GENERAL INSURANCE
Code Governance Committee

Annual Report: General Insurance in Australia

2018–19 and current insights

April 2020

Contents

Chair's message

I am pleased to present the Code Governance Committee's annual report on the general insurance industry. The report covers the 2018–19 financial year and the early part of 2019–20, and is a snapshot of trends and service standards in the general insurance industry, with a focus on retail general insurance products and services.

Impact of the Financial Services Royal Commission

During the period covered by this report, the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry came to an end after almost 14 months of public hearings and submissions. While at times shocking, the Royal Commission shone vital sunlight on the financial services sector. The general insurance industry was not immune, as we learnt in two weeks of evidence given by insurers and the Insurance Council of Australia (ICA). Indeed, the Royal Commission's final report, released in February 2019, contained 76 recommendations, 15 of which addressed issues specific to the insurance industry, including misconduct over commissions, claims handling, cold calling and the sale of add-on insurance.

The Royal Commission sent shockwaves throughout the industry that are still being felt more than a year after its conclusion. As the Commissioner, the Honourable Kenneth Hayne AC QC, emphasised in the final report, much of the misconduct that came to light was in large part the result of poor organisational culture that rewarded misconduct and placed profits ahead of good consumer outcomes.

Commissioner Hayne identified six principles that underpin a healthy organisational culture, where dealings with customers occur in a fair, honest and transparent manner:

- obey the law
- do not mislead or deceive
- act fairly
- provide services that are fit for purpose
- deliver services with reasonable care and skill, and
- when acting for another, act in the best interests of that other.

The General Insurance Code of Practice[1] provides a blueprint for ensuring that Code subscribers embody these principles. The Code Governance Committee has oversight of subscribers' culture through our Code monitoring and investigation functions. Yet, the Royal Commission, along with the investigations as part of our own motion inquiry into the adequacy of subscribers' compliance frameworks caused us to reflect deeply on how subscribers were interpreting the Code and the extent to which they were taking their Code obligations seriously.

There was evidence from the own motion inquiry that subscribers in some cases had reverted to black letter law in response to the Royal Commission – an approach that is clearly not within the spirt of the Code, which aims for higher standards. Several subscribers were found to have a poor grasp of Code standards that contain elements of honesty,

[1] 2014 General Insurance Code of Practice

fairness and transparency, and many failed to recognise the difference between a standard breach and a significant breach. There were also clear issues with some subscribers' incident reporting systems and governance frameworks that led to Code breaches and poor outcomes for customers.

A surge in breaches: the pros and cons

Not unexpectedly, the findings in this year's annual report reflect much of what we found in the own motion inquiry. We saw a dramatic spike in the number of breaches and significant breaches recorded in 2018–19, continuing an upward trend that has been occurring year on year since 2014–15. Over two-thirds of all Code subscribers self-reported more breaches in 2018–19 than the previous year. Subscribers reported that they had breached the Code 31,186 times during the year, compared with 13,668 times in 2017–18. This amounts to a more than two-fold increase in reported breaches year on year. The two Code standards most consistently breached were those relating to the handling of claims and complaints.

Significant breaches increased to four times their 2017-18 level, with the Committee opening 69 significant breach files as a result of self-reporting by 15 different Code subscribers.

Such a substantial increase in breaches is concerning, as it means that consumers and small businesses are not receiving the protection afforded to them by the Code, and that subscribers' breach prevention processes are inadequate.

The Committee expects all subscribers to have strong, robust and accessible incident reporting frameworks that employees can access easily, and which support the timely reporting of incidents. The Committee also expects subscribers to encourage their employees and their representatives to report incidents, and to provide appropriate training so they can confidently identify incidents that could indicate non-compliance with the Code.

At the same time, the Committee acknowledges that more breach reporting can be viewed as evidence that:

- subscribers are taking their auditing and monitoring functions more seriously;
- their breach detection mechanisms are more robust and effective; and
- culturally, they are more open to reporting Code breaches to the Committee, investigating and learning from the root causes and putting in place measures to prevent a recurrence.

This is pleasing, as it appears that both the Royal Commission and the Committee's increased focus on subscribers' Code compliance and governance frameworks during the year have encouraged subscribers to look more closely at their compliance obligations.

Our expectation is that breach numbers will remain at historically high levels for some time, as the insurance industry progressively introduces and beds down better compliance and monitoring arrangements and adjusts to the requirements of the new Code.

Preparing for the 2020 Code

Improved monitoring and compliance, along with an unwavering focus on good consumer outcomes, will be crucial going forward, as subscribers prepare to transition to the new 2020 General Insurance Code of Practice[2]. The Code has been comprehensively updated and

[2] 2020 General Insurance Code of Practice

rewritten, and takes into account the recommendations in the final report of the Royal Commission and most of the reform suggestions made by this Committee.

The new Code includes several significant improvements that enhance consumers' understanding of their rights when buying and claiming insurance, and making complaints. It also provides Code subscribers with greater clarity around their obligations when dealing with consumers, particularly those in financial hardship or experiencing vulnerability.

Importantly, the new Code provides the Code Governance Committee with enforceable sanction powers in the event of a Code breach by a subscriber.

Code subscribers commenced their transition to the new Code from 1 January 2020 and all Code signatories are required to be compliant by 1 January 2021, with an additional requirement to introduce and implement a publicly available policy to support customers affected by family violence by 1 July 2020.

From a Code compliance point of view, subscribers will be measured against the 2014 Code for the 2019–20 reporting period, with corrective actions aimed at complying with corresponding obligations under the 2020 Code.

By now, work on aligning Code subscribers' operations, compliance frameworks and reporting capabilities with the 2020 Code should be well underway. The commencement of the 2020 Code is an ideal opportunity for all Code subscribers to assess the robustness of compliance frameworks to ensure they can meet their obligations.

For the Committee's part, we have begun work on mapping our governance requirements and operations to the 2020 Code. We view the new Code as an opportunity to rethink how we collect industry data. We are developing our database to incorporate new data sets that are closely aligned to the new Code, and to improve the granularity of the information we collect from subscribers. It is hoped that this will result in more dynamic reporting that helps subscribers to mitigate risk, detect issues early and help keep breach incidents at appropriate levels.

Responding to Australia's bushfires

The Committee acknowledges the tireless work being undertaken by the general insurance industry, with ASIC and other key stakeholders, to assist communities affected by the devastating bushfires that occurred across Australia in December 2019 and January 2020. There is much work to do in the months ahead to support impacted customers as they recover and rebuild.

I remind subscribers of their obligation to act within the spirit of the Code when dealing with individuals and small businesses, particularly in relation to claims handling.

Irrespective of conflicting policy wording, subscribers must ensure that they show compassion and sensitivity towards customers affected by bushfire; that they conduct claims handling in an honest, fair, transparent and timely manner, fast-tracking the assessment and decision process and/or providing an advance payment to customers in urgent financial need; and making financial hardship protections available where customers may be unable to afford payment of applicable excesses.

Subscribers should also keep in mind ASIC's expectation that they act in the spirit of the obligations of the new 2020 Code of Practice – including treating claims for the total loss of homes sensitively, and dispensing with the need to provide proof of ownership or a list of lost/damaged insured property.

Coronavirus (COVID-19)

In the weeks leading up to the release of this report, Australia began to experience the impact of the worldwide Coronavirus pandemic. As well as the threat to the health of individuals, extensive restrictions are now in place that affect people's lives and their work. These restrictions are likely to continue for some time and have far reaching consequences for many.

The Code requires subscribers to be open, fair and honest in all dealings with consumers and small business. That commitment has never been more important – consumers and small business need the protections provided by the Code, especially during this time of extreme crisis when they are most likely to be affected by family violence and financial hardship. It is therefore essential that subscribers prioritise vulnerable consumers, those in financial hardship, and those whose damaged properties pose a risk to them or others.

During this period, the Committee will continue to maintain its focus on outcomes that constitute or are indicative of significant consumer harm and expects industry to fulfil its obligations in such circumstances in accordance with the spirit of the Code. This includes an expectation that industry will continue to monitor compliance, provide timely reports of breaches to their boards and notify us of significant breaches.

Committee priorities for 2019–20

The Committee's workplan priorities for 2019–20 include a range of activities designed to help subscribers further improve their Code compliance.

In October 2019, the Committee launched an independent website. The website includes information for consumers, small businesses and Code subscribers about the Committee's role and activities. Each of the Committee's reports, submissions and guidance notes are published on the website, and consumers are able to report a concern if they believe a subscriber has breached the Code.

In the first half of 2020, we will publish a Guidance Note for Code subscribers on identifying and reporting significant breaches to the Committee. We will also release *Living the Code: Embedding Code obligations in compliance frameworks*, an important publication that combines the findings from the Committee's own motion inquiry into the adequacy of subscribers' compliance frameworks with a commentary and key recommendations on issues of culture, leadership and governance within the general insurance industry.

Thanks

The ICA has made an important contribution to the Code Governance Committee's achievements in 2018–19, working closely with us on a number of issues relating to the general insurance industry and the release of the new Code. I would like to thank Richard Enthoven, President of the Insurance Council of Australia until 31 December 2019 and Gary Dransfield, the current ICA President for their high level of engagement and interest in Code effectiveness.

I especially want to express my deep appreciation to Rob Whelan, the ICA's Executive Director, for his responsiveness and continuing support over the course of this year and for the nearly ten years that the Committee has engaged with him. We wish him well in his next endeavours after he retires from the ICA.

I extend my thanks to the Code team at the Australian Financial Complaints Authority (AFCA). Ably led by our General Manager, Sally Davis, and Compliance Manager Rose-Marie Galea, the Code team provides invaluable assistance to the Committee in monitoring subscribers' compliance with the Code and providing support for our many other activities throughout the year.

I would also like to thank my fellow Committee members, Philippa Heir (Consumer Member), and Cheryl Chantry (Industry Member), along with their predecessors, Andy Cornish (Industry Member from 1 July 2018 to 31 May 2019) and Brenda Staggs (Consumer Member from 1 April 2018 to 13 December 2018). Each has provided invaluable industry and consumer insight in Committee discussions and decision-making during their tenure.

This is my last year as Chairperson of the General Insurance Code Governance Committee. It has been an honour and a privilege to have had the opportunity to chair the Committee over the past six years. I would like to thank personally, the many subscribers to the Code who have responded well to our work and engaged actively with us over this period. Sometimes the going has been tough, but I now feel like we have come through some pretty rough waters following the Royal Commission and that the industry is now in a much better place to face the future so long as it maintains its focus on consumers and compliance.

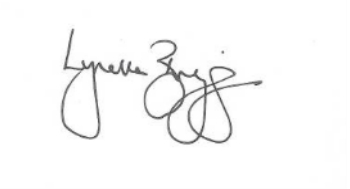
Good luck with the new Code; it's going to be great!

Closing remarks

As with all reports and publications issued by the Code Governance Committee, this report includes recommendations to assist subscribers to comply with their Code obligations. The Committee expects subscribers to distribute this report to all levels within their organisations, including their Board of Directors and Executive Management.

As Commissioner Hayne wrote in the final report of the Royal Commission, Boards need access to the right information in order to discharge their functions – including information about breaches of law and standards of conduct, and issues that may give rise to poor outcomes for customers.

The data and information contained in this report, including that around current significant Code breaches, provides valuable insights into emerging issues on risk and compliance, as well as customer complaint trends. Subscribers should highlight and implement the recommendations to improve Code compliance.



Lynelle Briggs AO
Independent Chair, General Insurance Code Governance Committee
April 2020

Recommendations

The Committee makes 17 recommendations throughout this report for subscribers to adopt to improve their compliance with the Code, and to enhance their monitoring and reporting processes.

Recommendation 1: Put in place systems and procedures that enable customer refunds to be paid promptly following a policy cancellation.

Subscribers should review their policy cancellation systems and procedures, to ensure they assess a consumer's or small business' eligibility for a refund and process payment in a timely manner. This is best done by automating processes so that timeframes are automatically monitored, and assessors are prompted to complete their eligibility assessment, notify the consumer or small business and provide any refund within 15 business days.

Recommendation 2: Assess the severity of breaches against the significant breach criteria in section 15 of the Code.

Subscribers must assess breaches against the five criteria outlined in section 15 of the Code ('Definitions') to determine whether they are significant:

- the number and frequency of similar previous breaches
- the impact of the breach or likely breach on your ability to provide your services
- the extent to which the breach or likely breach indicates that your arrangements to ensure compliance with Code obligations is inadequate
- the actual or potential financial loss caused by the breach
- the duration of the breach.

Subscribers should err on the side of caution and report a breach to the Committee as a possible significant breach if they are unsure.

Recommendation 3: Review issues straight away to determine if they are significant breaches

Subscribers must review incidents and issues as soon as possible after they become aware of them, to assess if they represent a significant breach of the Code.

Where a subscriber has a breach review committee that reviews issues/breaches and determines if a significant breach has occurred, this committee should meet monthly so that it can review issues in a timely manner after they become evident.

The Committee is likely to find a breach of subsection 13.3 of the Code if a subscriber takes too long to review an issue and determine that a significant breach occurred.

Recommendation 4: Report matters to the Committee as soon as possible

Subscribers should report a matter to the Committee as soon as they determine that it is a significant breach, irrespective of the ten-day timeframe in the Code for reporting a significant breach.

Recommendation 5: Make sure that the sales processes of all distributors comply with the Code.

Subscribers must ensure their distributors are fully aware of the Code and their compliance obligations. Subscribers should check that their distributors know how to identify and report breaches and potential breaches of the Code. This should be done by including clauses in their contracts/service level agreements (SLAs) that require this and stipulate the consequences for non-compliance.

The amendments to the new 2020 Code of Practice relating to the sale of insurance by distributors provide a good opportunity for subscribers to review and, where appropriate, redraft their contracts/SLAs with their distributors to ensure that Code compliance obligations are included and understood.

Recommendation 6: Make sure that internal complaints processes encourage consumers and small businesses to refer unresolved complaints to AFCA

Subscribers' internal complaints processes should be robust enough to encourage consumers and small businesses to refer their unresolved complaints to AFCA. Subscribers can ensure this by:

- reviewing the clarity and quality of information they provide to consumers and small businesses about their right to escalate complaints to AFCA, and
- monitoring final responses to complaints to ensure that they consistently include information about the right to escalate complaints to AFCA.

Recommendation 7: Ensure that learnings from AFCA are used to improve internal complaints processes

Subscribers must ensure that employees responsible for providing effective and fair review of complaints are well-trained and competent. A critical element of this is using the outcomes of complaints from AFCA to improve these employees' knowledge and understanding of products, claims processes, general insurance law and principles, and applicable consumer protection laws.

Recommendation 8: Subscribers must accurately record the reasons for complaints

Subscribers must accurately record the reasons for complaints received from consumers and small businesses so that they can identify trends and areas of emerging risk, and respond accordingly.

Recommendation 9: Ensure customers understand their cover

Subscribers should:

- analyse why consumers and small businesses think their policy covers them when it does not, including looking at their sales processes, consider the product itself and whether it meets their needs
- ensure consumers and small businesses know when their cover begins and ends at the time they buy or renew cover, and understand they cannot claim for an event that falls outside the cover period
- review disclosure documents and supporting explanatory material available at the time of buying or renewing cover and when making a claim. This documentation should be updated if necessary to make sure it clearly and accurately explains that claims can only be made for events that fall within the period of cover, and
- check the start and end date of cover when consumers and small businesses enquire about making a claim. If a consumer or small business decides to proceed with a claim, the Code prohibits a subscriber from discouraging them from doing so and must inform them that the question of coverage will be fully assessed if a claim is lodged[3]. This Code standard may have contributed to the large number of claims that were made but fell outside the scope of cover.

Recommendation 10: Review reasons motor claims are being withdrawn

Subscribers should review why the rate of withdrawn motor claims continues to rise, especially given the withdrawal of 81,826 claims by consumers or small businesses without providing a reason. Subscribers need to do more to understand why so many motor claims are withdrawn and record the reasons accurately.

Recommendation 11: Make sure customers understand their motor cover

Subscribers should:

- review their sales processes for motor insurance, particularly online sales processes, to ensure they are clear and transparent about the extent of cover and allow consumers and small businesses to make a genuine informed decision
- ensure consumers and small business understand when the motor cover they intend to buy or have bought does not cover them for loss or damage to their own vehicles, and
- review disclosure documents and supporting explanatory material available at the time of buying or renewing cover and when making a claim. They should update these documents if required to clearly and accurately explain the limitations of motor cover which does not provide comprehensive cover.

[3] Subsection 7.8, 2014 General insurance Code of Practice

Recommendation 12: Determine and record why customers are withdrawing claims before a decision is made, to identify, analyse and learn from any trends.

Subscribers should examine why consumers or small businesses withdrew their claims before a formal decision was made to either accept or deny them. Subscribers should ensure that claimants are making informed decisions when they withdraw their claims.

Subscribers should also ensure that they inform claimants that if their claims are subsequently denied they have the right to:

- ask for information about why the claim was denied and receive copies of any reports from service suppliers or experts that subscribers relied on in assessing their claims, together with information about subscribers' complaints processes
- complain about such decisions to the subscriber and subsequently to AFCA if they are unhappy with the subscribers' final decisions.

Subscribers should also work hard to ensure that the reasons for claims withdrawals are accurately recorded so that trends can be identified, analysed and learnt from.

Recommendation 13: Examine why time time-based benchmarks are not being met

Subscribers should closely examine why time-based benchmarks such as standard 7.13 and Standard 7.14 are not always being met, even though employees, and other industry participants to whom these standards may apply, are required to comply with the prescribed timeframes.

Subscribers must identify why these breaches persist in their organisations despite established processes and procedures. For example, the breaches may be indicative of under-resourcing when there is an unexpected influx of claims; inconsistent monitoring of email inboxes to which consumers/small businesses send their requests for information; individuals that do not understand these benchmarks are requirements.

For subscribers to manage the end-to-end claims process and the steps within it a way that is honest, efficient, fair, transparent and timely way, they must meet these requirements.

The Committee reiterates that subscribers should ensure they have adequate claims handling systems and processes in place, and that claims areas are adequately resourced to manage claims within Code timeframes, by individuals who have the appropriate knowledge and expertise, and understand an organisation's commitment to the Code.

Recommendation 14: Analyse the root cause of multiple incidents and breaches to determine whether they constitute a significant breach.

Subscribers must closely examine and record the root cause of all incidents and breaches to determine any trends or patterns. If multiple breaches share the same root cause, they are likely to constitute a significant breach of the Code and must be reported to the Committee.

When considering the Code's definition of a significant breach (as set out in section 15), subscribers should take a broad view, considering each of the factors identified in the definition.

Recommendation 15: Consider the individual needs of a person when providing financial hardship assistance

Subscribers need to improve their practices when it comes to working with a person who is entitled to financial hardship assistance. Rather than adopting a 'one size fits all' approach, subscribers must take each person's circumstances into account to ensure they offer assistance and support that is flexible and appropriate.

Recommendation 16: Make debt collection agents aware of their Code obligations, and monitor their compliance with the Code's financial hardship standards.

Subscribers must ensure that all agents acting on their behalf to recover debt, including legal firms, are fully aware of the relevant obligations in sections 6 of the Code. This should be done by specifying the Code standards that apply to collecting debts from people who indicate they are experiencing financial hardship and proactively monitoring agents' compliance with these obligations.

Recommendation 17: Proactively identify significant breaches of the Code's financial hardship standards

Using the significant breach criteria set out in section 15 of the Code, subscribers must analyse in detail all breaches of the Code's financial hardship standards to identify if the issue is more widespread and whether there has been a significant breach.

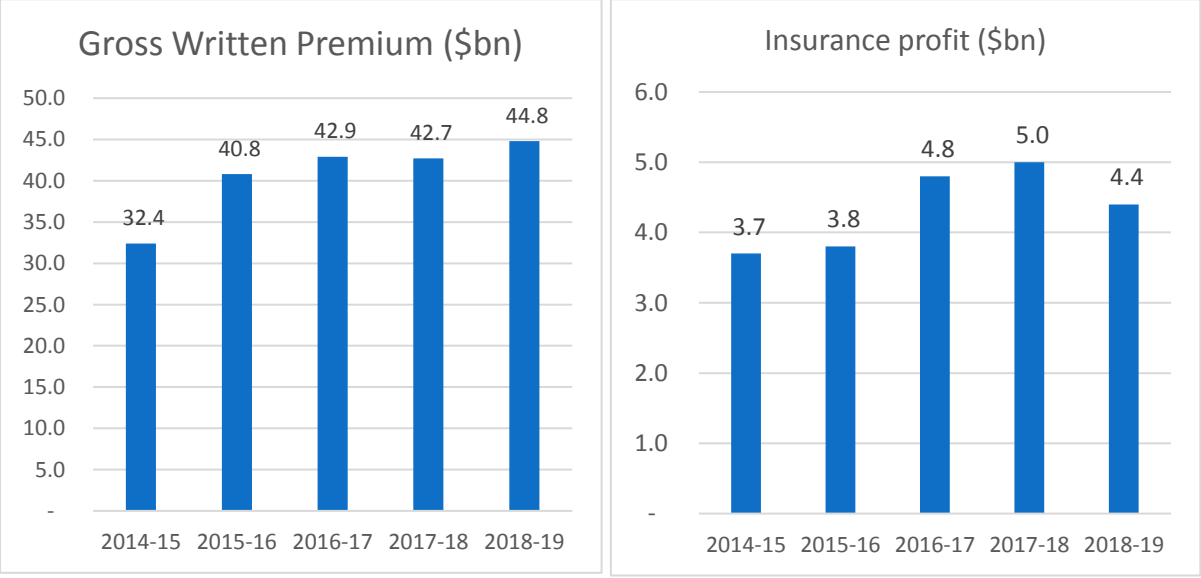
The general insurance industry

General insurance in Australia is a vast, complex and profitable industry. The report examines how Code subscribers sold insurance to consumers and small businesses, handled claims, worked with people in financial hardship, and managed complaints and disputes in 2018–19. It also looks at the changes that will result from the release of the 2020 Code of Practice and how they will impact subscribers, consumers and small businesses. With this wide-ranging and in-depth review, the Committee's aim is to highlight areas where industry can do better, lifting service standards and improving the relationship with customers.

Financial landscape[4]

Despite steady growth in recent years, insurance profit for the 2018–19 reporting period declined 12% to $4.4 billion. This was mainly due to higher natural catastrophe costs associated with significant weather events across the country during the year, and lower prior period reserve releases out of portfolios. Gross written premium increased by 5% to $44.8 billion in the year to 30 June 2019, thanks largely to re-pricing for claims cost inflation, after a slight dip in 2017–18. This rise in gross written premium reflects the state of the market and is likely to result in more price increases in the year ahead (**Chart 1**).

Chart 1: Gross written premium and insurance profit, 2014–15 to 2018–19

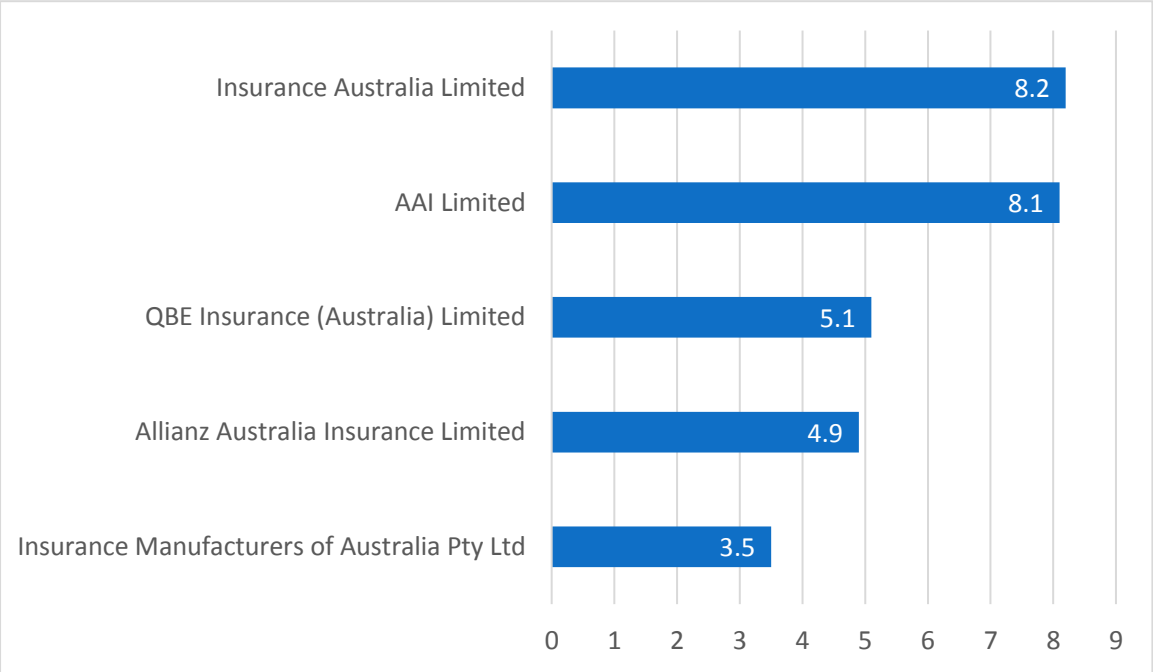


Source: KPMG (2019) *General Insurance Industry Review 2019*, based on APRA[5] General Insurance Performance Statistics.

[4] This data includes retail and insurance products, including products that are outside the scope of the Code, as well as entities that do not subscribe to the Code.
[5] APRA defines "Direct Insurers" as "those insurers who predominantly undertake liability by way of direct insurance business.

In 2018–19, the top five direct sellers of insurance were valued at almost $30 billion, based on gross written premium. The two insurers with the largest direct insurance market share were Insurance Australia Group (comprising Insurance Australia Limited and Insurance Manufacturers of Australia Pty Limited) and Suncorp (AAI Limited), worth $11.7 billion and $8.1 billion respectively (**Chart 2**).

