GENERAL INSURANCE
Code Governance Committee

Submission to the Insurance Council of Australia (ICA) 2017 Code Review – Response to ICA Interim Report

21 December 2017

Contents

Executive Summary

On 17 February 2017, the Insurance Council of Australia (ICA) launched its review of the 2014 General Insurance Code of Practice (the Code). As part of this review the Code Governance Committee (the Committee) provided a submission to the ICA on 30 May 2017 covering various sections of the Code, including suggested additional standards, ways to address gaps in the existing standards, and clarification on the application of standards where necessary.

On 8 November 2017, the ICA presented its Interim Report of the Review of the General Insurance Code of Practice 2017 (Interim Report) for consultation. The ICA asked stakeholders to consider all matters raised and called for further submissions.

The Committee welcomes the work of the ICA review thus far, and acknowledges the depth and detail of the Interim Report, which seeks to address matters of significance to consumers.

The Committee has considered its responses to all the proposals in the Interim Report. Considering the depth of the Interim Report, the Committee has also prioritised the issues it considers to be of highest importance.

This paper sets out the Committee's submission in response to the ICA's Interim Report. The paper begins with areas that the Committee has identified as a priority, followed by its response in detail to each of the ICA's eight proposals, additional Code review themes and areas outside the scope of the Code Review.

Committee's Top Priorities

The Committee has endeavoured to respond to all of the ICA's proposals and additional Code review themes outlined in the Interim Report. However, there are a number of issues which the Committee sees as priority issues to be addressed as follows:

ICA Proposal 5.

The Committee's top priority is to strengthen Code standards to all third party distributors.

This would mean extending sections 4 'Buying insurance' and 5 'Standards for our Employees and Authorised Representatives' of the Code, to apply to all third party product sellers, including AFSLs and distributors that sell Retail Insurance products on behalf of Code Subscribers.

The Committee supports an approach that strengthens the standards relating to sales processes and services to ensure that consumers who buy insurance products from third party sellers are protected.

This is an area that has attracted particular criticism of the industry, and disadvantaged many unwitting consumers. It is important that it is corrected before even more distributed selling mechanisms are introduced, with the arrival of Amazon and other players.

The Committee recognises that this will require some time to implement, just as it did when Authorised Representatives were brought under the Code some years ago. Nonetheless, there must be a clear standard governing the ethical selling of insurance irrespective of the means by which it is sold. The products being sold are the insurer's

products and it remains the insurer's reputation that is at risk as a result of mis-selling by third parties. In addition, the Code itself would be seen to be a stronger form of self-regulation if it was extended to cover all distribution channels.

The Committee endorses the position that any formal agreement an insurer enters into with a third party to sell its product should include the principles listed by the ICA.

Strengthened standards should also require a third party distributor to notify the insurer:

- if it has reported a significant breach (including a likely breach) to ASIC relating to the conduct of its sellers, and
- the outcomes of compliance monitoring of sellers, particularly in relation to legal requirements and applicable codes of practice (e.g. insurance brokers, banking).

There is currently a difference between the obligations the Code imposes on authorised representatives and employees of related entities, as opposed to other third party sellers.

The Committee supports extending the scope of Sections 4 and 5 to all third party sellers of Retail Insurance products that sell such products for Code subscribers, however understands that this would take some time for the industry to adapt to, and to implement.

ICA Discussion Point 8.1

The Committee's second priority is amending the principles based standards in the Code (subsections 4.4, 6.2, 7.2 and 10.4) by removing the words "…in accordance with this section", so that it is clear that each of these subsections operates as a stand-alone provision.

The Committee has considered carefully the views outlined by the ICA. This is an area of considerable concern for the Committee and it remains strongly of the view that subsections 4.4, 6.2, 7.2 and 10.4 should be amended by removing the words "…in accordance with this section". This will ensure it is clear that each of these subsections operates as a stand-alone provision. The Committee has outlined its reasons below.

1. Principles-based obligations are intended to set out the way in which an entity conducts business and provides services to consumers. This means that a principles-based obligation should operate independently, and not be conditional on another standard, unless a significant event has occurred that would justify overriding its application.
2. The elements of honesty, efficiency, fairness, transparency and timeliness represent core principles that underpin the Code and, accordingly, the way in which subscribers conduct their businesses and provide their services to consumers.
3. Between 2006 and 2014 (prior to the commencement of the current Code), the General Insurance Code of Practice contained unconditional principles-based obligations, that operated independently. Those obligations were the same as, or similar to, subsections 4.4, 6.2, 7.2 and 10.4 of the Code.

4. The Committee disagrees with the ICA's statement that it is necessary for the rest of the standards in the relevant section to act as a measure of whether a subscriber has complied with the principles.[1]

5. During 2015–16 [2] and 2016–17, the Committee dealt with or finalised eight significant breaches of subsection 4.4, identified and reported to the Committee by subscribers. In all eight instances, the subscribers identified conduct that breached the elements of "fairness" and/or "transparency" which led to consumers sustaining financial detriment. Each significant breach was unrelated to any of the other standards in section 4.

6. In the Committee's view, retaining conditional principles-based obligations that did not operate independently would be a retrograde step and represents a narrowing of the application of such principles-based standards.

7. Such an approach is inconsistent with the Legislature's approach in relation to similar principles-based obligations, such as section 912A(1)(a) of the *Corporations Act 2001 (Cth)* (the Act).

8. Section 912A(1)(a) of the Act provides as follows:

> *(1) A financial services licensee must:*
>
> *(a) do all things necessary to ensure that the financial services covered by the licence are provided efficiently, honestly and fairly; ….*

9. In relation to section 912A(1)(a) the Committee notes the following:

   a. The Act does not define the terms "efficiently", "honestly" and "fairly".

   b. Section 912A(1)(a) is not read against other provisions when assessing whether a financial services licensee's conduct has met the required obligation.

   c. In ASIC RG 104.7[3] Licensing: Meeting the general obligations, July 2015, ASIC stated that obligations, such as section 912A(1)(a), are general obligations that "…are principles-based and designed to apply in a flexible way" and "[f]or this reason, we do not think we can or should give prescriptive guidance on what you need to do to comply with them. The Corporations Act places responsibility on you to decide how to comply."

   d. Subscribers could potentially breach their obligation to comply with section 912A(1)(a) of the Act, if they limited measurement of their compliance with the Code's principles-based obligations in the way suggested by the ICA. In this regard, the Code clearly states that "[w]here this Code imposes an obligation on us in addition to obligations applying under a law, we will also comply with this Code except where doing so would lead to a breach of a law."

