General Insurance Code of Practice

Annual Industry Data and Compliance Report 2019-20

March 2021

GENERAL INSURANCE
Code Governance Committee

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Chair's message

I am pleased to present the General Insurance Code Governance Committee's annual industry data and compliance report. The report covers the 2019–20 financial year and the early part of 2020–21 and includes an analysis of trends and service standards in the general insurance industry, with a focus on retail general insurance products and services.

From a Code compliance point of view, subscribers to the General Insurance Code of Practice have been measured against the 2014 Code[1] for the 2019–20 reporting period, with corrective actions aimed at complying with corresponding obligations under the 2020 Code[2], which will supersede the 2014 Code completely on 1 July 2021.

Acknowledging former Committee Chair, Lynelle Briggs AO

My predecessor, Lynelle Briggs AO, was the Chair of the Committee during the 2019–20 period, with her final term as Chair ending in June 2020. Lynelle worked tirelessly during her six years in the role to improve and enforce the understanding of good industry practice, and to strengthen the credibility of the Committee and its compliance monitoring activities. Her work in advocating for general insurers to 'Live the Code' through their culture, leadership and governance is a particular legacy that will guide industry best practice for years to come. I take this opportunity to thank Lynelle for her strong leadership, dedication and commitment to the role of Committee Chair.

Code compliance in a difficult year

2019–20 has been a period like no other. The year started with industry responding to regulatory changes following the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry (the Royal Commission), and preparing to transition to a new Code of Practice. As the year progressed, devastating bushfires and floods hit parts of Australia, and the COVID-19 pandemic caused a global health and economic crisis that continues to affect people's lives and livelihoods.

The Committee acknowledges that general insurers have rarely, if ever, been presented with such operational challenges. The unforeseen events we have witnessed during 2019–20 have put enormous pressure on Code subscribers to manage an influx of claims and customer enquiries while managing their own business continuity issues.

Even so, we remind subscribers that one of the Code's key purposes is to ensure that consumers are treated in a fair, reasonable and ethical manner, particularly when they are experiencing high levels of stress and financial hardship due to loss of income, homelessness, ill health or property damage. In this context, demonstrated compliance with the Code has never been more vital.

Analysis of the data supplied by subscribers for 2019–20 indicates that Code compliance levels are similar to the previous reporting period. The number of self-reported standard Code breaches increased by 5%, while the number of significant breaches reported to the Committee fell by 6%. There was, however, a considerable increase of 42% in the number of breaches identified by the Committee through our investigations work, with notable increases across most sections of the Code. This increase has been driven by a 20% increase in investigations closed by the Committee in 2019–20, as well as an increase in referrals from the Australian Financial Complaints Authority (AFCA) over the same period.

1 https://insurancecode.org.au/resources/2014-general-insurance-code-of-practice/
2 https://insurancecode.org.au/resources/2020-general-insurance-code-of-practice/

Concerningly, non-compliance with the Code's principles-based standards for selling insurance and for claims handling – particularly those that require subscribers to be fair and efficient in their dealings with consumers – continues to be an issue for many subscribers. As was the case in the previous year, most significant breaches during 2019–20 were of the Code's standard on conducting sales processes efficiently, honestly, fairly and transparently, while just over half (51%) of all self-reported standard breaches were of the Code's claims handling standards, many resulting from subscribers failing to meet their claims assessment and notification timeframe obligations.

Even accounting for the year's extraordinary events and their impact on subscribers' operations, it is discouraging to see consistently high breach numbers in areas of the Code where the Committee has previously set expectations and provided guidance for achieving compliance. It is especially disappointing to see the prevalence of significant and standard Code breaches being attributed to systems-related issues, processes and procedures not being followed, and to human error.

Through individual meetings and the publication of our seminal report *Living the Code: Embedding Code obligations in compliance frameworks (Living the Code)*[3], the Committee has engaged extensively with subscribers during the year about their mechanisms for identifying and reporting Code breaches. We have provided an abundance of recommendations for implementing the organisational culture and corporate governance required for robust Code compliance, and we expect all subscribers to take these recommendations on board as a matter of urgency as they transition to the new 2020 Code.

Welcoming the 2020 Code

With parts of the 2020 Code already in force, and the remainder due to follow from 1 July this year, Code subscribers' operations, compliance frameworks and reporting capabilities should already be closely aligned to the obligations of the new Code.

The new Code has been comprehensively updated and rewritten to enhance consumers' understanding of their rights when buying insurance, making a claim or lodging a complaint, and to provide subscribers with greater clarity around their obligations when dealing with consumers. It takes into account most of the Committee's suggested reforms, feedback from consumers, and the recommendations outlined in the final report of the Royal Commission.

