GENERAL INSURANCE
Code Governance Committee

GENERAL INSURANCE CODE OF PRACTICE ANNUAL REPORT 2015–2016

Contents

Chair's message

I am pleased to present the General Insurance Code Governance Committee's Annual Report for 2015–16. This year saw the general insurance industry's full transition to the 2014 Code. The transition brought new responsibilities for the Committee, making this an exciting year of firsts and learning for Committee members.

In 2014–15, as we geared up for the transition, one of our priorities was to increase our engagement with consumer advocates, facilitating a free flow of information about both the Committee's work and emerging consumer issues. In 2015–16, these efforts bore fruit, with more consumer advocates and individual consumers coming forward with allegations of Code breaches. Determining these matters – many of which involved the Code's important new hardship provisions – has been a major part of the Committee's work this year. We have also extended our focus on financial hardship with a program of desktop audits focused on the systems, processes and procedures that underpin compliance with the new standards.

For the first time, the Committee has access to the names of general insurance companies involved in breach allegations and the responsibility to take breach decisions. This has increased our obligations and enriched our insights into the industry, whilst also making us a more effective Code Governance Committee, especially in terms of consumer protections.

We are very conscious of the tide of community concern about financial services practices. Growing community and political attention to the financial services industry might lead to a Royal Commission or other high-profile government inquiry. At the very least, we expect to see substantial changes in the oversight and operating environment for financial services and higher expectations of responsiveness to consumer concerns.

For the moment, the industry has the benefit of a relatively benign claims environment and is experiencing a rare moment of opportunity to act in advance of any Government changes. It is an opportune time for industry to focus on preventative maintenance: improving governance; enhancing processes, policies and procedures; and fine-tuning data collection and reporting. With the Financial Ombudsman Service identifying in its 2015–16 Annual Review a sizeable increase in general insurance disputes, attention may also need to be directed to internal dispute resolution mechanisms as well as the underlying causes of increased disputes.

High-quality data is the key that unlocks insight, allowing us to identify and understand the trends that are shaping the industry. This year, the Committee prepared its first General Insurance Industry Data Report, showcasing the data we collected from Code Subscribers in 2014–15 Annual Returns. This exercise revealed gaps and inconsistencies in the data, and underscored for us just how important data integrity is. Over the coming year, we will be working closely with industry to build a firm foundation for better data collection. The aim is not to impose an onerous new set of obligations, but to ensure that industry has the information it needs for proactive and continual improvement. This will put industry on the front foot for any coming government review.

As another consequence of public focus on the financial services industry, the Code itself is under increasing scrutiny. We will be looking to identify any gaps in the Code and make recommendations to the Insurance Council of Australia on amendments to the Code to facilitate its objectives.

The Committee could not carry out its work without the skilled support of the Code team at the Financial Ombudsman Service Australia, capably led by Sally Davis. Sally, along with Compliance Manager Rose-Marie Galea and the rest of the staff, have been an immense help to the Committee as we oversaw the transition to the 2014 Code and took on new tasks and responsibilities.

This year, we continued to work in close communication and collaboration with the Insurance Council of Australia. I would like to thank the Insurance Council of Australia and in particular, Rob Whelan, Executive Director & CEO and Vicki Mullen, General Manager Consumer Relations and Market Development, for their support and contributions.

And finally, I express my thanks to my fellow Committee members, Ian Berg and Julie Maron, who have contributed their efforts and insight to Committee discussions and decision-making on behalf of the general insurance industry and consumers. They represent their constituent groups well and enliven each and every Committee discussion.

It has been a pleasure to work with you all.

Lynelle Briggs AO
Independent Chair
Code Governance Committee

Year at a glance

2 reports released	• **Annual Report 2014–15** • **General Insurance Industry Data Report 2014–15**
32 breaches finalised	• **20 on claims standards** • **6 on complaints and disputes standards** • **4 on financial hardship** • **2 on buying insurance**
9 significant breach matters considered	• **2 closed** • **7 under review – implementation of corrective actions including addressing consumer detriment**
A full compliance program	• **Annual Return 2015–16 initiated** • **Own Motion Inquiry into Claims Investigations and Outsourced Services initiated** • **Compliance Statements** • **significant breach reporting** • **consumer and FOS Code breach allegations** • **desktop audits on financial hardship**

Introduction

This Annual Report details the General Insurance Code Governance Committee's compliance monitoring and other activities during the 2015–16 financial year and examines Code Subscribers' compliance with the 2014 General Insurance Code of Practice (the Code).

The Code Governance Committee

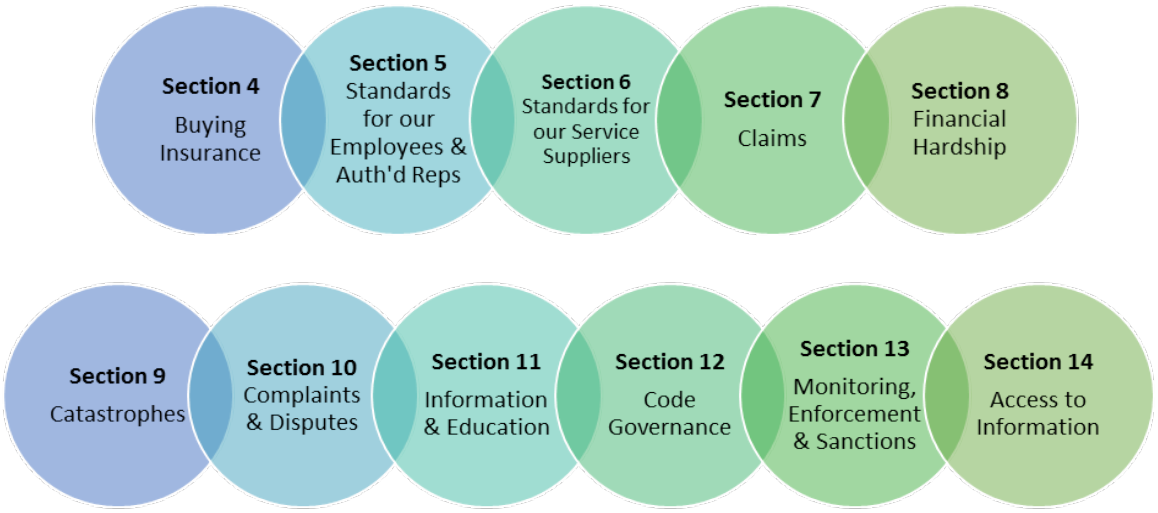
The Code Governance Committee (the Committee) is the independent body responsible for monitoring Code Subscribers' compliance with Code standards. Under an outsourcing agreement, the Code team at the Financial Ombudsman Service (FOS) Australia acts as Code administrator, with responsibility for monitoring Code compliance on the Committee's behalf.

The General Insurance Code of Practice

The Insurance Council of Australia (ICA) developed the Code as a voluntary industry code that promotes high standards of service and better customer relationships in the general insurance industry. The Code was first introduced in 1994 and has undergone significant revisions since then to ensure its continued relevance and effectiveness.

The current version of the Code, which became operational on 1 July 2015, applies primarily to retail (rather than wholesale) general insurance products. It contains standards on a range of areas of general insurer practice, outlined in **Figure 1**.