[1] See page 44, Interim Report, available for download from http://codeofpracticereview.com.au/assets/interim%20report/02112017_Interim_Report.pdf.
[2] See pages 16 & 17, *General Insurance Code Governance Committee Annual Report 2015–16*, available for download from http://codeofpractice.com.au/assets/GICGC%20AR%202015-16.pdf.
[3] See page 6, paragraph RG 104.7, ASIC RG 104 *Licensing: Meeting the general obligations*, which is available for download from http://www.asic.gov.au/regulatory-resources/find-a-document/regulatory-guides/.

10. The Committee shares ASIC's view of the way in which principles-based obligations are intended to operate.

ICA Proposal 7.

The Committee's third priority is to include mandatory standards for claims investigations.

The Committee welcomes the ICA's Proposal 7 and refers to its 2017 *Own Motion Inquiry on investigation of claims and outsourced services* report and its resultant recommendations in relation to the conduct of investigators (Appendix 5 of the ICA's Interim Report[4]), which provide additional detail.

The Committee recommends that the claims investigation and interview standards contained in Appendix 5 of the ICA's Interim Report should be included in the Code as mandatory standards.

ICA Proposal 1.9 and 1.10

The Committee's fourth priority is to introduce mandatory standards in the Code on recognising and responding to instances of family violence.

The Committee supports an approach that:

- strengthens the Code's financial hardship standards,
- requires Code Subscribers to proactively identify and assist consumers who are in financial hardship,
- requires Code Subscribers to respond to express or implied requests for financial hardship assistance,
- requires Code Subscribers to assess requests for financial hardship assistance within a specified timeframe, and
- provides for clear access to internal complaints processes.

Appendix 2 is titled "Family violence guidance document" and targets vulnerable consumers who are experiencing family violence.[5] The ICA stated that its guidance documents, including Appendix 2, are voluntary and do not prescribe binding obligations on individual insurers. Appendix 2 proposes guidance on a range of areas including access to financial hardship (see 5. Access to financial hardship) and outlines options for retaining the policy where a consumer says they cannot meet their premium payments, in the context of family violence.

The Committee recommends that the ICA convert and extend some of the requirements noted in Appendix 2 into mandatory standards such as (but not limited to) the following:

[4] See page 101, *Interim Report, Review of the General Insurance Code of Practice, Insurance Council of Australia (Interim Report)*, which is available for download from http://codeofpracticereview.com.au/.
[5] See page 79, refer to Footnote 4.

- Staff training to improve responses to customers affected by family violence including during claims handling.
- Where a customer has disclosed family violence, ensuring there are systems in place to keep a customer's contact information secure and confidential, including treating all information about a customer affected by family violence as sensitive information.
- Service Suppliers used by Code Subscribers to work with claimants should also be trained to recognise possible family violence, and to respond accordingly.
- Fast-track hardship requests where family violence has been disclosed as an issue.
- Code Subscribers should ensure that contracts with agents and debt purchasers include a requirement to comply with the family violence guidance document.
- Where a Code Subscriber is made aware that a customer's debt involves a situation of family violence, the debt must not be referred to or sold on to third-party debt collection agencies.

More generally, the Committee considers that these requirements should apply to all consumers who are in financial hardship, and not only to those experiencing family violence.

In relation to providing options for retaining the policy where a customer says they cannot meet their premium payments, the Committee recommends that the ICA:

- extends the proposed options to all vulnerable consumers in financial hardship (not only those experiencing family violence) who are entitled to access the protections outlined in Section 8 of the Code (Financial Hardship standards), and
- implements the proposed options as binding obligations on Code Subscribers (and not as voluntary guidance).

ICA Proposals 1.20 and 1.21

The Committee's fifth priority is to clarify sections 8 'Financial Hardship' and 10 'Complaints and Disputes' so it is clear that any individuals who come within the scope of section 8 have access to the internal complaints process described by section 10, and that this access is not limited to recovery of money owed in connection with Retail Insurance products.

The Committee considers that section 10 of the Code should be amended so that it is clear that any individuals who come within the scope of section 8:

- have access to the internal complaints process described by section 10, and
- that this access is not limited to recovery of money owed in connection with Retail Insurance products.

Several Code Subscribers have suggested that uninsured third parties are not entitled to access the internal complaints process within section 10 of the Code. In response to this suggestion, the Committee specifically notes that section 10 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.

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 Committee is of the view that the Code should capture all consumers within the scope of section 8 – insureds, third party beneficiaries, and uninsured third parties – across recovery of money arising under/connected with retail and wholesale insurance products.

This is because Section 8 clearly states that it applies to all three types of consumers and does not explicitly state that it applies only to retail insurance (all other sections limited to retail insurance include an explicit statement that the relevant standard applies only to retail insurance). As a result, persons within the scope of, and who make complaints about matters that are covered by Section 8 must have access to Section 10 of the Code.

ICA Discussion Point 1.5

The Committee's sixth priority is to clarify that, where the Code requires an insurer to notify or inform a consumer about an entitlement or right, this information should be provided in writing. This applies to a number of subsections including subsections 7.19 (Claim denials), 9.3 (Catastrophes) and 10.10 (Complaints and Disputes).

The Committee's view is that subsection 7.19 of the Code should make it clear that when a claim is denied, all of the information that is required to be provided should be in writing.

The Committee adds that where a Code Subscriber is required to notify or inform a consumer about an entitlement or right, best practice requires that all such information is provided in writing.

In addition to subsection 7.19, the Code should clarify that such information should be provided in writing in several other subsections including but not limited to the following subsections:

- 4.8, when insurance is not offered
- 7.17 and 7.18, regarding the making of a claim decision within the specified timeframe
- 8.6, regarding a decision that a consumer is not entitled to financial hardship assistance
- 8.8(e), regarding a failure to reach an agreement on the nature of financial hardship assistance
- 8.11, regarding the requirement that agents provide details of a Code Subscriber's financial hardship process
- 9.3, regarding the assessment of claims arising from catastrophes, and

- 10.10, regarding the requirement to provide a final decision in response to a complaint within 45 calendar days.

ICA Discussion Point 12j

The Committee's seventh priority is to provide assistance to the Committee in the collection of industry data.

The Committee notes the ICA's comments in relation to the provision of data/access to information:

> "There is scope for this work to be carried out by independent data experts, in order that it does not take up a large amount of the CGC's resourcing which could be used for Code investigations. Granular data could then be provided to the CGC, the ICA and insurers, and the CGC could use it to determine whether there are systemic issues to be addressed in Code compliance.
>
> The ICA will seek to work with the CGC and Code Subscribers to ascertain the best mechanism for improving industry data collection and reporting once the requirements related to AFCA are known."

The Committee sees the provision of data as a very important issue and agrees that data continues to be an area where improvements need to be made, especially in terms of core data sets, compliance with standardised industry definitions, and access to new data.

The Committee supports enhancements to the data collection process, but it has some concerns in relation to the independence of data collection and the interpretation of trends if the ICA's suggestions are implemented.