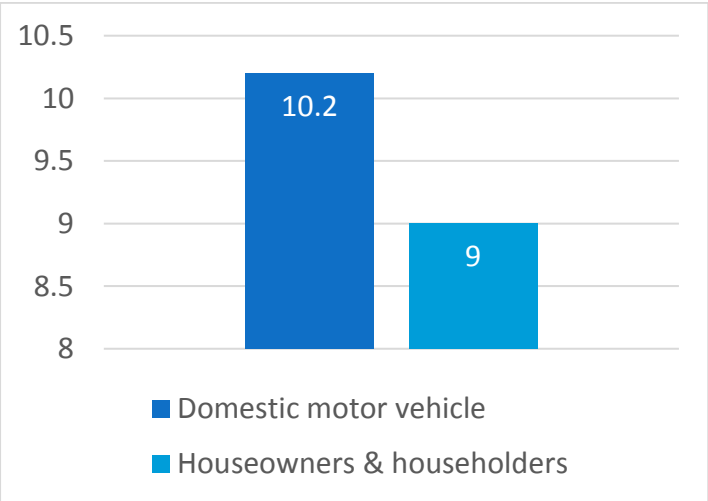
Chart 2: Top five Direct insurers gross written premium (GWP) ($bn) for 2018–19



Source: APRA quarterly general insurance institution level statistics database – June 2019

The motor and home insurance sectors account for two-thirds of retail insurance policies in force at any one time and have the highest exposure levels to consumers and small businesses. In the year ending 30 June 2019, motor and home insurance together were worth $19.2 billion in gross written premium – $10.2 billion for motor and $9 billion for home – or about 43% of the total (**Chart 3**).

Chart 3: Domestic motor and home gross written premium (GWP) ($bn) for 2018–19



Source: APRA quarterly general insurance performance statistics database – June 2019

Workforce

Committee data about the general insurance workforce in Australia shows that there were 97,476 people working in the industry in 2018–19. More than half (60%) were employees of Code subscribers and related entities, with the rest comprising people who work in one of the following categories:

- Individual Authorised Representatives
- Corporate Authorised Representatives
- Other external sellers & contractors
- Service suppliers.

Overall, the total number of people working in the industry in 2018–19 was down 4.7% from the previous year. But at 60% of the workforce, employees represented a greater percentage of the workforce than in 2017–18, when they accounted for 44%.

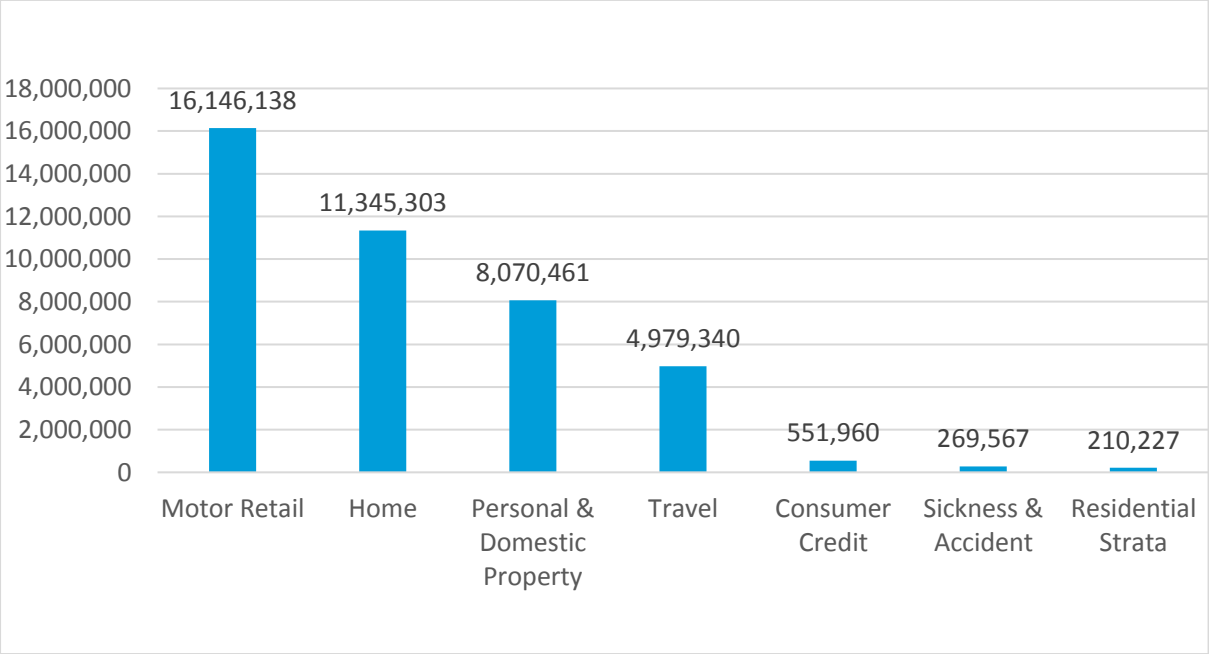
A snapshot of insurance products and claims

Policies

After seeing the total number of policies sold for retail and wholesale combined fall by 2% in 2017–18, this year saw a rise of 4% on last year's figure, with 44,326,288 policies sold. Retail insurance, which accounted for 94% of these policies, also saw a 4% increase in sales – a change from 2017–18, when sales of retail insurance policies fell by 2%.

The number of group policies (retail and wholesale combined) sold in 2018–19 remained similar to 2017–18 (down by less than 1%) and covered 28,520,007 people and assets. The number of people and assets covered by group policies for retail insurance products fell 3% over the year to 22,179,179.

Chart 4: Retail policies (individual and group) for 2018–19



When broken down by class of insurance, motor accounted for the majority (39%) of retail general insurance policies (both individual and group policies) for 2018–19. This was followed by home insurance (27%), personal & domestic property insurance (19%) and travel insurance (12%) (**Chart 4**).

Lodged claims

Consumers and small businesses lodged a total of 4,710,907 general insurance claims with Code subscribers during the year, representing an increase of 1% from the previous year. The total number of retail claims lodged also went up slightly (2%) to 4,157,244 (**Table 1**), while lodged claims in the wholesale general insurance product category declined 5% to 553,663 claims lodged.

Declined claims

Code subscribers declined 185,789 claims in 2018–19. The vast majority of these were retail claims (179,722), while wholesale claims accounted for the remainder (6,067). The total number of declined claims increased by 10% from the previous year and all of these were retail general insurance claims (**Table 1**).

Withdrawn claims

The number of claims withdrawn by consumers or small businesses during the year increased 7% to 353,261. Almost all of these withdrawn claims (327,191 or 97%) were retail general insurance claims and there were 10% more retail claims withdrawn than the previous year (**Table 1**).

Table 1: Retail insurance claims lodged, declined and withdrawn in 2018–19

	Lodged claims		**Declined claims**		**Withdrawn claims**	
	No.	**Percent change**	**No.**	**Percent change**	**No.**	**Percent change**
Retail classes	4,157,244	Up 2%	179,722	Up 10%	327,191	Up 10%

A snapshot of internal complaints

The Code permits a Code subscriber to operate a two-stage internal complaints process. Stage one is an initial review of a consumer's or small business's complaint. The consumer or small business, if unhappy with the Code subscriber's decision, may escalate their complaint to stage two. The review of a complaint in stage two should be conducted by a person who was not involved in the stage one decision.

If the consumer or small business is unhappy with the Code subscriber's stage two decision, they have a right to refer the dispute to AFCA for external dispute resolution (EDR). Code subscribers must inform consumers and small businesses of this right during and at the end of the internal complaints process.

Each stage of the internal complaints process must be completed within 15 business days. At the end of each stage, a Code subscriber must respond to the consumer's or small

business's complaint in writing and provide information about their rights in the event they are unhappy with the outcome. A Code subscriber must provide its final decision in response to a consumer's or small business's complaint within 45 calendar days of receiving it.

Complaints received

Code subscribers received 34,653 complaints in 2018–19, 12% more than the 30,898 received the previous year. All but 1,893 of these were complaints about retail insurance products and had entered stage two of subscribers' internal complaints process. The balance were complaints related to wholesale insurance products.

Complaints finalised

The number of complaints finalised – i.e. those that had completed stage two of subscribers' internal complaints process – increased by 13% from the previous year to 34,138. This incorporates complaints from both wholesale and retail insurance classes.

Finalised complaints found in favour of subscribers totalled 20,321, while those found in favour of consumers or small businesses made up the remaining 13,817.

Finalised complaints relating just to retail insurance accounted for 32,371 of all finalised complaints in 2018–19, which is 13% more than was recorded the previous year. Some 19,105 of these finalised retail complaints were found in subscribers' favour and the remaining 13,266, some 40%, were found in the favour of consumers or small businesses.

A snapshot of subscribers' Code compliance

In the wake of the Financial Services Royal Commission and of the Committee's increased focus on the adequacy of subscribers' Code compliance and governance frameworks during the year, it is clear that subscribers are looking closely at their compliance with the Code. However, while this is generating a fair degree of activity in terms of breach and significant breach reporting, it has also exposed a shortfall in subscribers' compliance with Code requirements. Increased vigilance is needed.

Breaches and significant breaches

The Committee has been engaging extensively with subscribers about the effectiveness of their monitoring processes. The upshot is that we have seen a spike in reported breaches (**Table 2** and **Chart 5**).

It is unclear if this increase is because more breaches occurred or is due to better monitoring and reporting, or both.

Subscribers breached the Code 31,186 times in 2018–19. This was more than double the number of breaches (or 128% more breaches) than in 2017–18.

Table 2: Breaches by subscribers for the past five years[6]

Breaches	2014–15	2015–16	2016–17	2017–18	2018–19
Subscriber A	30	5	19	7	**20**
Subscriber B		1	2	2	**19**
Subscriber C	2	2	2		
Subscriber D	51	155	475	628	**799**
Subscriber E					**2**
Subscriber F	56	7	18	7	**32**
Subscriber G				1	
Subscriber H	7				
Subscriber I		2		3	**2**
Subscriber J	305	42	51	125	**15**
Subscriber K					**1**
Subscriber L					**26**
Subscriber M	53	406	521	414	**1,138**
Subscriber N	12				**3**
Subscriber O	177	100	152	293	**442**
Subscriber P	98	1,127	1,503	4,931	**15,961**
Subscriber Q				1	**8**
Subscriber R		15			
Subscriber S	631				
Subscriber T			121	194	**106**
Subscriber U			1	3	**1**
Subscriber V			2		**5**
Subscriber W	134	351	753	529	**3,524**
Subscriber X					**15**
Subscriber Y		4		5	**64**
Subscriber Z			22	28	**101**
Subscriber A1				2	**2**
Subscriber B1					**4**
Subscriber C1		1			
Subscriber D1	29	47	34	40	**32**
Subscriber E1					**8**
Subscriber F1	172	91	90	92	**166**
Subscriber G1					**35**
Subscriber H1	1		5	3	**6**
Subscriber I1	112	172	293	3,262	**3,350**
Subscriber J1	73	70	210	155	**140**
Subscriber K1	27				
Subscriber L1	443	421	330	304	**343**
Subscriber M1					**130**

[6] Where figures differ from those published in previous years' reports, this is due to improvements in the extraction and reporting of data. The number of subscribers has fluctuated over the past five years. While some organisations have ceased subscribing to the Code, new subscribers have joined. Code subscribers have also been the subject of mergers and acquisitions, consolidation and reorganisation within corporate groups, and name changes.

Breaches	2014–15	2015–16	2016–17	2017–18	2018–19
Subscriber N1				84	**236**
Subscriber O1	103	141	65	118	**101**
Subscriber P1	14				
Subscriber Q1			345	355	**463**
Subscriber R1					**64**
Subscriber S1	3	14	32	47	**95**
Subscriber T1					**4**
Subscriber U1	1				
Subscriber V1					**5**
Subscriber W1			2		
Subscriber X1	344	688	345	359	**1,968**
Subscriber Y1	1				**48**
Subscriber Z1	39	10	9	10	**2**
Subscriber Z2					**3**
Subscriber A2	1				
Subscriber B2					**4**
Subscriber C2	609	835	3,184	1,494	**1,348**
Subscriber D2			3	2	
Subscriber E2	1			1	
Subscriber F2	3	15	22	33	**5**
Subscriber G2	4				**1**
Subscriber H2	101	70	89	56	**124**
Subscriber I2					**1**
Subscriber J2	34	106	58	44	
Subscriber K2	127	115	12	30	**205**
Subscriber L2					**2**
Subscriber M2		4	2		**6**
Subscriber N2				3	
Subscriber O2	2	4		3	**1**
TOTAL	**3,800**	**5,021**	**8,772**	**13,668**	**31,186**

Some subscribers reported low breach numbers but increased their reporting of significant breaches to the Committee during 2018–19. One subscriber had 205 breaches including 30 self-reported significant breaches, many more than any other subscriber.

Eighty-four per cent of all breaches were attributed to just five subscribers:

- Subscriber P reported 15,961 breaches including 10 significant breaches.
- Subscriber W reported 3,524 breaches including 25 significant breaches.
- Subscriber I1 reported 3,350 breaches including 14 significant breaches.
- Subscriber X1 reported 1,968 breaches including 6 significant breaches.
- Subscriber C2 reported 1,348 breaches including 6 significant breaches.

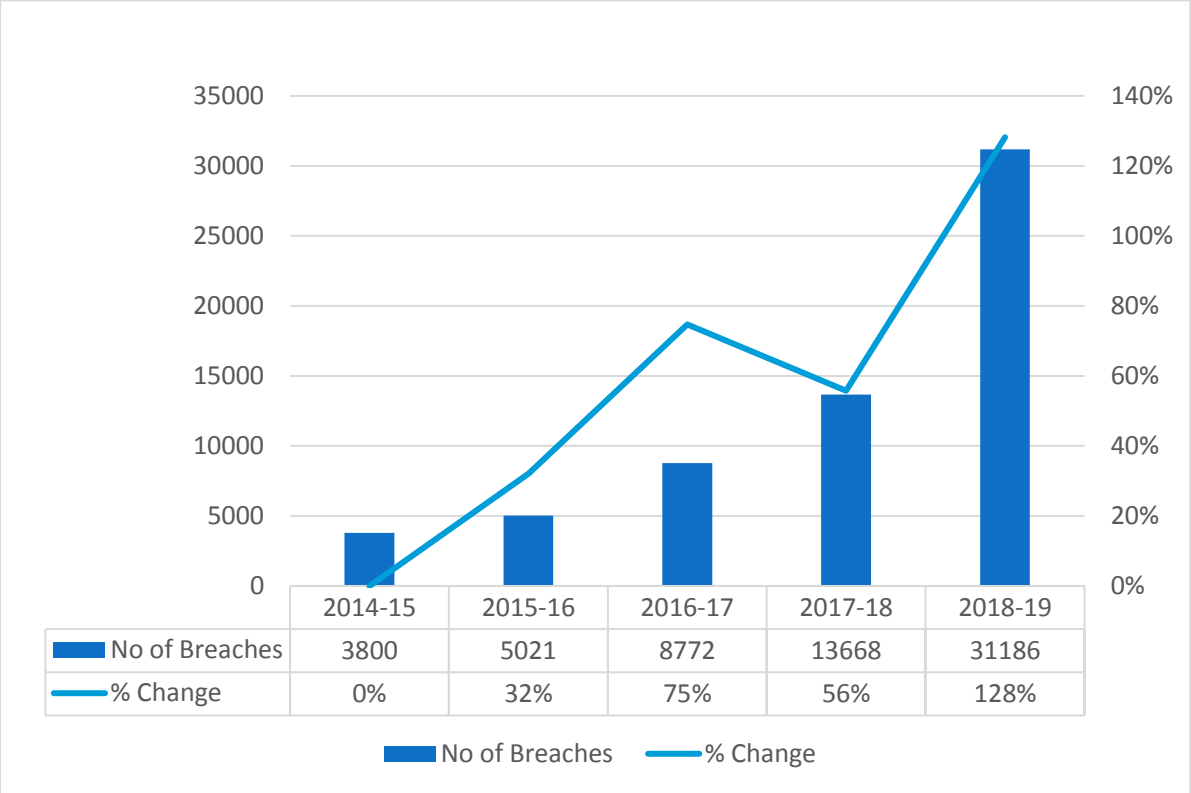
Subscriber P reported more breaches this year than it had the previous year, and on its own was responsible for 51% of all the breaches reported in 2018–19. In response, Subscriber P informed the Committee during the year that it had:

- made significant enhancements to its incident reporting management system which simplified its incident reporting process, and improved accessibility so that its employees could raise incidents in a timely manner
- enhanced its governance framework by incorporating a governance stream within its first line risk function, and focused on building the competency of employees so that they could identify and report compliance incidents.

These changes led to an improved and consistent approach to incident reporting across the organisation. The Committee acknowledges that Subscriber P's improvements to incident reporting and increased focus on Code requirements and compliance have contributed to the identification of a substantially greater number of breaches.

In view of the continuing low levels of breach reporting by other subscribers, Subscriber P's approach should encourage discussion around normalising the reporting of breach data and consistency of approach to breach identification and reporting across the industry.

Chart 5: Breaches by subscribers for the past five years[7]



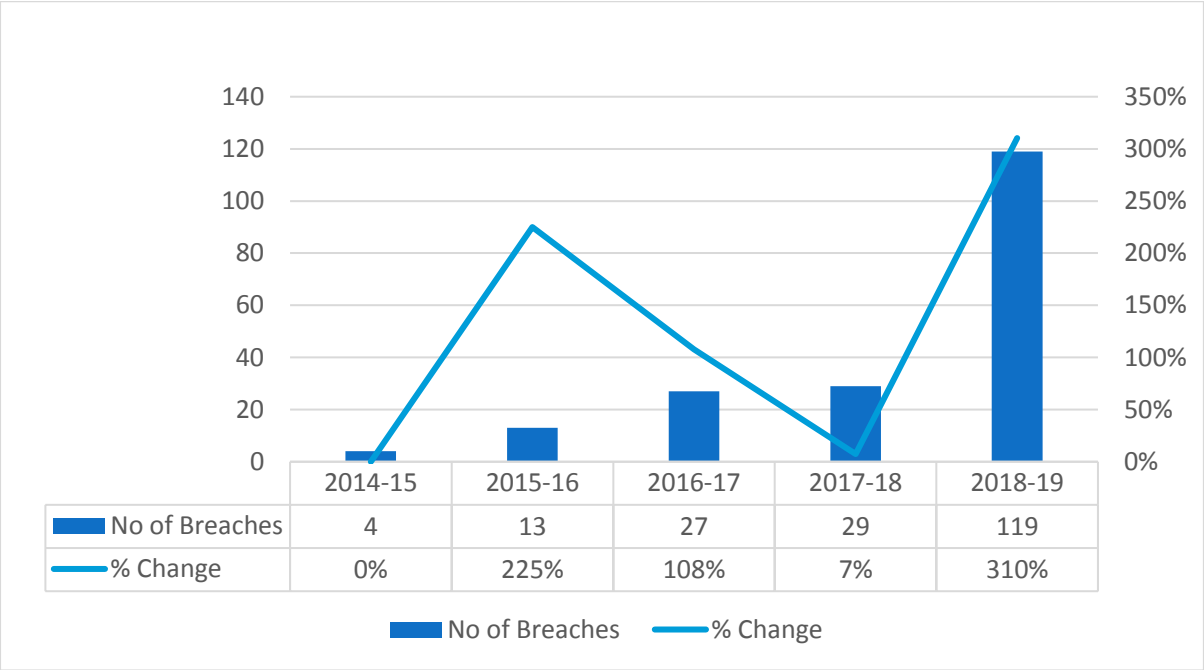
	2014-15	2015-16	2016-17	2017-18	2018-19
No of Breaches	3800	5021	8772	13668	31186
% Change	0%	32%	75%	56%	128%

[7] Where figures differ from those published in previous years' reports, this is due to improvements in the extraction and reporting of data.

The Committee notes the increase in significant breaches reported in 2018–19. This level of significant breaches reported is more consistent with what the Committee would have expected for an industry of this size and complexity. We have been surprised over the years that we haven't seen more significant breaches reported[8]. We therefore draw subscribers' attention to their significant breach reporting obligations under the Code.

When a subscriber reports a significant breach matter to the Committee it may include significant breaches of more than one subsection of the Code. **Chart 6** shows the number of individual significant breaches reported by subscribers over the past five years, and clearly shows the marked increase in 2018–19.

Chart 6: Individual significant breaches reported by subscribers for the past 5 years[9]



	2014-15	2015-16	2016-17	2017-18	2018-19
No of Breaches	4	13	27	29	119
% Change	0%	225%	108%	7%	310%

Based on current data, the 119 significant breaches reported in 2018–19 affected almost 380,000 consumers and involved remediation payments of close to $35 million.

In 2018–19 there were 49 individual significant breaches of subsection 4.4 reported by subscribers, more than any other subsection of the Code. These 49 significant breaches of subsection 4.4 affected 354,130 consumers and resulted in compensation payments of just over $29 million.

There were 50 significant breaches of the Code's claims handling standards (sections 6, 7 and 9) reported by subscribers in 2018-19, affecting 33,967 consumers and resulting in compensation payments of $5.8 million.

One matter involving significant breaches of subsections 7.2 and 7.11 impacted 18,908 consumers and resulted in compensation of almost $5.5 million. In this matter, some consumers who chose a sum insured below the maximum sum insured for the premium they paid and had a total loss claim did not receive the full amount they were entitled to claim.

[8] Over the past five years, 18 Code subscribers have reported significant breaches.

[9] Where figures differ from those published in previous years' reports, this is due to improvements in the extraction and reporting of data.

Many of the significant breaches of the Code's claims handling standards did not result in compensation payments as they did not cause financial detriment to the claimants. These significant breaches involved delays in claims handling – either a failure to make claim decisions within the required timeframe, delays in settling claims and/or a failure to respond to claimants within required timeframes.

Significant breaches are important because of their impact on consumers, but they tend to signal systemic problems that need to be addressed. Subscribers need to reflect and understand the cause of breaches to see where the problems are. This requires active reviewing of breaches to make informed decisions and respond appropriately.

While a number of subscribers are now reporting more significant breaches, there is still inconsistent treatment of significant breaches across the industry. Therefore, the Committee intends to publish a guidance note for subscribers on the identification, assessment and reporting of significant breaches.

The Committee's view is that more breaches and significant breaches reported doesn't always mean bad outcomes. It means that subscribers are 'living the Code', taking their obligations seriously and proactively identifying and addressing issues as they arise.

The Code is only as robust as the commitment by industry to a self-regulating Code.

The most breached sections of the Code in 2018–19

As was the case in 2017–18, the majority of breaches this year were related to the Code's claims handling standards (Section 7), with 15,649 breaches reported. This was followed in second place by the Code's complaints handling standards (section 10), which saw a total of 6,374 breaches reported. Rounding out the top three Code sections breached was section 14, which relates to access to information. There were 5,399 breaches of this Code section in the year to 30 June 2019 (**Chart 7**).

Not unexpectedly, the five most breached subsections of the Code are within the "Claims", "Complaints and disputes", and "Access to information" Code sections (**Chart 8**).

There were 5,388 breaches of subsection 14.1, which requires subscribers to comply with privacy laws when collecting, storing, using and/or disclosing personal information. This was the most breached subsection during 2018–19.

The second, third and fourth most breached subsections were those relating to claims timeframes. There were 5,102 breaches of subsection 7.13, which requires customers to be informed about the progress of their claim every 20 business days; 3,594 breaches of subsection 7.14, which requires subscribers to respond to routine customer requests for information within 10 business days; and 1,476 breaches of subsection 7.16, which requires subscribers to make a decision to accept or deny a claim once all information is received, and to notify the customer of that decision within 10 business days.

The fifth most breached subsection was 10.4, with 1,332 breaches. This subsection requires the handling of complaints to be conducted in a fair, transparent and timely manner by subscribers.

Chart 7: Top three Code sections breached (by total breach numbers) in 2018–19

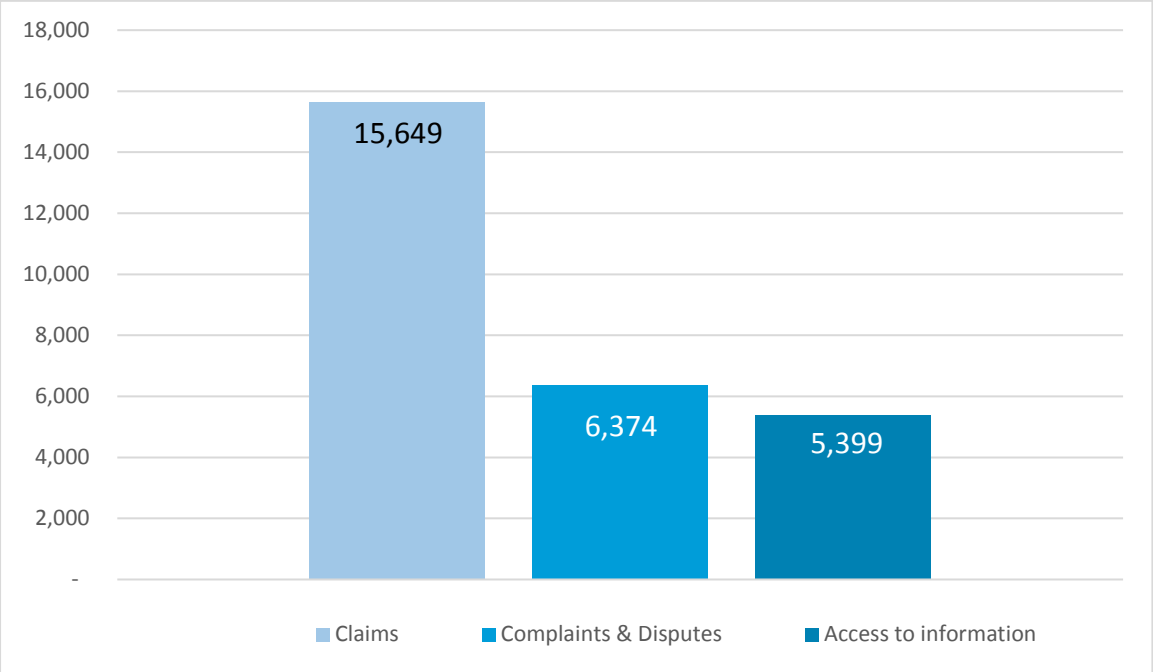
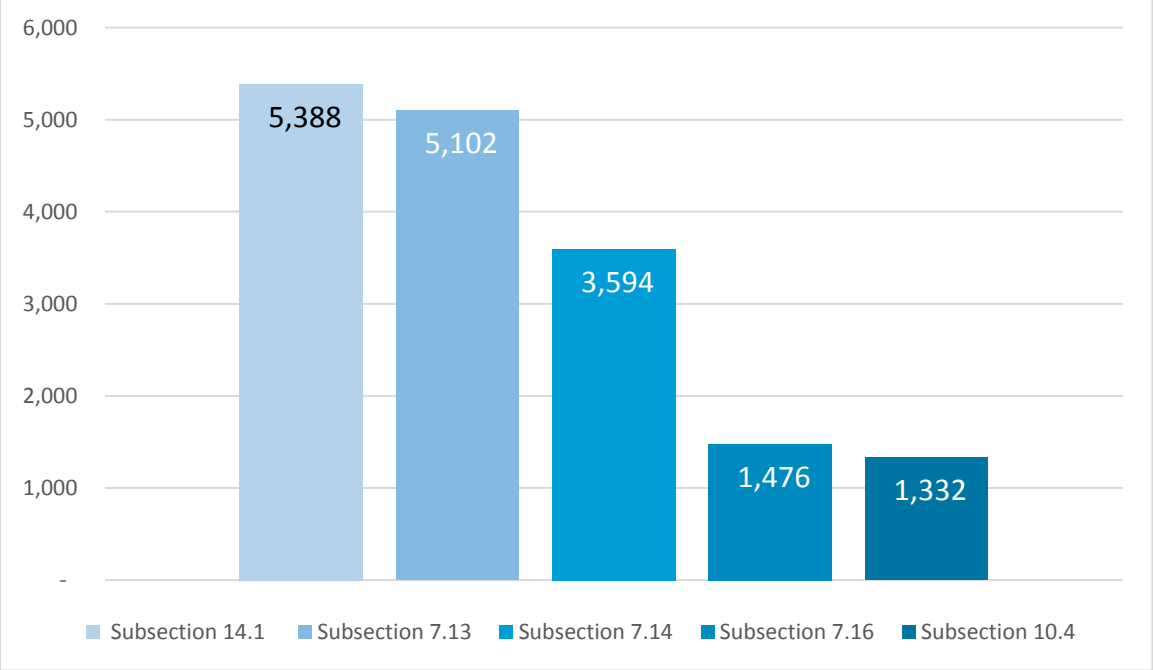


Chart 8: Top five Code subsections breached (by total breach numbers) in 2018–19[10]



[10] **Subsection 14.1**: We will abide by the principles of the Privacy Act 1988 when we collect, store, use and disclose personal information about you.
Subsection 7.13: We will keep you informed about the progress of your claim at least every 20 business days.
Subsection 7.14: We will respond to routine requests made by you about your claim within ten business days.
Subsection 7.16: Once we have all relevant information and have completed all enquiries, we will decide whether to accept or deny your claim and notify you of our decision within ten business days.
Subsection 10.4: We will conduct Complaints handling in a fair, transparent and timely manner, in accordance with this section.

