GENERAL INSURANCE
Code Governance Committee

The General Insurance Industry Data Report 2014–2015

2012 General Insurance Code of Practice

2 June 2016

CHAIR'S MESSAGE

I am pleased to present the Code Governance Committee's General Insurance Industry Data Report 2014–15. The report's combination of general insurance industry figures and self-reported Code compliance data forms an illuminating snapshot of the state of play in the industry.

This is the Committee's first year preparing the report, which was, for several years, the work of the Financial Ombudsman Service Australia Code Compliance and Monitoring team and its predecessors. The yearly publication, previously called the Aggregated Industry Data Report Overview, has made a unique contribution to understanding the general insurance industry, and has been highly valued by stakeholders. As such, the Committee was pleased to assume responsibility for the report as part of the transition to the new 2014 Code.

Data for this report is sourced directly from Code Subscribers. In our early review of the figures submitted, sizeable year-to-year variation on some measures alerted us to possible data quality problems. We went back to Code Subscribers, asking for more detail on what was and was not included in the figures, as well as how they had been calculated. This investigation brought to light gaps and inconsistencies in data collection and calculation approaches – both between and within Code Subscribers' businesses.

Although the picture painted by this revised data is still incomplete, it allows us to identify broad trends, enhancing our understanding of developments in the general insurance industry. Within the report, we have highlighted those figures that should be treated as indicative only, and, where relevant, have included detailed explanations of how the data should be interpreted in light of what we know about how it was collected and calculated.

Looking forward, the Committee expects industry to build from this year's baseline. Data integrity is of fundamental importance: quality data is the foundation for identifying patterns, understanding their causes and, ultimately, improving practices and service standards. Over the next 12 months, we will work closely with the Insurance Council of Australia Code Reference Group and individual Code Subscribers to improve data collection and reporting, with the shared goal of an industry dataset that is comprehensive, consistent and reliable. This means that industry should also collect data about the number of claims it accepts as well as the number of claims that it partially accepts, so that we can provide a comprehensive picture of claims outcomes.

One of the important trends revealed in the data for 2014–15 was a marked increase in both denied and withdrawn claims. In the absence of consistent, quality data on the reasons that claims were denied or withdrawn, the origins and meaning of this increase are difficult to interpret. We acknowledge that the increase may reflect a range of factors, among them increased encouragement for consumers to lodge claims even where they are likely to fall outside of the policy. However, the trend may also signal problems, such as gaps in consumers' understanding of the products that they are buying and lack of knowledge of internal dispute resolution options. We note also that, even though industry accepted less claims and consumers withdrew more claims, consumers raised fewer internal disputes about declined claims and the proportion of dispute outcomes in their favour also fell.

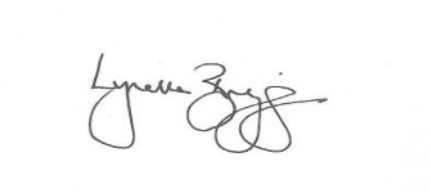
At the same time the Financial Ombudsman Service Australia reported virtually no change in the number of general insurance disputes it received from consumers during the same period.

In the future, more and higher quality data on the reasons claims are declined and withdrawn will allow any such problems to be identified and addressed. Already, we have heard promising reports from some Code Subscribers that – prompted by the increase in withdrawn claims identified here – they have begun reviewing their claims data to better understand what has contributed to this trend.

We hold a strong view that it is critical the general insurance industry develops a consistent and robust discipline for collecting and reporting data to us, together with clear, cogent and specific reasons for why industry declines to accept consumers' claims and why consumers withdraw their claims. We will be seeking this information again from Code Subscribers when we begin collecting data for the 2015–16 reporting period. As a general comment, higher quality data at first instance, without the need for further queries, will also enable the Committee to release the report in a more timely manner.

Later this year, the Committee will release its Annual Report on Code compliance, reporting in detail on industry's efforts to comply with the Code in 2015–16. In the meantime, the self-reported compliance data in this Industry Data Report suggests pleasing breach decreases in some areas, while also raising questions about the adequacy of Code Subscribers' own compliance monitoring of critical hardship provisions. We encourage Code Subscribers to sustain their commitment to the Code and to continually improve service and standards for consumers.

Finally, it is interesting to see some change within the general insurance industry workforce. While Schedule 3 shows that employee, corporate and individual authorised representative numbers in the industry have been relatively stable over the last 5 years, the number of agents and contractors has grown dramatically in the 3 years to 2014-15 – and is now almost 3 times the size, suggesting the need for ongoing review by the industry.



Lynelle Briggs AO
Independent Chair
Code Governance Committee

YEAR AT A GLANCE

PERSONAL INSURANCE POLICIES AND CLAIMS

	compared to last year
48,135,084 *(includes people & assets covered by group policies) policies issued*	↑ 15%
3,690,113 *claims lodged*	↑ 8%
122,875 *claims declined*	↑ 16%
206,222 *claims withdrawn*	↑ 61%

DISPUTES AND BREACHES

	compared to last year
21,719 *personal insurance disputes lodged*	↓ 15%
21,424 *personal insurance disputes reviewed internally*	↓ 17%
3,743 *self-reported Code breaches*	↓ 33%

GENERAL INSURANCE WORKFORCE

	compared to last year
67,734 *employees, corporate & individual authorised reps, agents & contractors*	↑ 7%
33,828 *received Code training*	↓ 6%

KEY OBSERVATIONS

INDUSTRY ISSUED OR RENEWED MORE THAN 50 MILLION GENERAL INSURANCE POLICIES

In 2014–15, industry issued or renewed 51,829,110 general insurance policies – the large majority of them were personal insurance policies. Most of these policies were in the Motor, Travel and Home classes. Together they accounted for more than three quarters of all personal insurance policies. We observed a significant spike in Travel policy numbers in 2014–15. On further investigation, we concluded that this increase in Travel was largely the result of some Code Subscribers becoming able for the first time to estimate and report the number of people covered by complimentary Travel insurance accompanying credit cards.

As a result, our analysis of the policy data shows that the industry remained relatively stable overall with only modest growth occurring within some areas of personal insurance. The variable data collection and reporting among Code Subscribers mean that the group cover data is inconsistent in providing a complete picture of the industry. We encourage industry to improve data quality and consistency to enable future trend analysis.

INDUSTRY DECLINED AN INCREASING PROPORTION OF CLAIMS

The number of personal insurance claims industry declined continued to trend upwards across all classes except Residential Strata and Travel – a trend that is only partly explained by an overall increase in claims.

THERE WAS AN UNEXPLAINED INCREASE IN WITHDRAWN CLAIMS

Alongside the trend of increased claim refusals, the number of claims withdrawn by consumers grew by a substantial 61%. Industry data on the reasons for claim withdrawal is patchy – so the cause of this concerning trend is unclear. Clearly, however, there is a gap between consumer expectations and how these products operate in practice.

INTERNAL DISPUTES DECREASED

Despite the growth in declined and withdrawn claims, internal disputes continued to trend downwards during 2014–15, with disputes about personal insurance products and services falling 15% to 21,719.

SELF-REPORTED BREACHES DECREASED

Industry reported a 33% fall in the number of Code breaches it identified during 2014–15. Much of this was driven by a similar fall in the claims handling breaches.

INDUSTRY IDENTIFIED VERY FEW BREACHES OF HARDSHIP PROVISIONS

In 2014–15 only one Code Subscriber reported a breach of the 2012 Code's financial hardship standards – whereas the Committee's own monitoring work identified nine such breaches over the same period. We are concerned that industry may not be adequately monitoring its compliance with these critical Code standards.

INTRODUCTION

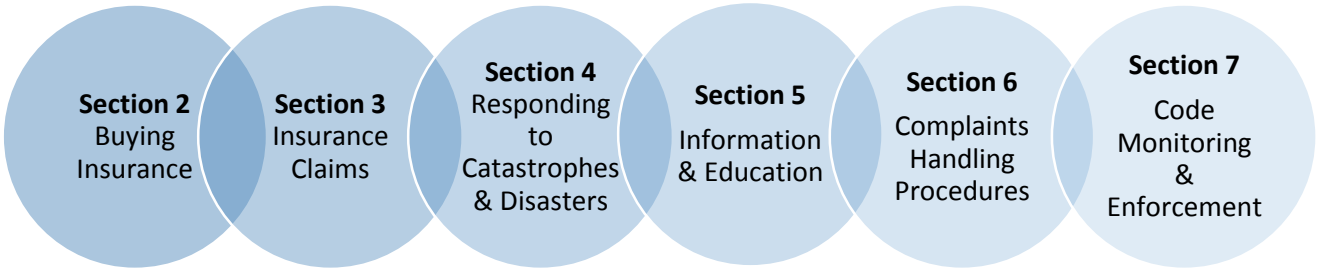
This is the Code Governance Committee's General Insurance Industry Data Report (Data Report) for the reporting period 1 July 2014 to 30 June 2015 (2014–15). The Data Report aggregates general insurance industry data provided by subscribers to the General Insurance Code of Practice (the 2012 Code[1]). Code Subscribers comprise 162 general insurers and Lloyd's Australia Limited coverholders and claims administrators from around Australia (**Schedule 1** provides a list of current Code Subscribers).

Our data collection focused on retail classes of general insurance[2] and covered policies, claims, declined claims, withdrawn claims and internal disputes. Our analysis of this industry data is combined with data on compliance with the 2012 Code, creating a comprehensive picture of industry trends in 2014–15.

GENERAL INSURANCE CODE OF PRACTICE

The Insurance Council of Australia (ICA) launched the General Insurance Code of Practice (the Code) in July 2005. The 2012 Code began on 1 July 2012. Its standards are outlined in **Diagram 1**.

Diagram 1 – 2012 Code standards



On 1 July 2014 the ICA launched revised Code standards, set out in the 2014 General Insurance Code of Practice (the 2014 Code). The 2014 Code applies primarily to retail insurance products[3] and was widened to cover third party beneficiaries of insurance policies and to incorporate new financial hardship obligations.

In 2014–15, industry transitioned to the new standards of the 2014 Code and, at the same time, we continued to oversee industry's compliance with the 2012 Code.[4] Because the 2014 Code only became operational on 1 July 2015, this report focuses on the 2012 Code, which applied during the reporting period.

[1] The 2012 Code is available at www.codeofpractice.com.au/.
[2] This is consistent with the main focus of the new 2014 General Insurance Code of Practice (2014 Code), which replaced the 2012 Code on 1 July 2015. The 2014 Code is available at www.codeofpractice.com.au.
[3] Only some of the 2014 Code standards apply to wholesale general insurance products.
[4] During 2014–15 industry remained bound by the standards of the 2012 Code – sections 1.6 and 7.4.

THE DATA IN THIS REPORT

This Data Report analyses two sets of data provided by industry:

- Data about policies, claims, declined claims, withdrawn claims, internal disputes and their outcomes across personal classes of general insurance (which we refer to as "personal insurance"), namely Consumer Credit, Home, Motor, Personal & Domestic Property, Residential Strata, Sickness & Accident and Travel. This data is consolidated in **Schedule 2**, with a five-year industry overview in **Schedule 3** and further data in **Schedules 5** to **10**.
- Industry-identified breach data, which is summarised in **Schedule 4**.

While we focus attention on personal insurance products in the body of the report, we have outlined commercial data in **Schedule 2** and **Schedules 5** to **10**.

INTERPRETING THE DATA

To ensure that the industry data published by the Committee is as accurate as possible, we rely on Code Subscribers to carefully review the data they submit to us to ensure its accuracy, and to let us know if there are any errors in previously submitted data. We do not audit the data submitted by Code Subscribers.

In order to understand and interpret the data, we consult with Code Subscribers on trends, asking for their views on factors that may have influenced change at an individual company or industry level. Code Subscribers' views on these factors are recorded in the report and should be kept in mind when interpreting the data.

Variation in the data reported to us occurs for various reasons, including reporting frameworks that differ from company to company. As a result, the data is only indicative of current trends. We continue to consult with industry to build a more consistent and robust reporting framework into the future.

COMPARISON WITH PREVIOUS REPORTS

All the data in the Data Report was correct at the time of reporting. Minor differences between this and previous industry data reports reflect the outcome of a review of our data and reporting frameworks for Code Subscribers.

REPORT CONVENTIONS AND TERMINOLOGY

Many of the charts and tables in this report use percentages. We have rounded all percentages to the nearest whole number. Because of this, the sum of the percentages in a chart or table might not add up to 100%.

A glossary of terms is in **Schedule 11**.

BUYING INSURANCE

Industry reported 51,829,110 general insurance policies issued or renewed in 2014–15, of which the large majority (48,134,529) were personal insurance policies (**Table 1**).[5]

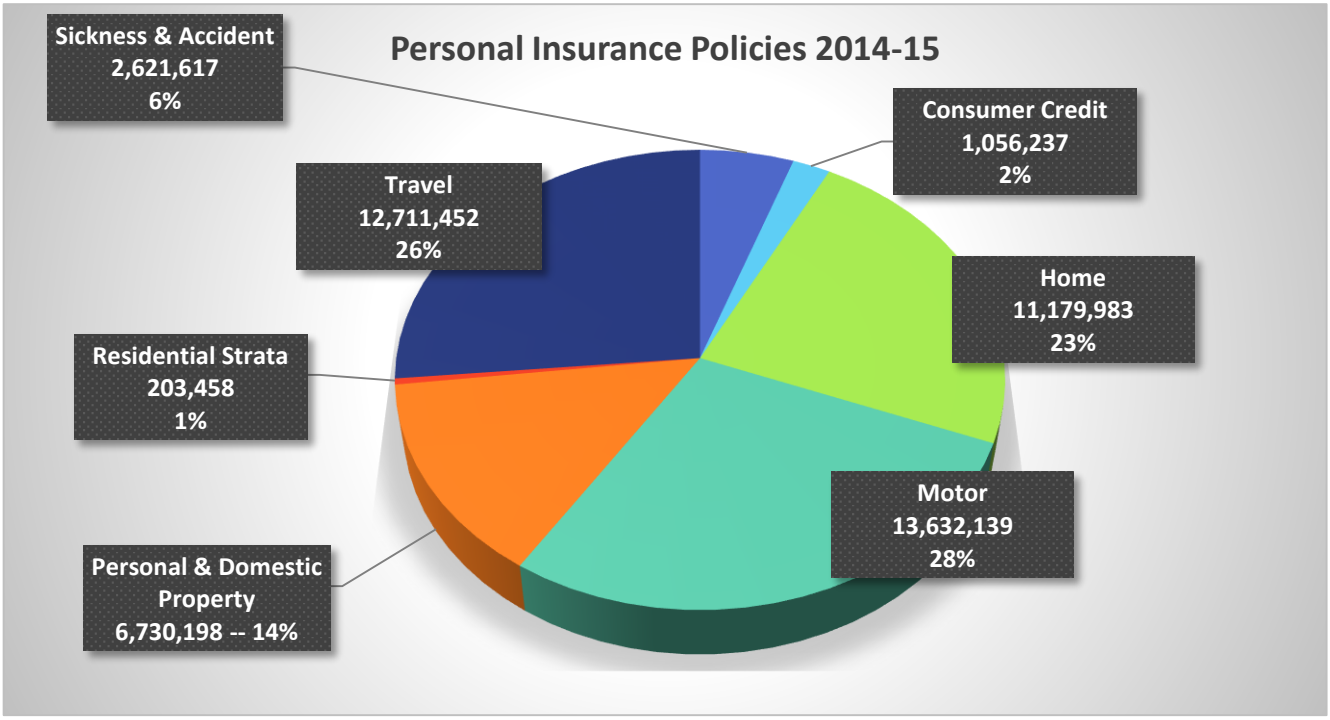
Table 1: General insurance classes – policy numbers 2014–15

	Personal Classes of General Insurance	Commercial Classes of General Insurance	All Classes of General Insurance
Number of policies	48,135,084	3,694,026	**51,829,110**

PERSONAL INSURANCE POLICIES

The top three classes of personal insurance products consumers acquired in 2014–15 were Motor, Travel and Home (**Chart 1**).

Chart 1: Personal insurance classes in 2014–15 – policy numbers and share



Motor includes products that provide comprehensive motor vehicle cover and third party property damage cover. This was the largest class, accounting for 28% of personal insurance products

[5] The number of policies includes the number of people and assets covered by group policies.

acquired by consumers during 2014–15. The next largest class was Travel, which comprised 26% of all personal general insurance products in 2014–15. Consumers bought or had the benefit of 12,711,452 Travel insurance policies during 2014–15. Home insurance – which comprises Home Building, Home Contents, Home Building & Contents and Landlord insurance products – represented 23% (11,179,983 policies) of all personal insurance products issued to consumers in 2014–15.