Figure 1. The Code standards



The Code introduced a number of new obligations relating to financial hardship. These standards are set out in Section 8 of the Code and were a major area of the Committee's focus during 2015–16. The 162 general insurers, coverholders and claims administrators who subscribe to the Code agree to comply with its standards. See **Schedule 1** for a list of current Code Subscribers.

Compliance monitoring

In 2015–16, the Committee's compliance monitoring program comprised a number of self-assessment and reporting activities; the investigation and determination of code breach allegations; and in-depth, targeted monitoring of specific areas of Code standards.

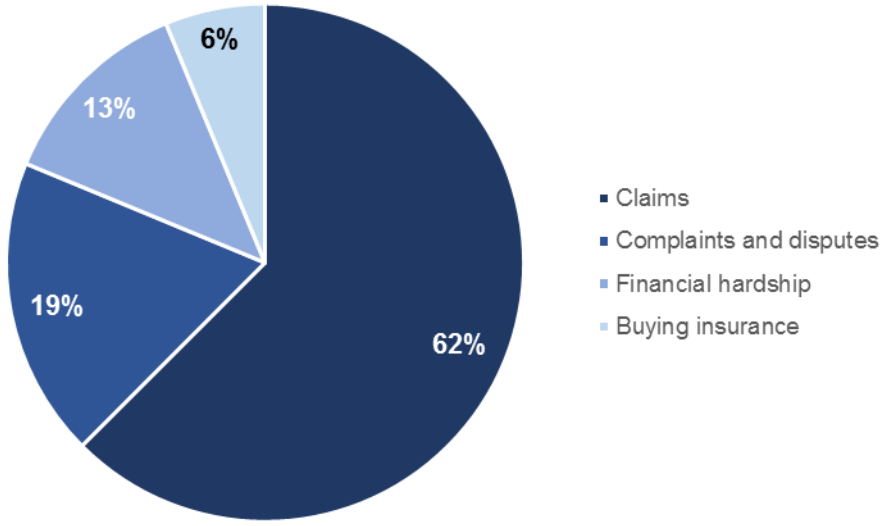
BREACH OVERVIEW

Over 2015–16, the compliance monitoring program saw the Committee resolve and close a total of 32 breaches by 11 Code Subscribers. Most of these breaches were identified via referrals of possible Code breaches from FOS or consumer Code breach allegations; one was the result of a self-reported significant breach.

Nature of breaches

Figure 2 shows which types of Code standard were breached in 2015–16 and the detailed data is presented in **Schedule 2**.

Figure 2. Finalised Code breach areas, 2015–16



Claims

Of the 32 total breaches, most (62%) involved the Claims standards in Section 7 of the Code. Most commonly, claims-related breaches had to do with the general requirement that claims handling be conducted in an honest, fair, transparent and timely manner (subsection 7.2). A number of other breaches related to the provision of information, including regular progress updates (subsection 7.13) and information about denied claims (subsection 7.19(b)).

Complaints and disputes

The standards that apply to the handling of complaints and disputes (Section 10) accounted for nearly one in five breaches (19%). Again, most breaches in this area related to the general requirement for fair, transparent and timely complaints handling (subsection 10.4). Other breaches concerned referral to FOS (subsections 10.19(b) and 10.22).

Financial hardship

Financial hardship provisions (Section 8) made up 13% of closed breaches. Half of these breaches concerned the requirement to provide a hardship application form and financial counselling hotline referral to consumers who say that they are in financial hardship (subsection 8.4). One breach related to compliance with regulatory guidelines on debt collection (subsection 8.12) and one to notification and explanation of decisions about financial hardship assistance applications (subsection 8.6).

Buying Insurance

Non-compliance with standards on buying insurance (Section 4) contributed the remaining 6% of breaches and concerned the requirement to conduct sales in an efficient, honest, fair and transparent way (subsection 4.4).

Causes of breaches and corrective actions

Most of the breaches finalised during 2015–16 arose from a failure to follow processes and procedures (66%) or administrative error (19%).

Code Subscribers are required to take action to address and correct breaches. In 2015–16, the most common corrective action was remedial training, which was provided in relation to 69% of breaches, either alone or alongside other measures.

Enhanced processes and procedures and improved monitoring were other common corrective actions.

Schedule 3 contains details of the breach causes and corrective actions during 2015–16.

CODE BREACH ALLEGATIONS

Sources of Code breach allegations

Under the Code, a Code Subscriber's customer or a person it is seeking payment from for damage or loss they caused to its customer's insured property, can allege that it has breached standards, while FOS is also able to report possible Code breaches to us.

The Committee then investigates these allegations, determining whether a breach has occurred and agreeing with Code Subscribers on any corrective measures to be applied.

In 2015–16 the Committee:

- received 202 new Code investigations, comprising 152 (75%) from FOS, 26 (13%) from consumers and 24 (12%) from consumer advocates (see **Schedule 4**)
- closed 229 Code investigations
- identified 49 Code breaches as a result of investigations and of these, 32 were closed and 17 remained open.

Referrals from FOS

Twenty-three of the Code breaches the Committee closed during 2015–16 came from possible Code breaches referred to us by FOS. It finalised these breaches on the basis they were not indicative of a significant breach or systemic in nature, and that each Code Subscriber had appropriately rectified the breaches.

Case Study – A claims management service fails to include information about FOS in its final response to a complaint

A Code Subscriber had outsourced the handling of certain claims to a service supplier (claims management service). In its final written response to a consumer's complaint, the claims management service did not inform them of the availability of FOS as an external dispute resolution scheme. The claims management service had omitted information about FOS because the consumer had lodged a dispute with FOS without first lodging a complaint with it.

The Code obligations

Under subsection 10.19 of the Code, when a Code Subscriber provides its final response to a consumer's complaint, the response must be in writing and include:

- its final decision and reasons
- the consumer's right to take their complaint to FOS if dissatisfied with the decision, FOS's contact details and the timeframe within which they must take their complaint to FOS.

The outcome

The Code Subscriber established that the claims management service had removed information about FOS from its final decision letter only because the consumer clearly knew about her right to lodge a dispute with FOS. The Code Subscriber reviewed the claims management service's template final decision letters and this confirmed that the templates included the required information about FOS.

The Committee notified the Code Subscriber that the claims management service's final decision letters must include the required information about FOS to ensure that consumers are aware of their options, notwithstanding that an individual consumer may be aware of FOS through other avenues.

Consumer Code breach allegations

During 2015–16, determining Code breach allegations made by or on behalf of consumers was a particular focus of the Committee's work. It made determinations on seven Code breach allegations brought by consumer advocates and two made by consumers directly.

Financial hardship provisions

Of the nine consumer Code breach allegations the Committee determined in 2015–16, five concerned alleged breaches of the Code's new financial hardship provisions. Most of these matters involved Code Subscribers seeking to recover from the consumer costs for damage to insured motor vehicles.

In each case, the consumer sought hardship assistance and later alleged one or more breaches of relevant standards, including those requiring that Code Subscribers and their service suppliers:

- supply a financial hardship assistance application form and financial counselling hotline number when a consumer says that they are in hardship (subsection 8.4)
- only request information that is reasonably necessary to assess an application for assistance (subsection 8.5)
- notify consumers of the outcome of an application for assistance as soon as reasonably practicable (subsection 8.6)
- work with a consumer who is entitled to assistance to consider an arrangement, confirm this in writing, and to provide complaint process details if an agreement cannot be reached (subsection 8.8)
- comply with regulatory debt collection guidelines (subsection 8.12).