Looking ahead – improving the data

Assessing how the industry operates is about trying to understand the relationships between the various data sets.

For over 10 years, the Committee has collected industry related data to try and obtain the right amount of context about the industry and to help identify how compliance with the Code should operate as an underpinning principle of good business practices.

Policies sold, and lodged claims data helps provide context about the number of consumers that purchase general insurance products and how many times they have been used (with regard to the number of claims lodged on them).

Declined and withdrawn claims data help show how the products are performing in relation to whether they are clear and if they effectively provide cover to the majority of consumers that buy them.

There have been various events and disruptors to the industry in recent years that have given consumers a stronger voice. This has shown the industry the increased importance of reputational risk.

The new Code is an opportunity to rethink how the industry data collection should operate. It doesn't have to be an annual exercise. The development of the Committee's database may enable more dynamic reporting that can help mitigate risk, detect issues early and help keep breach incidents at appropriate levels.

Selling insurance

With consumers and small businesses purchasing more than 41.5 million retail insurance policies during 2018–19, the importance of the Code's standards on buying insurance cannot be understated. These standards specify what is expected of Code subscribers when selling, renewing and administering insurance policies, and include a general requirement that they conduct their sales processes efficiently, honestly, fairly and transparently.

Monitoring and improving how insurance is sold in Australia

A snapshot of breach activity

After seeing a decline in breaches of the Code's standards on selling insurance in 2017–18, the Code Governance Committee recorded an increase of nearly three-fold (or 280%) in selling standards breaches in 2018-19. Compared with 633 breaches of section 4 in 2017–18, there were 2,405 in 2018–19, accounting for 8% of the total number of breaches this year.

Despite the considerable increase in breaches, selling insurance moved from being the third most breached section of the Code in 2017–18 to the fourth most breached section in 2018–19, behind claims (15,649, 50%), complaints (6,374, 20%) and access to information (5,399, 17%) – all of which also recorded substantial breach increases this year.

Most sales breaches could be attributed to one of two issues: errors in sales systems; and poor sales practices when selling insurance products to consumers.

The Committee expects that Code subscribers will have in place robust systems and processes to monitor compliance with the Code's buying insurance standards. Compliance and reporting frameworks must enable subscribers to identify and address any issues or deficiencies with their sales processes. And the sales systems themselves must be monitored and tested regularly to ensure all information – particularly around pricing and the calculation of premiums – is up to date and accurate.

Better oversight and training of those employed or engaged to sell insurance is also needed. Code subscribers have an obligation to ensure that all their salespeople – whether they are employees or authorised third-party representatives – act in an efficient, honest, fair and transparent manner when dealing with consumers. This requires rigorous, effective and regular training to ensure that sales representatives understand and comply with their Code obligations to consumers, as well as ongoing monitoring of their conduct when dealing with consumers.

For many subscribers a cultural change is also required, so that salespeople put the interests of consumers and good consumer outcomes ahead of the pursuit of sales and short-term profit.

Top five breach areas – guiding compliance improvement

1. Customer refunds

The biggest source of breaches of the Code's buying insurance standards, for the third year in a row, was customer refunds. Under subsection 4.9 of the Code, subscribers are required to refund any money owed to a consumer or small business within 15 business days of them cancelling their insurance policy. There were 1,062 breaches of this subsection in 2018–19, up 144% on last year. This made it the seventh most breached Code subsection.

The Committee is disappointed that customer refunds continue to be an area of non-compliance for subscribers. We are concerned to see the number of breaches rising each year, despite subscribers committing to undertake remedial measures such as staff training and improvements to processes and monitoring.

The 2020 Code of Practice includes a specific section on cancelling an insurance policy, making the commitment to a 15-business-day timeframe for refunds very clear to consumers. As such, subscribers should make every effort to comply with this standard or risk more breaches and complaints in the future.

Recommendation 1: Put in place systems and procedures that enable customer refunds to be paid promptly following a policy cancellation.

Subscribers should review their policy cancellation systems and procedures, to ensure they assess the consumer's or small business' eligibility for a refund and process payment in a timely manner. This is best done by automating processes so that timeframes are automatically monitored, and assessors are prompted to complete their eligibility assessment, notify the consumer or small business and provide any refund within 15 business days.

2. Efficient, honest, fair and transparent sales

Subsection 4.4 of the Code provides assurance to consumers and small businesses that subscribers will conduct their sales processes in an efficient, honest, fair and transparent manner. Subscribers breached subsection 4.4 a total of 748 times in 2018–19, making it the second most breached standard relating to the sale of insurance, and the 13th most breached Code subsection overall. There was also a substantial increase (760%) in breaches of this kind from the previous year, when 87 breaches were recorded.

Non-compliance with subsection 4.4 continues to be the leading significant breach issue for the Code, with almost three-quarters of all significant breach files opened in 2018–19 relating to the conduct of subscribers' sales processes and services. In spite of the learnings from the Financial Services Royal Commission, it seems that some insurers are yet to fully embrace an organisational culture that places good consumer outcomes ahead of making profits.

This is clearly an area of major risk for the general insurance industry. In a recent decision by the Full Federal Court in ASIC v Westpac Securities Administration Limited[11], the court identified 'fairness' as a new legal obligation. Westpac is appealing this judgement; however, the Committee expects Code subscribers to treat the notion of 'fairness' as a legal obligation even though it may not be captured exactly by the letter of every law.

[11] ASIC v Westpac Securities Administration Limited [2019] FCAFC 187

In the Committee's view, subsection 4.4 has wide application across a subscriber's sales processes and the services it provides to consumers. In the broadest sense, it applies to all dealings between consumers and a subscriber that are connected to or arise from the intention to acquire, or the acquisition of, an insurance product. This means that subsection 4.4 also captures the way in which a subscriber complies with its obligations under the Insurance Contracts Act.

The increase in breach and significant breach reporting in relation to this Code subsection suggests that subscribers, on the whole, are interpreting it broadly. However, it would appear that some Code subscribers are not doing so, as they are not reporting the number of significant breaches of this standard that the Committee would expect to see, given their size and the volume of insurance policies they sell.

As the Committee has communicated previously to subscribers, it expects them to apply a broad interpretation of subsection 4.4 when they are assessing whether certain conduct or incidents constitute a breach or significant breach of the Code. Further insight and recommendations are provided below under 'Significant breaches'.

3. Correcting errors in a customer's insurance application

If a consumer's or small business' application for insurance contains an error, the subscriber must take corrective action as soon as the error comes to light. This obligation is set out in subsection 4.7 of the Code and was the source of 467 breaches in 2018–19.

Breach numbers increased substantially in 2018-19 (up from 23 breaches in 2017–18), making it the third most breached buying insurance standard for the year and the 16th most breached subsection of the Code overall.

Such a sharp increase leads the Committee to infer that some subscribers have inadequate processes for identifying and resolving issues that arise when consumers or small businesses purchase insurance, or that staff are not being trained appropriately to recognise and correct errors in insurance applications. Subscribers should therefore review and improve their processes and training around subsection 4.7.

4. Declining a consumer's application for insurance

The fourth most breached area of the Code's buying insurance standards was subsection 4.8, which specifies the steps that subscribers must take when they decline a consumer's or small business' application for insurance. There were 69 breaches of subsection 4.8 in 2018–19, similar to the previous year, when 70 breaches were recorded.

5. Requesting information from an insurance applicant

Rounding out the top five breach areas of section 4 of the Code was subsection 4.6, which states that subscribers will only ask for and rely on information and documents relevant to their decision in assessing a consumer's or small business' insurance application. Again, breach numbers increased from the previous year. There were 38 breaches recorded in 2018–19 compared with 12 in 2017–18.

Significant breaches

Of the 69 significant breach files opened during 2018–19, 51 files (73%) involved the Code's buying insurance standards. All but two of these 51 files involved significant breaches of subsection 4.4, across 10 different Code subscribers, making it by far the leading significant breach issue for the year. Eight of the nine 'possible significant breach' files opened for the same period also related to subsection 4.4.

Based on the data for the first four months of the 2019–20 reporting year, significant breaches of the Code's standards for the sale of insurance appear to be on an upward trend, with 18 new significant breach files and three 'possible significant breach' files relating to section 4 of the Code opened between 1 July and 31 October 2019. Again, most of these involve non-compliance with subsection 4.4.

While the number of standard breaches relating to the Code's section on buying insurance increased substantially in 2018–19, this was not reflected in the number of self-reported significant breaches of this section, other than for subsection 4.4. This suggests that subscribers may not be taking the necessary steps for determining a significant breach. The Committee expects subscribers to assess all breaches against the significant breach criteria set out in section 15 of the Code and to report them as 'possible significant breaches' when in doubt.

The definition of a significant breach is clearly outlined in section 15 of the Code. There are five possible criteria for determining whether a breach is significant, which consider:

- the number and frequency of similar previous breaches
- the impact of the breach or likely breach on your ability to provide your services
- the extent to which the breach or likely breach indicates that your arrangements to ensure compliance with Code obligations is inadequate
- the actual or potential financial loss caused by the breach
- the duration of the breach.

Subscribers must assess a breach of the Code against each of these five criteria to determine whether or not it should be classified as a significant breach. It does not need to meet all five criteria to be significant; if it meets only one of the criteria, it counts as a significant breach. Similarly, a significant breach does not need to impact multiple consumers. If the breach meets any of the above criteria but impacts even a single consumer, it will still be considered a significant breach.

Recommendation 2: Assess the severity of breaches against the significant breach criteria in section 15 of the Code.

Subscribers must assess breaches against the five criteria outlined in section 15 of the Code ('Definitions') to determine whether they are significant:

- the number and frequency of similar previous breaches
- the impact of the breach or likely breach on your ability to provide your services
- the extent to which the breach or likely breach indicates that your arrangements to ensure compliance with Code obligations is inadequate

- the actual or potential financial loss caused by the breach
- the duration of the breach.

Subscribers should err on the side of caution and report a breach to the Committee as a possible significant breach if they are unsure.

Recommendation 3: Review issues straight away to determine if they are significant breaches

Subscribers must review incidents and issues as soon as possible after they become aware of them, to assess if they represent a significant breach of the Code.

Where a subscriber has a breach review committee that reviews issues/breaches and determines if a significant breach has occurred, this committee should meet monthly so that it can review issues in a timely manner after they become evident.

The Committee is likely to find a breach of subsection 13.3 of the Code if a subscriber takes too long to review an issue and determine that a significant breach occurred.

Recommendation 4: Report matters to the Committee as soon as possible

Subscribers should report a matter to the Committee as soon as they determine that it is a significant breach, irrespective of the ten-day timeframe in the Code for reporting a significant breach.

Incorrectly calculated premiums

As was the case in 2017–18, the most common issue in significant breaches of subsection 4.4 was subscribers calculating premiums incorrectly, resulting in consumers or small businesses being overcharged, provided with incorrect refunds or not benefiting from discounts for which they were eligible. In some instances, this had been occurring for several years before the subscriber detected the breach.

While they spanned a range of insurance classes, the significant breaches were mainly for home or motor policies.

Subscribers listed various reasons for their significant breaches, most of which related to errors in the operation of IT systems used for claims, policy and pricing, and in some cases human error. Overall, the Committee found that subscribers' pricing systems were not rigorously tested before being rolled out or updated, and their sales processes and systems were inadequately monitored.

Subscribers have corrected the significant breaches with customer remediation programs involving interest-accrued refund payments and communications to affected consumers or small businesses; system fixes to ensure that premiums are calculated correctly; enhanced monitoring of sales and pricing systems; and increased testing for future system changes.

Case study: Inadequate testing of a pricing tool results in customers not receiving discounts for which they are eligible

The subscriber detected a significant breach of subsection 4.4 of the Code when it discovered, as part of an internal review of the product offering for one of its portfolios, that the pricing calculator tool it provides to its brokers was not accurately reflecting the discounts provided to consumers or small businesses in the relevant product disclosure statements and guides. The subscriber further identified that its brokers were not always correctly applying the discounts included in the pricing calculator tool.

The significant breach was caused by a failure to fully test the pricing calculator tool before making it available to brokers, and inadequate monitoring of how the brokers were using it when selling insurance policies to consumers.

To remediate the breach, the subscriber has:

- updated the pricing calculator tool to ensure that it correctly reflects the discounts customers are entitled to
- advised brokers of the breach and provided them with training on how to use the pricing calculator tool
- repaid the affected consumers or small businesses the difference in premium they would have received had the discount been properly applied, plus interest
- implemented enhanced governance arrangements to prevent a recurrence of the problem.

Incorrect advice on websites

The next most common issue in significant breaches relating to subsection 4.4 was the publication on a subscriber's website and/or other online sales platform of incorrect or misleading information about insurance products (mainly travel policies) during the sales process. This occurred where:

- subscribers had incorrect or out-of-date information on their own websites
- the websites of authorised representatives and partner organisations selling insurance on the subscriber's behalf had incorrect or out-of-date information, including incorrect versions of product disclosure statements (PDSs)
- purchase confirmation emails to customers contained incomplete or incorrect policy information or incorrect PDSs
- quotes obtained online included only the basic excess and not additional excesses that applied.

Many consumers and small businesses now shop online for insurance, so it is vital that subscribers provide up-to-date and accurate information on their websites about the products and policies they sell. Publishing incorrect or misleading information on a website or other online sales platform can give consumers or small businesses a false understanding of the policy's benefits and lead to them unknowingly purchasing a policy that does not provide them with the desired level of cover[12].

[12] The Committee draws subscribers' attention to pages 379–398 of the Final Report of the Financial Services Royal Commission, which includes a case study about misleading and deceptive content that appeared on the travel insurance pages of Allianz's website between 2012 and 2018.

Subscribers have addressed these significant breaches by reviewing their websites and those of their partners and authorised representatives to ensure information is current and correct, and by communicating with their customers to inform them of the correct level of cover. Some subscribers have also provided their customers with an increased level of cover free of charge, and accepted claims based on the PDS provided to customers or the level of cover advertised on its website.

Recommendation 5: Make sure that the sales processes of all distributors comply with the Code.

Subscribers must ensure their distributors are fully aware of the Code and their compliance obligations. Subscribers should check that their distributors know how to identify and report breaches and potential breaches of the Code[13]. This should be done by including clauses in their contracts/service level agreements (SLAs) that require this and stipulate the consequences for non-compliance.

The amendments to the new 2020 Code of Practice relating to the sale of insurance by distributors provide a good opportunity for subscribers to review and, where appropriate, redraft their contracts/SLAs with their distributors to ensure that Code compliance obligations are included and understood.

Case study: A subscriber pays high commissions to its authorised representatives to sell unnecessary add-on insurance products to consumers

ASIC contacted the subscriber with concerns that some of the add-on insurance products being sold on the subscriber's behalf in motor vehicle dealerships were being bought by consumers who had no need for them. When the subscriber investigated the issue, it confirmed that this was the case. In some instances, consumers were sold add-on insurance for which they would have been ineligible to claim. In other instances, the add-on insurance product was designed to protect consumers against something that was already covered in their existing insurance policy.

It also transpired that the motor dealerships were earning high commissions for selling the subscriber's add-on insurance products and were therefore incentivised to sell products to consumers that they did not need.

The subscriber reported the matter to the Committee as a significant breach of subsection 4.4 of the Code and undertook corrective actions, including making restitution payments worth $3.37 million to the 5,232 affected consumers; changing sales processes and reviewing controls to prevent a recurrence of the issue; and providing Code compliance training for staff, including the Board.

[13] The case study of IAG/Swann in the Final Report of the Financial Services Royal Commission (pages 398–414) should be viewed by subscribers as a cautionary tale of what can happen when insurers do not effectively monitor the sales processes of their distributors and service suppliers.

Internal disputes relating to the sale of insurance

Of all the retail insurance disputes subscribers received in 2018–19, a total of 3,704 (or 11%) related to the sale of insurance. This placed it second on the list of the most complained about sections of the Code, behind claims (27,225 or 83%). Compared with 2017–18, there was a marginal (11%) increase in retail disputes relating to the sale of insurance.

Five out of the seven different class types for retail insurance recorded more disputes than the previous year – motor, home, travel, personal and domestic property, and sickness and accident insurance (**Table 3**). Although there were fewer disputes involving consumer credit insurance and residential strata insurance in 2018–19, the decrease for each was minimal.

Table 3: Retail internal disputes about the sale of insurance by class

Insurance class	2017-18 disputes	2018-19 disputes	% change
Motor	2,039	2,235	10%
Home	955	1,066	12%
Travel	40	68	70%
Personal & domestic property	118	146	24%
Residential strata	11	10	-9%
Sickness & accident	4	18	350%
Consumer credit	173	161	-7%
Total	**3,340**	**3,704**	**11%**

Looking forward – the 2020 Code of Practice

The 2020 Code includes a number of amendments that improve consumers' and small businesses' understanding of their rights when buying insurance. It also provides Code subscribers with greater clarity around their obligations when selling retail insurance products to consumers and small businesses, and of the obligations of those who sell products on subscribers' behalf.

Many of the 2014 Code's buying insurance standards are now spread across three distinct sections within the new Code:

- *Part 3: Our obligation to you*
- *Part 4: Standards for us and our distributors*
- *Part 6: Buying insurance.*

Part 3 requires Code subscribers and those who distribute their products to be honest, efficient, fair, transparent and timely in their dealings with consumers and small businesses. Part 4 specifies the conduct consumers and small businesses can expect from subscribers and their distributors when buying insurance, as well as committing subscribers to provide professional and competent sales practices supported by appropriate education, training and monitoring of employees and distributors. Part 6 includes obligations related to pressure selling, applying for or renewing insurance policies, premium comparison and the sale of consumer credit insurance.

One of the key updates to the Code following the ICA's review is the removal of the term 'authorised representative'.

Under the 2014 Code of Practice, an 'authorised representative' is defined as a person, company or other entity authorised by a Code subscriber to provide financial services on their behalf under the subscriber's Australian Financial Services licence (AFSL). This definition led to some confusion about the Code's application, particularly in relation to subsection 4.4.

The ICA has addressed this in the new Code by replacing 'authorised representative' with 'distributor' and providing a much clearer definition:

Distributor *means a person, company or entity that is not an* ***Employee****;*

(a) when acting on our behalf and authorised to provide financial services under our Australian Financial Services Licence, in accordance with the Corporations Act 2001; or

(b) when acting on our behalf in relation to a general insurance product issued by us (excluding an interim contract) that is covered by this ***Code*** *when they are authorised to:*

(i) enter into that product under binder; or

(ii) make a decision to pay or settle a claim made under that product as if they were us.

The Committee has long advocated for the Code's buying insurance standards to encompass all third parties who sell retail general insurance products on behalf of Code subscribers. This includes external sellers who act under their own AFSL, or who act under the AFSL of another entity that does not subscribe to the Code.

While the new Code provides some clarification around which third parties are covered by the Code's selling insurance standards, it does not go so far as to ensure that all external sellers are covered. Those entities operating under their own AFSL but without a binder in place will continue to fall outside of the scope of the Code but are subject to other regulation and the requirements of their own voluntary codes.

Claims

Claims handling is a major focus of the Code and the work the Committee does with Code subscribers. The main interaction that happens between consumers, small business and Code subscribers is when a claim is lodged. This is when customers find out how the insurance product they have purchased works, and what level of service the Code subscriber provides.

Claims handling is one of the main activities of Code subscribers. In 2018–19, more than 4.1 million retail insurance claims were lodged by consumers and small businesses. The Committee's data on the claims lodged, withdrawn and declined highlights important trends across the insurance industry and within individual retail insurance classes.

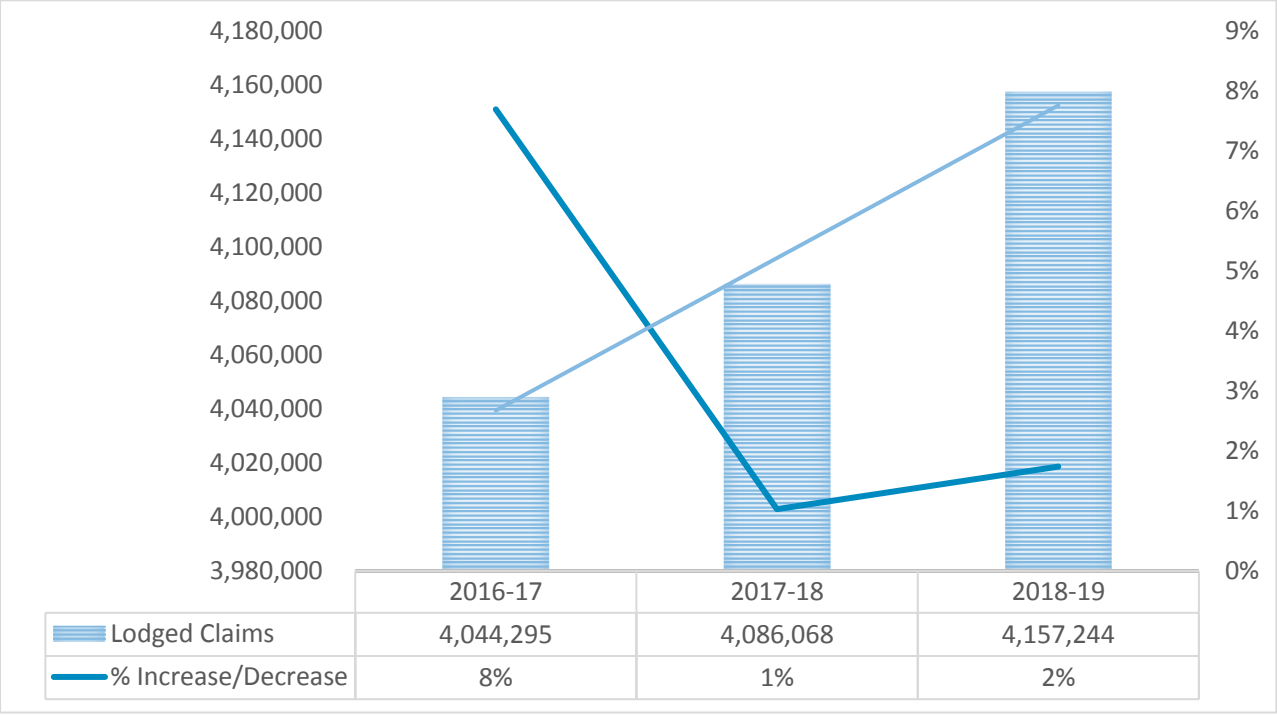
A picture of claims activity in the Australian insurance industry

In 2018–19, 88% of the 4,710,907 claims subscribers received were retail claims.

Lodged claims

Consumers and small business made 4,157,244 retail claims during 2018–19, up 2% on 2017–18 (**Chart 9**). There were 102 retail claims made per 1,000 retail policies in 2018–19, compared to 100 retail claims per 1,000 retail policies in 2017–18.