Importantly, the new Code provides the Committee with enforceable sanction powers in the event of a Code breach by a subscriber. With the passage of Financial Sector Reform (Hayne Royal Commission Response) Bill 2020, the Australian Securities and Investments Commission (ASIC) will have additional powers to take action on breaches of enforceable provisions of ASIC-approved codes. While the 2020 Code is not currently ASIC-approved, the Committee notes that the Insurance Council of Australia (ICA) has publicly supported the recommendations made by the Royal Commission. These recommendations included that the ICA and ASIC take the steps needed to have enforceable code provisions designated.

Committee priorities for 2020–21

The Committee's workplan priorities for 2020–21 include progressing and completing our plan for transitioning to the 2020 Code and ensuring that our governance arrangements and operational procedures align with the new Code and new Charter.

We are closely monitoring subscribers' compliance with the 2014 Code and the obligations of the new Code that have come into force. This has included checking whether subscribers have published their Family Violence policy on their website. We are also monitoring their compliance with the obligations in parts 9 and 10 of the 2020 Code (Supporting customers experiencing vulnerability, and Financial hardship). Mindful that the impacts of the pandemic are ongoing, and that the industry faces another difficult year, we are continuing to provide guidance and support to Code subscribers as they transition to the new Code, including guidance on our approach to imposing sanctions.

Further work is being carried out on our website and our new data sets pilot program, and we are engaging further with subscribers on identifying, reporting, remediating and preventing significant breaches.

3 https://insurancecode.org.au/resource/living-the-code/

The Committee collects a range of data from Code subscribers on policies, claims, disputes and breaches. This data is provided by class of insurance for each subscriber and is not broken down according to brands. However, it is often the brands in the market that consumers are aware of/identify with, rather than the Code subscribers behind them. The Committee is keen to understand more about the brands subscribers operate under – for example whether there are differences in compliance and consumer outcomes between the brands operated by a subscriber. The Committee will look to obtain further information from subscribers about their different brands, as it attempts to further enhance its data collection and develop a more complete picture of the general insurance industry.

Appreciation

The ICA has continued to make an important contribution to the Code Governance Committee's achievements this year. I would like to thank past ICA Presidents Richard Enthoven and Gary Dransfield, both of whom served during the 2019–20 reporting year, as well as the current President, Sue Houghton, who was appointed to the role in July 2020. Each has provided vital support to the Committee. I am also grateful to Rob Whelan and Andrew Hall, respectively the former and current Executive Director and CEO of the ICA, for their willing engagement this year.

The Code team at AFCA has provided invaluable support and assistance to the Committee and I thank our General Manager, Sally Davis, our Code Compliance and Operations Manager, Elizabeth McNess, her predecessor, Rose-Marie Galea, and the rest of the Code team staff for their dedicated work this year.

And finally, I take this opportunity to express my gratitude to my fellow Committee members, Cheryl Chantry and Philippa Heir, for their expertise and insightful contributions to Committee activities this year, and for their support of me in my first year as Chair.

Veronique Ingram PSM
Independent Chair, General Insurance Code Governance Committee
March 2021

Year at a glance 2019–20

50
CODE SUBSCRIBERS
AS OF 30TH JUNE 2020

43,784,507
TOTAL GENERAL INSURANCE POLICIES SOLD
TO CONSUMERS AND BUSINESSES

SELF-REPORTED BREACHES 5-YEAR TREND

SIGNIFICANT CODE BREACHES

112
SIGNIFICANT BREACHES OF THE CODE
↓DOWN 6% FROM 119 IN 2018–19

COMPLAINTS

41,608
COMPLAINTS RECEIVED BY
SUBSCRIBERS
↑UP 20% FROM 34,653 IN 2018–19

CLAIMS LODGED

4,720,724
CLAIMS LODGED IN 2019-20
↑UP 0.21% FROM 2018–19

DECLINED CLAIMS

231,480
↑25% INCREASE IN DECLINED
INSURANCE CLAIMS FROM 2018–19

4%
↑INCREASE IN
WITHDRAWN CLAIMS
FROM 2018-19

37%
OF ALL POLICIES
SOLD COMPRISED OF
MOTOR INSURANCE

16%
OF TRAVEL
INSURANCE CLAIMS
DECLINED

Introduction

This report presents an overview of the general insurance industry's compliance with the 2014 General Insurance Code of Practice (the Code) during the period 1 July 2019 to 30 June 2020 (2019–20). The report is based on data provided to the General Insurance Code Governance Committee (the Committee) by Code subscribers.
This report aims to inform all stakeholders including subscribers, consumer organisations, consumers, dispute resolution providers, regulators and policy makers about subscribers' compliance with the Code.

The Code

The Code was developed by the Insurance Council of Australia (ICA) and took effect on 1 July 2015. The Code replaced earlier versions that were first introduced in 1994. The Code commits subscribers to high standards of services to promote better and more informed relationships between insurers and their customers. The Code provides for independent monitoring and enforcement by the Committee which is constituted through the Code Governance Committee Association Inc. The Code Compliance and Monitoring team (Code team) at the Australian Financial Complaints Authority (AFCA) acts as secretariat and administrator for the Committee.

