Turks LEGAL

THE LIFE INSURANCE CODE OF PRACTICE
CLAIMS

PART 2

INSURANCE ■ COMMERCIAL ■ BANKING

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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 that are relevant to the claims function and presents the Code in a way that allows claims managers and claims consultants 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 that deals with claims, 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

Claims Philosophy

✓ Consider other or additional benefits

The company must consider all of the features of the policy which are potentially relevant to the customer's claim in order to ensure the customer is claiming for all available benefits under the policy. (8.2)

✓ Do not discourage a customer from making a claim

Companies cannot discourage a customer from making a claim. (8.2)

✓ Exercise empathy, compassion and respect

Companies acknowledge that empathy is required in claims management and will treat customers with compassion and respect. (8.24)

✓ Support early rehabilitation and optimising health outcomes

Companies will engage with treating doctors and/or employers to support the customer's recovery at the early stage of the claim and will promote best-practice rehabilitation and injury management. (8.26)

✓ Give urgent financial relief

Customers that demonstrate that they are in urgent financial need of the benefits they are covered for under their policy must be prioritised and/or given an advance payment of their benefit. (8.27 to 8.30)

SUBJECT 2

Opening a Claim

✓ Create a single point of contact

Companies must provide customers with a single point of contact for the duration of the claim. (8.26(c))

✓ Provide introductory claims information

Once it is notified that a customer wants to make a claim, the company must;

- explain to the customer the features of their cover, the claim process and why the company will request certain information
- inform of any waiting period before payments will be made
- provide contact details that the customer can use to get information about their claim (8.3)

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SUBJECT 3

Claims Handling Timeframes

✓ Introductory claims information (within 10 days from notification)

Provide introductory claims information (see above) within 10 days of notification of a potential claim. (8.3)

✓ Respond to claims of urgent financial need (within 5 days of documentary proof of need)

If the customer is in urgent need of a benefit they are insured for, the company may ask for documentary proof of need and if satisfied by this information, must arrange to make advance payment within 5 days. (8.3)

✓ Seek reports from IME examinations and other experts (within 10 days from examination)

If the company asks the insured to attend an assessment with a third party service provider (such as an IME), it must ask the provider to deliver their report on the assessment within ten business days of the assessment. (5.8)

✓ Seek other reports from company appointed experts (within four weeks of the date of request)

If the company requests any other reports from third party service providers that do not require the insured to attend an assessment, the company must ask for the report to be provided within four weeks of the date of request. (5.8 and 8.8)

✓ Provide provision of regular updates (every 20 business days)

Unless otherwise agreed with the customer or the Group Policy-owner, the company must keep the customer informed about the progress of the claim at least every twenty business days. (8.4)

✓ Respond to queries (within ten business days of date of request)

Companies must respond to requests for information about claims within ten business days. This includes requests for documents a company has relied on to deny a claim. (8.4 and 8.19)

✓ Claims decisions (within ten business days of all evidence being received)

Once all the information is received to assess a claim (including the customer's response to any evidence that has been presented to the customer), the company must advise the customer of its decision on the claim within ten business days. (8.15)

✓ Deadline for acceptance or denial - IP Claims (within two months of the end of the waiting period)

Decisions on "income-related claims" must be communicated no later than two months after the later of the date of lodgement or two months from the end of the relevant waiting period, unless "Unexpected Circumstances" apply, in which case the deadline is 12 months. (8.16)

✓ Deadline for acceptance or denial - all other claims (six months)

Decisions on other claims must be made no later than 6 months after the company is notified of the claim or the end of any waiting period, unless "Unexpected Circumstances" apply.

Where "Unexpected Circumstances" apply, there is a deadline of 12 months to complete the claims assessment, with a requirement to notify the customer of the reasons for the delay. If a decision is not made within 12 months, the customer will be provided with details of the complaints process. (8.17)

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✓ Responses to complaints (retail 45 days, group 90 days)

Companies must respond to retail complaints in 45 days and superannuation group life complaints in sufficient time so that the trustee can provide a final response within 90 calendar days of the superannuation fund trustee receiving the Complaint. (9.10 and 9.11)

✓ What are "Unexpected Circumstances?"

Unexpected Circumstances means:

(a) The claim has been notified more than 12 months after the later of the date of disability or the end of the waiting period, and there are resulting delays obtaining evidence necessary for the assessment of the claim.

(b) In relation to a TPD claim the company is unable to satisfy itself that the claim meets the policy definition on the basis of the information provided in the six months after the end of the waiting period.

(c) The company has not received information reasonably requested from a Third Party Service Provider, a treating doctor, a government agency or other person or entity (including a reinsurer).

(d) A group policy-owner has disputed or taken a protracted period to consider the company's decision.

(e) The customer has not responded to reasonable enquiries or requests for documents or information concerning the claim.

