Submission on the Draft General Insurance Code of Practice

To: codeofpractice2026@insurancecouncil.com.au

Consultation: Draft General Insurance Code of Practice, Public Consultation Draft, June 2026

From: [redacted]

Date: 21 July 2026

Declaration: In accordance with the Insurance Council's request, I declare that I used an AI tool to assist in drafting this submission.

Who is making this submission

My family of seven has been displaced from our home since an insured event arising from the declared catastrophe in early 2025. At the time of this submission, we have been displaced for sixteen months. For thirteen months, we lived in tents on the deck of our own damaged house, going inside each day to use the facilities. Five of us are children. Our insurer recorded our household as experiencing vulnerability at the start of the claim. The claim was accepted early and it is still not resolved.

I am not a lawyer. I make this submission from the experience of a long home building and contents claim, and from reading the draft against it.

Our insurer is [redacted] I name them not to relitigate our claim in this forum, but because a Code consultation should know which of its members' conduct produced the experience described here. Nothing in this submission depends on their identity. Every issue I raise is structural, and each would apply equally to any insurer operating under this Code. I do not ask the Code to determine or retrospectively remedy my individual claim. I use my experience only to test whether the proposed Code would prevent, identify or address the structural problems that arose.

In preparing this submission I have read, in full: the Consultation Draft; the Consultation Paper; the Insurance Council's Use of Expert Reports: Industry Best Practice Standard, August 2024, referred to at paragraph 71 of the draft; the December 2024 Final Report of the Independent Review of the 2020 General Insurance Code of Practice, including its final recommendations and its comparison of those recommendations with the recommendations of the Parliamentary Flood Inquiry; the Insurance Council's Initial Industry Response of December 2024, including its tables of accepted recommendations; and the Insurance Council's General Insurance Industry Action Plan of March 2025, including Attachment A, its recommendation by recommendation response.

I have checked the quotations from those documents against the source documents available to me.

At the time of preparing this submission, I have not been able to access Attachment 2 to this consultation, the comparison of current and redrafted provisions, or Attachment 4, the guide on Extra care for customers experiencing vulnerability. Where a point of mine turns on either, I have said so. If either document addresses or resolves any point I have raised, I would welcome that clarification in the consultation response. I would rather be corrected than published wrong.

What the draft gets right

I want to say this first, because most of what follows is critical and I do not want that read as a rejection of the redraft.

Making the Code contractually enforceable is a genuine and significant improvement, and it goes further than the Insurance Council's own stated position in response to recommendation C-101. Bringing the substance of the family violence and mental health guides into the Code, so that they bind rather than guide, is exactly right. Expanding Urgent Financial Need to include essential needs is a real change. The language at sentence level is markedly plainer than the 2020 Code.

The redraft is a better document than the one it replaces. My concern is narrower, and it is this.

The thesis of this submission

A customer can receive perfect compliance with this Code for two years and still be in a tent.

That is what I found when I tested the draft against sixteen months of my own claim, paragraph by paragraph. The draft is procedurally sophisticated and operationally incomplete. It regulates decisions, communications and processes, and stops short of requiring the action that resolves the customer's problem or prevents avoidable harm.

The same shape appears again and again. Experts may recommend, and nothing requires the insurer to act. Decisions have timeframes, and repairs do not. Vulnerability may be recorded, and need not influence the claim. Responsibility for defective repairs exists, and has no timetable. Hardship is recognised when the customer owes the insurer money, and not when the insurer's delay puts the customer into hardship with someone else.

Every recommendation below is an instance of that one problem.

What I am asking for

The twenty recommendations below are proposed amendments or clarifications to the draft, grouped according to the structural problem they address. Although I make twenty recommendations, three are foundational: requiring action to prevent further loss, attaching timeframes to fulfilment, and ensuring that vulnerability protections have operational effect on the claim.

I am asking for three things.

First, that Recommendation 18 be checked before this draft goes further, because it concerns something in the Insurance Council's own consultation material that I do not think can be intended.

Second, that Recommendations 1, 2, 7 and 9 be adopted, because without them the Code does not require a claim to be fixed.

Third, that where the draft departs from a recommendation the Insurance Council has already agreed to, the Consultation Paper say so and explain why. There are four such departures among recommendations the Insurance Council expressly marked "Agree", set out under Category A below. I separately identify five further areas, under Category B, where the draft appears not to give effect to recommendations that the Action Plan addressed as "Agree in principle", "Noted", "Understand the intent" or "Support the intent". A consultation in which accepted recommendations quietly do not appear is not one stakeholders can respond to properly.

The one thing I would most ask to be checked

This is a request that the Insurance Council look again at something in its own consultation material.

Paragraph 21 of the current Code reads: "We, our Distributors and our Service Suppliers will be honest, efficient, fair, transparent and timely in our dealings with you." Paragraph 22 reads: "The Code sets out how

we will meet this obligation to you."

The Independent Review, conducted by a panel the Insurance Council appointed, recommended at 40 that paragraph 21 "should be retained," and at 41 that paragraph 22 be clarified so that it does not limit paragraph 21.

The Consultation Paper states that "Paragraph 21 of the current Code has been included in the principles."

The draft states that "The Industry Principles are a guide only and do not form part of the Code or our policy with you."

Draft paragraph 31 confines Code Governance Committee monitoring to "Sections 1 to Section 9." The Principles are not Sections 1 to 9.

So the obligation which the current Code exists to meet is proposed to sit outside the Code, and outside independent monitoring, in the same exercise presented as strengthening both.

I do not assert that this is intended. I ask whether it was the intended outcome of the proposed drafting. It is set out in full at Recommendation 18.

Where the draft departs from what was already agreed

In testing the draft I also read the Independent Review's Final Report, the Insurance Council's Initial Industry Response of December 2024, and its Industry Action Plan of March 2025. A number of the gaps I had found were not new. The Review Panel or a parliamentary committee had found them first, and the Insurance Council had responded.

Those responses matter, and they divide into two kinds.

Category A: recommendations the Insurance Council expressly marked "Agree", where the draft appears not to give full effect to the recommendation.

The Insurance Council's Initial Industry Response of December 2024 and its Industry Action Plan of March 2025 record the industry's response to each recommendation. Four of the recommendations marked "Agree" bear directly on this submission.

Recommendation 75, that the Code state the purpose of appointing experts as assessments of "the cause and extent of damage and loss." Response: "Agree." The draft defines External Expert as contracted "solely... about the likely cause." Extent is gone; "solely" is new. See Recommendation 1.

Recommendation 78, that the Code mandate compliance with the Expert Reports Standard. Response: "Agree." Paragraph 71 incorporates a Standard which, on my reading, contains one express mandatory obligation directed to insurers, with the overwhelming majority of its substantive provisions expressed as "should". See Recommendation 1.

Recommendation 74, that the Code require Scopes of Work to be "clear, standardised, and provide a full description of work and costs." Response: "Agree." Paragraph 85 requires information about the scope on request, subject to an exception the insurer states. See Recommendation 20.

Recommendation 86, that insurers request information "only if it is strictly relevant," "avoid multiple requests," and clearly communicate why each item is necessary. Response: "Agree. The Insurance Council and its members will explore appropriate revisions to the Code to strengthen Paragraph 67." Paragraph 58 says "best endeavours to limit the number of requests." Paragraph 67 says "relevant," not "strictly relevant." See Recommendation 12.

Category B: recommendations the Insurance Council addressed as "Agree in principle", "Noted", "Understand the intent" or "Support the intent", where the draft appears not to implement the stated commitment or rationale.

These recommendations fell within what the December 2024 response called "the remainder," which the Insurance Council said it was "actively reviewing." Its March 2025 Industry Action Plan completed that response, and I have read it. Where the Action Plan gives a stated reason, I have quoted it and engaged with it rather than ignored it. Where I accept the reason, I have said so and narrowed my recommendation accordingly.

Flood Inquiry recommendation 57, that the twelve month automatic acceptance "would be triggered where internal dispute resolution has commenced but is not resolved." Response: "Agree in principle," with the circumstances outside an insurer's control identified as "new information" and "an intermediary." Draft paragraph 76(c) removes the protection where a complaint is lodged "with us." See Recommendation 4.

Recommendations 40 and 41, that paragraph 21 be retained, and that paragraph 22 be clarified so it does not limit paragraph 21. Response: "Noted," with a commitment to "explore how to clarify how these obligations are applied in the update to the Code." The draft moves paragraph 21 outside the Code and outside Code Governance Committee monitoring. See Recommendation 18.

Recommendation 21 and Flood Inquiry recommendation 39, compliance with ISO 22458. Response: "Agree in principle," with a commitment to "explore what ISO principles may be suitable to adopt in the Code." Draft paragraph 141 substitutes the Insurance Council's own guidance, which sits outside the Code. See Recommendation 7.

Flood Inquiry recommendation 20, three months notice before changes to temporary accommodation. Response: "Understand the intent," with a commitment to "explore appropriate revisions to the Code to ensure reasonable notice." I cannot find any notice provision in the draft. See Recommendation 19.

Recommendations 66 and 67, "meaningful progress updates" and three business days for routine enquiries. Answered via Flood Inquiry recommendation 33: "Support the intent," on the basis that real time app access is prescriptive. The draft adopted the update frequency without the word "meaningful," and says ten business days rather than three. See Recommendation 13.

I accept that no redraft can adopt every recommendation, and that reasonable people weigh cost, competition law and proportionality differently.

Category A is different. Those four recommendations were expressly recorded as "Agree", although in two cases the response also contemplated further work on implementation. The issue in each case is not whether the industry agreed with the recommendation. It did. The issue is whether the draft gives effect to the substance of what was agreed.

