GENERAL INSURANCE
Code Governance Committee

General Insurance Code of Practice
Industry Data Report 2015–16

March 2017

Contents

Chair's message

I am pleased to present the Code Governance Committee's General Insurance Code of Practice Industry Data Report for 2015–16. In this report, we have brought together Code compliance and industry data – sourced directly from Code Subscribers – to offer a unique window on developments in the general insurance industry during the year.

The data provided in Schedules 2 - 5 of this report provides an in-depth view of general insurance industry trends, and the Year at a Glance and Key Observations sections provide an overview of 2015–16.

This is the Committee's second report on the state of the industry and it is also the first industry data report under the 2014 General Insurance Code of Practice (the 2014 Code). We were gratified by the response to the 2014–15 report, which was welcomed by industry, regulators and consumer advocates alike. Notwithstanding the usefulness of the analysis presented in that report, in it we also identified some issues with the quality of the data collected from Code Subscribers.

We sent a strong message about the fundamental importance of data integrity, which is the foundation for identifying patterns, understanding them and improving practices and service standards. We flagged our intention to improve data collection and reporting to create a comprehensive, consistent and reliable industry dataset.

Over the next year, we worked closely with the Insurance Council of Australia (ICA) Code Reference Group and individual Code Subscribers to put those aspirations into action. We went to industry with a proposal for improved data collection and used their feedback to refine this new framework. Industry responded very positively to our request for better data and this report is the product of that joint effort.

Among the improvements is a much clearer understanding of coverage and the breakdown of group and individual policies. This gives us a baseline for future comparisons and provides crucial context for understanding and interpreting other industry trends. Another enhancement is our expanded workforce data collection, which paints a more comprehensive picture of the general insurance workforce and, critically, their knowledge of the 2014 Code.

The new data collection framework has also put us in a better position to confidently identify general insurance industry trends. Of note in 2015–16, we saw continued and substantial increases in both declined and withdrawn claims.

While Code Subscribers have largely attributed increases in withdrawn claims to an artefact of enhanced collection and reporting methodologies, the Committee is concerned that they may also point to gaps in consumers' understanding of the insurance products they are purchasing. Code Subscribers have also given us limited insights into the factors underlying increases in declined claims, referring to strong business growth as the main reason why they are declining more claims. However, the Committee does not believe that this adequately explains the growth in declined claims frequency, given that the number of retail insurance claims grew only slightly.

This reporting period also brought a marked increase in customer complaints, with internal disputes rebounding after a drop in the previous period. This trend can be understood as the flow-on from increases in declined claims which is a key trigger for customer complaints. The Committee would like to see industry do more to identify and understand the factors underlying year on year increases in declined claims data. This type of analysis will assist industry in reducing consumer dissatisfaction with claim outcomes.

Code Subscribers have made big strides in improving data collection and reporting. Now, it's important to keep the momentum going, both collectively and internally within individual businesses. We believe that this means extending data about retail insurance claims to include data about partially accepted claims – without this type of data we continue to have an incomplete picture about retail insurance claims. We recognise that a first step toward accurate and consistent recording and reporting of partially accepted claims data is the development of a consistent definition of 'partially accepted claims' and we will continue to work with Code Subscribers on this.

The next frontier is more systematic collection of the information that will give businesses, the industry and stakeholders insight into the circumstances and practices driving trends. In turn, this insight can inform action that improves services for consumers and trust in the industry.

The Committee would like to thank Code Subscribers for the effort and goodwill they have brought to the task of improving their data collection processes. We would especially like to thank the Committee's Secretariat for the many months of work they have contributed to this process and the significant enhancements they have guided at the Committee's behest.

Lynelle Briggs AO
Independent Chair
General Insurance Code Governance Committee
March 2017

2015–16: Year at a glance

Retail insurance – policies and claims [1]

compared with last year

44,171,089
issued policies

3,755,643
lodged claims ↑ 2%

270,799
withdrawn claims ↑ 29%

143,445
declined claims ↑ 14%

Retail insurance – internal disputes

compared with last year

28,587
received disputes ↑ 32%

25,563
reviewed disputes ↑ 19%

Code breaches

compared with last year

5,021
self-reported Code breaches ↑ 33%

General insurance workforce [2]

compared with last year

143,338
employees, authorised reps, agents & contractors ↑ 112%

102,186
Individuals who received Code training ↑ 202%

[1] We have not compared 2015–16 policy data with 2014–15. Refer to **Buying insurance** at page 11 for further details.
[2] Some of the increases in the general insurance workforce data are due to the inclusion of employees of Code Subscribers' related entities. Refer to **General insurance workforce** at page 45 for further details.

Key observations

47 million general insurance policies were issued

In 2015–16, we obtained a clearer picture of how many general insurance policies were issued, and the number of people or assets covered by group policies, giving us a new baseline for future comparisons.

Code Subscribers reported that they issued 47,279,460 general insurance policies, including 44,171,089 retail insurance policies (44,117,605 individual and 53,484 group retail insurance policies) and 3,108,371 wholesale insurance policies (2,937,380 individual and 170,991 group wholesale insurance policies).

The most common type of retail insurance policies bought by consumers were Motor insurance products, representing 14,490,946 policies, followed closely by Home insurance products with 11,636,781 policies.

Retail insurance claim numbers remained steady

The number of retail insurance claims lodged by consumers in 2015–16 remained relatively stable compared with 2014–15 (last year), with a slight growth of 2% to 3,755,643 claims. Code Subscribers reported that even though there were severe weather events in 2015–16, these events did not cause as much damage as weather events in 2014–15.

The most frequent types of claims were for Motor insurance products with 2,001,361 claims, up 6% on last year. The trend for Motor claims contrasted sharply with Home insurance claims which were down by 13% to 810,901, reflecting the less severe nature of weather events in 2015–16.

Claims acceptance rates ranged from 99.5% of Motor claims to 85.4% of Consumer Credit claims. For the first time, we took into account the number of withdrawn claims when determining the claims acceptance rate.

Retail insurance declined claim numbers continued to increase

In 2015–16, the number of declined claims continued to trend upwards across most retail general insurance classes.

For instance, the number of declined Travel insurance claims climbed 28% to 31,090 while Personal & Domestic Property insurance claims grew by 17% to 44,592.

Code Subscribers provided limited insights into declined claim increases and many cited strong business growth as having the largest impact on the frequency of declined claims. In our view, this does not adequately explain the declined claims data trends given that overall retail insurance claims grew only slightly.

Withdrawn retail insurance claims continued to increase

The number of withdrawn claims for retail insurance continued to rise, increasing 29% in 2015–16. For instance, the frequency of withdrawn Motor claims increased 37% to 128,072 and for Personal & Domestic Property, withdrawn claims increased by 205% to 24,143.

We know that some of this increase was due to enhancements Code Subscribers have made to their systems and reporting frameworks. However, few other underpinning reasons for these increases were provided, raising concerns that:

- There may still be gaps in consumers' understanding of how some of these products operate in practice.
- Some withdrawn retail insurance claims may represent claims that would otherwise have been declined. Unlike the requirements that apply to declined retail insurance claims, Code Subscribers are not under any obligation to provide written notification of a claim withdrawal or the reasons, or to notify consumers of their rights to access information underlying the assessment of their claim, internal and external complaints and dispute resolutions processes.

Not all Code Subscribers were able to provide data about withdrawn retail insurance claims due to changes and improvements to their legacy systems. As a result, the data remains incomplete. We continue to work with Code Subscribers to develop a more complete data set to enable better analysis.

Internal disputes about retail insurance products increased

The number of disputes Code Subscribers received about retail insurance products in 2015–16, increased across all classes and overall by 32%. This contrasts with the decrease seen last year and is reflective of the higher number of claims declined by Code Subscribers in 2015–16. The largest increase in disputes occurred in relation to Personal & Domestic Property insurance products, jumping sharply from 855 in 2014–15 to 3,862 in 2015–16.

As with declined retail insurance claims, Code Subscribers provided limited insights into trends seen in internal disputes data and generally pointed to strong business growth having a flow-on effect on the data.

The increase in disputes may have contributed to a 20% increase in general insurance disputes registered at the Financial Ombudsman Service Australia (FOS) during 2015–16.[3]

Self-reported Code breaches increased

In 2015–16, the number of self-reported Code breaches increased to 5,021, 33% more than in 2014–15 and reaching similar levels to those reported in 2013–14. Of the self-reported breaches, 76% related to how Code Subscribers handled claims.

The increase in the number of self-reported breaches, particularly those relating to claims handling, raises some concerns about how effective, clear and transparent Code Subscribers are when they interact with consumers. The increase may also suggest that some Code Subscribers do not have adequate processes, systems, training and/or resources in place to meet their obligations under the 2014 Code.

Few self-reported breaches of financial hardship provisions

Code Subscribers reported 27 breaches of the 2014 Code's financial hardship standards (section 8) in 2015–16, compared with only one breach of similar standards in the former Code in 2014–15. This

[3] See *FOS Circular* – issues October 2015, January 2016, May 2016 and August 2016, available from http://fos.org.au/publications/the-fos-circular.jsp.

may be indicative of the enhanced standards in the 2014 Code and more active monitoring of compliance in this area.

Nevertheless, we have seen a marked increase in non-compliance with financial hardship standards through our investigations work in the first half of 2016–17. This trend is likely to continue during the remainder of 2016–17 and we encourage Code Subscribers to continue to increase their focus on monitoring compliance with their financial hardship obligations.

Low number of breaches of catastrophe provisions

Code Subscribers reported only two breaches of the standards in section 9 in 2015–16, compared with 27 breaches of the corresponding standards of the former Code in 2014–15. The improvement in non-compliance reflects the lower number of catastrophe claims lodged during 2015–16.

While reported breaches of the catastrophe standards remained very low, we recommend that Code Subscribers continue to closely monitor compliance with section 9 and encourage them to review claims handling processes and systems to ensure sufficient flexibility and responsiveness.

Industry compliance initiatives following implementation of 2014 Code

In 2015–16 Code Subscribers engaged in numerous compliance initiatives to monitor and improve compliance with their enhanced obligations under the 2014 Code, which became operational on 1 July 2015. These initiatives covered claims and complaints handling, staff development and training, compliance and risk reviews, reporting and analysis.

Broadening of participants in general insurance workforce

We expanded the scope of data collected about participants in the general insurance workforce to take account of a wider definition of ‘employee’ introduced by the 2014 Code. ‘Employee’ now includes employees of a Code Subscriber’s related entity. The size of the general insurance workforce at 143,338 people is now more than double that recorded last year.

The data relating to training of participants on the 2014 Code shows that Code Subscribers have extended this training to Service Supplier, even though there is no obligation to do so. This is a positive step in ensuring that Service Suppliers understand the extent to which the 2014 Code applies to them when acting on behalf of Code Subscribers.

Introduction

This is the Code Governance Committee's General Insurance Industry Data Report (report) for the reporting period 1 July 2015 to 30 June 2016 (2015–16). This report contains aggregate data about the general insurance industry as provided by companies that subscribe to the General Insurance Code of Practice (the 2014 Code[4]).

The data analysed and discussed in this report centres on retail insurance, as this is the focus of the 2014 Code and accounts for most general insurance transactions.

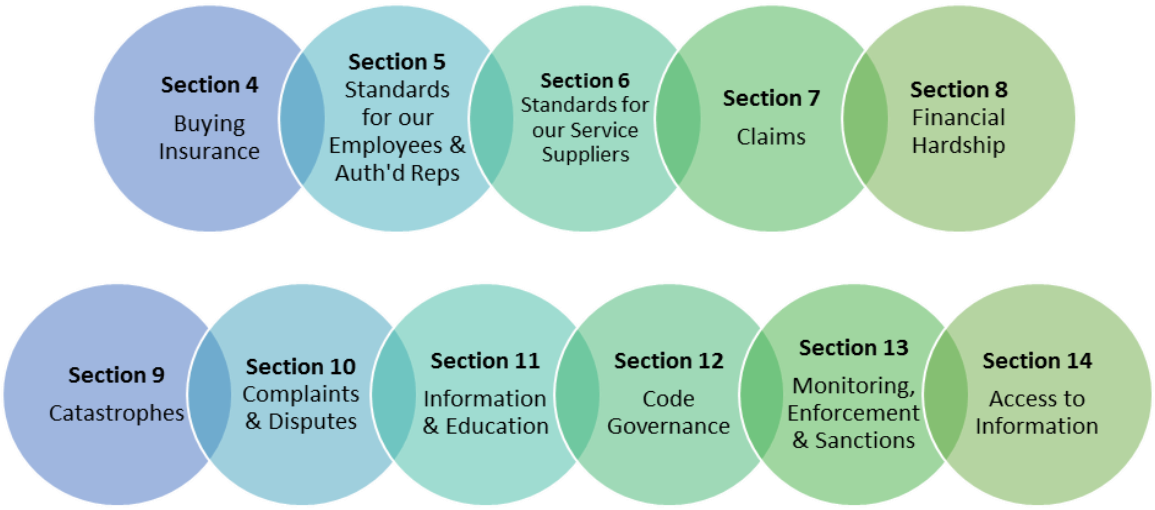
By collecting and reporting on a wide range of retail insurance data, we aim to provide useful information that gives insight into the general insurance industry, improves service standards and promotes better relationships between insurers and consumers.

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. 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 was launched on 1 July 2014 and became operational on 1 July 2015. It applies primarily to retail (rather than wholesale) general insurance products. It contains standards on a range of areas of general insurer practice. The standards are outlined in the diagram below.

The 2014 Code Standards



[4] The 2014 Code is available at www.codeofpractice.com.au/.

Data and terminology

Data sets in this report

This report presents and discusses the following sets of data.

General insurance policies (policies)

Data about:

a) individual policies – these are policies (contracts of insurance) issued to an insured (usually a person) to provide cover for themselves or their assets, for example:

- a car or home or pet, or
- financial interests, such as their liability to repay a personal loan when unable to do so because of an accident, illness or unemployment.

b) group policies and the people or assets covered by them – these are master policies (contracts of insurance) issued to an entity, such as a financial institution, employer or school, which cover a group of people or a group of assets, for example:

- complimentary travel insurance for a financial institution's credit card holders
- sickness and accident cover for a company's employees
- devices, such as tablets, used by a school's students.

Claims

Data about lodged claims, declined claims and withdrawn claims.

Internal disputes

Data about disputes in the second stage (Stage Two) of Code Subscribers' internal complaints processes by dispute type as follows:

a) disputes received in Stage Two
b) disputes that have completed Stage Two (finalised disputes)
c) disputes finalised in favour of consumers
d) disputes finalised in favour of Code Subscribers.

Compliance

Data about:

a) the extent of training on the 2014 Code
b) Code breaches identified by Code Subscribers (self-reported breaches)
c) Code Subscribers' compliance monitoring and initiatives.

Workforce data

Data about:

a) Employees, including employees of related entities
b) Authorised Representatives

c) Service Suppliers: claims management services, collection agents, investigators, loss assessors or loss adjusters

d) agents

e) independent contractors.

General insurance classes

For the data sets about policies, claims and internal disputes, we asked Code Subscribers to consolidate data about the general insurance products they issued into 'retail' or 'wholesale' classes of insurance as outlined in Table 1.

Table 1 Insurance classes

Retail Insurance	Wholesale Insurance
1. Consumer Credit	1. Business
2. Home	2. Business Pack
3. Motor	3. Contractors All Risks
4. Personal & Domestic Property	4. Industrial Special Risks
5. Residential Strata	5. Liability
6. Sickness & Accident	6. Motor Wholesale
7. Travel	7. Other
	8. Primary Industries
	9. Primary Industries Pack

Home insurance products

Code Subscribers consolidate data about home building, home contents and combined home building & contents insurance products, including landlord insurance, under 'Home'.

Personal & Domestic Property insurance products

Personal & Domestic Property insurance includes products that cover pets, and items such as caravans, trailers, pleasure craft, spectacles and consumer electronics such as laptops, tablets and mobile phones. It also includes extended warranty products that apply to items such as consumer electronics, whitegoods, motor vehicle tyres & rims, and motor vehicles.

Residential Strata insurance products

Residential Strata insurance provides cover for damage to common property on a residential strata plan, which is owned collectively by the individual unit holders. 'Common property' means such things as passages, stairs, walls, windows, ceilings, floors, wiring, pathways, driveways, lifts, foyers, gardens and fences.

It is issued to owners' corporations comprised of the individual unit holders on a residential strata plan. Although the owners' corporation is the insured party, the insurance cover is for the benefit of the individual unit holders who are third party beneficiaries under the contract of insurance.

While Residential Strata insurance is not specifically listed as a retail insurance product in the 2014 Code or the relevant Regulations of the *Corporations Act 2001 (Cth)* (the Act), it is our view that we should treat it as a retail insurance product under the 2014 Code because:

- The nature and purpose of the product meet the criteria for what is considered 'a home building insurance product' under the Act and Regulations.[5]
- The 2014 Code lists 'a home building insurance product' as a 'Retail Insurance' product.
- The standards of the 2014 Code focus largely on protecting consumers who rely on retail insurance products, whether as insureds or as third party beneficiaries.

Changes to the data collection framework

In 2015–16, we made several changes to our collection framework to help improve the quality and consistency of the data and to align it with the 2014 Code's standards and framework. We worked with Code Subscribers to establish a clearer and more robust collection framework. Our aim was to help enhance how they produce the data as well as our ability to analyse it meaningfully.

This means that we collected some types of data for the first time or in a new way and established new baselines for future comparisons. As a result, we cannot yet provide accurate 'like for like' comparisons for some data sets with previous years.

A key example of this is data about policies. In the past, we asked Code Subscribers to submit data about policies under a single category that was inclusive of group policies, and some Code Subscribers also included the number of people or assets covered under group policies. However, as the industry and its reporting capabilities changed, this approach no longer provided us with a clear picture of how the industry was operating. For that reason, we decided that it would be better to break this data down to provide a more accurate representation of the number of individual and group policies issued and the number of people or assets covered by group policies. Code Subscribers are now working towards enhancing their reporting frameworks to meet our new approach.