The Committee requires timely, reliable, consistent and targeted data. There is a clear need for the Committee to obtain the data it requires, and not have the industry determine what is provided.

Moreover, the Committee needs to be able to identify trends that point to:

- areas that require clarification for consumers
- a need for improvement in practices of Code Subscribers – not always indicative of non-compliance but about best practice, and
- areas that may need improvement under the Code (because there is a gap, for example).

The Committee agrees with the ICA's comments that there is scope for input of specialist data expertise in the data collection work. As a result, it looks forward to working with the ICA to establish the best mechanism for improving industry data collection and reporting in the future.

ICA's Discussion Points 9, 9.1 and 9.2

The Committee's eighth priority is the promotion of the Code and providing further information about the Committee's role and its areas of focus.

The Committee agrees that it would be very beneficial if the Code included more information about the Committee's role and its areas of focus. In particular, information about the Committee's role in providing leadership to industry and helping subscribers understand and comply with their obligations, and seeking continuous improvement in insurance practices.

A statement about the role of the CGC might be to:

1. provide leadership to industry and help Code Subscribers understand and comply with their Code obligations
2. monitor and enforce the Code
3. collect industry data
4. engage with consumers about the Code, and
5. liaise with the ICA on relevant matters, including Code compliance, improvements to the Code and how the CGC's functions could be enhanced.

The Committee supports the expansion of the Code website to include further information such as, but not limited to, the items specified by the ICA. The Committee acknowledges that the ICA currently promotes the Committee's work by publishing its reports on the Code website. The Committee welcomes working further with the ICA to effect secure and independent control and operation of a website that reflects the work of the Committee and ensures the inclusion of the content anticipated by the ICA.

The Committee does not support the introduction of any separate charter that might potentially detract from the Code. The Committee is open to including a summary of relevant Code requirements for consumers on its website, but not in the form of a separate charter that adds additional requirements for insurers.

ICA Proposal 8:

The Committee's ninth priority is to support the ICA's position to seek ASIC approval for the revised Code under ASIC Regulatory Guideline 183 'Approval of financial services sector codes of conduct' (RG183).

The Committee supports the ICA's position to seek ASIC approval of the Code under ASIC RG 183 'Approval of financial services sector codes of conduct' (RG183).

In respect of the issues around the timing of reviews, the Committee supports a process/practice which allows for rolling enhancements to the Code when necessary, with the certainty of an independent review after three years.

The Committee will impose any sanctions that the ICA deems appropriate.

ICA Discussion Point 8.3

The Committee's tenth priority relates to the proposal to introduce a process for Code subscribers to appeal the Committee's decisions.

The Committee considers that the suggestion of a more formal appeals process is inconsistent with the purpose of a voluntary industry code of practice. It would call into question the independence of the Committee. Historically, layers of appeals tend to be costly and time-consuming; adding enormous amounts of process for very little return.

Moreover, the Committee considers it to be inappropriate and unnecessary to implement an appeal process as suggested by the ICA because the Committee's Charter currently has a complaints process in place. Paragraph 7.1 of the Charter provides as follows:

7.1 Complaints

(a) The CGC Chair will consider and investigate any complaint that the CGC has not acted in accordance with the Code or the Charter received by the CGC or referred to it by the ICA or FOS.

(b) The CGC Chair will make recommendations to the CGC in respect of what, if any, steps should be taken in respect of the complaint.

(c) If the CGC Chair believes that a complaint raises issues which involve the Chair or a CGC Member in a conflict of interest, then the CGC Chair may appoint an Independent person to consider and investigate and make recommendations to the CGC in respect of the subject matter of the complaint.

(d) The CGC will advise a complainant of its determination in relation to any complaint.

(e) The CGC Chair may report complaints and their outcomes to the Association Chair.

The Committee notes that subscribers have contractually agreed to be bound by the Code and, as a result, by the Committee's findings. The Committee has an obligation to pursue the objectives of the Code having regard to the law, and acknowledging that a contract of insurance is a contract based on the utmost good faith.

Key Terms

ASIC	Australian Securities & Investments Commission
Code	The 2014 General Insurance Code of Practice
CGC or Committee	Code Governance Committee
ICA	Insurance Council of Australia
RG	Regulatory Guide

ICA Proposals

Proposal 1	CGC position/comments
The Code should strengthen standards relating to vulnerable consumers: • Including a new section on vulnerable consumers	**Question 1:** The Committee agrees with the ICA's suggestion that the Code should include a new section on vulnerable consumers.
	Question 1.1: The Committee has considered the ICA's suggestion and has no further comments to add.
	Question 1.2: The Committee has considered the ICA's suggestion and has no further comments to add.
	Question 1.3: The Committee considers the provision of more tailored options to ensure all consumers can access products that meet their needs in an affordable manner is an important issue worthy of further consideration. The Committee suggests further investigation into how payment arrangements, such as Centrepay, would work in practice, and would support a full study and cost-benefit analysis, to inform possible changes to the Code in this area.
	Question 1.4: The Committee agrees with the ICA's suggestion that the Code should require assistance to be provided to those who have trouble meeting identification requirements.
	Question 1.5: The Committee agrees that the principles listed by the ICA satisfactorily reflect best practice standards for the use of interpreters.
• Providing Code guidance on best practice mental health principles	**Question 1.6:** The Committee agrees with the ICA's proposal to develop the mental health best practice principles (detailed in Appendix 1 of the Interim Report) into an ICA guidance document.
	Question 1.7: The ICA has proposed that the Code: • should not contain guidelines for complying with the *Disability Discrimination Act 1992 (Cth)* (DDA), and • could include a statement explaining how underwriting decisions will be made. The Committee considers that the relevant legislation is the appropriate basis for action and regulation. The Committee proposes that in its consideration of the issues, the ICA should be guided by ASIC RG 183, which expects an effective code of practice to do at least one of the following three things: (a) address specific industry issues and consumer problems not covered by legislation; (b) elaborate on legislation to deliver additional benefits to consumers; and/or

Proposal 1	CGC position/comments
	(c) clarify what needs to be done from the perspective of a particular industry, practice or product to comply with legislation.[6]
	Question 1.8: The Committee believes that the Code should require insurers to provide, on request, a summary of the type of data or a description of the relevant factors relied upon, and why that data or those factors are relevant when insurers rely on the DDA to make a decision about the provision of insurance or about a claim. This information should be provided in writing to consumers.
• Providing Code guidance on recognising and responding to instances of family violence	**Questions 1.9, 1.10:** **The Committee's fourth priority is to introduce mandatory standards in the Code on recognising and responding to instances of family violence.** The Committee supports an approach that: • strengthens the Code's financial hardship standards, • requires Code Subscribers to proactively identify and assist consumers who are in financial hardship, • requires Code Subscribers to respond to express or implied requests for financial hardship assistance, • requires Code Subscribers to assess requests for financial hardship assistance within a specified timeframe, and • provides for clear access to internal complaints processes. Appendix 2 is titled "Family violence guidance document" and targets vulnerable consumers who are experiencing family violence. The ICA stated that its guidance documents, including Appendix 2, are voluntary and do not prescribe binding obligations on individual insurers. Appendix 2 proposes guidance on a range of areas including access to financial hardship (see 5. Access to financial hardship) and outlines options for retaining the policy where a consumer says they cannot meet their premium payments, in the context of family violence. The Committee recommends that the ICA convert and extend some of the requirements noted in Appendix 2 into mandatory standards such as (but not limited to) the following: • Staff training to improve responses to customers affected by family violence including during claims handling.