The twenty recommendations

#	Recommendation	Provision
1	Require insurers to act on their own experts' recommendations to prevent further loss	paras 66, 68 to 72; Standard 3(c)
2	Attach timeframes to fulfilment, not only to the Decision	paras 74, 75, 83 to 85; definition of Decision
3	Timeframes and independent assessment for rectification of defective works	paras 83, 84
4	A complaint or dispute process should not remove the twelve month protection	para 76(c), (d)

#	Recommendation	Provision
5	Define cooperation, and require notice before it is relied on	para 76(a)(i)
6	Paragraph 23(c)(iii) substantially removes the right granted by paragraph 22	paras 21, 22, 23
7	Require Extra Care to have operational effect on claims handling	Section 7
8	Address hardship caused by the insurer, and loss of essential services	Section 8; paras 55, 56
9	Require insurers to reconcile their own divergent expert reports	Standard 1(c)
10	Require the expert briefing to be disclosed	Standard 1(d), 1(e)
11	Require qualifications for condition, contamination and salvage determinations	para 69, 183; Standard 1(a)
12	Require insurers to specify what information would be sufficient	paras 58, 67
13	Require disclosure where an insurer decides to stop work	para 59
14	Cash settlement review period should run from discovery, not payment	para 92
15	Defects in clarity identified in the draft	various
16	Applicability in the future	Section 4 generally
17	Require a live chronology of material developments	paras 59, 66
18	An obligation currently in the Code has been moved out of the Code	current para 21; Industry Principles; Consultation Paper
19	Require reasonable notice before temporary accommodation ends or changes	Review rec 69; Flood Inquiry recs 19, 20
20	Require Scopes of Work to be clear, standardised, complete and provided without request	para 85; Review rec 74

They fall into five themes.

Prevent deterioration: Recommendations 1 and 17. Complete accepted claims: Recommendations 2, 3, 13, 19 and 20. Procedural fairness: Recommendations 5, 9, 10, 11, 12 and 14. Make the protections mean something: Recommendations 4, 6, 7, 8 and 18. Drafting and durability: Recommendations 15 and 16.

They are grouped by theme throughout this submission rather than in numerical order. Recommendation 18 is presented first, in Part A, because it addresses the overarching structural architecture of the Code. The table above is the index.

Areas addressed

The Insurance Council invited submissions to consider six areas. This submission addresses them as follows:

Area	Where addressed
The contractually enforceable nature of the redrafted Code	Recommendation 6, and Recommendation 1 on paragraph 71
The consumer protections in the redrafted Code	Recommendations 1 to 4, 8, 9, 12, 13, 14
Protections for customers experiencing vulnerability	Recommendation 7, and Recommendation 8
The clarity and accessibility of the redrafted Code's language	Recommendation 15
The applicability of the redrafted Code in the future	Recommendation 16
Any further recommendations	Recommendations 5, 10, 11, 17, 19, 20

Part A: The overarching issue

Recommendation 18: An obligation currently in the Code has been moved out of the Code

I have given this issue disproportionate attention because it appears to concern the architecture of the redraft rather than a discrete consumer protection.

What the draft says. The Industry Principles include that services "will be provided efficiently, honestly and fairly," that insurers "will support customers in their time of need," and that they are "committed to providing Extra Care support to customers experiencing Vulnerability."

The draft then states: "The Industry Principles are a guide only and do not form part of the Code or our policy with you."

Paragraph 21 of the draft makes Sections 1 to 9 part of the contract. The Principles are excluded. So is Section 10.

A note on numbering, because it matters here. Paragraph 21 has different subject matter in the current Code and the draft. Paragraph 21 of the current Code is the honest, efficient, fair, transparent and timely obligation. Paragraph 21 of the draft is the provision incorporating Sections 1 to 9 into the policy. Throughout this recommendation I say which one I mean.

What the Consultation Paper says. The Insurance Council's Consultation Paper sets out the rationale for each significant change. Under the heading "Honest, efficient and fair," it states:

"Paragraph 21 of the current Code has been included in the principles, aligning its language with the Corporations Act."

What paragraph 21 of the current Code says. The 2020 Code, as published by the Code Governance Committee, provides:

"21. We, our Distributors and our Service Suppliers will be honest, efficient, fair, transparent and timely in our dealings with you."

"22. The Code sets out how we will meet this obligation to you."

Those two paragraphs describe the architecture of the current Code. Paragraph 21 is the obligation. Paragraph 22 states that the Code sets out how that obligation will be met.

Under the redraft, the obligation moves into the Industry Principles, which "do not form part of the Code." Every procedure built to serve it remains inside the Code.

The method stays. The thing the method was for does not.

The problem. Paragraph 21 of the current Code is, at present, in the Code. Under the redraft it is in the Principles. The Principles are "a guide only" and "do not form part of the Code or our policy with you."

I accept that the current Code is not contractually enforceable, so this is not a point about contract. It is a point about two other things.

First, it is no longer in the Code. It is expressly not part of the document. Everything else in this redraft is being moved toward the customer. This one obligation is being moved out of the instrument entirely.

Second, and this appears not to have been raised anywhere in the consultation material, it falls outside Code Governance Committee monitoring. Paragraph 31 of the draft provides: "The Code Governance Committee will monitor our compliance Sections 1 to Section 9 of the Code in accordance with their Charter." The Principles are not Sections 1 to 9.

Under the current Code, paragraph 21 is a Code obligation. On the face of the current Code's monitoring architecture, it forms part of the Code framework overseen by the Code Governance Committee. Under the redraft, however, the corresponding obligation is expressly placed outside the Code, while paragraph 31 expressly confines monitoring to Sections 1 to 9.

So the obligation loses its place in the Code and, on the face of paragraph 31, falls outside the express scope of the Code Governance Committee's monitoring function, in the same exercise that is presented as strengthening both.

This is therefore not simply a question of whether paragraph 21 should be enforceable. It is a question of whether the redraft's architecture is internally coherent about what belongs in the Code, what is contractually enforceable, and what is subject to independent Code monitoring.

The Consultation Paper describes the redraft as delivering "a significant uplift in protections for consumers." That may well be true of the document as a whole. It does not appear to be true of this obligation, and the rationale given for moving it is that this aligns its language with the Corporations Act.

Alignment of language does not necessarily justify relocating an obligation into material that is expressly non-binding and expressly unmonitored. If the language of current paragraph 21 should track section 912A, it can track section 912A inside the Code. The two propositions are not connected.

I make no claim about what the Corporations Act does or does not require, and I do not suggest the Insurance Council has misunderstood it. I say only that the stated reason addresses wording, and the change made addresses status.

Why this matters beyond that one paragraph. Making the Code contractually enforceable is a genuine improvement, and I say that plainly. But enforceability without an interpretive framework produces a particular result. Where the only enforceable content is a set of discrete technical paragraphs, and the standards those paragraphs were written to serve sit outside the Code, compliance becomes a question of whether each paragraph was technically met rather than whether the customer was treated honestly, efficiently and fairly.

Most of this submission consists of examples of that. An insurer can send an update every twenty business days that says nothing. It can accept a claim and never fulfil it. It can record a customer as vulnerable and change nothing. It can decline its own expert's recommendation and record no reason. Each of those is compliant. None of them is honest, efficient and fair in any sense a consumer would recognise.

Therefore the more precisely the Code is drafted, the more effectively a technically compliant insurer can defeat its purpose, unless the purpose is somewhere in the enforceable text. And the purpose has just been moved out of it.

What the Independent Review recommended.

The Independent Review of the 2020 Code was conducted by a panel appointed by the Insurance Council, comprising Helen Rowell, Gerard Brody and Paul Muir. Its Final Report of December 2024 sets out its final recommendations. Under the heading "The Code and the law," recommendations 40 and 41 read:

"40. Paragraph 21 should be retained and amended to clarify that it operates alongside other Code paragraphs."

"41. Paragraph 22 should be clarified to make it clear that it does not limit the general obligation in paragraph 21."

The Consultation Paper states that the redrafted Code "draws on the Industry Action Plan, released in March 2025, which followed recommendations from the Independent Code Review and the Parliamentary Flood

Inquiry." The Insurance Council's media release for this consultation says the same.

What the Insurance Council said in response. The Insurance Council published its General Insurance Industry Action Plan in March 2025, completing its response to the recommendations. Attachment A of that document sets out, recommendation by recommendation, the industry's position.

Its response to recommendation C-40 reads, in full:

"Noted. The Insurance Council and its members will explore how to clarify how these obligations are applied in the update to the Code, noting that duplication with existing regulation will be minimised where possible."

Its response to recommendation C-41 reads, in full:

"Recommendation C-40 is noted. Insurers will continue to be required to conduct themselves honestly, efficiently and fairly. The Corporations Act also regulates this under 912A(1)(a). Accepting recommendation C-41 could have the result of expanding the remit of the CGC beyond the scope of the Code. This would duplicate the role of ASIC and duplicate breach reporting requirements. The Insurance Council and its members will explore appropriate revisions to the Code to clarify how these obligations are applied."

The Action Plan defines its own response categories. "Noted" means: "The industry notes the recommendation and will consider whether implementation/adoption is appropriate following relevant workstream completion."

So the Insurance Council did not reject these recommendations, and I do not suggest it did. It said it would explore how to clarify how these obligations are applied in the update to the Code.

My question is whether the present drafting is that.

The commitment was to clarify how the obligations apply in the update to the Code. The draft does not clarify them in the Code. It relocates them outside it, into material that expressly does not form part of the Code, and outside Code Governance Committee monitoring under paragraph 31.