In all five cases, the Committee determined that the Code Subscriber or its service supplier had breached one or more of these standards. In one of these cases, the Code Subscriber had failed to comply with the debt collection guidelines because, although a consumer in hardship had initiated contact with the Code Subscriber several times, their lawyer was unaware of the contact. In three of the five cases, the Committee also determined that complaints handling standards had also been breached.

Case Study – A claims management service rejects a customer's request for hardship assistance

The customer, who had comprehensive motor vehicle insurance, was involved in a single vehicle accident that caused damage to his car. He lodged a claim with his insurer – a Code Subscriber – which outsourced handling of the claim to a service supplier (claims management service). The claims management service told the customer that he would need to pay a $750 excess on his claim. When the customer said that he couldn't afford this excess and asked for financial hardship assistance, the claims management service told him that he would not qualify. As a result, the customer instead borrowed $650 to pay for repairs that he arranged.

The Code obligations

Under the Code, Code Subscribers have obligations to consumers in financial hardship, including their customers. These obligations extend to service suppliers. If a customer owes but can't afford to pay money to a Code Subscriber – typically an upfront excess on a claim – the Code Subscriber

has to consider a request for assistance. This means providing a financial hardship assistance application form and contact details for the national financial counselling hotline.

The outcome

The Committee notified the Code Subscriber of the Code breach concern, which prompted the Code Subscriber to waive the excess and reimburse the customer's $650 repair costs. Considering the evidence, the Committee determined that the Code Subscriber had breached the Code by failing to appropriately consider the customer's request for financial hardship assistance. The Code Subscriber acknowledged the breach and supervised refresher training on financial hardship for the service supplier's staff and team managers.

In two of the cases that the Committee determined, it was satisfied that Code Subscribers had unreasonably delayed reviewing the consumers' applications for financial hardship assistance. In one case – see the case study below – there was a delay of more than seven weeks before the Code Subscriber responded to the hardship assistance request and only did so when the Committee brought the matter to its attention. In the second case, the hardship assistance request was not reviewed until more than three months later after the Committee notified the Code Subscriber of the lack of response.

Case Study – A Code Subscriber fails to respond to requests for financial hardship assistance and complaint escalation

The consumer was involved in a car accident with a person who was insured by the Code Subscriber. Considering that the accident was the consumer's fault, the Code Subscriber tried to recover from him the cost of the insured's repairs.

On behalf of the consumer, a community legal centre contacted the Code Subscriber and asked that it waive the debt on financial hardship grounds. The Code Subscriber sought and was provided with supporting documentation.

When the community legal centre received no further response to the request for hardship assistance, it recontacted the Code Subscriber and asked for the matter to be referred to its internal complaints process. Again, it received no response and as a result it contacted the Committee.

The Code obligations

This alleged breach involved several Code standards relating to financial hardship and complaints handling. When an individual applies for hardship assistance, Code Subscribers are required to notify the individual of the outcome as soon as reasonably practicable (subsection 8.6).

The Code sets out standards that apply to complaints within stages one and two of Code Subscribers' internal complaints processes.

When a complaint is in stage one:

- Subsection 10.11 requires Code Subscribers to complete the review of the complaint and respond within 15 business days.
- Subsection 10.13 requires Code Subscribers to provide their response to the complaint in writing together with information about a consumer's right to escalate their complaint to stage two and later to FOS if unhappy with the outcome.

When Code Subscribers have completed the review of a complaint under stage two, subsection 10.19 requires them to respond in writing and sets out information they must include, such as a consumer's right to refer their complaint to FOS.

The outcome

After the Committee notified the Code Subscriber of its Code breach concern, the Code Subscriber did consider the consumer's request for hardship assistance and agreed to waive their debt. Nevertheless, the Committee determined that the Code Subscriber had breached the Code for the following reasons:

- The Code Subscriber delayed its review of and response to the request for hardship assistance for more than seven weeks: while the relevant staff member identified that they needed more information to assess the request they failed to action the request.
- The Code Subscriber failed to respond within the required timeframe to the community legal centre's complaint about the lack of response to its request for hardship assistance: the staff member did not escalate the complaint to the Code Subscriber's internal complaints process.
- When the Code Subscriber did respond to the complaint, it again breached the Code by failing to advise the consumer of their right to take the complaint to FOS and omitting FOS contact details: the staff member didn't use the Code Subscriber's template for complaint responses which included the required information about FOS.

These were isolated breaches, resulting from errors by a particular staff member who had since left the company. The Code Subscriber reviewed the staff member's other files to ensure that all correspondence had been actioned.

Claims

The remaining consumer Code breach allegations that the Committee determined in 2015–16 centred on the Code's claims standards.

Two of these cases concerned motor vehicle damage claims that the insurer declined, alleging fraud on the part of the consumer. In each of these cases the Committee found that the Code Subscriber had failed to handle the claim in a fair, transparent and timely way. The Committee also found in one of these cases that the Code Subscriber also breached the Code by taking irrelevant information into account when deciding whether to accept or decline the claim.

Case Study – A Code Subscriber fails to handle a claim fairly and transparently

The customer damaged the insured motor vehicle in a collision with another motor vehicle and lodged a claim with the Code Subscriber. The Code Subscriber conducted an investigation into the circumstances of the customer's claim, and seven months later it refused the claim alleging the incident resulting in the damage to the motor vehicle had been staged.

The customer lodged a dispute with FOS about the denial of the claim and FOS determined that the Code Subscriber was required to pay the claim.

A community legal centre acting on behalf of the customer referred several Code breach allegations to the Committee including that:

- The overall evidence underlying the Code Subscriber's decision to refuse the claim was unsatisfactory and insufficient to support a fraud allegation.

- There were no exceptional circumstances that applied to the claim and as a result the Code Subscriber should have made a decision about the claim within four months.

The Code obligations

Under the Code, Code Subscribers have an obligation to conduct claims handling in a fair, transparent and timely manner and only ask for and take into account relevant information when deciding on a claim. Code Subscribers are also required to make a decision whether to accept or deny the claim within four months, or if exceptional circumstances (this is defined) apply, within 12 months.

The outcome

The Committee determined that exceptional circumstances applied to the claim. It was satisfied that the Code Subscriber was entitled to investigate the claim because of its suspicion of fraud. In addition, the Code Subscriber was waiting for the consumer to provide a number of documents relevant to its investigation and had not taken an unusually long time to complete its investigation.

However, the Committee determined that the Code Subscriber had taken into account irrelevant information when deciding whether to deny the claim and did not properly prepare its evidence or review the evidence in a fair and reasonable manner before making a fraud allegation.

In this instance the Code Subscriber had relied on:

- an expert's report about the circumstances of the motor vehicle accident which was flawed because:
    - it had given the expert incorrect and incomplete information about the circumstances of the accident
    - the expert had omitted inconclusive findings from the report, had not evaluated or established whether the type of impact which occurred was consistent with the layout of the intersection, did not give any analysis of the other driver's vehicle and did not consider if this type of vehicle could have caused the damage
- witnesses who reportedly saw a person flee the scene after the incident – this person was never identified and so it was not possible to draw any meaningful conclusions.