The entire Code extends to retail insurance products bought by consumers and small businesses[4]. The Code defines retail insurance as a type 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: motor, home building, home contents, sickness & accident, consumer credit insurance, travel insurance, pet insurance and personal & domestic property insurance.[5] Only some sections of the Code apply to wholesale insurance products: section 1 – Introduction, section 2 – Objectives, section 3 – Application, section 5 – Standards for our employees and authorised representatives, section 8 – Financial hardship, section 11 – Information and education, section 12 – Code governance, section 13 – Monitoring, enforcement and sanctions, section 14 – Access to information, and section 15 – Definitions.[6]

Throughout this report a reference to 'consumer/s' means a consumer, small business or third party beneficiary that has bought a retail insurance product, as defined by the Code.

> *"The Code commits subscribers to high standards of services to promote better and more informed relationships between insurers and their customers."*

4 The Code defines 'small business' as *"... 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"*.

5 See section 15 of the Code for the full definition of 'retail insurance'.

6 See section 3.7 of the Code.

About this report

Under the Code and its Charter[7], the Committee is required each year to collect and report on aggregated industry data and provide a consolidated analysis of compliance with the Code. The Code and the Charter also require the Committee to prepare an annual report that provides an overview of its monitoring and enforcement activities, recommendations for Code improvements, and to confirm the Committee's compliance with the Charter.[8]

The report is based on data provided by 49 General Insurance Code subscribers and 132 Lloyd's Coverholders and Claims administrators, using a questionnaire that was developed through stakeholder consultation. It includes, for both direct and group channels: the volumes and types of cover in force; the volume of claims lodged, declined and withdrawn; the main reasons claims were declined or withdrawn by type of cover; the number, type and resolution of disputes by type of cover; the number of Code breaches by Code section; and, the corrective action taken. The questionnaire also includes information about activities subscribers have undertaken to improve their ability to comply with the Code, as well as information about the subscribers' workforce and training. This contextual information is complemented with data on subscribers' compliance with the Code sourced from the Committee's compliance monitoring work.

> *"Reliable, accurate and instructive data is vital for providing a measure of how the general insurance industry is complying with the Code."*

Data – now and into the future

Reliable, accurate and instructive data is vital for providing a measure of how the general insurance industry is complying with the Code. As part of our annual data collection this year, we asked subscribers three questions related to the quality and accuracy of their data and their Code compliance capabilities. All subscribers reported that they had a 'three lines of defence' model, had the capacity to comply with the Code and were satisfied that their data was accurate.

However, the Committee notes that some Code subscribers continue to report high numbers of breaches and significant breaches that are caused by processes and procedures not being followed. The Committee is concerned that this indicates that some subscribers may not have the capacity to comply with all areas of the Code.

Throughout the year, the Committee worked with subscribers to expand its industry data collection framework with the aim of gaining a deeper understanding of where the industry is doing well, where improvements are needed, and areas of emerging risk and poor practice. The new data sets include:

- value of premiums collected
- value of claims paid
- value of partially accepted claims, including reasons for partial payment
- the number of customers impacted by breaches and their financial impact.

The data in this report is presented on a de-identified basis in line with clause 11.2 of the Code Governance Committee Charter. The Committee invites feedback from report users about the types of data it has collected and reported and what information is most useful to stakeholders.

7 https://insurancecode.org.au/app/uploads/2019/08/The-Code-Governance-Committee-Charter.pdf

8 Code Governance Committee Charter, clause 9.

Recommendations

In advance of the full 2020 Code commencing on 1 July 2021, the Committee's overarching recommendation is that subscribers ensure that their people, policies, processes, systems and governance arrangements are in place and sufficiently tested to ensure compliance with the full 2020 Code from 1 July 2021.

The Committee makes 6 recommendations throughout this report for subscribers to adopt to improve their compliance with the Code, and to enhance their monitoring and reporting processes.

RECOMMENDATIONS

- ☑ Subscribers should ensure that paragraph 21 of the 2020 Code, which requires distributors and service suppliers to act honestly, efficiently, fairly and transparently, is interpreted and applied broadly when selling general insurance products to consumers.
- ☑ Subscribers should test sales processes and address any problematic areas – including the competency of their sales staff and the operation of their pricing systems.
- ☑ Subscribers should review and address the root causes for significant breaches relating to claims handling timeframes in subsections 7.9, 7.10, 7.14 and 7.16.
- ☑ Subscribers should review the recommendations in Living the Code to ensure that the causes of Code breaches are better understood, and appropriate preventative action is undertaken.
- ☑ Subscribers must have appropriate claims handling systems and processes in place. To meet consumers needs, claims staff must have the knowledge and expertise to make claims decisions within the Code's timeframes.
- ☑ Training on the processes and procedures relating to the sale of insurance should have a focus subscriber obligations under both the Code and the law.