Chart 9: Retail claims lodged, 2016–17 to 2018–19



	2016-17	2017-18	2018-19
Lodged Claims	4,044,295	4,086,068	4,157,244
% Increase/Decrease	8%	1%	2%

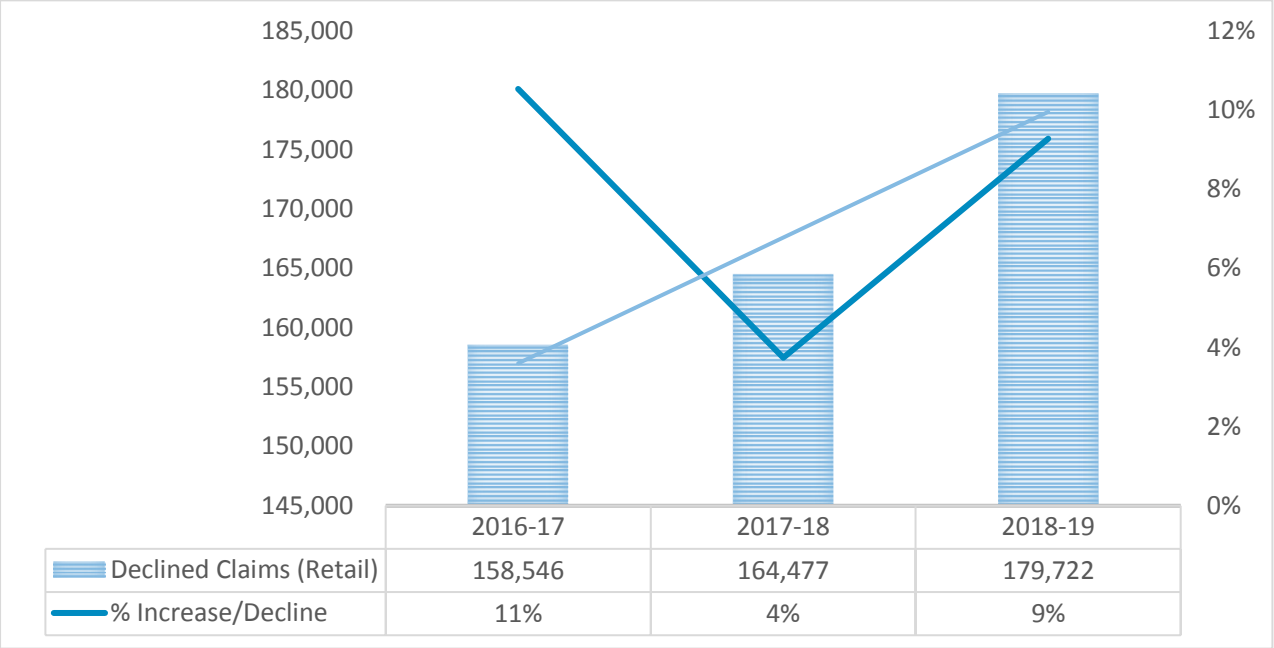
Declined claims

Subscribers declined 179,722 retail claims in 2018-19, an increase of about 10% on 2017–2018 (**Chart 10**). There were 43 claims declined per 1000 received, up from 40 claims declined per 1000 claims received in 2017–18.

A claim is declined when a subscriber has formally determined that it will not accept a claim or not accept liability for it, after they have assessed it based on all relevant facts, the terms of the insurance cover and the law.

A declined claim does not include a claim that has been withdrawn or a claim that a subscriber has partially accepted (or partially declined).

Chart 10: Retail claims declined, 2016–17 to 2018–19



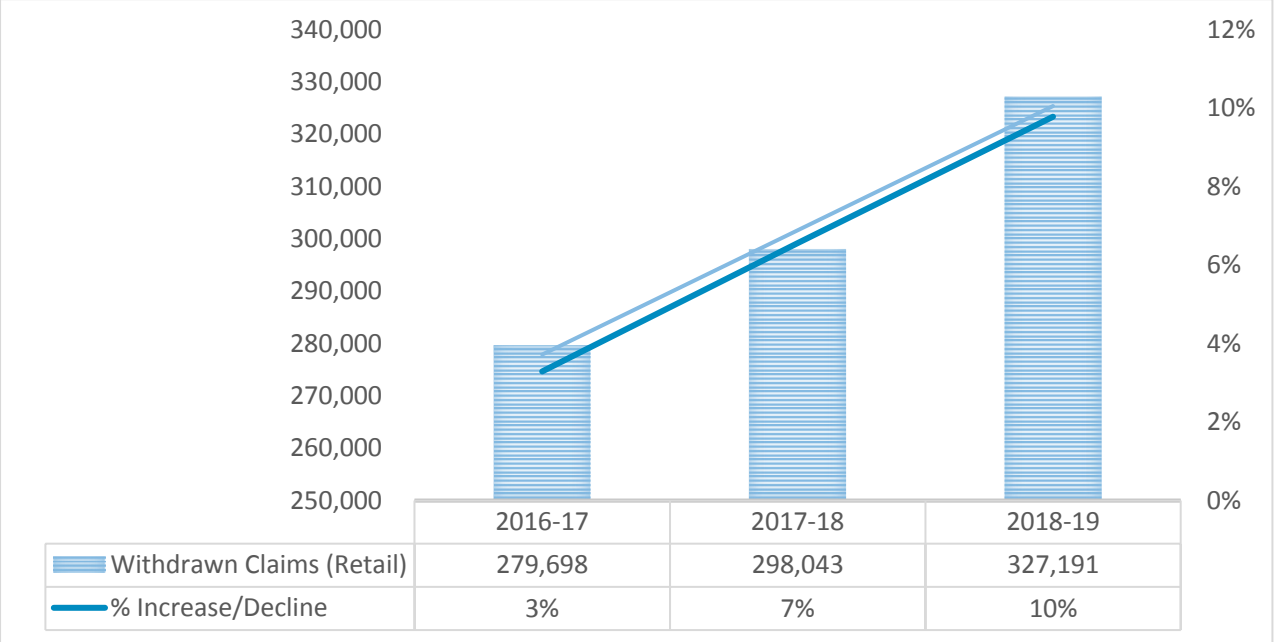
Withdrawn claims

The number of withdrawn retail claims increased by 10% in 2018–19, compared to a 5% increase in 2017–18 (**Chart 11**). In 2018–19 subscribers treated 79 claims as withdrawn per 1000 claims received, up from 73 per 1000 in 2017–18.

If a claim is withdrawn, it is discontinued before a subscriber has formally decided whether to accept or deny it. A withdrawn claim includes a claim that may be described as "cancelled", “closed”, “discontinued” or “withdrawn”.

A claim may be withdrawn at the request (or with the agreement) of a consumer or small business (claimant), or by a subscriber. A claimant may ask a subscriber to withdraw a claim for various reasons, such as the value of the claim falling below the value of the excess, the absence of valid cover, or in response to an anticipated adverse decision about their claim. A subscriber may independently treat a claim as discontinued, and as a result withdrawn, because of a loss of contact with a claimant.

Chart 11: Retail claims withdrawn, 2016–17 to 2018–19



The Committee's thoughts on subscribers' failure to understand why claims were declined and withdrawn

As part of our annual industry data collection, we ask subscribers to tell us their top five reasons why retail claims are declined or withdrawn.

Although we ask subscribers to detail their reasons so we can obtain useful insights and identify emerging issues, some subscribers continue to use generic terms when recording their reasons. For example, a reference to "no cover" (or similar) is unclear: it is difficult to know whether this means a claimant's policy had lapsed, or if the claimant had made a claim for an event that fell outside the period of cover, or even if a policy exclusion or condition applied which resulted in "no cover".

We first asked for reasons behind declined and withdrawn claims as part of our data collection for 2014–15. Over time the quality of information we receive from subscribers has improved: some can specify a policy exclusion or condition on which they based a decision to deny a claim, or why a claim was treated as withdrawn. However, it is disappointing that other subscribers are not making significant efforts to ensure their data on declined and withdrawn claims is accurate, consistent and comprehensive, and are continuing to provide generic reasons that lack detail.

We have consistently stated that a lack of detail in the reasons for claims being declined or withdrawn makes it difficult for us to draw out robust insights and identify emerging trends that might help subscribers improve their insurance products, and the way they deliver their services to consumers and small business.

Critically, this absence of detail makes it difficult for subscribers to analyse and track why retail claims are being declined or withdrawn. As a result, they have little to no insight into:

- whether claims are being declined fairly and in line with the relevant facts, policy terms and the law

- why some consumers and small businesses abandon their claims
- whether consumers and small businesses are making informed decisions when they withdraw their claims
- whether policy terms or conditions need to be changed so insurance products meet consumers' needs, or if there are gaps in consumers' understanding of products that need to be addressed.

Data quality

We continue to see that not all subscribers are able to provide consistently accurate and informative quantitative and qualitative data about claims. This applies to hard data around lodged claims, declined claims and withdrawn claims, as well as the reasons why claims were declined or withdrawn.

Some subscribers continue to report revisions to claims data for a variety of reasons. Adjustments were made to declined claims data because partially denied claims were included. In addition, adjustments were made to claims lodged data because:

- claims notifications and temporary claims had been included
- claims for different risks under a package policy were not reported as individual claims against the relevant risks
- data was reported at exposure to risk level rather than at claims level
- claims data was duplicated.

Classes with the largest number of claims

Subscribers received over 4 million retail claims from consumers and small business during 2018–19 (**Table 4, Chart 12**).

Half of all retail claims (2,082,486) were in the motor retail products class. While the number of motor claims barely increased in 2018–19 (<1%), subscribers received fewer motor claims for every 10,000 motor products bought by consumers and small businesses than in 2017–18. There were 129 claims per 10,000 policies in 2018–19, down from 136 claims per 10,000 policies in 2017–18.

The second largest group of claims was for personal & domestic property retail insurance products, which accounted for 21% of all retail claims and came in ahead of home retail claims for the first time.

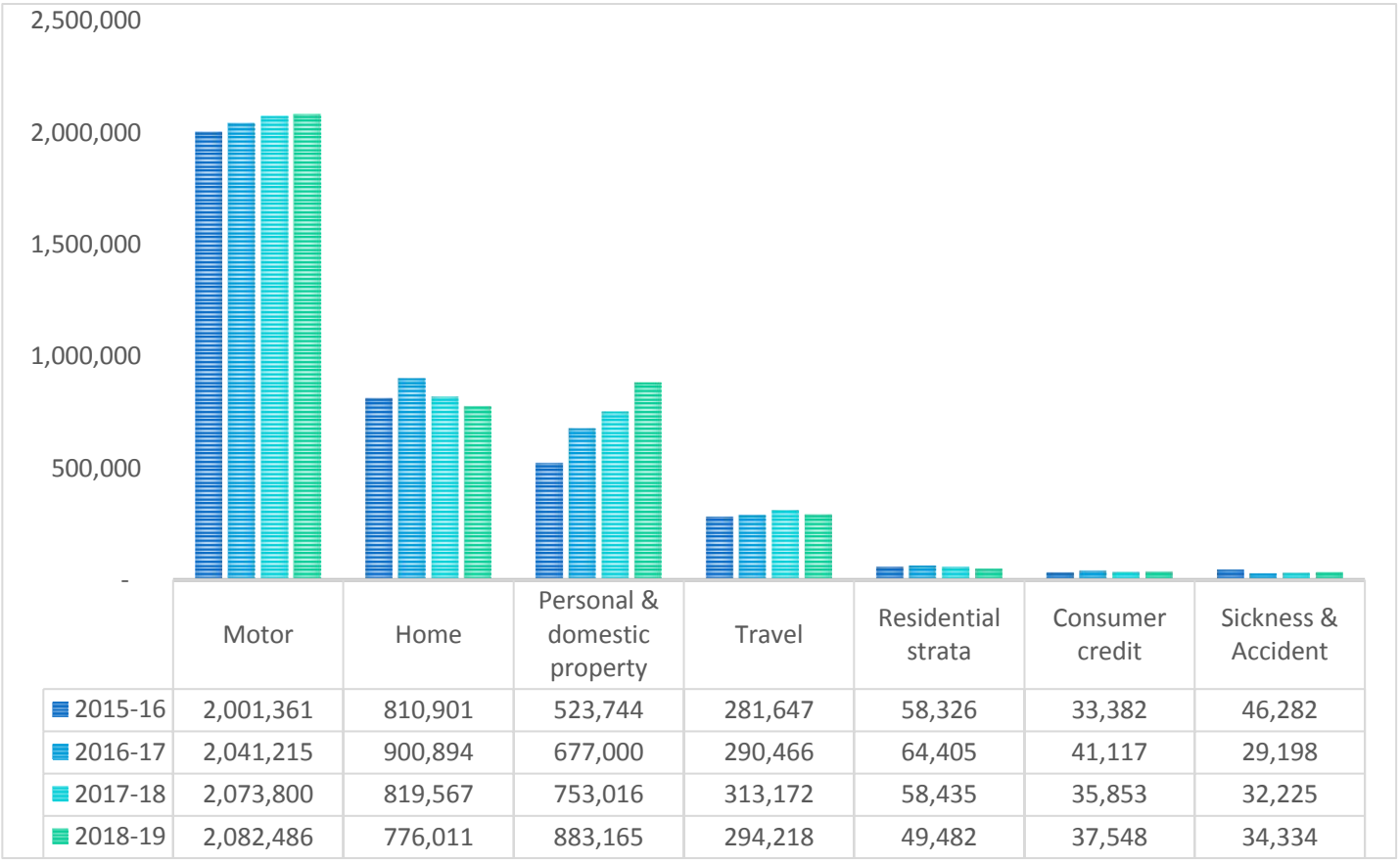
There was a 15% increase in claims made (883,165). Subscribers also received more personal & domestic property claims for every 10,000 of these products in 2018–19, with 109 claims made per 10,000 products, up from 99 claims per 10,000 products in 2017–18.

Home claims came in third, comprising 19% of all retail claims (776,011). This class was down overall by 5% and the number of claims for every 10,000 products was also down, with 68 home claims per 10,000 home products, compared to 74 per 10,000 in 2017–18.

Table 4: Retail claims trends in 2018–19

Retail insurance	2017-18 Claims lodged	2018-19 Claims lodged	2018-19 Claims/1000 policies	% difference
Motor	2,073,800	2,082,486	129	<1%
Personal & domestic property	753,016	883,165	109	17%
Home	819,567	776,011	68	-5%
Travel	313,172	294,218	59	-6%
Residential strata	58,435	49,482	235	-15%
Consumer credit	35,853	37,548	68	5%
Sickness & accident	32,225	34,334	127	7%
Total – Retail	**4,086,068**	**4,157,244**	**100**	**-2%**

Chart 12: Retail claims lodged by class, 2015–16 to 2018–19



	Motor	Home	Personal & domestic property	Travel	Residential strata	Consumer credit	Sickness & Accident
2015-16	2,001,361	810,901	523,744	281,647	58,326	33,382	46,282
2016-17	2,041,215	900,894	677,000	290,466	64,405	41,117	29,198
2017-18	2,073,800	819,567	753,016	313,172	58,435	35,853	32,225
2018-19	2,082,486	776,011	883,165	294,218	49,482	37,548	34,334

Internal disputes relating to claims

In 2018–19 consumers and small businesses escalated 32,760 complaints about or related to retail products from stage one to stage two of subscribers' internal complaints processes. The largest number of complaints in stage two related to motor, home and personal & domestic property.

At the end of stage two a subscriber must provide the complainant with a response (a final decision) to the review of their complaint, no later than 45 days after the complaint was first raised.[14] The final decision must be provided to the complainant in writing and include the subscriber's reasons for the decision and the complainant's right to refer their complaint to Australian Financial Complaints Authority (AFCA)[15] if they are unhappy with the final decision.[16]

Subscribers reported that during 2018–19 they finalised 32,371 retail insurance complaints in stage two. In a trend consistent with past years, at the end of stage two subscribers had finalised most complaints – 19,105 complaints (60%) – in their own favour. Yet during the same period, consumers or small businesses escalated only 10,803 complaints to AFCA, representing about 56% of unfavourable stage two complaint outcomes.

It is unclear why little over half of complaints that had unfavourable outcomes for consumers or small businesses reached AFCA. Subscribers should examine this gap closely to identify the factors that are contributing to this and address them. The inconsistency between the two sets of data could be due to inaccuracies in stage two complaints data. However, of greater concern is that the gap may indicate that some consumers or small businesses do not understand or are unaware of their right to escalate their complaints to AFCA.

Recommendation 6: Make sure that internal complaints processes encourage consumers and small businesses to refer unresolved complaints to AFCA

Subscribers' internal complaints processes should be robust enough to encourage consumers and small businesses to refer their unresolved complaints to AFCA. Subscribers can ensure this by:

- reviewing the clarity and quality of information they provide to consumers and small businesses about their right to escalate complaints to AFCA, and
- monitoring final responses to complaints to ensure that they consistently include information about the right to escalate complaints to AFCA.

In addition, the proportion of complaints resolved by AFCA in favour of complainants was much greater compared with outcomes reached by subscribers at the end of stage two: AFCA resolved 77% of complaints by agreement or in favour of complainants.[17] If internal complaints processes are working effectively, the Committee would expect to see greater alignment between complaint outcomes reached by subscribers and complaints resolved by AFCA.

[14] Subsection 10.10, 2014 General Insurance Code of Practice.
[15] Australian Financial Complaints Authority (AFCA) provides consumers and small businesses with fair, free and independent dispute resolution for financial complaints that come within its Rules. For more information to AFCA's website: www.afca.org.au.
[16] Subsection 10.19, 2014 General Insurance Code of Practice.
[17] AFCA Annual Review 2018–19 at page 35

Recommendation 7: Ensure that learnings from AFCA are used to improve internal complaints processes

Subscribers must ensure that employees responsible for providing effective and fair review of complaints are well-trained and competent. A critical element of this is using the outcomes of complaints from AFCA to improve these employees' knowledge and understanding of products, claims processes, general insurance law and principles, and applicable consumer protection laws.

Motor

Motor attracted the largest number of complaints from consumers and small business, accounting for 46% of all retail complaints. There were 15,054 complaints, up 20% on last year. In addition, the number of complaints per 10,000 policies increased to 9.32 in 2018–19 from 8.20 per 10,000 in 2017–18.

These 15,054 motor complaints included 12,484 complaints about or related to claims. Another 549 of these complaints were about motor claims connected with a catastrophe, up 235% on 2017–18. There were 100,272 motor claims lodged as a result of the NSW hailstorm on 20 December 2018, so it is perhaps to be expected that there would follow a spike in complaints as Code subscribers attempt to handle this volume of claims.

The remaining 11,935 claims-related complaints were up 19%. Subscribers received 25.33 complaints per 10,000 claims, up from 21.52 per 10,000 in 2017–18.

The trend of complaints being about the value of claims rather than declined claims continued. In 2018–19 consumers and small businesses escalated 4,550 complaints about the value of motor claims, up 34% at 9.66 complaints per 10,000 claims. In 2017–2018 there were 7.27 per 10,000 claims.

There were 1,807 complaints about declined claims, down 10% on 2017–18. This represented 3.84 complaints per 10,000 claims, compared to 4.31 per 10,000 claims in the previous year.

However, the largest source of complaints related to motor claims were about 'other' claims issues. While we don't know what these types of complaints were about, they may have included complaints about delays in claims handling, the quality of claims service, complaints over liability for a car accident or insurance excess. There were 5,576 of these types of complaints in 2018–19, up 20% on 2017–18. There were 11.84 complaints of this nature per 10,000 motor claims, up from 9.94 per 10,000 in 2017–18. AFCA's Annual Review 2018–19 states that of all insurance products, the most complaints it received were about motor products (2,805).

Recommendation 8: Subscribers must accurately record the reasons for complaints

Subscribers must accurately record the reasons for complaints received from consumers and small businesses so that they can identify trends and areas of emerging risk, and respond accordingly.

Home

The second largest class of complaints related to home insurance with 10,635 complaints made, an increase of 3% on 2017–18. This accounted for 32% of all retail complaints. There was only a slight difference in the number of complaints per 10,000 policies with 9.37 complaints per 10,000 policies in 2018–19, compared to 9.32 in 2017–18. Home was also second in AFCA's top three most complained about retail insurance products, with 2,421 complaints about home building and home contents received in 2018–19.

These 10,635 complaints about home insurance products included 9,407 complaints about or related to claims. This included 634 complaints about claims related to a catastrophe, up 36% on 2017–18. The balance of 8,773 claims-related complaints were largely unchanged from 2017–18. The rate of 18.62 complaints per 10,000 claims was also about the same as in 2017–18.

Unlike in motor, most claims-related complaints in home were about declined claims although there were fewer than in 2017–18:

- Consumers and small business escalated 5,298 complaints about declined home claims, down 10%, with subscribers receiving 11.25 complaints per 10,000 claims, compared to 12.68 per 10,000 in the previous year.
- Complaints about the value of home claims were up 7% to 1,679, with 3.56 complaints per 10,000 claims, little changed from 2017–18.
- Complaints about other types of claims issues affecting home were up 12% to 1,382.
- There were also 414 complaints about subscribers' decisions to refuse to re-open withdrawn claims. There were none reported in 2017–18.

Declined claims – key trends

The Code requires a subscriber to carry out claims handling in an honest, fair, transparent and timely manner – this applies to how a subscriber decides whether it will accept or deny a claim received from a consumer or small business customer (claimant).

If a subscriber declines a retail insurance claim, the Code requires it to inform the claimant in writing about the reasons for its decision, and the claimant's right to:

- ask for information about them that the subscriber relied on in assessing the claim, and supply that information within 10 business days if it is requested
- ask for copies of the reports from any service suppliers or external experts the subscriber relied on in assessing their claim, and supply them within 10 business days
- provide details of the subscriber's complaints process.[18]

[18] Subsection 7.19 of the Code

Classes with the largest number of declined claims

Subscribers reported that they declined claims in each of the seven retail insurance classes (**Table 5**) and in 2018–19 (compared to 2017–18).

Home showed a marked decrease in the rate of declined claims compared to 2017–18. Subscribers declined 65 in every 1,000 home claims in 2018–19 compared to 71 per 1,000 in 2017–18.

Table 5: Retail insurance trends in 2018–19: declined claims (absolute numbers and per 1000 retail claims received) compared to 2017–18

Retail Class	No. of declined claims in 2018–19 and % change	No. of declined claims/1000 claims received (v 2017-18)
Consumer credit	2,681, down 17%	71(90)
Home	50,433, down 14%	65 (71)
Motor	9,764, up 7%	5 (4)
Personal & domestic property	79,566, up 30%	91 (81)
Residential strata	1,468, up 5%	30 (24)
Sickness & accident	1,153, down 3%	34 (37)
Travel	34,657, up 20%	118 (93)
Total - Retail	**179,722, up 10%**	**43 (40)**

For motor, while more claims were refused overall, Subscribers declined fewer claims for every 1,000 claims they received, this dropped from 5 in 2017–18 to 4 in 2018–19.

There was a substantial increase in declined travel and personal & domestic property claims – both overall and per 1,000 claims received.

Subscribers declined fewer claims overall for consumer credit, home and sickness & accident (both in volume of declined claims and as a number per 1,000 claims they received).

Declined claims in personal & domestic property

Personal & domestic property insurance provides consumers and small business with cover for personal items such as laptops, mobile phones and jewellery. Pet insurance is the largest of the personal & domestic property product types.

In 2018–19, subscribers received 883,165 personal & domestic property claims (up 17%). Most of these (581,342 or 66%) were for pet insurance. The remaining claims were for cover of personal items, for example, spectacles, mobile phones and laptops.

Subscribers declined 30% more claims (79,566) overall, at a rate of 90 claims per 1,000 claims received, up from 81 claims per 1,000 in the previous period. Of these declined claims, 61,353 (or 77%) related to pet insurance.

Subscribers gave their top five reasons for declining claims in this class, which applied to 71,706 (90%) of these claims.

However, 31,008 pet insurance claims were declined due to the application of an unspecified exclusion or condition of the cover, and 3,664 claims were declined because of an ambiguous "no cover".

For the remaining 37,034 claims, subscribers gave the following reasons they were declined:

- 25,364 claims were declined because a pet's diagnosed condition was not covered, the condition was pre-existing, or within the waiting period that applied to the cover
- 4,099 claims were declined because they fell under the cover's applicable excess level
- 4,052 claims were declined for other specified reasons including defects, wear and tear, faulty workmanship or mechanical breakdown
- 3,069 claims were declined because claimants did not have any cover in place at the time of the loss. This included 2,966 pet insurance claims that were ineligible because the event that gave rise to the claim fell outside the period of cover.

It is not clear why some claimants believed they were covered when they initially claimed, only to find that they had no cover in place when their claims were formally declined.

Recommendation 9: Ensure customers understand their cover

Subscribers should:

- analyse why consumers and small businesses think their policy covers them when it does not, including looking at their sales processes, consider the product itself and whether meets their needs
- ensure consumers and small businesses know when their cover begins and ends at the time they buy or renew cover, and understand they cannot claim for an event that falls outside the cover period
- review disclosure documents and supporting explanatory material available at the time of buying or renewing cover and when making a claim. This documentation should be updated if necessary to make sure it clearly and accurately explains that claims can only be made for events that fall within the period of cover, and
- check the start and end date of cover when consumers or small businesses enquire about making a claim. If a consumer or small business decides to proceed with a claim, the Code prohibits a subscriber from discouraging them from doing so and must inform them that the question of coverage will be fully assessed if a claim is lodged[19]. This Code standard may have contributed to the large number of claims that were made but fell outside the scope of cover.

[19] Subsection 7.8, 2014 General insurance Code of Practice

Internal complaints relating to personal & domestic property

In 2018–19 consumers and small business escalated 2,632 complaints relating to personal & domestic property cover to stage two of subscribers' internal complaints processes. This was an increase of 26% on the previous period. The number of complaints received by subscribers for every 10,000 personal & domestic property policies issued was 18% higher with 3.3 disputes per 10,000 policies, up from 2.8 disputes per 10,000 in 2017–18.

Of these 2,632 complaints, most (2,469) related to claims. Consumers and small businesses made 5.2 claims-related complaints per 10,000 personal & domestic property claims, up from 4.2 per 10,000 in 2017–18.

Of these 2,469 claims-related complaints:

- 1,979 related to a subscriber's decision to refuse to pay a claim
- the remaining complaints were about the amount paid under a claim (173) or other claims-related issues (317).

Travel

Although subscribers received 6% fewer travel claims (294,218) in 2018–19, they declined 20% more claims (34,657) than in 2017–18. Further, subscribers declined 118 per 1,000 claims they received, up from 93 in 2017–18. We asked subscribers to tell us their top five reasons for declining travel claims and received reasons for 15,181 of these (44%). In general, the reasons given were generic.

The reason subscribers gave for 64% (9,773) of these claims was that there was "no cover for the claim or a policy exclusion or condition applied". These subscribers did not specify the exclusion or condition and referred to the ambiguous "no cover" as a reason.

Subscribers gave specific reasons for why they declined the remaining 5,408 travel claims including:

- 3,455 claims were for amounts under the cover's excess.
- 1,091 claims were refused because the cause of the event that resulted in the claim was a pre-existing medical condition.
- 662 claims were not paid because items, including luggage, were left unattended.

Internal complaints related to travel

Consumers and small businesses escalated 3,450 complaints to stage two of subscribers' internal complaints processes, up 5% on 2017–18. The number of complaints per 10,000 travel policies was almost the same as the previous year, with subscribers receiving 6.93 travel complaints per 10,000 policies compared to 6.94 in 2017-18. In 2018–19, travel was the third largest category of insurance products that consumers and small businesses complained about to AFCA, with 1,029 travel complaints made (most complaints were for motor, followed by home).