(f) There are difficulties in communicating with the customer in relation to the claim due to circumstances beyond the company's control.

(g) There is a delay in the claims process that the customer has requested.

(h) The claim is fraudulent or reasonably suspected to be fraudulent.

(15)

✓ Claims timeframes at a glance

Action	Time Limit
Provision of introductory claims information	within 10 days from notification
Response to a claim of urgent financial need	five business days
Reports from IME examinations and other experts	within 10 days from examination
Other reports from company appointed experts	within four weeks of the date of request
Regular updates	every 20 business days
Responses to queries and provision of documents	within ten business days of request
Claims Decisions	within ten business days of all evidence being received
Deadline for acceptance or denial - IP Claims	within two months of the end of the waiting period*
Deadline for acceptance or denial - all other claims	Six months*
Responses to Complaints	(retail 45 days, group 90 days)

**Unless "Unexpected Circumstances" apply*

For claims that already exist on the date a company agrees to be bound by the Code, if the Code requires something to be done within a specified timeframe, that timeframe begins on the date the company is bound by the Code. (2.10)

✓ Breach of timeframes

The company must keep the customer aware of any breach by a Third Party Service Provider of the 4 week timeframe for providing the material sought from them and keep the customer informed of progress in obtaining the report. (5.8)

Where the company cannot comply with a claims deadline required by the Code due to a delay that is out of its control, it is not considered to have breached the Code. (8.14)

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SUBJECT 4

Obtaining Information from the Customer

✓ Authorities

A company will only use a general authority to obtain information it reasonably believes is relevant to the customer's claim.

Companies will accept authorities that only authorise the obtaining of particular information with the warning that this may cause delays in the assessment of the customer's claim and may result in the company having to seek further authorities from time to time. (8.6)

✓ Avoiding multiple or irrelevant requests

A company must request the information the company needs as early as possible and avoid multiple information requests where possible. (5.9)

A company will only ask for information and assessments that are relevant to a customer's claim and policy. (8.5)

✓ Explaining why information is necessary

The company must explain why it is asking for information and if the customer disagrees with the relevance of any information, it must review the request. (8.5)

✓ Errors in the information on file

If a company becomes aware of errors in the claim or the information it has asked for, it must address them and implement corrections. (8.13)

✓ Independent medical examinations

Companies must pay the cost of the appointment (excluding missed appointment fees).

Companies must pay the customers agreed "extraordinary" travel costs in advance.

Customers may request to choose from a list of doctors the company is willing to appoint, subject to the warning that this may cause delays depending on the chosen doctor's availability.

Companies will avoid requesting more than one independent medical examination for the same specialty within six months.

If a company does require more (such as where the claim is for a terminal illness or where superannuation legislation requires this), the company should let the customer know the reasons for this.

If the customer requests it, they can obtain copies of their independent medical examination reports which the company will send to them or their doctor where it deems it appropriate. (8.10)

An independent medical examiner engaged by the company must have satisfactory expertise, experience and qualifications and the company will require that they comply with AMA's Ethical Guidelines on Medical Assessment (or equivalent overseas). (10.4 and 10.5)

The company will not request a medical opinion for the sole reason of processing a regular payment entitlement.

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The company will only request financial information at reasonable frequencies and in circumstances where it is required to assess eligibility to claim or to calculate the amount of the entitlement.

If the customer disagrees with the relevance of any requested information, the company will review the request and if it means the next payment is going to be delayed, must notify the customer prior to this and let the customer know the reasons for the delay. (8.9)

✓ Claimant interviews

The interviewer must inform the customer of their identity and on whose behalf they are acting, their reason for making contact and the customer's right to have a representative or other support person present.

If the customer has requested that communication is through a representative, the interviewer must advise the representative before contacting the customer.

If the interview is in connection with a mental illness claim, the company will only use an interviewer that has appropriate training or experience.

If the interview is to be recorded, the customer must be asked for permission before the interview starts.

Interviews have a maximum duration of two hours, (with breaks) unless the customer agrees to an extension and must be conducted respectfully.

A customer may choose to be interviewed at a mutually acceptable location other than their home, unless a home interview is essential to the nature of the claim.

The customers can choose to have someone attend the interview with them, including an interpreter. (8.11)

Records must be kept of all investigation activities. (10.9)

✓ Surveillance

Alternative methods of verifying information will be sought prior to arranging surveillance.

Companies are only to arrange surveillance where they "reasonably believe" prior to carrying out the surveillance that the claim appears to be inconsistent with information available.

Companies must document the reasons why they think the claim appears to be inconsistent with information available.

Surveillance must be internally reviewed and approved by a "senior" claims manager. (8.12)

Other people's identity must be protected and people in the company of the subject will be "pixelated" in footage. Surveillance will be terminated where there is evidence from an independent medical examiner that it is adversely impacting on the customer's health.