General insurance business

Subscribers

As set out in subsection 3.4 of the Code, the Code applies to all industry participants who have adopted it, and it extends to their product distributors and service suppliers. Members of the ICA, any other general insurers, and such other entities as are approved by the ICA, may adopt the Code. Each subscriber enters into a deed of adoption with the ICA and the Code Governance Committee Association Inc.

As of the 30th June 2020, there were 182 entities bound by the Code, consisting of:

- 50 Code subscribers (49 subscribers provided data for the annual report)
- 132 Coverholders and nine Claims administrators bound by the Code through Lloyd's Deed of Adoption and individual binder agreements with Lloyd's Australia Limited for the sale of insurance and/or the handling of claims (all Coverholders and claims administrators provided data for the annual report).

The 50 Code subscribers comprised:

- 46 general insurers – companies that issue general insurance cover to consumers usually through direct or group channels
- four other industry participants – entities that operate in the general insurance industry by providing services which include selling insurance and/or handling claims, that have elected to sign up to the Code.

General insurers range from large insurance companies that offer products in a range of different insurance classes (for example, home; motor; sickness & accident) to smaller specialist insurers who may only offer one specific type of insurance cover (for example, travel insurance; pet insurance).

Of the 50 Code subscribers, 46 (92%) are members of the ICA.

A full list of Code subscribers is in Appendix 1; Lloyd's Coverholders and Claims administrators are listed in Appendix 1(a).

Workforce

Data provided by subscribers indicated that the number of people working directly for subscribers or providing services to subscribers grew by 21% in 2019–20 to 118,089 people[9]. Employees of Code subscribers and related entities accounted for just under half (49%) of the overall general insurance workforce reported by subscribers. The remaining 51% comprised people who work in one of the following categories:

- individual Authorised Representatives
- corporate Authorised Representatives
- other external sellers and contractors
- service suppliers.

As a result of the COVID-19 pandemic, some subscribers experienced disruptions in the make-up of their workforce. Some reductions in their workforce were due to redundancies but, in other cases, offshore processing and call centres were brought back to Australia, leading to additional employment and some workforce re-training across these areas.