We have observed a gradual upward trend in policy volumes year on year over the last five years across general insurance products. However, reviewing the industry data on policies issued or renewed in 2014–15, we noted a large increase over the figures reported for 2013–14, as seen in **Table 2**. This volatility was particularly marked for Travel policies, which appeared to have increased sharply, up 72% from 7,392,489 policies in 2013–14 to 12,711,452 in 2014–15. In addition, while the numbers are relatively low, Residential Strata showed a 40% increase to 203,458 policies. All other personal insurance classes remained relatively stable or grew only slightly, ranging from 1% growth in Consumer Credit insurance products to 4% growth in Personal & Domestic Property.

Table 2: Personal classes – number of policies, 2014–15 v 2013–14

PERSONAL INSURANCE CLASSES	2014-15
Consumer Credit	1,056,237 ^ 1%
Home	11,179,983 ^ 3%
Motor	13,632,139 ^ 3%
Personal & Domestic Property	6,730,198 ^ 4%
Residential Strata	203,458 ^ 40%
Sickness & Accident	2,621,617 ^ 2%
Travel	12,711,452 ^ 72%
PERSONAL TOTAL	**48,135,084** ^ 15%

Consistent with previous years, industry was asked to include group cover policies in their data and, if possible, an estimate of the number of people and assets covered. Historically, policy data has consisted of a combination of policies, group policies and estimates of people or assets covered by group policies. However, the volatility in the 2014–15 data alerted us to inconsistencies in whether and how Code Subscribers incorporated group policy-related data into their figures.

On further investigation, we found that rather than reflecting actual growth in the number of policies issued or renewed, this trend was largely the result of changes in some Code Subscribers' data collection and reporting practices. Specifically, some Code Subscribers said that for the first time they had been able to estimate and report the number of people covered by complimentary Travel insurance accompanying credit cards – a type of group cover arrangement.

A group cover policy is a master policy taken out by a policyholder – such as a financial institution, employer, school or sporting association – that provides insurance cover of various types for numerous people, or for assets such as cars, laptops or residential strata units. As a result, we asked industry for more information about how group cover policies had been accounted for in their reporting, which we have outlined and discussed in the next section.

GROUP COVER

Of the 162 Code Subscribers that submitted policy data for 2014–15, 21 Code Subscribers indicated their data included group policy data and gave us additional information. We have aggregated the responses of these 21 Code Subscribers in **Table 3** below.

We found that these 21 Code Subscribers varied in their ability, need and desire to identify the number of group policies or the number of people or assets covered by group policies. For some of these Code Subscribers, collecting this information was considered administratively impractical or unnecessary. Others reported that they estimate the number of people or assets covered by group cover policies, and some had done so for the first time in 2014–15.

The breakdown of policy type attributable to the 21 Code Subscribers who contributed additional group cover data and information for the relevant personal insurance products are:

- Consumer Credit – 2 Code Subscribers
- Motor – 1 Code Subscriber
- Personal & Domestic Property – 2 Code Subscribers
- Residential Strata – 2 Code Subscribers
- Sickness & Accident – 15 Code Subscribers, and
- Travel – 6 Code Subscribers.

Of the remaining 141 Code Subscribers, 11 did not specify whether their data included group policies, one reported that it was unable to identify whether group policy data was included, and the balance confirmed that they did not provide group cover.

The data presented in **Table 3** is indicative only for some of the following reasons:

- The data collected from these 21 Code Subscribers confirmed that all personal insurance classes except Home included the number of people or assets covered by group policies or the number of group policies. The extent to which this occurred varied across Code Subscribers and the type of personal insurance products.
- Some of the Code Subscribers confirmed that the policy data submitted to us included the number of people or assets covered where they were able to do so. Others said that they only included the number of group policies, even if they were able to estimate the number of people or assets covered.
- Of the 21 Code Subscribers, 20 gave us the number of group policies for all of the relevant classes of personal insurance products.
- Although all 21 Code Subscribers could provide estimates of people or assets covered by group policies, they did not do so for all of their personal insurance products or for all of the group policies within a particular personal insurance class. This is because some respondents did not provide this information, some were unable to provide an estimate, some said it was not practical to record this data and one said it did not need this information for rating the underwriting risk.

As such, the data in column 1 does not add up to the sum of the data in columns 2 and 3 and does not always add up to the sum of the data in columns 2 and 4.

Table 3: Personal classes – Group cover policy data in 2014–15

Class	Total policies reported by all Code Subscribers[6]	Group cover data/information from 21 Code Subscribers			
		Column 1	Column 2	Column 3	Column 4
		Total policies reported	Estimated non-group cover policies	Estimated group cover policies	Estimated people or assets covered by group policies
Consumer Credit	1,056,237	84,870	62,297	13	22,761
Home	11,179,983	n/a	n/a	n/a	n/a
Motor	13,632,139	618	160	5	458
Personal & Domestic Property	6,730,198	198,809	74,996	8	123,813
Residential Strata	203,458	62,122	0	12,580	53,658
Sickness & Accident	2,621,617	2,590,020	295,266	6,749	3,622,719
Travel	12,711,452	9,180,280	1,673,677	18,855	10,048,348
Total	**48,135,084**	**12,116,719**	**2,118,020**	**49,907**	**13,881,543**

PERSONAL INSURANCE TRENDS

So what can we say about the policy data in 2014–15 and what does the additional group cover data tell us?

The data shows a modest growth of 3% in Home insurance products during the reporting period, meaning that more consumers bought these products in 2014–15.

Our analysis of the group cover data suggests that almost all of the reported Motor policy data consisted of policies covering a single vehicle and not groups of vehicles. The modest growth of 3% in Motor insurance products is consistent with more consumers buying these products during the reporting period.

The 72% increase in Travel policy numbers compared with 2013–14 largely reflects some Code Subscribers reporting for the first time the number of people covered under complimentary Travel insurance cover. The group cover data suggests that at least 80% of the total number of Travel policies originally reported by the six Code Subscribers who responded, reflected the number of people covered under group Travel policies. This is indicative only because some of the responding Code Subscribers were unable to estimate the number of people covered. Nevertheless the group cover data confirms that there has not been a true growth in Travel policy numbers since 2013–14.

[6] We collected data from 162 Code Subscribers for the 2014–15 period.

This data presents a strong case for industry to separately report the number of non-group and group cover policies and develop the capacity to identify and report the number of people that could be covered by group Travel policies, in particular complimentary Travel cover. This will enable us to obtain a better and more comprehensive picture of the number of consumers covered by Travel products, and will assist in interpreting trends emerging in claims, declined claims, withdrawn claims and internal disputes.

Similarly, the group cover data for Sickness & Accident shows that about 88% of the original policy data reported by the responding Code Subscribers consisted of people covered by group policies. However, there is very little difference between that number and the total number of Sickness & Accident policies reported by industry. This suggests that the relevant Code Subscribers have provided data consistently in this way year on year, and that the overall policy data has remained stable with a small increase of 1% in 2014–15.

The total number of Personal & Domestic Property policies reported by industry indicated a 4% growth compared with 2013–14. The group cover data shows that about 3% of the total number of policies in this class included the number of assets covered. Given the small component that is attributable to group cover, much of the aggregated industry data for this class consists of policies that cover a single asset.

Consumer Credit remained stable in 2014–15 with just 1% growth overall. The group cover data shows that almost all of the policy data reported by industry consists of policies that cover an individual.

Residential Strata provides an incomplete picture. One of the two Code Subscribers who responded said that they do not need to know the number of units covered. In addition, there are other Code Subscribers who sell Residential Strata products but were unable to assist us with our enquiries.

We now have a better understanding of how group cover is accounted for in industry data on policies issued and renewed. This means that in future we will continue to ask for policy data to be separated into non-group policies and group policies when it is reported to us and, to also report separately the number of people or assets covered by group policies.

We encourage industry during 2016–17 to improve the quality of the data where possible, so that from 1 July 2017 the data that we collect will enable us to establish a better baseline for future trend analysis and give us a clearer picture of how industry is performing.

CODE COMPLIANCE

Section 2 of the 2012 Code sets standards for the way in which Code Subscribers sold, renewed and administered general insurance policies, and responded to consumer enquiries about insurance products. These standards applied to Code Subscribers, their Employees and Authorised Representatives.

In its 2013–14 industry data report,[7] it was noted that Code Subscribers had identified and remedied 604 breaches of section 2, accounting for 11% of all non-compliant activity that year. We had expected the 2014–15 breach data to show industry had continued to improve its compliance with fairness and transparency obligations in subsections 2.1.4 and 2.4.1, which apply to the conduct of sales processes and services.

However, the 2014–15 breach data shows that section 2 breaches increased by 32% to 795 breaches and comprised 21% of all breaches identified and reported by industry. The increase in non-compliant activity was particularly marked for subsection 2.4.1, which requires Code Subscribers to conduct services honestly, efficiently, fairly and transparently. There were 435 breaches of this subsection, up from 164 in 2013–14. Non-compliance with subsection 2.4.1 was the third most frequent area of non-compliant activity in 2014–15.

In contrast, industry reported only 22 breaches of subsection 2.1.4, which requires that sales processes be conducted in a fair, honest and transparent manner. This was a decrease from 153 breaches in the previous period.

Subsection 2.1.3 requires a Code Subscriber to take immediate action to correct an error or mistake in assessing a consumer's application for insurance. In 2014–15 there were 102 breaches of subsection 2.1.3, up from 19 in 2013–14. There were also 110 breaches of subsection 2.1.5(b), which requires a Code Subscriber to refer a consumer to another insurer, the ICA or National Insurance Brokers Association (NIBA) for assistance, if it is unable to give them insurance cover. This was up from 46 in the previous reporting period.

These instances of non-compliance occurred within the context of 51,829,110 individuals, assets and businesses covered by general insurance cover.

Detailed compliance data for 2014–15, including the top five areas of non-compliance, is in **Schedule 4** at the end of the Data Report.

ADDRESSING CODE BREACHES

Code Subscribers reported that most non-compliance occurred because employees or Authorised Representatives did not follow an established procedure. Accordingly, Code Subscribers addressed most instances of non-compliance by providing those employees or Authorised Representatives with further training or individual (tailored) coaching.

In some instances, Code Subscribers also contacted consumers to provide them with or obtain from them the required information or to refund insurance premiums. **Table 4** shows examples of self-reported breaches and how they were addressed.

[7]The *2012 General Insurance Code of Practice Aggregated Industry Data Report Overview of the Year 2013–14* is available from http://www.fos.org.au/custom/files/docs/fos-gi-code-annual-report-201314.pdf.

Table 4: Selected breaches and how they were addressed

What happened?	How did the Code Subscriber fix the breach?
Field audits identified that some Authorised Representatives did not check whether consumers had correctly completed a form authorising the purchase of insurance cover and providing direct debit details for the payment of insurance premiums. The Authorised Representative and consumer were also required to sign the form.	The Code Subscriber: • arranged for the consumers to complete a new form with the required information • provided coaching to the Authorised Representatives to reinforce the correct process.
Complaints from consumers established that some Authorised Representatives had not clearly explained the scope of the insurance cover when arranging it.	The Code Subscriber: • cancelled the policies and refunded the premium to affected consumers • provided remedial training to the Authorised Representatives.
Several Code Subscribers' call monitoring identified sales employees failing to follow an approved script when selling insurance products under a "no advice model", which may have misled consumers.	The Code Subscribers: • contacted affected consumers to provide the required information • gave sales employees individual coaching and implemented additional call monitoring or evaluation of job performance.
A Code Subscriber displayed the wrong business entity and contact details on several websites during its sales process.	The Code Subscriber: • amended the information on the websites.
A Code Subscriber's employees gave incorrect product information, breached privacy, failed to follow scripting or failed to verify customers' identity.	The Code Subscriber: • gave the required information to relevant consumers • provided employees with further training to reinforce legal and Code requirements.
A Code Subscriber's Authorised Representative's advertisement did not include the required disclosures.	The Code Subscriber: • immediately removed the advertisement • amended it to include the required disclosures.
Some of a Code Subscriber's employees recorded the wrong information about some consumers when arranging their insurance cover.	The Code Subscriber: • contacted the affected consumers to correct the errors.
A Code Subscriber's employees did not refer consumers to another insurer, ICA or NIBA when unable to provide them with insurance cover.	The Code Subscriber: • provided individual coaching to the relevant employees.

GUIDANCE TO INDUSTRY

The 2012 Code required general insurers to sell, renew and administer insurance in a fair and transparent manner and the 2014 Code contains similar standards.

Monitoring plays an important part here: Code Subscribers that actively monitor compliance with their fairness and transparency obligations can respond quickly to breaches, minimising consumer

detriment both by fixing problems for customers already affected and by picking up on and responding to areas of risk as they emerge.

When breaches are identified, Code Subscribers commonly respond by providing training or coaching to the employees or Authorised Representatives involved in the breach. The Committee notes that these instances are also an opportunity for Code Subscribers to reinforce compliant procedures across a whole team.

With regard to breach reporting, occasionally Code Subscribers do not record instances of non-compliance as breaches because the cause of non-compliance was human or administrative error. The Committee acknowledges that such errors will occur from time to time, even where Code Subscribers' standard processes are compliant. Nevertheless, any non-compliance with Code standards by an employee or Authorised Representative does constitute a breach and should be recorded as such.

CLAIMS, DECLINED CLAIMS AND WITHDRAWN CLAIMS

The number of general insurance claims, declined claims and withdrawn claims continued to grow in 2014–15 (**Table 5**).

Table 5: General insurance classes – claim numbers 2014–15 v 2013–14

GENERAL INSURANCE	*Number of Claims*	*Number of Declined Claims*	*Number of Withdrawn Claims*
PERSONAL CLASSES	***3,690,113 up 8%***	***122,875 up 16%***	***206,222 up 61%***
COMMERCIAL CLASSES	***550,156 up 8%***	***6,510 up 50%***	***11,216 up 177%***
ALL CLASSES	***4,240,269 up 8%***	***129,385 up 17%***	***217,438 up 65%***

In 2014–15, consumers and businesses lodged 4,240,269 general insurance claims, up 8%. Industry refused to accept 17% more claims than in 2013–14, taking declined claims to 129,385.[8] This means that industry refused to accept about 3 of every 100 insurance claims lodged in 2014–15, unchanged since 2013–14.

The ratio of declined claims to claims does not take into account the number of withdrawn claims during the same period.

During the reporting period, consumers and businesses also withdrew 217,438 claims, up 65% when compared with 2013–14.

PERSONAL INSURANCE TRENDS

Focusing on personal insurance, **Table 6** shows claims, declined claims and withdrawn claims for different classes in 2014–15 compared with data from 2013–14.

Industry accepted 97 of every 100 personal insurance claims lodged by consumers during 2014–15. The acceptance rate ranged from 85% of Consumer Credit claims to more than 99% of Motor claims. Due to the inconsistency in withdrawn claims data, we have not included withdrawn claims in our calculation of claims acceptance figures.

[8] In this report, the terms “refusal to accept”, “deny” and “decline”, in relation to claims, are used synonymously.

Table 6: Personal classes – claims, declined claims & withdrawn claims, 2014–15 v 2013–14

	Claims 2014-15	Declined Claims 2014-15	Withdrawn Claims 2014-15
Consumer Credit	34,573 ^ 32%	5,102 ^ 35%	894 v 21%
Home	928,330 ^ 30%	43,140 ^ 19%	89,928 ^ 72%
Motor	1,882,948 -	7,946 ^ 26%	93,367 ^ 47%
Personal & Domestic Property	494,504 ^ 12%	38,275 ^ 16%	7,230 ^ 38%
Residential Strata	41,195 v 25%	501 v 45%	269 ^ 69%
Sickness & Accident	54,811 ^12%	3,702 ^ 138%	165 v 84%
Travel	253,752 ^ 2%	24,209 -	14,369 ^ 236%
PERSONAL TOTAL	**3,690,113 ^ 8%**	**122,875 ^ 16%**	**206,222 ^ 61%**

DECLINED CLAIMS

We observed sharp increases in the number of declined claims in 2014–15 compared to the previous reporting period. For instance, declined Sickness & Accident claims climbed 138%, while Consumer Credit claims increased by 35% and declined Motor claims increased 26%.

Industry initially identified three main reasons for this increase in declined claims. Firstly, they noted that the increase in declined claims was consistent with growth in the number of policies issued in 2014–15. It also followed an increase in claims as a result of increased severe weather events in 2014–15. A third contributor was an improvement in the recording and reporting of declined claims data by some Code Subscribers, including some intermediaries who reported this type of data for the first time.

WHY CLAIMS WERE DECLINED

We asked Code Subscribers for more information about why claims were declined. Only some Code Subscribers could give us general reasons for the decline of claims, and even fewer could provide specific decline reasons. Many Code Subscribers did not consistently record reasons for declining claims across their product offerings and they were unable to accurately report the number of claims declined for a general or specific reason.

As a result, in the discussion below about declined claims across each class of personal insurance, we have described the five most commonly cited reasons in no particular order and without reference to the number of claims declined for each reason.

In future, we will be asking for more detail from Code Subscribers on the reasons for declined claims as it can highlight gaps in consumers' understanding of policies or changes in the way that Code Subscribers are administering claims.