Clarifying an obligation and removing it from the instrument are different acts, and the second is not a way of doing the first.

On duplication. The stated concern was that duplication with existing regulation "will be minimised where possible." I understand that concern and do not dismiss it.

But current paragraph 21 has coexisted with section 912A of the Corporations Act since 2020. Whatever duplication exists is not created by retaining it. The duplication already exists, and has for five years without apparent difficulty. Removing current paragraph 21 does not minimise duplication. It removes an obligation.

On the Code Governance Committee.

The stated concern about recommendation C-41 was that accepting it "could have the result of expanding the remit of the CGC beyond the scope of the Code."

The concern was expansion.

The present drafting removes the honest, efficient, fair, transparent and timely obligation from the CGC's remit altogether, because paragraph 31 confines monitoring to Sections 1 to 9 and the Principles are not Sections 1 to 9.

That is contraction. It goes considerably further than avoiding expansion requires, and the Consultation Paper does not explain why.

On section 912A. The response observes that "Insurers will continue to be required to conduct themselves honestly, efficiently and fairly. The Corporations Act also regulates this under 912A(1)(a)."

That is correct, and I make no claim about what the Corporations Act requires. I note only that section 912A binds licensees and is enforced by ASIC. It is not a right the consumer holds in their own contract, and it is not monitored by the Code Governance Committee. So the existence of section 912A does not deliver to a consumer what current paragraph 21 delivers, and its existence in 2020 did not prevent current paragraph 21 from being adopted then.

A note in fairness. The Insurance Council's response to recommendation C-101, that the Code be made contractually enforceable, was also "Noted," with the observation that it would "work with ASIC on the issue of enforceability." The draft goes considerably further than that response, and delivers contractual enforceability. I mention this because it demonstrates that a "Noted" response does not predict the outcome, and that the Insurance Council is capable of exceeding its stated position where it chooses to. That makes the treatment of C-40 and C-41 more striking, not less.

There is one further point, and I raise it because I cannot reconcile it with the rest of the redraft.

The Consultation Paper states that key principles from the Insurance Council's family violence and mental health guides are being brought into the Code, and that the industry "anticipates replacing these Guides with the proposed Code's new contractually enforceable obligations." The reason is self-evident, and the Insurance Council's own family violence guide states it plainly: "This guide does not bind insurers."

So in this same exercise, two sets of guidance are being moved into the Code because guidance does not bind, while the honest, efficient and fair obligation is being moved out of the Code into material that is expressly a guide.

I do not understand why those two changes point in opposite directions, and the Consultation Paper does not explain it.

Recommendation:

1. Return the substance of current paragraph 21 to the body of the Code. If its language is to be aligned with the Corporations Act, align it there.
2. In any event, ensure the obligation remains within Code Governance Committee monitoring under paragraph 31.
3. Amend paragraph 21 of the draft, the provision incorporating Sections 1 to 9 into the policy, so that the Industry Principles, while not creating standalone obligations, operate as the interpretive framework for the paragraphs that do.
4. Provide that where a paragraph of the Code is capable of more than one construction, it is to be construed consistently with the Industry Principles.
5. If the Principles are to remain outside the Code entirely, remove from them any statement a consumer would reasonably read as a promise. A document that opens by saying insurers "will support customers in their time of need," and then says that sentence is not part of the Code or the policy, is capable of misleading the people it is addressed to.
6. Whatever is decided, the Consultation Paper should say plainly that an obligation presently in the Code is proposed to be moved out of it. Readers of a consultation document should not have to cross-reference a rationale table against a definitions section to discover that.

Part B: Nothing in the Code requires the claim to be fixed

Recommendation 1: Require insurers to act on their own experts' recommendations to prevent further loss

Of the twenty recommendations, this is the single change that would have made the greatest difference to my family.

This is a recommendation about loss mitigation. It applies with equal force to a leaking roof, an unstable structure, a burst pipe, fire damage, an electrical hazard, or any circumstance in which someone qualified tells an insurer that the loss will get worse if nothing is done. My own facts happen to involve contamination. The gap in the Code does not.

The issue is not that expert reports should determine claims outcomes. It is that where an insurer commissions expert advice identifying a risk of further loss, the Code should regulate what the insurer must do with that advice.

What happened to us

The insurer's own contractor recommended accommodation on day two. It was not actioned. On day nine, the insurer's own contractor recommended full decontamination. It was declined. On day eleven, an appointed hygienist made recommendations. They were not actioned for thirteen months. Two further appointed parties confirmed structural drying was required. It was never carried out. Engineering controls were not installed until 429 days after the insured event. By then, independent air sampling recorded airborne fungal levels at multiple locations within the house at 60 to 120 times outdoor baseline.

Every one of those recommendations came from people appointed or engaged within the insurer's claims process. Not from me. A substantial part of the damage that has kept my family out of our home occurred after those recommendations were made and not acted upon.

The gap in the draft Code

Nothing in the draft requires an insurer to act on a recommendation from its own appointed expert or contractor to prevent further loss. Nothing requires it to record why it did not. Nothing requires it to tell the customer that a recommendation was made and declined.

Paragraph 66 requires only that the insurer "consider" relevant facts, the policy, and the law. Paragraphs 68 to 72 govern appointment, expertise, a 60 business day reporting deadline, compliance with the Expert Reports Standard, and monitoring. None of them requires action.

An insurer may commission an expert, be advised in writing that urgent mitigation is required, decline to act, watch the loss multiply for a year, and breach no paragraph of this Code.

Therefore the consumer bears a loss that was identified as preventable, by the insurer's own expert, before it occurred.

Why the expert framework does not reach the problem

External Expert is defined as a party contracted "solely to provide an independent, detailed and expert report to us about the likely cause of your loss or damage."

On the face of the draft's definition of External Expert, the framework in paragraphs 68 to 72 is confined to experts contracted "solely" to report on the likely cause of loss or damage. A party who assesses contamination and recommends remediation is not contracted solely to report on cause. A restorer is separately defined as a Claims Fulfilment Provider. The paragraphs governing expertise, reporting and

monitoring do not reach the very advice that would prevent a loss escalating.

There is a further difficulty with the word "solely," which I do not think can be intended. If an insurer contracts an expert to report on cause, that expert is an External Expert, and paragraphs 68 to 72 apply to them. If the insurer contracts the same expert to report on cause and to advise what should be done about it, the expert is arguably no longer contracted solely to report on cause, and falls outside the definition altogether. No expertise requirement, no reporting timeframe, no Expert Reports Standard.

Therefore the narrower and less useful the brief, the more regulated the expert. The broader and more useful the brief, the less regulated. That cannot be the intention, and it is worth checking whether the word "solely" produces it.

The Insurance Council agreed to a wider purpose than the draft adopts

This part does not depend on any inference.

Recommendation 75 of the Independent Review states:

"The Code should state the purpose of the appointment of experts, being to provide independent, detailed, and professional assessments of the cause and extent of damage and loss."

Flood Inquiry recommendation 6 is to the same effect, recommending that the Code state "the intent that experts are to provide independent, detailed, clear, comprehensible and professional assessments of the cause and extent of loss."

In December 2024 the Insurance Council published its Initial Industry Response to the Code Review and Flood Inquiry recommendations. Table 2 of that document lists the Code Review recommendations the industry accepted. Against recommendation 75 it records a one word response, with no qualification:

Response: "Agree."

Both the Independent Review and the Flood Inquiry said cause and extent. The Insurance Council agreed. The draft's definition says "solely... about the likely cause."

Extent has been dropped, and "solely" has been added.

I do not know whether that was deliberate. But the effect is that the expert framework reaches a narrower class of expert than either review recommended, and than the Insurance Council agreed to, and does not reach an expert assessing how bad the damage is or what should be done about it.

The same table records recommendation 78, "The Code should mandate compliance with ICA Standard 'Use of Expert Reports: Industry Best Practice Standard'," also with the response "Agree." Paragraph 71 of the draft does incorporate the Standard. Whether that amounts to mandating compliance is dealt with next.

The Expert Reports Standard does not fill the gap, and in one respect makes it worse

Paragraph 71 requires compliance with a document it calls the "Guide: Use of Expert Reports." The document is in fact titled "Use of Expert Reports: Industry Best Practice Standard," and I refer to it below as the Standard. I have read it. It does not close this gap, for four reasons.

First, it has the same scope limitation. The Standard states: "For the purposes of the Industry Best Practice Standard, an Expert Report is a report produced by an External Expert as defined in the General Insurance Code of Practice, as amended from time to time, and specifically excludes any reports produced for routine matters." It therefore inherits the causation-only limitation. It also excludes "reports produced for routine matters," a term the Standard does not define.

Second, it requires consideration, not action. Section 3(a) provides that "the expert report should be considered by claims managers alongside all other information." That is the same standard as paragraph 66. Nothing in the Standard requires an insurer to act on a recommendation.

Third, and most significantly, it creates a potential conflict where an expert identifies a need for urgent mitigation outside the scope of the expert's brief. Section 3(c) provides: "Insurers should disregard any claims, statements, or opinions made in the expert report that are outside of the scope of the report or the expert's expertise."

If an expert briefed narrowly on causation also identifies a need for urgent mitigation, that recommendation may be characterised as outside the scope of the brief, depending on the terms of the engagement. On the face of Section 3(c), the insurer should then disregard it.

I do not believe that is the intention. But it is what the text is capable of producing, and it sits directly on top of the harm my family has suffered. Section 1(e) permits an expert who "believes there is a need to further investigate issues outside the briefing" to state as much in their report. Section 3(c) then tells the insurer to disregard it.

