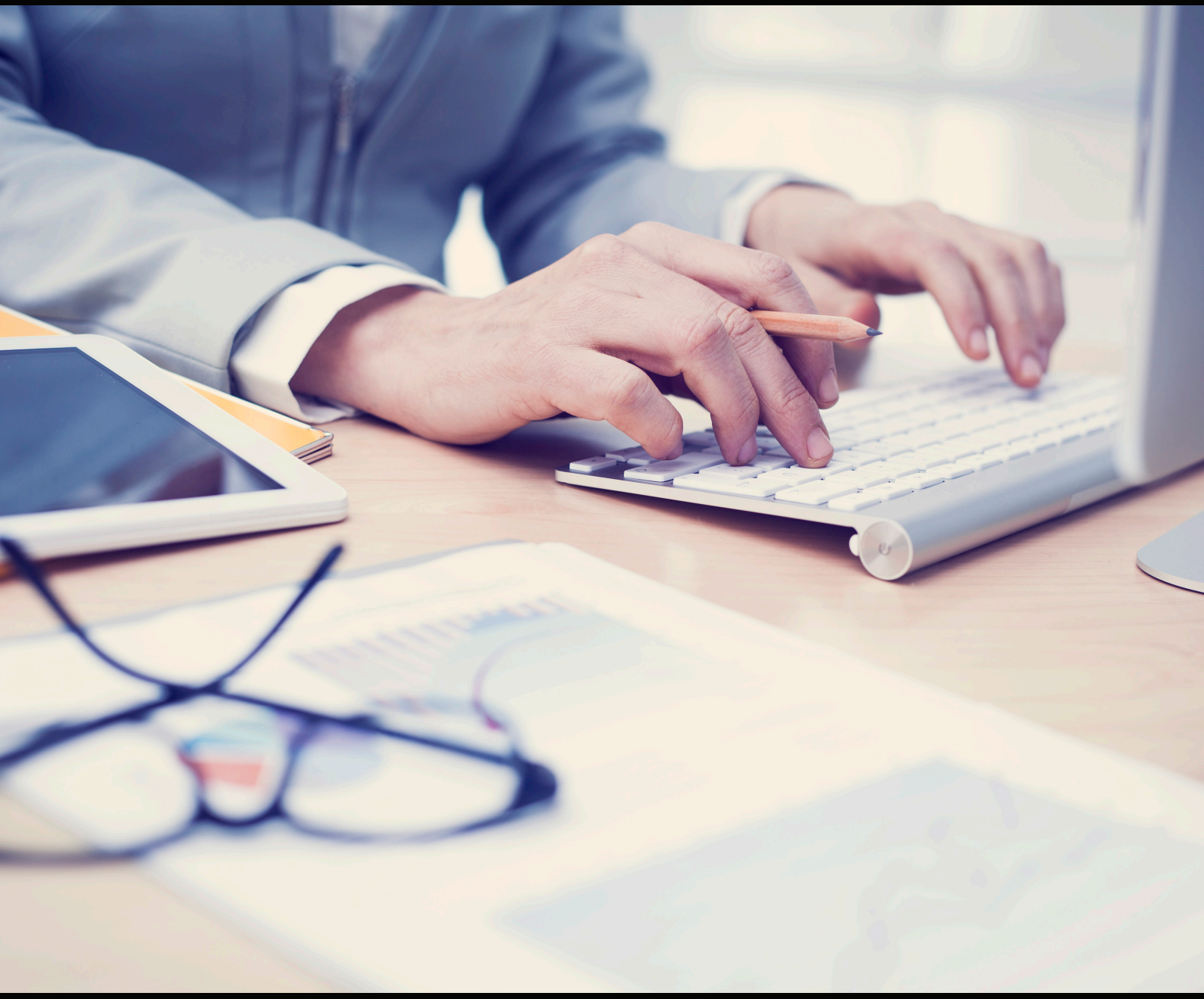
THE LIFE INSURANCE CODE OF PRACTICE

NEW BUSINESS AND UNDERWRITING

PART 3



INSURANCE ■ COMMERCIAL ■ BANKING

Table of Contents

Introduction

The FSC's Life Insurance Code of Practice opens a new dialogue with the industry's customers about how the industry will work with them.

It is intended to:

- Promote high standards of service to consumers
- Provide a benchmark of consistency within the industry
- Establish a framework for professional behaviour and responsibilities

The Code contains ten "Key Code Promises" which are reflected in the individual sections of the Code. Because the Code is a promise to the customer it is not written in a way that is function specific for the individual business units of companies. This guide extracts the parts of the Code in a way that allows people that work in insurance companies to see how the Code will apply to what they do on a day-to -day basis.