The Code Subscriber had also alleged there may have been a connection between the customer and the other driver involved in the accident. However, the evidence provided by the Code Subscriber did not support such a conclusion.

As a result, the Committee also determined that the Code Subscriber had failed to meet the requirements of fairness and transparency when handling the customer's claim.

The Committee was satisfied that this matter was an isolated instance because the Code Subscriber reviewed:

- a random selection of claims handled by the relevant staff and this did not identify any other similar errors
- its incidents and complaints databases which confirmed that there were no other similar incidents or complaints involving similar circumstances
- the results from monthly audits of open claim files which did not identify any issues of a similar nature.

The Code Subscriber implemented several measures to minimise a reoccurrence of the non-compliance including:

- raising this matter with the relevant staff and requiring them to complete further Code training
- working more closely with the expert to ensure its reports contain all necessary information and analysis of all relevant factors
- a quality assurance review of contentious claims to ensure compliance with the relevant standards of the Code.

Guidance for industry

Customers in financial hardship

On 1 July 2015 the Code's enhanced financial hardship obligations became operational and for the first time extended protection to an individual insured or third party beneficiary who owes a Code Subscriber money under an insurance policy it has issued. These standards do not apply to the payment of premiums under an insurance policy.

The most typical situation involves a customer who is unable to pay a claim excess because of financial hardship. Code Subscribers must ensure their staff and service suppliers understand they have an obligation to assist customers in financial hardship. This is particularly important for front line staff who are usually a customer's first point of contact when lodging a claim and likely to inform them that an excess is payable.

Consumers in hardship who are represented

It is not unusual for a consumer in hardship to independently contact a Code Subscriber even though it is aware that the consumer has an authorised representative who is actively involved in the management of their hardship case.

Consumers in hardship must be recognised as vulnerable individuals. It is the Committee's strong view that if a represented consumer in hardship initiates contact with a Code Subscriber about their matter, it should always notify the authorised representative that such contact has occurred. This ensures that the representative is aware of the contact and in particular the nature of the discussions.

Timeframe for assessing hardship assistance requests and notifying consumers about outcomes

The Committee expects Code Subscribers to respond quickly and appropriately to consumers who have requested hardship assistance and can assess whether they have a capacity to meet their financial obligations. This means that Code Subscribers need to:

- understand the nature and impact of the difficulties that consumers are experiencing
- only ask consumers to provide information genuinely necessary to assess their application for assistance
- identify as soon as possible what further information is needed and request it
- ensure that any request for information does not unreasonably or unnecessarily delay the assessment of the hardship request, if the information initially provided is insufficient.

The Committee's approach is consistent with the Australian Securities and Investments Commission's (ASIC) expectations of credit providers responding to debtors who request a change to the terms of their credit contracts on the basis of hardship, under the National Credit Code[1].

The Committee is concerned that the Code does not define what "reasonably practicable" means or specify a timeframe for assessing a hardship request. In the hardship cases highlighted earlier, both Code Subscribers unreasonably delayed the assessment of the hardship request. In addition, their hardship procedures did not provide any guidance as to what a reasonable timeframe could be. This was also apparent from the desktop audits of 14 Code Subscribers' compliance with the financial hardship obligations during the reporting period: only 3 Code Subscribers specified a timeframe for assessing a hardship request, ranging from 7 to 21 calendar days.

The National Credit Code sets out the timeframes that apply to credit providers' consideration of consumers' requests for hardship assistance. Based on the timeframes outlined in the National Credit Code, after a Code Subscriber receives a consumer's request for hardship assistance the Committee recommends that:

- Within 21 calendar days, the Code Subscriber should assess the consumer's application for hardship assistance and inform them of its hardship decision, in accordance with subsection 8.6, or inform them that it needs more information.
- If the Code Subscriber needs more information, it should allow the consumer at least 21 calendar days to provide it.
- Within 21 calendar days of the consumer providing the requested information, the Code Subscriber must make its hardship decision and inform the consumer of its decision in accordance with subsection 8.6.
- If the consumer fails to provide the requested information, then the Code Subscriber must make its hardship decision on the information available within 28 calendar days, and inform the consumer of the decision, in accordance with subsection 8.6.

SELF-ASSESSMENT AND REPORTING

The Committee conducts a number of compliance monitoring activities that rely on self-assessment of Code compliance and reporting by Code Subscribers. Annual Returns and Compliance Statements are completed by some or all Code Subscribers as scheduled. In addition, Code Subscribers are required to self-report any significant breaches as they occur.

Annual Return

Each year, all Code Subscribers complete an Annual Return detailing the outcomes of internal complaints handling, self-identified breaches and compliance initiatives for the financial year. Code Subscribers also provide contextual data on the numbers of policies, claims, declined claims and withdrawn claims. Data from these Annual Returns is aggregated, analysed and reported in an industry data report. This unique yearly report sets out practical tips for industry and is an important and valued source of data and insight for all industry stakeholders.

[1] The National Credit Code regulates credit contracts between consumers and credit providers and is in Schedule 1 of the *National Consumer Credit Protection Act 2009*.

2015–16 Annual Return data collection began after the end of the reporting period, in July 2016, with the data to be analysed and published in early 2017. Over 2015–16, the Committee collected, collated and analysed Annual Return data for the previous financial year. Its report on this analysis, the General Insurance Industry Data Report 2014–15, was published in June 2016.

Collaborating to improve data quality

Perhaps the most important finding to emerge from our analysis of 2014–15 Annual Returns was that there were gaps and inconsistencies in data collection and calculation approaches – both between and within Code Subscribers' businesses. This inconsistency made it difficult to identify patterns and draw firm conclusions about the cause and meaning of any trends.

As a result, the Committee identified data quality as a priority area for its work with the ICA and individual Code Subscribers through to 2016–17. The Committee developed a plan to revise its data collection questionnaire, clarifying questions and parameters to ensure that they are clear, unambiguous, specific and accurate. To inform changes, during 2016–17 the Committee will seek input from the ICA Code Reference Group on specific data collection issues. It will also introduce some new reporting requirements and work with Code Subscribers to determine how quickly they can incorporate these new requirements into their data collection and reporting frameworks.

Compliance Statements

Compliance Statements are another self-reporting tool included in our annual compliance monitoring program. Each year, the Committee selects a group of Code Subscribers to complete a Compliance Statement, in which they self-assess compliance with all relevant 2014 Code standards and provide a statement about their compliance status. Whereas the Annual Return collects data on events during the previous year, including specific instances of non-compliance, Compliance Statements instead focus on the underpinning policies, processes and procedures and ask Code Subscribers to report any gaps in compliance identified through the self-assessment.

As a result, the Compliance Statement requires a Code Subscriber to:

- review all procedures, processes and systems enabling its employees and those of related entities, authorised representatives and service suppliers, to comply with all applicable obligations under the Code
- ensure that an authorised individual completes the applicable declaration about the status of its compliance with Code obligations
- report Code breaches that it identified through the self-assessment, including what caused the breaches and how it addressed them.