Most complaints (3,370) related to claims. In 2018–19 subscribers received about the same number of complaints for every 10,000 travel claims, with 7.15 complaints per 10,000 claims compared to 6.9 complaints per 10,000 in 2017–18.

Of these claims-related complaints, 2,634 were about a subscriber's decision to refuse a claim. The number of complaints about declined claims per 10,000 travel claims was about the same as the previous year, with 5.59 complaints per 10,000 claims compared to 5.93 per 10,000 claims in 2017-2018.

The balance of 736 claims-related complaints comprised:

- 419 complaints about the value of a claim payment – double the number in 2017–18
- 317 complaints about other claims-related issues, up 28%.

The data on travel insurance in recent years, in particular the rising number of declined claims, has revealed this to be an area of concern. Accordingly, the Committee is currently scoping a targeted inquiry into travel insurance, including an examination of the effect of different sales channels on customer outcomes.

Withdrawn claims – key trends

Classes attracting the largest number of withdrawn claims

In 2018–19 subscribers reported they recorded 327,191 withdrawn retail claims, up 10% on 2017–18 (**Table 6**). This represented 79 claims withdrawn for every 1,000 claims subscribers received (up from 73 per 1,000 claims).

Table 6: Retail insurance trends in 2018–19: withdrawn claims (absolute numbers and per 1,000 retail claims received) compared to 2017–18

Retail Class	WITHDRAWN CLAIMS	Withdrawn claims per 1000 claims lodged
Total - Retail	**327,191** **Up 10%**	**78.70** **(72.62 in 2017–18)**
Motor	157,221 Up 12%	75.50 (67.63 in 2017–18)
Personal & domestic property	34,333 Up 19%	38.87 (38.19 in 2017–18)
Home	113,810 Up 7%	146.66 (129.30 in 2017–18)
Travel	17,291 Down 5%	58.87 (58.00 in 2017–18)
Residential strata	1,914 Up 36%	38.68 (24.03 in 2017–18)
Consumer credit	923 Down 9%	24.58 (28.31 in 2017–18)
Sickness & accident	1,699 Up 44%	49.48 (36.56 in 2017–18)

The two largest contributors to withdrawn retail claims were motor, which accounted for 48% of withdrawn claims, followed by home with 35%.

The Committee is concerned that the data received still does not provide a complete picture of withdrawn claims. The Committee therefore plans to conduct an inquiry focussed on withdrawn claims, to gain a greater understanding of the reasons for withdrawn claims and whether subscribers' claims processes influence consumers and small businesses to withdraw claims.

Motor

The number of withdrawn motor claims continues to increase and accounted for 48% of all withdrawn retail claims, 157,221 motor claims were withdrawn, up 12%. The data shows that for every 1,000 motor claims subscribers received, 76 were treated as withdrawn (compared to 68 per 1,000 last year).

Subscribers gave their top five reasons why motor claims were withdrawn – this applied to 137,693 withdrawn motor claims.

- The most frequent reason cited was a decision by a claimant not to proceed with the claim, without giving a reason. This applied to 81,826 (59%) motor claims.
- 12,080 were treated as withdrawn because subscribers did not receive any response from a claimant, or the claimant failed to provide information that supported their claim.
- 11,806 claims were considered withdrawn because a claimant decided not to claim for the damage or loss.
- 9,823 claims were withdrawn because the value of the claim fell below the value of the excess.
- 9,031 were withdrawn for a reason cited as "other".

As mentioned earlier, a lack of precision in reasons why claims were withdrawn hinders our ability to draw out insights and identify emerging trends that might help subscribers improve their insurance products and the way they deliver their services to consumers and small businesses. If subscribers themselves do not understand why claims are withdrawn, we cannot be confident that consumers and small businesses are making informed decisions when they withdraw their claims.

Recommendation 10: Review reasons motor claims are being withdrawn

Subscribers should review why the rate of withdrawn motor claims continues to rise, especially given the withdrawal of 81,826 claims by consumers or small businesses without providing a reason. Subscribers need to do more to understand why so many motor claims are withdrawn and record the reasons accurately.

In 2018–19, a total of 3,600 claimants withdrew their claims because they did not hold comprehensive motor vehicle insurance. As a result, they could not claim for damage or loss to their own vehicles.

Recommendation 11: Make sure customers understand their motor cover

Subscribers should review their sales processes for motor insurance, particularly online sales processes, to ensure they are clear and transparent about the extent of cover and allow consumers and small businesses to make a genuine informed decision.

Subscribers should ensure consumers and small business understand when the motor cover they intend to buy or have bought does not cover them for loss or damage to their own vehicles.

Subscribers should review disclosure documents and supporting explanatory material available at the time of buying or renewing cover and when making a claim. They should update these documents if required to clearly and accurately explain the limitations of motor cover which does not provide comprehensive cover.

When claimants enquire about making a claim, they should be clearly informed that their motor cover is not comprehensive, and they cannot claim for any damage or loss to their own vehicles. If a claimant decides to lodge a claim, the Code prohibits the subscriber from discouraging them from doing so and must inform them that the question of coverage will be fully assessed if a claim is lodged[20]. This Code standard may have been a contributing factor to some of these claims that were made but later withdrawn because of the absence of comprehensive motor cover, however this is an example of how capturing this data provides transparency of an issue subscribers should pay attention to.

Home

The number of withdrawn home claims also increased in 2018–19, accounting for 35% of all withdrawn retail claims. There were 113,810 withdrawn home claims in 2018–19, an increase of 7% on the previous year.

Home attracted the highest rate of claim withdrawal of all retail classes. In 2018–19 subscribers reported that 147 home claims were withdrawn for every 1,000 home claims they received, up from 129 for every 1,000 in 2017–18. By comparison, the withdrawal rate for motor was 76 claims in every 1,000 during 2018–19.

Subscribers gave us their top five reasons for the withdrawal of home claims. This information applied to 101,779 of the 113,810 withdrawn home claims:

- The most frequent reason cited for the withdrawal of home claims applied to 61,496 (60%) claims. Subscribers reported that claims were withdrawn by, or with the knowledge of, a claimant who decided not to proceed and did not give a reason.
- 11,635 home claims were withdrawn by, or with the knowledge of, a claimant because their claim was not covered, including as a result of the application of a policy exclusion or condition.
- Claimants withdrew 9,308 home claims because the value of the claim was less than the policy's excess.

[20] Subsection 7.8 of the Code

- 8,006 home claims were closed by subscribers because of a lack of response from the claimant.
- 5,851 home claims were withdrawn either by subscribers without giving a reason or for “other” reasons.

The Committee is concerned that some 11,635 home claims were withdrawn by, or with the knowledge of, a consumer or small business because their claim was not covered, including as a result of the application of a policy exclusion or condition.

Recommendation 12: Determine and record why customers are withdrawing claims before a decision is made, to identify, analyse and learn from any trends.

Subscribers should examine why consumers or small businesses withdrew their claims before a formal decision was made to either accept or deny them. Subscribers should ensure that claimants are making informed decisions when they withdraw their claims.

Subscribers should also ensure that they inform claimants that if their claims are subsequently denied they have the right to:

- ask for information about why the claim was denied and receive copies of any reports from service suppliers or experts that subscribers relied on in assessing their claims, together with information about subscribers’ complaints processes
- complain about such decisions to the subscriber and subsequently to AFCA if they are unhappy with the subscribers’ final decisions.[21]

Subscribers should also work hard to ensure that the reasons for claims withdrawals are accurately recorded so that trends can be identified, analysed and learnt from.

Improving claims handling

Standard breaches and significant breaches

The Committee’s monitoring and investigation of breaches and significant breaches of the Code helps subscribers improve the claims service they offer consumers and small businesses by highlighting those areas where subscribers should focus their compliance efforts.

Claims handling is a critical pillar of the Code. It prescribes a range of standards that apply to claims handling including those set out in “Section 7 Claims”, “Section 6 Standards for our Service Suppliers” and “Section 9 Catastrophes”. Monitoring subscribers’ compliance with claims handling and related standards is a central focus of the Committee’s work.

The standards in the Code relating to claims are crucial in making sure consumers and small businesses receive a high standard of service when their claims are handled, especially when claimants are dealing with the consequences of a catastrophe or experiencing financial distress.

[21] Subsection 7.19 of the Code

Three sections of the Code relate to claims:

- Section 7 sets out extensive claims standards which specify the obligations subscribers have when receiving claims, assessing and investigating them, and making decisions about them. They also include obligations concerning workmanship and materials.
- Section 6 includes standards for how subscribers use service suppliers. It covers their competency and suitability, their contracts with subscribers and how they must respond to complaints.
- Section 9 sets out the standards that apply to claims related to catastrophes.

Increase in claims breaches

Unless otherwise stated, all references to breaches and significant breaches means closed breaches or significant breaches.

In 2018–19 there was a marked increase in reports of significant breaches from subscribers.

We opened 69 files as a result of reports of significant breaches received from 15 Code subscribers. Of the 69 significant breach matters, 15 files (22%) involved the Code's claims handling standards (section 7).

The rate of significant breach reporting by subscribers has not decreased. In the first four months to 31 October 2019, we opened 26 significant breach files as a result of reports of significant breaches from 12 subscribers. Of these 26 files, eight (31%) involved breaches of claims and/or related standards.

Key themes from significant breaches of claims handling:

- Delays in keeping consumers informed of claims progress and claims decisions (8 reports).
- Incorrect denial of claims based on policy exclusion clauses (3 reports).
- Failure to inform consumers of right to access claims information (2 reports).
- Incorrect determination of settlement amounts (2 reports).
- Miscellaneous (5 reports), including:
    - Add-on insurance dealer monitoring and supervision (1 report)
    - Incorrect registration of claims correspondence (1 report)
    - Inadequate reporting processes to prevent Code breaches (1 report)
    - Incorrect application of multiple excesses for a single event (1 report)
    - Failure to provide the basis for claims denials and complaints processes in Claims Denial Letters (1 report).

Claims-related breaches comprised 51% (15,852) of all Code breaches. Almost all these breaches related to section 7 which prescribes a range of claims handling standards. They included breaches of:

- subsection 7.2: conducting claims handling in an honest, fair, transparent and timely manner
- subsection 7.19: requirements that apply when a claim is denied, which include providing reasons for the decision in writing, rights about accessing information about the decision and the internal and external complaints processes.
- subsection 7.13: informing a claimant about the progress of their claim at least every 20 business days.

In 2018–19, there were 15,649 breaches of section 7, an increase of 80% on the previous year. This included 46 significant breaches.

As noted earlier (see also discussion on breaches in chapter “Industry landscape”) one subscriber (Subscriber P) accounted for the majority of Code breaches recorded in 2018–19, being responsible for 42% (6,514) of claims-related breaches.

Subscriber P informed us that during 2018–19 it made significant enhancements to its incident reporting management system and governance framework. These changes simplified its incident reporting process, improved accessibility so employees could raise incidents in a timely manner, heightened employees’ awareness of Code requirements so they could identify and report compliance incidents, and introduced a consistent approach across their organisation. As a result of these changes, its employees reported many more incidents than previously, some of which Subscriber P confirmed were breaches of the Code.

The balance of the claims-related breaches comprised:

- 183 breaches of Section 6 Standards for our Service Suppliers – more than a tenfold increase (there were 15 breaches in 2017–18).
- 20 breaches of Section 9 Catastrophes – the number of breaches was significantly down on 2017–18 (172 breaches). This included one significant breach reported by a subscriber during 2018–19.

It is evident from the increase in reports of breaches and significant breaches to the Committee that subscribers are looking closely at their compliance with the Code, however it is also exposing a shortfall in compliance.

The Committee expects all subscribers to have strong, robust and accessible incident reporting frameworks that:

- employees can access easily
- lead to consistency of approach across organisations
- support timely reporting of incidents by employees.

The Committee also expects subscribers to encourage their employees to report incidents, and to provide appropriate training so employees can confidently identify incidents that could indicate non-compliance with the Code.

Top five claims-related breaches

1. Keeping consumers and small businesses informed of progress

When a consumer or small business makes a claim, the subscriber is obliged to keep them informed of the progress of their claim at least every 20 business days, as per subsection 7.13 of the Code. This makes the claims process more transparent, lets customers know how their claims are progressing and helps subscribers manage customers' expectations. Communicating with claimants is especially important when the subscriber has a backlog of claims.

There were 5,102 breaches of subsection 7.13 in 2018–19, a marked increase on 2017–18. There were 11 breaches per 10,000 claims (an increase of 246%) compared to 3 breaches per 10,000 claims in 2017–18. A significant contributor to this spike is Subscriber P's heightened focus on incident reporting and subsequently breach identification, with 2,073 breaches recorded (41% of breaches of subsection 7.13). Breaches related to subsection 7.13 ranked second last year.

Case study: A routine operational audit revealed a large number of breaches

After a routine operational audit, a subscriber discovered 483 breaches out of 992 claims. The highest number of these breaches related to subsection 7.13 "We will keep you informed about the progress of your claim at least every 20 days".

The breach occurred due to an increase in active claims due to a series of weather events. The subscriber attempted to manage this increase through staff overtime, recruitment and streamlining processes.

A total of 220 customers were impacted by delays.

The subscriber has undertaken a number of initiatives to remediate the situation.

- Redefining the tasks of the home claims team is allowing it to focus on customer-led activities.
- Implementing a continuous improvement project has resulted in changes to processes relating to claim declines and claims awaiting approval. This has improved turnaround time.
- The subscriber has reviewed its recruitment strategy and is now leveraging more partners to assist resourcing.
- Customer automated messaging during the claims process was introduced to update customers on progress and next steps.
- A specialist team has been set up to manage complex claims.
- Workflow reporting based on Code obligations has been introduced. This will make claims timelines and customer communications more visible.

In 2018–19 and the first four months of 2019–20, the Committee received 12 reports of significant breaches which included subsection 7.13, from nine subscribers.

The Committee noted in last year's report that subsection 7.13 has been consistently among the most-breached sections of the Code since 2014–15: "This highlights a persistent inability to keep consumers and small businesses informed of the progress of their claims – part of a more general difficulty meeting claims standards that involve timeframes and communication with consumers and small businesses, such as the requirements in subsections 7.9, 7.10 and 7.16 (discussed below). More needs to be done to work out why subscribers have been consistently failing in this area and what can be done to improve regular communication with consumers and small businesses."[22]

2. Responding to routine requests for information from consumers and small businesses

According to standard 7.14, subscribers are required to respond to routine requests from consumers and small businesses related to their claims. In 2018–19, breaches of standard 7.14 increased to 3,594 (compared to 430 for the previous year). This means there were eight breaches per 10,000 claims (up 717%) compared to one breach per 10,000 claims in 2017–18. Breaches of 7.14 were ranked sixth last year.

In 2018–19 and the first four months of 2019–20, the Committee received seven reports of significant breaches which included subsection 7.14, from six subscribers. A significant contributor to this spike is Subscriber P's breach data, which accounted for 83% (2,991) of these breaches. It informed the Committee that the breaches occurred because employees were not following established processes. This was addressed with remedial training.

Recommendation 13: Examine why time time-based benchmarks are not being met

Subscribers should closely examine why time-based benchmarks such as standard 7.13 and Standard 7.14 are not always being met, even though employees, and other industry participants to whom these standards may apply, are required to comply with the prescribed timeframes.

Subscribers must identify why these breaches persist in their organisations despite established processes and procedures. For example, the breaches may be indicative of under-resourcing when there is an unexpected influx of claims; inconsistent monitoring of email inboxes to which consumers/small businesses send their requests for information; individuals that do not understand these benchmarks are requirements.

For subscribers to manage the end-to-end claims process and the steps within it a way that is honest, efficient, fair, transparent and timely way, they must meet these requirements.

The Committee reiterates that subscribers should ensure they have adequate claims handling systems and processes in place, and that claims areas are adequately resourced to manage claims within Code timeframes, by individuals who have the appropriate knowledge and expertise, and understand an organisation's commitment to the Code.

[22] See page 44, General Insurance in Australia 2017–18 and current insights at www.insurancecode.org.au.

3. Informing consumers and small businesses about declined claims

According to standard 7.19, if a subscriber denies a consumer's or small business's claim it must provide its reasons for the decision in writing, and notify the claimant of their rights regarding access to the information underlying the decision to decline the claim and complaints processes.

Case study: A subscriber's narrow interpretation of subsection 7.19 led to a significant breach

The Committee identified a subscriber's breach of subsection 7.19 during an investigation. The breach related to personal motor claims handling. The breach arose because the letters the subscriber sent to clients advising them their claim had been declined did not provide enough information for claimants to understand the decision, or the details of the subscriber's complaints process. The subscriber had believed they had been fulfilling this obligation by conveying this information to customers verbally and /or via email.

The subscriber reviewed the content in its claim system that related to the wording around declined claims. It established a remediation project team to update the claim letters and also invested in staff training. The subscriber's investigations department has also adopted a new process for its claim decline letters to ensure detailed information about the reason for the rejection is sent to consumers

In 2018–19 and the first four months of 2019–20, the Committee reviewed two reports of significant breaches which included subsection 7.19, from two subscribers.

There were 1,674 breaches of 7.19 in 2018–19 (compared to 2,093 in 2017–18). There were four breaches per 10,000 claims in 2018-19, 20% down from five per 10,000 in the previous year. Last year breaches of subsection 7.19 were ranked first.

4. Informing consumers and small businesses of claims decisions

Section 7.16 specifies that once a subscriber has gathered the information needed to assess a claim and form a view of its liability, it must decide to accept or deny the claim and advise the claimant of the decision within 10 business days.

There were 1,476 breaches of subsection 7.16 in 2018–19. The number of breaches per 10,000 claims stayed about the same, at three per 10,000 claims, even though the volume of breaches increased from 1,070 in 2017–18. This ranking was unchanged from last year.

In 2018–19 and the first four months of 2019–20, the Committee received seven reports of significant breaches which included subsection 7.16, from six subscribers.

The obligation in subsection 7.16 is crucial. Claimants are entitled to have their claims assessed promptly and paid in accordance with their policy. Delays can have significant negative impacts, especially where a claim is made for significant damage to a home or where the outcome of the claim will determine whether or not a claimant will be able to meet their financial obligations (for example, if a person has lost their job and can't meet their loan repayments).

The standard is one of several critical standards in section 7 that ensures subscribers deal with claims in an honest, fair, transparent and timely way. The timetable that applies to decision-making – whether to accept or deny a claim – triggers a critical contact with the

consumer or small business, which may include informing them of their right to access internal and external dispute resolution.

Subscribers must have appropriate claims handling systems and processes in place. Claims areas must be resourced to meet the needs of consumers and small businesses and be staffed by individuals who have the knowledge and expertise to make claims decisions within the Code's timeframes.

Case study: Delays in claims processing led to significant Code breaches

The subscriber identified breaches of a number of subsections of the Code after two Committee investigations, and a review of all claims it had declined in 2018. The review was focused on timeframes under subsections 7.13, 7.16 and 7.17 of the Code and aimed to assess any potential negative impacts on customers because of these delays.

The results of the review indicated:

- there was weakness in the control environment, leading to breaches of 7.13
- 85 claims were deemed non-compliant with subsection 7.16
- 40 claims were non-compliant under subsection 7.17
- the wording in the subscriber's letter denying claims did not explicitly advise consumers of their right to obtain copies of the information used to assess their claim, or their right to obtain copies of the service supplier reports. This was a breach of subsections 7.19 (b) and (c).

As a result of these delays the subscriber estimated financial harm to the value of $8,932 involving 27 consumers. The subscriber undertook a number of corrective actions, including:

- improving the reporting of Code-driven diaries so potential breaches under subsection 7.17 could be better identified
- starting a program of works to extend the capability of their claims system
- expanding the general insurance quality assurance team to increase Code compliance samples
- introducing a compliance transformation program
- reviewing its claim denial template letters, and
- reviewing its training materials.

5. Handling claims honestly, fairly and transparently and in a timely way

Under subsection 7.2, subscribers have a general requirement to handle claims in an 'honest, fair, transparent and timely' way. Breaches of subsection 7.2 increased sharply from 231 in 2017–18 to 902 in 2018–19. These breaches increased from less than one per 10,000 claims to two breaches per 10,000 claims, up 282%.

In 2018–19 and the first four months of 2019–20, the Committee received 13 reports of significant breaches which included subsection 7.2, from 10 subscribers. This was ranked 11th last year.

Subsection 7.2 is one of several Code standards that directly address culture, describing how subscribers will conduct claims handling. It is likely that subscribers' heightened focus on Code compliance has resulted in far more breaches being detected than previously. This standard is therefore a critical pillar of subscribers' commitment to openness, fairness and honesty in all dealings with consumers and small businesses.

6. Failure to identify claims-related breaches as significant Code breaches

Some subscribers are failing to correctly identify multiple breaches connected to the same underlying cause as a reportable significant breach, instead including them as standard breaches in their annual report of breach data.

Two subscribers, including Subscriber P, revised their 2018–19 annual breach data after the Committee asked them to re-assess specific breach data because it indicated a significant breach. Under subsection 13.3 of the Code, significant breaches are reportable to the Committee within 10 business days of being identified. As a result, these two subscribers reported three significant breaches of the Code in December 2019, two of which involved significant breaches of subsections 7.11 and 9.3 (the third significant breach was of subsection 10.13). Subscriber P subsequently determined that multiple breaches of subsection 7.11 and subsection 9.3 should have been identified as significant breaches and reported to the Committee.

Subsection 7.11 requires a subscriber to assess a consumer or small business's claim on the basis of all relevant facts, the terms of their insurance policy, and the law.

Subsection 9.3 requires a subscriber to provide important information to consumers and small businesses which includes their 12-month cooling off rights, which allow them to request a review if they believe their assessment was inaccurate or incomplete, when finalising claims including claims settled on a cash basis.

Recommendation 14: Analyse the root cause of multiple incidents and breaches to determine whether they constitute a significant breach.

Subscribers must closely examine and record the root cause of all incidents and breaches to determine any trends or patterns. If multiple breaches share the same root cause, they are likely to constitute a significant breach of the Code and must be reported to the Committee.

When considering the Code's definition of a significant breach (as set out in section 15), subscribers should take a broad view, considering each of the factors identified in the definition.

Looking forward – the 2020 Code of Practice

In May 2017 the Committee released a report on its own motion inquiry into the way in which subscribers investigated claims and outsourced their claims services.[23] In that report, the Committee made 30 recommendations aimed at helping subscribers improve compliance with Code standards including being transparent about claims investigations, interviewing consumers including minors, accessing interpreters and support persons, and about investigators' conduct.

The Committee also recommended that the ICA and subscribers should develop a set of best practice standards in relation to the conduct of investigators that incorporate the recommendations the Committee made in the report, among many others.

[23] Code Governance Committee's *Own Motion Inquiry – Investigation of Claims and Outsourced Services (May 2017)*

The Committee is pleased to see that among the most important changes introduced into the 2020 Code are 43 new standards that apply to the investigation of claims, with many drawn from the Committee's earlier recommendations.

These new standards, within part 15 "Claims investigation standards", apply to investigations carried out by subscribers' employees and their external investigators and cover:

- general investigation obligations – paragraphs 193 to 204
- before, during, and after a formal interview of a claimant – paragraphs 205 to 223
- obligations that apply to external investigators only – paragraphs 224 to 231, and
- surveillance – paragraphs 232 to 235.

Financial hardship

The Code plays a vital role in helping to ensure that consumers and uninsured people experiencing financial difficulty are treated fairly and respectfully. It outlines the standards expected of subscribers when working with financial hardship cases, including the provision of financial hardship assistance and the collection of money owed. The Committee expects subscribers to have mature processes in place to identify, assess and respond to situations involving financial hardship, to ensure fair outcomes for these most vulnerable consumers.

Monitoring and improving financial hardship compliance

A snapshot of breach activity

Breaches of the financial hardship standards in section 8 accounted for just 1% of all Code breaches in 2018–19, making it the sixth most breached Code section for the second year in a row.

Despite this low overall representation, financial hardship breaches increased 185% from the previous year (268 in 2018–19 compared to 94 in 2017–18), continuing an upswing in breaches of this kind that has occurred every year since 2015–16.

Historically, most financial hardship breaches have been identified by the Committee through its monitoring and investigation work, rather than identified by subscribers themselves. This was the case in the two previous reporting years, when the Committee identified more than half of all recorded financial hardship breaches. In 2018–19, however, almost 96% of financial hardship breaches were self-reported by subscribers, while the Committee identified 10 breaches and closed one significant breach matter during the year.

The increase in both the total number of breaches and the number of self-reported breaches likely reflects that subscribers have improved their understanding of and compliance with this section of the Code over the last year. This was one of the recommendations outlined by the Committee in last year's annual report, and it is pleasing to see subscribers becoming better at applying the standards and identifying when breaches occur.

It should not be forgotten, however, that any breach of the financial hardship standards will have a detrimental impact on society's most vulnerable consumers. Like the Committee, subscribers should be alarmed that financial hardship breach numbers continue to rise each year, as it means that those who need insurance support the most are not receiving the protection intended by section 8 of the Code.

The Royal Commission's Final Report had much to say on the way that the financial services industry has failed vulnerable consumers and those in financial distress, and the ICA has responded to this by strengthening the financial hardship standards in the new Code. As well as ensuring their processes, procedures and compliance monitoring frameworks are sufficiently robust to respond to the new Code provisions on financial hardship and

vulnerability, subscribers must work to improve their interactions with these consumers, providing assistance where possible to ensure outcomes that are mutually beneficial for all.

Top five breach areas – guiding compliance improvement

1. Working with consumers who are entitled to financial hardship assistance

Subsection 8.8 contains particularly important standards for Code subscribers, as it outlines the obligations they must meet once they have determined that a consumer is entitled to financial hardship assistance. These obligations include working with the consumer to consider different arrangements for settling a debt, confirming a debt waiver or other arrangement in writing, and providing details of the subscriber's complaints process if an agreement cannot be reached with a consumer.

In 2017–18, there were just seven breaches of subsection 8.8. In 2018–19, this jumped by more than ten-fold to 78 breaches, making it the most breached of all the financial hardship subsections for the reporting period. This is concerning, as it indicates that subscribers' practices for assisting those experiencing financial hardship are inadequate or ineffective, and that financially vulnerable consumers are not receiving the protection intended by section 8 of the Code.

It is vital that subscribers have appropriate systems and processes in place for ensuring that these consumers are treated in a fair and understanding manner, and that each consumer's situation is considered on its own merits, with solutions that are appropriately tailored to the individual circumstances.