[6] See paragraph 183.5, ASIC RG 183 *Approval of financial services sector codes of conduct,* which is available for download from http://www.asic.gov.au/regulatory-resources/find-a-document/find-a-regulatory-document/.

Proposal 1	CGC position/comments
	• Where a customer has disclosed family violence, ensuring there are systems in place to keep a customer's contact information secure and confidential, including treating all information about a customer affected by family violence as sensitive information. • Service Suppliers used by Code Subscribers to work with claimants should also be trained to recognise possible family violence, and to respond accordingly. • Fast-track hardship requests where family violence has been disclosed as an issue. • Code Subscribers should ensure that contracts with agents and debt purchasers include a requirement to comply with the family violence guidance document. • Where a Code Subscriber is made aware that a customer's debt involves a situation of family violence, the debt must not be referred to or sold on to third-party debt collection agencies. More generally, the Committee considers that these requirements should apply to all consumers who are in financial hardship, and not only to those experiencing family violence. In relation to providing options for retaining the policy where a customer says they cannot meet their premium payments, the Committee recommends that the ICA: • extends the proposed options to all vulnerable consumers in financial hardship (not only those experiencing family violence) who are entitled to access the protections outlined in Section 8 of the Code (Financial Hardship standards), and • implements the proposed options as binding obligations on Code Subscribers (and not as voluntary guidance). **(See the Committee's Top Priorities.)**
• Including stronger Code standards on financial hardship	**Question 1.11:** The Committee supports the ICA's suggestion that the Code should require insurers and Service Suppliers to receive training on their obligations with regard to consumers in financial hardship, and to identify signs of financial hardship when engaging with individuals who owe money to an insurer.
	Question 1.12: The Committee's view is that there are no reasons for the Code not to require debt recovery letters to include information about the financial hardship process.
	Question 1.13: The Committee believes that an insurer who is contacted directly by a consumer in hardship, who is aware that the consumer has a representative, should always be required to notify the representative that such contact has occurred. The Committee understands that this adds an extra step. However when dealing with vulnerable consumers in hardship, insurers

Proposal 1	CGC position/comments
	should assist them as much as possible by facilitating their assistance and support throughout the process. The Committee believes any privacy implications arising from this can be managed.
	Question 1.14: The Committee agrees that the Code should require that financial hardship applications should be processed in line with the timeframes in the National Credit Code.
	Question 1.15: The Committee has considered the ICA's views and has no further comments to add.
	Question 1.16: The Committee agrees that the financial hardship section of the Code should make it clear that it applies to situations where a customer cannot pay their excess, and that the options for financial hardship assistance in clause 8.8 should include "deduction of the excess from the claim payment".
	Question 1.17: The Committee believes that the Code should specify that if a consumer experiencing financial hardship has the ability to pay their debt in instalments, then the insurer should not refuse this option.
	Question 1.18: The Committee has considered the ICA's question and has no further comments to add.
	Question 1.19: The Committee agrees that the financial hardship process should include a complaint handling timeframe of 21 days, in line with the timeframe for credit disputes in RG 165.
	Questions 1.20, 1.21: **The Committee's fifth priority is to clarify sections 8 'Financial Hardship' and 10 'Complaints and Disputes' so it is clear that any individuals who come within the scope of section 8 have access to the internal complaints process described by section 10, and that this access is not limited to recovery of money owed in connection with Retail Insurance products.** The Committee considers that section 10 of the Code should be amended so that it is clear that any individuals who come within the scope of section 8: • have access to the internal complaints process described by section 10, and • that this access is not limited to recovery of money owed in connection with Retail Insurance products. Several Code Subscribers have suggested that uninsured third parties are not entitled to access the internal complaints process within section 10 of the Code. In response to this suggestion, the Committee specifically notes that section 10 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.

Proposal 1	CGC position/comments
	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 Committee is of the view that the Code should capture all consumers within the scope of section 8 – insureds, third party beneficiaries, and uninsured third parties – across recovery of money arising under/connected with retail and wholesale insurance products. This is because Section 8 clearly states that it applies to all three types of consumers and does not explicitly state that it applies only to retail insurance (all other sections limited to retail insurance include an explicit statement that the relevant standard applies only to retail insurance). As a result, persons within the scope of, and who make complaints about matters that are covered by Section 8 must have access to Section 10 of the Code. **(See the Committee's Top Priorities**.)

Proposal 2	CGC position/comments
The Code should provide guidance on best practice disclosure principles	**Question 2:** The Committee endorses the best practice principles detailed in Appendix 3, and believes the principles should be in plain language to provide clarity.
	Question 2.1: The Committee agrees that the Code should require key information to be provided in plain language, and be consumer tested to ensure it is clear and informative enough for a consumer to reasonably assess the suitability of the policy for them.
	Question 2.2: The Committee agrees with the ICA's suggestion that the Code require insurers to provide access to an accurate and informative sum insured calculator as part of the home building insurance application process.

Proposal 3	CGC position/comments
The Code should include product design and distribution principles and provide guidance to insurers	**Question 3:** The Committee endorses the inclusion of the six listed principles as a means of improving product suitability.
	Question 3.1: The Committee agrees that the design considerations in Appendix 4 can be applied to all general insurance products, and provide sufficient detail as to how the principles are to be applied.
	Question 3.2: The Committee supports the inclusion of the listed principles in the Code to help consumers to purchase insurance that is suitable for them.
	Question 3.3: The Committee has considered Appendix 4 and the questions posed by the ICA, and has no further comments to add.
	Question 3.4: The Committee endorses the inclusion of options for consumer redress in the Code, for circumstances where an insurer identifies issues with the distribution of its products.

Proposal 4	CGC position/comments
The Code should provide product design and distribution guidance specific to add-on insurance products	**Question 4:** The Committee is currently conducting an Own Motion Inquiry (OMI) into add-on insurance. This OMI will help inform the Committee and the ICA about the extent of this issue. The Committee considers that it is likely that some guidance in the Code will be necessary as a result.
	Question 4.1: The Committee supports the consideration for the Code to play some part in the implementation of a deferred sales model for add-on products sold through the motor dealer channel.