It doesn't reproduce every provision in the Code, but is our selection of the things that we think are most important and which companies will need to incorporate if they need to change their procedures to comply.

We have not designed it as a commentary or explanation of the Code, as the Code speaks for itself and it will be up to each company to decide how it achieves (and hopefully exceeds) the standards and objectives set out in the Code in its own way.

Though the Code is now live on the FSC website (you can download a copy here), companies have until 1 July 2017 to be compliant. Individual companies may choose to make their activities subject to the Code earlier than this if they wish.

We hope you find this guide helpful in your journey toward successful implementation.

John Myatt
Partner and Head of Insurance & Financial Services, TurksLegal

SUBJECT 1

Products covered by the Code

Life insurance policies

- Once a company adopts the Code, it applies to all the products that are Life Insurance policies as defined in the definition's section of the Code1. This basically adopts the definition in section 9 of the Life Insurance Act 1995, with some exceptions (see below). It also applies to policies that are deemed by APRA to be life insurance business under section 12A of that Act.

Types of policy covered

- term life insurance/death and terminal illness;
- total and permanent disability (TPD);
- trauma/critical illness insurance;
- disability insurance;
- funeral insurance;
- income protection/salary continuance;
- business expense cover; and
- consumer credit insurance ('CCI') issued by a life insurer

(2.10)

What products are excluded?

- The Code does not apply to interactions with customers in relation to:
  - annuities and investment life products, except any component considered as a life insurance policy;
  - whole-of-life and endowment insurance products;
  - general insurance products (including but not limited to sickness and accident covers); and
  - health insurance products.

(2.11)

Policies bought before the company adopted the Code

- The Life Insurance Code of Practice became available for adoption by companies from 1 October 2016 but it does not apply to a company's interactions with customers until the company notifies the FSC and Life CCC that it agrees to be bound by it. (2.8)
- The provisions of the Code that apply to purchasing cover (See Section 5: "When you buy insurance") do not apply to interactions the company had with the customer before it was bound by the Code though once the company adopts the Code it will bound to apply it in relation to subsequent claims or complaints. (2.10)
- Once a company adopts the Code it applies to all interactions from that date, including interactions relating to a pre-existing claim or complaint. (2.9)

For further detail regarding:

- When does the Code apply to a company's interactions with customers?
- Who is bound by the Code?

see The Life Insurance Code of Practice: Coverage and Complaints and Code Governance

[1] Definitions appear in section 15 of the Code.

back to top

SUBJECT 2

Product Design and Product Review

Suitable customers

- New retail policies introduced after a company adopts the Code must have a list of defined suitable customers for the product and include benefits intended to cover genuine risks that affect those customers. (3.1)
- Companies must regularly review their retail products to ensure they remain generally suitable for the relevant customers. (3.1)

Updating of medical definitions

- The definitions that apply to benefits that are payable on the occurrence of a defined medical event must be reviewed in consultation with relevant medical specialists at least every three years and updated where necessary to ensure the definitions remain "current". (3.2)
- Companies must inform customers when medical definitions are updated. (3.2)
- These obligations do not appear to apply in relation to group products as the policy owner may agree with the insurer about changes to the benefit design from time to time and inform the individuals covered by the policy of those changes. (3.3)

SUBJECT 3

Underwriting Philosophy

Evidence based and compliant with legislation

- Underwriting decisions must be evidence-based, involving relevant sources of information where this is available, and where no data is available, having regard to any other relevant factors. (5.17)
- Companies will regularly review underwriting decision-making processes to ensure they are not relying on out-of-date or irrelevant sources of information. (5.17)
- Decisions will comply with the requirements of anti-discrimination law. (5.17)
- Companies will monitor underwriters to ensure the questions asked and the decisions made are consistent, evidence-based and compliant with legislation and regulation. (5.18)

Electronic underwriting

- Companies must regularly review and monitor electronic underwriting applications to ensure the questions asked and the decisions made are consistent, compliant with legislation and they are, so far as the company can tell, based on "information, analysis and evidence" necessary to assess a customer's application. (5.19)
- Companies will agree to review an underwriting decision has been made via an electronic method where customers have "questions or concerns" about the outcome. (5.19)

back to top

SUBJECT 4

What happens when a person is underwritten?

