes or reports with the insurers. This places the consumer at significant disadvantage, and can lead to long, complex claim disputes and delays.

Redacting key information in a report is never necessary, and is a tactic used by some insurers to make the process so opaque that the consumer gives up and accepts what is on offer.

Expert reports relied upon by insurers should also meet minimum standards of quality and transparency. Reports should be conclusive within the scope of the expert's instructions, rather than expressing speculative or ambiguous opinions that leave key issues unresolved. Experts should only provide opinions on matters within their area of professional expertise and should not stray into matters outside their qualifications. Reports should also be written in plain, accessible language so that consumers can understand the findings, the reasons for the conclusions reached, and how those conclusions have informed the insurer's decision.

Feedback from a financial counsellor: 'hidden' expert reports

Through casework, we saw that many people impacted across the state by the January 2026 fires were not provided with expert and building reports to help them understand their insurance claim and insurers position. Instead, they were notified by a financial counsellor that they have the right to request these and review. This appeared to be very common across total loss claims especially, leaving it difficult to understand if all entitlements under the policies had been addressed.

This is a long-standing issue - in casework undertaken after the October 2022 floods, it was common practice for insurers to delay or withhold expert reports, even when requested. It was also common for some insurers to redact price and other information necessary for the consumer to determine if they needed their own reports and/or quotes,

or to support informed decision making. This issue sat across many insurers, and was the cause of many disputed claims, resulting in long delays in claim settlement.

Whilst some insurers have made efforts to improve their claims management processes, approaches across the sector remain inconsistent. This Code must strengthen, not weaken consumer rights.

Providing reports proactively would improve confidence in the claims process while allowing factual inaccuracies or omissions to be identified and addressed much earlier.

Recommendation 12: The ICA should create and regularly review a standard claims management information sheet (similar to the current cash settlements information sheet) for insurers to provide to consumers once a claim is lodged.

Recommendation 13: Where an insurer relies upon an expert report to assess or determine a claim, that report should automatically be provided to the customer or their authorised representative within 14 days of being received by the insurer.

Recommendation 14: The Code should expressly comply with the Recommendations 75-78 of the Independent Review, and Recommendation 6 of the Parliamentary Inquiry, in relation to the use of expert reports.

Cash settlements and actionable scopes of work

Consumers cannot make informed decisions about accepting a cash settlement unless they understand the scope of works required, the assumptions underpinning the insurer's valuation and the additional policy benefits that may be available.

Case study 4: actionable Scope of Works in a cash settlement

A business owner client was impacted by severe flooding in their Victorian town in October 2022. They also owned some investment properties in the same town, and so were managing three claims directly with the same insurer.

During this claims process, there were significant delays in 'make safe' works and Scope of Work corrections. In February 2024, months after the disaster event, the insurer proposed a cash settlement based on the insurers' builder's quotes. The client declined this settlement as they knew the quotes weren't actionable.

The client expressed their loss of faith to the insurer and pointed out the considerable delay in settling the claim. The client advised the insurer they were exhausted and that the ongoing burden of the dispute had impacted their mental health.

The client proposed a cash settlement based on a builder's estimate of repairs to similar properties, without fully understanding all their entitlements. The client requested the insurer settle or "we take the cases to the insurance ombudsman". After 15 months of the claim being in dispute, the insurer finally settled due to the risk of the client taking the matter to the Australian Financial Complaints Authority.

The Code should therefore require insurers to provide an actionable scope of works before offering **any** cash settlement, including in total loss claims. Scopes should be based upon actionable quotations that are capable of being commenced in a matter of weeks rather than months, to protect consumers from making decisions based on outdated pricing that may no longer reflect prevailing construction costs.

Consumers should also receive a comprehensive schedule outlining all additional policy entitlements, including temporary accommodation, contents storage, clean-up costs, pet accommodation and other applicable benefits. These entitlements should be itemised with its value, together with the available payment options so that consumers can properly evaluate any settlement offer.

Finally, we continue to support the provision of the ICA cash settlements fact sheet to consumers whenever a cash settlement is offered. Wording in this fact sheet should be strengthened to the consumer's benefit with a reference to seeking qualified independent advice, and the fact sheet should be regularly reviewed with the input of consumer advocates. Financial counsellors regularly support clients who unknowingly relinquish valuable policy entitlements because they were unaware of the broader implications of accepting a lump sum payment.

Consumers should not be expected to make one of the most significant financial decisions arising from an insurance claim without access to complete information and independent advice.

Recommendation 15: Amend Code wording to require provision of an actionable Scope of Works for all cash settlement offers, even in cases of 'total loss'.

Recommendation 16: Amend the Code to ensure consumers are given sufficient time to consider the cash settlement offer, free from pressure or arbitrary deadlines, after having received qualified independent advice.

Section 8: Financial Hardship

Access to hardship assistance should not be unnecessarily burdensome

Consumers seeking hardship assistance are frequently doing so during periods of significant personal disruption. They may have lost their home, important documentation or access to financial records. Others may be escaping family violence or managing deteriorating health or other distressing personal circumstances.