Interpreting trends, previous reports, reporting conventions and terminology

We do not audit the data submitted by Code Subscribers. We rely on Code Subscribers to carefully review their data to ensure its accuracy and to inform us about any errors in data submitted previously. When analysing trends in the data, we consult with Code Subscribers and ask them for their views on factors that may have influenced change at the company or industry level. Code Subscribers' views on these factors are discussed in this report and should be kept in mind when interpreting the data. Variations in the data reported to us can occur for several different reasons including (but not limited to) changes to systems, migration to new systems, and reporting frameworks that differ between companies. As a result, the data in this report is indicative only. We continue to work with Code Subscribers to enhance how the data is produced and collected (by us) to improve accuracy and consistency.

All the data in this report was correct at the time of reporting. Minor differences between this report and previous reports reflect the outcome of a review of our data collection and reporting frameworks for Code Subscribers. Many of the charts, diagrams and tables in this report use percentages. We have rounded most 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%.

We have included a glossary of terms in Schedule 6 of this report.

[5] See section 761G (5), *Corporations Act 2001 (Cth)* and Regulation 7.1.12 (3)(a).

Buying insurance

In the past, we asked Code Subscribers to consolidate data about the number of general insurance policies issued under a single 'policies' category, largely because their systems and reporting restrictions meant they were unable to break this data down.

Code Subscribers are now able to provide more comprehensive policy data about the number of policies issued, how many of these policies are group policies, and the number of people or assets covered by group policies. This has given us a more accurate and inclusive picture of consumer coverage in 2015–16.

Policies

Code Subscribers reported that they issued 47,279,460 general insurance policies in 2015–16, of which the large majority, 44,171,089 (93%), were retail insurance policies.

Table 2 shows the total policy data for retail and wholesale insurance broken down into individual and group policies.

Table 2 General insurance policies issued in 2015–16

Insurance class	Individual policies	Group policies	Total policies
All Classes	**47,054,985**	**224,475**	**47,279,460**
Retail	44,117,605	53,484	44,171,089
Wholesale	2,937,380	170,991	3,108,371

The retail insurance policy data is outlined in Table 3 and shows that:

- Motor was the largest retail class comprising 34%, while Home accounted for 26%.
- Group policies accounted for just 0.12% of all retail insurance policies.
- Most group policies consisted of Sickness & Accident and Travel policies.
- Group Sickness & Accident policies represented 58% of all retail group policies.

Table 3 Retail insurance policies issued in 2015–16

Insurance class	Individual policies	Group policies	Total policies
Retail Total	**44,117,605**	**53,484**	**44,171,089**
Motor	14,980,946	8	14,980,954
Home	11,636,781	2	11,636,783
Travel	7,600,924	21,219	7,622,143
Personal & Domestic Property	6,606,816	151	6,606,967
Sickness & Accident	2,077,617	30,956	2,108,573
Consumer Credit	992,615	1	992,616
Residential Strata	221,906	1,147	223,053

Group policies

Table 4 shows data about retail and wholesale group policies and the number of people or assets covered by them. The data highlights that although wholesale group policies outnumbered retail group polices by three to one, retail group polices provided protection for substantially more people or assets.

Table 4 Group policies and people/assets covered by them in 2015–16

Insurance class	Group policies	People or assets
All Classes	**224,475**	**9,858,711**
Retail	53,484	8,065,635
Wholesale	170,991	1,793,076

Table 5 shows data about retail group policies and the number of people or assets covered by them. Sickness & Accident includes the largest number of group policies, followed by Travel. Together, these two retail classes provide cover for the benefit of 7,447,087 people or assets and account for 92% of all people or assets covered by group policies.

Table 5 Retail group policies and people/assets covered by them in 2015–16

Insurance class	Group policies	People or assets
Retail Total	**53,484**	**8,065,635**
Travel	21,219	4,999,873
Sickness & Accident	30,956	2,447,214
Personal & Domestic Property	151	603,569
Residential Strata	1,147	13,841
Home	2	498
Motor	8	443
Consumer Credit	1	197

Code compliance

Section 4 of the 2014 Code sets standards for the way in which Code Subscribers are required to sell, renew and administer insurance policies, and respond to consumer enquiries about insurance products.

In 2015–16, Code Subscribers identified and reported substantially fewer breaches of section 4, compared with 2014–15. Code Subscribers identified and remedied 391 breaches relating to buying insurance, a 51% decrease from 795 breaches last year. Breaches of section 4 as a proportion of all non-compliant activity decreased to 8% from 21% last year.

Code Subscribers identified and reported breaches against eight different subsections of section 4. The highest number of breaches was for subsection 4.4, which requires Code Subscribers to conduct their sales processes in an efficient, honest, fair and transparent manner.

Code Subscribers reported 323 breaches of subsection 4.4, down 29% compared with a combined 457 breaches of the equivalent standards in the former Code.[6]

Some of the breaches of subsection 4.4 occurred because employees or Authorised Representatives:

- gave some customers incomplete policy information because they did not fully explain sub-limits, exclusions or information about dependants or pre-existing medical conditions
- sold some customers the wrong product
- recorded incorrect dates in policy information
- gave some customers incorrect policy documents
- did not inform some customers of their obligation to comply with the duty of disclosure
- did not ask some customers questions relevant to assessing their application for insurance cover
- did not send renewal notices to some customers at least 14 days before policy expiry.

In 2015–16 breaches of subsection 4.4 ranked fourth in the top five areas of non-compliance across all sections of the 2014 Code.

We have provided detailed compliance data for 2015–16, including the top five areas of non-compliance across all sections of the 2014 Code, in Schedule 4 of this report.

Addressing breaches

The most common cause reported for breaches of section 4 was employees or Authorised Representatives failing to follow established processes.

As a result, consumers were under informed or misinformed about the products they were purchasing which led to a lack of clarity and transparency during the sales process. To address this, Code Subscribers adopted a variety of remedies including:

- providing the relevant employees and Authorised Representatives with further training or coaching to ensure that they clearly understood the process and applied it correctly
- improving internal monitoring frameworks
- correcting policy information and providing updated information to customers
- refunding premiums
- providing statutory insurance cover to give affected customers time to review their insurance renewal.

Guidance for industry

Most section 4 breaches were identified through complaints made by consumers to Code Subscribers. The most common reason for these types of breaches was a failure to follow established processes when selling insurance to consumers.

We make the following recommendations for better and more effective compliance by Code Subscribers.

[6] Subsections 2.1.4 and 2.4.1 were the equivalent standards in the 2012 (former) Code.

Recommendation 1 – Proactive compliance monitoring of sales and related processes

Code Subscribers should take a proactive rather than reactive approach to compliance monitoring. While complaints data is very useful in tracking compliance issues or risks, it should be accompanied by active monitoring of compliance with Code obligations.

This will enable Code Subscribers to identify and assess emerging risks and issues, and rectify problems in a timely way, lessening the risk of broad consumer detriment. Code Subscribers should also regularly review their monitoring frameworks to ensure they align with relevant Code and regulatory requirements and remain effective.

Recommendation 2 – Clear and effective training in sales and related processes

Code Subscribers should ensure they have the right measures in place to assess the effectiveness of their training of employees and Authorised Representatives. Where a failure to follow processes is a key cause of non-compliance, Code Subscribers may need to assess whether their training packages are clear and effective.

Recommendation 3 – Clarity and accessibility of sales and related processes

Similarly, Code Subscribers should regularly review their processes and test their effectiveness to ensure that employees and Authorised Representatives can easily access and apply them.

We note that there have been some steep decreases in the number of breaches reported of section 4 compared with last year, which suggests that Code Subscribers have paid closer attention to this area and have made changes or put measures in place to improve compliance. However, we encourage Code Subscribers to continually review their training, systems and processes to reduce the risk of non-compliance and consumer detriment.

Claims, declined claims and withdrawn claims

Although the number of claims made by consumers remained about the same as last year, the number of declined and withdrawn claims continued to grow in 2015–16. Table 6 shows the 2015–16 figures for claims compared with last year.

Table 6 Retail and wholesale general insurance claims in 2015–16

Insurance class	Lodged claims		Declined claims		Withdrawn claims	
All Classes	**4,261,310**	**0%**	**148,697**	**↑ 12%**	**287,203**	**↑ 29%**
Retail	3,755,643	↑ 2%	143,445	↑ 14%	270,799	↑ 29%
Wholesale	505,667	↓ 8%	5,252	↓ 19%	16,404	↑ 46%

In 2015–16, the number of general insurance claims lodged by consumers remained unchanged with 4,261,310 claims.

However, declined general insurance claims grew to 148,697, up 12% and withdrawn general insurance claims grew to 287,203, up 29%, driven largely by similar increases in retail declined and withdrawn claims.

To provide a clearer picture of the ratio of general insurance claims accepted by Code Subscribers, we have taken into account withdrawn claims. As a result, Code Subscribers accepted 96.3% of general insurance claims in 2015–16.

In our view, data about general insurance claims remains incomplete because we do not collect data about partially accepted claims as yet. We will continue to work with Code Subscribers on developing a consistent definition of 'partially accepted claims' to facilitate accurate and consistent recording of such data, as a first step toward collecting it.

Retail insurance trends

In 2015–16, Code Subscribers reported that consumers made 3,755,643 claims under retail insurance products, 2% more than last year.

However, Code Subscribers declined 143,445 retail insurance claims, 14% more than in 2014–15. The data also shows that withdrawn retail insurance claims grew by 29% to 270,799.

Code Subscribers accepted 95.9% of retail insurance claims in 2015–16. Across retail insurance classes, the claims acceptance rate ranged from 85.4% for Consumer Credit claims to 99.5% for Motor claims. All further references to acceptance rates for retail insurance claims in this chapter (and elsewhere if applicable) take into account withdrawn retail insurance claims.

Table 7 shows the 2015–16 data for retail insurance claims and changes since 2014–15 and we have provided the claims acceptance rates in Chart 1.

Table 7 Retail insurance claims in 2015–16

Insurance class	Lodged claims		Declined claims		Withdrawn claims	
Retail Total	**3,755,643**	**2%**	**143,445**	**14%**	**270,799**	**29%**
Motor	2,001,361	6%	8,680	9%	128,072	37%
Home	810,901	13%	50,582	9%	102,003	9%
Personal & Domestic Property	523,744	6%	44,592	17%	24,143	205%
Travel	281,647	11%	31,090	28%	13,933	3%
Residential Strata	58,326	42%	1,722	244%	704	162%
Sickness & Accident	46,282	16%	2,096	43%	588	256%
Consumer Credit	33,382	3%	4,683	8%	1,356	52%

Chart 1 Retail insurance claims acceptance rates in 2015–16

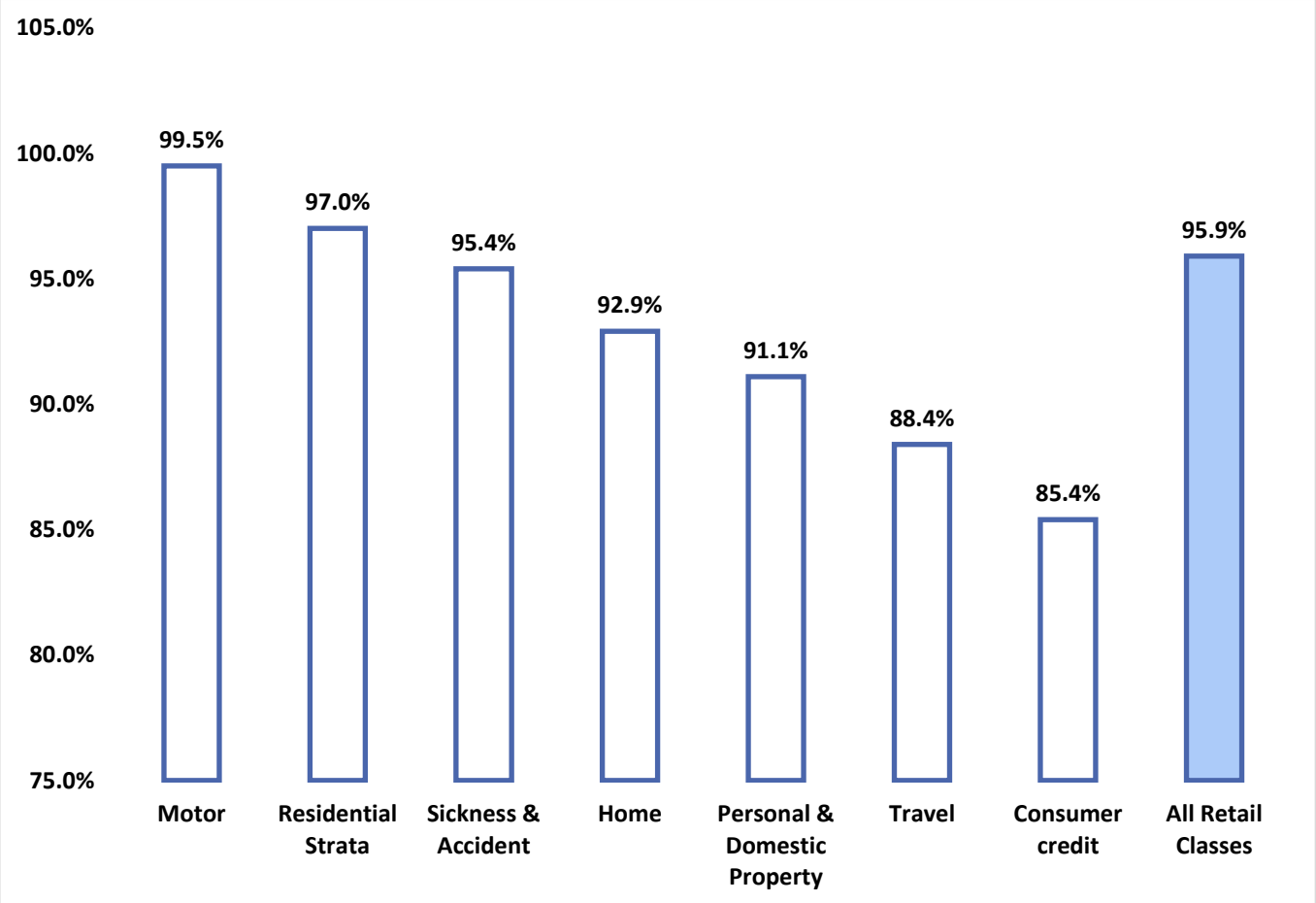
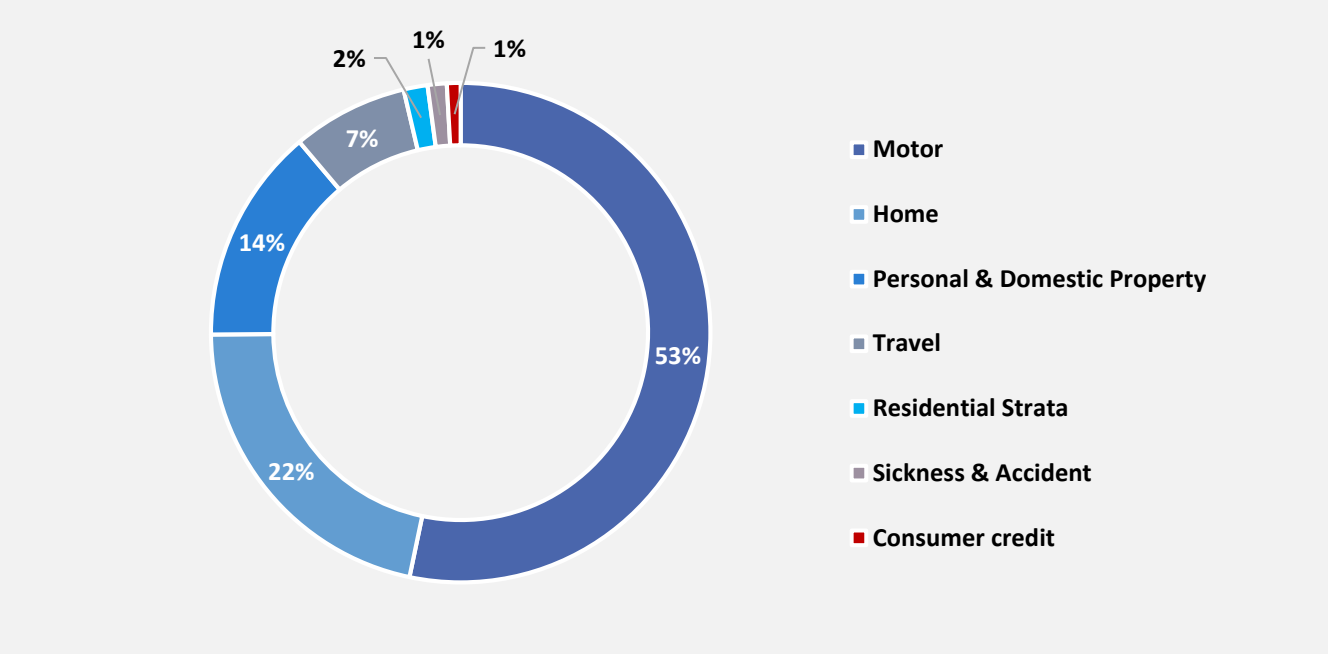


Chart 2 shows the proportion of retail insurance claims by class as a proportion of all retail insurance claims in 2015–16.

Chart 2 shows retail insurance claims by class as a proportion of all retail insurance claims in 2015–16.

The most frequent types of claims by consumers were under Motor insurance products, accounting for 53% of all retail insurance claims in 2015–16. Home claims represented 22% of retail insurance claims, while Consumer Credit and Sickness & Accident each accounted for 1%.

Chart 2 Retail insurance claims in 2015–16



In 2015–16, we worked with Code Subscribers to collect better data about the most common reasons claims were declined and withdrawn, and expanded our data collection framework to collect this information.

We also asked Code Subscribers to describe these reasons in their own words to set a foundation and create a standardised way of collecting this information in the future. Our aim is to work with Code Subscribers to improve consistency in the recording and reporting of this information and our ability to analyse the information, identify trends and emerging issues.

Not all Code Subscribers have the capacity to record why claims are declined or withdrawn, so the information provided by Code Subscribers is not complete or precise. While we were able to draw some high level conclusions from the information reported by Code Subscribers, as outlined later in this chapter, conclusions are indicative only.

Declined claims

Five of the seven retail insurance classes experienced increases in declined claims leading to an overall increase of 14% to 143,445.

The increase in declined claims frequency is largely due to Home, Personal & Domestic Property and Travel retail insurance classes, which together accounted for 88% of all declined claims in 2015–16, an increase of 16% compared with last year. Only Consumer Credit and Sickness & Accident classes resulted in fewer declined claims compared with last year.