Assessing applications

- Companies must request the information they need to consider an application as early as possible and try to avoid multiple information requests. (5.9)
- Companies may conduct direct discussions with a customer's medical attendant (and other relevant parties) or ask them for information or reports to further assist with the assessment of an application. (5.5)
- Once the necessary information required to make a decision on an application is available, the company must let the customer know its decision **within five business days**. (5.4, 5.12)
- Companies must comply with current FSC Guidance notes that affect underwriting when carrying out assessments[2]. (5.16)

Independent medical examinations and other tests

- A company may also require a customer to attend a medical examination by an "Independent Service Provider" ('ISP') that it selects, but only where it believes this to be "relevant and reasonable for the assessment of the application".[3] (5.6)
- If it arranges an examination with an ISP the company must tell the customer the reasons why it is required and if the customer disagrees, they must be shown how to make a complaint. (5.6)
- The company must meet the cost of an ISP appointment and extraordinary travel costs agreed in advance (but not missed appointment fees). (5.7)[4]
- Companies that appoint an examination by an ISP must ask for the report to be provided within ten business days. (5.8)
- The company must ask for any ISP reports that do not require the customer to attend an assessment to be provided no later than four weeks after the date of its request. (5.8)
- If an ISP fails to provide the material required with this timeframe, the company must inform the customer of this and keep them informed of its progress in obtaining the report. (5.8)

Errors or mistakes

- If the company becomes aware during the application process of any errors or mistakes it must "address them promptly" and seek additional information to implement corrections. (5.10)

Refusal of cover or terms of acceptance

- The Code permits a company to refuse cover outright after considering an application, or it may make an offer of cover on special terms such as:
  - the exclusion of specific events, activities or medical conditions (NB: the nature of any exclusion has to be explained – see Subject 5);
  - altering a standard waiting period;
  - altering the benefit period or the term of the cover;
  - altering the terms of the standard policy.

  (5.13)
- If a customer disagrees with an underwriting decision or considers that the information the company relied on to make the decision is incorrect or out of date, they may ask for the decision to be reviewed and if the customer remains unsatisfied the company must tell them how to make a complaint. (5.14)

[2] Currently the Code lists the following as standards and guides applicable; *Genetic Testing Policy, (Standard No. 1) Family Medical History Policy (Standard No.16) Mental Health Education Program and Training (Standard No.21) - Underwriting Guidelines for Mental Health Conditions(Guidance Note No.15) and HIV/AIDS Underwriting Guidelines (Guidance Note No. 32).*
[3] See the standards that apply generally to ISPs under section 10 of the Code.
[4] The Code does not say when a travel cost will be regarded as "extraordinary", so to avoid disputes, companies ought to pro-actively seek information from their customers in advance.

back to top

SUBJECT 5

Initial policy information on purchase

Informing customers about the outcome of their application

- If a company declines an application or offers modified terms it must let the customer (or their doctor) know about the reasons for its underwriting decision. The customer must also be told at this time that they have a right to obtain copies of the information the company has relied on.[5] (5.14)
- A customer has the right to the information that the company has relied on to make its decision (including referrals to reinsurers), and if the customer requests this information it must be provided to them (or their doctor), within ten business days, in accordance with the Access to Information provisions (section 14) of the Code. (5.14, 14.2,14.3)

Health information about a life insured

- Where the policy-owner is different from the life insured, companies will not communicate personal medical information about the life insured to a policy-owner unless the life insured has given consent for this.[6] (5.2)

Information that must be provided

- When a customer buys a retail policy they must be provided with a clear explanation of the following in "plain language":
  - the types of cover the customer is insured for;
  - the amount of cover (if there is a fixed amount assigned to their cover);
  - how much the cover costs;
  - the cooling-off period;
  - applicable exclusions;
  - for key medical definitions where a benefit is payable for a medical event, a general description of circumstances in which benefits would be paid and in particular whether benefits are payable on diagnosis or require a certain degree of security to be payable;
  - waiting period;
  - how the price the customer pays is structured;
  - the impact of claims on other benefits or income; and
  - information about the complaints process.
- There is no distinction between standard policy exclusions and exclusions that were included in the underwriting process, so this appears to apply to both. (13.4)
- Note, further requirements apply to pre-existing conditions exclusions - see Subject 6.

[5] The company must let the customer know its decision within five business days once it has the necessary information. (See Subject 4)
[6] Companies should be aware that under s75 of the *Insurance Contracts Act* (1984) the policy owner has the right to obtain "a statement in writing setting out the insurer's reasons" for not accepting a risk. This suggests a certain amount of care will be required to comply with both the ICA and the Code where the enquiry relates to a life insured that has not consented to having their health information disclosed.

back to top

SUBJECT 6

Pre-Existing Conditions exclusions

Explanation of PECs

- Companies must provide customers with an explanation in plain language of how a pre-existing conditions exclusion ('PEC') works including when the exclusion applies and the potential implications of it in the context of a claim. This appears to apply to blanket PECs as well as exclusions that are applied to specific conditions as result of underwriting. (3.5 (a))