Fourth, it is expressed almost entirely in non-mandatory terms. On my reading, the Standard contains one express mandatory obligation directed to insurers, at Section 1(a): "insurers must ensure the expert being briefed is relevant, qualified, and objective." The overwhelming majority of the Standard's substantive recommendations are expressed as "should", rather than "must". The only other use of "must" is directed at experts rather than insurers, requiring that their findings "must be based on evidence."

Paragraph 71 of the draft states: "We will comply with, and instruct External Experts to comply with, the Insurance Council of Australia's Guide: Use of Expert Reports." Paragraph 21 of the draft makes Sections 1 to 9 part of the policy, and paragraph 71 sits within Section 4, so paragraph 71 is contractually enforceable.

It is unclear what a consumer enforces. An insurer complies with a "should" by considering it. A binding obligation to comply with a document of recommendations produces an obligation of indeterminate content.

The Code Governance Committee has itself observed that stronger Code obligations are needed to ensure insurers engage external experts with the right skills, qualifications and independence, and that reports are clear, evidence-based and confined to the expert's area of expertise. Consumer advocates made the same point when the Standard was released: that compliance and enforceability were the outstanding questions. Paragraph 71 does not resolve them.

Recommendation

The first three elements below are the core recommendation. The remaining points are consequential amendments needed to make that recommendation operational and to prevent the existing expert framework from defeating it.

1. Where an insurer's appointed expert, contractor or representative recommends action to prevent or limit further loss, require the insurer to either implement the recommendation within a defined period, or make a contemporaneous written record of its decision not to.
2. Require that record to state what the recommendation was, who made the decision not to follow it, the reasons, and what alternative action was taken instead. A record that says only that the insurer disagreed with the recommendation is not sufficient.
3. Require the insurer to provide the customer with a copy of any such recommendation, and of that record, within a defined period.

4 Extend the obligations in paragraphs 68 to 72 beyond causation experts, so they reach parties engaged to assess contamination, damage extent, or required remediation.

5 Provide that a recommendation to prevent or limit further loss is not to be disregarded as outside scope, and amend Section 3(c) of the Standard accordingly.

6 Provide that, where an insurer declines to act on a recommendation from its own appointed party to prevent further loss, the insurer should not be permitted to rely on the resulting avoidable escalation of loss against the customer, to the extent that the escalation was caused by the insurer's failure to act.

7 Either give the Expert Reports Standard mandatory force where paragraph 71 of the draft incorporates it, or import its substantive requirements into the Code as binding paragraphs. The drafting correction to the Standard's title is set out at Recommendation 15.

8 As an additional safeguard: where a statutory authority or appropriately qualified independent expert has determined that a property is unsafe or uninhabitable, provide that an insurer may not rely solely on a desktop review to decline make-safe works or accommodation.

Recommendation 2: Attach timeframes to fulfilment, not only to the Decision

What the draft says. Paragraph 74 requires a Decision within four months, or twelve months where paragraph 76 applies. Paragraph 75 provides for automatic acceptance if no Decision is made within twelve months.

The gap. "Decision" is defined as "our determination as to what, if any, part of your claim is covered by your policy. It is not a decision about how the loss will be fixed and/or how much money you will receive under the claim."

The entire timeframe architecture of Section 4 attaches to coverage, and not to whether anyone ever repairs the home.

An insurer can accept a claim in week one, comply fully with paragraphs 73 to 78, and leave a family displaced for years without breaching a single timeframe in this Code.

That is my situation. Our claim was accepted within weeks. The Decision was made. Sixteen months later we remain displaced. On my reading, no timeframe in Section 4 has been breached at any point.

Section 4's "Claims fulfilment" paragraphs, 83 to 85, contain no timeframes at all. The Code regulates how quickly an insurer decides and is silent on how quickly it acts.

Therefore a consumer whose claim is accepted has no Code timeframe requiring the claim to be fulfilled within any defined period.

For a consumer, the Decision is not the thing that matters.

I am not proposing that insurers guarantee a completion date. Repairs depend on trades, materials, weather and, after a catastrophe, on capacity that does not exist. I understand that. What I am proposing follows the same architecture as Recommendation 1: give an estimate, and if it is missed, say so and explain. That obligation is capable of being met in every case, including the hard ones.

Recommendation:

1 Introduce timeframes for claims fulfilment, not only for the Decision.

2 Require the insurer, within a defined period of accepting a claim, to provide a written scope of works and an estimated completion date.

3 Require written notification, escalation to a senior employee, and a revised completion date whenever an estimated completion date is not met.

4 Extend the principle in paragraph 75 to fulfilment: where an accepted claim has not been fulfilled within a defined period, a defined consequence should follow.

Recommendation 3: Require timeframes and independent assessment for rectification of defective authorised works

What the draft says. Paragraph 83: "We are responsible for the quality of work and materials used where we have selected and directly authorised a repairer to repair your damaged property." Paragraph 84 requires the insurer to arrange and cover accommodation where "we are satisfied" that further work is required.

The gap. Paragraph 83 establishes responsibility but attaches no timeframe or standard. Paragraph 84 conditions the customer's protection on the insurer being "satisfied" further work is needed, leaving the assessment with the insurer or its authorised repair process, despite paragraph 83 placing responsibility for the quality of the work and materials on the insurer.

Where an insurer's authorised contractor causes additional damage during works, the Code provides no timeframe for rectification, no independent mechanism for determining whether further work is required, and no obligation to disclose that the damage occurred.

Recommendation:

1 Attach timeframes to the responsibility in paragraph 83.

2 Amend paragraph 84 so that where the customer disputes the insurer's assessment, the question may be determined by an independent expert.

3 Require insurers to disclose in writing where authorised works have caused additional damage.

Recommendation 20: Require Scopes of Work to be clear, standardised, complete and provided without request

What was agreed. Recommendation 74 of the Independent Review states: "The Code should require Scopes of Work to be clear, standardised, and provide a full description of work and costs."

The Insurance Council's December 2024 Initial Industry Response records this recommendation as accepted, with the response: "Agree. The Insurance Council will work with its members to explore the best approach to delivering a customer facing summary of a Scope of Works."

Flood Inquiry recommendation 18 endorsed it, and recommended "Stronger Code provisions in relation to quality of Scopes of Work (as per Recommendation 74 of the Independent Review of the General Insurance Code of Practice)."

What the draft says. Paragraph 85 provides: "If you request it, we will provide you with information about the scope of works for the repairs to your damaged property, unless we tell you why we cannot."

That is not a requirement that Scopes of Work be clear, standardised, or provide a full description of work and costs. It is a requirement to provide information on request, subject to an exception the insurer states.

The Insurance Council's own response glossed recommendation 74 as delivering "a customer facing summary of a Scope of Works," which is narrower than the recommendation it agreed to. Paragraph 85 does not deliver that either. It does not require a summary, it requires information, only if asked, and only if the insurer does not explain why it cannot.

Why this matters. The Scope of Works determines what will be repaired and what will not. It is the document that decides whether a home is restored. A customer who cannot read what has been scoped cannot know what has been left out, and cannot say so until the works are finished and the omission is standing in front of them.

Therefore a customer must ask for a document they may not know exists, can be refused it with an explanation, and if they receive it, it need not be complete.

Recommendation:

1. Implement recommendation 74 as accepted: require Scopes of Work to be clear, standardised, and to provide a full description of work and costs.
2. Require the Scope of Works to be provided without the customer having to request it.
3. Remove or narrow the exception in paragraph 85.

Part C: The protections have holes in them

Recommendation 4: A complaint or dispute process should not remove the twelve month protection

What the draft says. Paragraph 75's automatic acceptance does not apply where, per paragraph 76(c), "you have lodged a Complaint with us or with the Australian Financial Complaints Authority that impacts our ability to make a Decision on your claim within the relevant timeframe." Paragraph 76(d) does the same where the customer has "commenced any Court, Tribunal or dispute handling process against us."

The problem. The customers most likely to need the twelve month protection are also likely to be customers who have complained about delay. Delay is what causes complaints. Under this drafting, exercising a complaint right may remove the protection designed to address delay, where the insurer considers that the complaint impacts its ability to make a Decision.

The concern is not that every complaint automatically stops the clock. It is that the exception is capable of being engaged by an internal complaint, notwithstanding the Flood Inquiry's express recommendation that the twelve month protection should instead be triggered where internal dispute resolution has commenced but remains unresolved.

This creates a disincentive to complain. A customer at month ten watching a claim stall must weigh raising a complaint against the risk of forfeiting the protection at month twelve. That is backwards.

It also leaves significant control with the insurer. The exception is engaged where a complaint "impacts our ability to make a Decision." The insurer assesses that in the first instance.

The Flood Inquiry expressly addressed this and said the opposite. Recommendation 57 of the House of Representatives Standing Committee on Economics Inquiry into insurers' response to 2022 major flood claims recommended implementation of Code Review recommendation 63, and then specified:

"This would not be triggered where a claim has been lodged with the Australian Financial Complaints Authority. This would be triggered where internal dispute resolution has commenced but is not resolved. If the insurer has not made a decision by 12 months, the claim must be paid."

The Committee turned its mind to precisely this question and said so in terms. The words "with us" in paragraph 76(c) do the very thing it said should not be done.