9 Source: Code Governance Committee annual general insurance Code subscriber data collection, 2019-20

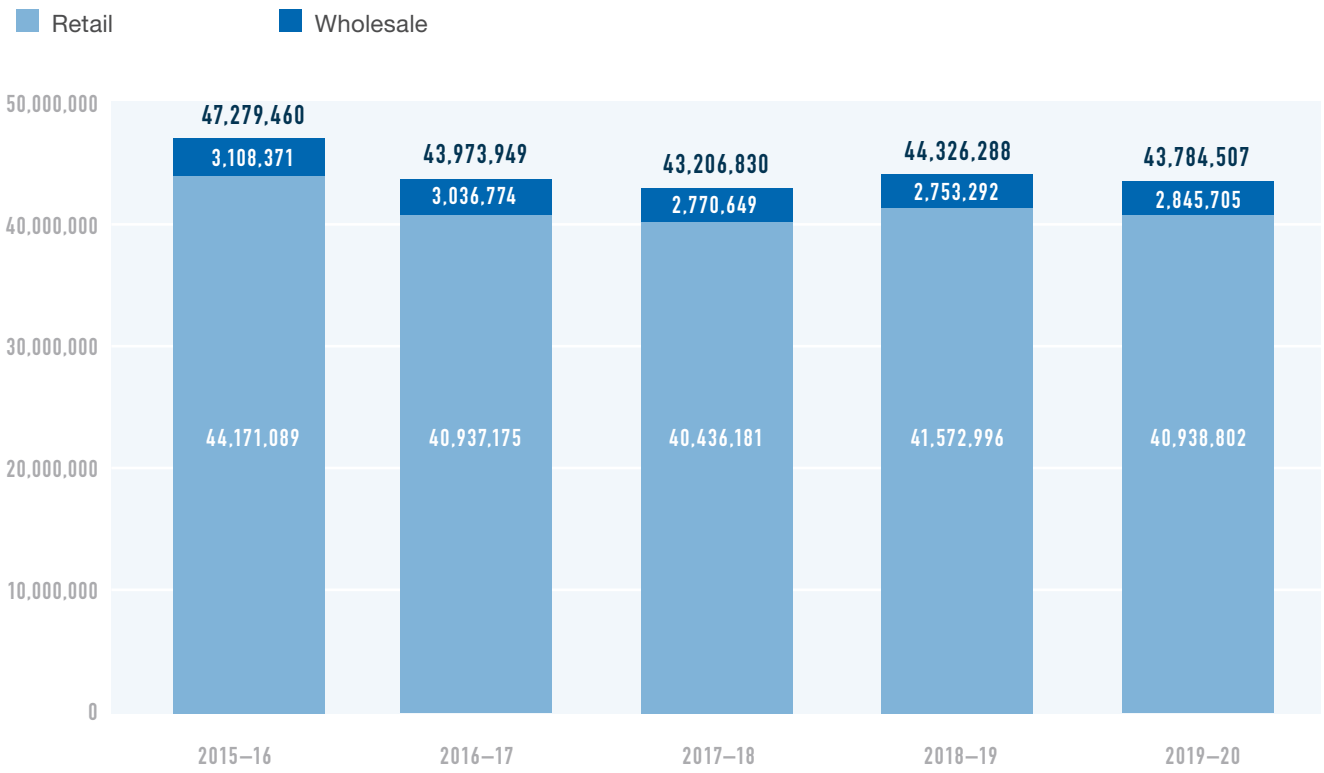
Policies

In 2019–20, Code subscribers reported to the Committee that they sold 43,784,507 general insurance policies to consumers and businesses, comprising 40,938,802 retail policies and 2,845,705 wholesale policies.

Retail motor insurance accounted for 37% of all policies sold and retail home insurance (encompassing home building cover, home contents cover, and combined home building & contents cover) made up 26% of all policies sold, making these the most dominant types of cover bought by consumers in 2019–20. Personal & domestic property cover was the next largest type of retail insurance sold and made up 19% of all policies sold - this category covers a wide range of products including accidental damage cover, extended warranty, guaranteed asset protection insurance, and pet insurance.

Travel insurance was the fourth largest type of insurance sold to consumers in the year, totalling 11% of all polices sold in 2019–20. While COVID-19 impacted all classes of general insurance in 2019–20, travel insurance was particularly affected. See 'Focus on travel insurance' for a detailed review of the claims, complaints and issues related to travel insurance during the year.

FIGURE 1: TOTAL POLICIES SOLD – FIVE-YEAR TREND



Source: Code Governance Committee annual general insurance Code subscriber data collection, 2015-16, 2016-17, 2017-18, 2018-19 & 2019-20

FIGURE 2: POLICIES SOLD 1 JULY 2019 TO 30 JUNE 2020

Insurance class	Total policies	% of all policies sold
Retail	**40,938,802**	**94%**
Wholesale	**2,845,705**	**6%**
Total	43,784,507	100%
Retail		
Motor retail	16,082,095	37%
Home	11,188,464	26%
Personal & domestic property	8,110,930	19%
Travel	4,723,561	11%
Consumer credit	347,056	<1%
Sickness & accident	253,318	<1%
Residential strata	233,378	<1%
Retail total	**40,938,802**	**94%**
Wholesale		
Business pack	1,191,348	3%
Liability	613,020	1%
Motor wholesale	288,167	1%
Primary industries pack	286,785	1%
Other	177,411	<1%
Business	166,309	<1%
Industrial special risks	57,534	<1%
Contractors all risks	38,991	<1%
Primary industries	26,140	<1%
Wholesale total	**2,845,705**	**6%**

Source: Code Governance Committee annual general insurance Code subscriber data collection, 2019-20

