Submission on the Draft General Insurance Code of Practice

Public consultation submission — Insurance Council of Australia

Introduction

Thank you for the opportunity to comment on the draft General Insurance Code of Practice.

I make this submission as a consumer with direct, lived experience of the home insurance claims process. My own claim was with a major Australian general insurer (referred to below as Insurer A) and involved a complex dispute regarding the cause of loss, multiple expert and service provider reports, repeated internal complaint reviews, and an eventual determination by the Australian Financial Complaints Authority (AFCA). Having exhausted those avenues, the matter is now likely to proceed to litigation, a process that carries significant financial cost, time and emotional burden. It is this experience that has reinforced my view that the Code should place greater emphasis on ensuring the correct decision is reached before consumers are left with no practical alternative but legal proceedings.

This submission is not intended to revisit the merits of my individual claim. Rather, I use my experience to illustrate several procedural gaps that, in my view, remain in the draft Code.

I welcome many of the proposed reforms, particularly contractual enforceability and the introduction of the 12-month deemed acceptance rule. However, I believe the draft Code remains primarily focused on improving timeliness rather than ensuring that contested claims are decided correctly. While timely decisions are important, accuracy, transparency and procedural fairness are equally essential to maintaining public confidence in the insurance industry.

In my view, the purpose of the claims process should be to determine the correct outcome based on the weight of all available evidence before a decision is made. The complaints process should exist to address exceptional circumstances or genuine disagreements, not to provide consumers with their first meaningful opportunity to identify errors in the evidence relied upon by an insurer.

This submission focuses primarily on the consumer protection and enforceability areas identified for consultation, drawing on my direct experience of a contested claim. I have also included brief comments on the Code's approach to Vulnerability, the clarity of its language, and its future applicability.

1. The 12-month deemed acceptance protection disappears when a customer escalates a dispute

Clauses 75–76

Clause 75 introduces an important safeguard by providing for deemed claim acceptance where a decision has not been made within 12 months.

However, clauses 76(c) and (d) remove that protection where the customer has lodged a complaint with the insurer or AFCA that "impacts our ability to make a Decision", or has commenced court, tribunal or other dispute resolution proceedings.

In practice, this means that the very act of protecting one's rights may remove the protection intended to address prolonged delay.

A customer who remains silent may benefit from automatic acceptance after 12 months.

A customer who escalates because the insurer has failed to properly assess the claim does not.

This creates a perverse incentive that undermines the purpose of the provision.

Suggested amendment

Clauses 76(c) and (d) should be amended so that lodging an AFCA complaint or other dispute resolution process does not automatically suspend the 12-month timeframe. Instead, the insurer should demonstrate that the external process genuinely prevented a decision from being made.

2. The Code does not require insurers to explain why conflicting evidence is rejected

Clause 66 requires insurers to consider relevant facts, policy terms and the law.

Clauses 79 and 80 require reasons to be given when declining a claim.

However, nowhere does the draft Code require an insurer to explain why evidence submitted by a customer has been rejected where that evidence conflicts with the insurer's preferred findings.

During my own claim, I provided an independent expert report together with documentary, photographic, video and audio evidence that directly contradicted the findings relied upon by Insurer A. I also identified material factual inaccuracies within the insurer's preferred report.

Despite lodging this material before the claim decision and again during multiple internal complaints, none of the written decisions substantively addressed that evidence.

The current draft Code permits this because it requires reasons for the insurer's decision, but not reasons for rejecting contrary evidence submitted by the customer.

Suggested amendment

Clause 80 should require that where a customer has submitted evidence that materially conflicts with the insurer's findings before a decision is made, the written decision must specifically address that evidence and explain why it was accepted or rejected.

3. The Code requires insurers to consider evidence but not investigate it

The draft Code repeatedly refers to insurers considering relevant information.

However, there is an important distinction between considering evidence and investigating it.

Where a customer provides credible evidence that directly contradicts the insurer's assumptions, the Code should require reasonable enquiries to resolve that conflict.

Simply stating that evidence has been “considered” should not satisfy the insurer's obligations where significant factual disputes remain unresolved.

The objective of a claims assessment should not simply be to gather sufficient information to support a decision. It should be to actively resolve material factual disputes before a decision is made. A process that requires customers to identify unresolved issues only after a claim has been determined shifts the burden of investigation from the insurer to the consumer.

Suggested amendment

The Code should require insurers to make reasonable enquiries into credible evidence submitted by customers where that evidence could materially affect the outcome of the claim.

4. Reports relied upon by insurers should be provided simultaneously to both parties

Clause 81 requires insurers to provide customers with copies of External Expert reports relied upon when making a claim decision.

While this is a welcome improvement, the draft Code is silent on when those reports must be provided and does not extend the same principle to reports prepared by other service providers that may materially influence a claim.

In practice, insurers routinely rely on reports prepared by engineers, builders, hygienists, leak detection specialists, restoration contractors and other service providers. Regardless of who prepares the report, if it is capable of influencing a claim decision, the customer should have access to it at the same time as the insurer.