Recommendation 15: Consider the individual needs of a person when providing financial hardship assistance

Subscribers need to improve their practices when it comes to working with a person who is entitled to financial hardship assistance. Rather than adopting a 'one size fits all' approach, subscribers must take each person's circumstances into account to ensure they offer assistance and support that is flexible and appropriate.

2. Timely assessment of applications for financial hardship assistance

The second most breached financial hardship standard in 2018–19 was subsection 8.6, which requires subscribers to provide a timely assessment of a consumer's request for financial hardship assistance. This includes an obligation to provide consumers who are found not to be eligible for such assistance with the reasons for the subscriber's decision, along with information about the subscriber's complaints process.

There were 49 breaches of subsection 8.6 in 2018–19 compared to only 12 breaches in 2017–18.

The Committee reminds subscribers that, as with all subsections under section 8 of the Code, subsection 8.6 applies to uninsured individuals who owe a debt as a result of damage they caused to an insured's property. These individuals are entitled to seek financial hardship assistance to help pay off any debt to the subscriber, and should be afforded the same treatment as insured customers experiencing financial difficulty. This includes providing them with the opportunity to make a complaint to the subscriber and have their complaint assessed as part of the subscriber's internal dispute handling process.

3. Requiring agents to notify subscribers of requests for financial hardship assistance

Code subscribers often use a collection agent or a legal firm to recover money owed by an uninsured person for damage to an insured customer's property. Under the Code, collection agents (including legal firms) fall under the definition of service suppliers, meaning they are required to comply with the standards set out in section 6 ('Standards for our service suppliers'). Collection agents are also subject to the obligations set out in subsections 8.10 and 8.11 to ensure that persons experiencing financial hardship are treated fairly during the debt recovery process. As a result, the Code holds subscribers accountable for the conduct of their collection agents.

If a person tells a collection agent they are experiencing financial hardship, the Code requires, under subsection 8.11, that the collection agent notifies the subscriber (or to request that the person notifies the subscriber directly). In such cases, the collection agent is also required to provide the person with details of the subscriber's financial hardship process.

In 2018–19, there were 37 breaches of subsection 8.11, making it the third most breached of all the financial hardship subsections. By contrast, there were only two breaches of this subsection in 2017–18, suggesting this is an area of emerging risk for subscribers.

Code subscribers are urged to remind collection agents acting on their behalf, including any legal firms engaged in this capacity, of their obligations to comply with subsection 8.11 when recovering debt from financially vulnerable individuals.

Recommendation 16: Make debt collection agents aware of their Code obligations, and monitor their compliance with the Code's financial hardship standards.

Subscribers must ensure that all agents acting on their behalf to recover debt, including legal firms, are fully aware of the relevant obligations in sections 6 of the Code. This should be done by specifying the Code standards that apply to collecting debts from people who indicate they are experiencing financial hardship and proactively monitoring agents' compliance with these obligations.

4. Supplying an application form and financial counselling hotline number

Breaches of subsection 8.4 rose by 54% in 2018–19. There were 36 breaches recorded, making it the fourth most breached financial hardship standard.

When a person tells a subscriber that they are experiencing financial hardship, subsection 8.4 of the Code requires the subscriber to give them an application form for financial hardship assistance, along with the contact details of the national financial counselling hotline. This obligation is particularly important, as it begins the financial hardship assistance process and links people in hardship to financial counselling if they have not already accessed it.

Not all consumers will explicitly state that they are experiencing financial hardship and require assistance to repay a debt. However, they may provide the subscriber or debt collection agent with information that implies they are financially vulnerable, such as an offer to pay a reduced sum or to pay off a debt via instalments, or by stating that they have recently become unemployed.

The Committee expects Code subscribers and their collection agents to recognise when a consumer is in financial hardship, even when the consumer has not explicitly stated this, and to respond by outlining the financial hardship assistance process, providing the financial hardship assistance form and giving the consumer the financial counselling hotline number.

5. Complying with the ACCC and ASIC Debt Collection Guideline

The fifth most breached financial hardship standard was subsection 8.12 of the Code, which requires compliance with the *ACCC and ASIC Debt collection guideline: for collectors and creditors*[24] (Guideline) when taking any recovery action against a person. There were 16 breaches of subsection 8.12 in 2018–19, up from eight breaches the previous year.

The Guideline outlines the rights and obligations of creditors, collectors and debtors to ensure that debt collection activity is undertaken in a way that is consistent with consumer protection laws. All Code subscribers and their agents are bound by the Guideline.

Significant breaches

Between 1 July 2018 and 31 October 2019, the Committee opened two significant breach matters involving the financial hardship standards of the Code, both of which were identified following Committee investigations. These significant breach matters are included below as case studies.

Despite the rise in the number of self-reported standard breaches of Code section 8, subscribers did not identify or self-report any significant breaches of this kind during the reporting period. This suggests that subscribers' processes and procedures for detecting and reporting significant breaches of the Code's financial hardship standards are inadequate and/or that subscribers are incorrectly assessing significant breaches as standard breaches.

Case study: A subscriber's collection agent fails to inform uninsured persons that it is acting on the subscriber's behalf

Investigating a Code breach allegation from a consumer advocate on behalf of an uninsured person, the Committee found the subscriber breached subsection 8.10 when the debt collection letter its agent sent to the uninsured person did not identify the subscriber as the insurer on whose behalf it was collecting the debt. The letter only listed the claims management agency that appointed the collection agent, not the subscriber.

After the Committee found this breach and informed the subscriber, the subscriber reviewed its files and found 505 similar breaches. The subscriber confirmed that this constituted a significant breach of the Code.

The subscriber addressed the issue by ensuring that the collection agent amended its template debt collection letters to include advice that the agent is acting on the subscriber's behalf. The agent also reminded its staff of their obligation to include this information in their debt collection correspondence to uninsured debtors.

[24] ACCC & ASIC Debt collection guideline: for collectors and creditors

Recommendation 17: Proactively identify significant breaches of the Code's financial hardship standards

Using the significant breach criteria set out in section 15 of the Code, subscribers must analyse in detail all breaches of the Code's financial hardship standards to identify if the issue is more widespread and whether there has been a significant breach.

Internal disputes relating to financial hardship

Code subscribers received 143 retail insurance internal disputes relating to the Code's financial hardship provisions in 2018–19 (**Table 7**). This represents just 0.44% of all internal disputes in the retail insurance category for the year and is slightly fewer than for the previous year (146 in 2017–18).

As was the case in 2017–18, the majority of financial hardship-related disputes concerned motor products (81%) and home insurance (17%).

Table 7: Retail internal disputes about financial hardship by class

Insurance class	2017-18 disputes	2018-19 disputes
Motor	107	116
Home	33	24
Travel	0	0
Personal & domestic property	2	0
Residential strata	0	0
Sickness & accident	2	3
Consumer credit	2	0
Total	**146**	**143**

Financial hardship disputes concerning 'Customers' accounted for 131 of the total number, while those relating to 'Recoveries' made up the remaining 12. This means that 92% of the disputes came from subscribers' own customers and just 8% from uninsured consumers from whom subscribers were attempting to recover debt.

These figures are somewhat concerning in light of the number of allegations the Committee received in 2018–19 from uninsured people about breaches of the Code's financial hardship standards. A total of 19 investigations were opened by the Committee during the year as a result of these allegations, many of which came from community legal centres and consumer advocates on behalf of uninsured consumers from whom subscribers were trying to recover payment for damage caused to an insured customer's property (most often a motor vehicle).

The discrepancy in the number of self-reported financial hardship disputes concerning 'Recoveries' and the number of allegations received and investigated by the Committee suggests that subscribers are incorrectly recording and handling complaints from uninsured third parties.

Once again, we remind subscribers that financially vulnerable third parties whom the subscriber is pursuing for a debt are entitled, under section 10 of the Code, to make a complaint to the subscriber and have their complaint handled in accordance with the subscribers' internal dispute resolution process.

Case study: A subscriber fails to consider an uninsured third party's complaint through its IDR process

The Committee alleged that a Code subscriber had breached its obligation to consider an uninsured person's complaint through its IDR process. After reviewing the matter, the subscriber deemed it to be a significant breach caused by a misinterpretation of subsections 10.4 and 10.19 of the Code.

The subscriber had refused to consider a complaint from an uninsured party from whom it was attempting to recover a debt, as the subscriber believed the complaint was outside the jurisdiction of its IDR process. When the subscriber conducted a review of its practices in handling debt recoveries from uninsured third parties, it established that this was not an isolated occurrence and there were similar occurrences in 41 matters.

There was also a possible significant breach of subsection 8.12 of the Code, which requires subscribers to comply with the ACCC and ASIC Debt Collection Guideline when taking any recovery action against a consumer. Section 13a of the Guideline states that collection activity should be suspended if a person contacted about a debt disputes liability for the debt. The subscriber failed to cease debt recovery action when the consumer first disputed the liability. The Committee subsequently opened a significant breach investigation, which is ongoing.

Looking forward – the 2020 Code of Practice

One of the most significant improvements to the new Code of Practice is the strengthening of the financial hardship standards to ensure that vulnerable people are treated fairly.

Part 10 of the new Code contains enhanced financial hardship standards around communication with consumers, clarity on assessment timeframes, and training for employees and debt collection agents on the financial hardship requirements of the new Code, including how to identify financially vulnerable consumers.

The 2020 Code also sees the addition of a new section (Part 9) with specific provisions for consumers experiencing vulnerability, including a requirement for subscribers to ensure that appropriate staff are trained to understand if a consumer may be vulnerable and to decide how best to support them. And while Code subscribers have until 1 January 2021 to complete their transition to the new Code, all must have a publicly available policy in place by 1 July 2020 that supports consumers experiencing family violence.

The Committee welcomes the enhancements to the financial hardship provisions in the new Code for the higher standards they expect of subscribers when dealing with vulnerable and financially disadvantaged consumers, and for the improvements to consumer outcomes. We expect all Code subscribers to closely review Parts 8 and 9 of the new Code to ensure their existing processes for managing financial hardship and supporting vulnerable consumers are compliant.

Committee activities 2018–19

During 2018–19 the Committee monitored Code subscribers' compliance with Code standards. Under an outsourcing agreement, the Code team at AFCA acts as Code administrator, with responsibility for monitoring Code compliance on the Committee's behalf.

How the Committee monitors subscribers' compliance with the Code

Investigating Code breach allegations

Code breach allegations from customers, third parties, AFCA since 1 November 2018, and prior to that FOS, are sources of the Code breaches considered by the Committee. The Code gives the Committee the power to investigate these allegations, determine whether any breaches have occurred and work with Code subscribers to agree on any corrective measures they should apply. As well as informing the Committee's work with individual Code subscribers, the insights from these investigations help to inform decisions about the focus of the Committee's other monitoring activities.

In 2018-19, the Committee received 213 matters for investigation. Almost two-thirds (65.7%) of these were referrals from AFCA; 18.8% were from consumers or lawyers acting on behalf of consumers; 4.7% came from consumer advocates; 8.9% were initiated by the Code team following desktop audits of Code subscribers' internal dispute resolution obligations; and 1.9% were referred by Code subscribers themselves.

By the end of 2018–19, the Committee had closed 240 investigations, including some that were carried over from 2017–18.

Significant breaches

Some breaches of the Code's standards are considered more serious; these are labelled significant breaches. A breach is classified as significant depending on characteristics of the breach itself – its duration, the potential or actual financial loss caused, and how it affects the Code subscriber's ability to provide its services – as well as the number and frequency of previous similar breaches and whether the breach suggests that compliance arrangements are inadequate. When a Code subscriber identifies a significant breach, it must report it to the Committee within ten business days.

In 2018–19, the Committee opened 69 significant breach files as a result of self-reporting by 15 different Code subscribers. This was a sharp increase (393%) from the previous year when the Committee dealt with 14 significant breach matters, and is largely due to subscribers focusing more closely on their compliance obligations following the Royal Commission and the Committee's inquiry into subscribers' compliance frameworks.

Almost three-quarters of this year's significant breach files concerned the Code's standards on how insurance is sold, with all but two of those relating specifically to subscribers' obligation to conduct their sales processes in an efficient, honest, fair and transparent manner (subsection 4.4). Of the remaining significant breach files, 21.7% involved the Code's claims handling standards and 7.25% concerned complaints and disputes standards.

By the end of the 2018–19 reporting year, the Committee had closed 23 significant breach matters, capturing 49 significant Code breaches.[25] This was 10 more matters closed and 27 more matters captured than in 2017–18.

Between 1 July and 31 October 2019, the Committee opened an additional 26 significant breach files.

'Possible significant breaches'

During the year, the Committee also dealt with 23 'possible significant breach' matters involving 12 subscribers. These are matters created as a result of ASIC media releases, AFCA referrals of possible or definite systemic issue matters, and referrals by subscribers who are in the process of investigating whether or not the breach is significant.

Of the 23 'possible significant breach' matters:

- nine involved the sale of insurance, including eight related to subsection 4.4
- 10 involved standards for claims handling
- three involved standards for complaints and disputes handling.

Between 1 July and 31 October 2019, the Committee opened a further four 'possible significant breach' files.

Targeted monitoring activities and Publications

During 2018–19, the Committee developed two publications and undertook two targeted monitoring activities to gather additional information on subscribers' Code compliance.

General insurance in Australia 2017–18 and current insights

Published in March 2019, the Committee's Annual Report provided an overview of the general insurance industry in Australia, along with a snapshot of trends and service standards in the industry during 2017–18 and the first half of 2018–19. The report also included 16 recommendations for subscribers to improve practice and compliance with the Code.

There was significant media interest in the report's findings. Articles about the report appeared in the *Australian Financial Review*, *Herald Sun*, *Brisbane Times*, *Sydney Morning Herald*, *The Age* and *Insurance News*.

New industry data sets pilot program

The Committee has been working with subscribers to expand our industry data collection framework to gain deeper insights, and help subscribers identify emerging risks and areas of poor industry practice that need to be examined more closely.

On 29 November 2018, we informed subscribers of our intention to collect new data under a pilot program and subsequently asked for their feedback and any queries about the new data sets. We also received feedback from the National Code Committee. This enabled us to develop guidance on the interpretation and application of the new data definitions.

[25] Some significant breach matters involved significant breaches of more than one section of the Code.

Phase one of the pilot program commenced in October 2019.

The new data sets that we are collecting from subscribers under the pilot program include:

- premiums collected
- claims accepted
- claims partially accepted
- number of consumers affected by breaches
- financial impact of breaches.

These new data sets are subsets of the data that the Committee collects from subscribers under the existing industry data framework.

Inquiry into culture, leadership, governance and the adequacy of subscribers' compliance frameworks

In 2018, the Royal Commission asked the Committee to provide information about trends in subscribers' breaches from 2014 to 2018. Compiling and analysing this data gave the Committee an opportunity to reflect on subscribers' Code compliance and reporting over the four-year period. The Committee concluded that overall, subscribers were underreporting instances of Code breaches, and that breach numbers across the four years were inconsistent, fragmented and questionable – potentially indicating weaknesses in subscribers' compliance monitoring and governance frameworks.

The Committee's overarching concern was that these weaknesses were an indication that some subscribers had an insufficient grasp of the scope and understanding of the Code's true purpose, or that they were not taking their Code obligations seriously. In light of this, the Committee launched an own motion inquiry in September 2018 to investigate the adequacy of subscribers' compliance frameworks.

The findings of the inquiry validated the Committee's concerns about weaknesses in subscribers' compliance frameworks and highlighted issues or potential issues from a cultural, leadership and governance perspective in many subscribers' organisations that indicate subscribers are not "living the Code". Accordingly, the scope of the report widened to incorporate commentary on the Committee's expectations around culture, leadership and governance, as well as recommendations on how subscribers can improve in these areas.

The report, titled *Living the Code: Embedding Code obligations in compliance frameworks*, will be published by the Committee during the first half of 2020.

Audit into how subscribers handle consumer complaints

Released in January 2019, the Committee's *How insurers handle consumer complaints* report detailed the findings of a desktop audit of subscribers' compliance with the Code's standards relating to complaints and disputes.

The audit was undertaken in the context of growing numbers of consumer complaints, indications of problems with insurers' internal dispute resolution processes, increased focus on complaints handling processes as highlighted by the Royal Commission, ASIC initiatives to collect and publish complaints data, and the ICA's review of the Code.

The purposes of the audit were to:

- benchmark current industry practice and performance against the Code's complaint standards
- identify any non-compliance and monitor implementation of Code subscribers' corrective actions
- provide guidance to subscribers where practices require improvement
- provide guidance to subscribers about risk management and mitigation to reduce the likelihood of non-compliance occurring or recurring.

A sample of 20 subscribers completed a questionnaire that asked them to describe how they comply with the Code's complaints and disputes standards. The Committee reviewed subscribers' responses and supporting evidence to assess whether their processes, procedures and systems facilitate compliance and 18 recommendations were issued in the report.

Engagement with stakeholders

The Committee remained committed to engaging with a range of stakeholders during 2018–19, including consumer groups, Code subscribers, regulators and AFCA.

Consumer advocates

The Committee met with various consumer advocates throughout 2018–19, including Legal Aid Queensland, Westjustice Community Legal Centre, Consumer Action Law Centre and Settlement Services International. We also attended a number of consumer advocate conferences during the year including the Financial Counselling Australia National Conference, the 2018 National Community Legal Centres Conference, and the Financial and Consumer Rights Council Conference.

These meetings and events enabled us to build on our previous positive engagement with consumer advocates, and to gain valuable insights into issues affecting consumers, such as misleading advertising, product comparison and the treatment of consumers experiencing vulnerability and/or financial hardship.

Government and regulators

During 2018–19, the Committee and the Secretariat met several times with ASIC, APRA and Treasury to share work in progress and discuss regulatory matters of pertinence to the general insurance industry.

The Secretariat continued to hold quarterly and ad hoc meetings with ASIC about issues such as claims investigations, the Code, governance and work activities being undertaken by both ASIC and the Committee. In May 2019, Secretariat members also attended the ASIC Annual Forum.

The Committee/Secretariat held discussions with APRA in late 2018 about the general insurance statistics APRA collects, and about the Committee's use of several of APRA's definitions as part of the Committee's new data collection. The Committee Chair and the Secretariat General Manager also met with APRA's Deputy Chair and other senior APRA representatives in August 2019 to discuss the Committee's inquiry into the adequacy of compliance and reporting frameworks and APRA's findings and recommendations from institutions' self-assessments.

The Committee Chair, along with the Chairs of all other Code Committees, met with Treasury in November 2018 to discuss developments in the context of the Royal Commission into Financial Services, in particular the enforceability of Codes. Periodic telephone meetings between the Secretariat and the Treasury took place throughout the year.

Industry

The Committee Chair and the Secretariat General Manager also met with the Boards and Chief Executives of several subscribers during the year to discuss their reporting of breaches and significant breaches, their APRA self-assessments and Committee reports, as part of the Committee's inquiry into the adequacy of governance, culture and compliance frameworks.

The Committee and Secretariat met with 17 individual Code subscribers during 2018–19 in relation to Code breach investigations and subscribers' self-reports of significant breaches. A total of 32 meetings were held with individual subscribers throughout the year, providing the opportunity to progress investigations, identify where breach acknowledgements were appropriate, discuss the interpretation of Code standards, and check that Code subscribers' remedial actions addressed the underlying causes of Code breaches.

Further subscriber engagement included a workshop run by the Secretariat in August 2018 on the Committee's new industry data sets. This event was also attended by representatives of the ICA and members of the Committee.

The Committee and Secretariat maintained regular communication with the ICA during the year, providing the ICA Board with quarterly reports on the Committee's activities; meeting monthly with ICA staff to discuss issues relating to the general insurance industry and the Code; providing feedback at ICA workshops about the collection of industry data and the new Code; and welcoming ICA representatives to Committee meetings.

The Committee also worked closely with the National Code Committee and the Financial Services Council during the year, meeting regularly with both bodies to discuss the Committee's activities and Code matters. The Committee also welcomed NCC Chair, Anabelle Butler, to two Committee meetings in 2018–19, to discuss issues including the NCC's role in developing the new Code, and the Committee's new datasets pilot program.

Australian Financial Complaints Authority (AFCA)

The Committee enjoyed a close working relationship with AFCA[26] during 2018–19. We provided the authority with ongoing support in the lead-up to its launch on 1 November 2018 and continued this close engagement throughout the year.

The Committee and Secretariat participated in a number of activities that helped build a good working relationship with AFCA during its first year of operation, including:

- attending an AFCA strategic values workshop on 18 September 2018
- inviting AFCA CEO and Chief Ombudsman David Locke to the Committee's meeting on 29 October 2018 to provide an update on AFCA's launch
- providing monthly updates to Mr Locke and AFCA's Senior Leadership Group on the activities of the Committee and Code team
- holding quarterly meetings with the AFCA Systemic Issues Team to discuss ongoing investigations, trends and emerging issues
- attending monthly AFCA General Insurance Ombudsman and Case Managers' meetings
- attending AFCA's GI Open Forums during the year and presenting on the Code and Committee's work at the Sydney, Melbourne and Brisbane forums
- the Committee Chair meeting with the chairs of the other financial services Code Governance Committees supported by AFCA on 19 November 2018
- providing Code induction to new AFCA employees throughout the year
- inviting AFCA GI Lead Ombudsman John Price to provide an update on GI EDR issues at the Committee's meeting on 20 May 2019
- attending meetings of the AFCA Consumer Advisory Panel in March and June 2019
- participating in the AFCA fairness project working group meetings in June, July and August 2019
- the Secretariat General Manager, Sally Davis, addressing the AFCA GI industry liaison group meeting in Sydney on 19 June 2019.

Submissions

Financial Services Royal Commission

As reported in the Committee's Annual Report for 2017–18, the Committee Chair, Lynelle Briggs, provided a witness statement to the Royal Commission on behalf of the Committee in September 2018. The witness statement formed part of the Royal Commission's investigation into the operation and effectiveness of self-regulation in the financial services industry, and included historical data on Code breach allegations, self-reported breaches and significant breaches, as well as an overview of the Committee's sanctions powers and activities, and how it works with Code subscribers to identify breaches and monitor corrective actions.

[26] On 1 November 2018, AFCA replaced the Financial Ombudsman Service (FOS), the Credit and Investments Ombudsman (CIO) and the Superannuation Complaints Tribunal (SCT).

Code Review

During 2018-19, the Committee continued its engagement with the ICA on its review of the Code. The Committee provided further comments and recommendations as the ICA finalised its review process and prepared for the release of the new Code.

Treasury

In April 2019, the Committee Chair, in collaboration with the Chairs of the Banking, Customer Owned Banking and Life Insurance Code Compliance Committees, provided a joint submission to Treasury in relation to its consultation paper on the enforceability of financial services Codes.

The consultation paper was released in response to the recommendation in the Royal Commission's final report for ASIC to be given increased oversight of financial services industry Codes, and for breaches of some Code provisions to be made illegal as a way of preventing systemic failures in applying the Code.

While endorsing in principle any recommendation to improve service standards for consumers, the Chairs' joint submission urged Treasury to consider that enforcement by regulators of part (or all) of a Code could result in a Code that is adhered to on the basis of what is strictly legal rather than what is the right thing to do. This, in turn, could have unintended, adverse consequences for consumers.

Articles

In conjunction with the Code Compliance Committees for Banking, Customer Owned Banking, and Life Insurance, we published two articles in the Consumers' Federation of Australia (CFA) newsletter in 2018 – one in October ('Codes of Practice – Consumers benefit') and another in December ('Codes of Practice and financial difficulty'). Both articles were aimed at informing consumers about the financial services Codes of Practice and their rights under the Codes, with the second article focused specifically on Code subscribers' obligations to consumers experiencing financial difficulty.

Decision-making

Each year the Committee convenes a strategy meeting to consider its aims and where it will focus its monitoring efforts. The Committee examines the intelligence gleaned through its own recent monitoring, including desktop audits, own motion inquiries and Code breach investigations; information on ASIC activities; issues arising in AFCA cases; and input from consumer advocates, all of which build a picture of industry trends, consumer experience and possible areas of emerging risk. This picture informs the Committee's strategic decisions. This reporting year, the strategy meeting took place in Brisbane in February 2019.

The Committee met a further 10 times in 2018–19, in line with its Charter and Deed obligations. Meetings were held in Sydney, Melbourne and Brisbane, and via teleconference.

Workplan priorities

For the coming year, the Committee's workplan priorities are to:

- publish the final report on the Committee's own motion inquiry into the adequacy of subscribers' governance, culture and compliance frameworks
- manage the transition to the new 2020 General Insurance Code of Practice, including close liaison and consultation with the ICA and Code subscribers
- plan and commence the Committee's 2019–20 data collection program, working proactively with subscribers to improve reporting and data accuracy
- commence the next phase of the Committee's new data sets pilot program
- continue to develop the Committee's independent website as a resource for stakeholders and to promote the Code and the work of the Committee.

Committee members

The Committee comprises three members: an independent chair, a consumer member and an industry member.

Lynelle Briggs AO – Independent Chair

Lynelle Briggs is a Royal Commissioner into Aged Care Quality and Safety. She was the Chairperson of the NSW Planning Assessment Commission. She serves on the Boards of Maritime Super, the Aid Governance Board and Goodstart Early Learning. She was formerly a member of the Council of the Royal Australian College of General Practitioners and of the Australian Rail Track Corporation Board. She was also Chairperson of the Australian Security Intelligence Organisation's Audit and Risk Commission and Chairperson of the Jigsaw Theatre Company Board. She was the independent reviewer into Communications Legislation on Online Safety. She has chaired the Shipping Workforce Development Forum, the Inquiry into Compliance, Work Health and Safety Laws in the ACT Construction Industry, and the Catholic Development Fund Steering Committee. She was the Independent Project Facilitator for the Millers Point Accommodation Project. During her executive career, she was Australia's Public Service Commissioner and Chief Executive of Medicare Australia.

Philippa Heir – Consumer Member

Philippa Heir is currently the Managing Lawyer – Insurance at the Consumer Action Law Centre in Melbourne. Having started her career in private practice acting for insurers, for the past five years, she has been advising and advocating for consumers experiencing insurance issues. She is also involved in insurance campaigns at Consumer Action, including the Stop Selling Junk campaign, which involved the development of a self-help web tool, DemandARefund.com, to help people seek refunds for add-on insurance. In 2018, Philippa represented and supported two clients to give evidence at the Financial Services Royal Commission about their experience with the insurance industry.