We asked Code Subscribers to explain any year-to-year change in declined claims frequency greater than 10%. Only some Code Subscribers provided reasons for increases in declined claims, restricting our ability to explain the trends in the data. These Code Subscribers broadly attributed the trend to increased sales of retail insurance products, leading to more claims and subsequently more declined claims in 2015–16 compared with 2014–15. They also identified a continuing improvement in the recording of data about declined claims.

We note that in 2015–16 consumers lodged 65,530 additional retail insurance claims, 2% more than last year. Yet Code Subscribers declined 20,570 additional claims, an increase of 14% compared with last year. In our view, the factors attributed by Code Subscribers to the increase in declined retail claims do not adequately explain these data trends. Code Subscribers have informed us that they are continuing to enhance their reporting frameworks to better understand these changes.

We strongly encourage Code Subscribers to accurately and consistently record the reasons why claims are declined, and review declined claims data on a quarterly basis. In our view, this approach will enable Code Subscribers to better identify and analyse the causes underlying emerging trends. We highlighted in our previous report that this type of information and analysis may also highlight gaps in consumers' understanding of their policies or changes in the way that Code Subscribers are managing retail insurance claims.

Withdrawn claims

The number of withdrawn retail claims also continued to increase in 2015–16, reaching 270,799. This represented a 29% increase, building on a 61% increase in 2014–15. Apart from Travel (down 3%), all other classes saw substantial increases in withdrawn claims. Motor and Home accounted for 85% of withdrawn claims in 2015–16.

Code Subscribers again provided only limited information about factors contributing to the increase in withdrawn claims, restricting our ability to explain the trends shown by the data or identify emerging trends.

It is crucial that Code Subscribers record accurate data about withdrawn claims including detailed reasons for their withdrawal and we remain concerned that these increases in withdrawn retail claims may indicate that:

- There may still be gaps in consumers' understanding of how some of these products operate in practice.
- Some withdrawn claims may represent claims that would otherwise have been declined.

Unlike the requirements that apply to declined claims, Code Subscribers are not under any obligation to provide consumers with written notification of a claim withdrawal and the reasons, or to notify consumers of their rights to access information underlying the assessment of their claim, internal and external complaints and dispute resolutions processes

Motor

Lodged Motor claims

Consumers lodged 2,001,361 claims under Motor insurance products in this period, up by 6%. Motor insurance accounted for 53% of all retail insurance claims in this period compared with 51% in 2014–15.

Declined Motor claims

The frequency of declined Motor claims fell from a 26% increase in 2014–15 to a 9% increase in 2015–16, with 8,680 declined Motor claims. Motor has the highest claims acceptance rate of all retail classes at 99.5%.

Code Subscribers provided reasons why they declined 6,474 (75%) of the 8,860 Motor claims declined in 2015–16. Some of the most common reasons were that:

- The policy did not cover the claim – 1,947 claims.
- The insured did not comply with their duty of disclosure or made a misrepresentation at the time they bought their policy – 1,435 claims. Some examples were non-disclosure of driving history or unacceptable vehicle modifications.
- The policy was not valid at the time of the incident resulting in the claim – 1,306 claims.
- The policy excluded the claim – 843 claims. Some examples of exclusions included the age of the driver; the driver was unlicensed; damage or loss caused by a structural, mechanical or electrical failure; damage due to wear and tear; and driving under the influence of alcohol/drugs.
- The claimant did not cooperate – 393 claims.

One Code Subscriber reported that it declined 10 Motor claims based on fraud.

Withdrawn Motor claims

Motor has the highest number of withdrawn claims of any retail insurance class. Although Code Subscribers only declined 9% of Motor claims, the frequency of withdrawn Motor claims in 2015–16 jumped 37% to 128,072.

Two Code Subscribers informed us that the increases in their withdrawn claims data was substantially due to improved recording of withdrawn claims data and data migration from multiple legacy claims systems to a single claims system.

Code Subscribers provided reasons why 56,253 (44%) of the 128,072 Motor claims were withdrawn in 2015–16 and the top reasons were that:

- The ‘claim was not pursued’ and includes no response or no further contact from the claimant – 21,756 claims.
- The value of the claim was less than the applicable excess – 9,759 claims.
- The customer withdrew their claim or decided not to proceed – 7,963 claims.

Code Subscribers reported that 1,542 Motor claims were withdrawn after completing their review or investigation of these claims and included one Code Subscriber who reported that 7 Motor claims were withdrawn due to the presence of fraud indicators.

Home

Lodged Home claims

Home claims accounted for 22% of all retail claims lodged in 2015–16, falling by 13% to 810,901 claims from 928,330 claims in 2014–15. This reflected a relatively benign claims environment compared to 2014–15, which saw a 30% increase in Home claims largely attributable to the severe weather events during that period.

Declined Home claims

At 50,582 declined claims, the Home class is the largest contributor to declined retail insurance claims, representing 35% of the total.

Code Subscribers accepted 92.9% of Home claims lodged in this period. There was a 9% increase in the number of Home claims declined in this period down from 19% in 2014–15.

Code Subscribers identified several factors contributing to the number of declined Home claims including:

- Migration of data from multiple legacy claims systems to a single claims system.
- Strengthened decision-making and capability in claims to ensure better adherence to policy wordings and internal claims procedures. This included increased use of specialist building consultants to assess building claims, leading to more accurate identification of the proximate causes of loss or damage.
- Some claims that were lodged in 2014–15 were not decided until 2015–16.

Code Subscribers provided reasons why they declined 40,166 (79%) of the 50,582 declined Home claims in 2015–16. The most common reasons were that a policy exclusion applied to the claim or the policy did not cover the loss or damage claimed. These reasons applied to 37,658 claims including 9,415 claims excluded because there was no insured event.

Some Home claims were declined because the loss or damage was attributed to:

- interior water damage unconnected to a storm-created opening
- wear and tear
- gradual deterioration
- a leaking shower base
- earth or soil movement.

Withdrawn Home claims

The number of withdrawn Home claims in 2015–16 was 102,003, an increase of 9%. Home has the second highest number of withdrawn claims after Motor.

Code Subscribers reported that the increase in withdrawn Home claims could have been due to the following factors:

- Staff might not have coded claims correctly when closed; artificially inflating withdrawn claims data.
- Migration of data from multiple legacy claims systems to a single claims system has improved data quality.
- Recording of withdrawn claims data has improved.
- Reporting methods now include all claims that were closed where no decision to accept or deny the claim was made.

Code Subscribers gave us reasons for the withdrawal of 49% (49,981) of the 102,003 Home claims withdrawn in 2015–16 and some of the most common reasons were that:

- The ‘claim was not pursued’ and includes no response or no further contact from the claimant – 18,139 claims.

- The claimant withdrew the claim – 12,927 claims.
- The value of the claim was less than the applicable excess – 4,653 claims.
- A policy exclusion applied or the incident was not covered by the policy – 1,325 claims. This included a failure to show that the damage or loss was caused by an insured event or that it was due to wear and tear.

Code Subscribers reported that 1,877 Home claims were withdrawn after they completed their review or investigation of these claims.

One Code Subscriber reported that 10 Home claims were withdrawn due to the presence of fraud indicators and another Code Subscriber informed us that 14 Home claims were withdrawn because the insured did not cooperate.

Personal & Domestic Property

Lodged Personal & Domestic Property claims

Consumers lodged 523,744 Personal & Domestic Property claims, up by 6% in 2015–16. Some Code Subscribers reported strong business growth as the main reason for increases in claims lodged with them.

This class of insurance accounted for 14% of all retail claims in this period and Code Subscribers accepted 91.1% of these claims.

Declined Personal & Domestic Property claims

Code Subscribers declined 44,592 Personal & Domestic Property claims in 2015–16, an increase of 17%. A similar increase of 16% was seen last year.

Personal & Domestic Property claims represented 31% of all declined retail insurance claims, second to Home. Some Code Subscribers attributed the increased frequency of declined claims in this class to strong business growth.

Code Subscribers explained why they declined 34,482 (77%) of the 44,592 Personal & Domestic Property claims declined in 2015–16, and the most common reasons were that:

- The policy did not cover the claim – 16,733 claims. This included claims that fell outside the policy period or claims made in relation to expired policies.
- A policy exclusion applied to the claim – 16,031 claims.

Some examples of policy exclusions were:

- excluded diagnoses or first clinical sign within waiting period (pet insurance)
- no sim card in mobile phone or mobile phone left unattended (mobile phone insurance)
- the item was covered by a statutory warranty
- the item was stolen from an unlocked/unattended motor vehicle
- the damage was due to wear and tear.

Code Subscribers reported that 157 Personal & Domestic Property claims were declined in this class because of fraud or non-cooperation by the insured.

Withdrawn Personal & Domestic Property claims

In 2015–16, the number of withdrawn Personal & Domestic Property claims grew substantially from 7,912 claims in 2014–15 to 24,143 claims, an increase of 205%. Code Subscribers attributed this increase to:

- Changed reporting methods.
- The inclusion of all claims that were closed where no decision to accept or deny the claim was made.
- Increases in the number of new and renewed policies and claims.

Code Subscribers provided reasons why 2,526 (11%) of the 24,143 Personal & Domestic Property claims were withdrawn in 2015–16, and the main reasons were that:

- The claimant decided not to proceed with their claim – 959 claims. This includes claims withdrawn because they fell within the applicable claim excess; the insured carried out repairs/replacement at their own cost; or the repairs were covered by a product warranty.
- The claimant did not pursue the claim or there was no response from them – 1,041 claims.

Some claims were withdrawn after Code Subscribers completed their review or investigation, or because the claimant did not cooperate, or due to the presence of fraud indicators – this applied to 65 claims.

Travel

Lodged Travel claims

Consumers lodged 281,647 Travel claims in 2015–16, an 11% increase from the previous year.

Travel represents 7% of all retail claims lodged in the period and had the second lowest claims acceptance rate – Code Subscribers accepted 88.4% of these claims.

Declined Travel claims

The frequency of declined Travel claims rose 28%, taking the number to 31,090 in 2015–16.

Code Subscribers reported strong business growth through the acquisition of new partnerships and distribution channels as the primary reason for more Travel claims and more declined Travel claims. Outside of this, Code Subscribers were unable to provide any other clear underpinning reasons for the increased frequency of declined Travel claims.

Code Subscribers provided us with reasons why they declined 33% (10,347) of the 31,090 Travel claims declined in 2015–16. These reasons included declining a claim because a policy exclusion applied or a policy condition was not met, which applied to 7,449 claims.

Some examples of exclusions were:

- the claim exceeded the cover's limit
- pre-existing illness or medical condition
- luggage left unattended
- no cover for work-related conditions.

Withdrawn Travel claims

There was a 3% decrease in withdrawn Travel claims to 13,933 in 2015–16. Code Subscribers outlined why 6,870 (49%) of these claims were withdrawn and the most common reasons were that:

- There was no further activity on the Travel claim including no contact from the claimant – 2,383 claims.
- The Travel claim fell under the applicable excess – 1,183 claims.
- 609 Travel claims were discontinued after Code Subscribers completed their investigation or review.

Consumer Credit, Sickness & Accident and Residential Strata

Lodged claims – Consumer Credit, Sickness & Accident and Residential Strata

Code Subscribers reported that consumers lodged:

- 33,382 Consumer Credit claims, down 3% from last year. This class had the lowest claims acceptance rate at 85.4%.
- 46,282 Sickness & Accident claims, down 16%. The claims acceptance rate for this class is 95.4%.
- 58,326 Residential Strata claims, up 42%, with a claims acceptance rate of 97%, the second highest rate of all retail classes.

Consumer Credit, Sickness & Accident and Residential Strata classes combined represent only 4% of all retail insurance claims.

Declined and withdrawn claims – Consumer Credit, Sickness & Accident and Residential Strata

Each of these three classes have relatively small volumes of declined and withdrawn claims which means that any data changes are more apparent, as follows:

- The number of declined Consumer Credit claims dropped by 8% to 4,683 claims in 2015–16, contrasting with a 35% increase last year. Withdrawn claims increased by 52% to 1,356 claims.
- In 2015–16, the number of declined Sickness & Accident claims fell 43% to 2,096 claims, compared with a 135% increase in 2014–15. Withdrawn claims increased 256% to 588 claims.
- The frequency of declined Residential Strata claims increased sharply by 246% to 1,722, and withdrawn claims also increased by 162% to 704 claims.

Code Subscribers attributed the following reasons to increased withdrawn Consumer Credit and Sickness & Accident claims in 2015–16:

- Code Subscribers gathered better information during the management of claims.
- Employees improved their recording of claims status codes.

Code Subscribers did not highlight any reasons for the increases seen in declined and withdrawn Residential Strata claims. We did not ask Code Subscribers to provide us with the reasons why Residential Strata claims were declined and withdrawn in 2015–16, but we will be collecting this data for future reports. In addition, we will continue to monitor these trends and consult with Code Subscribers if required, to obtain more information.

Reasons for declined claims – Consumer Credit and Sickness & Accident

In relation to Consumer Credit, we received reasons why Code Subscribers declined 2,620 (56%) of the 4,683 claims declined in 2015–16, including the following:

- 1,644 claims were excluded from coverage.
- 262 claims fell within the applicable claim excess.
- Code Subscribers declined 108 claims because the insured did not comply with their duty of disclosure.

Some of the exclusions that applied to declined Consumer Credit claims included:

- pre-existing medical conditions
- voluntary departure from employment
- in casual or temporary employment
- still employed at the relevant time
- loss of employment due to wilful misconduct or
- a maximum annual benefit had been reached.

Code Subscribers provided reasons why they declined 548 (26%) of the 2,096 Sickness & Accident claims declined in 2015–16. Of these 548 claims, Code Subscribers declined 455 because of an exclusion clause, such as:

- The claim was due to a pre-existing medical condition.
- The claimant's condition did not meet the definition of 'injury'.
- The claim fell within the policy waiting period.
- A Medicare exclusion applied to the claim.

Reasons for withdrawn claims – Consumer Credit and Sickness & Accident

Code Subscribers provided reasons why 921 (68%) of the 1,356 Consumer Credit claims were withdrawn in 2015–16. Some of the reasons were that:

- The claim did not proceed or the insured decided not to proceed any further – 661 claims.
- There was no response from the claimant – 168 claims.
- The claim was withdrawn because of an investigation – 23 claims.

In relation to the 588 withdrawn Sickness & Accident claims, Code Subscribers provided reasons for 57 (10%) of these:

- 55 claims were withdrawn because they were lodged in error.
- The remaining two claims were withdrawn because the insured decided not to proceed with them.

Code compliance

The Code devotes substantial attention to claims. Section 7 of the 2014 Code sets out standards that apply to the handling of claims by Code Subscribers and their Service Suppliers. Breaches of this section represented the largest area of non-compliance in 2015–16 and accounted for four of the top five areas of non-compliance.

There were 3,808 breaches of claims standards, accounting for 76% of the 5,021 breaches reported overall. This is a 41% increase from 2,702 breaches recorded in 2014–15[7] and brings the level of non-compliance back to the levels reported in 2013–14 (3,835).

This non-compliant activity occurred in a highly active general insurance claims environment comprising 3,755,643 retail claims (up 2%), 143,445 declined claims (up 14%) and 270,799 withdrawn claims (up 29%).

We have provided detailed claims handling compliance data in Schedule 4 of this report.

Updating consumers about claims

The largest area of non-compliance in 2015–16 was subsection 7.13, which requires Code Subscribers to update consumers about the progress of their claim at least every 20 business days. Industry reported 1,464 breaches of this standard, up 111% from 693[8] in 2014–15.

Code Subscribers reported that about half of the breaches happened because processes and procedures were not followed. About one third of breaches occurred due to administrative errors. Code Subscribers addressed this non-compliance by improving processes and procedures, providing remedial training to staff and increasing staff resources.

Guidance to industry

In last year's report, we noted that there are at least two ways Code Subscribers can assist employees and Service Suppliers 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, which could be monitored by team leaders and managers.

Recommendation 4 – Review controls that apply to updating consumers about claims

Given the increase in non-compliance in this area in 2015–16, we encourage all Code Subscribers to review their systems, processes and procedures for updating customers about claims to ensure that sufficient controls are in place to support compliance.

Decision-making timeframes

The 2014 Code contains two standards that require 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 7.9 applies when a Code Subscriber can make a claim decision on the information supplied when the

[7] Section 3.3 was the equivalent standard in the 2012 Code.
[8] Section 3.2.3 was the equivalent standard in the 2012 Code.

claim was lodged.[9] There were 491 breaches of subsection 7.9 reported in 2015–16, down 6% from 521 in 2014–15.

Section 7.16[10] states that when a Code Subscriber has all relevant information and has completed all enquiries, it will decide whether to accept or deny a consumer's claim and notify them of its decision within ten business days. There were 363 breaches of this standard, an increase of 56% from 2014–15.

The reasons Code Subscribers identified for failing to comply with decision-making timeframes mainly related to a failure to follow processes and procedures and administrative errors. Two Code Subscribers reported that too few staff was a cause of non-compliance in this area.

Code Subscribers addressed non-compliance with these standards by:

- providing remedial training to staff
- providing information to consumers
- improving processes and procedures
- increasing staff resources.

Guidance to industry

Subsections 7.9 and 7.16 are designed to ensure that Code Subscribers make decisions about claims within a reasonable amount of time. It requires Code Subscribers to proactively manage claims by:

- collecting all the information they require to make a decision about the claim, and
- informing consumers about their decision as soon as reasonably practicable within the specified timeframe.

Restoring consumers to the position they were in before the loss is paramount. As a result, claim decisions should be made in a timely and efficient manner to reduce the impact on consumers after they have suffered a loss.

We have concerns about the number of breaches being reported against these sections as they rank second and third in the top five areas of non-compliance.

There has been a decrease in the number of breaches reported against subsection 7.9, which suggests that Code Subscribers have made improvements to how they make decisions about claims where they do not require any further information, assessment or investigation. However, breaches of subsection 7.16 increased 56% suggesting that Code Subscribers are experiencing challenges in:

- making claim decisions within the designated timeframe, after they have received all the relevant information and completed their enquiries
- resourcing claims handling areas of their businesses
- the efficiency of claims handling processes.

We discussed similar issues in our previous report in which we highlighted the importance of paying closer attention to compliance with the equivalent standard in the 2012 Code.

[9] Section 3.1 was the equivalent standard in the 2012 Code.
[10] Section 3.2.5 was the equivalent standard in the 2012 Code.