In 2015–16, 125 Code Subscribers completed a Compliance Statement and of these, 120 Code Subscribers confirmed they had compliant systems, processes and procedures in place. The remaining five compliance statements were under review as at 30 June 2016.

Significant breaches

Some instances of Code non-compliance qualify as a 'significant breach'. Whether or not a breach (or likely breach) is classified as significant depends on:

- the number and frequency of similar previous breaches

- how it affects the Code Subscriber's ability to provide its services
- the extent to which it indicates inadequate Code compliance arrangements
- potential or actual financial loss caused
- the duration of the breach.

Code Subscribers that identify a significant breach are required to report it to the Committee within 10 business days. They must also correct the breach within agreed timeframes. Although significant breaches can also be identified through our other compliance work, all significant breaches that the Committee dealt with in 2015–16 were self-reported by Code Subscribers.

Number of significant breaches

The Committee dealt with nine significant breaches in 2015–16, some of which were open matters carried over from the previous financial year. Two significant breaches were closed during the reporting period, while the remaining seven, many of which involved complex issues, were still being considered and remediated at the close of the financial year.

Buying insurance

More than half of these significant breaches – including both of those closed during 2015–16 – concerned buying insurance, specifically the requirement to conduct sales processes and services in an efficient, honest, fair and transparent manner (subsection 4.4).

Table 1 summarises the nature and impact of those significant breaches, as well as the remedial action taken as of 30 June 2016.

Table 1. Significant breaches of subsection 4.4

BREACH AND IMPACT	REMEDIAL ACTION
Consumers who automatically renewed certain types of home insurance products were incorrectly charged a higher premium due to a pricing error caused by a coding mistake. This significant breach affected 26,285 policies.	At closure, the Code Subscriber had: • paid $481,998 (including interest) to affected consumers • fixed the pricing issue and verified that the system was working correctly • checked that no other home insurance products were affected • increased the sensitivity of the pricing system's testing process to identify human error.
Consumers who renewed certain types of home insurance products were entitled to a discounted premium. An ambiguity in the Code Subscriber's premium, excess and discount guide led to a pricing system error that meant the correct discount was not applied to premiums. This significant breach affected 124,190 policies.	At closure, the Code Subscriber had: • paid $1,209,213.09 (including interest) to affected consumers • fixed the pricing issue and verified that the system was working correctly • reviewed its product development methodology and pricing manual to ensure the pricing system and product disclosure documents aligned.

Around 40,000 consumers renewing their motor vehicle insurance were affected by a pricing system error that saw them not receive a 'no claim' discount on their premiums that they were eligible for.	The Code Subscriber had begun to take remedial action, having: • fixed the pricing issue and verified that the system was working correctly • begun developing a consumer restitution program.
Consumers with consumer credit insurance for personal loans cancelled cover or discharged their loans early. They did not receive a refund of the unused portion of the premium that they were eligible for. At least 126 consumers were affected.	The Code Subscriber had begun to take remedial action, having: • sent letters to 126 affected consumers apologising for the error and advising of the amount owed • sent letters to another 226 consumers who might be entitled to reimbursement • implemented additional controls to ensure that the manual refund process operated correctly.

Claims

A further two significant breaches related to the standards which set out timeframes for claims decisions (subsections 7.17 and 7.18). These are summarised in **Table 2**.

It is noteworthy that the second of these significant breaches was not identified until six months after the breaches began, suggesting a failure in the Code Subscriber's own monitoring processes.

Table 2. Significant breaches of subsections 7.17 and 7.18

BREACH AND IMPACT	REMEDIAL ACTION
Delays in processing claims management tasks saw some consumers' home insurance claims remain in an 'undecided' status over a period of nine months. Around 3,845 claims may have been affected.	The Code Subscriber had begun reviewing the relevant claims to determine appropriate remedial action.
Over a six-month period, consumers' home insurance claims were not handled within timeframes as a result of: • inappropriate workflow management and supervision • lack of awareness of the importance of breach logging • unusually high workload demands. At least 3,000 claims were affected.	The Code Subscriber had begun to take remedial action, having: • notified its Board Risk and Compliance Committee • reviewed its training, induction, education and Code compliance awareness • increased staff resources • reviewed compliance with documented procedures and Code claims handling timeframes and breach logging obligations.

One significant breach (**Table 3**) concerned the requirement that within 10 business days of receiving a claim, a Code Subscriber must either:

- decide whether to accept or deny the claim (subsection 7.9) or
- if further information, assessment or investigation is needed, notify the consumer of what it needs to make a claim decision and give an initial estimate of the likely claim decision timeframe and process (subsection 7.10(a) and (c)).

Table 3. Significant breaches of subsections 7.9 and 7.10 (a) and (c)

BREACH AND IMPACT	REMEDIAL ACTION
Some consumers who made personal & domestic property insurance claims were affected when a defect in a service supplier's new electronic claims management system resulted in staff being taken from other areas of its business to manually issue claims cheques to consumers. Over three months, remaining claims staff were unable to process new claims for acceptance and make payments to consumers within required timeframes. 2,658 claims were affected.	The Code Subscriber reported that it had addressed the backlog of claims files, made outstanding claims payments to 1,268 consumers and fixed the new claims management system. However, it had not paid interest on delayed claims payments, which is a requirement under the *Insurance Contracts Act 1984*. When the Committee determined that interest payments were required, the Code Subscriber made payments totalling $18,649.

Complaints and disputes

The remaining significant breach (**Table 4**) concerned four of the Code's complaints and disputes standards.

Table 4. Significant breaches of subsections 10.13, 10.16, 10.18 and 10.19

BREACH AND IMPACT	REMEDIAL ACTION
The Code Subscriber prematurely closed complaints about a range of general insurance products due to: • a flaw in modifications to its complaints management system • staff closing complaints after sending an information request form on the basis that they would be re-opened when the information was received. At least 88 complaints were affected.	The Code Subscriber had begun to take remedial action, having: • overturned two claims decisions, making payments totalling $405.07 (including interest) • reviewed 86 complaints, upholding the original claim decision and advising consumers of their right to refer complaints to FOS • removed the information request form from its system, instead requiring staff to obtain and request information over the phone • provided further complaints handling training. It was also in the process of reviewing a sample of complaints from a three-year period to determine whether other consumers were affected.

TARGETED MONITORING ACTIVITIES

In addition to the Committee's regular monitoring and investigation activities, from time to time it also conducts targeted monitoring activities to examine in greater depth Code Subscribers' compliance with specific areas of Code standards. In 2015–16, the targeted work comprised desktop audits focused on financial hardship standards and initiation of an Own Motion Inquiry into Claims Investigations and Outsourced Services.

Desktop Audits

Desktop audits are used to examine whether and how Code standards are reflected in a Code Subscriber's processes, policies and procedures. The Code Subscriber is required to demonstrate how it complies by responding to a questionnaire based on the specific Code obligations under examination. It is also required to provide relevant documents, such as policies, procedures and training programs to support its responses.

The information provided is reviewed and assessed against Code obligations, to determine whether the Code Subscriber has appropriate processes and systems in place to comply and monitor its compliance. If compliance gaps are identified, the Committee works with the Code Subscriber to identify the actions required to address them and assist in formulating a plan to implement the necessary changes within an agreed timeframe.