The Insurance Council agreed in principle to that recommendation. Its Industry Action Plan of March 2025 responds to Flood Inquiry recommendation 57, quoting it in full including the dot point above, and states:

"Agree in principle. The Insurance Council and its members will consider appropriate revisions to the Code. In the vast majority of cases, home, contents and motor insurance related claims should not take more than 12 months from the time a claim is acknowledged to have a decision made. The Code will recognise that there are circumstances outside of an insurer's control, for example, where new information is made available on an existing claim, or an intermediary is being used which may cause additional delays. The Insurance Council and its members will work with ASIC and the Code Governance Committee in relation to any Code obligation."

The Action Plan defines "Agree in principle" as: "The industry agrees to the recommendation, noting that implementation method will need to be considered."

The industry agreed to the recommendation. The recommendation expressly included the words "This would be triggered where internal dispute resolution has commenced but is not resolved."

The response then identifies the circumstances the Code will recognise as outside an insurer's control, and gives two examples: new information on an existing claim, and the use of an intermediary.

A complaint made to the insurer is neither of those. Nor is it outside the insurer's control, since the insurer is the party handling it.

Therefore paragraph 76(c) is capable of removing the protection in a circumstance the industry agreed it should not be removed, on a basis not identified in the industry's own stated implementation.

Paragraph 76(d) compounds this. AFCA is the free, industry funded scheme the Code itself directs consumers to at paragraphs 24, 131 and 136. AFCA is a dispute resolution process rather than court or tribunal litigation. If paragraph 76(d) is intended to capture a complaint to AFCA as a "dispute handling process", the Code should not direct consumers to AFCA in one provision and then remove a protection because they followed that direction in another.

Recommendation:

1. Delete paragraph 76(c) in its entirety.
2. If it is retained, delete the words "with us or," so that an internal complaint does not remove the protection. That is the minimum change required to give effect to Flood Inquiry recommendation 57, which the Insurance Council agreed to in principle.
3. Amend or clarify paragraph 76(d) so that it is not engaged by a complaint to AFCA.
4. If an exception of this kind is retained in any form, require the insurer to demonstrate to the Code Governance Committee that the complaint genuinely prevented a Decision.

Recommendation 5: Define cooperation, and require notice before it is relied on

What the draft says. Paragraph 76(a)(i) gives, as an example of something outside the insurer's control, "you request a delay or you or your Nominee do not cooperate with us or respond to our reasonable enquiries or requests for documents or information about your claim."

The problem. The Code does not define cooperation. It does not require the insurer to notify the customer that this characterisation has been formed. It provides no process to respond to it or challenge it. The determination is made by one party, about the other, and the other party need never know it has been made.

I accept that the chapeau of paragraph 76(a) requires the circumstance to have actually prevented a Decision, and that the characterisation would be open to testing at AFCA or by the Code Governance Committee. My concern is procedural, not an allegation that insurers will misuse it.

The practical consequence is that a customer may lose the benefit of paragraph 75 without ever having been told there was a concern, and without any opportunity to address it. A customer told at month six that their responsiveness is a problem can act on that. A customer who learns of it afterwards, if at all, cannot.

I raise this because there is a real risk that disagreement is recorded as non-cooperation. A customer who provides information but disputes the insurer's interpretation of it, who asks why information is required, or who seeks a review or disputes a decision, is cooperating. The Code should say so expressly.

Recommendation:

1. Define cooperation for the purposes of paragraph 76(a)(i). For this purpose, cooperation should mean responding within a reasonable time to reasonable and relevant requests, while preserving the customer's right to question, challenge or complain about the request or the claim.
2. Require the insurer to notify the customer in writing before relying on non-cooperation, and to give a reasonable opportunity to respond.
3. Provide expressly that disputing a decision, requesting reasons, seeking specification of an information request, or exercising a complaint right or seeking a review does not constitute non-cooperation.

Recommendation 6: Paragraph 23(c)(iii) substantially removes the right granted by paragraph 22

What the draft says. Paragraph 21 of the draft incorporates Sections 1 to 9 into the policy. Paragraph 22 of the draft provides that if the insurer breaches those paragraphs, "you will have legal rights to enforce those paragraphs as part of it, unless the exceptions at paragraph 23 apply."

Paragraph 23(c)(iii) then provides that the insurer will not be liable "for any loss that does not arise naturally, including any indirect or consequential loss."

The problem. In a displacement claim, many of the losses that may flow from a Code breach are likely to be characterised as indirect or consequential losses, depending on the applicable legal principles. These may include additional accommodation costs, duplicated utilities, additional damage caused by delay, and costs incurred in responding to the consequences of the breach. These are the losses that flow from an insurer failing to comply.

Excluding consequential loss in a consumer insurance contract risks rendering contractual enforceability illusory, because the primary loss suffered from a Code breach in a home displacement claim is very often of that character.

The enforceable right created by paragraph 22 is therefore substantially narrowed in practical effect by paragraph 23(c)(iii). A consumer may have a contractual right to enforce the Code while being unable to

recover some of the consequential loss caused by the breach.

I am not suggesting that the Code should convert an uninsured loss into an insured loss. The issue is whether a customer should have an effective remedy where additional loss is caused by the insurer's own breach of an enforceable Code obligation.

Paragraph 23(c)(iv) compounds this by excluding liability "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." In my experience, an insurer that declines to pay a covered cost, and then relies on the customer's duty to mitigate when harm follows, is using the customer's own obligations as a shield against the consequences of its inaction.

Recommendation:

1. Amend paragraph 23(c)(iii) so that loss reasonably foreseeable as a consequence of a Code breach is recoverable.
2. Amend paragraph 23(c)(iv) so it cannot be relied on where the insurer's own non-compliance created the circumstance in which the customer was required to mitigate.
3. Consider providing for defined, accessible remedies for serious or repeated breaches of specified paragraphs, including remedies available through AFCA. A right that can only be vindicated by a displaced and financially exhausted family commencing proceedings in court is not, in practice, a right at all.

Part D: Vulnerability, hardship and displacement

Recommendation 7: Require Extra Care to have operational effect on claims handling

What the draft says. Section 7 requires insurers to identify vulnerability, record it with consent, communicate through the customer's preferred channel where able, provide interpreters where possible, train employees, publish information, and refer customers to external support services.

The problem. Section 7 requires nothing about the claim.

There is no obligation for a customer's recorded vulnerability to affect any claims handling decision, any timeframe, any priority, or any outcome. Extra Care is defined in Section 7 as "the additional support or flexibility we are able to provide," and paragraph 139 limits it to Extra Care "that we have agreed with you." It is discretionary at both ends.

My household is formally recorded by our insurer as experiencing vulnerability. In practice this has meant referrals to crisis support services. When we asked the vulnerability team for practical assistance with a claim issue, we were told in writing that its function is to support the vulnerability side of the claim, not claim management or outcomes.

That answer is entirely consistent with this draft. Section 7 creates a communications and referral function that sits alongside the claim with no ability to affect it. Recording vulnerability without requiring operational consequences turns it into an administrative classification rather than a consumer protection.

Therefore a customer identified as vulnerable receives sympathy and referrals, while the circumstance producing the vulnerability continues unaddressed.

The definition of Vulnerability expressly includes "a natural disaster or other catastrophic event" and "displacement or trauma." The draft Code recognises displacement as a source of vulnerability while requiring nothing to resolve it.

Both the Independent Review and the Flood Inquiry recommended an external standard. The draft substitutes the Insurance Council's own guidance.

Recommendation 21 of the Independent Review states: "Paragraph 91 should be amended to require insurers to comply with ISO 22458 'Consumer Vulnerability'." Paragraph 91 of the current Code is the vulnerability provision, and its counterpart in the draft is paragraph 141. Recommendation 22 offers an alternative: requiring insurers to demonstrate organisational commitment by following the key principles in ISO 22458, including designing customer service and claims processes to be inclusive.

Recommendation 39 of the Flood Inquiry endorsed it: the Code should "require insurers' identification of vulnerable customers and training of staff be designed so that customer interaction is compliant with ISO 22458 2022-04, the International Organization for Standardization's document Consumer vulnerability."

The Review Panel's own comment records: "The Review Panel welcomes the Flood Inquiry endorsement of Recommendation 21."

The Insurance Council agreed in principle. Its Industry Action Plan of March 2025 responds to Flood Inquiry recommendation 39:

"Agree in principle. The Insurance Council and its members are in the process of developing a vulnerability framework in 2025 and will partner with ANZIIF on drafting accompanying training modules... The Insurance Council and its members will also explore what ISO principles may be suitable to adopt in the Code."

The Action Plan defines "Agree in principle" as: "The industry agrees to the recommendation, noting that implementation method will need to be considered."

So the commitment was to explore what ISO principles may be suitable to adopt in the Code.

Paragraph 141 of the draft reads: "We will develop our systems, processes and training in accordance with the principles from the Insurance Council of Australia's Guidance on Vulnerability."

An international standard has been replaced by guidance the Insurance Council writes and can amend, which sits outside the Code. I am not able to identify which ISO principles have been adopted in the Code. If the intention is that the draft implements only selected ISO principles, the Consultation Paper should identify those principles and explain why the remaining relevant principles have not been adopted.

The Insurance Council has adopted this approach, in this same redraft, in relation to two other areas.

The Consultation Paper lists among the new commitments:

"Strengthened and expanded Code provisions to include key principles from the Insurance Council's Guide to helping customers affected by family violence and Guide on Mental Health. Industry anticipates replacing these Guides with the proposed Code's new contractually enforceable obligations."

That is the industry recognising that guidance is not sufficient, and moving the substance of two guides into the Code so that it binds. I think that is exactly right, and I support it.

The Insurance Council's own guides expressly acknowledge this. Its Guide to helping customers affected by family violence states: "This guide does not bind insurers."