Recommendation 5 – Timely identification of emerging risks and adequate resourcing of claims handling

Considering the increase in the number of breaches reported against subsection 7.16, we recommend, and reiterate, that Code Subscribers should:

- review complaints about delays in making claim decisions to try and identify areas of emerging risk
- conduct regular reviews of current and closed claim files, including denied claims, to assess whether employees and Service Suppliers are complying with subsection 7.16
- test claim decision making processes to ensure they operate at optimal efficiency
- assess and ensure resourcing of claims handling areas is adequate to allow for timely and efficient claim decisions.

Requiring further information or assessment to make a claim decision

Subsection 7.10 details standards for Code Subscribers where a claim requires further information or assessment. Within ten business days of receiving a claim Code Subscribers must:

- notify a consumer of any information they require to make a claim decision (subsection 7.10(a))
- appoint a loss assessor or loss adjuster where necessary (subsection 7.10(b))
- provide an initial estimate of the timetable and process for making a claim decision (subsection 7.10(c)).

There were 560 breaches of subsection 7.10 in 2015–16, and of these breaches, 50% related to subsection 7.10(c). Breaches of subsection 7.10 were up 63% compared with 344 breaches in 2014–15.[11]

The main reasons that Code Subscribers identified for the failure to comply with subsection 7.10 were administrative errors, and processes and procedures not being followed. Code Subscribers addressed non-compliance with these standards by:

- providing remedial training to staff
- providing information to consumers
- improving processes and procedures.

Guidance to industry

The standards in subsection 7.10 aim to promote a higher level of transparency with consumers so they are clear on:

- what is required to progress their claim
- what Code subscribers need to do to make a claim decision
- how long the decision may take.

[11] Subsection 3.2.1 was the equivalent standard under the 2012 Code.

It is important that Code Subscribers meet these standards by actively engaging with consumers and progressing claims in a timely and efficient way.

There have been some notable increases in the number of breaches reported against this subsection, specifically subsection 7.10(c) which requires Code Subscribers to provide an initial estimate of the timetable and process for making a claim decision. Subsection 7.10 (c) ranks fifth in the top five areas of non-compliance, raising concerns about the ability of Code Subscribers to comply and actively engage with consumers.

Like many other breaches of section 7, Code Subscribers reported that the primary causes for these types of breaches was either a failure to follow a process and/or an administrative error. To try and address these issues, Code Subscribers continued to improve processes and provide remedial training.

However, considering the increased frequency of breaches reported against this subsection, we suggest that Code Subscribers may need to do more to identify how and why their `communication with consumers is not as clear, effective and timely as it should be and to make improvements.

Recommendation 6 – Review controls that apply to claims handling

We recommend that Code Subscribers:

- test and assess how clear and effective their processes are in meeting this standard
- review training programs to ensure that employees clearly understand how to apply the relevant processes
- put measures in the place to help reduce the risk of administrative errors.

Financial hardship

Code compliance

The 2014 Code defines 'financial hardship' as a situation where an individual has difficulty meeting their financial obligations to a Code Subscriber.

The enhanced financial hardship standards in the 2014 Code provide protection to a Code Subscriber's own customers (insureds and third-party beneficiaries who owe money to it, except in respect of outstanding premiums) as well as third parties. A third party is an individual who owes money to a Code Subscriber because the Code Subscriber holds them responsible for loss or damage caused to a customer's insured property.

If a customer or third party informs a Code Subscriber that they are experiencing financial hardship, a Code Subscriber must provide them with an application form for financial hardship assistance and contact details for the national financial counselling hotline (subsection 8.4), and it must notify them as soon as reasonably practicable of whether they are entitled to assistance (subsection 8.6).

If a Code Subscriber determines that a customer or third party is entitled to financial hardship assistance it must consider arrangements for the payment of the debt such as extending the due date for payment, paying in instalments or paying a reduced lump sum, and it must confirm any agreed arrangement in writing (subsection 8.8(a)). If a Code Subscriber determines a customer or third party is not entitled to financial hardship assistance, it must provide details of its complaints process (subsection 8.8(e)).

As well as applying to Code Subscriber's employees, the financial hardship standards also apply to its Collection Agents. The 2014 Code defines a Collection Agent as a Service Supplier.

Code Subscribers and their employees and Collection Agents must comply with the Australian Competition and Consumer Commission (ACCC) and Australian Securities and Investments Commission (ASIC) Debt Collection Guideline[12] when taking any recovery action (subsection 8.12).

Collection Agents must provide a consumer with details of a Code Subscriber's financial hardship process (subsection 8.11) and suspend recovery action (subsection 8.7) if the consumer informs them they are experiencing financial hardship.

In addition to the financial hardship standards in section 8, Collection Agents are bound by the broader obligation in subsection 6.2 to provide their services on behalf of a Code Subscriber in an honest, efficient, fair and transparent manner. These obligations also extend to a Code Subscriber's Claims Management Service (also a Service Supplier) authorised to handle debt recovery matters connected with claims it is managing for the Code Subscriber.

In 2015–16 Code Subscribers reported 27 breaches of the financial hardship standards in section 8 of the 2014 Code compared with two breaches of the former Code's financial hardship standards last year.[13] This may be indicative of the enhanced standards in the 2014 Code and more active monitoring by Code Subscribers of compliance in this area.

[12] Available from https://www.accc.gov.au/publications/debt-collection-guideline-for-collectors-creditors
[13] The equivalent financial hardship standards in the 2012 Code were subsections 3.11, 3.12 and 3.13.

In 2015–16 we also identified four breaches of the financial hardship standards through our monitoring work,[14] down from nine in the previous period.

Code Subscribers reported that most breaches had occurred because employees or Service Suppliers had not followed standard financial hardship processes and procedures. Code Subscribers responded to these breaches by providing remedial training about identifying and dealing with individuals experiencing financial hardship.

There were 197 internal disputes about financial hardship issues lodged by consumers with Code Subscribers in 2015–16, down from 310 in 2014–15. Code Subscribers' own customers lodged 131 of these disputes (up from 25 in the previous period), while 66 were lodged by third parties (down from 285). The increase in financial hardship disputes lodged by customers follows the expansion of the financial hardship standards in the 2014 Code to provide protection to an insured or third party beneficiary who owes a Code Subscriber money under an insurance policy it has issued (except in relation to the payment of premiums).

Guidance to industry

Section 8 is a new section in the 2014 Code, and many of the standards represent increased obligations for dealing with individuals in financial hardship. Code Subscribers need to take these obligations seriously. This means that Code Subscribers should have processes that comply with the financial hardship standards and monitor compliance to ensure that their employees and Collection Agents always follow these processes.

The enhanced standards reflect the importance of dealing with individuals experiencing financial hardship in a fair, constructive and practical manner. It is particularly important for a Code Subscriber to correctly identify those individuals experiencing financial hardship as soon as reasonably practicable, and then work with them to determine what assistance is appropriate for their circumstances.

Although the 27 breaches of the financial hardship standards represent less than 1% of the overall number of breaches reported in 2015–16, this was still a notable increase on last year's two reported breaches.

Recommendation 7 – Sustain and increase monitoring of compliance with financial hardship standards

We have also seen a marked increase in non-compliance with financial hardship standards in our monitoring work in the first half of 2016–17 and encourage industry to sustain and increase its focus on monitoring compliance in this area.

Of the 27 reported breaches, nine related to subsection 8.4, which requires a Code Subscriber to provide an application form for financial hardship assistance and details for financial counselling when a customer or third party informs them they are experiencing financial hardship.

[14] See Schedule 2 Overview of breaches closed in 2015-16 on page 29 of our General Insurance Code of Practice Annual Report 2015-16. The report is available from **http://codeofpractice.com.au/governance-and-monitoring**

Code Subscribers need to ensure their employees, Collection Agents and Claims Management Services are aware of their immediate obligation to assist consumers, not only when they receive an explicit request for assistance but also when a response indicates possible financial hardship.

It is imperative that Code Subscribers also put in place similarly vigilant procedures for monitoring their Collection Agents' and Claims Management Services' compliance with financial hardship standards.

Consumers experiencing financial hardship are often vulnerable individuals. This accentuates the importance of having appropriate processes for dealing with financial hardship assistance requests – processes that are responsive, flexible and, above all, fair.

Recommendation 8 – Enhancement and awareness of financial hardship processes

We recommend that Code Subscribers proactively:

- look for ways to enhance their financial hardship processes
- ensure that their own employees, their Collection Agents and Claims Management Services are aware of these processes and their obligations under the 2014 Code.

Responding to catastrophes

During 2015–16 the ICA declared five separate events to be catastrophes:

Table 8 Catastrophes and associated claims in 2015–16[15]

Catastrophe	Associated claims
Pinery Bushfires: impacted towns and cropping areas to the north of Adelaide (26 November 2015 to 28 November 2015)	2,030 claims lodged by 25 March 2016.
Tornado Kurnell: severe storm in Sydney's southern and eastern suburbs (16 December 2015)	5,199 claims lodged by 25 March 2016.
Great Ocean Road Bushfires: 116 homes destroyed along the Great Ocean Road in Victoria (24 December 2015 to 27 December 2015)	527 claims lodged by 25 March 2016.
Yarloop Bushfires: 181 buildings destroyed in a Western Australian fire event (6 January 2016 to 12 January 2016)	1,358 claims lodged by 25 March 2016.
East Coast Low: an intense east coast low moved south along the Queensland, New South Wales and Victoria coastlines, before then causing flooding throughout north west Tasmania. (6 March 2016 to 6 July 2016)	32,000 claims lodged by 16 June 2016.

Consumers lodged 41,114 claims in 2015–16 as a result of these catastrophes, down from the 171,775 claims resulting from catastrophes in 2014–15. Although the number of catastrophes declared was only one less than the previous year, the events themselves were less severe, leading to fewer claims.

Code Subscribers cited the number of claims resulting from catastrophes in 2014–15 as a contributory factor to the rise in the overall number of retail claims lodged in that period. While there were around 130,000 fewer catastrophe claims in 2015–16, the overall number of retail claims increased by just over 2%. Many Code Subscribers attributed this increase to strong business growth, particularly in the Motor, Travel and Personal & Domestic Property classes, leading to more claims.

[15] Media Centre - Insurance Council Australia

Code compliance

Section 9 of the 2014 Code outlines the standards that apply to Code Subscribers in circumstances where the ICA declares an event a catastrophe because it results in many claims involving multiple insurers.

Subsection 9.2 contains a broad obligation requiring Code Subscribers to respond to such catastrophes in an efficient, professional, practical and compassionate manner.

While the standards in section 9 are largely similar to the standards in section 4 of the 2012 Code which covered catastrophes and disasters, there is one significant change. Under subsection 4.3 of the 2012 Code, where a catastrophe-related property claim was finalised within one month of the catastrophe, consumers had six months to:

- check whether the settlement of their claim included everything that was lost or damaged
- ask Code Subscribers to review the claim if they thought the assessment of their loss was not complete or accurate, even if they had previously signed a release.

Subsection 9.3 now allows consumers up to 12 months from the date their catastrophe-related claim was finalised to ask Code Subscribers to review their claim. Code Subscribers are also required under subsection 9.3 to inform consumers about this review period entitlement and their complaints process when they finalise a claim.

In 2015–16 industry reported only two breaches of the standards in section 9, compared with 27 breaches of the corresponding standards in section 4 of the 2012 Code last year. We did not identify any breaches of section 9 through our monitoring work, a similar outcome to last year. In our view, the decrease in the number of breaches reflects the lower number of catastrophe claims lodged in 2015–16.

Guidance to industry

The 2014 Code standards reflect the importance of responding to catastrophes in a practical and compassionate manner. We encourage Code Subscribers to bear in mind the difficulties consumers are likely to be facing in the aftermath of a catastrophe, particularly when contacting them to request documents and information in relation to a claim.

Recommendation 9 – Continue close monitoring of compliance with catastrophe standards

While the number of reported breaches of the catastrophe standards remained very low, we recommend that Code Subscribers continue to closely monitor their compliance with section 9.

We encourage Code Subscribers to review their claims handling processes and systems to ensure they are sufficiently flexible and responsive to cope with severe weather events.

Internal disputes

This chapter focuses on complaints raised by consumers in Stage Two of a Code Subscriber's internal complaints process because they were not resolved in Stage One. In this report, we have described these unresolved complaints as 'internal disputes'.

Table 9 shows that the number of internal disputes about general insurance products and services increased notably in 2015–16, in contrast to the downward trends in previous years. Overall, internal disputes increased 31% to 30,171 in 2015–16, due largely due to a 32% rise in disputes about retail general insurance products (retail insurance disputes) to 28,587, compared with 2014–15.

Code Subscribers completed reviews of 27,071 internal disputes in Stage Two and were required to notify consumers of the outcome of the review of the dispute, and of their right to take disputes to FOS's external dispute resolution service, if not satisfied with the outcome.[16]

Table 9 All Stage Two internal disputes in 2015–16

	Internal disputes in Stage Two			
Insurance class	Received by Code Subscribers		Reviewed by Code Subscribers	
All Classes	**30,171**	**↑ 31%**	**27,071**	**↑ 19%**
Retail	28,587	↑ 32%	25,563	↑ 19%
Wholesale	1,584	↑ 14%	1,508	↑ 16%

The data in Table 10 shows that in 2015–16 the number of internal disputes that completed Stage Two with outcomes in favour of consumers rose to 7,808, representing 29% of internal disputes, compared with 21% in 2014–15.

Table 10 All internal disputes that completed Stage Two in 2015–16

	Outcomes of all internal disputes that completed Stage Two		
Insurance class	Total number completed	Outcomes in favour of Consumers	Outcomes in favour of Code Subscribers
All Classes	**27,071**	**7,808 (29%)**	**19,263 (71%)**
Retail	25,563	7,486 (29%)	18,077 (71%)
Wholesale	1,508	322 (21%)	1,186 (79%)

[16] Acceptance of a dispute at FOS is subject to its Terms of Reference, available at http://www.fos.org.au/about-us/terms-of-reference.jsp.

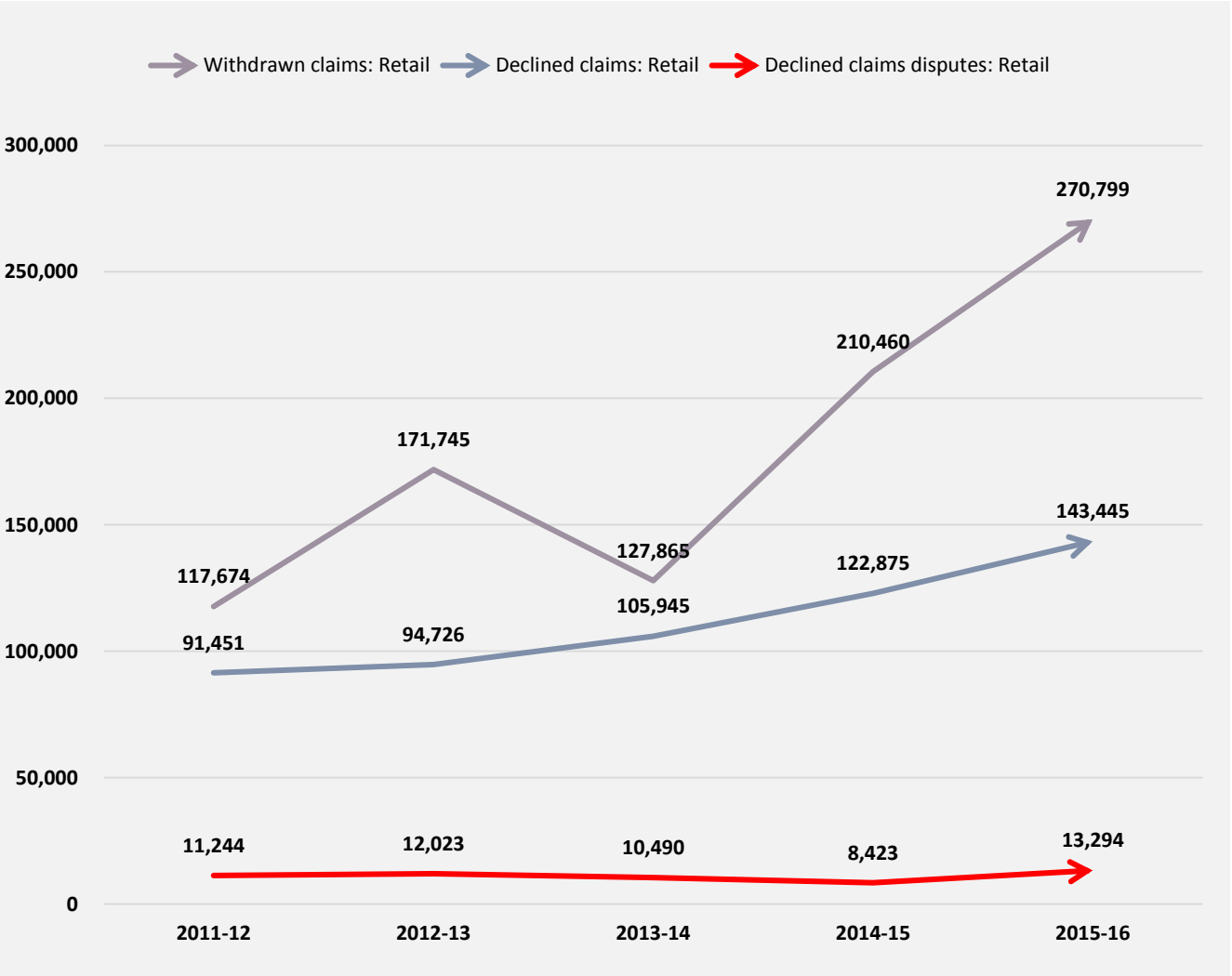
Trends

Chart 3 shows the five-year trend for withdrawn claims, declined claims and internal disputes about declined claims, across retail insurance classes.

The data shows that withdrawn retail claims have largely trended upwards; the only exception was in 2013–14 when some Code Subscribers who had previously reported withdrawn claims data were unable to do so for that period. Similarly, since 2011–12 the number of declined retail claims has steadily increased.

The trend for internal disputes about declined retail claims had been heading downwards since 2013–14, despite steady growth in the number of retail declined claims. However, in 2015–16 this trend reversed so that the number of internal disputes about declined retail claims rose sharply to its highest level over the last five years.