This year, the Committee conducted a small number of desktop audits focused on the new financial hardship standards in Section 8 of the Code. Fourteen Code Subscribers were chosen to participate, completing a questionnaire and providing supporting evidence of their compliance with the financial hardship standards. Of these desktop audits, seven have been finalised, one has disclosed breaches while the remaining six were under review as at 30 June 2016.

In relation to the non-compliant desktop audit outcome, while the Code Subscriber's procedures and processes correctly incorporated the financial hardship standards, training on the Code's financial hardship standards did not clearly reflect this, including that the training program:

- Did not clearly inform staff that they are obligated to comply with the debt collection guidelines.
- Did not highlight that the Code's financial hardship standards also apply to the Code Subscriber's customers – insureds and third party beneficiaries.

The Committee is working with the Code Subscriber to address the compliance gaps.

As highlighted earlier in ***Consumer Code Breach Allegations Financial Hardship Provisions***, one of the outcomes of the desktop audits was that only three Code Subscribers had specified a timeframe for assessing a hardship request, ranging from 7 to 21 calendar days. The absence of a timeframe for assessing a hardship request is not in itself a breach of the financial hardship standards. However, the Code does not define "reasonably practicable" for the purpose of assessing a hardship request and notifying a consumer of the outcome. As seen in the two cases determined by the Committee, the lack of a timeframe in Code Subscribers' procedures for assessing hardship requests means that employees and debt collection agents are left without guidance.

Own Motion Inquiry into Claims Investigations and Outsourced Services

Own motion inquiries are an important part of our Code monitoring and information-sharing work. Through these inquiries, the Committee takes a targeted, in-depth look at a particular area of Code standards, examining instances of both non-compliance and good industry practice. Based on the findings, the Committee develops and shares specific guidance for Code Subscribers looking to improve their service standards and compliance. Prompted by feedback from consumers and consumer advocates, this year the Committee initiated its first own motion inquiry, looking at Code Subscribers' investigation of claims and their outsourcing of services.

Aims

The aim of this inquiry is to develop a full understanding of how general insurers investigate claims and how their outsourced services operate. To do this, the Committee is examining how Code Subscribers handle claims both internally and via service suppliers, as well as their processes and procedures for outsourcing claims handling and debt collection activities to service suppliers. Across both areas, it is investigating whether the relevant Code standards are being embedded in processes and procedures, applied in practice, and monitored appropriately – both internally and when services are outsourced.

Approach

The Committee began gathering data for the inquiry during 2015–16. In June 2016, it distributed an Information Paper setting out the purpose and scope of the Inquiry. At the same time, it contacted Code Subscribers with a detailed questionnaire and sent a second questionnaire to consumer representatives for their input. Responses are due to be received and analysed over August and September 2016 and, based on these responses, a final report will be prepared and published, likely before the end of 2016.

Selling of Code Subscribers' products by other licensees

One of the matters that we raised directly with the ICA Board during 2015–16 is that there is a gap in coverage under the Code in relation to the selling of general insurance products by entities who are not Authorised Representatives[2] of a Code Subscriber, but are licensed to sell general insurance products by ASIC. These entities may include insurance brokers, banks or credit unions.

While subsection 5.5 of the Code enables a policyholder to ask a Code Subscriber to address concerns about the selling practices of these entities, and to report their concerns to us, we are unable to breach the Code Subscriber if these entities do not comply with the Code when selling its general insurance products under their own Australian financial services licenses. This is because subsection 13.4 of the Code stipulates that a Code Subscriber will be in breach of the Code only if its Employees, Authorised Representatives or Service Suppliers fail to comply with the Code while acting on its behalf.

Given the concerns identified by ASIC and some consumer legal groups about selling arrangements, we intend to examine this area in 2016–17.

[2] The Code defines **Authorised Representative** to mean "a person, company or other entity authorised by us to provide financial services on our behalf under our Australian Financial Services licence, in accordance with the Corporations Act 2001."

Engaging with stakeholders

In 2015–16, stakeholder engagement was a major part of the Committee's work to raise awareness of the Code and to encourage and highlight good industry practice.

INDUSTRY

Insurance Council of Australia and other industry bodies

The Committee works in close liaison with the ICA. During 2015–16, the Committee provided quarterly updates to the ICA, attended ICA Board meetings and had a number of ad hoc meetings with ICA staff. The ICA also has a Code Reference Group which we met with to discuss Code monitoring matters.

The Committee contributed to the work of the ICA Effective Disclosure Taskforce, providing background information and a final response.

The Committee attended the ICA Annual Forum in March 2016 and Annual Dinner in May 2016.

It also met with other industry associations and professional bodies including the Australian and New Zealand Institute of Insurance and Finance.

Sally Davis, General Manager of the Code team presented updates on the Code and compliance issues to delegates at FOS's General Insurance Open Forums and Industry Liaison Group meetings in Melbourne and Sydney.

Code Subscribers

Throughout the year, the Code team met regularly with individual Code Subscribers to discuss specific compliance matters. The Code team also liaised with industry via FOS General Insurance Open Forums in Melbourne and Sydney in October 2015 and again in Melbourne in March 2016.

Other Code Compliance Committees

The Code team at FOS provides secretariat services to three other code committees. In 2015–16 the Code team arranged for each member of the Committee to participate in meetings with their counterparts from the compliance committees under the Code of Banking Practice, the Customer Owned Banking Code of Practice and the Insurance Brokers Code of Practice.

These meetings provided the Committee with an opportunity to discuss the challenges presented by their respective roles and gain insights into how the other code compliance committees monitor industry compliance.

CONSUMER ADVOCATES

In August 2015 the Committee met with consumer advocates from Caxton Legal Centre and the Consumer Protection Legal Unit from Legal Aid Queensland. On behalf of the Committee, the Code team at FOS met regularly with advocates from consumer organisations, financial counselling bodies and community legal centres.

These meetings were opportunities to discuss Code matters and emerging consumer issues. In some cases, meetings prompted Code breach allegation referrals.

The Code team also attended or presented at the following consumer conferences and events:

HOST	EVENT	DATE
Queensland Association of Independent Legal Services	Community legal centre GI Code training	7 August 2015
Financial & Consumer Rights Council (FCRC)	Victorian Financial Counselling Conference	9–11 September 2015
FCRC	Consumer advocates code training day	18 November 2015
Consumer Action Law Centre, FCRC, Financial Counselling Australia (FCA)	New premises launch	8 December 2015
Seniors Rights Victoria	4th National Elder Abuse Conference	24–25 February 2016
FCA	FCA Conference	16 May 2016
Financial Counsellors' Association of Queensland (FCAQ)	FCAQ Annual Conference 2016	8–9 March 2016

REGULATORY

Australian Securities and Investments Commission

Through the Code team, the Committee was in regular communication with ASIC, with whom quarterly meetings were held throughout 2015–16. ASIC also attended a meeting of the Committee in the first quarter of 2015–16. On 21–22 March 2016, the Committee and Code team members attended the ASIC Annual Forum in Sydney.

Financial Ombudsman Service Australia

The Committee met with John Price, FOS's Lead Ombudsman in General Insurance. The meeting enabled the Committee to gain an insight into FOS's new external dispute resolution process, and discuss emerging industry issues including the substantial increase in the number of general insurance disputes being received by FOS.