Against this background, excessive evidentiary requirements risk excluding precisely those consumers the hardship provisions are intended to protect. The Code should therefore require insurers to adopt a flexible and proportionate approach when requesting supporting information. Evidence should only be sought where reasonably necessary, and insurers should recognise that alternative forms of verification may be appropriate where standard documentation is unavailable.

Hardship processes should be designed to facilitate access to assistance, not create additional barriers.

Recommendation 17: Requests for supporting information should be made only where reasonably necessary in the circumstances, with an obligation for Code subscribers to take a flexible and proportionate approach.

Debt recovery should cease while hardship is being considered

Situations where debt collection activity continues while hardship applications remain under assessment or while related disputes proceed through internal or external dispute resolution undermine the purpose of hardship protections and creates unnecessary anxiety for consumers already experiencing financial distress.

Recommendation 18: Where a hardship application has been made, or where hardship-related decisions are under review through internal or external dispute resolution, all debt recovery activity should cease until those processes have concluded.

Section 9 - Standards for Representatives

Consumers generally do not distinguish between an insurer and the representatives acting on its behalf. Whether a customer is dealing with an employee, assessor, builder, engineer, loss adjuster or other contractor, they reasonably expect that person to demonstrate the same professionalism, competence and commitment to the standards established by the Code.

The draft Code recognises the important role of representatives, but it should go further to ensure consumers receive a consistent experience regardless of who is acting on behalf of the insurer.

Financial counsellors continue to observe significant variation in the conduct of external representatives. While many provide high quality, customer-focused services, others demonstrate limited understanding of vulnerability, financial hardship and trauma-informed engagement. This inconsistency can undermine otherwise appropriate claims handling and contributes to avoidable disputes.

Case study 5: poor behaviour by a representative

After the October 2022 floods, a client reported an insurer's builder repeatedly entered their property without notice when they weren't home.

The client contacted the insurer, but the builder made another unauthorised site visit. On this occasion, the builder moved some salvaged doors and hardware out of the house, that were earmarked for reinstatement. It subsequently rained, and the doors were destroyed.

When the client next saw the builder, the builder was rude and abusive. The client had not only lost their home, but also their business premises, and was significantly distressed. They contacted the insurer again, who disputed the damage. The situation took the financial counsellor two months to rectify, with the insurer conceding the builder had acted inappropriately and caused further damage.

Equally important is the capability of those representatives to recognise and respond appropriately to consumers experiencing vulnerability or financial hardship. Training should not be viewed simply as a compliance obligation. It is fundamental to ensuring consumers are treated fairly and consistently throughout the claims process.

Where contractors or subcontractors have not received appropriate training, discussions involving vulnerability, hardship or complex customer circumstances should be referred back to appropriately trained staff employed by the insurer.

Consumers should have confidence that every person acting on behalf of an insurer possesses the skills necessary to deliver the standard of service promised by the Code.

Recommendation 19: The Code should require all representatives acting on behalf of Code Subscribers to comply with a consistent minimum standard of conduct.

Recommendation 20: All staff and representatives who engage directly with customers undertake regular training on vulnerability, family violence, financial hardship and trauma-informed practice. This training should be delivered or developed with appropriately qualified external experts rather than relying solely on internal training programs.

Conclusion

Financial counsellors work with consumers at the point where insurance either fulfils its purpose or falls short of community expectations.

Every day, our members see the difference that timely communication, transparent decision-making and fair claims handling can make to consumers recovering from unexpected events, navigating family violence, managing illness or experiencing financial hardship. They also see the consequences when these standards are absent.

The revised General Insurance Code of Practice presents an important opportunity to strengthen confidence in the general insurance industry by establishing clear, consistent and enforceable expectations for insurers and meaningful protections for consumers.

FCVic is concerned that, in its current form, the draft Code does not consistently realise that opportunity.

Several provisions weaken existing consumer protections, ignore direct recommendations of the Independent Review and the Parliamentary Inquiry, introduce unnecessary discretion or fail to reflect the realities of contemporary insurance claims, particularly following large-scale disasters. Consumers require greater certainty, not greater ambiguity. They require rights that are enforceable, not commitments that depend upon individual insurer practice.

The recommendations contained in this submission are intended to strengthen the Code while supporting more consistent decision-making across the industry. They draw directly from the experience of financial counsellors who assist consumers through some of the most complex and challenging insurance matters in Victoria.

FCVic urges the Insurance Council of Australia to adopt these recommendations, together with those advanced in the submissions by FRLC and FCA, to ensure the final Code delivers practical, enforceable and consumer-centred protections that reflect the expectations of the Australian community.

We welcome the opportunity to discuss this submission further and to continue working collaboratively with the ICA, consumer representatives and insurers to improve outcomes for people accessing general insurance.

Thank you for the opportunity to provide this submission, on behalf of Victorian financial counsellors who are supporting Victorians grappling with the complexities of insurance claims in difficult and traumatic situations.