Surveillance cannot be conducted;

- in a court or other judicial facility
- in a medical or health facility
- in a bathroom, change room, lactation room
- inside the customer's house

Surveillance operatives must not communicate with neighbours or work colleagues in ways which might reveal that the customer is or may be the subject of surveillance. (8.12)

Surveillance can only be carried out by a licensed private investigator and they must comply with any relevant legislation.

The investigator must not use illegal means to carry out the investigation and cannot engage in any form of pretext activity to bring about behaviour that they would not have performed without the involvement of the investigator.

Records must be kept of all investigation activities. (10.9)

SUBJECT 5

Customer's Access to Information

✓ Claims or underwriting information

Subject to "special circumstances" customers can access the information that the company has relied on in assessing their application for insurance cover, or in relation to a claim or Complaint. (14.2)

✓ Third party service providers

Subject to "special circumstances", customers can also access the reports from third party service providers that the company has relied on in assessing the application or claim. (14.3)

✓ Special circumstances

Special circumstances exist where:

a) information is protected from disclosure by law, including the Privacy Act 1988;

b) the company reasonably determines that the information should be provided directly to the treating doctor;

c) the release of the information may be prejudicial to the company in relation to a dispute about an insurance cover or your claim, or in relation to a complaint; or

d) the company reasonably believes that the information is commercial-in-confidence.

(14.5)

✓ What companies must do when refusing an information request

Companies:

(i) may not unreasonably refuse a request;

(ii) must provide a schedule of the documents they have declined to provide and give reasons for doing so; and

(iii) must provide details of their complaints process.

(14.6)

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SUBJECT 6

Non-Disclosure Investigations

✓ Customer Right of Review

If the company becomes aware after the cover is issued that information the customer provided in their application for insurance was incorrect or incomplete at the time the policy was issued:

a) if the information is important for the cover, the company must ask the customer to provide an explanation, including giving them an opportunity to review any relevant documents, before it makes a decision such as changing the terms or canceling the cover; and

b) once it has made a decision, the company must advise the customer of that decision and any actions it is taking, as well as the process to have this decision reviewed or to make a complaint.

(5.20)

This must be done within 10 days. (see 8.14)

✓ Non- disclosure and IP claims

The company must not stop payments during a non-disclosure investigation unless it reasonably believes there is evidence that will lead to the claim being declined or the policy being avoided. (8.21)

SUBJECT 7

Applying PECs

✓ Providing customers with details of how a PEC exclusion works

The company must in the sales process have provided customers with details of how a PEC exclusion works, when the exclusion applies and the potential implications of this in plain language. (3.6 (a))

✓ PECs not to apply to underwritten cover

For policies where cover is provided in response to a question seeking disclosure of medical information, if the insured makes an accurate medical disclosure in response to the question, the company will not apply a pre-existing exclusion clause in relation to that condition unless it agrees this with the customer in writing when the policy is issued. (3.6 (b))

SUBJECT 8

Income Protection Claims

✓ Income-protection and business expense cover

The company will not require ongoing medical certifications from the customer's doctor more frequently than reasonably necessary for their medical condition to determine their ongoing entitlement to periodic benefits. A company may also seek certification every six months, even if the customer's condition is stable.

✓ Ongoing payments

If continuing income protection benefits are conditional, additional or different requirements need to be met in the course of the claim, the company must give the customer three months' notice of this and tell them what they need to provide for payments to continue. (8.22)

✓ Delayed payments

If a payment is going to be delayed, the company must give the customer advance notice and give reasons. (8.9)

✓ End of benefit period

If the company knows that the customer's income-related claim payments are coming to an end, it must contact the customer to confirm when the last payment is to be made, either:

a) at least 30 days in advance of the last payment if the benefit period is expiring; or

b) as soon as possible after receiving information that has caused the company to cease all future payments. (8.23)

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SUBJECT 9

Accepting and Declining Claims

✓ Accepting claims lump sums and commutations

If a company accepts a lump sum claim it must suggest the customer seeks financial advice before they accept an offer to commute an income protection claim. (8.18)

✓ Declining Claims

When a company declines a claim it must do it in writing and set out;

a) the reasons for the decision;

b) that the customer has the right to copies of the information the company relied on;

c) that if the customer requests it, the company must provide the customer (or their doctor, where appropriate) with copies of the relevant documents within ten business days; and

d) that the customer has the right to request a review of the company's decision and details of the complaint's process.

(8.19)

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

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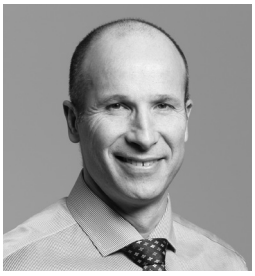

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