WITHDRAWN CLAIMS

Withdrawn personal insurance claims increased by 61% in 2014–15 to 206,222. However, this data should be treated as indicative only – some Code Subscribers do not record this data, while others do so inconsistently across their product offerings. Despite this, the data suggests that at least 6% of claims were withdrawn by consumers during the reporting period.

As with declined claims, industry identified growth in policies issued, increased claims resulting from severe weather events and improved data collection, as the main reasons for this overall increase in withdrawn claims.

Code Subscribers informed us that they re-open withdrawn claims if asked to do so and as a result, are generally unlikely to receive complaints from consumers about a refusal to re-open a withdrawn claim. Some Code Subscribers said that if a consumer did complain they would respond by re-opening the withdrawn claim, resolving the complaint. Very few Code Subscribers had the ability to identify the number of re-opened withdrawn claims and even then, this data was not consistently captured. Those Code Subscribers who could identify re-opened withdrawn claims indicated that these were usually Home and Motor claims.

WHY CLAIMS WERE WITHDRAWN

We asked Code Subscribers for data about the reasons consumers withdrew claims. While not all Code Subscribers were able to provide this information, industry identified five main reasons for the withdrawal of claims, generally consistent across all classes of personal insurance. In no particular order, these are:

- The consumer did not give a reason or a reason was not recorded.
- The consumer chose not to pursue the claim or did not respond to requests for further information to support the claim.
- The value of the claim was less than the excess that applied to the claim.
- The claim was created in error (usually as a duplicate of an existing claim).
- The claim was not the result of an insured event.

Some Code Subscribers who did not record specific reasons for withdrawal of claims reported that in their experience consumers usually withdraw claims:

- Because they decide the claim is not economical to pursue, for example, because the value of the claim is less than the applicable excess.
- Because an insured event did not occur, and as a result, the claimant decides to withdraw the claim before it is formally declined.
- After a reasonable request is made for further information to verify the claim’s circumstances.

Some reasons for the withdrawal of claims are specific to a particular personal insurance class; these reasons are discussed below.

In response to our enquiries, a number of Code Subscribers have already begun working on modifying their systems to consistently and accurately record the reasons claims are declined or withdrawn. Other Code Subscribers continue to work on improving the way in which they record this information, including consistency in recording across all product offerings. We encourage and support these efforts.

We will continue to ask Code Subscribers for better data on withdrawn claims and information on the reasons for claims withdrawals, as these can be indicators of problems with consumers' understanding of policies, tougher administration, or consumers deciding that it is not worth the effort to pursue a small claim.

MOTOR

Consumers lodged 1,882,948 claims under Motor insurance products in 2014–15. With the highest number of claims, Motor represented 51% of all personal insurance claims – a proportion largely unchanged when compared with 2013–14.

DECLINED MOTOR CLAIMS

Following a 16% drop in declined motor claims the previous year, in 2014–15 we observed a 26% increase in the number of Motor claims industry declined. Despite the increase in declined claims, Motor had the highest rate of accepted claims, with industry accepting more than 99 of every 100 Motor claims (99.6%), unchanged since 2013-14 (99.7%).

The most common reasons for refusal to accept consumers' Motor claims in 2014–15 were:

- The policy did not cover the claimed event – for example, where cover was limited to third party property damage.
- The claim was not covered because the policy had lapsed.
- The policy excluded the claim or a policy condition was not met – for example misrepresentation, non-disclosure, loss/damage due to wear and tear.
- The claimant did not cooperate when asked to provide further information.
- There was no evidence to show that an insured event had occurred.

One Code Subscriber identified fraud as a specific reason for declining a number of Motor claims during the reporting period.

WITHDRAWN MOTOR CLAIMS

Industry reported a 47% increase in the number of withdrawn Motor claims to 93,367 – the highest number of withdrawn claims of any personal insurance class. These claims were largely withdrawn for the reasons described above. Three Code Subscribers also identified that consumers withdrew their Motor claims during investigation, because fraud was suspected, or because of the influence of alcohol, illegal drugs or medication at the time of the event that led to their claim.

HOME

The number of Home claims increased 30% to 928,330 in 2014–15 and accounted for one quarter (25%) of all personal insurance claims.

Industry reported that an increase in severe weather events in 2014–15 underlay the marked increase in Home claims, particularly for damage to buildings, and that this also contributed to the higher number of declined Home claims. One Code Subscriber reported that a single severe weather event in 2014–15 led to the largest number of claims that it had ever experienced, surpassing the number of claims received following the 2010–11 floods that affected the eastern states of Australia.

Other Code Subscribers identified growth in the sale of Home products or the maturing of new Home products as contributors to the increase in Home claims and declined claims.

DECLINED HOME CLAIMS

With 43,140 claims refused in 2014–15, Home accounted for 35% of all declined personal claims, up 19%. While Home was the source of the largest number of declined claims, industry accepted 95 of every 100 Home claims (95.4%), unchanged since 2013–14 (94.9%).

Industry's five top reasons for declining Home claims were:

- There was no cover for the claimed event because there was no policy in force, or the policy did not cover it (for example an insured event had not occurred).
- The claim was not covered because a policy condition or exclusion applied. For example, due to non-disclosure; or the claimed damage was not due to a storm-created opening or was due to wear and tear or occurred outside the policy period.
- There was no evidence to show that an insured event had occurred.
- The reason for declining the claim was not recorded.
- The claim's value was less than the applicable excess.

One Code Subscriber informed us that it refused to accept some Home claims during 2014–15 because of fraud.

WITHDRAWN HOME CLAIMS

Industry reported that consumers withdrew 89,928 Home claims, 72% up on 2013–14 data, largely for the reasons noted earlier. Some Code Subscribers informed us that they closed a number of Home claims after consumers failed to provide information to support their claims, while others noted that some withdrawn claims represented a notification of a possible claim. Two Code Subscribers reported fraud as a reason for some consumers discontinuing their Home claims during 2014–15.

PERSONAL & DOMESTIC PROPERTY

Personal & Domestic Property claims grew by 12% to 494,504 and represented 13% of all personal insurance claims in 2014–15.

DECLINED PERSONAL & DOMESTIC PROPERTY CLAIMS

Industry declined 38,275 Personal & Domestic Property claims in 2014–15, 16% more than in 2013–14. This class accounted for 31% of all declined personal insurance claims in 2014–15, second to Home. As a proportion of claims for this class, industry accepted 92 claims in every 100 Personal & Domestic Property claims (92.3%), unchanged since 2013–14 (92.5%).

Code Subscribers who recorded information about why they declined to accept Personal & Domestic Property claims told us they declined these claims usually for one of the following reasons:

- The event that led to the claim occurred during the policy's waiting period.
- Non-disclosure.
- A policy exclusion applied to the claim.
- The value of the claimed item was less than the excess that applied to the claim.
- The damage to the claimed item was caused by wear and tear.

WITHDRAWN PERSONAL & DOMESTIC PROPERTY CLAIMS

In 2014–15 industry reported that consumers withdrew 7,230 claims (up 38%). One Code Subscriber informed us that some claims were withdrawn during investigation or because of an allegation of fraud.

TRAVEL

Industry reported that consumers lodged 253,752 Travel claims in 2014–15, only 2% more than in 2013–14 and representing 7% of all personal insurance claims.

DECLINED TRAVEL CLAIMS

In 2014–15 Travel accounted for 20% of all declined personal insurance claims – 24,209 (virtually identical to 2013–14). The number of declined claims remained steady and this is reflected in the decline rate: industry accepted 90.5% of Travel claims, unchanged from 2013–14 (90.2%).

Code Subscribers reported that they refused to accept claims for Complimentary Travel insurance accompanying a credit card facility because:

- Consumers did not meet the credit card activation criteria.
- A pre-existing medical condition was the cause of the claim.
- The complimentary Travel cover provided only limited cover for losses caused by cancellation of travel arrangements.
- Consumers did not provide adequate evidence of ownership of items claimed as lost or stolen.
- The value of the claim was less than the excess that applied to the claim.

Purchased Travel insurance policy claims were declined for similar reasons, with Code Subscribers identifying the following reasons:

- A pre-existing medical condition was the cause of the claim.
- The claim was due to a close relative who did not meet the age criteria or because an airline had rescheduled flights.
- Consumers did not meet travel delay timeframes.
- Consumers did not provide adequate evidence of ownership of items claimed as lost or stolen.

WITHDRAWN TRAVEL CLAIMS

Industry reported a 236% increase in the number of withdrawn Travel claims – from 4,280 in 2013–14 to 14,369 in 2014–15.

Consumers failing to provide evidence to support their claims was the most common reason for withdrawal of Travel claims, followed by the claim excess exceeding the value of the claim and closure of claims after no further contact from consumers.

CONSUMER CREDIT AND SICKNESS & ACCIDENT

In 2014–15 consumers lodged 54,811 Sickness & Accident claims, up 12% and 34,573 Consumer Credit claims, up 32%. Each of these classes accounted for just 1% of all personal insurance claims in 2014–15. Industry generally attributed the increase in Sickness & Accident claims to improvements in the recording and reporting of data, including intermediaries reporting this type of data for the first time.

In relation to Consumer Credit claims, industry identified several factors underlying the increase, including depressed economic circumstances and increased unemployment. Administrative factors also contributed, including a new ability to separate and individually count different events reported on a single claim form; and improved procedures which enabled claims to advance from a "pending" status more quickly.

DECLINED CONSUMER CREDIT AND SICKNESS & ACCIDENT CLAIMS

Industry refused 5,102 Consumer Credit claims in 2014–15, 35% more than in 2013–14. As a class, Consumer Credit attracted the highest rate of declined claims – industry accepted 85.2% of Consumer Credit claims, consistent with 2013–14 (85.6%). One Code Subscriber informed us that it had enhanced its claims assessment processes which meant it collected better information about the dates and details underlying employment and cessation of employment.

While some Code Subscribers recorded detailed reasons for refusing Consumer Credit claims, others recorded very general reasons. The main reported reasons for refusal of Consumer Credit claims were:

- The consumer had ended their employment voluntarily, was made redundant or was dismissed because of misconduct; or their employment had ended because they were employed to complete a specified task or to work for a specified period.
- The consumer did not comply with their duty of disclosure.
- The consumer had cancelled their policy before the date of loss.
- The consumer's account had a nil balance or was in credit; the claimed item did not meet the benefit threshold; the benefit did not apply to the claimed item; the consumer had reached their annual benefit limit.
- The consumer did not meet a policy condition requiring them to work a minimum number of hours per week or they were unable to work because of a pre-existing medical illness or condition.

With regard to Sickness & Accident, industry declined 138% more claims in 2014–15, rising to 3,702. This is reflected in a change in the decline rate – in 2013–14 industry accepted 96.8% of Sickness & Accident claims, which dropped to 93.2% in 2014–15.

Code Subscribers generally attributed the increase in Sickness & Accident declined claims to improvements in the recording and reporting of data including the reporting of data for the first time by intermediaries.

We asked Code Subscribers for more specific reasons for declining these claims and they identified the following:

- The claim was related to a pre-existing medical condition or injury.
- The consumer did not hold any cover for the claimed condition or injury.
- The event occurred during the policy's waiting period.
- Non-disclosure of an occupation that was not coved or pre-existing condition or injury.
- The claim was caused by a work-related injury.

A number of Code Subscribers could not identify why they had declined Sickness & Accident claims – while they had the capacity to record this information, it was not usually recorded.

WITHDRAWN CONSUMER CREDIT AND SICKNESS & ACCIDENT CLAIMS

Withdrawn Consumer Credit claims also fell in 2014–15, down 21% to 894. The reasons for withdrawal of these claims included the following:

- The consumer did not provide the information needed to process their claim.
- The consumer asked the Code Subscriber to withdraw their claim (no reason given).
- The Code Subscriber had paid the benefit to the consumer under an earlier claim.
- The consumer had resumed working.

Industry reported that consumers withdrew a low 165 Sickness & Accident claims during 2014–15, a fall of 84% when compared with 2013–14. Code Subscribers were unable to tell us whether the fall was due to consumers withdrawing fewer claims or a failure to consistently record this data in 2014–15.

RESIDENTIAL STRATA

In 2014–15 Residential Strata claims fell 25% to 41,195. Declined claims fell 45% to 501, representing the second highest claims acceptance rate at 98.8% of lodged claims. At the same time, industry reported a 69% increase in withdrawn claims to 269.

Code Subscribers who recorded why claims were declined identified the following general reasons:

- The policy excluded the claim.
- The policy did not cover the item claimed or the event leading to the claim.
- Wear and tear caused the loss or damage.
- The loss or damage was due to defects.
- The loss or damage occurred before the consumer bought cover.

Those Code subscribers who could identify reasons for claim withdrawal reported the following:

- The consumer decided not to pursue the claim or the policy did not cover the loss or damage.
- The amount claimed was less than the claim excess.
- The claim was withdrawn after the Code Subscriber reviewed it.
- The consumer did not respond to the Code Subscriber’s request for further information.
- The claim was lodged in error or there was no policy in place at the time of the loss or damage.

CODE COMPLIANCE

The 2012 Code devoted substantial attention to claims, setting out, in section 3, standards that applied to the handling of claims by Code Subscribers and their Service Suppliers. Central to the claims handling standards was a statutory duty to act towards insureds with utmost good faith.[9]

This part of the Data Report focuses on Code Subscribers' compliance with claims handling standards in 2014–15, covering:

- Claims handling benchmarks and timeframes, including deciding whether to accept or refuse a claim (subsections 3.1, 3.2 and 3.4).
- Fairness, honesty, transparency and timeliness in claims handling, including the nature of information given to consumers when their claims are refused (subsections 3.5 and 3.7).

In its 2013–14 industry data report, it was noted that Code Subscribers had identified and addressed 3,835 breaches of section 3, representing 68% of all non-compliant activity that year. We had expected the 2014–15 breach data to show industry had continued to improve its compliance with fairness and transparency obligations in claims handling.

Industry reported 2,702 breaches of section 3 in 2014–15, 30% fewer than in 2013–14. Breaches of section 3 accounted for 72% of all non-compliant activity and four of the five top areas of non-compliance arose from this section. This non-compliant activity occurred within a highly active general insurance claims environment comprising 4,240,269 claims (up 8%), 129,385 denied claims (up 17%) and 217,438 withdrawn claims (up 65%).

Detailed claims handling compliance data is in Schedule 4 at the end of the Data Report.

UPDATING CONSUMERS ABOUT CLAIM PROGRESS

The largest area of non-compliance in 2014–15 was subsection 3.2.3, which required Code Subscribers to update consumers about the progress of their claims at least every 20 business days. Industry reported 693 breaches of this standard, up 7% on 2013–14.

Code Subscribers reported that about two-thirds of the breaches happened because employees or service providers overlooked their obligation to provide a claim update within the required timeframe. The remaining one-third of breaches occurred when employees or service providers had difficulties coping with a higher than usual influx of claims.

Code Subscribers addressed this non-compliance by ensuring that employees or service providers provided progress updates to consumers as soon as possible and reinforcing adherence to the Code standard.

GUIDANCE TO INDUSTRY

Subsection 3.2.3 placed a positive obligation on Code Subscribers to update consumers about claim progress; an obligation that is also found in subsection 7.13 of the 2014 Code. In addition, subsection 7.5 of the 2014 Code authorises Code Subscribers to negotiate with consumers an alternative timetable for claim updates if the prescribed timeframe is impractical because, for example, the claim is complex.

[9] Section 13(1), *Insurance Contracts Act 1984 (Cth)*. Insureds (section 13(1)) and now third party beneficiaries (section 13(3) & (4)) must also act towards general insurers with utmost good faith in relation to all matters that are connected with insurance contracts.

When Code Subscribers first contact consumers within 10 business days of receiving their claim, we encourage them to explain that they will provide consumers with progress updates at least every 20 business days. This helps to manage consumer expectations about contact and minimises misunderstandings. We also recommend that Code Subscribers identify as early as possible whether there is a need to negotiate a different timetable.

There are at least two ways Code Subscribers could assist employees and service suppliers[10] to update consumers at least every 20 business days. One way is to ensure that employees and service suppliers use a diary/task reminder system as a trigger for a progress update. Another way is to build the requirement into claims handling systems, automatically creating a task to be completed by a specified date that could be monitored by team leaders and managers.

If a progress update is usually delivered by telephone but contact is unsuccessful, employees and service suppliers should provide the update using an alternate method such as email or letter to ensure compliance.

TIMEFRAMES FOR DECISION-MAKING

The 2012 Code contained two standards that required a Code Subscriber to decide whether to accept or deny a consumer's claim and notify them of the decision within 10 business days. Subsection 3.1 applied when a Code Subscriber could make a decision on the information supplied with the claim when it was lodged. Industry reported 521 breaches of subsection 3.1, which is about the same as in 2013–14.

Subsection 3.2.5 applied to a claim if a Code Subscriber needed more information about the claim, or to conduct further assessment or investigation, before it could decide whether to accept or deny the claim. Breaches of subsection 3.2.5 increased 17% to 232.