Proposal 5	CGC position/comments
The Code should strengthen standards relating to third-party distributors	**Question 5:** **The Committee's top priority is to strengthen Code standards to all third party distributors.** **This would mean extending sections 4 'Buying insurance' and 5 'Standards for our Employees and Authorised Representatives' of the Code, to apply to all third party product sellers, including AFSLs and distributors that sell Retail Insurance products on behalf of Code Subscribers.** The Committee supports an approach that strengthens the standards relating to sales processes and services to ensure that consumers who buy insurance products from third party sellers are protected. This is an area that has attracted particular criticism of the industry, and disadvantaged many unwitting consumers. It is important that it is corrected before even more distributed selling mechanisms are introduced, with the arrival of Amazon and other players. The Committee recognises that this will require some time to implement, just as it did when authorised representatives were brought under the Code some years ago. Nonetheless, there must be a clear standard governing the ethical selling of insurance irrespective of the means by which it is sold. The products being sold are the insurer's products and it remains the insurer's reputation that is at risk as a result of mis-selling by third parties. In addition, the Code itself would be seen to be a stronger form of self-regulation if it was extended to cover all distribution channels. The Committee endorses the position that any formal agreement an insurer enters into with a third party to sell its product should include the principles listed by the ICA. Strengthened standards should also require a third party distributor to notify the insurer:

Proposal 5	CGC position/comments
	• if it has reported a significant breach (including a likely breach) to ASIC relating to the conduct of its sellers, and • the outcomes of compliance monitoring of sellers, particularly in relation to legal requirements and applicable codes of practice (e.g. insurance brokers, banking). There is currently a difference between the obligations the Code imposes on authorised representatives and employees of related entities, as opposed to other third party sellers. The Committee supports extending the scope of Sections 4 and 5 to all third party sellers of Retail Insurance products that sell such products for Code subscribers, however understands that this would take some time for the industry to adapt to, and to implement. **(See the Committee's Top Priorities.)**
	5.1: The Committee has considered this item and has no further comments to add.

Proposal 6	CGC position/comments
The Code should strengthen standards relating to Service Suppliers	**Question 6:** The Committee agrees that making the listed requirements explicit in the Code will help to strengthen insurers' responsibility for the conduct of their Service Suppliers.
	Question 6.1: The Committee has considered the ICA's question and has no further comments to add.
	Question 6.2: The Committee is of the view that the ICA could consider developing standards or guidance that would apply specifically to External Experts when engaged or consulted by subscribers in the context of claims handling. For example, standards such as (but not limited to): • Only appointing External Experts who reasonably satisfy the subscriber at the time of appointment that they are impartial, objective, suitably qualified and competent, to provide the requested expert opinion. • Agreeing on and documenting the nature and scope of the consultation. • Ensuring that External Experts document their conclusions and their basis. • Ensuring that contracts with External Experts reference the relevant States' and Territories' Expert Witness Code of Conduct. The Committee notes that the Life Insurance Code of Practice has a similar standard (see clause 10.4)[7]. • Where a professional association or body has established ethical guidelines for its members, requiring the relevant External Experts to comply with the applicable guidelines

[7] The *Life Insurance Code of Practice* is available for download from https://www.fsc.org.au/policy/life-insurance/code-of-practice/life-code-of-practice.pdf.

Proposal 6	CGC position/comments
	during their contract of engagement. The Committee notes that the Life Insurance Code of Practice has a similar standard (see clause 10.5)[8].

Proposal 7	CGC position/comments
The Code should include mandatory standards for Investigations	**Questions 7, 7.1, 7.2:** **The Committee's third priority is to include mandatory standards for claims investigations.** The Committee welcomes the ICA's proposal 7 and refers to its 2017 *Own Motion Inquiry on investigation of claims and outsourced services* report and its resultant recommendations in relation to the conduct of investigators (Appendix 5 of the ICA's interim report), which provide additional detail. The Committee recommends that the claims investigation and interview standards contained in Appendix 5 of the ICA's Interim Report should be included in the Code as mandatory standards. **(See the Committee's Top Priorities**.)

Proposal 8	CGC position/comments
The revised Code should meet the requirements for ASIC approval	**Questions 8, 8.1, 8.2, 8.3:** **The Committee's ninth priority is to seek ASIC approval for the revised Code under ASIC Regulatory Guideline 183 'Approval of financial services sector codes of conduct' (RG183).** The Committee supports the ICA's position to seek ASIC approval of the Code under ASIC RG 183 'Approval of financial services sector codes of conduct' (RG183). In respect of the issues around the timing of reviews, the Committee supports a process/practice which allows for rolling enhancements to the Code when necessary, with the certainty of an independent review after three years. The Committee will impose any sanctions that the ICA deems appropriate. **(See the Committee's Top Priorities**.)

[8] See Footnote 7.

Additional Code Review Themes

i Claims	CGC position/comments
Claims: a. Making a claim	**Discussion Point 1:** The Committee agrees that the listed requirements around making a claim should be incorporated in the Code.
Claims: b. Withdrawn claims	**Discussion Point 1.1:** The Committee agrees that the Code should make it clear that insurers will neither discourage a claim nor encourage a withdrawal.
	Discussion Point 1.2: The Committee agrees that the Code should include requirements that when a claim is withdrawn insurers should endeavour to record the reasons for this (if known), and ensure the customer is aware that they can make a complaint if they wish.
Claims: c. Claims decisions	**Discussion Point 1.3:** The Committee has considered this issue and has no further comments to add.
Claims: d. Claims denials and partial denials	**Discussion Point 1.4:** The Committee's view is that the Code should require that where a claim is partially accepted, this should be confirmed in writing.
	Discussion Point 1.5: **The Committee's sixth priority is to clarify that, where the Code requires an insurer to notify or inform a consumer about an entitlement or right, this information should be provided in writing. This applies to a number of subsections including subsections 7.19 (Claim denials), 9.3 (Catastrophes) and 10.10 (Complaints and Disputes).** The Committee's view is that subsection 7.19 of the Code should make it clear that when a claim is denied, all of the information that is required to be provided should be in writing. The Committee adds that where a Code Subscriber is required to notify or inform a consumer about an entitlement or right, best practice requires that all such information is provided in writing. In addition to subsection 7.19, the Code should clarify that such information should be provided in writing in several other subsections including but not limited to the following subsections: • 4.8, when insurance is not offered • 7.17 and 7.18, regarding the making of a claim decision within the specified timeframe • 8.6, regarding a decision that a consumer is not entitled to financial hardship assistance • 8.8(e), regarding a failure to reach an agreement on the nature of financial hardship assistance