Where companies cannot rely on a PEC

- If a company asks for medical information during the application process and the customer fully and accurately discloses information about a medical condition to the company, then the company will not apply a PEC in relation to that condition unless the PEC is specifically agreed with the customer in writing at the time the policy is issued. (3.5 (b))[7]

SUBJECT 7

Training, qualifications and support

Underwriters must be trained

- Underwriters must be appropriately skilled and trained. (5.15)
- Companies are not to allow underwriting decisions to be made by staff until they have demonstrated technical competency and an understanding of the relevant law, requirements of the Code and relevant FSC Standards and Guidance. (5.15)[8]

Underwriters will have access to professional advice

- Underwriters will have access to professional advice and support during the assessment process where required, in the relevant disciplines (for example, medical specialists and accountants). (5.15)

[7] This implies that PECs that are embedded in the policy terms may not be able to be relied on by companies where the relevant matter has been fully disclosed in the course of underwriting a case.
[8] Relevant laws in this context would appear to include insurance law, particularly as it applies to non-disclosure and misrepresentation and anti- discrimination law as the Code expressly confirms underwriters must comply with it. (See Subject 3 and (5.17))

back to top

SUBJECT 8

Third party providers

Standards required of Independent Service Providers

- Companies may use Independent Service Providers (ISPs) to assist with underwriting including but not limited to independent medical assessors.
- ISPs must:
  - act with honesty, fairness, respect, transparency and timeliness towards the company and to customers;
  - reasonably satisfy the company of their expertise, experience, qualifications and integrity; and
  - hold any required Federal, State, Territory or industry licensing.
- Agreements with ISPs that the company enters into or renews after they are bound by the Code, must reflect the standards of the Code.

Contracts with Independent Service Providers

- Contracts must:
  - reflect the standards of the Code (see above);
  - include reference to the relevant States' and Territories' Expert Witness Code of Conduct;
  - where the ISP is a medical assessor or examiner, require them to comply with the Australian Medical Association's Ethical Guidelines on Independent Medical Assessments or an equivalent international guideline for providers overseas;
  - require them to comply with the *Privacy Act* 1988 and maintain confidentiality of information, and only use that information for the purpose of the service they are providing; and
  - oblige them to notify the company if the customer makes a complaint about the services.

Independent Service Provider reports

- Companies can only rely on reports from treating doctors, allied health professionals and ISPs in relation to an application for insurance that they are satisfied are impartial and objective. All details in a report must be taken into account.

back to top

Contact Us

To discuss any aspect of the Life Insurance Code and what it means for you, please contact a TurksLegal team member.

John Myatt Partner
t: 02 8257 5740 **m:** 0419 983 575
e: john.myatt@turkslegal.com.au

Alph Edwards Partner
t: 02 8257 5703 **m:** 0417 268 780
e: alph.edwards@turkslegal.com.au

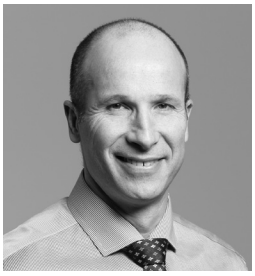
Fiona Hanlon Partner
t: 07 3212 6700 **m:** 0407 940 022
e: fiona.hanlon@turkslegal.com.au

Michael Iacuzzi Partner
t: 02 8257 5769 **m:** 0412 415 173
e: michael.iacuzzi@turkslegal.com.au

Lisa Norris Partner
t: 02 8257 5764 **m:** 0410 582 309
e: lisa.norris@turkslegal.com.au

Sandra Nicola Partner
t: 02 8257 5752 **m:** 0400 868 089
e: sandra.nicola@turkslegal.com.au

Darryl Pereira Partner
t: 02 8257 5718 **m:** 0418 223 798
e: darryl.pereira@turkslegal.com.au



Peter Riddell Partner
t: 03 8600 5005 **m:** 0417 465 295
e: peter.riddell@turkslegal.com.au

Helen Barnett Special Counsel
t: 03 8600 5004 **m:** 0409 043 642
e: helen.barnett@turkslegal.com.au

Ros Wicks Special Counsel
t: 02 8257 5779 **m:** 0417 023 604
e: ros.wicks@turkslegal.com.au

INSURANCE • COMMERCIAL • BANKING

Sydney | Level 44, 2 Park St, Sydney NSW 2000 | **T** 02 8257 5700 | **F** 02 9264 5600
Melbourne | The Rialto Towers, Level 8, South Tower, 525 Collins St, Melbourne VIC 3000 | **T** 03 8600 5000 | **F** 03 8600 5099
Brisbane | Level 27, 10 Eagle St, Brisbane QLD 4000 | **T** 07 3212 6700 | **F** 07 3212 6799

www.turkslegal.com.au