Throughout the year the Code team presented to various groups within FOS on the changes introduced by the Code and Code compliance issues and published information about the Committee's work in the FOS Circular.

Committee activities and achievements

MEETINGS

We complied with our Charter and Deed obligations and met seven times during 2015–16, with meetings taking place in Sydney, Melbourne or via teleconference.

At meetings we reviewed the Code team's quarterly compliance reports, determined Code breach allegations and discussed a range of Code-related matters.

WORK PLAN

Under our Annual Work Plan, our primary objectives for 2015–16 were to:

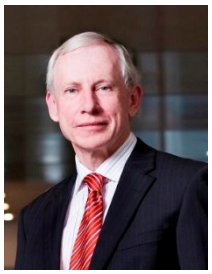
- engage proactively with Code Subscribers and other stakeholders to ensure effective transition and understanding of the 2014 Code
- consolidate the governance, investigations and code monitoring processes and procedures put in place since our commencement on 1 July 2014
- identify and remedy compliance gaps, including by providing proactive guidance to industry and consumers
- assess Code Subscribers' compliance with the new financial hardship obligations and with outsourcing obligations – work that we began with our financial hardship Desktop Audits and Own Motion Inquiry into Claims Investigations and Outsourced Services.

COMMITTEE MEMBERS

Lynelle Briggs AO – Independent Chair

Lynelle Briggs is Chairperson of the NSW Planning Assessment Commission. She serves on the Boards of Maritime Super and Goodstart Early Learning, and the Council of the Royal Australian College of General Practitioners.

Lynelle was formerly a member of the Australian Rail Track Corporation Board. She was also Chairperson of the Australian Security Intelligence Organisation's Audit and Risk Commission and Chairperson of the Jigsaw Theatre Company Board. She has chaired the Shipping Workforce Development Forum, the Inquiry into Compliance, Work Health and Safety Laws in the ACT Construction Industry, and the Catholic Development Fund Steering Committee. She was the Independent Project Facilitator for the Millers Point Accommodation Project. During her executive career, Lynelle Briggs was Australia's Public Service Commissioner and Chief Executive of Medicare Australia.



Ian Berg – Industry Representative

Ian retired from FM Global Australia's operations in March 2014 after 35 years with the group. He was Vice President and Operations Manager for Australia, Chief Executive Officer for FM Global in Australia and a director of FM Insurance Co. Ltd. Ian spent five years as a director on the ICA Board.

Starting his career as a loss prevention engineer, Ian has worked in engineering, business development, marketing, underwriting and management positions for FM Global in Australia, the UK and the US. Ian is a qualified engineer and a Member of the Australian Institute of Company Directors.

Julie Maron – Consumer Representative

Julie has been a practicing solicitor since 2001, having worked in private practice and government legal departments in Canberra, before moving to her current role as a senior consumer lawyer for Legal Aid NSW, based in Wagga Wagga in regional NSW.

Julie has assisted hundreds of consumers with insurance matters after natural disasters, including the 2010–2011 Queensland floods, the 2010 and 2012 Riverina floods and the 2013 Warrumbungles bushfire. Julie was the consumer adviser to the Independent Review of the General Insurance Code of Practice.

CODE TEAM

Sally Davis – General Manager

Sally Davis began her role as General Manager of the Code team at FOS and CEO of the Code Compliance and Monitoring Committee on 1 September 2015. Prior to her appointment to this role, Sally was Senior Manager of Systemic Issues at FOS and has worked at FOS and its predecessor schemes for over 15 years. Sally is a graduate of the Mt Eliza Business School and an accredited mediator. She holds a Bachelor of Commerce and a Bachelor of Laws degree from the University of Melbourne and a Graduate Diploma (Arts) from Monash University.

Sally regularly works with all relevant stakeholders to enhance the knowledge and effectiveness of Codes of Practice in the financial services industry and provides support to the Committees in their monitoring of those Codes, shares insights from monitoring activities and adds value back to industry and consumers.

Rose-Marie Galea – Compliance Manager

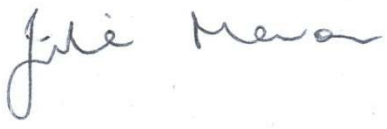
Rose-Marie has worked with FOS and its predecessor schemes since 2001 and has been involved in Code compliance monitoring within the general insurance industry since 2003.

Rose-Marie is a lawyer and also holds a Bachelor of Science with Honours from Monash University and has previously worked in private practice, the general insurance industry and the Queensland public service.

By the Committee

Lynelle Briggs AO

Ian Berg



Julie Maron

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		

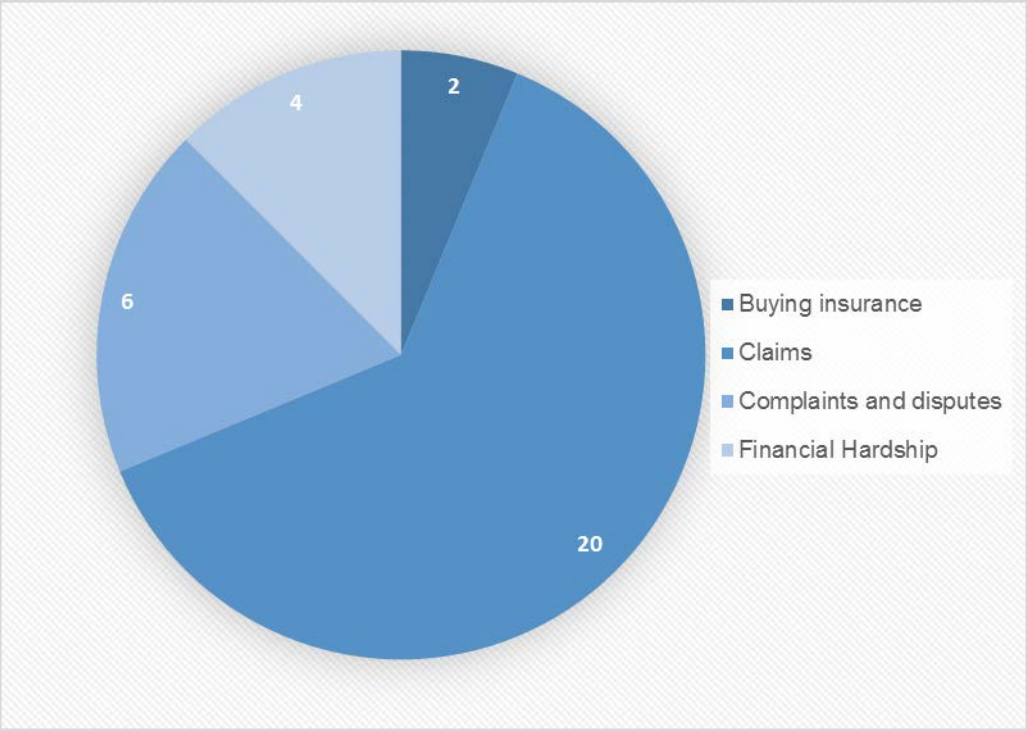
Lloyd's Australia Limited: Participating Coverholders and Claims Administrators			
1	AIS Insurance Brokers Pty Ltd	55	Jardine Lloyd Thompson Pty Ltd
2	AON Risk Services Australia Ltd	56	JMD Ross Insurance Brokers Pty Ltd
3	Arch Underwriting at Lloyd's (Australia) Pty Ltd	57	JUA Underwriting Agency Pty 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

Schedule 2 Overview of breaches closed in 2015–16

- 11 Code Subscribers contributed to the 32 Code breaches finalised (closed) in 2015–16.
- We have converted all breaches of the 2012 Code into the equivalent standards under the 2014 Code.
- The standards that apply to “Buying Insurance” are in section 4, 2014 Code.
- The standards that apply to “Claims” are in section 7, 2014 Code.
- The standards that apply to “Financial Hardship” are in section 8, 2014 Code.
- The standards that apply to “Complaints and disputes” are in section 10, 2014 Code.