i Claims	CGC position/comments
	• 8.11, regarding the requirement that agents provide details of a Code Subscriber's financial hardship process • 9.3, regarding the assessment of claims arising from catastrophes, and • 10.10, regarding the requirement to provide a final decision in response to a complaint within 45 calendar days. **(See the Committee's Top Priorities.)**
	Discussion Point 1.6: The Committee has considered the ICA's question and has no further comments to add.
	Discussion Point 1.7: The Committee supports an amendment to clause 9.3 of the Code, so that after a catastrophe there is an obligation to notify a claimant, in writing, about their entitlement to have their claim reviewed within 12 months.
Claims: e. External Expert reports	**Discussion Point 1.8:** The Committee has noted the issues and has no further comments to add.
Claims: f. Home building and vehicle repairs	**Discussion Point 1.9:** The Committee believes there would be no disadvantages if the Code were to require a written summary of the scope of work to be provided to the customer where the insurer engages a repairer, and that this would provide increased clarity to the customer.
	Discussion Point 1.10: The Committee endorses the idea that the Code should require insurers to arrange and pay for a hire car or accommodation costs over and above what is in the policy, in circumstances where a repairer organised by the insurer has done poor repairs. This will provide an incentive for insurers to work with quality repairers.
Claims: g. Total loss claims protocol	**Discussion Point 1.11:** The Committee agrees that insurers and their Service Suppliers must handle total loss claims, and claims following major events, with great sensitivity. In such circumstances, and whether or not the ICA has declared the event a "catastrophe" (as defined by the Code), the Committee is of the view that if a claimant's loss is equal to or greater than the full sum insured (or a sub-limit within this), the insurer should pay the full sum insured (or the sub-limit within this), unless it has a reasonable belief that the sum insured (or the sub-limit within this) is greater than the value of the property being claimed. Where the insurer has such a reasonable belief then the insurer and its Service Suppliers should assist the claimant to ascertain the extent of their loss.
Claims: h. Uninsured third party claims	**Discussion Point 1.12:** The Committee agrees that the Code should include the principles listed by the ICA, to clarify the rights of an uninsured third party driver making a claim with an at-fault driver's insurer.
Claims: i. Debt recovery	**Discussion Point 1.13:** The Committee supports the inclusion in the Code of a requirement that insurers should treat individuals from whom they are seeking a recovery of a debt in an honest, fair, transparent and timely manner.

i Claims	CGC position/comments
	Discussion Point 1.14: The Committee supports the inclusion in the Code of a requirement that the insurer should provide sufficient information in writing to a third party the insurer is seeking recovery from, to enable the third party to determine that the amount being recovered is fair and reasonable.
Claims: j. Provision of documents	**Discussion Point 1.15:** The Committee agrees that the Access to Information section of the Code should be updated to clarify that insurers will provide the specific information listed by the ICA on request.

ii Automatic renewals	CGC position/comments
	Discussion Point 2: The Committee is of the view that if insurers implement automatic renewals, they should offer them to consumers only as an opt-in choice. In addition, the Committee believes that insurers should provide 30 days' prior notice of an automatic renewal to prompt consumers to review their insurance arrangements.

iii Cancellation of policy	CGC position/comments
	Discussion Point 3: The Committee has considered the ICA's questions and has no further comments to add.

iv Complaints and disputes	CGC position/comments
a. Multi-tier complaints process	**Discussion Point 4:** The Committee continues to support a single-tier internal complaints process. It would: • provide a consumer with a single point of contact • provide a single decision that is final in response to the consumer's complaint, and • reduce confusion, complexity and delay for the consumer.
b. Customer representatives	**Discussion Point 4.1:** The Committee has considered this and supports a Code requirement that insurers and Service Suppliers contact a customer through their representative when this has been requested by the customer.

v Advertising and marketing	CGC position/comments
	Discussion Point 5: The Committee agrees that the provisions listed by the ICA provide adequate restrictions on advertising and marketing.

vi Pressure selling	CGC position/comments
	Discussion Point 6: The Committee supports extending the scope of Sections 4 and 5 to all third party sellers of Retail Insurance products that sell such products for Code subscribers, and the strengthening of agreements between insurers and third party sellers to include the obligations of the Code. See the Committee's top priority in response to ICA Proposal 5 (above).

vii Customer communications	CGC position/comments
a. When insurance is not offered	**Discussion Point 7:** The Committee's sixth priority outlined in response to the ICA's Discussion Point 1.5 (above) addresses its response to Discussion Point 7 and is repeated here for completeness. **The Committee's sixth priority is to clarify that, where the Code requires an insurer to notify or inform a consumer about an entitlement or right, this information should be provided in writing. This applies to a number of subsections including subsections 7.19 (Claim denials), 9.3 (Catastrophes) and 10.10 (Complaints and Disputes).** The Committee's view is that subsection 7.19 of the Code should make it clear that when a claim is denied, all of the information that is required to be provided should be in writing. The Committee adds that where a Code Subscriber is required to notify or inform a consumer about an entitlement or right, best practice requires that all such information is provided in writing. In addition to subsection 7.19, the Code should clarify that such information should be provided in writing in several other subsections including, but not limited to, the following subsections: • 4.8, when insurance is not offered • 7.17 and 7.18, regarding the making of a claim decision within the specified timeframe • 8.6, regarding a decision that a consumer is not entitled to financial hardship assistance • 8.8(e), regarding a failure to reach an agreement on the nature of financial hardship assistance • 8.11, regarding the requirement that agents provide details of a Code Subscriber's financial hardship process

vii Customer communications	CGC position/comments
	• 9.3, regarding the assessment of claims arising from catastrophes, and • 10.10, regarding the requirement to provide a final decision in response to a complaint within 45 calendar days. **(See the Committee's Top Priorities.)**
b. Verification of a customer's disclosure	**Discussion Point 7.1:** The Committee agrees that the Code should require an insurer to contact a customer as soon as it becomes aware of an issue with their disclosures, and not wait until the customer makes a claim to verify the disclosures. The Committee acknowledges that this is a challenging area for consumers and insurers. As a result, the Committee considers that it is important for the ICA to consider how customer disclosures might be improved at inception and on subsequent renewal of a policy of insurance.
c. Policies with no-claim discounts (NCDs)	**Discussion Point 7.2:** The Committee believes that the issue of increasing consumer understanding of NCDs is already addressed by existing standards in the Code.

viii Monitoring, enforcement and sanctions	CGC position/comments
a. Reporting of Code breaches	**Discussion Point 8:** The Committee supports redrafting Clause 13.1 of the Code to read "Anyone can report alleged breaches of this Code to the CGC".
b. Interpretation of Code standards and process for appeal	**Discussion Point 8.1:** **The Committee's second priority is amending the principles based standards in the Code (subsections 4.4, 6.2, 7.2 and 10.4) by removing the words "…in accordance with this section", so that it is clear that each of these subsections operates as a stand-alone provision.** The Committee has considered carefully the views outlined by the ICA. This is an area of considerable concern for the Committee and it remains strongly of the view that subsections 4.4, 6.2, 7.2 and 10.4 should be amended by removing the words "…in accordance with this section". This will ensure it is clear that each of these subsections operates as a stand-alone provision. The Committee has outlined its reasons below. 1. Principles-based obligations are intended to set out the way in which an entity conducts business and provides services to consumers. This means that a principles-based obligation should operate independently and not be conditional on another standard, unless a significant event has occurred that would justify overriding its application.