Code Subscribers identified a number of reasons for the failure to comply with timeframes for decision-making:

- While satisfied that employees or service providers had told consumers their claims had been accepted, this had not been documented on claim files.
- Employees or service providers had overlooked the 10 business day timeframe.
- Employees or service providers were unable to meet the timeframe because of an unexpected influx of claims.
- Delays occurred because employees or service providers made several requests for further information at various times when they could have asked for all of the required information at the one time.
- Employees or service providers delayed claims processing.

Code subscribers addressed non-compliance with these standards by expediting the assessment of delayed claims, advising affected consumers of their claim decision as soon as possible, and reinforcing the requirement to follow procedures and the Code's requirements with employees and service providers.

GUIDANCE TO INDUSTRY

Subsections 3.1 and 3.2.5 ensured that Code Subscribers made a claim decision within a reasonable period of time, after completing their assessment and enquiries, and proactively informing consumers of their decision within the specified timeframe. The intention behind these standards was to avoid a circumstance where a Code Subscriber fails to accept or deny the claim, compelling the consumer to

[10] The 2014 Code describes a "service provider" as a "service supplier".

act in response to the lack of a decision. Both standards are re-stated in the 2014 Code (subsections 7.9 and 7.16).

In view of increased non-compliance with subsection 3.2.5 of the 2012 Code, we believe Code Subscribers should pay close attention to their compliance with subsection 7.16 of the 2014 Code. An area to watch for is whether employees and service suppliers are deciding as early as practical whether they need to make further enquiries or obtain more information in order to decide a claim.

Quality assurance programs should include regular reviews of current and closed claim files, including denied claims. To assess whether employees and service suppliers are complying with subsection 7.16, such programs should also incorporate review of complaints about delays in making a claim decision, including disputes referred to FOS.

ACCESS TO INFORMATION ABOUT A DECISION TO DENY A CLAIM

Subsection 3.5.5 comprised several standards describing information a Code Subscriber was required to give to a consumer when it refused to accept their claim. This included:

- Written reasons for the decision to deny the claim (subsection 3.5.5(a)).
- Information about the consumer's right to ask for copies of information about them that the Code Subscriber relied on to assess the claim, and their right to ask for a review of a decision refusing access to that information (subsection 3.5.5(b)).
- Information about the Code subscriber's internal and external complaints process (subsection 3.5.5(c)).
- Upon request, copies of any service providers' and experts' reports used to assess the claim (subsection 3.5.5(d)).[11]

Industry data show that it identified and addressed 225 breaches of subsection 3.5.5 in 2014–15. This was a pleasing decrease of 30% since 2013–14, when we had expressed concern about growing non-compliance with subsection 3.5.5 in our Annual Report.

Of the 225 breaches in 2014–15, 217 were of part (a), which required a Code Subscriber to provide written reasons for its decision to deny a consumer's claim.

Industry reported that some of the breaches of part (a) occurred because their employees or service providers did not follow procedures requiring them to provide written reasons for the claim denial. In some instances, employees or service providers gave inadequate claim denial reasons while in other instances consumers were orally told about the claim denial but did not receive written reasons.

Code Subscribers addressed these breaches by giving written reasons to the affected consumers, improving monitoring of compliance with this standard and reiterating to service providers and employees their obligation to comply with these Code standards and adhere to procedures.

GUIDANCE TO INDUSTRY

The obligation to provide written reasons for the decision to deny a claim was one of the most important obligations imposed by the 2012 Code. It has been replicated in the 2014 Code within subsection 7.19.

Although overall compliance with subsection 3.5.5 improved during 2014–15, we encourage industry to remain vigilant, closely monitoring its compliance with all aspects of subsection 7.19 of the 2014 Code. Quality assurance programs should include regular reviews of claim denial files and complaints

[11] There are exceptions to accessing service providers' and experts' reports outlined in subsection 3.5.3, 2012 Code.

about denied claims to assess whether employees and service providers are complying with subsection 7.19.

We expect a Code Subscriber to clearly explain why it has refused a consumer's claim. If applicable, this explanation should include information about what the consumer needs to do in order to have their claim accepted.

When informing consumers of the decision to deny a claim, Code Subscribers must also give them clear information about their rights. These include the right to ask for the information that was used to assess their claim, including service suppliers' and external experts' reports;[12] and the right to complain about the decision. We encourage Code Subscribers to develop and implement claim denial templates that incorporate the consumer rights prescribed by subsection 7.19.

Some Code Subscribers set out these consumer rights within the body of the communication about the claim denial, while others provide it in a leaflet or brochure appended to the communication about a claim denial. If the latter, Code Subscribers must ensure that the communication clearly draws the consumer's attention to the appended document, noting that it contains important information about their rights.

[12] Access to information about a decision to decline a claim may be limited in some circumstances as outlined in section 14, 2014 Code.

FINANCIAL HARDSHIP

CODE COMPLIANCE

The 2012 Code sets out standards protecting third parties when Code Subscribers take any recovery action.

A third party is an individual who owes money to a Code Subscriber because it holds them responsible for loss or damage they caused to a customer's insured property. These standards were described in subsections 3.11 to 3.13 of the 2012 Code.

Subsection 3.11 required a Code Subscriber to act fairly and in a considerate manner when taking any recovery action against a third party, in accordance with the *ACCC and ASIC debt collection guideline: for collectors and creditors*[13] (the Debt Collection Guideline).

If a Code Subscriber was satisfied that a third party was in financial hardship, subsection 3.12 required the Code Subscriber to work with them and to consider a range of options for the repayment of a debt.[14] Debt repayment options included postponing one or more instalment payments for an agreed period.

Subsection 3.13 provided for circumstances where the third party in financial hardship could not reach an agreement with the Code Subscriber about the repayment of the debt. The standard required the Code Subscriber to inform the third party that they were entitled to access its internal complaints process to review the dispute about repayment of the debt. It also required the Code Subscriber to give the third party contact details for a national financial counselling hotline.

In 2014–15 only one Code Subscriber reported a breach of the 2012 Code's financial hardship standards, down from five reported breaches in 2013–14. In this instance, the Code Subscriber reported that it breached subsection 3.13 because it did not inform a third party in financial hardship that they were entitled to access its internal complaints process.

During the same period, however, we identified nine breaches of the financial hardship standards through our monitoring work.[15] Seven of the nine breaches involved non-compliance with subsection 3.11 because the relevant Code Subscribers failed to comply with aspects of the Debt Collection Guideline when taking recovery action against a third party.

[13] Available from https://www.accc.gov.au/publications/debt-collection-guideline-for-collectors-creditors or https://www.accc.gov.au/accc-book/printer-friendly/30173.
[14] A reference to a "debt" includes an "alleged debt".
[15] See Table 2, Breaches of Insurance Claims standards – 2014–15 compared with 2013–14, at page 29 of our *2012 General Insurance Code of Practice Annual Report 2014–15*. The report is available from http://codeofpractice.com.au/governance-and-monitoring.

GUIDANCE TO INDUSTRY

The enhanced financial hardship standards in section 8 of the 2014 Code reflect the importance industry continues to place on dealing with individuals in financial hardship in a fair, genuine and practical way.

The 2014 Code clearly and simply defines “financial hardship” as meaning where an individual has difficulty meeting their financial obligations to a Code Subscriber. In addition to third parties, the financial hardship standards now cover a Code Subscriber’s customers – insureds and third party beneficiaries who owe money to it – but do not apply to hardship in respect of outstanding insurance premiums (subsection 8.1).

A Code Subscriber’s collection agents are also bound by the financial hardship standards. For instance, collection agents must suspend recovery action when they have received an application for financial hardship assistance (subsection 8.7) and comply with the Debt Collection Guideline (subsection 8.12) when taking any recovery action.

A collection agent is also under a broader obligation to provide their services on behalf of a Code Subscriber in an honest, efficient, fair and transparent manner, as required by subsection 6.2. A collection agent may be contracted by a Code Subscriber or its claims management service to carry out recovery action. If recovery action is carried out by a Code Subscriber’s claims management service, it is also bound by the financial hardship standards and must operate under the general obligation outlined in subsection 6.2.

We are concerned by the extremely low reported incidence of non-compliance with financial hardship standards. Given that our own compliance monitoring identified a larger number of breaches, it appears that industry is not adequately monitoring its compliance with these critical Code standards.

In view of the importance that the 2014 Code places on the financial hardship standards, we encourage industry to increase its focus on this area by reviewing the adequacy and robustness of existing Code compliance arrangements, and vigorously monitoring compliance.

We recommend that Code Subscribers regularly review complaints about the conduct of employees, claims management services and collection agents within the financial hardship framework. In addition, audit programs should encompass debt recovery files managed by employees, collection agents and claims management services to assess whether adherence to the financial hardship standards is occurring in practice and to identify and address emerging issues and compliance gaps.

RESPONDING TO CATASTROPHES AND DISASTERS

Industry identified an increase in severe weather events as one cause of the growth in claims in 2014–15. During 2014–15, the ICA formally declared several events as catastrophes (**Table 7**).

Table 7: Selected catastrophes and associated claims, 2014–15[16]

Catastrophe	Associated claims
Hailstorm-affected areas of Brisbane and South-East Queensland (27 November 2014)	Policyholders had lodged 100,223 claims for property and motor vehicle damage by 15 January 2015.
Bushfire-affected regions near Adelaide, where properties and vehicles were severely damaged or destroyed (January 2015)	Policyholders had lodged 737 claims by 15 January 2015.
Parts of central Queensland, including Yeppoon and Rockhampton, affected by Severe Tropical Cyclone Marcia (20 February 2015)	Policyholders including businesses had lodged 29,565 claims by 12 March 2015.
Storm-affected parts of New South Wales, including the Central Coast, Hunter, Greater Sydney Metropolitan and Illawarra (22 April 2015)	Policyholders had lodged more than 24,250 claims by 23 April 2015.
Sydney Anzac Day hailstorm (25 April 2015)	Policyholders had lodged more than 9,500 claims by 1 May 2015.
Heavy rain and inundation in south-east Queensland and northern New South Wales (30 April 2015 to 3 May 2015)	Policyholders had lodged 7,500 claims by 4 May 2015.

[16] Media Centre - Insurance Council Australia

CODE COMPLIANCE

Section 4 of the 2012 Code defined the standards that applied to Code Subscribers in circumstances where catastrophes or disasters resulted in large numbers of claims.

Code Subscribers were under a broad obligation to respond to catastrophes and disasters in a fast, professional, practical and compassionate manner (subsection 4.2).

In addition, if a consumer had a property claim resulting from a catastrophe or disaster and a Code Subscriber finalised their claim within one month after the catastrophe or disaster, subsection 4.3 required it to inform the consumer:

- That they had a six month cooling off period to check whether the settlement of their claim included everything that was lost or damaged, and ask the Code Subscriber to review it, if they thought the assessment of their loss was not complete or accurate.
- The cooling-off period was available to the consumer even though they may have signed a release when their claim was finalised (subsection 4.3(a)).
- About its complaints processes (subsection 4.3(b)).

While we did not identify any breaches of the catastrophe standards through our monitoring work in 2014–15, industry reported 27 breaches of section 4 overall, comparable to outcomes for 2013–14.

Almost all of the breaches reported by industry involved subsection 4.3(a), with 26 breaches, while there was one breach of subsection 4.3(b).

Code Subscribers reported that the breaches of subsection 4.3(a) occurred because communications to consumers omitted information about their rights under subsection 4.3(a).

GUIDANCE TO INDUSTRY

While the incidence of non-compliance with section 4 was very low, we recommend that industry continue to closely monitor compliance with section 9, the equivalent standard in the 2014 Code. This is because although section 9 is very similar to the standard in the 2012 Code, it differs in one significant respect. Consumers now have up to 12 months from the date their claims were finalised to ask Code Subscribers to review their claims (subsection 9.3).

Code Subscribers often incorporate information about consumer rights into template documents, used to communicate with consumers at the times prescribed by the Code. It is our experience that templates may be altered by individuals; such modifications to targeted, systems-based template documents can cause unintended changes to other template documents. We recommend that Code Subscribers regularly review template documents to ensure they remain aligned with their Code obligations.

INTERNAL DISPUTES

This chapter focuses on disputes raised by consumers that have entered the second phase of a Code Subscriber's IDR process. It therefore includes some analysis of how internal dispute data aligns with FOS's data on insurance-related EDR disputes.

The number of internal disputes about general insurance products and services continued to trend downward in 2014–15 (**Table 8**).

Table 8: General insurance classes – internal disputes in 2014–15 compared with 2013–14

GENERAL INSURANCE	***Internal disputes received by industry***	***Internal disputes reviewed by industry***	***Outcomes in favour of Consumers***	***Outcomes in favour of Code Subscribers***
PERSONAL CLASSES	21,719 down 15%	21,424 down 17%	4,503	16,921
COMMERCIAL CLASSES	1,386 down 13%	1,229 down 19%	334	965
ALL CLASSES	23,105 down 15%	22,723 down 18%	4,837	17,886

Overall, internal disputes fell 15% to 23,105. This trend was largely due to a 15% fall in disputes about personal insurance products and services (personal insurance disputes) to 21,719 when compared with 2013–14.[17]

In 2014–15, 22,723 internal disputes completed stage two and Code Subscribers were required to inform consumers of their right to take their disputes to FOS if unhappy with the outcome.

The number of internal disputes that completed stage two with outcomes in favour of consumers fell to 4,837, representing 21% of internal disputes, compared with 30% in 2013–14. In the same period, FOS reported only a slight growth of 1% in the number of general insurance disputes it received from consumers and small businesses.[18]

Most internal disputes that consumers raised with industry were about claims. **Table 9** shows the proportion of internal disputes that were about claims and declined claims.

[17] Financial Ombudsman Service Australia Annual Review 2014–15 at page 63. The Annual Review is available from www.fos.org.au/publications/
[18] See footnote 16.

Table 9: Personal Insurance: internal disputes, claims and declined claims 2014–15 v 2013–14

Personal general insurance classes	All internal disputes received by industry	Number of internal disputes about claims[19]	Internal claims disputes as a % of all internal disputes	Number of internal disputes about declined claims[20]	Internal declined claims disputes as a % of all internal claims disputes
Consumer Credit	309 ᵛ27%	257 ᵛ30%	83% 86%	205 ^1%	80% 55%
Home	7,491 ᵛ16%	5,913 ᵛ9%	79% 72%	3,388 ᵛ19%	57% 64%
Motor	10,678 ᵛ12%	8,838 ᵛ12%	83% 83%	2,149 ᵛ33%	24% 32%
Personal & Domestic Property	855 ᵛ11%	754 ᵛ4%	88% 82%	610 ᵛ2%	81% 79%
Residential Strata	210 ᵛ29%	197 ᵛ30%	94% 95%	152 ᵛ22%	72% 69%
Sickness & Accident	233 ᵛ16%	188 ᵛ25%	81% 91%	161 ᵛ30%	77% 91%
Travel	1,943 ᵛ19%	1,916 ᵛ18%	99% 97%	1,758 ᵛ5%	92% 79%
Total	**21,719** **ᵛ15%**	**18,063** **ᵛ12%**	**83%** **81%**	**8,423** **ᵛ20%**	**47%** **51%**

Internal disputes fell across all classes of personal insurance, resulting in an overall drop of 15% to 21,719 disputes. Internal disputes about claims accounted for 83% of all personal insurance disputes during 2014–15, relatively unchanged compared with 2013–14.