So the position taken in this consultation is that where an obligation matters, it belongs in the Code rather than in a guide. For family violence and mental health, the industry has acted on that.

At the same time, the consultation material identifies a separate guide, "Extra care for general insurance customers experiencing vulnerability," which I understand is intended to sit outside the Code. And, as set out at Recommendation 18, the redraft moves the honest, efficient and fair obligation out of the Code and into the Principles.

Three things are moving in three different directions in one exercise. Two guides are being brought into the Code because guidance does not bind. A new guide is being created outside it. And an existing Code obligation is being moved into material that is expressly not the Code.

As noted in my introduction, Attachment 4 was inaccessible to me during the public consultation window. I do not think it matters for this point. However good that guidance is, and I have no reason to think it is not good, it is a guide. The Insurance Council has just told us, in this same consultation, what guides do and do not achieve. If Attachment 4 in fact incorporates ISO 22458 bound within the Code body, the Insurance Council should explicitly clarify this in the final release.

Therefore the question is why this guidance is not in the Code, when the Insurance Council's own reason for moving two other guides into the Code applies to it with equal force.

A drafting note. The definition of Extra Care differs between Section 7 and the Definitions section. Section 7 reads "the additional support or flexibility we are able to provide." The Definitions section reads "the additional support or flexibility we provide." The difference is not cosmetic. One is discretionary and one is not. The Definitions version also contains a typographical error, "while you are experience [sic] Vulnerability." These should be reconciled, and the discretionary framing should not be the version adopted.

Recommendation:

1 Require that recorded vulnerability be a mandatory relevant consideration in claims handling, not only in communication.

2 Where a customer is recorded as experiencing Vulnerability, require the insurer to consider the customer's vulnerability when determining the urgency of claims fulfilment and, where appropriate, prioritise or escalate the claim, and identify a decision-maker with authority to act.

3 Delete the words "that we have agreed with you" from paragraph 139. A protection that operates only where the insurer agrees to it is not a protection, it is a negotiation.

4 Replace the discretionary definition with a defined minimum standard of Extra Care that vests on identification, without further agreement. The drafting corrections needed to give effect to this are set out at Recommendation 15.

5 Where a customer's vulnerability arises from displacement following an insured event, provide that addressing the causes of prolonged displacement should be a primary consideration in the insurer's Extra Care response.

6 Apply to the Extra Care guidance the same treatment being applied to the family violence and mental health guides: bring its substantive requirements into the Code, so that they bind.

7 Implement Independent Review recommendation 21 and Flood Inquiry recommendation 39 by requiring compliance with ISO 22458, rather than with guidance the Insurance Council writes and can amend.

Recommendation 8: Address hardship caused by the insurer, and the loss of essential services

What the draft says. Section 8 addresses Financial Hardship, defined as "difficulty meeting your financial obligations to us."

The gap. Section 8 governs money the customer owes the insurer. It is silent on the reverse, and potentially more consequential, situation in a long claim: the insurer's delay or non-payment causing the customer to fall into hardship with someone else.

A displaced family carries costs that exist only because of the insured event. Where the insurer disputes or delays those costs, the exposure lands on the customer and on third-party creditors. In our case this has included a formal disconnection notice for electricity at our temporary accommodation, on an account the insurer had been on notice of for more than two months.

Nothing in this draft addresses that. There is no obligation to act where an insurer's delay places a customer at risk of losing an essential service. There is no obligation to prioritise a disputed amount where non-payment will cause imminent harm. There is no obligation to consider it at all.

Paragraph 55 comes closest, requiring the insurer to fast-track assessment or make an advance payment for Urgent Financial Need. The Consultation Paper lists among the new commitments an "expanded definition of 'Urgent Financial Need' to explicitly include essential needs," and I acknowledge that expansion.

The expansion does not reach the problem. Urgent Financial Need remains defined by reference to "an urgent payment of the benefit(s) you are entitled to under your policy." Adding essential needs widens what the payment may be for. It does not remove the condition that entitlement must first exist. Where entitlement is the very thing in dispute, the definition is circular and paragraph 55 does nothing, however essential the need.

Recommendation:

1. Extend Section 8 to address hardship caused by the insurer's own delay or non-payment, not only debts owed to the insurer.
2. Introduce an obligation, where an insurer is on notice that its delay or non-payment will result in the loss of an essential service to a customer, to act to prevent that loss pending resolution of the underlying dispute.
3. Amend the definition of Urgent Financial Need so it is not conditional on entitlement being established. Where an insurer disputes the scope or total of a loss, require it to advance any reasonably quantifiable undisputed amount, without prejudice to its position on the disputed balance.
4. Provide expressly that an insurer may make a payment on account without prejudice to its position, and that doing so is not an admission of liability, so that consumer protection does not require the insurer to concede the dispute.

Recommendation 19: Require reasonable notice before temporary accommodation ends or changes

Notice is not policy coverage. It does not raise competition issues, and it does not increase the scope of any benefit. Whatever the position on coverage, requiring reasonable notice before accommodation ends or materially changes is a modest procedural protection. I begin with that because it is the answer to the objections set out below, each of which I otherwise accept.

What both the Independent Review and the Flood Inquiry recommended. Recommendation 69 of the Independent Review states:

"The Code should require temporary accommodation benefits to extend until the property is fully repaired or rebuilt, up to a cap of 12 months. Insurers should also be required to contact customers at least three months before the benefits are set to conclude and advise whether any extension of the benefits is available if the repair or rebuild is not completed."

Recommendation 19 of the Flood Inquiry recommended fully paid temporary accommodation "until the insurer has closed the claim, unless the extension of the time required can be demonstrated to be a result of behaviour on the part of the policyholder that is unreasonably causing delay," and that "the cost of covering temporary accommodation should be a separate entitlement and not be funded out of the sum insured amount."

Recommendation 20 of the Flood Inquiry recommended that the Code "include an appropriate mechanism for ensuring policyholders that are being provided with temporary accommodation as part of their claim have at least 3 months' notice of any proposed substantive changes to the policyholders' living situation or the insurers' payments for the accommodation."

What the Insurance Council said in response. Its Industry Action Plan of March 2025 responds to Flood Inquiry recommendation 20:

"Understand the intent. The three-month timeframe is prescriptive and may not be viable where the benefit is shorter than three months or the changes are in the consumer's interest, such as where more suitable accommodation becomes available. The Insurance Council and its members will explore appropriate revisions to the Code to ensure reasonable notice."

I accept the point about three months being prescriptive. It is a fair objection and I do not press the three month figure.

But the response gave a commitment: to explore appropriate revisions to the Code to ensure reasonable notice.

On duration, the response to Flood Inquiry recommendation 19 states: "Understand the intent. Insurers support competition that drives diversity in the products made available to consumers, including the scope of temporary accommodation benefits. It is noted that increasing the coverage of policies, such as an undefined period of time or scope, will impact premiums for consumers. Insurers will commit to individually considering the most appropriate way to cover temporary accommodation within their policies, complying with competition law."

I accept that duration is a matter of policy coverage rather than Code drafting, and that competition law constrains a collective position. I do not press recommendation 69's twelve month cap.

What the draft says. I cannot find any provision in the draft that requires reasonable notice before temporary accommodation benefits conclude or substantively change.

Paragraph 84 requires the insurer to arrange and cover accommodation where it is "satisfied" that further work is needed following defective repairs. That is a narrow provision addressing a different situation. There is no provision addressing the duration of temporary accommodation, no requirement to give notice before it ends, and no provision that it is a separate entitlement rather than drawn from the sum insured.

Why this matters. Temporary accommodation is the provision that determines whether a displaced family has somewhere to live while an insurer takes its time. It is, for a displaced customer, the single most consequential provision in the policy. Both the Independent Review and the Flood Inquiry identified it. Both

made specific recommendations. The Review Panel's own comment records that the need for "more certainty for policyholders requiring temporary accommodation after an event" was "expressed strongly in submissions."

I can attest to that. My family has been displaced for sixteen months. We have received notice of changes to our accommodation arrangements with days rather than months to respond. Flood Inquiry recommendation 20 exists because that happens to people.

Therefore a customer displaced by a catastrophe has, under this draft, no more certainty about their accommodation than they had before either review reported.

Recommendation:

1. Give effect to the commitment made in response to Flood Inquiry recommendation 20 by including a provision in the Code requiring reasonable notice before temporary accommodation benefits conclude or substantively change.
2. Require the insurer, at that time, to advise whether any extension is available.
3. If a fixed period is considered too prescriptive, define reasonable notice by reference to the circumstances rather than omitting the obligation.

Part E: Experts, information and records

Recommendation 9: Require insurers to reconcile their own divergent expert reports before relying on one

What the draft says. Nothing.

What the Standard says. Section 1(c) addresses divergence in one narrow circumstance only: "where additional reports are provided and the expert's views diverge, this, and the reasons for the divergence, should be explained in their report." That is directed at an expert who has been given other reports to review. It is engaged only if the insurer chooses to provide them.

The gap. Neither the Code nor the Standard requires an insurer to reconcile conflicting reports from its own appointed experts before relying on one of them.

In our claim, three separate contractors appointed by our insurer reached three different conclusions about the cause of the damage. One attributed it squarely to the catastrophe. One found no event-related damage. One attributed it to wind-driven rain during the event. The insurer relied on the report least favourable to us, in a formal decision that quoted all three. The divergence was never reconciled or explained.

A consumer receiving that decision is being told the insurer's expert evidence supports its position, when the insurer's own expert evidence in fact contradicts itself.