viii Monitoring, enforcement and sanctions	CGC position/comments
	2. The elements of honesty, efficiency, fairness, transparency and timeliness represent core principles that underpin the Code and, accordingly, the way in which subscribers conduct their businesses and provide their services to consumers. 3. Between 2006 and 2014 (prior to the commencement of the current Code), the General Insurance Code of Practice contained unconditional principles-based obligations, that operated independently. Those obligations were the same as, or similar to, subsections 4.4, 6.2, 7.2 and 10.4 of the Code. 4. The Committee disagrees with the ICA's statement that it is necessary for the rest of the standards in the relevant section to act as a measure of whether a subscriber has complied with the principles.[9] 5. During 2015–16 [10] and 2016–17, the Committee dealt with or finalised eight significant breaches of subsection 4.4, identified and reported to the Committee by subscribers. In all eight instances, the subscribers identified conduct that breached the elements of "fairness" and/or "transparency" which led to consumers sustaining financial detriment. Each significant breach was unrelated to any of the other standards in section 4. 6. In the Committee's view, retaining conditional principles-based obligations that did not operate independently would be a retrograde step and represents a narrowing of the application of such principles-based standards. 7. Such an approach is inconsistent with the Legislature's approach in relation to similar principles-based obligations, such as section 912A(1)(a) of the *Corporations Act 2001 (Cth)* (the Act). 8. Section 912A(1)(a) of the Act provides as follows: *(1) A financial services licensee must:* *(a) do all things necessary to ensure that the financial services covered by the licence are provided efficiently, honestly and fairly; ….* 9. In relation to section 912A(1)(a) the Committee notes the following: a. The Act does not define the terms "efficiently", "honestly" and "fairly".

[9] See page 44, Interim Report, available for download from http://codeofpracticereview.com.au/assets/interim%20report/02112017_Interim_Report.pdf.
[10] See pages 16 & 17, *General Insurance Code Governance Committee Annual Report 2015–16*, available for download from http://codeofpractice.com.au/assets/GICGC%20AR%202015-16.pdf.

viii Monitoring, enforcement and sanctions	CGC position/comments
	b. Section 912A(1)(a) is not read against other provisions when assessing whether a financial services licensee's conduct has met the required obligation. c. In ASIC RG 104.711 Licensing: Meeting the general obligations, July 2015, ASIC stated that obligations, such as section 912A(1)(a), are general obligations that "…are principles-based and designed to apply in a flexible way" and "[f]or this reason, we do not think we can or should give prescriptive guidance on what you need to do to comply with them. The Corporations Act places responsibility on you to decide how to comply." d. Subscribers could potentially breach their obligation to comply with section 912A(1)(a) of the Act, if they limited measurement of their compliance with the Code's principles-based obligations in the way suggested by the ICA. In this regard, the Code clearly states that "[w]here this Code imposes an obligation on us in addition to obligations applying under a law, we will also comply with this Code except where doing so would lead to a breach of a law." 10. The Committee shares ASIC's view of the way in which principles-based obligations are intended to operate. **(See the Committee's Top Priorities.)**
	Discussion Point 8.2: The Committee supports the practice of regularly publishing its decisions on a de-identified basis.
	Discussion Point 8.3: **The Committee's tenth priority relates to the proposal to introduce a process for Code subscribers to appeal the Committee's decisions.** The Committee considers that the suggestion of a more formal appeals process is inconsistent with the purpose of a voluntary industry code of practice. It would call into question the independence of the Committee. Historically, layers of appeals tend to be costly and time-consuming; adding enormous amounts of process for very little return. Moreover, the Committee considers it to be inappropriate and unnecessary to implement an appeal process as suggested by the ICA because the Committee's Charter currently has a complaints process in place. Paragraph 7.1 of the Charter provides as follows:

[11] See page 6, paragraph RG 104.7, ASIC RG 104 *Licensing: Meeting the general obligations* which is available for download from http://www.asic.gov.au/regulatory-resources/find-a-document/regulatory-guides/.

viii Monitoring, enforcement and sanctions	CGC position/comments
	7.2 Complaints (a) The CGC Chair will consider and investigate any complaint that the CGC has not acted in accordance with the Code or the Charter received by the CGC or referred to it by the ICA or FOS. (b) The CGC Chair will make recommendations to the CGC in respect of what, if any, steps should be taken in respect of the complaint. (c) If the CGC Chair believes that a complaint raises issues which involve the Chair or a CGC Member in a conflict of interest, then the CGC Chair may appoint an Independent person to consider and investigate and make recommendations to the CGC in respect of the subject matter of the complaint. (d) The CGC will advise a complainant of its determination in relation to any complaint. (e) The CGC Chair may report complaints and their outcomes to the Association Chair. The Committee notes that subscribers have contractually agreed to be bound by the Code and, as a result, by the Committee's findings. The Committee has an obligation to pursue the objectives of the Code having regard to the law, and acknowledging that a contract of insurance is a contract based on the utmost good faith. **(See the Committee's Top Priorities.)**
c. Reporting of Significant Breaches	**Discussion Point 8.4:** The Committee has considered the views outlined by the ICA. The Committee's view is that subscribers need clarity around the interpretation of the words "likely breach" in paragraph (b) of the Code's definition of "Significant Breach". The Committee's approach to interpreting the meaning of "a likely breach" is consistent with the approach outlined by ASIC in RG 78.[12] The Committee considers that a subscriber is likely to breach a Code obligation if, and only if, the subscriber is no longer able to comply with relevant obligation. The Committee proposes that it could publish a guidance note to provide clarity on the interpretation of "likely breach", so that there is no confusion among subscribers.
d. Relationship between Code breaches and EDR	**Discussion Point 8.5:** The Committee acknowledges that there are instances where there may be confusion from submitters regarding the role of the Financial Ombudsman Service Limited (FOS) as an external dispute resolution (EDR) scheme and the Code breach investigation process conducted by the Committee.