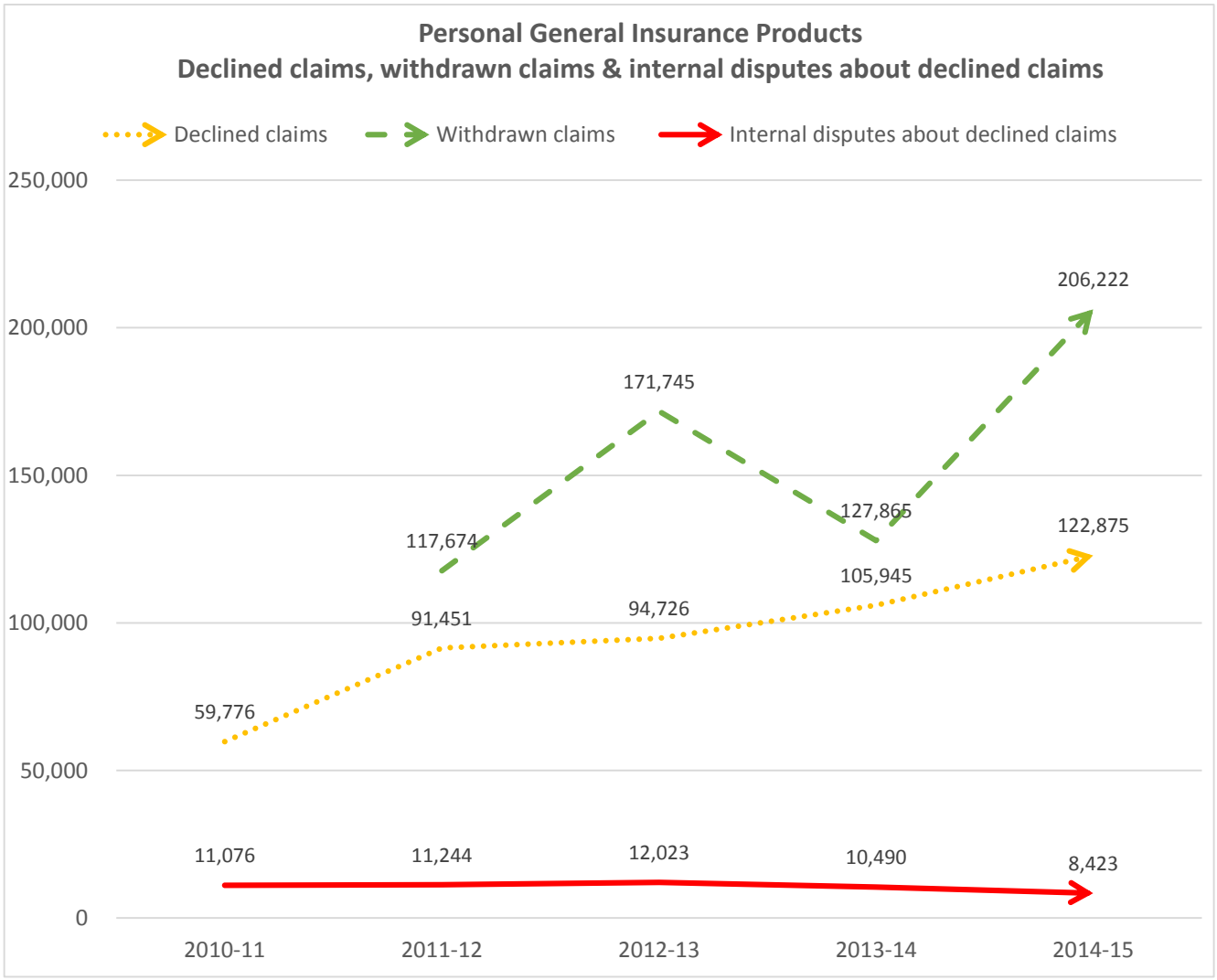
Internal dispute numbers fell because consumers lodged fewer disputes about declined claims. In 2013–14, 51% of internal disputes about claims were specifically about a Code Subscriber's decision to decline a claim. However, the number of internal disputes about declined claims accounted for 47% of disputes about claims, despite a growth of 16% in declined claims. In all classes except Motor most internal claims disputes were specifically about declined claims.

[19] The number of internal disputes about claims is a subset of all internal disputes.
[20] The number of internal disputes about declined claims is a subset of all internal disputes about claim.

We have provided a five year overview in **Graph 1** of trends in declined claims, withdrawn claims and internal disputes about declined claims. The data shows that:

- The number of declined claims has continued to climb steadily upwards.
- The number of withdrawn claims has moved sharply upwards (the exception was 2013–14 when some Code Subscribers who had previously reported withdrawn claims data were not able to do so for that period).[21]
- The number of internal disputes about declined claims has consistently fallen since 2012–13. Industry reported that one of the key factors influencing the number of internal disputes in 2012–13, was an increase in the number of Home and Motor claims, due to severe weather events in 2011–12 being closed in 2012–13.[22]

Graph 1: Personal Insurance: internal disputes, claims and declined claims – 5 year trends



[21] *2012 General Insurance Code of Practice, Aggregated industry data report, Overview of the year 2013–14*, see page 9. The report is available from Code Compliance publications :: Financial Ombudsman Service

[22] *General Insurance Code of Practice: Overview of the year 2012–13*, see page 35.

While the number of internal disputes fell, FOS reporting shows that its general insurance disputes remained stable over the same period. FOS accepted 6,780 general insurance disputes in 2014–15, up 1% on 2013. This figure included 6,401 domestic insurance disputes, up 3%. Of FOS's general insurance disputes, 65% were about the financial services provider's (FSP) decision, and in particular its decision to decline a claim.[23] FOS attributed the stability in general insurance disputes to "a reduced level of natural disasters and significant improvements in the industry's internal claims handling and dispute resolution processes."

Similarly, Code Subscribers reported that fewer disputes were escalated to stage two because of improved resolution rates at stage one of the IDR process. Some Code Subscribers attributed improved resolution rates at stage one to the involvement of more experienced or senior staff, while others reported that more consumers chose not to escalate to stage two because they accepted that their claims were not covered.

PERSONAL INSURANCE TRENDS

MOTOR

Motor consistently attracts the largest number of internal disputes overall. In 2014–15 consumers brought 10,678 internal disputes about Motor products and services to industry, accounting for 49% of all personal insurance disputes.

This was consistent with FOS's experience during the same period. FOS reported that consumers most often complained about Motor products and services, accounting for 38% of domestic insurance disputes in 2014–15.[24]

Although the proportion of internal disputes about Motor claims remained steady, the number of internal disputes about claims fell 12% to 8,838. Of these internal claims disputes, 24% (2,149) were about a decision to decline a Motor claim. Interestingly, this one-third decrease in internal disputes about declined Motor claims, occurred in the same year that industry declined 26% more Motor claims.

As in 2013–14, Motor was the only class where the majority of internal disputes about claims did not involve a Code Subscriber's decision to decline a claim.

HOME

Consumers escalated 7,491 internal disputes to industry about Home products and services in 2014–15, accounting for 34% of all personal insurance disputes, down 16% compared with 2013–14. Of these internal disputes, 5,913 were about Home claims, representing 79% of disputes in this class, compared with 72% in 2013–14. At the same time, consumers raised 19% fewer internal disputes about declined Home claims – 3,388 – despite a 19% increase in declined Home claims.

Home is the second largest source of internal disputes and again this is consistent with FOS's experience during the same period, where 31% of domestic insurance disputes involved Home products and services.[25]

[23] Financial Ombudsman Service Australia Annual Review 2014–15 at pages 63 - 64. The Annual Review is available from www.fos.org.au/publications/annual-review.jsp.
[24] Financial Ombudsman Service Australia Annual Review 2014–15 at page 64. See footnote above for website details.
[25] Financial Ombudsman Service Australia Annual Review 2014–15 at page 64. The Annual Review is available from www.fos.org.au/publications/annual-review.jsp.

TRAVEL

Internal disputes about Travel products and services fell 19% to 1,943 and almost all disputes were about claims, down 18%. Of the 1,943 internal disputes about Travel claims, 92% were about declined claims, compared with 79% in the previous period. Travel was one of three classes where the number of internal disputes about declined claims remained fairly stable.

Travel represented the third largest source of internal disputes, which was also consistent with FOS's experience in 2014–15. FOS stated in its 2014–15 Annual Review that the number of disputes about Travel increased 34% and were largely about a decision to deny a claim.[26]

PERSONAL & DOMESTIC PROPERTY

While the number of internal disputes about Personal & Domestic Property products and services fell 11% to 855, the number of internal disputes about claims – 754 – remained steady.

Despite a 16% increase in declined Personal & Domestic Property claims to 38,275, only 610 internal disputes were about declined claims, almost the same as in 2013–14.

CONSUMER CREDIT

Internal Consumer Credit disputes fell 27% to 309 and this included 257 disputes about claims, down 30% against 2013–14 data.

However the number of internal disputes about declined Consumer Credit claims remained unchanged at 205, even though industry declined 5,102 Consumer Credit claims, up 35%.

SICKNESS & ACCIDENT

The data shows a 16% fall in the number of internal disputes about Sickness & Accident products and services. In particular, consumers raised 188 disputes about claims, down 25%.

Of the 188 internal claims disputes, 161 were about declined Sickness & Accident claims, which was down 30% despite a 138% increase in declined claims to 3,702.

RESIDENTIAL STRATA

Internal Residential Strata disputes fell 29% to 210, driven by a 30% fall in disputes about claims and in particular a 22% fall in disputes about declined claims.

Residential Strata was the only class where the trend in internal disputes mirrored the trend in claims and declined claims, which were also down compared to 2013–14.

[26] Financial Ombudsman Service Australia Annual Review 2014–15 at page 64. See footnote above for website details.

CODE COMPLIANCE

Section 6 of the 2012 Code required that Code Subscribers have an internal dispute resolution (IDR) process to deal with consumer complaints and disputes.[27] The IDR process comprised an internal complaints phase (stage one) and an internal disputes phase (stage two).

The 2012 Code also prescribed that Code Subscribers must inform consumers of their right to refer an unresolved dispute (stage two) to FOS's external dispute resolution (EDR) process.[28]

Industry received 21,719 internal personal insurance disputes and completed stage two reviews of 21,424 internal personal insurance disputes during 2014–15. Over the same period, industry identified and addressed 230 breaches of section 6 of the 2012 Code, which prescribed standards for the handling of complaints and disputes. Breaches of section 6 accounted for 6% of all breaches identified by industry in 2014–15, compared with 20% of breaches reported in 2013–14.

Industry reported 73 breaches of subsection 6.2, which required Code Subscribers to respond to a consumer's complaint within 15 business days provided no further information or investigation was needed. This was the largest area of non-compliance.

Some Code Subscribers reported that they did not meet the 15 business day timeframe because employees or service providers did not identify the consumer's concerns as a complaint. Other Code Subscribers indicated that delays occurred because employees or service providers did not follow IDR processes or because they lacked sufficient resources to deal with complaints within the required timeframe.

Industry addressed this non-compliance by expediting complaint reviews, contacting affected consumers, reinforcing with staff the requirements of IDR processes including the definition of "complaint" and increasing staff resources.

The data also shows that industry identified 55 breaches of subsection 6.1.2, which required Code Subscribers to make available to consumers information about their complaints handling procedures. This was a substantial increase from 28 breaches in 2013–14.

Some Code Subscribers reported that the non-compliance occurred because employees or service providers did not adhere to their IDR procedures. Code Subscribers dealt with this issue by providing information about their complaints processes to affected consumers and reinforcing IDR requirements and procedures with employees or service providers.

GUIDANCE TO INDUSTRY

Overall the data shows that industry identified fewer instances of non-compliance with complaints handling standards. However, industry should remain vigilant in monitoring compliance with the complaints handling standards under the 2014 Code.

The quality of a Code Subscriber's internal complaints handling processes will determine the quality of a consumer's experience and, importantly, help them to decide whether to pursue their concerns further.

Industry's internal processes for handling consumer complaints and unresolved complaints must now meet the enhanced standards in section 10 of the 2014 Code. These standards are based on the

[27] The 2012 Code provided that insureds and third parties (in defined circumstances) could raise complaints or disputes with Code Subscribers.
[28] Acceptance of a dispute by FOS is dependent on its Terms of Reference. For more information about FOS's EDR role go to www.fos.org.au.

framework for IDR processes prescribed by ASIC Regulatory Guide 165, embodying guiding principles including visibility, accessibility, responsiveness and objectivity.[29]

Efficient, fair, timely and transparent IDR processes are critical in ensuring that consumers have an opportunity to challenge any aspect of their relationship with industry and that they can access such processes readily. This includes options for external dispute resolution, such as through FOS, if a customer is unhappy with the outcome of IDR.

Consequently, industry should ensure that IDR processes are adequately resourced. This includes appointing appropriately skilled staff to review complaints and unresolved complaints and supporting them to carry out these functions within the requirements of the Code.

[29] ASIC Regulatory Guide 165 Licensing: Internal and external dispute resolution and Australian Standard AS ISO 10002–2006 Customer satisfaction—Guidelines for complaints handling in organizations. This available here RG 165 Licensing: Internal and external dispute resolution | ASIC - Australian Securities and Investments Commission.

INDUSTRY COMPLIANCE INITIATIVES

During 2014–15 industry transitioned to their obligations under the new 2014 Code prior to beginning operations from 1 July 2015. Industry implemented specific initiatives to ensure a successful transition.

At the same time, industry continued to monitor compliance with their obligations under the outgoing 2012 Code and implemented a range of initiatives to enhance and strengthen existing risk and compliance frameworks. We have summarised those initiatives here.

PREPARING FOR OPERATIONS UNDER THE NEW 2014 CODE

- Benchmarked existing procedures against Code requirements and developed project teams and plans to work on implementation of the required changes.
- Developed new Code training materials for all employees, Authorised Representatives and Service Suppliers.
- Implemented specific training on Financial Hardship for claims recovery teams and provided Code training to employees and Authorised Representatives.
- Removed outdated material and templates from circulation.
- Reviewed current business documents, practices and processes, including financial hardship policies, complaints handling procedures and training materials, to identify requirements and implement changes.
- Reviewed and revised all consumer correspondence to ensure that advice is clear, succinct and compliant.
- Updated contracts with Authorised Representatives and service suppliers, telephone scripting and websites.
- Worked with stakeholders to identify requirements and implement changes including conducting onsite reviews of service suppliers' compliance measures.

CLAIMS HANDLING

- Developed and implemented new reports for pending claims to ensure timely follow-ups within Code timeframes and new and more robust reporting requirements for claims.
- Established severe weather response centres with additional staff resources to support consumers affected by such events and increased claims staff numbers to handle large influxes of claims, particularly during times of severe weather events.
- Implemented a new claims system that provides automated alerts, which creates a task in the case officer's work queue. Management monitors the reports of the completion of these tasks on a daily basis.

COMPLAINTS HANDLING

- Developed/enhanced complaints dashboards to highlight matters for escalation by risk & compliance teams.
- Developed and launched a new complaints tool and utilised a claims system to record complaints and internal disputes data.
- Developed and implemented new reports for pending complaints to ensure timely follow-ups within Code timeframes.
- Implemented a consumer feedback reporting system to record consumer queries that were resolved satisfactorily at the first point of contact where the consumer has not requested a written response.
- Standardised complaints handling procedures and complaints recording across businesses.

STAFF DEVELOPMENT AND TRAINING

- Developed new e-learning modules for employees on a range of requirements.
- Promoted awareness of a system used as a key compliance tool by a compliance team and key business stakeholders.
- Provided training for employees on incident/breach management and reporting systems and tools.
- Provided further training for employees and external service suppliers on complaints and disputes procedures and Financial Hardship.
- Reinforced internal policies, procedures and Code knowledge through tailored coaching with business areas and individual employees.

COMPLIANCE AND RISK SYSTEMS AND PROCESSES

- Appointed a chief risk officer to work with senior management in developing, implementing, maintaining and enhancing the risk management framework for the business.
- Developed an anti-fraud policy and incorporated it into the business's fraud and misconduct policy.
- Developed a new framework for risk and compliance; enhanced an existing system for use as a risk management tool including legislative requirements, regulations and Codes; and introduced a new electronic investigative tool to strengthen a compliance monitoring team's operations.
- Enhanced an incident management framework; improved breach/incident reporting and management by revising processes to incorporate a new incident log system and revisions to the breach reporting procedures; and updated a compliance breaches/incidents policy.
- Introduced call recording and transferred responsibility for call monitoring and file testing for insurance operations to a dedicated quality assurance team.
- Revised and rolled out a compliance framework to uplift knowledge of the current compliance environment and key regulatory obligations, including Code obligations.
- Rolled out incident/breach management and reporting systems and tools across intermediaries.

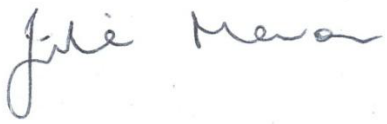
COMPLIANCE & RISK REVIEWS, REPORTING & ANALYSIS

- Conducted quarterly Code reviews and additional Code reviews on more complex claims; “deep dive” reviews targeting compliance with regulatory obligations including Code obligations; monitoring activities, including KPI and quality management reviews, of outsourced claims and complaints management services; and periodic audits of Authorised Representatives and brokers acting under binder arrangements.
- Implemented a dedicated Code-targeted claim review process within a quality assurance database and reporting methodology, as part of enhancements to a Code of Practice quality assurance program.
- Implemented self-assessed compliance questionnaires across the business including compliance questionnaires for executive management members.
- Implemented monthly exception-based reporting for management which includes incident reporting, compliance updates and operational risk updates.
- Introduced a new annual internal audit of catastrophe claims.
- Provided internet based questionnaires to all Authorised Representatives and Corporate Authorised Representatives requesting assurance for compliance with Code requirements.
- Reported outcomes of compliance reviews to executive management, quality assurance and customer relations teams.