Therefore the consumer must dispute a conclusion without ever being told why it was preferred over the insurer's own contrary evidence. This is a matter of procedural fairness rather than expert methodology.

Disclosure of all reports, not only the one relied on. Flood Inquiry recommendation 6 recommended that the Code "require the insurer to provide policyholders with any expert reports including, but not limited to, any reports that insurers have relied upon to deny a claim in whole or in part." Paragraph 81 of the draft provides only for "a copy of any External Experts' reports we relied on." The words "including, but not limited to" have not been given effect.

Recommendation:

1. Where an insurer holds two or more expert reports reaching materially different conclusions on the same question, require it to reconcile the divergence in writing before relying on any of them in a Decision.
2. Require the insurer to disclose all expert reports obtained or held for the purpose of assessing the claim that materially address the relevant question, not only the report relied upon in the Decision, subject to any narrowly defined legal privilege or other lawful exception, giving effect to Flood Inquiry recommendation 6.
3. Provide that an insurer may not rely on one of several materially divergent reports without addressing the divergence and explaining why it preferred the report or opinion relied upon.

Recommendation 10: Require the expert briefing to be disclosed

What the draft says. Nothing. The Standard, at Section 1(d), provides only: "In some instances, the insurer may consider it appropriate for the customer should also receive a copy of the briefing to the expert for transparency, although this will need to be considered in the context of claims processing timelines."

The problem. Section 1(e) of the Standard requires the insurer to "make it clear to the expert exactly what they want the expert to provide an opinion on by including specific questions."

The brief determines the report. The party that sets the questions substantially shapes the answers. Yet disclosure of the brief is entirely discretionary, and expressly subject to the insurer's own view of its processing timelines.

A customer receiving an expert report cannot assess it without knowing what the expert was asked, and what they were not asked.

Recommendation:

1. Require the insurer to provide the customer with the substantive briefing or instructions given to any expert whose report is relied upon in a Decision, at the time the report is provided, subject only to narrowly defined legal privilege or other lawful exception.
2. Remove the discretion in Section 1(d) of the Standard.

Recommendation 11: Require qualifications for condition, contamination and salvage determinations

What the draft says. Paragraph 69 requires that "External Experts will have appropriate expertise." Paragraph 183 requires that Claims Fulfilment Providers "reasonably satisfy us that they, and their employees, can deliver their services competently and professionally." Paragraph 184 requires any licence required by law.

What the Standard says. Section 1(a) contains the Standard's only mandatory obligation on insurers: "insurers must ensure the expert being briefed is relevant, qualified, and objective," giving the example of "ensuring a qualified hydrologist is appointed for hydrology matters, rather than a builder."

That is exactly the right principle. It applies only to External Experts.

The gap. A restorer is a Claims Fulfilment Provider. The only requirements are a licence to do the work and general competence. Neither paragraph 69 nor the Standard reaches them.

In practice, restoration contractors make determinations of considerable consequence: whether an area is contaminated, what condition it is in, whether a possession can be cleaned or must be destroyed. Those determinations decide what a customer gets back and what the claim is worth. Neither the Code nor the Standard says anything about whether the person making them is qualified to do so.

The Standard's own example, that a hydrologist should be appointed for hydrology rather than a builder, applies with equal force here. A determination about contamination condition should be made by someone qualified to make it.

Recommendation:

1. Require that any professional assessment or determination of contamination condition, damage extent, structural safety, restorability or salvage be undertaken by a person with qualifications appropriate to the subject matter of that assessment.
2. Provide that where a Claims Fulfilment Provider is tasked with assessing, measuring or certifying the safety, contamination or structural condition of a property, as distinct from carrying out physical works, it is deemed an External Expert for the purposes of that assessment and paragraphs 68 to 72 apply to it.
3. Require the insurer to record and disclose who made such a determination, and on what basis.

Recommendation 12: Require insurers to specify what information would be sufficient

What the draft says. Paragraph 67: "We will only request and rely on relevant information to assess your claim. We will explain why this information is relevant." Paragraph 58: "We will use our best endeavours to limit the number of requests we make and explain why we need the information."

The problem. These paragraphs regulate the relevance of information requested. Neither requires the insurer to identify what would be sufficient.

In practice this permits a pattern that is difficult to escape. The customer provides what is asked. The insurer says it is not enough. The customer asks what would be enough. The insurer repeats that the information provided is insufficient. Each exchange is individually compliant with paragraph 67. The claim does not advance.

I have twice asked our insurer to specify how many further documents are required, and confirmed in writing that we would provide them. That specification has not been given, while the position remains that what we have provided is insufficient.

The Insurance Council expressly marked this recommendation "Agree", while stating that it would explore appropriate revisions to the Code to strengthen paragraph 67. As set out under Category A above, recommendation 86 of the Independent Review states: "Insurers should request information only if it is strictly relevant to the claim, avoid multiple requests, and clearly communicate why each item of information is necessary and relevant."

The Insurance Council's Industry Action Plan of March 2025 responds:

"Agree. The Insurance Council and its members will explore appropriate revisions to the Code to strengthen Paragraph 67."

The Action Plan defines "Agree" as: "The industry agrees to implement this recommendation and will consider how best to progress this."

Three things were agreed: strictly relevant, avoid multiple requests, and communicate why each item is necessary and relevant. A commitment was given to strengthen paragraph 67.

The draft says the insurer will use "best endeavours to limit the number of requests," which is not the same as avoiding multiple requests, and "best endeavours" is materially less precise and less readily enforceable than a defined obligation. Paragraph 67 says "relevant," which is not "strictly relevant."

I am not able to identify how paragraph 67 has been strengthened.

This is worth raising as a practical matter as much as a fairness one. Customers do not become exhausted because they are asked for documents. They become exhausted because they cannot tell what success looks like. A customer who is told precisely what is required can provide it once. A customer who is told only that what they gave is insufficient will provide the wrong thing repeatedly, and the insurer will process each attempt. Specifying the requirement reduces the number of requests, which is what paragraph 58 says the insurer should be using its best endeavours to do.

Recommendation:

1. Require insurers, when advising that information provided is insufficient, to specify in writing what further information would be sufficient.
2. Replace "best endeavours" in paragraph 58 with a defined obligation.
3. Provide that where an insurer cannot specify what would be sufficient, it must make a Decision on the information available.

Recommendation 13: Require disclosure where an insurer decides to stop work

What the draft says. Paragraph 59(a) requires the insurer to "update you about your claim at least every 20 Business Days."

The gap. Nothing requires an insurer to disclose a decision to halt, hold or suspend work on a claim. A 20 business day update satisfied by saying nothing has changed is compliant with paragraph 59 even where the insurer has in fact decided to stop.

A decision to stop work on a damaged home is material. It affects the customer's property, their exposure to further loss, and their ability to make their own arrangements. It should not be capable of being made silently.

The Independent Review recommended the word the draft leaves out. Recommendation 66 states: "Paragraph 70 should be updated to require insurers to provide meaningful progress updates every 20 business days." Paragraph 70 of the current Code is the progress update provision, and its counterpart in the draft is paragraph 59(a).

The frequency was adopted. The word "meaningful" was not.

Recommendation 67 of the Independent Review states: "Paragraph 71 should be updated to require insurers to respond to routine inquiries within 3 business days." Paragraph 71 of the current Code is the routine enquiries provision, and its counterpart in the draft is paragraph 59(b). It should not be confused with paragraph 71 of the draft, which is the provision incorporating the Expert Reports Standard and is dealt with at Recommendation 1.

Paragraph 59(b) of the draft requires a response to routine enquiries within 10 business days. The Review recommended three. The draft says ten.

The stated reason does not appear to address either point. The Industry Action Plan answers recommendations 66 and 67 by cross-reference to Flood Inquiry recommendation 33, and responds:

"Support the intent. The Insurance Council and its members recognise that consumers should have access to the status of their claim however, a requirement for real time access via an app or platform is prescriptive, can often be dependent on third-parties and disproportionately impact smaller insurers. [Quoted as published.] The Insurance Council and its members will explore appropriate revisions to the Code, taking a holistic approach to align all communication timeframe recommendations, including legislated timeframes, where possible."

I accept that point entirely. Requiring real time app access would be prescriptive, would depend on third parties, and would fall hardest on small insurers. It is a fair objection and I do not press it.

But recommendation 66 did not ask for an app. It asked that updates be meaningful. Recommendation 67 did not ask for an app. It asked for three business days.

The objection answers a proposal neither recommendation made, and the two things they did ask for have not been delivered.

There is a related problem with paragraph 59 itself. An update every twenty business days that says the claim is progressing, or that the matter is under review, satisfies the paragraph on its face. An insurer can therefore remain compliant with its update obligation for years while taking no substantive step at all. The Code measures the frequency of communication and not the progression of the claim.

Therefore a customer can receive perfect compliance with paragraph 59 for two years and still be in a tent.

Recommendation:

1. Require insurers to notify the customer in writing, within a defined period, of any decision to halt, hold or suspend works, assessment or fulfilment, and the reasons for it.
2. Provide that the update obligation in paragraph 59 is not satisfied by an update that omits a decision of that kind.
3. Adopt Independent Review recommendation 66 in full by requiring updates under paragraph 59(a) to be meaningful, and defining what that requires.
4. Reconsider paragraph 59(b) against Independent Review recommendation 67, which recommended three business days rather than ten.
5. Where a claim remains unfulfilled beyond a defined period after acceptance, require each update to state what was done in the preceding period and what is scheduled for the next, and provide that a generic statement that the matter is progressing does not satisfy paragraph 59.