[12] See paragraphs 78.9 and 78.10 in ASIC RG 78 *Breach reporting by AFS licensees,* is available to download from http://www.asic.gov.au/regulatory-resources/find-a-document/regulatory-guides/.

viii Monitoring, enforcement and sanctions	CGC position/comments
	FOS is an EDR scheme approved by the Australian Securities and Investment Commission that offers dispute resolution for consumers who are unable to resolve complaints with member financial service providers. The General Insurance Code of Practice (the Code) is voluntary and sets standards of good industry practice for its subscribers and is monitored by the Committee. The Committee is independent of the ICA and FOS. FOS provides secretariat services to the Committee that are separate and independent from FOS's primary role as an EDR scheme. In accordance with the Code, the Committee has the ability to receive and investigate Code breach allegations from various sources including members of the public. Among other things, the Committee's role is to determine whether a Code breach has occurred but not to resolve a dispute or provide consumer redress. In relation to the specific suggestions made in Discussion Point 8.5, the Committee notes the following: a) The Committee can confirm that it already has in place processes to determine whether a breach allegation has also gone to internal dispute resolution (IDR) or EDR, and will refer to either IDR or EDR where appropriate. b) The Committee can confirm that it already has in place a process to consider whether or not it should delay its investigation of an alleged Code breach, where a related dispute is with FOS. The ICA's proposal that the Committee should await the outcome of the FOS investigation would not always be appropriate and so it does not agree with the inclusion of this proposal in the Code. c) The proposal that EDR should provide details of possible Code breaches to the Committee already exists in the current Code in subsection 13.17. The Committee is happy to work with the ICA to continue to clarify the distinction between the handling of Code breach allegations and FOS disputes through ongoing stakeholder engagement.

ix Promotion of the Code	CGC position/comments
	Discussion Points 9, 9.1 and 9.2: **The Committee's eighth priority is the promotion of the Code and providing further information about the Committee's role and its areas of focus.**

	The Committee agrees that it would be very beneficial if the Code included more information about the Committee's role and its areas of focus. In particular, information about the Committee's role in providing leadership to industry and helping subscribers understand and comply with their obligations, and seeking continuous improvement in insurance practices. A statement about the role of the CGC might be to: 1. provide leadership to industry and help Code Subscribers understand and comply with their Code obligations 2. monitor and enforce the Code 3. collect industry data 4. engage with consumers about the Code, and 5. liaise with the ICA on relevant matters, including Code compliance, improvements to the Code and how the CGC's functions could be enhanced. The Committee supports the expansion of the Code website to include further information such as, but not limited to, the items specified by the ICA. The Committee acknowledges that the ICA currently promotes the Committee's work by publishing its reports on the Code website. The Committee welcomes working further with the ICA to effect secure and independent control and operation of a website that reflects the work of the Committee and ensures the inclusion of the content anticipated by the ICA. The Committee does not support the introduction of any separate charter that might potentially detract from the Code. The Committee is open to including a summary of relevant Code requirements for consumers on its website, but not in the form of a separate charter that adds additional requirements for insurers. **(See the Committee's Top Priorities.)**

x Extending the scope of the Code	CGC position/comments
a. Corporate culture	**Discussion Point 10:** The Committee agrees that the Code should not contain a specific provision relating to corporate culture.
b. Residential strata	**Discussion Point 10.1:** The Committee maintains its previous position that the Code should clarify the meaning of 'Retail Insurance' to ensure that it includes residential strata title general insurance products. The application of the Code to a general insurance product is solely determined by reference to whether the product is a retail or wholesale general insurance product (as defined) – the value of the insurance or asset covered by the insurance has no bearing on such an assessment.

x Extending the scope of the Code	CGC position/comments
	The Committee supports an approach that ensures individuals who are provided with residential strata cover are not excluded from the scope of the Code and continue to have access to the standards that apply to retail general insurance products.
c. Extension of Code to business insurance	**Discussion Point 10.2:** The Committee supports extending the application of sections 4, 6, 7, 9 and 10 for small business consumers to general insurance products that currently fall outside the Code's definition of 'Retail Insurance' but which are covered by FOS's Terms of Reference (TOR). Under the FOS TOR, small businesses may access FOS in relation to disputes about Retail Insurance-related services/products as well as several non-Retail Insurance products including 'general property', 'theft' and 'loss of profits/business interruption'. The Committee's aim is for the Code to be consistent with the FOS approach to small businesses, including farmers, to the extent currently allowed in the FOS TOR. The Committee believes that the expansion of the Code in the manner suggested would ensure that small businesses, including farmers, have access to the protections offered by sections 4, 6, 7, 9 and 10 of the Code, in line with individuals who hold retail insurance products as defined by the Code. The Committee however is not supporting the expansion of the Code to all Wholesale products.
d. Application and guidance on the law	**Discussion Point 10.3:** The Committee notes that under RG 183 ASIC expects an effective code of practice to do at least one of the following three things: (a) address specific industry issues and consumer problems not covered by legislation; (b) elaborate on legislation to deliver additional benefits to consumers; and/or (c) clarify what needs to be done from the perspective of a particular industry, practice or product to comply with legislation.

xi Emerging technologies	CGC position/comments
	Discussion Point 11: The Committee has considered the ICA's view and has no further comments at this time.

What the Code does not cover:	CGC position/comments
a. to i.	**Discussion Point 12:** The Committee agrees that the areas listed in paragraphs a to j are not within the ambit of the Code or fall outside the scope of this Code review.

What the Code does not cover:	CGC position/comments
j. Provision of data/access to information	**Discussion Point 12j:** **The Committee's seventh priority is to provide assistance to the Committee in the collection of industry data.** The Committee notes the ICA's comments in relation to the provision of data/access to information: "There is scope for this work to be carried out by independent data experts, in order that it does not take up a large amount of the CGC's resourcing which could be used for Code investigations. Granular data could then be provided to the CGC, the ICA and insurers, and the CGC could use it to determine whether there are systemic issues to be addressed in Code compliance. The ICA will seek to work with the CGC and Code Subscribers to ascertain the best mechanism for improving industry data collection and reporting once the requirements related to AFCA are known." The Committee sees the provision of data as a very important issue and agrees that data continues to be an area where improvements need to be made, especially in terms of core data sets, compliance with standardised industry definitions, and access to new data. The Committee supports enhancements to the data collection process, but it has some concerns in relation to the independence of data collection and the interpretation of trends if the ICA's suggestions are implemented. The Committee requires timely, reliable, consistent and targeted data. There is a clear need for the Committee to obtain the data it requires, and not have the industry determine what is provided. Moreover, the Committee needs to be able to identify trends that point to: • areas that require clarification for consumers • a need for improvement in practices of Code Subscribers – not always indicative of non-compliance but about best practice, and • areas that may need improvement under the Code (because there is a gap, for example). The Committee agrees with the ICA's comments that there is scope for input of specialist data expertise in the data collection work. As a result, it looks forward to working with the ICA to establish the best mechanism for improving industry data collection and reporting in the future. **(See the Committee's Top Priorities.)**

What the Code does not cover:	CGC position/comments
k. Governance of the Code	**Discussion Point 12:** The Committee agrees that the matters outlined in paragraph k are not within the scope of this Code Review, and will take them up with the Code Governance Association.

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