During my own claim, reports prepared by external experts and service providers were generally provided to the insurer before they were provided to me. On one occasion, my claims adviser advised me that he had just received a report. When I immediately requested a copy, I was told he first needed to "go through it."

It also became apparent that several reports existed in multiple versions, with only the final versions being provided to me.

This meant I had no meaningful opportunity to identify factual inaccuracies or provide additional evidence before decisions were made.

The issue is not simply transparency.

It is about ensuring that claim decisions are based on the weight of all available evidence before they are made.

The current process effectively requires customers to challenge decisions after they have already been made. In many cases, the customer first becomes aware of factual inaccuracies or incorrect assumptions only after receiving the report relied upon to deny the claim.

That approach is backwards.

A transparent claims process should encourage the exchange and testing of relevant evidence before a decision is made, not afterwards through complaints or external dispute resolution.

Suggested amendment

Where an insurer intends to rely on a report, assessment or opinion prepared by an External Expert, Service Supplier or other third party:

- the report should be provided simultaneously to both the insurer and the customer;
- both parties should receive the identical version;
- any revised, amended or supplementary version should also be provided simultaneously to both parties;
- substantive amendments should be clearly identified together with the reason for the amendment; and
- the insurer should allow the customer a reasonable opportunity to identify factual inaccuracies, provide additional evidence or obtain a competing opinion before making its decision.

5. Transparency where report authors have access to additional information

The draft Code requires disclosure of reports relied upon by insurers but does not address circumstances where a report author has access to information that is unavailable to the customer, the instructing insurer or any subsequent reviewer.

Where external experts or service providers are engaged across related insurance claims arising from the same insured event, there is currently no requirement to identify potential conflicts, disclose additional material available to the report author or explain whether that material informed the report.

The issue is not whether such material changed the outcome.

The issue is transparency.

A claims process should not rely upon reports prepared using information that is unavailable to the customer or those responsible for reviewing the claim.

Suggested amendment

The Code should require insurers to ensure that where a report author has access to additional material from related claims, there is appropriate transparency about:

- the existence of that material;
- whether it materially informed the report;
- any potential conflicts arising from the service provider's involvement across related claims; and
- sufficient disclosure to enable customers, insurers and reviewers to understand the evidentiary basis upon which the report was prepared.

6. No obligation exists to disclose material that has informed the assessment of a claim

Clause 30 is a welcome improvement because it provides customers with access to information relied upon by the insurer.

However, clause 30(d) permits insurers to withhold information where disclosure may prejudice the insurer in relation to a complaint or dispute.

This creates an unintended consequence.

The point at which a customer most needs access to factual information is often when they are challenging an insurer's decision.

During my own claim, it became apparent that material had been available to a report author that was not available to me, my insurer or the external dispute resolution process. Regardless of whether that material ultimately influenced the report, the current Code contains no mechanism requiring transparency where information available to a report author is unavailable to those relying upon the report.

Suggested amendment

Clause 30(d) should not permit insurers to withhold factual material that has materially informed the assessment of a claim. The exception should be limited to genuinely privileged legal advice or litigation strategy.

7. Independent review should extend beyond formal investigations

Clauses 125–127

Clauses 125–127 introduce independent review where a formal Investigation continues beyond four months.

However, many complex property claims never become formal Investigations.

Instead, they involve repeated engineering reports, builder assessments, hygienist reports, leak detection reports and other technical opinions over many months.

Such claims can remain unresolved for extended periods without ever receiving the benefit of an independent review.

Suggested amendment

The independent review provisions should also apply where a claim remains undecided after four months because repeated technical or expert assessments are being undertaken, regardless of whether the matter falls within the Code's definition of an Investigation.

8. Complaint reviews should demonstrate genuine independent reconsideration

Clause 133 states that complaints must be handled by someone who was not involved in the original decision.

This is an important safeguard and one that should provide protections and trust within the process.

However, the draft Code contains no mechanism enabling customers to verify that this requirement has been satisfied.

During my own claim, I lodged multiple internal complaints and appeals and provided additional evidence throughout the process. On each occasion, the original decision was upheld. However, the complaint responses did not demonstrate that the competing evidence I had submitted had been genuinely reconsidered, nor did they explain why that evidence, including new evidence, had been rejected.

The purpose of a complaint review should not simply be to defend an earlier decision.

It should be to determine whether that decision remains correct in light of all available evidence.

Suggested amendment

Clause 133 should require insurers to identify, in writing, the person conducting the review and confirm that they were not involved in the original decision.

Clause 136 should also require complaint responses to specifically address any evidence submitted by the customer that conflicts with the original decision.

9. The Code's enforceability is undermined by broad exceptions

Clauses 21–24

Clause 21 is a significant and a welcome step, it makes key Code paragraphs part of the customer's contract, giving consumers legal rights to enforce them.