By the Code Governance Committee

Lynelle Briggs AO

Ian Berg



Julie Maron

SCHEDULES

SCHEDULE 1 CURRENT CODE SUBSCRIBERS

General Insurers			
1	AAI Limited	28	MTA Insurance Ltd
2	ACE Insurance Ltd	29	NTI Ltd
3	AIG Australia Ltd	30	OnePath General Insurance Pty Ltd
4	AIOI Nissay Dowa Insurance Company Australia Pty Limited (ADICA)	31	Progressive Direct Insurance Pty Ltd
5	Allianz Australia Insurance Ltd	32	QBE Insurance (Australia) Ltd
6	Ansvar Insurance Ltd	33	QBE Lenders' Mortgage Insurance Ltd
7	Assetinsure Pty Ltd	34	RAA Insurance Ltd
8	Auto & General Insurance Company Ltd	35	RAC Insurance Pty Ltd
9	AVEA Insurance Ltd	36	RACQ Insurance Ltd
10	Calliden Insurance Ltd	37	RACT Insurance Pty Ltd
11	Catholic Church Insurance Ltd	38	Sompo Japan Nipponkoa Insurance Inc
12	CGU Insurance Ltd	39	Southern Cross Benefits Ltd
13	Chubb Insurance Company of Australia Ltd	40	St Andrew's Insurance (Australia) Pty Ltd
14	Commonwealth Insurance Ltd	41	Sunderland Marine Mutual Insurance Company Ltd
15	Credicorp Insurance Pty Ltd	42	Swann Insurance (Aust) Pty Ltd
16	Defence Service Homes Insurance Scheme	43	The Hollard Insurance Company Pty Ltd
17	Factory Mutual Insurance Company	44	The Tokio Marine & Nichido Fire Insurance Co Ltd
18	Genworth Financial Mortgage Insurance Pty Ltd	45	Virginia Surety Company Inc
19	Great Lakes Re-insurance (UK) PLC	46	Wesfarmers General Insurance Ltd

20	Guild Insurance Ltd	47	Westpac General Insurance Ltd
21	Hallmark General Insurance Company Ltd	48	XL Insurance Company Ltd
22	Insurance Australia Ltd	49	Youi Pty Ltd
23	Insurance Manufacturers of Australia Pty Ltd	50	Zurich Australian Insurance Ltd
24	LawCover Insurance Pty Ltd		
25	Lloyd's Australia Ltd		
26	Medical Insurance Australia Pty Ltd		
27	Mitsui Sumitomo Insurance Co Ltd		

	Lloyd's Australia Limited: Participating Coverholders and Claims Administrators		
1	AIS Insurance Brokers Pty Ltd	55	Jardine Lloyd Thompson Pty Ltd
2	AON Risk Services Australia Ltd	56	JMD Ross Insurance Brokers Pty Ltd
3	Arch Underwriting at Lloyd's (Australia) Pty Ltd	57	JUA Underwriting Agency Pty Ltd
4	ASR Underwriting Agencies Pty Ltd	58	Latitude Underwriting Pty Ltd
5	ATC Insurance Solutions Pty Ltd	59	Leisureinsure Australia Pty Ltd
6	Austagencies Pty Ltd	60	Logan Livestock Insurance Agency Pty Ltd
7	Australian Income Protection Pty Ltd	61	London Australia Underwriting Pty Ltd
8	Australian Insurance Agency Pool	62	Magic Millions Insurance Brokers Pty Ltd
9	Australian Warranty Network	63	Manufactured Homes Insurance Agency Pty Ltd
10	Axis Underwriting Services Pty Ltd	64	Marsh Pty Ltd
11	Beazley Underwriting Pty Ltd	65	Millennium Underwriting Agencies Pty Ltd
12	Bizcover Pty Ltd	66	Miramar Underwriting Agency Pty Ltd
13	Blue Badge Insurance Australia	67	Mobius Underwriting Pty Ltd
14	Blue Cube Insurance Group	68	National Franchise Insurance Brokers
15	Blue Sky Insurance Pty Ltd	69	National Underwriting Agencies Pty Ltd
16	Broadspire by Crawford & Co	70	Nautilus Marine Insurance Agency Pty Ltd
17	Brooklyn Underwriting Pty Ltd	71	Newmarket Insurance Brokers Pty Ltd
18	Catlin Australia Pty Ltd	72	Nova Underwriting Pty Ltd
19	Cemac Pty Ltd	73	NWC Insurance Pty Ltd
20	Cerberos Brokers Pty Ltd	74	Offshore Market Placements Limited
21	Cerberus Special Risks Pty Ltd	75	Online Insurance Brokers Pty Ltd
22	Cheap Travel Insurance Pty Ltd	76	Pacific Underwriting Corporation Pty Ltd

23	Cinesure Pty Ltd	77	Panoptic Underwriting Pty Ltd
24	Claims Management Australasia	78	Pantaenius Australia Pty Ltd
25	Columbus Direct Travel Insurance Pty Ltd	79	Parmia Pty Ltd
26	Corporate Services Network Pty Ltd	80	Pen Underwriting Group Pty Ltd
27	Coversure Pty Ltd	81	Pen Underwriting Pty Ltd
28	DLA Piper Australia	82	Proclaim Management Solutions Pty Ltd
29	Dolphin Insurance Pty Ltd	83	Procover Underwriting Agency
30	Dual Australia Pty Ltd	84	Professional Risk Underwriting Pty Ltd
31	East West Insurance Brokers Pty Ltd	85	QBE Placement Solutions Pty Ltd
32	Edge Underwriting Pty Ltd	86	QBE Underwriting Services (Australia) Pty Limited
33	Elkington Bishop Molieaux Brokers Pty Ltd	87	Quanta Insurance Group Pty Ltd
34	Ensurance Underwriting Pty Ltd	88	Resource Underwriting Pacific Pty Ltd
35	Epsilon Underwriting Agencies Pty Ltd	89	Richard Oliver Underwriting Managers Pty Ltd
36	Fitton Insurance (Brokers) Australia Pty Ltd	90	RiskSmart Claims Management (part of Honan Insurance Group
37	Freeman McMurrick Pty Ltd	91	Savannah Insurance Agency Pty Ltd
38	Gallagher Bassett Service Pty Ltd	92	SLE Worldwide Australia Pty Ltd
39	Genesis Underwriting Pty Ltd	93	Specialist Underwriting Agencies Pty Ltd
40	Glenowar Pty Ltd	94	Sportscover Australia Pty Ltd
41	Go Unlimited Pty Limited	95	Starr Underwriting Agents (Asia) Ltd
42	Gow-Gates Insurance Brokers Pty Ltd	96	Sterling Insurances Pty Ltd
43	High Street Underwriting Agency Pty Ltd	97	Sura Hospitality Pty Ltd
44	Holdfast Insurance Brokers	98	Sura Labour Hire Pty Ltd
45	Honan Insurance Group	99	Sura Professional Risks Pty Ltd
46	Hotsure Underwriting Agency Pty Ltd	100	SureSave Pty Ltd
47	HQ Insurance Pty Limited	101	Travel Insurance Direct Pty Ltd
48	HW Wood Australia Pty Ltd	102	Trident Insurance Group Pty Ltd
49	IBL Limited	103	Trinity Pacific Underwriting Agencies Pty Ltd
50	Inglis Insurance Brokers	104	Triton Global (Australia) Ltd
51	Insurance Facilitators Pty Ltd	105	Windsor Income Protection Pty Ltd
52	Insure That Pty Ltd	106	Winsure Underwriting Pty Ltd
53	Ironshore Australia Pty Limited	107	Woodina Underwriting Agency Pty Ltd
54	iSure Pty Ltd	108	World Nomads Group Ltd

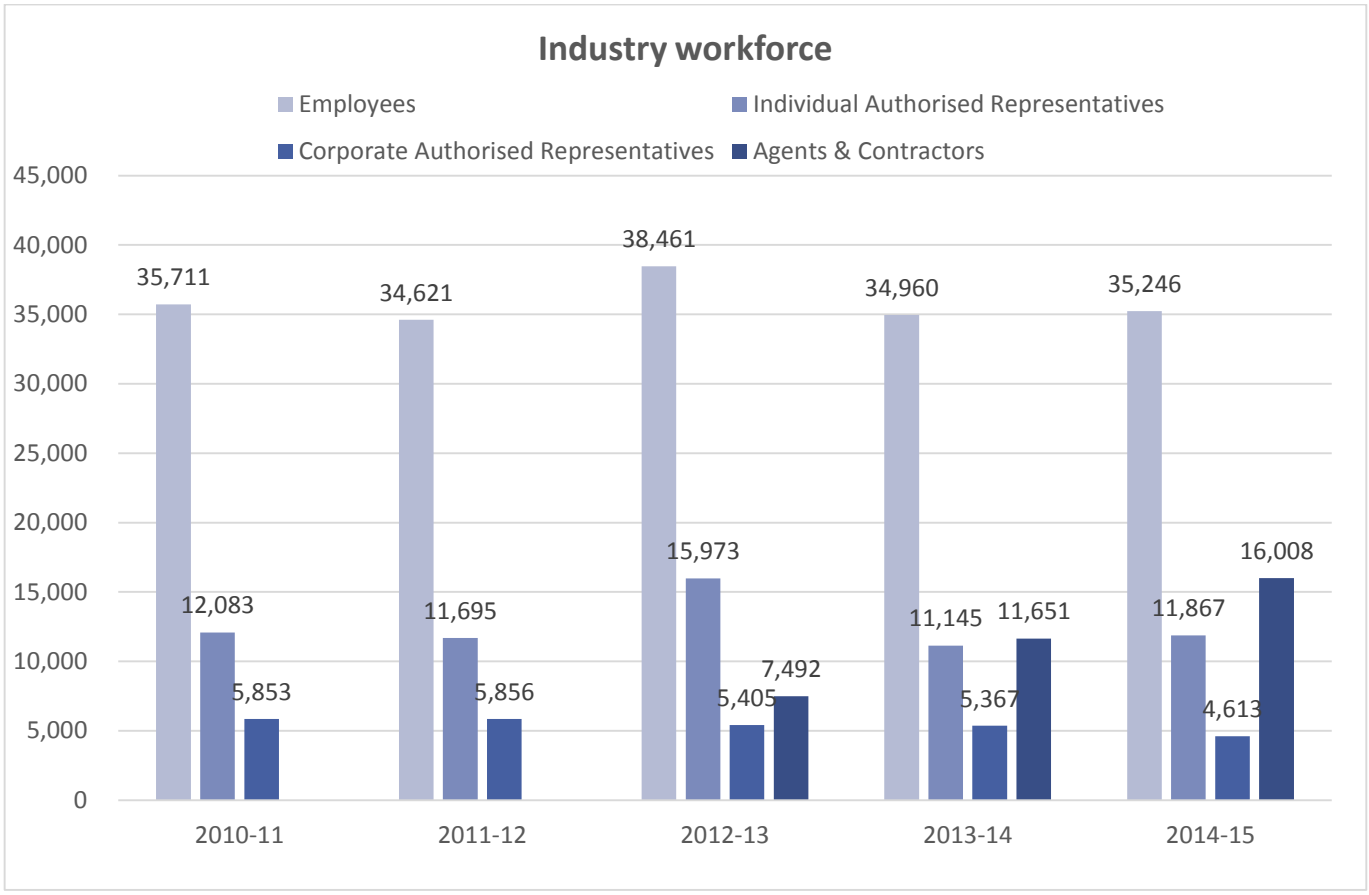
INSURANCE CLASS	POLICIES includes people & assets covered by group policies	CLAIMS	DENIED CLAIMS	WITHDRAWN CLAIMS	DISPUTES LODGED WITH INDUSTRY	DISPTES REVIEWED BY INDUSTRY
GRAND TOTAL	**51,829,110**	**4,240,269**	**129,385**	**217,438**	**23,105**	**22,723**
PERSONAL TOTAL	48,135,084	3,690,113	122,875	206,222	21,719	21,424
COMMERCIAL TOTAL	3,694,026	550,156	6,510	11,216	1,386	1,299
PERSONAL						
Consumer Credit	1,056,237	34,573	5,102	894	309	321
Home	11,179,983	928,330	43,140	89,928	7,491	7,306
Motor	13,632,139	1,882,948	7,946	93,367	10,678	10,604
Personal & Domestic Property	6,730,198	494,504	38,275	7,230	855	817
Residential Strata	203,458	41,195	501	269	210	215
Sickness & Accident	2,621,617	54,811	3,702	165	233	237
Travel	12,711,452	253,752	24,209	14,369	1,943	1,924
PERSONAL TOTAL	**48,135,084**	**3,690,113**	**122,875**	**206,222**	**21,719**	**21,424**
COMMERCIAL						
Business	1,157,482	115,089	2,861	2,729	490	446
Business Pack	510,421	58,568	880	477	171	172
Contractors All Risks	25,036	3,115	32	101	11	8
Industrial Special Risks	62,420	29,532	419	687	37	44
Liability	814,948	34,734	849	525	150	147
Motor	457,200	258,157	601	5,279	260	200
Other	397,059	5,748	121	84	155	154
Primary Industries	168,565	8,959	203	84	36	38
Primary Industries Pack	100,895	36,254	544	1,250	76	90
COMMERCIAL TOTAL	**3,694,026**	**550,156**	**6,510**	**11,216**	**1,386**	**1,299**

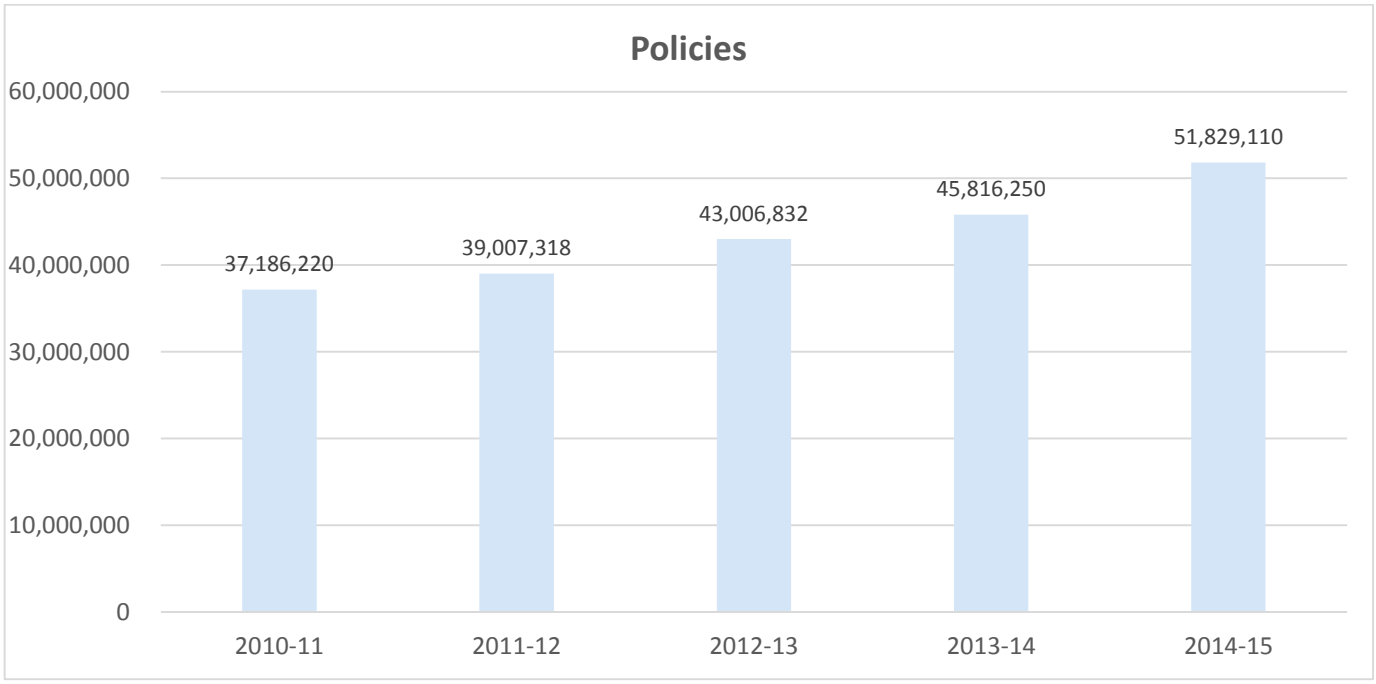
TYPES OF INTERNAL DISPUTES LODGED BY CONSUMERS WITH INDUSTRY IN 2014–15									
INSURANCE CLASS	AUTH REPS	EMPLOYEES	BUYING	CLAIMS	CUSTOMERS FINANCIAL HARDSHIP	THIRD PARTY RECOVERIES FINANCIAL HARDSHIP	CATASTROPHES	PERSONAL INFORMATION	TOTAL
GRAND TOTAL	**31**	**54**	**3,297**	**19,323**	**25**	**301**	**54**	**20**	**23,105**
PERSONAL TOTAL	28	54	3,192	18,063	25	285	53	19	21,719
COMMERCIAL TOTAL	3	0	105	1,260	0	16	1	1	1,386
PERSONAL									
Consumer Credit	0	0	52	257	0	0	0	0	309
Home	0	14	1,511	5,913	6	3	31	13	7,491
Motor	1	37	1,482	8,838	19	281	16	4	10,678
Personal & Domestic Property	0	1	98	754	0	1	0	1	855
Residential Strata	0	1	12	197	0	0	0	0	210
Sickness & Accident	27	0	13	188	0	0	5	0	233
Travel	0	1	24	1,916	0	0	1	1	1,943
PERSONAL TOTAL	**28**	**54**	**3,192**	**18,063**	**25**	**285**	**53**	**19**	**21,719**
COMMERCIAL									
Business	2	0	58	429	0	0	0	1	490
Business Pack	0	0	2	167	0	1	1	0	171
Contractors All Risks	0	0	1	10	0	0	0	0	11
Industrial Special Risks	0	0	3	34	0	0	0	0	37
Liability	0	0	9	141	0	0	0	0	150
Motor	0	0	13	241	0	6	0	0	260
Other	0	0	11	135	0	9	0	0	155
Primary Industries	1	0	5	30	0	0	0	0	36
Primary Industries Pack	0	0	3	73	0	0	0	0	76
COMMERCIAL TOTAL	**3**	**0**	**105**	**1,260**	**0**	**16**	**1**	**1**	**1,386**