Cheryl Chantry – Industry Member

Cheryl Chantry is an experienced industry leader who has significant capability in Board engagement, governance and management committees, as well as not for profit director experience. Cheryl has worked at senior executive levels in large, complex organisations such as IAG and Suncorp, leading customer facing, operational and strategy teams. She led the Claims function at IAG through its response to a number of large catastrophes, and in her last role there was the Executive General Manager, Customer Development. She now runs her own business focused on executive coaching and consulting.

Cheryl is a passionate advocate for the development of engaging organisational cultures where employee and customer well-being are a central focus, and a champion of the important role the insurance industry plays in the Australian economy.

Andrew Cornish – Industry Member – (from 1 July 2018 to 31 May 2019)

Andy Cornish has more than 40 years' experience in the insurance industry in Australia and overseas. He is an Independent Non-Executive Director of MLC Limited, Chair of the Risk Committee and a member of the Audit Committee, and is a Member of the Board of Larapinta Connect Pty Ltd and Australia New Car Assessment Programme (ANCAP). Andy, who has an MBA from Ashridge Management College, consults and advises various insurers in Australia.

Prior to retiring from executive life in June 2016, Andy was Chief Operations Officer at IAG and prior to that was Chief Executive Officer, Personal Insurance, IAG. He has also served as Chairman and President of the Insurance Council of Australia.

Brenda Staggs – Consumer Member (from 1 April 2018 to 13 December 2018)

Brenda has been a practicing solicitor since 2001. While studying law, Brenda worked as a senior claims officer with (then) CU Insurance, and then practiced insurance litigation working as a senior lawyer at several major law firms. In 2009, she followed her passion for social justice and joined the Redfern Legal Centre, running the centre's TAFE branch for six years. In 2015, Brenda joined Legal Aid NSW, combining her passion for justice with her insurance knowledge as Legal Aid's disaster response coordinator and insurance specialist.

On 4 January 2019 AFCA appointed Brenda as an Ombudsman where she independently investigates and resolves complaints brought by consumers and small business.

Committee's Secretariat

Under an outsourcing agreement, the Code team at AFCA acts as Code administrator, with responsibility for monitoring Code compliance on the Committee's behalf.

Sally Davis – General Manager

Sally Davis began her role as General Manager of the Code team and CEO of the Code Compliance and Monitoring Committee on 1 September 2015. Prior to her appointment to this role, Sally was Senior Manager of Systemic Issues at FOS and has worked at AFCA and its predecessor schemes for almost 20 years. Sally is a graduate of the Mt Eliza Business School, an accredited mediator and a graduate of the Australian Institute of Company Directors. She also holds a Bachelor of Commerce and a Bachelor of Laws degree from the University of Melbourne and a Graduate Diploma (Arts) from Monash University.

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

Rose-Marie Galea – Compliance Manager

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

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

Appendix 1: Code subscribers as at April 2020

1	1Cover Pty Ltd	81	Itrek Pty Ltd
2	AAI Limited	82	Jardine Lloyd Thompson Pty Ltd
3	About Underwriting Pty Ltd	83	JUA Underwriting Agency Pty Ltd
4	Advent Insurance Management Pty Limited	84	Keystone Underwriting Australia Pty Ltd
5	Agile Underwriting Services Pty Ltd	85	LawCover Insurance Pty Limited
6	AI Insurance Holdings Pty Ltd	86	Lloyd's Australia Limited
7	AIG Australia Ltd	87	Lockton Companies Australia Pty Ltd
8	AIOI Nissay Dowa Insurance Company Australia Pty Ltd	88	Logan Livestock Insurance Agency Pty Ltd
9	AIS Insurance Brokers Pty Ltd	89	London Australia Underwriting Pty Ltd
10	Allianz Australia Insurance Limited	90	Marsh Pty Ltd
11	Amazon Underwriting Pty Ltd	91	Millennium Underwriting Agencies Pty Ltd
12	Ansvar Insurance Limited	92	Miramar Underwriting Agency Pty Ltd
13	ANZ Lenders Mortgage Insurance Pty Ltd	93	Mitsui Sumitomo Insurance Co Ltd
14	AON Risk Services Australia Ltd	94	Newline Australia Insurance Pty Ltd
15	Arch Underwriting at Lloyd's (Australia) Pty Ltd	95	NIB Travel Services (Australia) Pty Ltd
16	Argenta Underwriting Asia Pte Ltd	96	NTI Limited
17	ASG Insurance Pty Limited	97	One Underwriting Pty Ltd
18	ASR Underwriting Agencies Pty Ltd	98	OnePath General Insurance Pty Limited
19	Assetinsure Pty Ltd	99	Pacific International Insurance Pty Limited
20	ATC Insurance Solutions Pty Ltd	100	Pacific Underwriting Corporation Pty Ltd
21	Australian Insurance Agency Pool Pty Ltd T/A Fairways Agencies	101	PD Insurance Agency Pty Ltd
22	Australian Warranty Network Pty Ltd	102	Pen Underwriting Pty Ltd
23	Auto & General Insurance Company Limited	103	Petplan Australasia Pty Ltd
24	Axis Underwriting Services Pty Ltd	104	PetSure (Australia) Pty Ltd
25	Berkshire Hathaway Specialty Insurance Company	105	PI Direct Insurance Brokers Pty Ltd
26	Bizcover Pty Ltd	106	Point Underwriting Agency Pty Ltd
27	BMS Risk Solutions Pty Ltd	107	Precision Underwriting Pty Ltd
28	Bovill Risk & Insurance Consultants Pty Ltd	108	Proclaim Management Solutions Pty Ltd
29	Broadspire by Crawford & Co	109	Procover Underwriting Agency
30	Canopius Australia & Pacific Pte Ltd t/a Canopius Australia & Pacific	110	Professional Risk Underwriting Pty Ltd
31	Catalyst Consulting (Aust) Pty Ltd	111	PSC NFIB Markets Pty Ltd
32	Catholic Church Insurance Limited	112	QBE Insurance (Australia) Limited
33	Cerberos Brokers Pty Ltd	113	QBE Lenders' Mortgage Insurance Limited
34	Cheap Travel Insurance Pty Ltd	114	Quanta Insurance Group Pty Ltd
35	Chubb Insurance Australia Limited	115	Quantum Insurance Holdings
36	Claims Management Australasia	116	RAA Insurance Limited
37	Coffre-Fort Pty Ltd	117	RAC Insurance Pty Limited
38	Columbus Direct Travel Insurance Pty Ltd	118	RACQ Insurance Limited
39	Commonwealth Insurance Limited	119	RACT Insurance Pty Ltd
40	Coversure Pty Ltd	120	Risk Partners Pty Ltd
41	Credicorp Insurance Pty Ltd	121	RiskSmart Claims Management (part of Honan)
42	Defence Service Homes Insurance Scheme	122	Savannah Insurance Agency Pty Ltd
43	Dual Australia Pty Ltd	123	Sedgwick

44	Duinsure Pty Ltd	124	SLE Worldwide Australia Pty Ltd
45	DWF Claims	125	Solution Underwriting Agency Pty Ltd
46	East West Insurance Brokers Pty Ltd	126	Sompo Japan Nipponkoa Insurance Inc
47	Edge Underwriting Pty Ltd	127	Southern Cross Benefits Limited
48	Elkington Bishop Molieaux Brokers Pty Ltd (also known as EBM Insurance Brokers)	128	Specialist Underwriting Agencies Pty Ltd
49	Emergence Insurance Pty Ltd	129	Sportscover Australia Pty Ltd
50	Ensurance Underwriting Pty Ltd	130	Starr Underwriting Agents (Asia) Limited
51	Epsilon Underwriting Agencies Pty Ltd	131	Steadfast IRS Pty Ltd
52	Eric Insurance Limited	132	Sterling Insurances Pty Ltd
53	Factory Mutual Insurance Company	133	Sura Hospitality Pty Ltd
54	Fitton Insurance (Brokers) Australia Pty Ltd	134	Sura Labour Hire Pty Ltd
55	Fullerton Health Corporate Services	135	Sura Professional Risks Pty Ltd
56	Gallagher Bassett Service Pty Ltd	136	Surafilm & Entertainment Pty Ltd
57	Gard Insurance Pty Ltd	137	SureSave Pty Ltd
58	Genesis Underwriting Pty Ltd	138	SureSeason Australia Pty Ltd
59	Genworth Financial Mortgage Insurance Pty Ltd	139	Swiss Re International SE
60	Glenowar Pty Ltd (Fenton Green & Co)	140	Talbot Underwriting Australia Ltd
61	Go Unlimited Pty Ltd	141	The Hollard Insurance Company Pty Ltd
62	Gow-Gates Insurance Brokers Pty Ltd	142	The North of England Protecting and Indemnity Association Ltd t/a Sunderland Marine
63	Great Lakes Insurance SE	143	The Tokio Marine & Nichido Fire Insurance Co Ltd
64	GSA Insurance Brokers Pty Ltd	144	Topsail Insurance Pty Ltd
65	Guild Insurance Limited	145	Travel Insurance Direct Pty Ltd
66	Hallmark General Insurance Company Limited	146	Trident Insurance Group Pty Ltd
67	High Street Underwriting Agency Pty Ltd	147	Victor Insurance Australia Pty Ltd
68	Holdfast Insurance Brokers	148	Virginia Surety Company Inc
69	Honan Insurance Group	149	W.E Cox (Australasia) Pty Ltd
70	Hostsure Underwriting Agency Pty Ltd	150	Westpac General Insurance Limited
71	HQ Insurance Pty Ltd	151	Windsor Income Protection
72	HW Wood Australia Pty Ltd	152	Winsure Underwriting Pty Ltd
73	IBL Ltd (Planned Professional Risks Underwriting Agency)	153	Woodina Underwriting Agency Pty Ltd
74	Imalia Pty Ltd	154	World Nomads Group Ltd
75	Inglis Insurance Brokers	155	Wymark Insurance Brokers Pty Ltd
76	Insurance Australia Limited	156	XL Catlin Australia Pty Ltd
77	Insurance Manufacturers of Australia Pty Limited	157	XL Insurance Company Ltd
78	Insure That Pty Ltd	158	Youi Pty Ltd
79	Insurx – Claim Central	159	YourCover Pty Ltd
80	Ironshore Australia Inc	160	Zurich Australian Insurance Ltd

Appendix 2: Aggregated industry data 2018-19

Policies and claims

Insurance class	Individual policies	Group policies	Total policies	Lodged claims	Declined claims	Withdrawn claims
Retail	40,667,129	905,867	41,572,996	4,157,244	179,722	327,191
Wholesale	2,553,127	200,165	2,753,292	553,663	6,067	26,070
Grand Total	**43,220,256**	**1,106,032**	**44,326,288**	**4,710,907**	**185,789**	**353,261**
Retail						
Motor	16,146,112	26	16,146,138	2,082,486	9,764	157,221
Home	11,341,106	4,197	11,345,303	776,011	50,433	113,810
Personal & domestic property	8,069,994	467	8,070,461	883,165	79,566	34,333
Travel	4,106,658	872,682	4,979,340	294,218	34,657	17,291
Consumer credit	551,960	0	551,960	37,548	2,681	923
Sickness & accident	241,072	28,495	269,567	34,334	1,153	1,699
Residential strata	210,227	0	210,227	49,482	1,468	1,914
Retail Total	**40,667,129**	**905,867**	**41,572,996**	**4,157,244**	**179,722**	**327,191**
Wholesale						
Business Pack	983,718	112,934	1,096,652	105,618	2,111	6,204
Liability	578,969	36,178	615,147	37,592	1,175	2,246
Primary Industries Pack	274,304	4,389	278,693	43,336	660	2,036
Motor Wholesale	211,670	28,012	239,682	288,864	241	11,802
Business	209,878	12,400	222,278	35,865	1,276	1,941
Other	174,990	1,802	176,792	8,016	182	224
Contractors All Risks	45,895	132	46,027	8,498	60	276
Industrial Special Risks	44,508	4,296	48,804	23,308	340	1,206
Primary Industries	29,195	22	29,217	2,566	22	135
Wholesale Total	**2,553,127**	**200,165**	**2,753,292**	**553,663**	**6,067**	**26,070**

Group policies and people & assets

Insurance class	Group policies	People or assets
Retail	905,867	22,179,179
Wholesale	200,165	6,340,828
Grand Total	**1,106,032**	**28,520,007**
Retail		
Travel	872,682	13,499,836
Sickness & accident	28,495	7,759,352
Personal & domestic property	467	696,935
Motor	26	7,235
Home	4,197	215,821
Consumer credit	0	0
Residential strata	0	0
Retail Total	**905,867**	**3**
Wholesale		
Business Packs	112,934	247,309
Liability	36,178	5,455,503
Motor Wholesale	28,012	574,587
Business	12,400	47,262
Primary Industries Pack	4,389	7,770
Industrial Special Risks	4,296	3,033
Other	1,802	2,776
Contractors All Risks	132	98
Primary Industries	22	2,490
Wholesale Total	**200,165**	**6,340,828**

Received internal disputes (stage two)

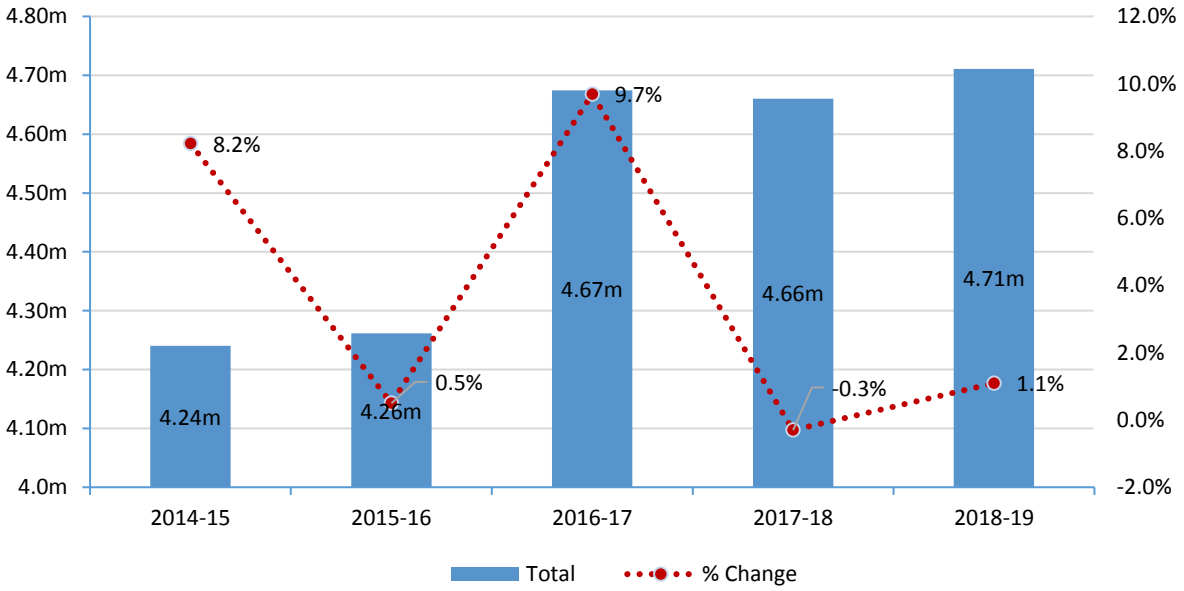
Insurance class	Access to information	Authorised Representatives	Buying	Catastrophes	Claims	Employees	Financial Hardship: Customers	Financial Hardship: Recoveries	Total
Retail	70	101	3,704	1,199	27,225	318	131	12	32,760
Wholesale	4	3	121	75	1,632	49	7	2	1,893
Grand Total	**74**	**104**	**3,825**	**1,274**	**28,857**	**367**	**128**	**14**	**34,653**
Retail									
Motor	43	10	2,235	549	11,935	166	105	11	15,054
Home	16	10	1,066	634	8,773	112	23	1	10,635
Travel	7	0	68	2	3,370	3	0	0	3,450
Personal & domestic property	0	4	146	4	2,469	9	0	0	2.632
Consumer credit	0	0	161	0	152	17	0	0	330
Residential strata	1	0	10	10	316	5	0	0	342
Sickness & accident	3	77	18	0	210	6	3	0	317
Retail Total	**70**	**101**	**3,704**	**1,199**	**27,225**	**318**	**131**	**12**	**32,760**
Wholesale									
Motor Wholesale	1	0	7	10	504	8	3	0	533
Business Pack	1	2	57	39	455	30	3	1	588
Liability	2	0	11	10	191	7	0	0	221
Business	0	0	12	4	161	0	1	0	178
Primary Industries Pack	0	0	1	6	114	0	0	1	122
Other	0	1	28	2	84	4	0	0	119
Primary Industries	0	0	3	1	58	0	0	0	62
Industrial Special Risks	0	0	1	3	49	0	0	0	53
Contractors All Risks	0	0	1	0	16	0	0	0	17
Wholesale Total	**4**	**3**	**121**	**75**	**1,632**	**49**	**7**	**2**	**1,893**

Finalised internal disputes (stage two)

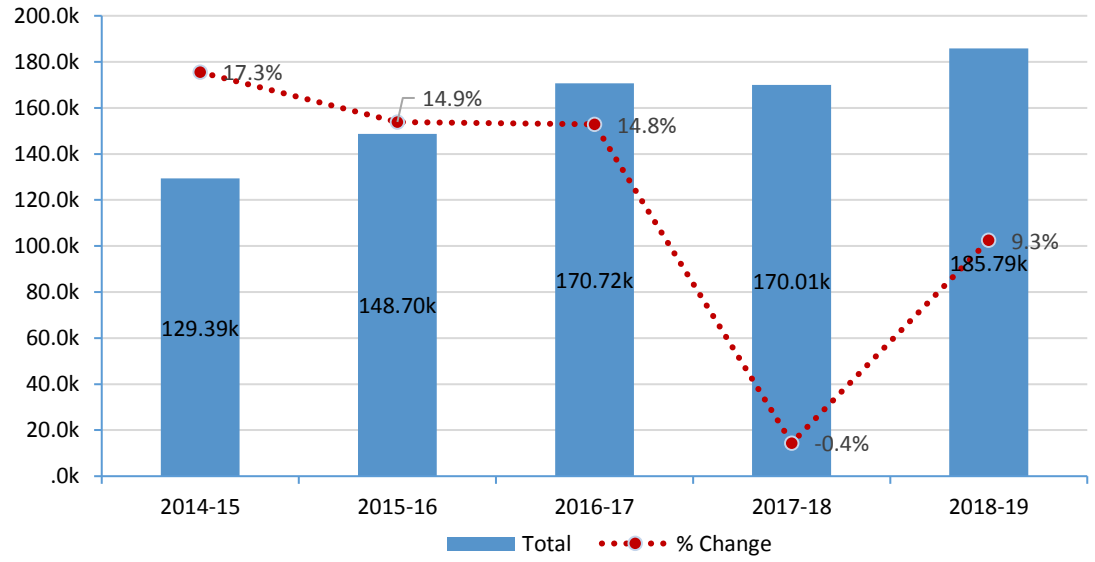
Insurance Class	Dispute Category	CUSTOMER: FINALISED DISPUTES 2018-19	SUBSCRIBER: FINALISED DISPUTES 2018-19	Total Finalised Disputes 2018-19
Total - Retail		13,266	19,105	32,371
Total - Wholesale		551	1,216	1,767
Grand Total		**13,817**	**20,321**	**34,138**
Retail	Access to information	15	33	48
Retail	Authorised Representatives	24	76	100
Retail	Buying	1,824	1,809	3,633
Retail	Catastrophes	576	589	1,165
Retail	Claims	10,652	16,333	26,985
Retail	Employees	111	176	287
Retail	Financial Hardship	64	89	153
Retail Total		**13,266**	**19,105**	**32,371**
Wholesale	Access to information	1	2	3
Wholesale	Authorised Representatives	0	2	2
Wholesale	Buying	30	83	113
Wholesale	Catastrophes	12	55	67
Wholesale	Claims	496	1,046	1,542
Wholesale	Employees	9	23	32
Wholesale	Financial Hardship	3	5	8
Wholesale Total		**551**	**1,216**	**1,767**

Appendix 3: Five-year data overviews

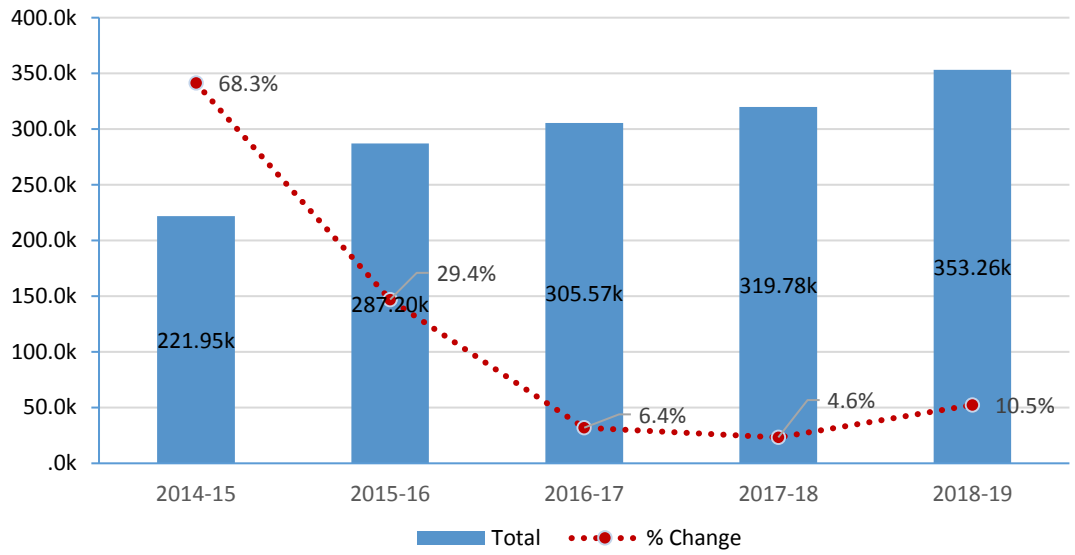
Lodged claims



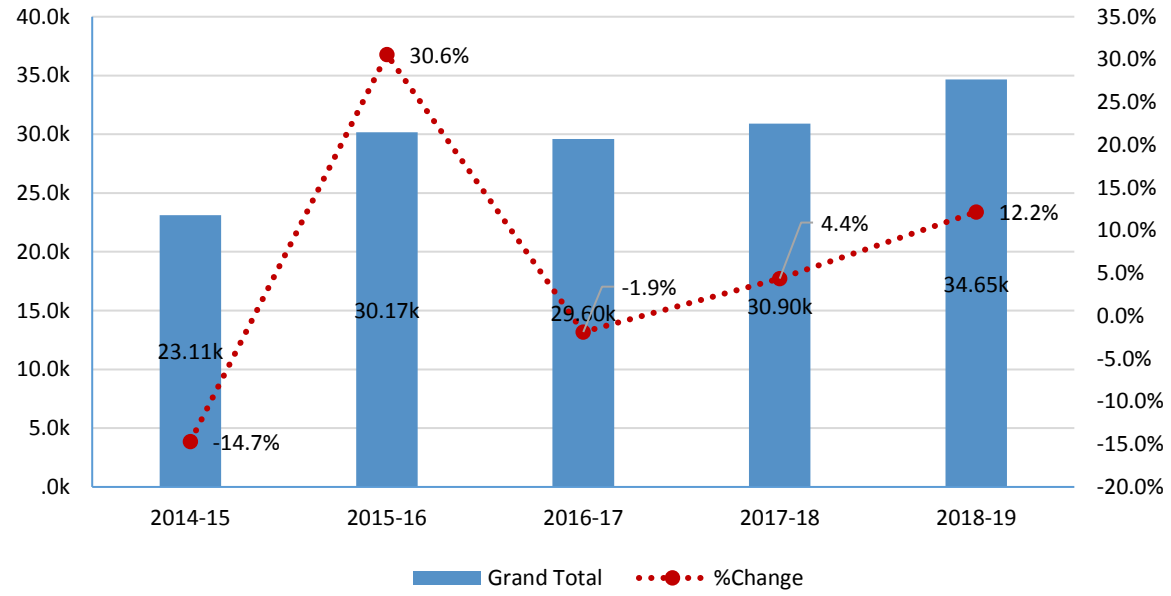
Declined claims



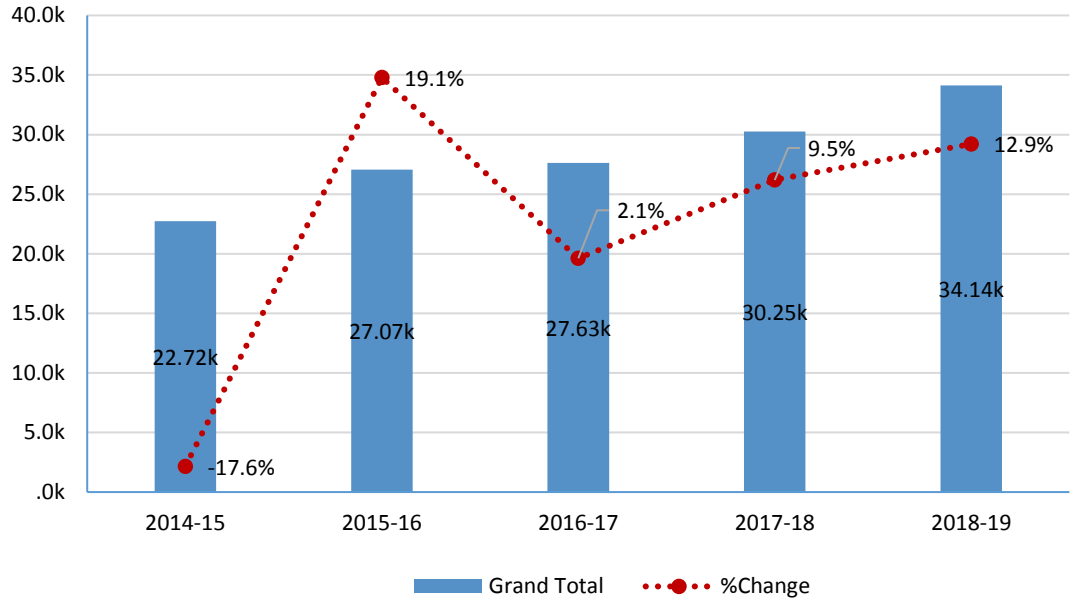
Withdrawn claims



Received internal disputes (stage two)



Reviewed internal disputes (stage two)



Appendix 4: Aggregated Code breach data 2018-19

The aggregated breach data presented in Appendix 4 comprises data from all sources: breaches and significant breaches identified by the Code Governance Committee (CGC), and breaches and significant breaches reported by Code subscribers.