However, clause 23 substantially narrows what that enforceability actually delivers in practice. Clause 23(b) states that Code compliance is “not a condition or warranty of the policy”, and clause 23(c)(ii) excuses non-compliance wherever it was “affected by some other event or circumstance” beyond the insurer's control or occurring “without fault or negligence on our part”.

These exceptions are broadly worded and largely self-assessed by the insurer in the first instance, which risks limiting contractual enforceability to only the clearest and most egregious breaches.

Suggested amendment

Clause 23(c)(ii) should be narrowed and made more specific, so that it cannot be relied upon as a general excuse for non-compliance without the insurer demonstrating, with evidence, that the specific circumstance genuinely prevented compliance.

10. Protections for customers experiencing Vulnerability rely on disclosure rather than proactive identification

Clauses 138–148

Clause 139 provides Extra Care where a customer "tells us" or the insurer "identifies" Vulnerability, and clause 140 requires insurers to have processes to identify signs a customer may need support.

However, the Code stops short of requiring insurers to proactively and consistently ask about relevant circumstances, particularly at points of known higher risk, for example, following a natural disaster, or when a claim has been declined.

The Independent Review's Final Report recommended alignment with ISO 22458 on consumer vulnerability. The current draft references ISO 22458 only as a guiding principle in the Industry Principles, not as a Code obligation.

Suggested amendment

Clause 141 should require insurers to comply with the substantive requirements of ISO 22458, not merely have regard to its principles, and clause 140 should require insurers to proactively ask about circumstances relevant to Vulnerability at defined trigger points in the claims process, rather than relying primarily on customer disclosure or passive identification.

11. Key defined terms are not intuitive to consumers and may cause confusion

Definitions; Clause 73

The Code relies heavily on capitalised defined terms that carry a specific meaning different from their everyday use.

The definition of "Decision", for example, is limited to "what, if any, part of your claim is covered by your policy" and explicitly excludes "how much money you will receive under the claim".

A consumer reading that they are entitled to receive a "Decision" within set timeframes may reasonably assume this includes the amount they will be paid, when it does not.

Given the Code is meant to be read and relied upon by consumers, not just insurers, this kind of gap between plain-English expectation and defined meaning undermines the accessibility the Code review process specifically sought to improve.

Suggested amendment

Key defined terms that diverge materially from their everyday meaning, particularly "Decision", should be accompanied by a plain-language explanation at first use, not only in the Definitions section, and the Code should distinguish more clearly between the coverage decision and the settlement or payment outcome throughout Section 4.

12. The Code's review cycle may not keep pace with a changing claims environment

Clause 210

Clause 210 commits to a formal independent review "at least every 5 years."

Given the pace of change in claims handling technology (including AI-assisted assessment), climate-driven catastrophe frequency, and the lessons still being absorbed from the 2022 floods, a fixed five-year cycle risks the Code falling behind emerging practices and consumer harms in the interim.

Suggested amendment

The Code should provide for an earlier, triggered review, for example, following a declared Extraordinary Event of a certain scale, or where the Code Governance Committee identifies a pattern of systemic issues, rather than relying solely on the five-year fixed cycle.

Conclusion

The draft General Insurance Code of Practice represents a significant improvement on previous versions and contains a number of welcome reforms.

However, my experience demonstrates that contested claims expose different problems from delayed claims.

Once a claim becomes disputed, the current drafting still allows insurers to:

- lose the benefit of the 12-month safeguard simply because a customer exercises their right to complain;
- reject conflicting evidence without explaining why;
- consider evidence without investigating it;
- make decisions before customers have had the opportunity to respond to reports relied upon;
- rely on reports prepared without transparency about the information that informed them;
- withhold factual material during disputes;
- conduct complaint reviews without any meaningful mechanism to demonstrate independence; and
- treat internal review as confirmation of an earlier decision rather than genuine reconsideration.

Collectively, these issues demonstrate that the current draft Code remains largely focused on reviewing decisions after they have been made rather than improving the quality of decision-making before those decisions are reached.

In addition, the exceptions to contractual enforceability, the reliance on customer disclosure to trigger Vulnerability protections, the accessibility of key defined terms, and the fixed five-year review cycle each warrant further strengthening, as set out above.

These are not simply procedural concerns. They directly affect whether consumers receive fair outcomes and whether they can have confidence in the claims process.

The best consumer protection is not a stronger complaints process. It is a claims process that is designed to reach the correct decision before a complaint ever becomes necessary. The Code should promote transparency, genuine engagement with all relevant evidence, and decision-making based on the weight of that evidence before a claim is determined, rather than requiring consumers to identify errors only after a decision has already been made.

I respectfully encourage the Insurance Council to strengthen these provisions before the Code is finalised. Doing so would improve confidence in the claims process for both consumers and insurers, reduce unnecessary disputes, and better achieve the Code's stated objective of promoting honest, efficient, fair, transparent and timely claims handling.

Thank you for considering this submission.