Chart 3 Retail declined claims, withdrawn claims & internal disputes about declined claims from 2011–12 to 2015–16



The data in Table 11 shows that overall the number of internal retail disputes received by Code Subscribers in 2015–16 increased by 32% and that all retail classes experienced increases. This increase in internal disputes may have contributed to a 20% increase in general insurance disputes registered at FOS during the same period.[17] The data shows shows that:

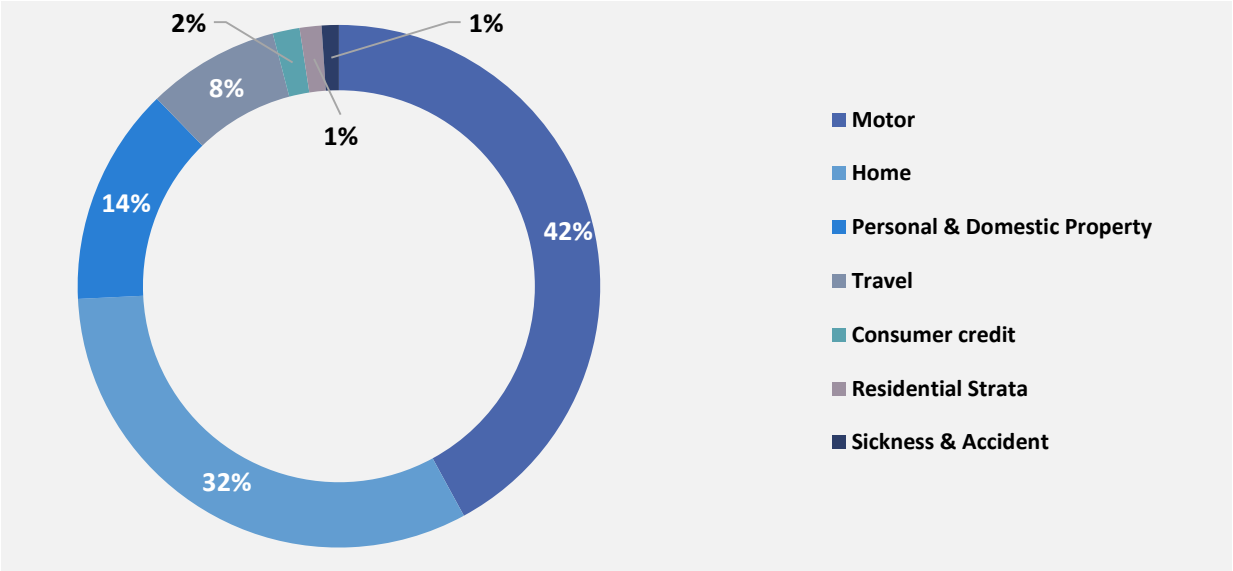
- consumers most often complained about Motor insurance products and services, with 12,024 internal disputes, followed by Home which attracted 9,195 internal disputes
- consumers lodged many more internal disputes about Personal & Domestic Property products and services than in the past, up 352% from last year.

Table 11 All internal disputes in 2015–16

Retail insurance class	All internal disputes		
Total	**28,587**	↑	**32%**
Motor	12,024	↑	13%
Home	9,195	↑	23%
Personal & Domestic Property	3,862	↑	352%
Travel	2,341	↑	20%
Consumer Credit	476	↑	54%
Residential Strata	386	↑	84%
Sickness & Accident	303	↑	30%

Chart 4 shows the proportion of internal disputes by retail insurance class in 2015–16. Motor attracted 42% of all internal retail disputes and Home ranked second with 32%.

Chart 4 Percentage internal disputes by retail insurance class in 2015–16



[17] See *FOS Circular* – issues October 2015, January 2016, May 2016 and August 2016, available at http://fos.org.au/publications/the-fos-circular.jsp.

Most internal disputes about retail insurance products were about claims and related services and these were mainly about decisions to decline claims.

The data in Table 12 shows that 24,647 (86%) of the 28,587 internal disputes received in 2015–16 were about claims and related services, an increase of 36% compared with last year. The frequency of these types of internal disputes substantially increased across all retail classes.

Table 12 Internal disputes about retail claims & services in 2015–16

Retail insurance class	Internal disputes about claims	
Retail Total	**24,647**	**36%**
Motor	10,095	14%
Home	7,446	26%
Personal & Domestic Property	3,812	406%
Travel	2,294	20%
Consumer Credit	407	58%
Residential Strata	381	93%
Sickness & Accident	212	13%

The data in Table 13 summarises internal disputes data specifically about declined retail claims in 2015–16:

- A total of 13,294 internal disputes were about declined retail claims, up by 54% from last year. These types of disputes accounted for 54% of internal disputes about retail claims and related services, up 47%.
- All classes apart from Consumer Credit experienced increases in the frequency of internal disputes about declined retail claims. For instance, the number of internal disputes about declined claims increased by 500% in Personal & Domestic Property and accounted for 96% of all claims-related internal disputes in that class.

Table 13 Internal disputes about declined retail claims in 2015–16

Retail insurance class	Internal disputes about declined claims	
Retail Total	**13,294**	**54%**
Home	4,461	32%
Personal & Domestic Property	3,661	500%
Motor	2,578	20%
Travel	1,950	11%
Residential Strata	284	87%
Consumer Credit	184	10%
Sickness & Accident	176	9%

Code Subscribers provided limited insights into trends seen in internal disputes data and the steep increase in internal disputes about declined claims. They generally pointed to strong business growth having a flow-on effect on claim numbers which in turn influenced the number of declined claims and subsequently increased internal disputes in this period.

We remain strongly of the view that this does not adequately explain the trends seen in internal disputes data. Clearly there is a strong link between declined claims and internal disputes about decisions to refuse to accept consumers' claims.

Recommendation 10 – More analysis of declined claims data is needed

Code Subscribers need to do more to identify and understand the factors underlying year on year increases in declined claims data. This type of analysis will assist them to reduce consumer dissatisfaction with claim outcomes.

Motor

In 2015–16 consumers brought 12,024 disputes about Motor products and services to Code Subscribers, an increase of 13% compared to 2014–15. As in previous years, this class accounted for the largest number of internal disputes overall, accounting for 42% of all retail insurance disputes.

This was also consistent with FOS's experience during the same period. FOS reported that consumers most often complained about Motor products and services, accounting for about 2,757 – 43% – of accepted domestic insurance disputes in 2015–16.[18]

The number of internal disputes about Motor claims rose 14% to 10,095. However only 25% of these disputes (2,578) were about declined claims. Motor was one of only two classes where most internal disputes about claims did not relate to a Code Subscriber's decision to decline a claim. This reflects the fact that Motor has the highest claims acceptance rate of all retail classes (99.5%). Most disputes about Motor claims related to issues other than claim denials, such as delays, quality of repairs, market value calculations, total loss assessments, quantum of settlements and payment of excesses.

Home

Consumers escalated 9,195 internal disputes to industry about Home products and services in 2015–16, an increase of 23% compared with 2014–15. This class accounted for 32% of all personal insurance disputes.

Of these internal disputes, 7,446 (or 81%) were about claims, a marginal increase from 79% in 2014–15. While the number of declined Home claims increased by 9% in 2014–15, internal disputes about declined Home claims saw an even greater increase rising by 32% to 4,461. Disputes about declined claims accounted for 60% of Home claims disputes.

Home was the second largest source of internal disputes. This was also consistent with FOS's experience during the same period, when 2,116 – 33% – of accepted domestic general insurance disputes involved Home products and services.

[18] Financial Ombudsman Service Australia Annual Review 2015-16 at page 69. The Annual Review is available from http://www.fos.org.au/publications/annual-review/

Personal & Domestic Property

The number of internal disputes about Personal & Domestic Property products and services rose from 855 in 2014–15 to 3,862 in 2015–16, an increase of 352%.

Personal & Domestic Property was the third largest source of internal disputes during 2015–16, accounting for 14% of the total. However, FOS's experience with disputes in this class differed. Of domestic insurance disputes accepted by FOS, only 5% – or about 320 – were about Personal & Domestic Property products and services.[19]

Disputes about claims accounted for 99% of all disputes in this class, compared with 88% in 2014–15 and 96% were about declined claims, up from 81%. In terms of numbers, this meant that consumers lodged 3,661 internal disputes about declined Personal & Domestic Property claims in 2015–16, up by 500%. At the same time, Code Subscribers declined 17% more Personal & Domestic Property claims to 6,317.

Travel

Internal disputes about Travel products and services rose 20% to 2,341 in 2015–16, accounting for 8% of all retail insurance disputes. Travel represented the fourth largest source of internal disputes, while for FOS Travel insurance was the third largest source of accepted domestic general insurance disputes during 2015–16, accounting for 12% of all general insurance disputes[20].

The proportion of Travel disputes relating to claims remained very high, at 98% (2,294 disputes). Of the disputes about Travel claims, 1,950 (85%) related to the decision to decline a claim, down from 92% in 2014–15. While the number of Travel claims declined by Code Subscribers increased by 28%, the number of disputes relating to declined claims increased by 11%.

Consumer Credit

Internal Consumer Credit disputes rose 54% to 476 in 2015–16. This included 407 disputes about claims, up 58% compared with 2014–15. The increase was largely due to 189 disputes received about the decision not to re-open a withdrawn claim, a figure which was recorded as zero in 2014–15. This was the first year that we asked Code Subscribers to separately identify this type of dispute; Consumer Credit and Home were the only classes for which this data was provided.

Disputes about declined claims made up 45% of all Consumer Credit claims disputes, down from 80% last year. In addition, disputes about declined claims fell by 10%, from 205 to 184. This was in line with an 8% drop in the number of Consumer Credit claims declined by Code Subscribers. FOS accepted about 128 domestic general insurance disputes about this class in 2015–16.[21]

Sickness & Accident

Consumers escalated 303 internal disputes to industry about Sickness & Accident products and services during 2015–16, an increase of 30%.

There were 212 disputes about Sickness & Accident claims, up 13% of which 176 (83%) were about declined claims. This is a small increase compared with 2014–15 despite a 43% decrease in the

[19] See footnote 18 for website details.
[20] See footnote 18 for website details.
[21] See footnote 18 for website details.

number of declined claims. In the same period FOS accepted about 128 domestic general insurance disputes about this class.[22]

Residential Strata

Internal disputes about Residential Strata insurance products and services in 2015–16 increased 84% compared with 2014–15. This was driven by an increase in disputes about declined claims which went up by 87% taking the figure to 284. The increase in the number of disputes about declined claims is reflective of a 244% increase in the number of claims declined in this period. At the same time FOS accepted about 64 domestic general insurance disputes about this class in 2015–16.

Code compliance

Section 10 of the 2014 Code requires that Code Subscribers have an internal complaints process to deal with consumer complaints and disputes. The internal complaints process comprises an internal complaints phase (Stage One) and an internal disputes phase (Stage Two). The 2014 Code also prescribes that Code Subscribers must inform consumers of their right to refer an unresolved dispute from Stage Two to FOS's external dispute resolution service.

Code Subscribers received 28,587 internal retail insurance disputes and completed Stage Two reviews of 25,563 internal retail insurance disputes during 2015–16. Over the same period, Code Subscribers identified and addressed 524 breaches of section 10 of the 2014 Code, which prescribes standards for the handling of complaints and disputes. Breaches of section 10 accounted for 10% of all breaches identified by industry in 2015–16. By way of comparison, in 2014–15 there were 230 breaches of the complaints handling standards,[23] accounting for 6% of all breaches reported.

In 2015–16, Code Subscribers reported 86 breaches of subsection 10.11, which requires Code Subscribers to respond to a consumer's complaint within 15 business days of receipt, provided no further information or investigation is needed. This was the largest area of non-compliance in 2015–16, as it was last year when there were 73 breaches.[24]

Some Code Subscribers reported that their failure to meet the 15 business day timeframe was due to employees or Service Suppliers not following standard processes and procedures for complaints handling. Other Code Subscribers reported that delays occurred because employees or Service Suppliers did not refer a complaint to their internal complaints process when first requested by a consumer, or due to administrative errors by staff.

Code Subscribers addressed this non-compliance by providing remedial training to relevant employees and Service Suppliers; improving communication and providing information to consumers; enhancing processes and procedures; and increasing staff resources.

Code Subscribers also identified 83 breaches of subsection 10.16, which required them to keep a consumer informed about the progress of a Stage Two review at least every 10 business days. This compares to 43 breaches in 2014–15.[25]

Code Subscribers reported that this non-compliance occurred because of IT system failures, insufficient staff resources or because employees or service providers did not follow internal complaints procedures. Code Subscribers dealt with these issues by improving systems and

[22] See footnote 18 for website details.
[23] Section 6 was the equivalent standard in the 2012 Code.
[24] Subsection 6.2 was the equivalent standard in the 2012 Code.
[25] Subsection 6.8 was the equivalent standard in the 2012 Code.

procedures, increasing staff resources and providing remedial training to employees and service providers.

Other subsections of the 2014 Code where industry identified a considerable number of breaches included subsection 10.4, which requires Code Subscribers to handle complaints in a fair, transparent and timely manner (58 breaches); subsection 10.13, which requires Code Subscribers to respond to complaints in writing (51 breaches); and subsection 10.12(b), which requires Code Subscribers to keep a consumer informed about the progress of a Stage One review at least every 10 business days, unless agreed otherwise (46 breaches).

Guidance to industry

Timeliness of complaints handling

Self-identified breaches of the 2014 Code's complaints and disputes handling standards increased in 2015–16. These standards were enhanced for the 2014 Code, based on the framework for internal complaints processes prescribed by *ASIC Regulatory Guide 165: Licensing: Internal and external dispute resolution*, embodying guiding principles such as visibility, accessibility, responsiveness and objectivity.

It is critical that internal complaints processes are accessible, to allow consumers the opportunity to lodge a complaint about any issue they are unhappy with. It is equally important that Code Subscribers respond promptly to any complaints they receive and communicate regularly throughout the internal complaints process. This includes informing consumers of their right to pursue a dispute through external dispute resolution, such as through FOS, if they are dissatisfied with the internal complaints outcome.

Recommendation 11 – Timeliness and communication when dealing with internal complaints

The complaints and disputes handling standards where most breaches were identified were those that related to timeframes for responding to consumers. This indicates that timeliness in internal complaints handling and communication with consumers is an area for Code Subscribers to focus on and improve.

Recommendation 12 – Adequately resource teams responsible for internal complaints handling

Code Subscribers should not only ensure that efficient, fair, transparent and timely internal complaints processes are in place, but also that internal complaints handling functions are adequately resourced and that staff are appropriately trained and supported, to enable them to comply with obligations under the 2014 Code.

Uninsured third parties and access to internal complaints processes

We highlighted earlier that section 8 of the Code sets out standards that apply to Code Subscribers and their Service Suppliers when dealing with consumers – insureds and third party beneficiaries (customers) and uninsured third parties – in financial hardship.

Several standards within section 8 place an obligation on Code Subscribers to provide their customers and uninsured third parties with access to their internal complaints process, as defined by the Code. Section 8 uses an expanded meaning of 'you' to ensure that uninsured third parties are

protected including by giving them access to the enhanced framework for complaints handling in section 10.

The availability of the Code's internal complaints process is a critical right for uninsured third parties in financial hardship and one that has been available to them since the 2006 edition of the Code. The ICA, which owns the Code, has clearly stated that it intended the financial hardship standards and the internal complaints standards to apply to such individuals. Further, the ICA provides information on its Code website to assist individuals in financial hardship, including the right to access Code Subscribers' internal complaints processes and provides a link to the complaints handling standards in section 10 of the Code.[26]

However, a few Code Subscribers have suggested to us during 2016–17 that uninsured third parties are not entitled to access their internal complaints process that complies with the enhanced standards in section 10.

This is a serious and concerning development and this report is an opportunity for us to remind Code Subscribers that the internal complaints process in section 10 of the Code, unequivocally extends to uninsured third parties who have a complaint about them because of matters that come within the scope of section 8 of the Code.

Ensure that uninsured third parties within the scope of section 8 have access to internal complaints processes under section 10

This means that we expect Code Subscribers to ensure that in relation to complaints arising from matters within the scope of section 8:

- They provide uninsured third parties who have such complaints access to their internal complaints processes.
- They handle such complaints within the enhanced framework of section 10 of the Code.

[26] The links are: ***http://codeofpractice.com.au/for-consumers/financial-hardship*** **and** ***http://codeofpractice.com.au/for-consumers/how-to-make-a-complaint***.

Industry compliance initiatives

Each year Code Subscribers implement initiatives to improve their compliance with the 2014 Code. In 2015–16 we saw a broad range of activities designed to enhance and strengthen risk and compliance frameworks, mainly in the areas of compliance reporting and analysis and staff development and training. Code Subscribers are to be congratulated for their continuous improvement efforts this year. We have summarised and grouped Code Subscribers' various initiatives here.

Operations under 2014 Code – Post-implementation

- Completed a post-implementation review to assess business processes and controls that had been implemented to ensure compliance with the changes to the 2014 Code.
- Conducted workshops with management on 2014 Code requirements.
- Reviewed changes to financial hardship procedures that were implemented for the commencement of the 2014 Code, and confirmed as operational.
- Created a central repository for all company templates used to communicate with customers to better manage their compliance business-wide, with regular reviews of the wording to check for compliance, accuracy and customer friendliness.

Claims handling

- Extensive enhancements to claims management system, with improved claims reporting to allow better oversight and analysis.
- Developed a systemised method of recording claimants who have been assessed as being in financial hardship, allowing the capture of high-quality data to monitor and audit claims involving financial hardship.
- Migrated to a new policy and claim management system, which incorporated the standards of the 2014 Code during the design and implementation phases, to ensure that a high level of control is maintained for monitoring Code compliance.
- Reviewed the claims department's first line assurance activities to determine what should remain, what should be enhanced and what (if anything) should be ceased.
- Introduced dedicated quality assurance assessor roles to expand the technical depth of claim reviews and audits.

Complaints handling

- Revised internal dispute resolution business feedback templates to include a specific field for reporting potential non-compliance by departments.
- Provided training on complaints handling and dispute resolution, with focus on compliance with the 2014 Code and identifying and reporting incidents and breaches.
- Conducted regular reviews, analysis and reporting (as required) of systemic issues and/or significant trends in complaints & disputes.