Breaches by Code category and source

Code section	Identified by CGC	Significant breaches	Identified by subscribers	Total
4 Buying insurance	1	51	2,353	2,405
5 Standards for Employees and Authorised Representatives	4	3	868	875
6 Standards for Service Suppliers	4	3	176	183
7 Claims	51	46	15,552	15,649
8 Financial hardship	10	1	257	268
9 Catastrophes	0	1	19	20
10 Complaints and disputes	49	8	6,317	6,374
11 Information and Education	0	0	5	5
13 Monitoring, enforcement and sanctions	1	6	1	8
14 Access to Information	1	0	5,398	5,399
Grand Total	**121**	**119**	**30,946**	**31,186**

Top five areas of non-compliance

Code section	Breaches
14.1 – Abide by privacy laws when collect/store/use/disclose personal information	5,388
7.13 - Inform on claim progress every 20 business days	5,102
7.14 – Respond to routine requests within 10 business days	3,594
7.16 - Decision made once all info/enquiries received/completed and notification within 10 business days of decision	1,476
10.4 - Complaints handling must be fair, transparent and timely.	1,332
Grand Total	**16,892**

Breaches by Code category and subsection

4 Buying insurance Note: "AR" means "authorised representatives"	**Identified by CGC**	**Significant breaches**	**Identified by subscribers**	**Total**
4.9 – If consumer/small business is entitled to cancel policy, must refund money owed within 15 business days.		1	1,061	1,062
4.4 - Sales processes and services of employees/AR must be efficient, honest, fair and transparent.	1	49	698	748
4.7 - Correct errors or mistakes related to application or when assessing application.		1	466	467
4.8(a-d) – What subscriber will do if can't provide insurance.			69	69
4.6 - Ask for and rely on relevant information or documents only in assessing application.			38	38
4.5 – Communications in plain language			10	10
4.10(a-b) – Provide written notice of instalment non-payment at least 14 calendar days prior to cancellation.			7	7
4.8(c) – Refer consumer/small business to ICA/NIBA for alternative insurance options.			4	4
4.8(b) – If consumer/small business asks, supply requested information underlying assessment of application.			0	0
Grand Total	**1**	**51**	**2,353**	**2,405**

5 Standards for Employees and Authorised Representatives (AR)	**Identified by CGC**	**Significant breaches**	**Identified by subscribers**	**Total**
5.1(a-e) – Education, training and monitoring of employees/AR			837	837
5.3 - AR to inform consumer/small business of subscriber's identity and services provided on its behalf.			3	3
5.1(a) – Education and training of employees/AR to ensure competent and professional services	3	2	3	8
5.1(c) - Monitoring performance of employees/AR to measure training effectiveness.	1		13	14
5.5 - AR to comply with Code when selling products on our behalf.		1	0	1
5.1(d) – Education and training to correct employees/AR shortcomings.			5	5
5.2 - AR to notify subscriber of complaints and must handle these under its complaints process.			7	7
Grand Total	**4**	**3**	**868**	**875**

6 Standards for Service Suppliers	Identified by Committee	Significant breaches	Identified by subscribers	Total
6.7 - Service suppliers to notify subscriber of complaints and these must be handled under its complaints process.		1	121	122
6.2 - Service suppliers must provide their services honestly, efficiently, fairly and transparently.	3	1	38	42
6.3(a) – Must use qualified service suppliers to provide competent and professional service.			9	9
6.4 – Service supplier contracts reflect code standards			8	8
6.5 – Service supplier must obtain approval before subcontracting their service		1		1
6.6 – Service suppliers to inform of insurer's identity and services provided on their behalf			1	1
Grand Total	**3**	**3**	**177**	**183**

7 Claims	Identified by CGC	Significant breaches	Identified by subscribers	Total
7.13 - Inform consumer/small business about claim progress every 20 business days.	3	8	5,091	5,102
7.14 - Respond to routine requests within 10 business days	2	4	3,588	3,594
7.16 - Decision made once all info/enquiries received/completed and notification within 10 business days of decision	3	4	1,469	1,476
7.19(a) - Reasons for decision must be in writing.			1,132	1,132
7.2 - Claims handling fair, transparent and timely	19	5	878	902
7.9 - Notify within 10 business days of claim acceptance/denial		4	885	889
7.11 - Claim assessed on basis of facts, policy terms and law	4	4	567	575
7.19(a-d) - Denial of claim		3	440	443
7.10(a-c) - Within 10 business days notify consumer/small business of further info/assessment required			302	302
7.21(b) - Conduct/timetable reasonable in the circumstances			164	164
7.4 - Correct errors or mistakes in dealing with claim.	3	1	159	163
7.17 – Claim decision made within 4 months of receiving claim unless exceptional circumstances apply. If no decision, must provide details of complaints process.	2		139	141
7.8 - Prior to lodging claim consumer/small business can ask if policy covers loss. Will not discourage claim lodgement.		1	108	109

7 Claims	Identified by CGC	Significant breaches	Identified by subscribers	Total
7.21(a) - Comply within agreed alternative timetable			80	80
7.3 - Ask for and rely on relevant information only when deciding claim.	1	1	66	68
7.7(a-c) - Urgent financial need of benefit under policy			63	63
7.12 - Notify within 5 business days of loss assessor/adjuster/investigator appointment		2	56	58
7.10(c) - Provide initial estimate of timetable/decision making process	1		48	49
7.19(b) - Inform of right to ask for info relied on in assessing claim – supply within 10 business days	3	1	43	47
7.21(c) - Cause of non-compliance if External Expert report delay and best endeavours used to obtain report			46	46
7.19(d) - Provide details of complaints process to consumer/small business		1	33	34
7.10(a) - Notify of any information required to make decision		3	31	34
7.18 - Decision made within 12 months if exceptional circumstances apply. If no decision, provide details of complaints process.		1	28	29
7.21(a-c) - Must comply within timetables			23	23
7.5 - Reasonable alternative time frame	1	1	19	21
7.19(c) - Inform of right to ask for copies of service suppliers or external expert reports – supply within 10 business days	3	1	14	18
7.6 - Complaints process available to policy holders		1	17	18
7.15 – Provide External Expert report to consumer/small business within 12 weeks of engagement or inform of report progress/delay.			16	16
7.10(b) - Appointment of loss assessor/adjuster			14	14
7.20(a-b) - Selection and authorisation of repairer by subscriber.	1		9	10
7.7(a) - Fast track claim assessment/decision process			9	9
7.22 - Timetable compliance doesn't apply if court/tribunal/EDR commenced (except AFCA)			6	6
7.7(b) - Advance payment within 5 business days to alleviate hardship			5	5
7.20(b) - Handle any complaint re quality/timeliness/conduct of work/repairer	2		3	5
7.20(a) - Accept responsibility for materials/workmanship quality	2			2

7 Claims	Identified by CGC	Significant breaches	Identified by subscribers	Total
7.7(c) - Provide details of complaints process			1	1
7.3 - Ask for/rely on relevant information only in deciding claim	1			1
Grand Total	**51**	**46**	**15,552**	**15,649**

8 Financial hardship	Identified by CGC	Significant breaches	Identified by subscribers	Total
8.8(a-e) - Entitled to financial hardship assistance			77	77
8.6 - Notify as reasonably practicable of financial hardship assessment. If no entitlement, provide reasons for decision and info on complaints process	5		44	49
8.11 - Agents notified of financial hardship required to provide details of financial hardship process			37	37
8.4 - Upon informing of financial hardship, must supply financial hardship application and counselling hotline			36	36
8.12 - Any recovery action must comply with ACCC/ASIC guidelines	3		13	16
8.3 - If money owed and experiencing financial hardship may ask if entitled to assistance	1		13	14
8.7 - Collections put on hold until financial hardship request is assessed, and notification of decision given.			12	12
8.5(a-b) - Reasonable evidence may assist in assessing financial hardship assistance			7	7
8.13 - If declaring bankruptcy, work together to provide written confirmation of debt owed. If no agreement, provide details of complaints process			6	6
8.9 – If not entitled and circumstances change, can make further request for fin hardship assistance			5	5
8.10 - Any communication from agent re money owed will identify insurer and specify nature of claim	1	1	6	8
8.8(d) - If release/discharge/waiver agreed to, confirm in writing and if requested, notify any finance			1	1
Grand Total	**10**	**1**	**257**	**268**

9 Catastrophes	Identified by CGC	Significant breaches	Identified by subscribers	Total
9.3(a-b) - If property claim finalised within 1 month of catastrophe, consumer/small business may request a review within 12 months of decision, even if released signed.		1	11	12
9.2 – Respond to catastrophe in efficient/professional/practical/compassionate manner			7	7
9.3(a) - Inform consumer/small business of entitlement to review claim decision when property claim finalised.			1	1
9.3(b) - Inform consumer/small business of complaints process when property claim finalised.			0	0
Grand Total		**1**	**19**	**20**

10 Complaints and Disputes	Identified by CGC	Significant breaches	Identified by subscribers	Grand Total
10.13(a-d) - Respond to complaint in writing.	6	1	466	473
10.10 - Stage 1 and 2 of complaints process not to exceed 45 calendar days. If unable to provide decision must inform consumer/small business of reasons for delay and right to go to AFCA.	6	1	846	853
10.4 - Complaints handling must be fair, transparent and timely.	8		1,324	1,332
10.16 - Inform consumer/small business of progress every 10 business days.	3		279	282
10.5 - Inform consumer/small business of right to make complaint and complaints process on website and in written communications.			165	165
10.11 - Respond to complaint within 15 business days if subscriber has all necessary information and completed investigation.	7	2	981	990
10.12(a-b) – What subscriber will do if can't respond to complain within 15 business days.	2	1	430	433
10.8 - Notify consumer/small business of name and contact details of employee assigned to handle complaint.	1		377	378
10.9 - Complaints process doesn't apply if complaint resolved within 5 business days and response not requested in writing, excluding complaints about a declined claim, claim value or financial hardship.	1		49	50
10.18 - Notify consumer/small business as soon as reasonably practicable within 15 business days of reasons for delay and agree on reasonable timeframe. If no agreement, advise consumer/small business of right to go to AFCA.	3		355	358
10.13(a) – Complaint decision must be in writing.			34	34
10.13(c) – Consumer/small business has right to take complaint to stage 2 if not satisfied with stage 1 decision.			11	11
10.17 – Within 15 business days of escalation of complaint to stage 2, subscriber must respond to complaint if it has all necessary information and completed investigation.	4		384	388
10.12(a) – Notify consumer/small business as reasonably practicable within 15 business days of response delay and agree to reasonable timeframe. If no agreement, advise consumer of right to move to stage 2.	2	1	121	124
10.13(b) – Provide reasons for decision in writing.			11	11
10.14 - If consumer/small business not satisfied with stage 1 decision, can ask subscriber to move to stage 2.			8	8
10.19(b) - Notify consumer/small business of right to go to AFCA including AFCA timeframe and contact details.			7	7

10 Complaints and Disputes	Identified by CGC	Significant breaches	Identified by subscribers	Grand Total
10.19(a-b) - Response to complaint must be in writing.		1	117	118
10.13(d) - If consumer/small business not satisfied with stage 2 decision, notify of right to go to AFCA.	2		9	11
10.19(a) - Final decision on complaint and reasons must be in writing.			2	2
10.6 - Only ask for and rely on relevant information when dealing with complaint. If consumer/small business asks, supply information relied on within 10 business days.			31	31
10.3 – Consumer/small business entitled to make complaint about any aspect of relationship with subscriber.	2		70	72
10.12(b) – Inform consumer/small business of progress every 10 business days unless otherwise agreed.	1	1	202	204
10.7 - Correct errors and mistakes in complaint handling.	1		16	17
10.15 - Stage 2 complaint must be reviewed by appropriately qualified and authorised employee(s). Where practicable employee should not be same employee who handled stage 1 or who was subject of complaint.			4	4
10.23 - AFCA determinations are binding on subscribers.			13	13
10.22 - If not satisfied with stage 2 decision or if complaint unresolved within 45 calendar days, consumer/small business entitled to refer complaint to AFCA.			5	5
Grand Total	**49**	**8**	**6,317**	**6,374**

11 Information and Education	Identified by CGC	Significant breaches	Identified by subscribers	Total
11.6 - Provide code info on website/product info			5	5
Grand Total			**5**	**5**

13 Monitoring, enforcement and sanctions	Identified by CGC	Significant breaches	Identified by subscribers	Total
13.3 – Report within 10 business days to CGC any significant code breach		3	1	4
13.2(a) - Have appropriate systems/processes to enable CGC compliance monitoring		2	1	3
13.2(b) – prepare an annual return to the CGC on compliance with this Code		1		1
Grand Total		**6**	**2**	**8**

14 Access to information	Identified by CGC	Significant breaches	Identified by subscribers	Total
14.1 - Abide by privacy laws when collecting, storing, disclosing personal information.			5,388	5,388
14.2 - If asked by consumer/small business, provide access to information relied on.	1		4	5
14.5(b) – If not giving access or disclosing information, provide reasons.				0
14.5(a) - Will not deny access or disclosure unreasonably.				0
14.3 - If asked by consumer/small business, give access to reports of Service Suppliers or External Experts relied on.			2	2
14.5(c) - Provide details of complaints process.				0
14.5(a-c) – What subscriber will do when declining access or disclosure.			3	3
14.4(a-c) - May decline access in special circumstances.			1	1
Grand Total	**1**		**5,398**	**5,399**

Appendix 5: Comparative data

Total policies (individual + group)

INSURANCE CLASS	TOTAL POLICIES 2017-18	TOTAL POLICIES 2018-19	% DIFFERENCE - TOTAL POLICIES	ABSOLUTE DIFFERENCE - TOTAL POLICIES
Retail				
Motor Retail	15,258,064	16,146,138	5.82%	888,074
Home	11,125,026	11,345,303	1.98%	220,277
Personal & Domestic Property	7,582,890	8,070,461	6.43%	487,571
Travel	4,720,533	4,979,340	5.48%	258,807
Consumer Credit	688,352	551,960	-19.81%	-136,392
Sickness & Accident	276,593	269,567	-2.54%	-7,026
Residential Strata	217,091	210,227	-3.16%	-6,864
Total - Retail	**39,868,549**	**41,572,996**	**4.28%**	**1,704,447**
Wholesale				
Business Pack	1,089,428	1,096,652	0.66%	7,224
Liability	515,503	615,147	19.33%	99,644
Primary Industries Pack	230,085	278,693	21.13%	48,608
Motor Wholesale	246,805	239,682	-2.89%	-7,123
Business	271,774	222,278	-18.21%	-49,496
Other	193,956	176,792	-8.85%	-17,164
Industrial Special Risks	49,378	48,804	-1.16%	-574
Contractors All Risks	44,015	46,027	4.57%	2,012
Primary Industries	131,731	29,217	-77.82%	-102,514
Total - Wholesale	**2,772,675**	**2,753,292**	**-0.70%**	**-19,383**
Grand Total	**42,641,224**	**44,326,288**	**3.95%**	**1,685,064**

Individual policies only

INSURANCE CLASS	TOTAL POLICIES 2017-18	TOTAL POLICIES 2018-19	% DIFFERENCE - TOTAL POLICIES	ABSOLUTE DIFFERENCE - TOTAL POLICIES
Retail				
Motor Retail	15,258,038	16,146,112	5.82%	888,074
Home	11,125,026	11,341,106	1.94%	216,080
Personal & Domestic Property	7,582,455	8,069,994	6.43%	487,539
Travel	3,986,544	4,106,658	3.01%	120,114
Consumer Credit	688,347	551,960	-19.81%	-136,387
Sickness & Accident	251,986	241,072	-4.33%	-10,914
Residential Strata	217,091	210,227	-3.16%	-6,864
Total - Retail	**39,109,487**	**40,667,129**	**3.98%**	**1,557,642**
Wholesale				
Business Pack	976,924	983,718	0.70%	6,794
Liability	484,263	578,969	19.56%	94,706
Primary Industries Pack	230,085	274,304	19.22%	44,219
Motor Wholesale	210,223	211,670	0.69%	1,447
Business	262,282	209,878	-19.98%	-52,404
Other	192,045	174,990	-8.88%	-17,055
Contractors All Risks	43,983	45,895	4.35%	1,912
Industrial Special Risks	45,606	44,508	-2.41%	-1,098
Primary Industries	131,358	29,195	-77.77%	-102,163
Total - Wholesale	**2,576,769**	**2,553,127**	**-0.92%**	**-23,642**
Grand Total	**41,686,256**	**43,220,256**	**3.68%**	**1,534,000**

Group policies only

Insurance class	2017-18	2018-19	No. (Change)	Percent (Change)
Retail				
Travel	733,989	872,682	138,693	18.9%
Sickness & accident	24,607	28,495	3,888	15.8%
Personal & domestic property	435	467	32	7.3%
Motor	26	26	0	0.0%
Consumer credit	5	0	-5	-100.0%
Home	0	4,197	4,197	419,700.0%
Residential strata	0	0	0	0.0%
Retail Total	**759,062**	**905,867**	**146,805**	**19.34%**
Wholesale				
Business Pack	112,504	112,934	430	0.4%
Motor Wholesale	36,582	28,012	-8,570	-23.4%
Liability	26,118	36,178	10,060	38.5%
Business	9,492	12,400	2,908	30.6%
Industrial Special Risks	3,772	4,296	524	13.9%
Other	1,911	1,802	-109	-5.7%
Primary Industries	373	22	-351	-94.1%
Contractors All Risks	32	132	100	312.5%
Primary Industries Pack	0	4,389	4,389	438,900.0%
Wholesale Total	**190,784**	**200,165**	**9,381**	**4.9%**
Grand Total	**949,846**	**1,106,032**	**556,191**	**16.4%**

People and assets

Insurance class	2017-18	2018-19	No. (Change)	Percent (Change)
Retail				
Travel	16,860,956	13,499,836	-3,361,120	-19.9%
Sickness & accident	6,499,910	7,759,352	1,259,442	19.4%
Personal & domestic property	566,226	696,935	130,709	23.1%
Motor	5,227	7,235	2,008	38.4%
Home	0	215,821	215,821	215,821.0%
Consumer credit	0	0	0	0.0%
Residential strata	0	0	0	0.0%
Retail Total	**23,932,319**	**22,179,179**	**-1,753,140**	**-7.3%**
Wholesale				
Liability	4,627,516	5,455,503	827,987	17.9%
Motor Wholesale	783,972	574,587	-209,385	-26.7%
Business Pack	232,995	247,309	14,314	6.1%
Business	75,539	47,262	-28,277	-37.4%
Industrial Special Risks	6,810	3,033	-3,777	-55.5%
Primary Industries	3,228	2,490	-738	-22.9%
Other	2,365	2,776	411	17.4%
Primary Industries Pack	0	7,770	7,770	777,000.0%
Contractors All Risks	0	98	98	98,000.0%
Wholesale Total	**5,732,425**	**6,340,828**	**608,403**	**10.6%**
Grand Total	**29,664,744**	**28,520,007**	**-1,144,737**	**-3.9%**

Lodged claims

Insurance class	2017-18	2018-19	No. (Change)	Percent (Change)
Retail				
Motor	2,073,674	2,082,486	8,812	0.4%
Home	827,785	776,011	-51,774	-6.3%
Personal & domestic property	753,015	883,165	130,150	17.3%
Travel	313,172	294,218	-18,954	-6.1%
Residential strata	58,460	49,482	-8,978	-15.4%
Consumer credit	35,853	37,548	1,695	4.7%
Sickness & accident	32,233	34,334	2,101	6.5%
Retail Total	**4,094,192**	**4,157,244**	**63,052**	**1.5%**
Wholesale				
Motor Wholesale	267,797	288,864	21,067	7.9%
Business Pack	113,484	105,618	-7,866	-6.9%
Business	50,002	35,865	-14,137	-28.3%
Primary Industries Pack	37,881	43,336	5,455	14.4%
Liability	32,672	37,592	4,920	15.1%
Industrial Special Risks	21,506	23,308	1,802	8.4%
Primary Industries	20,812	2,566	-18,246	-87.7%
Other	12,746	8,016	-4,730	-37.1%
Contractors All Risks	8,922	8,498	-424	-4.8%
Wholesale Total	**565,822**	**553,663**	**-12,159**	**-2.1%**
Grand Total	**4,660,014**	**4,710,907**	**50,893**	**1.1%**

Declined claims

Insurance class	2017-18	2018-19	No. (Change)	Percent (Change)
Retail				
Consumer credit	3,237	2,681	-556	-17.2%
Home	59,602	50,433	-9,169	-15.4%
Motor	9,125	9,764	639	7.0%
Personal & domestic property	60,922	79,566	18,644	30.6%
Residential strata	1,398	1,468	70	5.0%
Sickness & accident	1,194	1,153	-41	-3.4%
Travel	28,999	34,657	5,658	19.5%
Retail Total	**164,477**	**179,722**	**15,245**	**9.3%**
Wholesale				
Business	1,168	1,276	108	9.2%
Business Pack	2,012	2,111	99	4.9%
Contractors All Risks	87	60	-27	-31.0%
Industrial Special Risks	354	340	-14	-4.0%
Liability	839	1,175	336	40.0%
Motor Wholesale	190	241	51	26.8%
Other	211	182	-29	-13.7%
Primary Industries	78	22	-56	-71.8%
Primary Industries Pack	598	660	62	10.4%
Wholesale Total	**5,537**	**6,067**	**530**	**9.6%**
Grand Total	**170,014**	**185,789**	**15,775**	**9.3%**

Withdrawn claims

Insurance class	2017-18	2018-19	No. (Change)	Percent (Change)
Retail				
Consumer credit	1,015	923	-92	-9.1%
Home	107,191	113,810	6,619	6.2%
Motor	140,238	157,221	16,983	12.1%
Personal & domestic property	28,760	34,333	5,573	19.4%
Residential strata	1,404	1,914	510	36.3%
Sickness & accident	1,271	1,699	428	33.7%
Travel	18,164	17,291	-873	-4.8%
Retail Total	**298,043**	**327,191**	**29,148**	**9.8%**
Wholesale				
Business	2,195	1,941	-254	-11.6%
Business Pack	4,967	6,204	1,317	26.9%
Contractors All Risks	320	276	-44	-13.8%
Industrial Special Risks	1,017	1,206	195	19.3%
Liability	1,313	2,246	758	50.9%
Motor Wholesale	9,558	11,802	2,251	23.6%
Other	140	224	84	60.0%
Primary Industries	96	135	39	40.6%
Primary Industries Pack	2,128	2,036	-92	-4.3%
Wholesale Total	**21,816**	**26,070**	**4,254**	**19.5%**
Grand Total	**319,859**	**353,261**	**33,402**	**10.4%**

Received internal disputes (stage two)

Insurance class	2017-18	2018-19	No. (Change)	Percent (Change)
Retail				
Motor	12,518	15,054	2,536	20.3%
Home	10,374	10,635	261	2.5%
Travel	3,274	3,450	176	5.4%
Personal & domestic property	2,095	2,632	537	25.6%
Consumer credit	376	330	-46	-12.2%
Residential strata	288	342	54	18.8%
Sickness & accident	262	317	55	21.0%
Retail Total	**29,187**	**32,760**	**3,573**	**12.2%**
Wholesale				
Business Pack	573	588	15	2.6%
Motor Wholesale	362	533	171	47.2%
Business	245	178	-67	-27.3%
Liability	171	221	50	29.2%
Primary Industries Pack	143	122	-21	-14.7%
Other	89	119	30	33.7%
Primary Industries	66	62	-4	-6.1%
Industrial Special Risks	57	53	-4	-7.0%
Contractors All Risks	5	17	12	240.0%
Wholesale Total	**1,711**	**1,893**	**182**	**10.6%**
Total	**30,898**	**34,653**	**3,755**	**12.2%**

Reviewed internal disputes (stage two)

Insurance class	2017-18	2018-19	No. (Change)	Percent (Change)
Retail				
Motor	12,118	15,124	3,006	24.8%
Home	10,291	10,219	-72	-0.7%
Travel	3,275	3,435	160	4.9%
Personal & domestic property	2,089	2,601	512	24.5%
Consumer credit	347	338	-9	-2.6%
Residential strata	278	342	64	23.0%
Sickness & accident	262	312	50	19.1%
Retail Total	**28,660**	**32,371**	**3,711**	**12.9%**
Wholesale				
Business Pack	540	553	13	2.4%
Motor Wholesale	335	507	172	51.3%
Business	228	147	-81	-35.5%
Liability	168	210	42	25.0%
Primary Industries Pack	139	112	-27	-19.4%
Other	64	115	51	79.7%
Primary Industries	59	64	5	8.5%
Industrial Special Risks	49	45	-4	-8.2%
Contractors All Risks	4	14	10	250.0%
Wholesale Total	**1,586**	**1,767**	**181**	**11.4%**
Total	**30,246**	**34,138**	**3,892**	**12.9%**

Appendix 6: Glossary of terms

The following is a list of the key terms used in this report.

Authorised Representative means a person, company or other entity authorised by a **Code subscriber** to provide financial services on its behalf under its Australian Financial Services licence, in accordance with the Corporations Act 2001. An **authorised representative** is a type of **external seller**.

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

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

Code means the 2014 General Insurance Code of Practice.

Code subscriber means an organisation that has adopted the **Code**.

Code Team means the Code Compliance and Monitoring Team at the Australian Financial Complaints Authority (AFCA) (previously the Financial Ombudsman Service Limited (FOS)) appointed as code administrator 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. A **corporate authorised representative** is a type of **external seller**.

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 at 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 **Code** applies.

External seller means a person, company or other entity that sells or offers for sale a **Code subscriber's** general insurance products.

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 Australian Financial Services license (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**.

Contractor means a person, company or other entity engaged by a **Code subscriber** to provide insurance-related services, excluding the distribution of general insurance products.

Industry data means data about:

1. 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 **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 **Code** and comprising **Stage One** and **Stage Two**.

Lodged claim means a **claim** made on a general insurance policy.

Other external seller 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.

Policy means a contract of insurance.

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 & 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 & 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 is described in subsections 10.11, 10.12 and 10.13 of the **Code**.

Stage Two means the second stage of a **Code subscriber's internal complaints process** and is described in subsections 10.14 to 10.19 of the **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 **Code**, whether by name or otherwise, as a person to whom the benefit of the insurance cover provided by the **policy** extends.

Withdrawn claim means a **claim** that 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 **Code** which is not **Retail Insurance**.