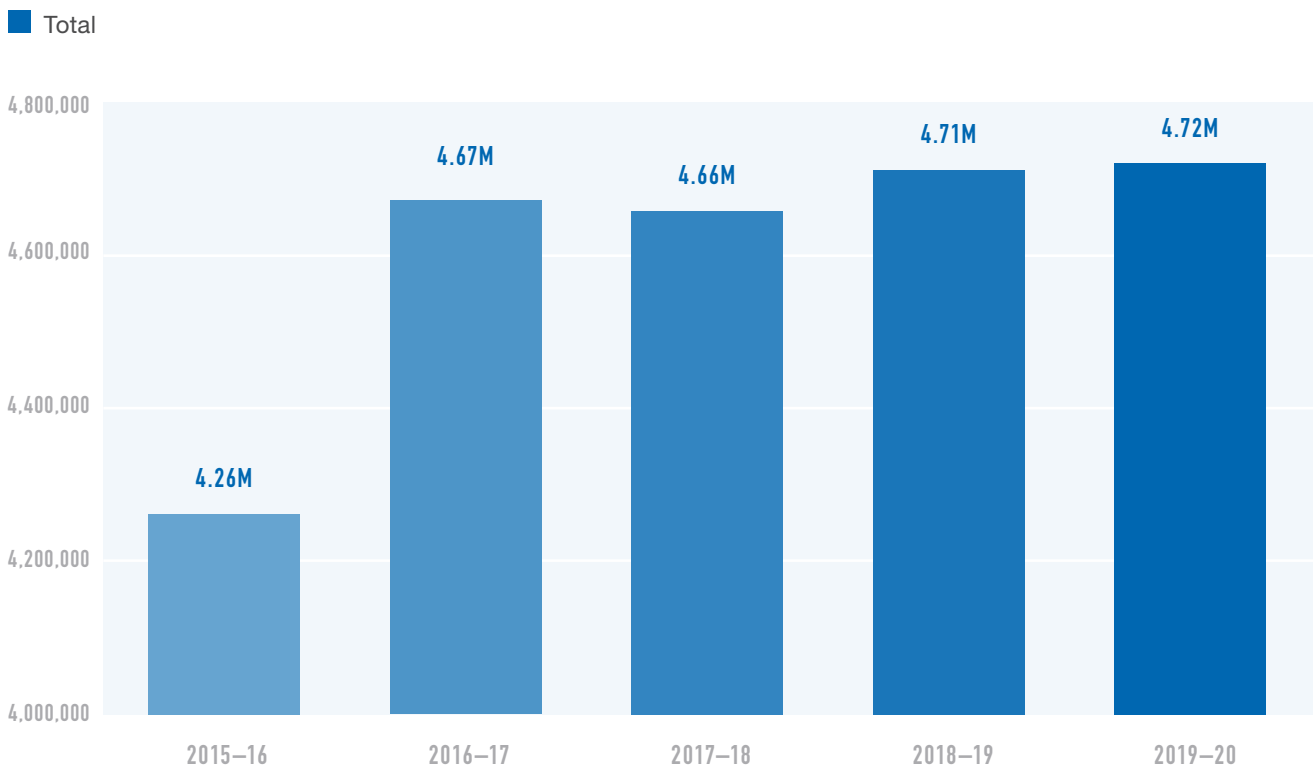
Claims

Consumers take out insurance policies for peace of mind that they will be protected when something goes wrong. It is critical that general insurers process claims in an honest, fair, transparent and timely manner. It is a concern that claim-related issues account for the majority of Code breaches subscribers report and are also the main cause of significant breaches they report.

Lodged claims

Subscribers reported that consumers and businesses lodged a total of 4,720,724 general insurance claims with Code subscribers during the year, of which 4,214,939 were retail insurance claims made by consumers. COVID-19 emerged as a consistent theme across claims in 2019–20. Subscribers noted that lockdowns and work-from-home arrangements resulted in fewer people driving, which in turn led to fewer motor insurance claims being lodged. In contrast, subscribers have reported an increase in claims for travel insurance as well as for consumer credit insurance.

FIGURE 3: INSURANCE CLAIMS LODGED IN THE PAST FIVE YEARS

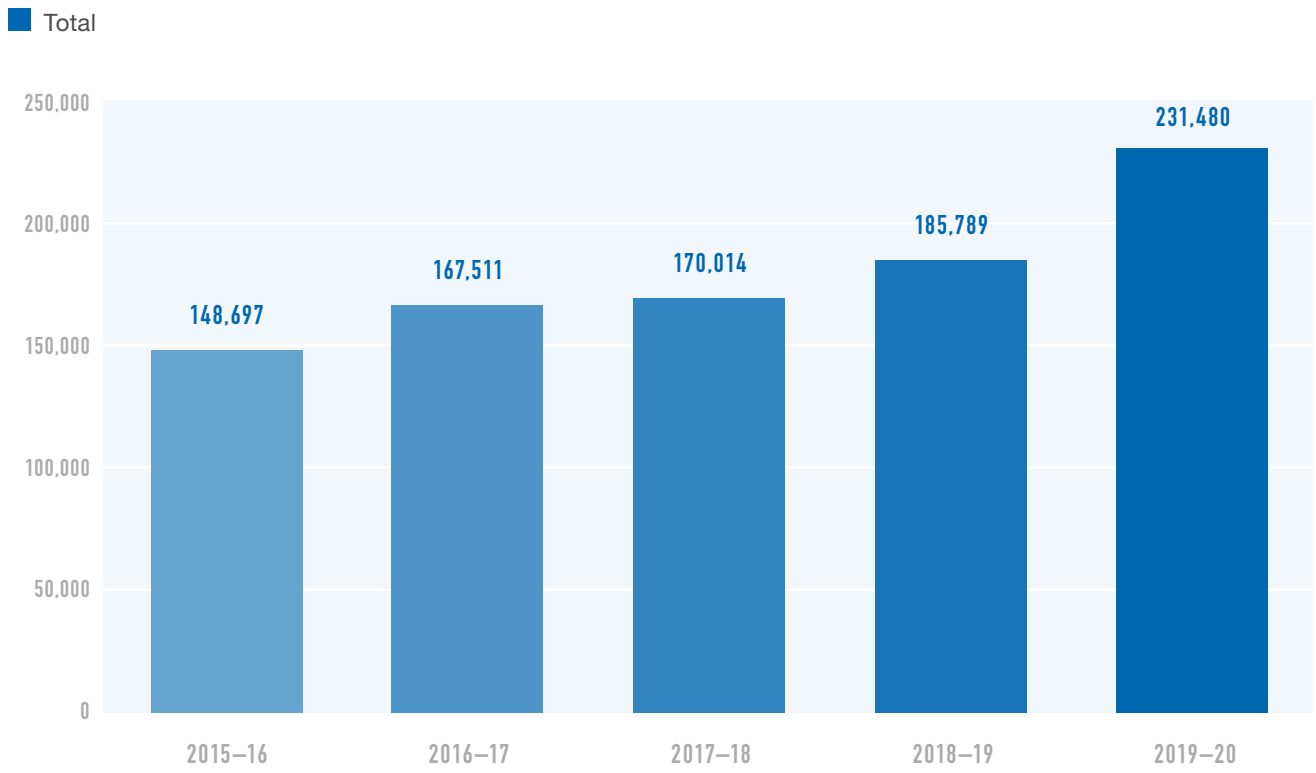


Source: Code Governance Committee annual general insurance Code subscriber data collection, 2015-16, 2016-17, 2017-18, 2018-19 & 2019-20