Staff development and training

- Provided face-to-face and online compliance training including sessions on key Code obligations, and identifying and reporting incidents and breaches.
- Reinforced the requirement to report breaches as part of mandatory Code training.
- Conducted regular monitoring and reporting of Code training completion rates.
- Enhanced data governance training through an internally developed e-module relating to relevant processes at different stages of the data lifecycle, and developed related policies and framework documents to ensure effective practices in this area.
- Delivered bite size learning sessions to staff regarding any trends identified through quality assurance process.
- Converted Code training to a new learning management system to provide greater traction and reporting capability.
- Revised both the new starter and refresher training programs on Code requirements, associated activities, incident/breach logging and monitoring and reporting.
- Provided Code upgrade training to all staff and provided resources and training to Service Suppliers to promote a wider culture of transparency, Code awareness and continuous improvement.
- Appointed dedicated quality assurance staff, specifically tasked with completing monthly audits to ensure Code breaches were properly recorded on the 2014 Code breach register.
- Ran training sessions for managers to provide them with tools for building strong risk and governance behaviours, and promoting effective Code monitoring.
- Engaged an internal auditor to conduct a workshop with coaching designed to enhance the skills of claims quality assurance staff who monitor compliance.

Compliance & risk reviews, reporting and analysis

- Introduced a new operating model with increased resourcing of risk and compliance teams and adopted a best practice methodology, which has assisted in lifting the maturity and understanding of risk and compliance obligations across the business.
- Improved the risk and incident reporting system to enhance the quality of data and reporting capabilities, and enhanced compliance maturity in line with a broader focus on risk maturity.
- Enhanced systems to enable a centralised approach to monitoring, identifying, recording and managing compliance obligations, with an ability to link legislative and compliance obligations to risks, controls, policies, procedures and incidents.
- Developed stronger monitoring of compliance obligations and assigned clear accountability to each team for their respective compliance obligations, by documenting key Code compliance obligations in risk and compliance databases.
- Enhanced existing compliance frameworks via a range of measures including: a new reporting framework for departments; new feedback mechanisms to consultants; new control attestation templates to improve captured data; an improved quality assurance program; revision of questions used in closed claim file reviews; expanded monthly assurance activities including call monitoring and training checks.

- Designed and implemented an electronic form on the company intranet for staff to report non-compliance, ensuring mandatory information is collected and thereby leading to improved reporting capabilities.
- Invested in an automated system that stores information on key compliance obligations and controls, includes incident management tools, and facilitates business self-assessments; enabling the identification and documentation of high priority obligations and the associated control framework in a way that facilitates interaction and understanding by business stakeholders.
- Implemented a risk and compliance management tool which captures incidents and breaches, removing the need for manual recording on spreadsheets.
- Rolled out a monitoring and supervision framework for entities who sell and/or administer insurance products.
- Used a comprehensive 'three lines of defence' model to ensure a robust approach to monitoring activities and associated breach reporting processes.
- Maintained an incidents, complaints and breaches register as part of an overall incident management framework, where all such issues are recorded, managed and reported; undertook root cause analysis and reported statistics, trends and significant matters monthly.
- Used policy and claims management systems with automated alerts and triggers for Code compliance reminders, enabling the business to self-monitor a wide number of internal controls relating to key compliance tasks.
- Carried out Code supervisory and review activities including: call monitoring of live and archived calls (for sales, claims and complaints functions); sales observations (for face-to-face sales staff); customer file reviews; customer surveys; claim decline deep dives; meetings of internal dispute resolution teams and decision makers; pending claims and complaints reports; control attestations; training record reviews; peer review of files; and reviewing exception reports.
- Conducted quarterly reviews of selected complex risk claims, focusing on compliance with the claims handling standards of the 2014 Code and adherence to internal business processes; outcomes reported to management and relevant operational teams.
- Ran a dedicated monitoring program involving quality assurance reviews, internal audits and independent external audits of the practices of key business teams as well as third-party administrators, Authorised Representatives and distributors to identify any gaps in processes and ensure compliance with Code requirements.
- Administered quarterly compliance surveys to business managers as part of a self-assessment program; results are reported via a compliance self-assessor toolkit and, when necessary, escalated to a risk management committee.

General insurance workforce

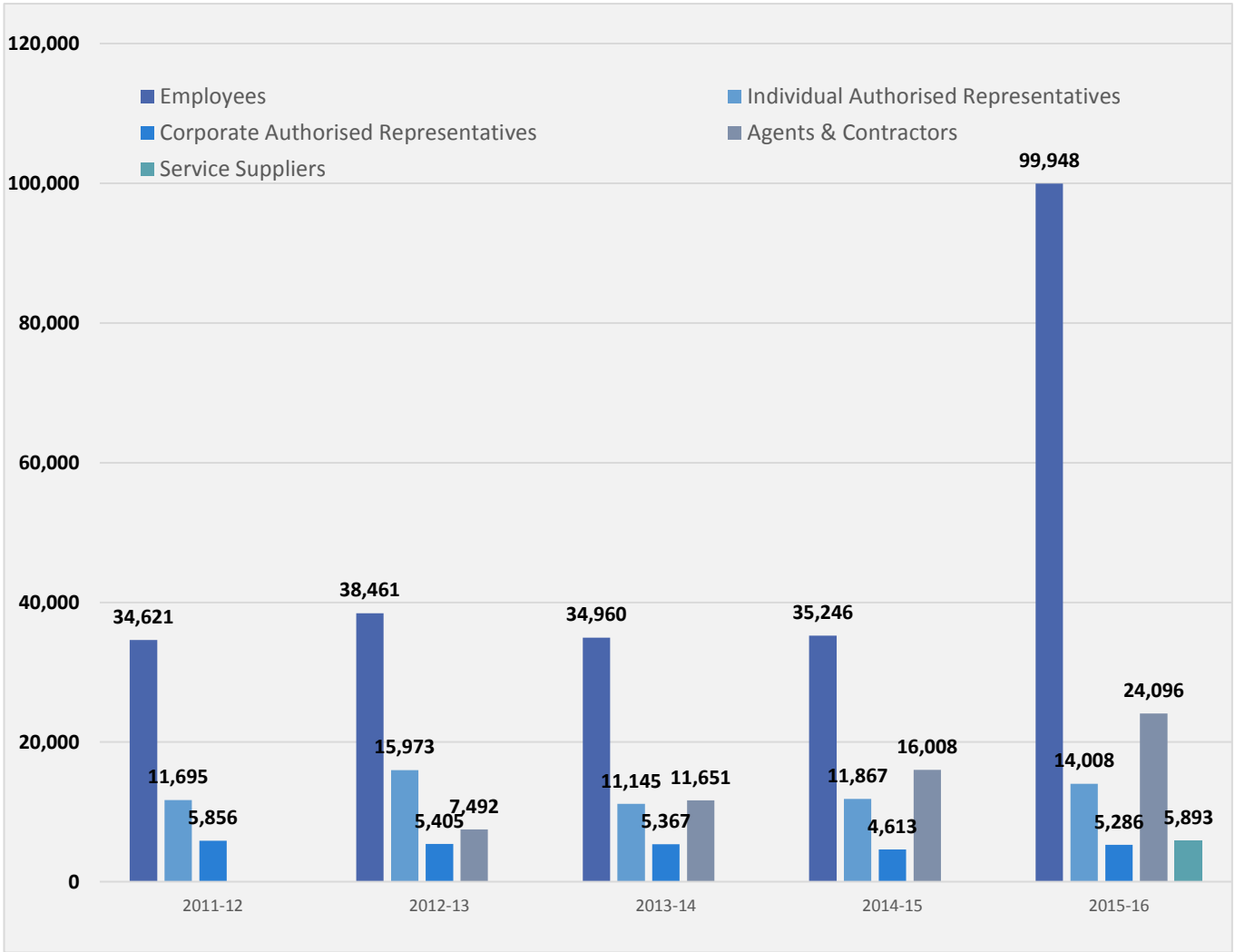
In this section, we present data about the size of the general insurance industry's workforce and outline the different entities used to carry out insurance-related services. We also present data about the proportion of the workforce that has received training about the 2014 Code.

This data provides some insight into how the industry is resourced to serve and assist consumers and the levels of knowledge and awareness about the 2014 Code.

Workforce trends

Chart 5 shows workforce data for the last five years, based on the categories we used in previous years, which were Employees, Individual Authorised Representatives, Corporate Authorised Representatives and Agents and contractors. We have also added a new category for Service Suppliers not previously captured in data.

Chart 5 General insurance workforce: 2011–12 to 2015–16



The large spike in employees in 2015–16 is the result of a significant data collection change. For this reporting period, we expanded the scope of data about employees to also include employees of related entities. This was done to align with the updated definition of 'employee' used in the 2014 Code[27] and provides a far more representative picture of the size of the general insurance industry sector.

Code Subscribers have gradually increased their use of agents and contractors each year since we started collecting data about them. Currently, the 2014 Code's standards do not directly apply to agents and contractors.

As this is the first time we have collected data about Service Suppliers, we are unable to provide any comparison with previous years. Using this year's data as a baseline, we will make this comparison in future reports.

Employees and Authorised Representatives

Code Subscribers are required to deliver training to employees (and employees of their related entities) and Authorised Representatives. Table 13 shows the number and types of participants in the general insurance industry and the proportion who received Code training.

Table 13 Industry workforce size and Code training in 2015–16

Entity type	Workforce number	Received Code training	% Trained
Employees (including employees of related entities)	99,948	87,003	87%
Individual Authorised Representatives	14,008	5,746	41%
Corporate Authorised Representatives	5,286	3,842	73%

Code Subscribers are required to provide employees and Authorised Representatives with, or require them to receive, appropriate education and training, including training on the 2014 Code.[28] However, the 2014 Code does not stipulate that training in the Code (or any other type of training that is required) needs to be delivered within a specified timeframe or that refresher training should be provided.

Authorised Representatives may have received Code training from other Code Subscribers they have done work for in the past. As a result, if other Code Subscribers use their services, recognition of previous learning would be considered sufficient, negating the requirement for another Code Subscriber to provide Code training.

These factors have an impact on the proportion of employees and Authorised Representatives that receive Code training in any given period and help explain why the proportion of employees and Authorised Representatives trained are lower than the workforce numbers.

[27] Refer to definition of Employee in 2014 Code available at www.codeofpractice.com.au/
[28] Refer to subsection 5.1 of the 2014 Code available at www.codeofpractice.com.au/.

Service Suppliers

Table 14 shows numbers of Service Suppliers of different types, as well as the number of these who had received Code training.

Table 14 Service supplier workforce size and training in 2015–16

Entity type	Workforce number	Received Code training	% Trained
Loss assessors or adjusters	2,628	2,289	87%
Claims management services	1,457	1,310	90%
Investigators	1,445	1,309	91%
Collection agents	363	339	93%

Although Service Suppliers are required to comply with the 2014 Code, Code Subscribers are not obligated to provide training about the 2014 Code to them. Nevertheless, as table 13 shows, the large majority of individuals engaged as Service Suppliers had received Code training in 2015–16 and training rates are high.

We see this as a positive development in raising standards of service provided by Service Suppliers and their professionalism, and supports their capacity to comply with Code obligations when acting on behalf of Code Subscribers.

Agents and independent contractors

Agents and independent contractors are used by some Code Subscribers to distribute insurance products (agents) or provide insurance-related services (independent contractors). Table 15 shows how many agents and independent contractors were engaged by Code Subscribers and received Code training.

These participants are not covered by the 2014 Code and so there is no obligation on Code Subscribers to provide them with Code training or to require them to comply with Code obligations in 2015–16.

Table 15 Agent and independent contractor workforce size and training in 2015–16

Entity type	Workforce number	Received Code training	% Trained
Agents	22,789	4,703	21%
Independent contractors	1,307	892	68%

Schedules

Schedule 1 Current Code Subscribers

General Insurers

1	AAI Limited	27	MTA Insurance Ltd
2	AIG Australia Ltd	28	NTI Ltd
3	AIOI Nissay Dowa Insurance Company Australia Pty Limited	29	OnePath General Insurance Pty Ltd
4	Allianz Australia Insurance Ltd	30	Progressive Direct Insurance Pty Ltd
5	Ansvar Insurance Ltd	31	QBE Insurance (Australia) Ltd
6	Assetinsure Pty Ltd	32	QBE Lenders' Mortgage Insurance Ltd
7	Auto & General Insurance Company Ltd	33	RAA Insurance Ltd
8	AVEA Insurance Ltd	34	RAC Insurance Pty Ltd
9	Calliden Insurance Ltd	35	RACQ Insurance Ltd
10	Catholic Church Insurance Ltd	36	RACT Insurance Pty Ltd
11	CGU Insurance Ltd	37	Sompo Japan Nipponkoa Insurance Inc
12	Chubb Insurance Australia Limited	38	Southern Cross Benefits Ltd
13	Commonwealth Insurance Ltd	39	St Andrew's Insurance (Australia) Pty Ltd
14	Credicorp Insurance Pty Ltd	40	Sunderland Marine Mutual Insurance Company Ltd
15	Defence Service Homes Insurance Scheme	41	Swann Insurance (Aust) Pty Ltd
16	Factory Mutual Insurance Company	42	The Hollard Insurance Company Pty Ltd
17	Genworth Financial Mortgage Insurance Pty Ltd	43	The Tokio Marine & Nichido Fire Insurance Co Ltd
18	Great Lakes Insurance SE	44	Virginia Surety Company Inc
19	Guild Insurance Ltd	45	Wesfarmers General Insurance Ltd
20	Hallmark General Insurance Company Ltd	46	Westpac General Insurance Ltd
21	Insurance Australia Ltd	47	XL Insurance Company Ltd
22	Insurance Manufacturers of Australia Pty Ltd	48	Youi Pty Ltd
23	LawCover Insurance Pty Ltd	49	Zurich Australian Insurance Ltd
24	Lloyd's Australia Ltd		
25	Medical Insurance Australia Pty Ltd		

26	Mitsui Sumitomo Insurance Co Ltd		

Lloyds Australia Limited: Participating Coverholders & Claims Administrators

1	1Cover Pty Ltd	63	iSure Pty Ltd
2	About Underwriting	64	Itrek Pty Ltd
3	Advent Insurance Management Pty Limited	65	Jardine Lloyd Thompson Pty Ltd
4	AIS Insurance Brokers Pty Ltd	66	JMD Ross Insurance Brokers Pty Ltd
5	Arthur J Gallagher & Co (Aus) Limited	67	JUA Underwriting Agency Pty Ltd
6	Amazon Underwriting Pty Ltd	68	Logan Livestock Insurance Agency Pty Ltd
7	AON Risk Services Australia Ltd	69	London Australia Underwriting Pty Ltd
8	Arch Underwriting Agency (Australia) Pty Ltd	70	Marsh Pty Ltd
9	Arch Underwriting at Lloyd's (Australia) Pty Ltd	71	Millennium Underwriting Agencies Pty Ltd
10	Argenta Underwriting Asia Pte Ltd	72	Miramar Underwriting Agency Pty Ltd
11	ASG Insurances Pty Ltd	73	Mobius Underwriting Pty Ltd
12	ASR Underwriting Agencies Pty Ltd	74	Morris Group Investments Pty Ltd
13	ATC Insurance Solutions Pty Ltd	75	Newline Australia Insurance Pty Ltd
14	Austagencies Pty Ltd	76	NM Insurance Pty Ltd
15	Australian Insurance Agency Pool Pty Ltd	77	Nova Underwriting Pty Ltd
16	Australian Warranty Network Pty Ltd	78	NWC Insurance Pty Ltd
17	Axis Underwriting Services Pty Ltd	79	One Underwriting Pty Ltd
18	Beazley Underwriting Pty Ltd	80	Online Insurance Brokers Pty Ltd
19	Bizcover Pty Ltd	81	Pacific Underwriting Corporation Pty Ltd
20	Blue Badge Insurance Australia Pty Ltd	82	Panoptic Underwriting Pty Ltd
21	Bovill Risk & Insurance Consultants Pty Ltd	83	Pantaenius Australia Pty Ltd
22	Broadspire by Crawford & Co	84	Pen Underwriting Group Pty Ltd
23	Brooklyn Underwriting Pty Ltd	85	Pen Underwriting Pty Ltd
24	Catalyst Consulting (Aust) Pty Ltd	86	PI Direct Insurance Brokers Pty Ltd
25	Cerberos Brokers Pty Ltd	87	Point Underwriting Agency Pty Ltd
26	Cerberus Special Risks Pty Ltd	88	Prime Underwriting Agency Pty Ltd
27	Cheap Travel Insurance Pty Ltd	89	Proclaim Management Solutions Pty Ltd
28	Claims Management Australasia Pty Ltd	90	Procover Underwriting Agency Pty Ltd
29	Coffre-Fort Pty Ltd	91	Professional Risk Underwriting Pty Ltd
30	Columbus Direct Travel Insurance Pty Ltd	92	Quanta Insurance Group Pty Ltd

31	Commercial and Trucksure Pty Ltd	93	Quantum Insurance Holdings Pty Ltd
32	Coversure Pty Ltd	94	Richard Oliver Underwriting Managers Pty Ltd
33	Cunningham Lindsey Australia Pty Ltd	95	Risk Partners Pty Ltd
34	Dracko Insurance Brokers Pty Ltd	96	RiskSmart Claims Solutions Pty Limited
35	Dual Australia Pty Ltd	97	Savannah Insurance Agency Pty Ltd
36	East West Insurance Brokers Pty Ltd	98	SLE Worldwide Australia Pty Ltd
37	Edge Underwriting Pty Ltd	99	Solution Underwriting Agency Pty Ltd
38	Elkington Bishop Molieaux Brokers Pty Ltd	100	Specialist Underwriting Agencies Pty Ltd
39	Emergence Insurance Pty Ltd	101	Sportscover Australia Pty Ltd
40	Ensurance Underwriting Pty Ltd	102	Starr Underwriting Agents (Asia) Limited
41	Epsilon Underwriting Agencies Pty Ltd	103	StarStone Underwriting Australia Pty Ltd
42	Fitton Insurance (Brokers) Australia Pty Ltd	104	Steadfast IRS Pty Ltd
43	Fullerton Health Corporate Services (Aust) Pty Ltd	105	Sterling Insurances Pty Ltd
44	Gallagher Bassett Service Pty Ltd	106	Sura Hospitality Pty Ltd
45	Gard Insurance Pty Ltd	107	Sura Labour Hire Pty Ltd
46	Genesis Underwriting Pty Ltd	108	Sura Professional Risks Pty Ltd
47	Glenowar Pty Ltd (Fenton Green & Co)	109	Surafilm & Entertainment Pty Ltd
48	Go Unlimited Pty Ltd	110	SureSave Pty Ltd
49	Gow-Gates Insurance Brokers Pty Ltd	111	SureSeason Australia Pty Ltd
50	GSA Insurance Brokers Pty Ltd	112	Talbot Risk Services Pte Ltd
51	High Street Underwriting Agency Pty Ltd	113	Topsail Insurance Pty Ltd
52	Holdfast Insurance Brokers Pty Ltd	114	Travel Insurance Direct Pty Ltd
53	Honan Insurance Group Pty Ltd	115	Trident Insurance Group Pty Ltd
54	Hostsure Underwriting Agency Pty Ltd	116	Trinity Pacific Underwriting Agencies Pty Ltd
55	HQ Insurance Pty Ltd	117	Triton Global (Australia) Ltd
56	HW Wood Australia Pty Ltd	118	Windsor Income Protection Pty Ltd
57	IBL Ltd	119	Winsure Underwriting Pty Ltd
58	Imalia Pty Ltd	120	Woodina Underwriting Agency Pty Ltd
59	Inglis Insurance Group Pty Ltd	121	World Nomads Group Ltd
60	Insurance Facilitators Pty Ltd	122	XL Catlin Australia Pty Ltd
61	Insure That Pty Ltd	123	YourCover Pty Ltd
62	Ironshore Australia Pty Ltd		