Recommendation 17: Require insurers to maintain a live chronology of material developments

What the draft says. Paragraph 59 requires updates every 20 business days and responses to routine enquiries within 10. Paragraph 66 requires the insurer to consider "all facts relevant to your claim that are known to us."

The gap. Nothing requires an insurer to maintain a concise running record of material developments across the life of a claim, or to review it.

On a claim that runs for months or years, with changing personnel, multiple contractors and repeated notifications, each notification tends to be handled as a discrete event by whoever is holding the file that week. The pattern across them is never seen, because no one is required to look.

In our claim, we notified the insurer of continuing water ingress in writing on at least ten separate occasions over the course of ten months, to the insurer, to its appointed builder, to its Chief Executive Insurance, and, incidentally, to an independent structural engineer who recorded it in his report. Each notification was answered, if at all, on its own terms. The fact that they formed a continuous chronology of the same unresolved problem, worsening over time, was never engaged with, because nothing required anyone to assemble them.

Paragraph 66's obligation to consider "all facts relevant to your claim that are known to us" is, in a long claim, one that cannot practically be met without such a record. The facts are known to the organisation and not to the person holding the file.

Therefore a customer who reports the same deteriorating problem ten times is, in practice, reporting it for the first time on each occasion.

This reform is not only a consumer protection. Large catastrophe portfolios suffer from staff turnover, contractor turnover, evolving damage and claims that change character over time. A live chronology preserves institutional memory across handler changes. An insurer whose fourth claims manager can see, on one page, what the first three were told is better placed to make a sound decision, and less exposed to the disputes that arise when it cannot. I raise it as an operational improvement as much as a consumer one.

Recommendation:

1. Require insurers to maintain a concise live chronology of material developments on any claim that remains open beyond a defined period, recording notifications received, recommendations made by appointed parties, decisions taken, and works undertaken. This is a record of material developments, not of every contact.
2. Require the chronology to be reviewed by a person with appropriate authority at defined intervals, and on any change of the person handling the claim.
3. Require the chronology to be provided to the customer on request.

Part F: Cash settlements

Recommendation 14: The review period should run from discovery, not from payment

What the draft says. Paragraph 92 permits a customer to request a review of a Cash Settlement amount "within 12 months of receiving it," where they have not been paid the full sum insured and can show the settlement is not enough to complete the repairs.

The problem. A customer usually cannot show a settlement is inadequate until works begin and the true scope is exposed. On a large or contested claim, works may not begin within twelve months of settlement. The window can close before the evidence exists.

In our claim, the inadequacy of the settlement became apparent only when the contractor's own scope expanded substantially after its first physical inspection of the property, more than twelve months after settlement.

Paragraph 92 gives a right that expires before it can be exercised.

Recommendation:

1. Amend paragraph 92 so the twelve month period runs from the date the customer knew or ought reasonably to have known that the Cash Settlement was insufficient.
2. In applying that test, the commencement of works, or the provision of a scope of works reflecting the actual condition of the property, may each serve as the point at which the customer could reasonably first have known.

Part G: Clarity, accessibility and future applicability

Recommendation 15: Defects in clarity identified in the draft

The Insurance Council has invited comment on the clarity and accessibility of the draft's language. I identified the following while preparing this submission. Each is dealt with more fully in the recommendation noted.

1. **Extra Care is defined twice, differently.** Section 7 reads "the additional support or flexibility we are able to provide." The Definitions section reads "the additional support or flexibility we provide." The difference is not cosmetic. One is discretionary and one is not. See Recommendation 7.
2. **The Definitions section contains a typographical error.** The definition of Extra Care reads "while you are experience [sic] Vulnerability." It should read "experiencing." See Recommendation 7.
3. **Paragraph 71 of the draft refers to a document by the wrong name.** It refers to the "Guide: Use of Expert Reports." The document is titled "Use of Expert Reports: Industry Best Practice Standard." See Recommendation 1.
4. **"Decision" is a defined term whose meaning is materially narrower than a consumer would ordinarily assume.** A consumer reading "we will make a Decision about your claim within 4 months" would reasonably understand that to mean their claim will be resolved. It means only that coverage will be determined. The definition is in a green box, but the word carries an everyday meaning that the definition narrows considerably. Consider renaming it, for example "Coverage Determination." See Recommendation 2.
5. **Paragraph 31 contains a grammatical error.** It reads: "The Code Governance Committee will monitor our compliance Sections 1 to Section 9 of the Code in accordance with their Charter." It should read "compliance with Sections 1 to 9." I mention it because paragraph 31 defines the scope of independent monitoring, and is central to Recommendation 18.
6. **Paragraph 23 substantially qualifies paragraph 22 without signalling it.** Paragraph 22 tells the consumer they have legal rights to enforce the Code. The qualification "unless the exceptions at paragraph 23 apply" carries the entire weight of paragraph 23(c), which removes consequential loss. A consumer reading paragraph 22 would not understand that. See Recommendation 6.
7. **Paragraph 71 has different subject matter in the current Code and the draft.** Paragraph 71 of the current Code is the routine enquiries provision, which the Independent Review addressed at its recommendation 67. Paragraph 71 of the draft is the provision incorporating the Expert Reports Standard. See Recommendations 1 and 13.

8 **Paragraph 21 has different subject matter in the current Code and the draft.** Paragraph 21 of the current Code is the honest, efficient, fair, transparent and timely obligation. Paragraph 21 of the draft is the provision incorporating Sections 1 to 9 into the policy. Because the redraft proposes to move the first, and because the second is what makes the Code enforceable, the collision is unhelpful during a transition in which both documents will be referred to. See Recommendation 18.

A general observation on accessibility. The draft is written in plain language at sentence level, and that is a genuine improvement. But its effect can only be understood by reading defined terms against operative paragraphs against an externally incorporated industry standard. I could not have understood what this Code actually requires without assistance. Plain sentences are not the same thing as an accessible document.

Recommendation:

1 Reconcile the two definitions of Extra Care, and adopt the version that is not framed as discretionary.

2 Correct the typographical error in the definition of Extra Care.

3 Correct the reference in paragraph 71 of the draft to the Standard's actual title.

4 Rename the defined term "Decision," or state expressly at paragraph 74 that a Decision does not mean the claim will be resolved.

5 Correct the grammatical error in paragraph 31.

6 Signal at paragraph 22 the effect of the exceptions at paragraph 23, rather than leaving the qualification to a cross-reference.

7 Renumber to avoid provisions of the current Code and the draft sharing numbers during a transition in which both will be referred to. Paragraphs 21 and 71 are both affected.

8 Test the draft for accessibility by asking whether a consumer can determine what it requires without reading a separate industry standard.

Recommendation 16: Applicability in the future

The Insurance Council has invited comment on the draft's applicability in the future.

My observation is narrow and it comes from experience. The draft is built around a model in which a claim is assessed, decided, and resolved. Its obligations attach to that sequence. The protections thin out sharply for claims that do not follow it: claims where coverage is accepted but fulfilment does not follow, claims involving progressive damage that worsens after the Decision, claims where the insurer's own works cause further loss, and claims that run for years.

Those are precisely the claims that catastrophes produce, and catastrophes are becoming more frequent. The draft Code's definition of Vulnerability expressly includes "a natural disaster or other catastrophic event" and "displacement."

A Code whose primary claims-handling timeframe is built around a four-month Decision period will not be fit for purpose in an environment where long, complex, progressive-damage claims following declared catastrophes become more common. Paragraph 94 requires catastrophe plans, but a plan to manage volume is not the same as an obligation to fulfil.

Two features of the proposal make this more pressing rather than less.

The Consultation Paper states that the Code review cycle will move to "at least every five years (instead of every three years)," with the rationale that this provides "sufficient opportunity for industry to assess the impact of the new Code and to account for the ASIC approval processes." It also anticipates "a 24-month transition period."

Taken together, on the timetable described in the Consultation Paper, a Code settled now may not take effect until around 2028, with the next scheduled review potentially not occurring until around 2033. That is a long time to be locked to a model of claims handling in an environment the Insurance Council itself describes as one where "customers face more frequent extreme weather, more complex claims."

Therefore the cost of drafting for the ordinary claim rather than the long one is not borne now. It is borne by whoever is displaced in 2030.

Recommendation:

1. Test the draft against the long-claim scenario rather than the standard one. For each obligation, ask what it requires at month eighteen of an accepted but unfulfilled claim.
2. Where an insured event is part of a declared catastrophe, and the customer remains displaced beyond a defined period, provide for escalating obligations.
3. Reconsider the extension of the review cycle from three years to five, or provide for an earlier review triggered by a declared catastrophe of defined scale.

A closing observation

The draft opens with Industry Principles, including that insurers will "support customers in their time of need" and will provide "accessible support to customers who need it."

The draft then states that the Industry Principles "are a guide only and do not form part of the Code or our policy with you."

The commitments a consumer would most readily recognise as the promise of insurance sit in the one part of the document that is expressly unenforceable. Meanwhile the enforceable timeframes attach to a defined "Decision" that expressly excludes how the loss will be fixed and/or how much money will be received. The twelve month protection is capable of being lost if the customer complains. The right to enforce the Code excludes the consequential loss that a breach most often causes. And the one document that addresses expert conduct in detail is incorporated by an enforceable paragraph while itself expressed almost entirely in non-mandatory terms.

I make that point because, after sixteen months displaced with my family, my strong impression is that this draft would not have prevented what happened to us. That is a comment on what this draft would require, not on any insurer's compliance with the Code that currently applies.

That is the problem worth solving.

I would be pleased to provide any further information that may assist the consultation process.

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