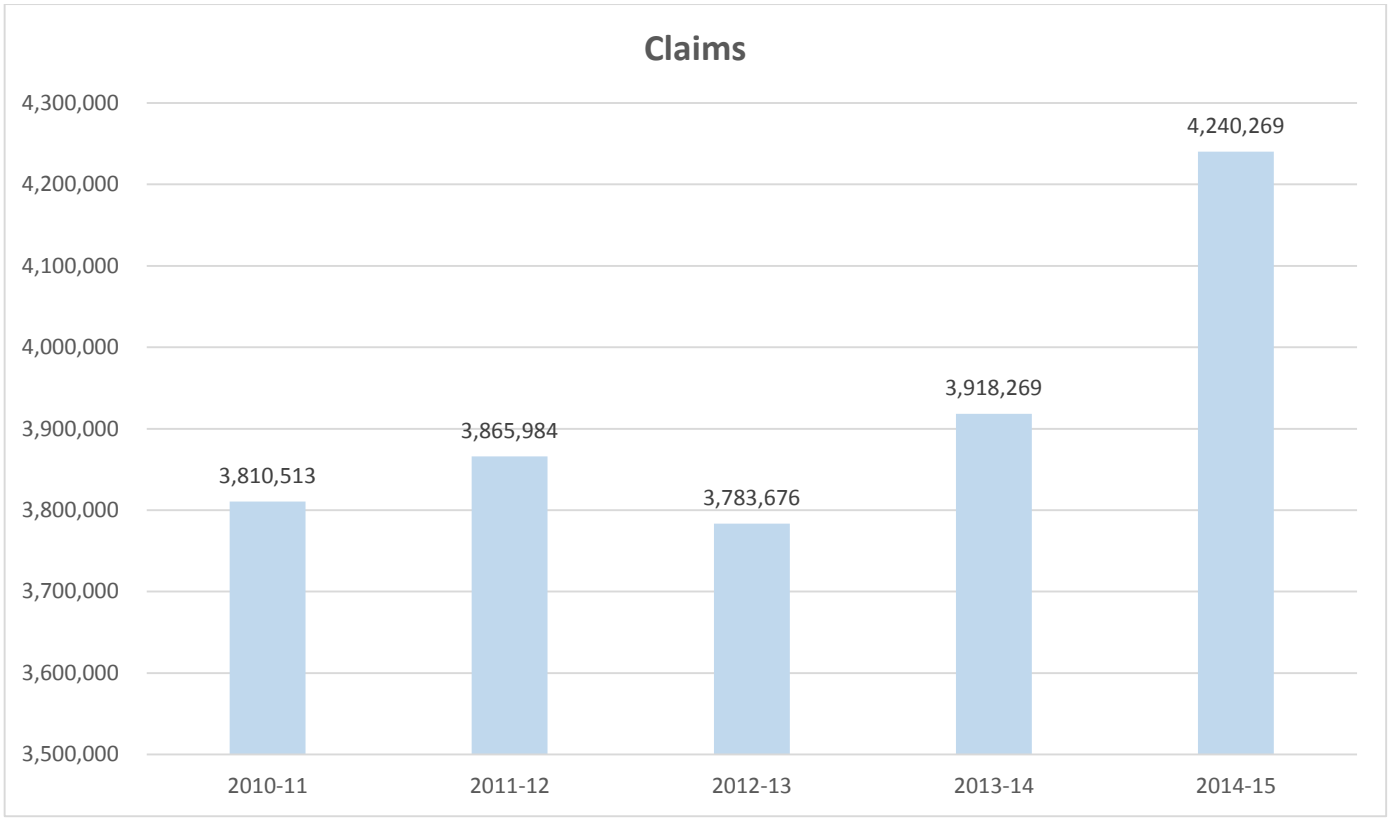
	INTERNAL DISPUTES REVIEWED BY INDUSTRY IN 2014–15 & THEIR OUTCOMES			INTERNAL DISPUTES LODGED WITH INDUSTRY IN 2014–15
INSURANCE CLASS	CODE SUBSCRIBER	CUSTOMER	TOTAL	TOTAL
GRAND TOTAL	**17,886**	**4,837**	**22,723**	**23,105**
PERSONAL TOTAL	**16,921**	**4,503**	**21,424**	**21,719**
COMMERCIAL TOTAL	**965**	**334**	**1,299**	**1,386**
PERSONAL				
Consumer Credit	206	115	321	309
Home	5,483	1,823	7,306	7,491
Motor	8,800	1,804	10,604	10,678
Personal & Domestic Property	601	216	817	855
Residential Strata	127	88	215	210
Sickness & Accident	176	61	237	233
Travel	1,528	396	1,924	1,943
PERSONAL TOTAL	**16,921**	**4,503**	**21,424**	**21,719**
COMMERCIAL				
Business	358	88	446	490
Business Pack	108	64	172	171
Contractors All Risks	7	1	8	11
Industrial Special Risks	25	19	44	37
Liability	115	32	147	150
Motor	161	39	200	260
Other	112	42	154	155
Primary Industries	28	10	38	36
Primary Industries Pack	51	39	90	76
COMMERCIAL TOTAL	**965**	**334**	**1,299**	**1,386**

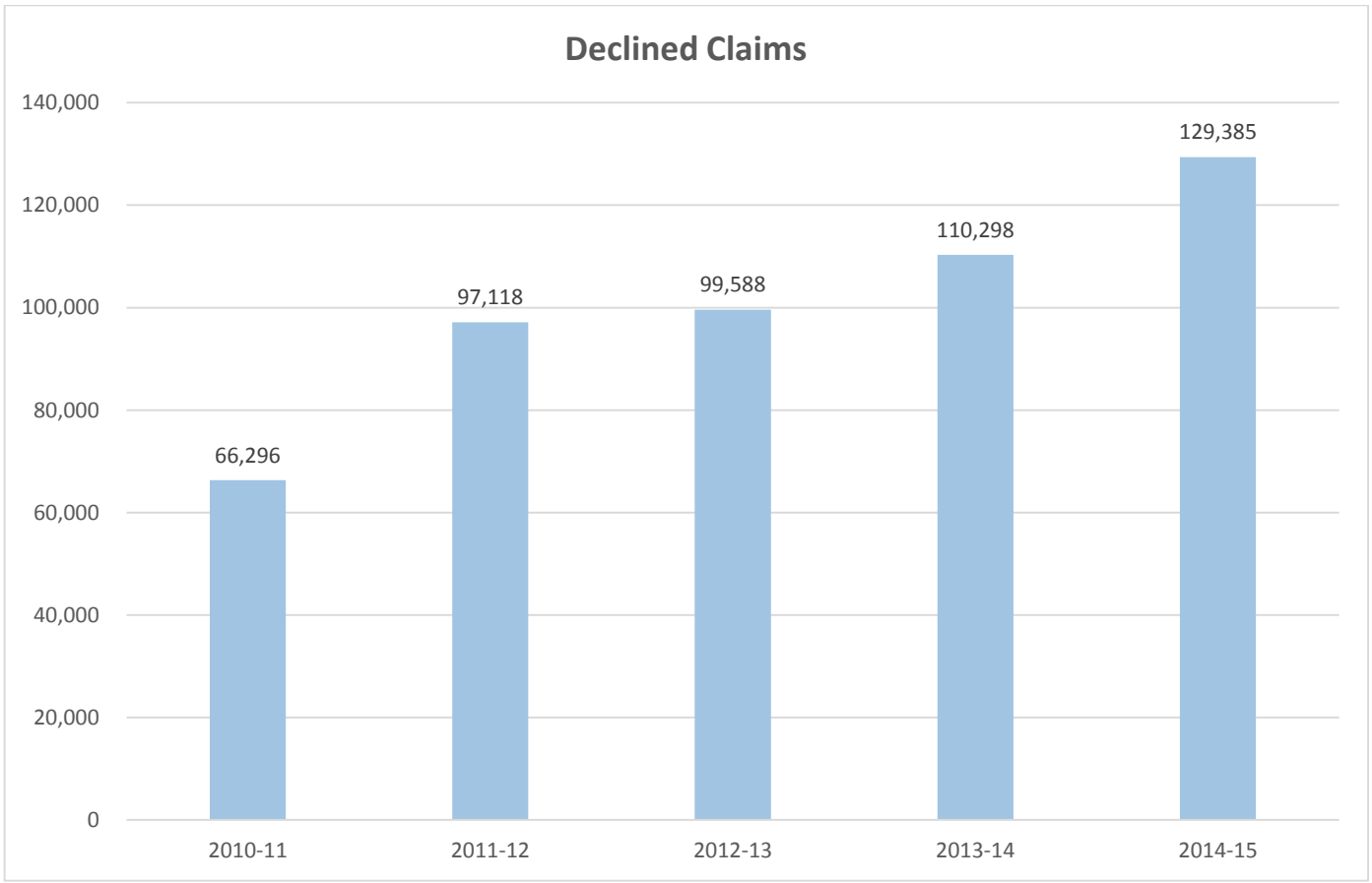
SCHEDULE 3 INDUSTRY DATA – 5 YEAR OVERVIEW

Note: We did not collect data about Agents & Contractors before 2012–13.

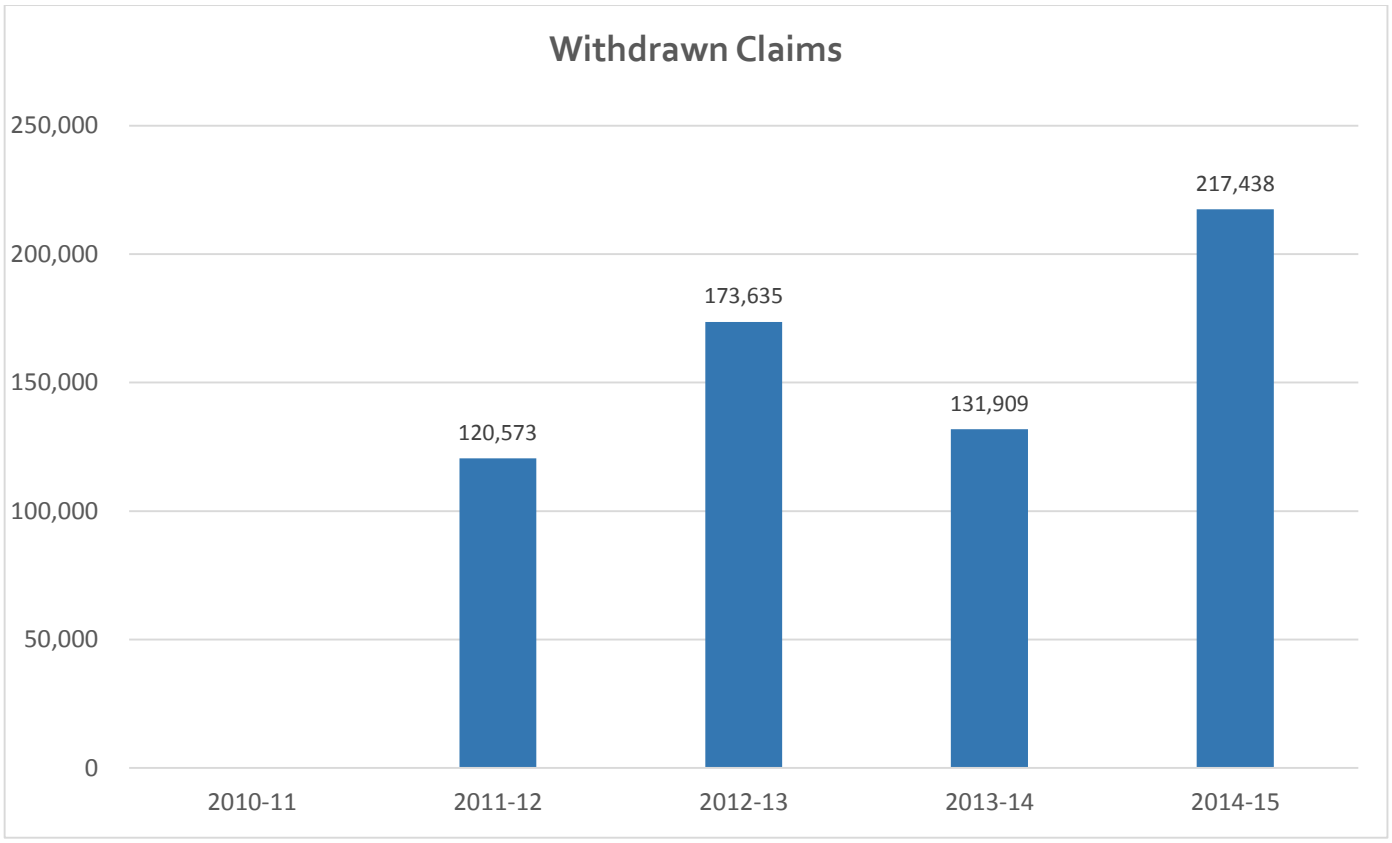


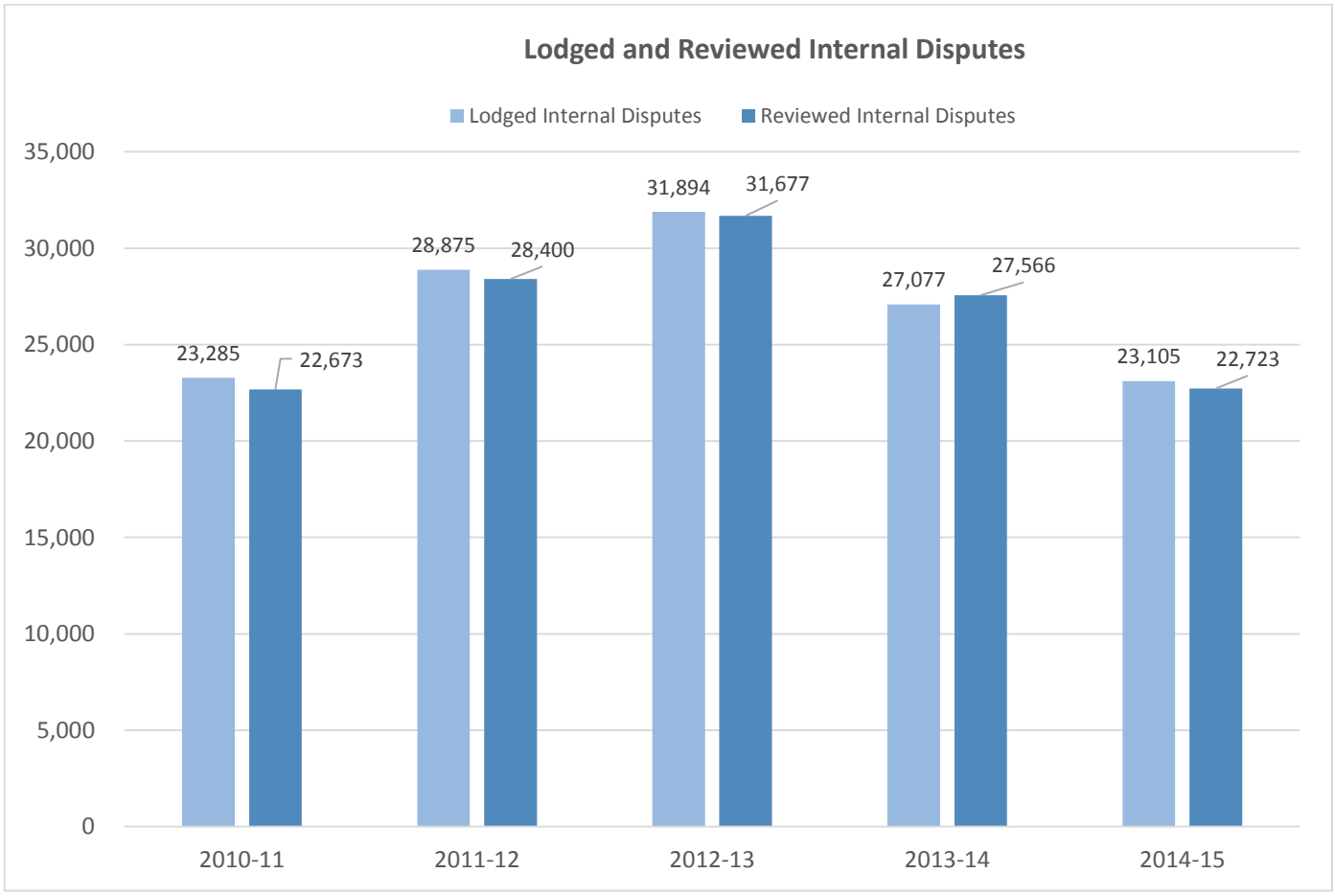



Claims
4,300,000
4,200,000
4,100,000
4,000,000
3,900,000
3,800,000
3,700,000
3,600,000
3,500,000
3,810,513
3,865,984
3,783,676
3,918,269
4,240,269
2010-11
2011-12
2012-13
2013-14
2014-15


Declined Claims
140,000
120,000
100,000
80,000
60,000
40,000
20,000
0
66,296
97,118
99,588
110,298
129,385
2010-11
2011-12
2012-13
2013-14
2014-15

Note: We did not collect data about withdrawn claims before 2011–12.