Schedule 2 Aggregated Industry Data 2015–16

General insurance policies, claims, declined claims and withdrawn claims in 2015–16

General Insurance Class	Individual Policies	Group Policies	Total Policies	Claims	Declined Claims	Withdrawn Claims
Grand Total	**47,054,985**	**224,475**	**47,279,460**	**4,261,310**	**148,697**	**287,203**
Retail Total	44,117,605	53,484	44,171,089	3,755,643	143,445	270,799
Wholesale Total	2,937,380	170,991	3,108,371	505,667	5,252	16,404
Retail						
Motor	14,980,946	8	14,980,954	2,001,361	8,680	128,072
Home	11,636,781	2	11,636,783	810,901	50,582	102,003
Travel	7,600,924	21,219	7,622,143	281,647	31,090	13,933
Personal & Domestic Property	6,606,816	151	6,606,967	523,744	44,592	24,143
Sickness & Accident	2,077,617	30,956	2,108,573	46,282	2,096	588
Consumer Credit	992,615	1	992,616	33,382	4,683	1,356
Residential Strata	221,906	1,147	223,053	58,326	1,722	704
Retail Total	**44,117,605**	**53,484**	**44,171,089**	**3,755,643**	**143,445**	**270,799**
Wholesale						
Business	389,508	21,597	411,105	84,890	1,092	1,827
Business Pack	883,312	124,462	1,007,774	112,171	1,585	3,165
Contractors All Risks	35,262	0	35,262	7,707	36	166
Industrial Special Risks	51,542	1,619	53,161	23,224	371	922
Liability	449,510	13,248	462,758	28,899	530	811
Motor	246,136	7,530	253,666	172,983	662	7,059
Other	252,568	2,535	255,103	17,106	101	132
Primary Industries	196,452	0	196,452	4,453	94	224
Primary Industries Pack	433,090	0	433,090	54,234	781	2,098
Wholesale Total	**2,937,380**	**170,991**	**3,108,371**	**505,667**	**5,252**	**16,404**

General insurance group policies, people & assets in 2015–16

General Insurance Class	Group Policies	People or assets covered by group policies
Grand Total	**224,475**	**9,858,711**
Retail Total	53,484	8,065,635
Wholesale Total	170,991	1,793,076
Retail		
Travel	21,219	4,999,873
Sickness & Accident	30,956	2,447,214
Personal & Domestic Property	151	603,569
Residential Strata	1,147	13,841
Home	2	498
Motor	8	443
Consumer Credit	1	197
Retail Total	**53,484**	**8,065,635**
Wholesale		
Liability	13,248	727,353
Other	2,535	430,513
Business	21,597	277,209
Business Pack	124,462	251,983
Motor	7,530	102,910
Industrial Special Risks	1,619	3,108
Contractors All Risks	0	0
Primary Industries	0	0
Primary Industries Pack	0	0
Wholesale Total	**170,991**	**1,793,076**

Stage Two of Code Subscribers' internal complaints process – all internal disputes received by Code Subscribers in 2015–16

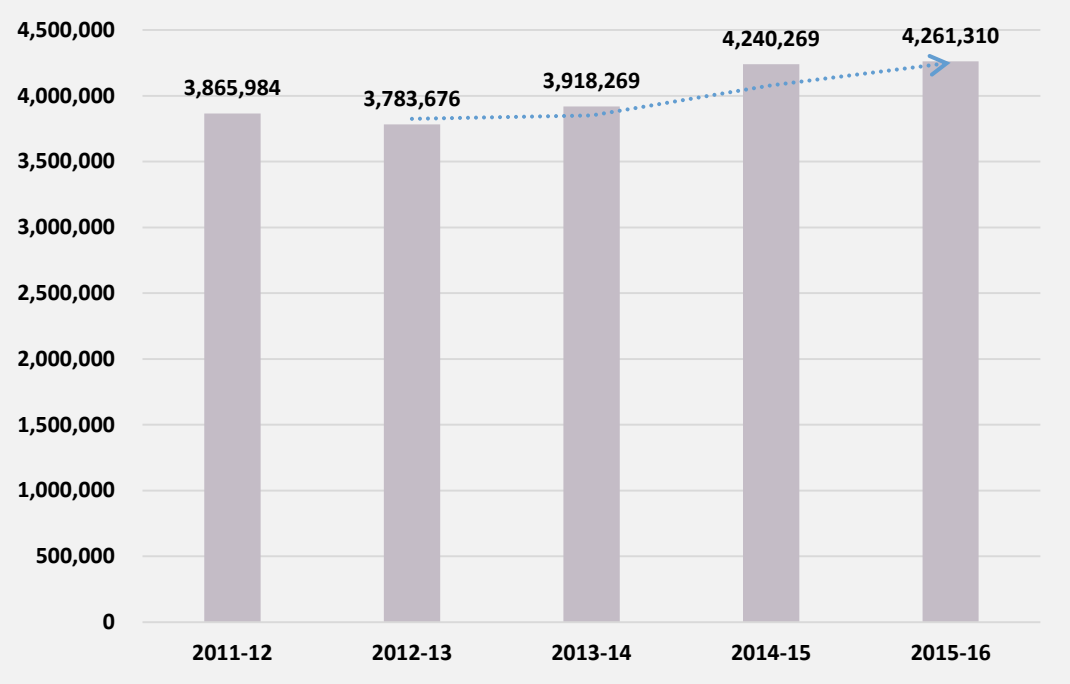
General Insurance Class	Access to information	Authorised Representatives	Buying Insurance	Catastrophes	Claims	Employees	Financial Hardship: Customers	Financial Hardship: Recoveries	Received Disputes Total
Grand Total	**111**	**98**	**3,142**	**393**	**26,177**	**43**	**139**	**68**	**30,171**
Retail Total	109	95	3,116	383	24,647	40	131	66	28,587
Wholesale Total	2	3	26	10	1,530	3	8	2	1,584
Retail									
Motor	66	46	1,671	28	10,095	17	36	65	12,024
Home	41	18	1,247	335	7,446	16	92	0	9,195
Personal & Domestic Property	0	2	45	3	3,812	0	0	0	3,862
Travel	1	0	27	13	2,294	5	1	0	2,341
Consumer Credit	0	2	65	0	407	1	0	1	476
Residential Strata	0	0	1	4	381	0	0	0	386
Sickness & Accident	1	27	60	0	212	1	2	0	303
Retail Total	**109**	**95**	**3,116**	**383**	**24,647**	**40**	**131**	**66**	**28,587**
Wholesale									
Business	0	0	4	1	211	1	0	0	217
Business Pack	1	0	5	3	263	0	0	0	272
Contractors All Risks	0	0	0	0	12	0	0	0	12
Industrial Special Risks	0	0	0	1	45	0	0	0	46
Liability	0	0	1	1	92	0	0	0	94
Motor	0	3	7	1	233	0	0	2	246
Other	1	0	3	0	506	2	8	0	520
Primary Industries	0	0	2	0	13	0	0	0	15
Primary Industries Pack	0	0	4	3	155	0	0	0	162
Wholesale Total	**2**	**3**	**26**	**10**	**1,530**	**3**	**8**	**2**	**1,584**

Outcomes of all internal disputes reviewed by Code Subscribers' in Stage Two of their internal complaints processes in 2015–16

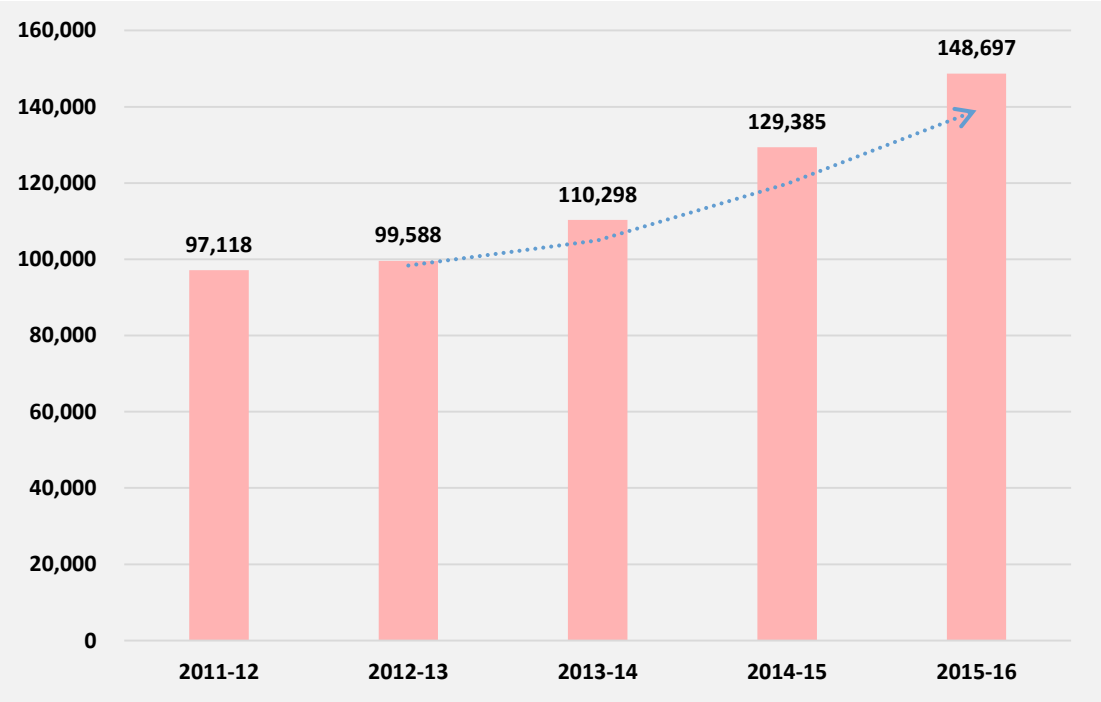
General Insurance Class	Code Subscribers: Reviewed disputes	Consumers: Reviewed disputes	Total reviewed disputes
Grand Total	**19,263**	**7,808**	**27,071**
Retail Total	18,077	7,486	25,563
Wholesale Total	1,186	322	1,508
Retail			
Motor	8,503	2,207	10,710
Home	5,708	2,183	7,891
Personal & Domestic Property	1,612	2,062	3,674
Travel	1,596	595	2,191
Consumer Credit	300	179	479
Residential Strata	194	133	327
Sickness & Accident	164	127	291
Retail Total	**18,077**	**7,486**	**25,563**
Wholesale			
Business	143	56	199
Business Pack	209	76	285
Contractors All Risks	9	2	11
Industrial Special Risks	30	12	42
Liability	75	21	96
Motor	144	90	234
Other	452	16	468
Primary Industries	14	1	15
Primary Industries Pack	110	48	158
Wholesale Total	**1,186**	**322**	**1,508**

Schedule 3 Five-year data overviews

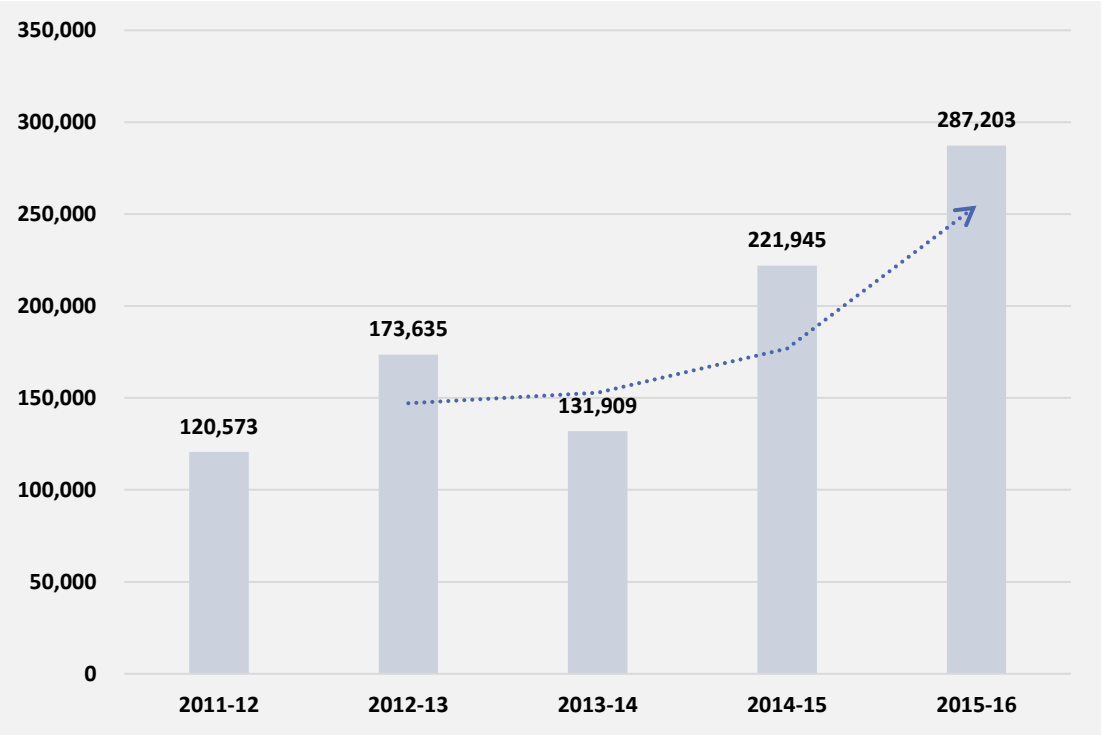
All general insurance claims received by Code Subscribers



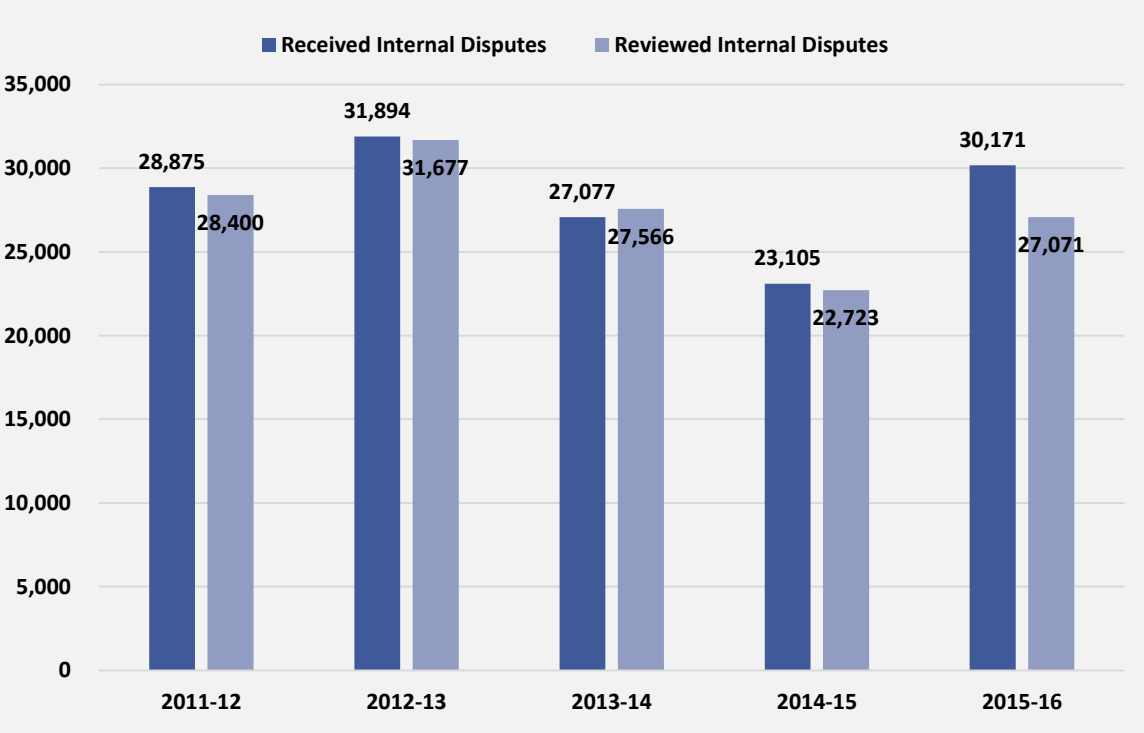
All general insurance claims declined by Code Subscribers



All general insurance claims recorded as withdrawn by Code Subscribers



All Stage Two general insurance internal disputes – received and reviewed



Schedule 4 Self-reported Code breaches in 2015–16

Breaches by Code section

2014 Code Section	Breaches
7 - Claims	3,808
10 - Complaints & Disputes	524
4 – Buying Insurance	391
14 - Access to Information	188
5 - Employees & Authorised Representatives	68
8 - Financial Hardship	27
6 - Service Suppliers	9
11 - Information & Education	4
9 - Catastrophes	2
Grand Total	**5,021**

Top five areas of non-compliance

CODE SUBSECTION	BREACHES
7.13 – Provide claim progress updates at least every 20 business days.	1,464
7.9 – Notify customer within 10 business days of decision to accept or decline claim.	491
7.16 – On completion of information gathering & enquiries, within 10 business days decide whether to accept or decline claim & notify customer.	363
4.4 – Conduct sales process & services efficiently, honestly, fairly & transparently.	323
7.10(c) – Provide customer with an initial estimate of timetable & decision-making process.	279