Declined claims

Code subscribers reported that they declined to accept 231,480 claims in 2019–20. The substantial majority of these were retail claims (225,638), while wholesale claims accounted for the remainder (5,842). The Committee will continue to monitor declined claims to better understand the reasons they were declined and the subscribers' responses in line with Code obligations.

FIGURE 4: INSURANCE CLAIMS DECLINED IN THE PAST FIVE YEARS

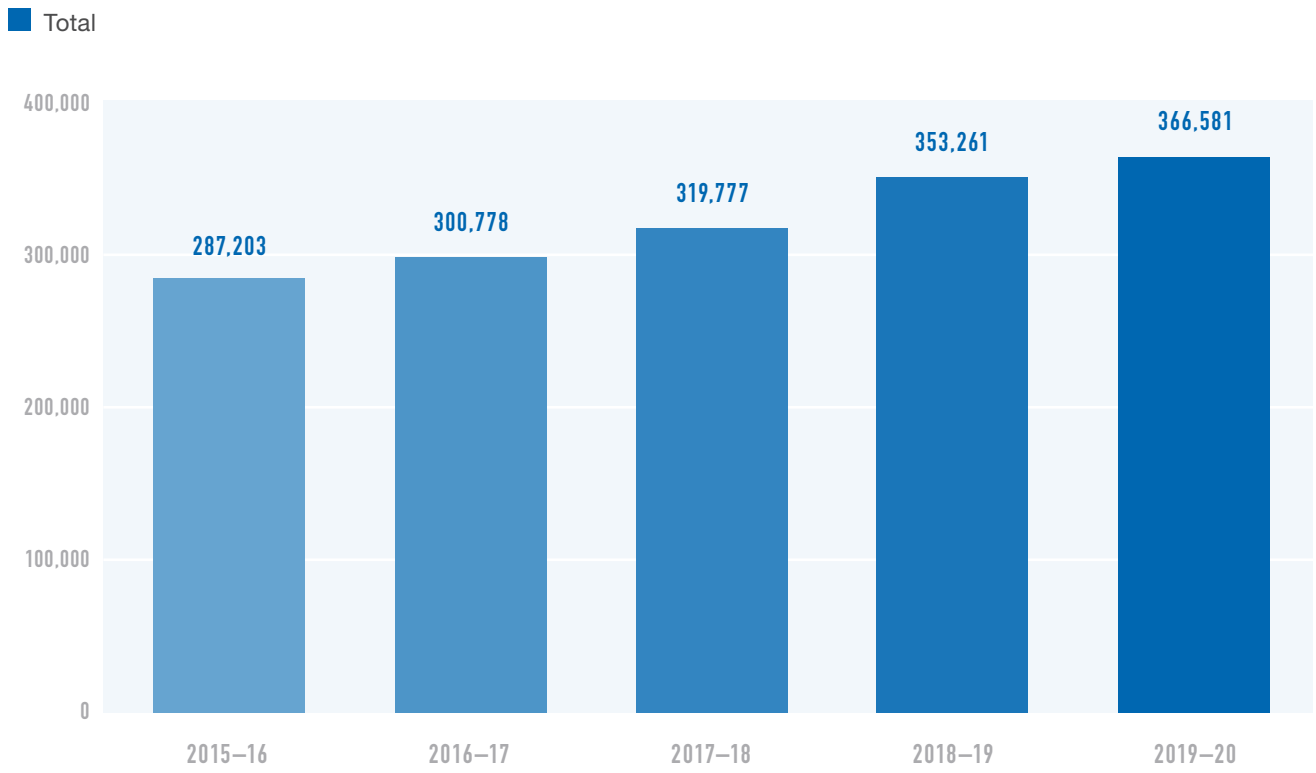


Source: Code Governance Committee annual general insurance Code subscriber data collection, 2015-16, 2016-17, 2017-18, 2018-19 & 2019-20

Withdrawn claims

Subscribers reported that the number of claims withdrawn by consumers or businesses during the year totalled 366,581. Most of these withdrawn claims (337,938 or 92%) were retail general insurance claims. Subscribers pointed to the introduction of JobKeeper by the Federal Government as one of the reasons for an increase in the number of withdrawn income protection claims related to consumer credit insurance.