SCHEDULE 4 INDUSTRY IDENTIFIED & REPORTED CODE BREACHES 2014–15

Industry's top 5 areas of non-compliance in 2014–15		
Code Section	Description	Number of breaches
3.2.3	Update customer on claim progress	693
3.1	Make a claim decision & inform customer of decision within 10 business days if no further information, assessment or investigation is needed	521
2.4.1	Employees & Authorised Representatives will conduct their sales services honestly, efficiently, fairly and transparently	435
3.2.5	Within 10 business days of gathering all information and completing investigation, make a claim decision and notify customer	232
3.5.5(a)	If a claim is denied provide reasons in writing to a customer	217

All breaches identified and remedied by industry in 2014–15		
Code Section	Description	Number of breaches
2.1.2	Customer has right to access information relied on in assessing their insurance application and correct mistakes or inaccuracies	1
2.1.3	Take action to correct error/mistake in assessing an insurance application	102
2.1.4	Conduct sales process in a fair, honest & transparent manner	22
2.1.5(b)	If unable to provide cover, refer customer to another insurer/ICA/NIBA for alternative insurance	110
2.2	Refund (if applicable) premium within 15 business days if customer has cancelled cover	80
2.3	Product & Code information will be available when buying insurance and on request	29
2.4.1	Employees & Authorised Representatives will conduct their sales services honestly, efficiently, fairly and transparently	435
2.4.3	Authorised Representatives will inform customer of the services they have been asked to perform	2
2.4.4	Functions of Employees & Authorised Representatives must match their expertise	11
2.4.5	Functions of Employees & Authorised Representatives must match their expertise	1
2.4.6(c)	Training of Employees & Authorised Representatives must be adequate	2
3.1	Make a claim decision & inform customer of decision within 10 business days if no further information, assessment or investigation is needed	521

3.2.1(a)	Within 10 business days of receiving claim, notify customer of required information	184
3.2.1(b)	Within 10 business days of receiving claim, appoint loss assessor/adjuster	12
3.2.1(c)	Within 10 business days of receiving claim, provide initial time estimate to make claim decision	148
3.2.2	Notify customer of appointment of loss assessor/adjustor/investigator within 5 business days	33
3.2.3	Update customer on claim progress at least every 20 business days	693
3.2.4	Respond to customer's routine requests for information within 10 business days	96
3.2.5	Within 10 business days of gathering all information and completing investigation, make a claim decision and notify customer	232
3.3	Agree on alternative timeframes for claims benchmarks & if unable to, customer has right to access complaints process	171
3.4.1(a)	Make a decision to accept/deny claim within 4 months if no exceptional circumstances	12
3.4.1(b)(i)	If a claim decision is not made within 4 months inform customer in writing of right to access IDR	12
3.4.1(b)(ii)	If a claim decision is not made within 4 months inform customer in writing of right to escalate to EDR	10
3.4.3(a)	If customer asks whether a claim is covered by a policy ask whether they wish to lodge a claim	2
3.4.3(c)	If customer asks whether a claim is covered by a policy must not discourage them from lodging claim	62
3.4.4	External expert to provide report within 12 weeks and if there is a delay provide customer with progress updates	2
3.5.1	Conduct claims handling in fair, transparent and timely manner	124
3.5.2	Ask for and take into account relevant information when deciding claim	127
3.5.3	Customer has a right to access information used to assess a claim	6
3.5.4	Take action to correct error/mistake in assessing a claim	5
3.5.5(a)	If a claim is denied provide reasons in writing to a customer	217
3.5.5(b)(i)	If a claim is denied inform the customer of right to access information used to assess claim	2
3.5.5(b)(ii)	If a claim is denied inform the customer of right to ask for a review of a decision to refuse access	3
3.5.5(c)	If a claim is denied provide the customer with information about complaints handling procedures	3
3.7.1	Employees & Service Providers to conduct claims services honestly, efficiently, fairly & transparently	9
3.7.2	Service Providers must notify Code Subscriber of any complaint received against them	2

3.8(a)	Fast-track claim assessment and decision process when customer is in financial hardship	7
3.8(b)	Make an advance payment within 5 business days to alleviate immediate customer financial hardship	5
3.7.11	Code Subscriber must handle complaints relating to or received by Service Providers under its complaints handling procedures	1
3.13(a)	If unable to reach agreement on debt repayment give information to the person about complaints procedures	1
4.2	Respond to catastrophes and disasters in a fast, professional, practical way and in a compassionate manner	12
4.3(a)	If a claim is settled within one month of a catastrophe/disaster inform customer of right of review	14
4.3(b)	If a claim is settled within one month of a catastrophe/disaster inform customer of complaints processes	1
5.1	Code Subscriber must support industry initiatives aimed at explained general insurance to consumers and the community	1
5.2(c)	Make readily available information about key premium factors	9
5.2(d)	Make readily available information about Code and its operation	9
6.1.1	Conduct complaints handling in a fair, transparent and timely manner	23
6.1.2	Make available information about complaints handling procedures.	55
6.1.4	Customer has right to access information relied on in assessing their complaint and correct mistakes or inaccuracies	1
6.1.5	Take action to correct error/mistake in assessing a complaint	5
6.2	Respond to a complaint within 15 business days if no further information or investigation is needed	73
6.3	Agree on alternative timeframes if unable to respond within timeframe. If unable to agree treat the complaint as a dispute	1
6.4	Keep customer informed of progress	3
6.5	When responding to a complaint provide information about the next step	1
6.6 (a)	Must treat a complaint as dispute if a customer wants the response to the complaint reviewed	9
6.6(c)	Must respond to a dispute within 15 business days	5
6.8	Provide progress updates to the customer	43
6.10	If unable to resolve complaint within 45 days inform a customer of delay and right to refer to EDR	11
	Grand Total	**3,773**

SCHEDULE 5 GENERAL INSURANCE POLICIES 2014–15 & 2013–14

Note: The number of policies includes the number of people or assets covered by group policies.

POLICIES

INSURANCE CLASS	2014-15	2013-14	DIFFERENCE	VARIANCE
PERSONAL				
Consumer Credit	1,056,237	1,042,586	13,651	1%
Home	11,179,983	10,901,783	278,200	3%
Motor	13,632,139	13,274,831	357,308	3%
Personal & Domestic Property	6,730,198	6,481,045	249,153	4%
Residential Strata	203,458	145,424	58,034	40%
Sickness & Accident	2,621,617	2,560,921	60,696	2%
Travel	12,711,452	7,392,489	5,318,963	72%
PERSONAL TOTAL	**48,135,084**	**41,799,079**	**6,336,005**	**15%**
COMMERCIAL				
Business	1,157,482	1,568,972	-411,490	-26%
Business Pack	510,421	NO DATA	NO DATA	NO DATA
Contractors All Risks	25,036	34,532	-9,496	-27%
Industrial Special Risks	62,420	59,280	3,140	5%
Liability	814,948	1,238,628	-423,680	-34%
Motor	457,200	485,285	-28,085	-6%
Other	397,059	375,181	21,878	6%
Primary Industries	168,565	255,293	-86,728	-34%
Primary Industries Pack	100,895	NO DATA	NO DATA	NO DATA
COMMERCIAL TOTAL	**3,694,026**	**4,017,171**	**-323,145**	**-8%**
GRAND TOTAL	**51,829,110**	**45,816,250**	**6,012,860**	**13%**

SCHEDULE 6 GENERAL INSURANCE CLAIMS 2014–15 & 2013–14

CLAIMS

INSURANCE CLASS	2014-15	2013-14	DIFFERENCE	VARIANCE
PERSONAL				
Consumer Credit	34,573	26,237	8,336	32%
Home	928,330	714,768	213,562	30%
Motor	1,882,948	1,875,728	7,220	0%
Personal & Domestic Property	494,504	441,116	53,388	12%
Residential Strata	41,195	55,147	-13,952	-25%
Sickness & Accident	54,811	48,894	5,917	12%
Travel	253,752	248,801	4,951	2%
PERSONAL TOTAL	**3,690,113**	**3,410,691**	**279,422**	**8%**
COMMERCIAL				
Business	115,089	124,656	-9,567	-8%
Business Pack	58,568	NO DATA	NO DATA	NO DATA
Contractors All Risks	3,115	5,921	-2,806	-47%
Industrial Special Risks	29,532	20,450	9,082	44%
Liability	34,734	41,998	-7,264	-17%
Motor	258,157	260,751	-2,594	-1%
Other	5,748	7,644	-1,896	-25%
Primary Industries	8,959	46,158	-37,199	-81%
Primary Industries Pack	36,254	NO DATA	NO DATA	NO DATA
COMMERCIAL TOTAL	**550,156**	**507,578**	**42,578**	**8%**
GRAND TOTAL	**4,240,269**	**3,918,269**	**322,000**	**8%**

SCHEDULE 7 DECLINED GENERAL INSURANCE CLAIMS 2014–15 & 2013–14

DECLINED CLAIMS

INSURANCE CLASS	2014-15	2013-14	DIFFERENCE	VARIANCE
PERSONAL				
Consumer Credit	5,102	3,791	1,311	35%
Home	43,140	36,213	6,927	19%
Motor	7,946	6,282	1,664	26%
Personal & Domestic Property	38,275	32,930	5,345	16%
Residential Strata	501	905	-404	-45%
Sickness & Accident	3,702	1,553	2,149	138%
Travel	24,209	24,271	-62	-0%
PERSONAL TOTAL	**122,875**	**105,945**	**16,930**	**16%**
COMMERCIAL				
Business	2,861	1,996	865	43%
Business Pack	880	NO DATA	NO DATA	NO DATA
Contractors All Risks	32	78	-46	-59%
Industrial Special Risks	419	416	3	1%
Liability	849	627	222	35%
Motor	601	714	-113	-16%
Other	121	143	-22	-15%
Primary Industries	203	379	-176	-46%
Primary Industries Pack	544	NO DATA	NO DATA	NO DATA
COMMERCIAL TOTAL	**6,510**	**4,353**	**2,157**	**50%**
GRAND TOTAL	**129,385**	**110,298**	**19,087**	**17%**

SCHEDULE 8 WITHDRAWN GENERAL INSURANCE CLAIMS 2014–15 & 2013–14

WITHDRAWN CLAIMS				
INSURANCE CLASS	**2014-15**	**2013-14**	**DIFFERENCE**	**VARIANCE**
PERSONAL				
Consumer Credit	894	1,126	-232	-21%
Home	89,928	52,423	37,505	72%
Motor	93,367	63,578	29,789	47%
Personal & Domestic Property	7,230	5,235	1,995	38%
Residential Strata	269	159	110	69%
Sickness & Accident	165	1,064	-899	-84%
Travel	14,369	4,280	10,089	236%
PERSONAL TOTAL	**206,222**	**127,865**	**78,357**	**61%**
COMMERCIAL				
Business	2,729	2,326	403	17%
Business Pack	477	NO DATA	NO DATA	NO DATA
Contractors All Risks	101	27	74	274%
Industrial Special Risks	687	254	433	170%
Liability	525	271	254	94%
Motor	5,279	869	4,410	507%
Other	84	139	-55	-40%
Primary Industries	84	158	-74	-47%
Primary Industries Pack	1,250	NO DATA	NO DATA	NO DATA
COMMERCIAL TOTAL	**11,216**	**4,044**	**7,172**	**177%**
GRAND TOTAL	**217,438**	**131,909**	**85,529**	**65%**

INTERNAL DISPUTES

INSURANCE CLASS	2014-15	2013-14	DIFFERENCE	VARIANCE
PERSONAL				
Consumer Credit	309	426	-117	-27%
Home	7,491	8,942	-1,451	-16%
Motor	10,678	12,189	-1,511	-12%
Personal & Domestic Property	855	957	-102	-11%
Residential Strata	210	297	-87	-29%
Sickness & Accident	233	276	-43	-16%
Travel	1,943	2,399	-456	-19%
PERSONAL TOTAL	**21,719**	**25,486**	**-3,767**	**-15%**
COMMERCIAL				
Business	490	676	-186	-28%
Business Pack	171	NO DATA	NO DATA	NO DATA
Contractors All Risks	11	14	-3	-21%
Industrial Special Risks	37	75	-38	-51%
Liability	150	138	12	9%
Motor	260	341	-81	-24%
Other	155	150	5	3%
Primary Industries	36	197	-161	-82%
Primary Industries Pack	76	NO DATA	NO DATA	NO DATA
COMMERCIAL TOTAL	**1,386**	**1,591**	**-205**	**-13%**
GRAND TOTAL	**23,105**	**27,077**	**-3,972**	**-15%**

SCHEDULE 10 INTERNAL DISPUTES REVIEWED BY INDUSTRY 2014–15 & 2013–14

REVIEWED INTERNAL DISPUTES

INSURANCE CLASS	2014-15	2013-14	DIFFERENCE	VARIANCE
PERSONAL				
Consumer Credit	321	441	-120	-27%
Home	7,306	9,274	-1,968	-21%
Motor	10,604	12,272	-1,668	-14%
Personal & Domestic Property	817	982	-165	-17%
Residential Strata	215	319	-104	-33%
Sickness & Accident	237	280	-43	-15%
Travel	1,924	2,389	-465	-19%
PERSONAL TOTAL	**21,424**	**25,957**	**-4,533**	**-17%**
COMMERCIAL				
Business	446	650	-204	-31%
Business Pack	172	NO DATA	NO DATA	NO DATA
Contractors All Risks	8	14	-6	-43%
Industrial Special Risks	44	76	-32	-42%
Liability	147	140	7	5%
Motor	200	350	-150	-43%
Other	154	165	-11	-7%
Primary Industries	38	214	-176	-82%
Primary Industries Pack	90	NO DATA	NO DATA	NO DATA
COMMERCIAL TOTAL	**1,299**	**1,609**	**-310**	**-19%**
GRAND TOTAL	**22,723**	**27,566**	**-4,843**	**-18%**

SCHEDULE 11 GLOSSARY OF TERMS

Claims: This data consists of the number of all claims lodged with Code Subscribers during the reporting period. We asked Code Subscribers to ensure that this data excluded possible claims or enquiries about claims and withdrawn claims.

Commercial Other: This class includes (but is not limited to) commercial insurance products such as aviation property, home warranty and lenders mortgage insurance products.

Declined claims: This data consists of the number of all claims that Code Subscribers declined (or refused) during the reporting period. It does not include data about withdrawn claims or claims that Code Participants have partially declined/accepted.

Home: This class of personal insurance comprises Home Building, Home Contents, combined Home Building & Contents products and Landlord personal insurance products.

Internal disputes: We have collected two types of data about internal disputes from Code Participants as follows:

- The number of internal disputes lodged with Code Subscribers: This is the number of disputes lodged by consumers with Code Subscribers during the reporting period awaiting internal review. The Code defines a "dispute" as an "unresolved complaint" and the relevant 2012 Code standards are sections 6.6 to 6.10.

- The number and outcomes of disputes internally reviewed: This is the number of all disputes that Code Subscribers internally reviewed during the reporting period, including the number of disputes finalised in favour of consumers and in favour of Code Subscribers.

Liability: This class of commercial insurance products includes data about Medical Indemnity insurance. Although Medical Indemnity insurance is excluded from the 2012 Code one Code Participant deals in this type of cover.

Motor: This class of personal insurance comprises cover for motor vehicles and motorcycles, whether comprehensive, third party property damage fire & theft, or third party property damage only.

Personal & Domestic Property: This class of personal insurance includes but is not limited to cover for caravans/mobile homes, pleasure craft, trailers, pet insurance and portables/valuables such as laptops, tablets and mobile telephones.

Policies: This data comprises the number of all new and renewed policies issued by each Code Subscriber during the reporting period. Where a policy covered more than one class of business, we asked Code Subscribers to count each class (or risk) separately where possible.[30] If a master policy or group/fleet policy covered a number of individuals or assets, we asked Code Subscribers to count each individual or asset separately where possible.[31]

[30] For example package policies.
[31] For example, in the case of a group Accident & Sickness policy which covers a number of employees or complimentary Travel cover provided by financial institutions to their credit card customers.

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END DOCUMENT
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