All breaches by Code sub-section

CODE SECTION	BREACHES
BREACHES OF SECTION 4 – BUYING INSURANCE	
4.4 **–** Conduct sales process & services efficiently, honestly, fairly & transparently	323
4.9 **–** If customer entitled to cancel policy, refund premium within 15 business days	26
4.7 **–** Correct error or mistake in customer's insurance application or in assessment of application	22
4.6 **–** Ask customer for/rely on relevant information/documents only in assessing insurance application	12
4.8 **–** If cannot provide insurance: give reasons, information relied on, refer to ICA/NIBA for alternative insurance operations, and information about complaints process if dissatisfied	3
4.8(a) **–** If cannot provide insurance give reasons why insurance cannot be provided	3

4.5 **–** Communications with customer in plain language	1
4.8(c) **–** If cannot provide insurance refer to ICA/NIBA for alternative insurance options	1
4 – Buying Insurance Total	**391**

BREACHES OF SECTION 5 – STANDARDS FOR OUR EMPLOYEES & AUTHORISED REPRESENTATIVES (AR)	
5.1 – Employees/AR acting on behalf of insurer	41
5.1(b) – Employees/AR provide only services matching expertise	21
5.1(a) – Education/training of Employees/AR to provide competent/professional service	6
5 – Employees & Authorised Representatives Total	**68**

BREACHES OF SECTION 6 – STANDARDS FOR OUR SERVICE SUPPLIERS	
6.2 – Service Suppliers honest/efficient/fair/transparent	4
6.3 – Appointing of Service Suppliers	2
6.7 – Service Suppliers to notify of complaints, to be handled under complaints process	2
6.5 – Approval before subcontracting	1
6 – Service Suppliers Total	**9**

BREACHES OF SECTION 7 – CLAIMS	
7.13 – Provide you with claim progress updates at least every 20 business days	1,464
7.9 – Notify within 10 business days of claim acceptance/denial	491
7.16 – On completion of information gathering & enquiries, decide whether to accept/deny your claim & notify you within 10 business days	363
7.10(c) – Provide initial estimate of timetable/decision–making process	279
7.14 – Respond to your routine claim requests within 10 business days	238
7.10 – Notify within 10 business days of further info/assessment required	205
7.2 – Conduct claims handling in honest, fair, transparent & timely manner	172
7.19(a) – Reasons for decision to be in writing	99
7.8 – Prior to lodging claim can ask if policy covers the loss. Will not discourage lodging claim & coverage to be fully assessed	65
7.12 – Notify within 5 business days of loss assessor/adjuster/investigator appointment	60
7.5 – Reasonable alternative time frame	58
7.4 – Correct error/mistake in dealing with a claim	46
7.17 – Decision made within 4 months of receiving claim unless exceptional circumstances, if no decision provide details of complaints process	40
7.10(b) – Appointment of Loss Assessor/Adjuster	39
7.10(a) – Notify of any information required to make decision	37

7.11 – Claim assessed on facts/policy terms/law	32
7.20(b) – Handle any complaint re quality/timeliness/conduct of work/repairer	23
7.19(d) – Provide details of complaints process	16
7.15 – External Expert report provided within 12 weeks of engagement or inform of report progress/delay	14
7.19(c) – Inform of right to request copies of service suppliers/external expert reports, to be supplied within 10 business days	12
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	9
7.21 – Must comply with timetables	9
7.3 – Ask for & rely on only relevant information when deciding your claim	7
7.21(b) – Conduct/timetable reasonable in the circumstances	7
7.6 – Complaints process available to policy holders	6
7.21(a) – Comply with agreed alternative timetable	6
7.18 – Decision made within 12 months if exceptional circumstances, if no decision provide details of complaints process	4
7.7(a) – Fast track claim assessment/decision process	2
7.7(c) – Provide details of complaints process	2
7.21(c) – Cause of non–compliance if External Expert report delay & best endeavours used to obtain report	2
7.7 – Urgent financial need of insurance policy benefit	1
7 – Claims Total	**3,808**

BREACHES OF SECTION 8 – FINANCIAL HARDSHIP	
8.4 – Provide financial hardship application form and counselling hotline number, if you tell us you are in financial hardship	9
8.8(a) – Work together to consider an arrangement	5
8.12 – Comply with the ACCC & ASIC debt collection guidelines.	4
8.3 – If money owed & experiencing financial hardship may ask if entitled to assistance	3
8.6 – Notify you of decision on financial hardship assistance application as soon as reasonably practicable. Provide reasons if no entitlement to assistance	2
8.7 – Collections put on hold until financial hardship request is assessed & notification of decision given	1
8.8 – Entitled to financial hardship assistance	1
8.10 – Any communication from agent about money owed will identify insurer and specify nature of claim	1
8.11 – Agents notified of financial hardship required to provide details of fin hardship process	1
8 – Financial Hardship Total	**27**

BREACHES OF SECTION 9 – CATASTROPHES	
9.2 – Respond to catastrophes in efficient/professional/practical/compassionate manner	1
9.3 – If property claim arising from catastrophe finalised within 1 month, may request a review within 12 months of decision, even if released signed	1
9 – Catastrophes Total	**2**

BREACHES OF SECTION 10 – COMPLAINTS & DISPUTES	
10.11 – Respond to complaint within 15 business days if has all necessary info/completed investigation	86
10.16 – Inform of progress every 10 business days	83
10.4 – Conduct complaints handling in fair, transparent and timely manner.	58
10.13 – Respond to complaint in writing	51
10.12(b) – Inform of progress every 10 business days unless otherwise agreed	46
10.13(a) – Decision in relation to complaint in writing	46
10.14 – If not satisfied stage one decision, can advise to move to stage two	30
10.10 – Stage one and two of complaints process not exceed 45 calendar days. If unable, will inform of reasons for delay & right to go to FOS	20
10.8 – Notify name/contact details of assigned complaint handling employee	18
10.5 – Inform of right to make complaint & complaints process on website/written communications	15
10.17 – Respond within 15 business days after advised of move to stage two, provided has all necessary info/completed investigation	12
10.3 – Entitled to make complaint about any aspect of relationship	11
10.12(a) – Notify as reasonably practicable within 15 business days of delay & agree to reasonable timeframe. If no agreement, advise of right to move to stage two	10
10.13(c) – Right to take complaint to stage two if not satisfied with stage one decision	8
10.7 – Correct error/mistake in complaint handling	5
10.9 – Complaints process not apply if complaint resolved within 5 business days & response not requested in writing, except for declined claim/claim value/financial hardship complaints	4
10.13(d) – If not satisfied with Stage 2 decision, notify of right to go to FOS	4
10.19(a) – Our final decision to complaint & reasons for decision in writing	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	4
10.12 (a)–(b) – Cannot respond within 15 business days because doesn't have all necessary info/completed investigation	3
10.6 – Only ask for/rely on relevant information in dealing with complaints. If requested, supply within 10 business days information relied on in complaint assessment	2
10.15 – Stage two complaint reviewed by employee(s) with appropriate experience/knowledge/authority & different to person subject of complaint/involved in stage one	2

10.13(b) – Reasons for decision in writing	1
10.18 – If cannot respond within 15 business days agree reasonable timeframe. If no agreement, advise of right to refer to FOS	1
10 – Complaints & Disputes Total	**524**

BREACHES OF SECTION 11 – INFORMATION & EDUCATION	
11.6 – Provide code info on website/product info	3
11 – Information & Education	1
11 – Information & Education Total	**4**

BREACHES OF SECTION 14 - ACCESS TO INFORMATION	
14.1 – Abide by privacy laws when collect/store/use/disclose personal information	188
14 – Access to Information Total	**188**

TOTAL OF ALL CODE BREACHES IN 2015–16	**5,021**

Schedule 5 Comparative data

Lodged claims

Insurance Class	2015–16	2014–15	Difference	Variance
Retail				
Consumer Credit	33,382	34,573	-1,191	-3%
Home	810,901	928,330	-117,429	-13%
Motor	2,001,361	1,882,948	118,413	6%
Personal & Domestic Property	523,744	494,504	29,240	6%
Residential Strata	58,326	41,195	17,131	42%
Sickness & Accident	46,282	54,811	-8,529	-16%
Travel	281,647	253,752	27,895	11%
Retail Total	**3,755,643**	**3,690,113**	**65,530**	**2%**
Wholesale				
Business	84,890	115,089	-30,199	-26%
Business Pack	112,171	58,568	53,603	92%
Contractors All Risks	7,707	3,115	4,592	147%
Industrial Special Risks	23,224	29,532	-6,308	-21%
Liability	28,899	34,734	-5,835	-17%
Motor Wholesale	172,983	258,157	-85,174	-33%
Other	17,106	5,748	11,358	198%
Primary Industries	4,453	8,959	-4,506	-50%
Primary Industries Pack	54,234	36,254	17,980	50%
Wholesale Total	**505,667**	**550,156**	**-44,489**	**-8%**
Grand Total	**4,261,310**	**4,240,269**	**21,041**	**0%**

Declined claims

Insurance Class	2015–16	2014–15	Difference	Variance
Retail				
Consumer Credit	4,683	5,102	-419	-8%
Home	50,582	46,268	4,314	9%
Motor	8,680	7,946	734	9%
Personal & Domestic Property	44,592	38,275	6,317	17%
Residential Strata	1,722	501	1,221	244%
Sickness & Accident	2,096	3,702	-1,606	-43%
Travel	31,090	24,209	6,881	28%
Retail Total	**143,445**	**126,003**	**17,442**	**14%**
Wholesale				
Business	1,092	2,861	-1,769	-62%
Business Pack	1,585	880	705	80%
Contractors All Risks	36	32	4	13%
Industrial Special Risks	371	419	-48	-11%
Liability	530	849	-319	-38%
Motor Wholesale	662	601	61	10%
Other	101	121	-20	-17%
Primary Industries	94	203	-109	-54%
Primary Industries Pack	781	544	237	44%
Wholesale Total	**5,252**	**6,510**	**-1,258**	**-19%**
Grand Total	**148,697**	**132,513**	**16,184**	**12%**

Withdrawn claims

Insurance Class	2015–16	2014–15	Difference	Variance
Retail				
Consumer Credit	1,356	894	462	52%
Home	102,003	93,753	8,250	9%
Motor	128,072	93,367	34,705	37%
Personal & Domestic Property	24,143	7,912	16,231	205%
Residential Strata	704	269	435	162%
Sickness & Accident	588	165	423	256%
Travel	13,933	14,369	-436	-3%
Retail Total	**270,799**	**210,729**	**60,070**	**29%**
Wholesale				
Business	1,827	2,729	-902	-33%
Business Pack	3,165	477	2,688	564%
Contractors All Risks	166	101	65	64%
Industrial Special Risks	922	687	235	34%
Liability	811	525	286	54%
Motor Wholesale	7,059	5,279	1,780	34%
Other	132	84	48	57%
Primary Industries	224	84	140	167%
Primary Industries Pack	2,098	1,250	848	68%
Wholesale Total	**16,404**	**11,216**	**5,188**	**46%**
Grand Total	**287,203**	**221,945**	**65,258**	**29%**

Received Internal Disputes

Insurance Class	2015–16	2014–15	Difference	Variance
Retail				
Consumer Credit	476	309	167	54%
Home	9,195	7,491	1,704	23%
Motor	12,024	10,678	1,346	13%
Personal & Domestic Property	3,862	855	3,007	352%
Residential Strata	386	210	176	84%
Sickness & Accident	303	233	70	30%
Travel	2,341	1,943	398	20%
Retail Total	**28,587**	**21,719**	**6,868**	**32%**
Wholesale				
Business	217	490	-273	-56%
Business Pack	272	171	101	59%
Contractors All Risks	12	11	1	9%
Industrial Special Risks	46	37	9	24%
Liability	94	150	-56	-37%
Motor Wholesale	246	260	-14	-5%
Other	520	155	365	235%
Primary Industries	15	36	-21	-58%
Primary Industries Pack	162	76	86	113%
Wholesale Total	**1,584**	**1,386**	**198**	**14%**
Grand Total	**30,171**	**23,105**	**7,066**	**31%**

Reviewed Internal Disputes

Insurance Class	2015–16	2014–15	Difference	Variance
Retail				
Consumer Credit	479	321	158	49%
Home	7,891	7,306	585	8%
Motor	10,710	10,604	106	1%
Personal & Domestic Property	3,674	817	2,857	350%
Residential Strata	327	215	112	52%
Sickness & Accident	291	237	54	23%
Travel	2,191	1,924	267	14%
Retail Total	**25,563**	**21,424**	**4,139**	**19%**
Wholesale				
Business	199	446	-247	-55%
Business Pack	285	172	113	66%
Contractors All Risks	11	8	3	38%
Industrial Special Risks	42	44	-2	-5%
Liability	96	147	-51	-35%
Motor Wholesale	234	200	34	17%
Other	468	154	314	204%
Primary Industries	15	38	-23	-61%
Primary Industries Pack	158	90	68	76%
Wholesale Total	**1,508**	**1,299**	**209**	**16%**
Grand Total	**27,071**	**22,723**	**4,348**	**19%**

Schedule 6 Glossary of terms

Terms marked with '*' – these are terms that are defined in the 2014 Code or based on such terms.

Agent means a person, company or other entity that is not an authorised representative but is engaged in the distribution of a **Code Subscriber's** general insurance products.

Authorised Representative* means 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.

Baseline means a minimum starting point used for comparisons.

Breach means a failure to comply with a **Code** standard.

CGC or Code Governance Committee* means the independent body responsible for monitoring, reporting and enforcement of **Code** compliance.

Claim means a formal request from an **insured** or **third-party beneficiary** for coverage of loss or damage under a general insurance policy.

Claims Management Service* means a person or company who is not a **Code Subscriber's employee** but is contracted by it to manage a **claim** on its behalf.

Collection Agent* means a person or company who is not a **Code Subscriber's employee** but is contracted by it to recover money owing to it.

Code* means the 2014 General Insurance Code of Practice.

Code Subscriber* means an organisation that has adopted the 2014 Code.

Code Team means the 2014 Code Compliance and Monitoring Team at FOS appointed to monitor **Code** compliance on behalf of the **CGC**.

Complaint* means an expression of dissatisfaction made to a **Code Subscriber**, related to its products or services, or its **complaints** handling process, where a response or resolution is explicitly or implicitly expected.

Corporate authorised representative* means a company authorised by **a Code Subscriber** to provide financial services on its behalf under its Australian Financial Services license (AFSL), in accordance with the Corporations Act 2001.

Data set means a collection of related sets of information.

Declined claim means a **claim** on a general insurance policy that a **Code Subscriber** has declined or not accepted.

Dispute means a **complaint** that is in or has completed **Stage Two** of a **Code Subscriber's internal complaints process**.

Dispute type means a category used to aggregate data about similar types of **disputes.**

Employee* means a person employed by a **Code Subscriber**, or related entity, that provides services to which the 2014 Code applies.

Group policy means a master general insurance policy held by an **insured** that provides cover for numerous people or assets within a defined group.

Individual authorised representative* means a person or partnership authorised by **a Code Subscriber** to provide financial services on its behalf under its AFSL, in accordance with the Corporations Act 2001.

Individual policy means a general insurance policy held by an **insured** that is not a **group policy**.

Independent contractor means a person, company or other entity engaged in providing insurance-related services, excluding the distribution of general insurance products, for a **Code Subscriber**.

Industry data means data about:

1. general insurance workforce,
2. compliance,
3. policies,
4. claims,
5. declined claims,
6. withdrawn claims and

7. internal disputes.

Insurance class means a category used to aggregate data about similar types of general insurance products.

Insured* means a person, company or entity seeking to hold or holding a general insurance product covered by the 2014 Code, but excludes a **third-party beneficiary**.

Internal complaints process means a **Code Subscriber's** internal process for dealing with **complaints**, broadly defined by subsections 10.3 to 10.10 of the 2014 Code and comprising **Stage One** and **Stage Two**.

Investigator* means a person or company who is not a **Code Subscriber's employee** but is contracted by it to verify the circumstances relating to a claim.

Loss Assessor or Loss Adjuster* means a person or company who is not a **Code Subscriber's employee** but is contracted by it to examine the circumstances of a **claim**, assess the damage or loss, determine whether the **claim** is covered under the **policy**, and assist in obtaining repair/replacement quotes to help settle the **claim**.

Policy means a contract of insurance between an insurer and an insured.

Retail Insurance* means a general insurance product that is provided to, or to be provided to, an individual or for use in connection with a **Small Business**, and is one of the following types:

a) a motor vehicle insurance product (Regulation 7.1.11);

b) a home building insurance product (Regulation 7.1.12);

c) a home contents insurance product (Regulation 7.1.13);

d) a sickness and accident insurance product (Regulation 7.1.14);

e) a consumer credit insurance product (Regulation 7.1.15);

f) a travel insurance product (Regulation 7.1.16); or

g) a personal and domestic property insurance product (Regulation 7.1.17), as defined in the Corporations Act 2001 and the relevant Regulations.

Service Supplier* means an **Investigator**, **Loss Assessor or Loss Adjuster**, **Collection Agent**, **Claims Management Service** (including a broker who manages claims on behalf of an insurer) or its approved sub-contractors acting on behalf of a Code Subscriber.

Small Business means a business that employs:

a) less than 100 people, if the business is or includes the manufacture of goods, or

b) otherwise, less than 20 people.

Stage One means the first stage of a **Code Subscriber's internal complaints process** and which is described by subsections 10.11, 10.12 and 10.13 of the 2014 Code.

Stage Two means the second stage of a **Code Subscriber's internal complaints process** and which is described by subsections 10.14 to 10.19 of the 2014 Code.

Third-party beneficiary means a person, company or entity who is not an **insured** but is seeking to be or is specified or referred to in a general insurance policy covered by the 2014 Code, whether by name or otherwise, as a person to whom the benefit of the insurance cover provided by the **policy** extends.

We, **us** or **our** means the **CGC** or **Code Team**.

Withdrawn claim means a **claim** that for various reasons does not proceed to a decision to accept or deny it and includes a **claim** that may be described as "cancelled", "closed", "discontinued" or "withdrawn".

Wholesale Insurance* means a general insurance product covered by the 2014 Code which is not **Retail Insurance**.

END DOCUMENT