All breaches finalised in 2015–16 by Code section



All finalised breaches in 2015–16 – number of contributing Code Subscribers

Code Section	Total	Number of Code Subscribers contributing to the breaches
Buying insurance	**2**	**2**
Claims	**20**	**6**
Complaints and disputes	**6**	**5**
Financial Hardship	**4**	**3**
Grand Total	**32**	**11 Code Subscribers in total**

Breaches of Section 4 – Buying Insurance

2014 CODE SECTION	SUBSECTION	NUMBER OF BREACHES
2 Buying insurance	4.4 - Conduct sales process & services efficiently, honestly, fairly & transparently.	**2**
	TOTAL	**2**

Breaches of Section 7 – Claims

2014 CODE SECTION	SUBSECTION	NUMBER OF BREACHES
7 Claims	7.2 - Conduct claims handling in honest, fair, transparent & timely manner.	**8**
	7.3 - Ask for & rely on only relevant information when deciding your claim.	**1**
	7.12 - If a loss assessor/adjuster or investigator is appointed, notify you within 5 business days.	**1**
	7.13 - Provide you with claim progress updates at least every 20 business days.	**4**
	7.14 - Respond to your routine claim requests within 10 business days.	**1**
	7.16 - On completion of information gathering & enquiries, decide whether to accept/deny your claim & notify you within 10 business days.	**1**
	7.19 Standards that apply to the denial of your claim.	**2**
	7.19(b) - When claim denied, inform you of right to ask for information used in assessing claim, and provide it within 10 business days of your request.	**2**
	TOTAL	**20**

Breaches of Section 8 – Financial Hardship

2014 CODE SECTION	SUBSECTION	NUMBER OF BREACHES
8 Financial Hardship	8.4 - Provide financial hardship application form and counselling hotline number, if you tell us you are in financial hardship.	**2**
	8.6 - Notify you of decision on financial hardship assistance application as soon as reasonably practicable. Provide reasons if no entitlement to assistance.	**1**
	8.12 - Comply with the ACCC & ASIC debt collection guidelines.	**1**
	TOTAL	**4**

Breaches of Section 10 – Complaints and disputes

2014 CODE SECTION	SUBSECTION	Grand Total
10 Complaints and disputes	10.4 - Conduct complaints handling in fair, transparent and timely manner.	**4**
	10.22 - If Stage 2 decision does not satisfy you or your complaint is not resolved within 45 calendar days of date first received, you may refer it to FOS.	**1**
	10.19(b) - Provide Stage 2 response to your complaint in writing and notify you of FOS rights.	**1**
	TOTAL	**6**

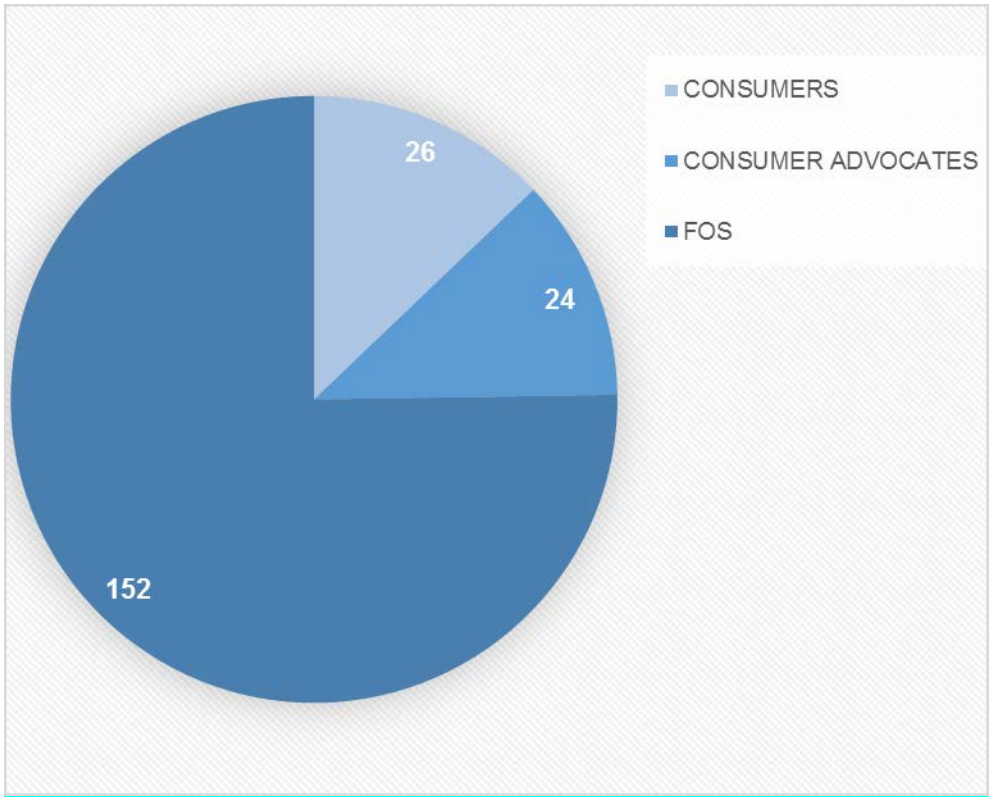
Schedule 3 Overview of breach causes and corrective actions in 2015–16

	What caused the Code breach?						
Code Section	**Administrative error**	**Poor processes & procedures**	**Processes & procedures not followed**	**Report misinterpreted**	**Systems failure**	**Too few staff**	**Sum of Total Breaches**
Buying insurance		1			1		2
Claims	4		15	1			20
Complaints and disputes	2		4				6
Financial Hardship			2			2	4
Grand Total	**6**	**1**	**21**	**1**	**1**	**2**	**32**

What actions did Code Subscribers implement to address and correct the breaches?

Code Section	Consumer comms improved	Information to consumers, processes & procedures improved	Monitoring improved	Monitoring improved & remedial training	Payment to consumers and improved processes & procedures	Process or system improved, remedial training & updated policy documents	Processes & procedures improved	Remedial Training	Total Breaches
Buying insurance		1			1				2
Claims				2		2	3	13	20
Complaints and disputes	1						2	3	6
Financial Hardship			2					2	4
Grand Total	**1**	**1**	**2**	**2**	**1**	**2**	**5**	**18**	**32**

Schedule 4 Sources of Code breach allegations in 2015–16



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