FIGURE 5: INSURANCE CLAIMS WITHDRAWN IN THE PAST FIVE YEARS



Source: Code Governance Committee annual general insurance Code subscriber data collection, 2015-16, 2016-17, 2017-18, 2018-19 & 2019-20

Complaints

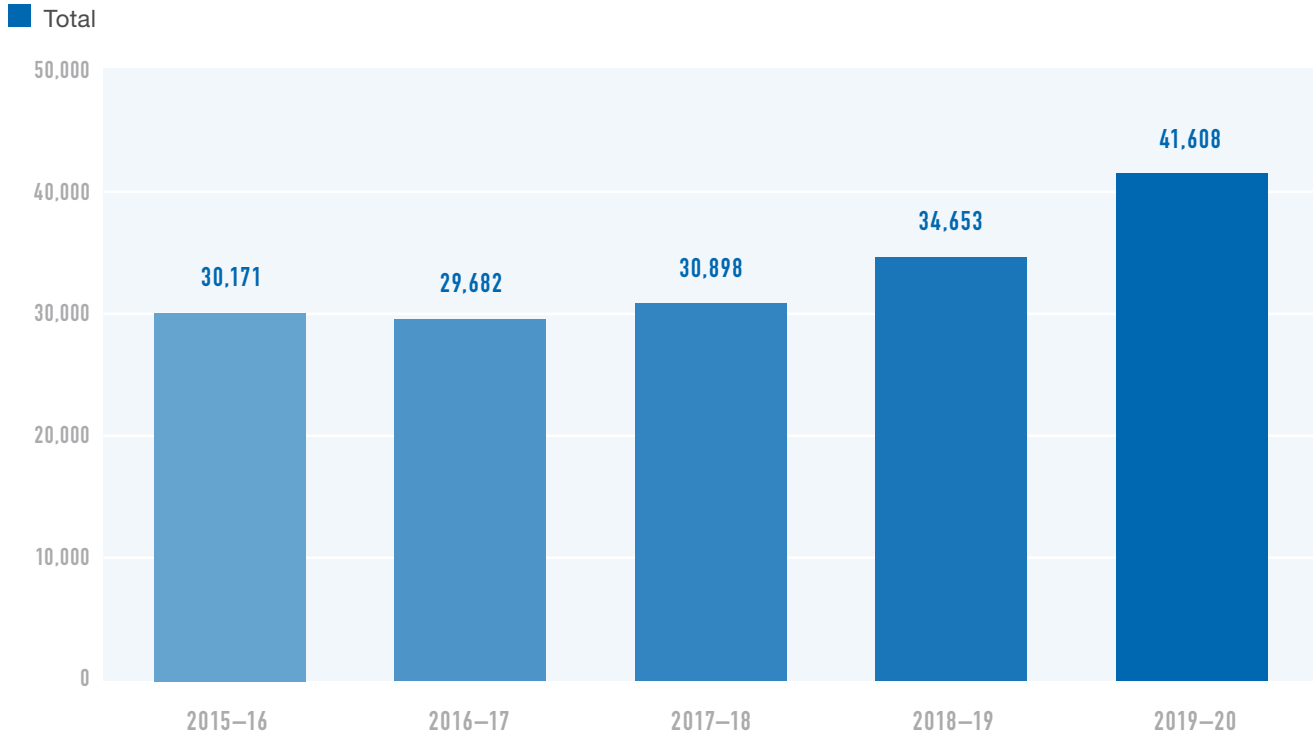
Complaints are an important indicator of subscribers' ability to comply with the Code and meet its objectives. Understanding the reasons for an expression of dissatisfaction provides subscribers with important insights into their products, compliance frameworks and organisational approach. The Committee will continue to monitor complaints to better understand the reasons behind the complaints as well as subscribers' responses.

The Code sets out a two-stage internal complaints process, with an overall timeframe of 45 calendar days.[10] Stage One allows subscribers up to 15 business days to resolve a complaint before a consumer can take it to the Stage Two process. If a consumer is unhappy with a Code subscriber's decision at the end of the Stage Two process, they have a right to refer their unresolved complaint to AFCA for external dispute resolution (EDR). Code subscribers must inform consumers of this right during and at the end of the internal complaints process. The complaints data collected by the Committee relates to Stage Two complaints.

Complaints received by subscribers

Subscribers reported that the number of complaints they received from consumers jumped 20% this year, from 34,653 (2018–19) to 41,608 (2019–20). Complaints about retail insurance accounted for 39,509 of all complaints, with the balance (2,099) related to wholesale insurance products. Home, retail motor and travel insurance accounted for the majority of complaints, followed by personal & domestic property and residential strata insurance. Subscribers reported that the complaints were largely due to catastrophe claims (bushfires and hail events), policy exclusions around COVID-19 for travel insurance claims and supply chain issues (such as assessor access, materials delays or builders experiencing delays) due to travel restrictions implemented by the various state governments.

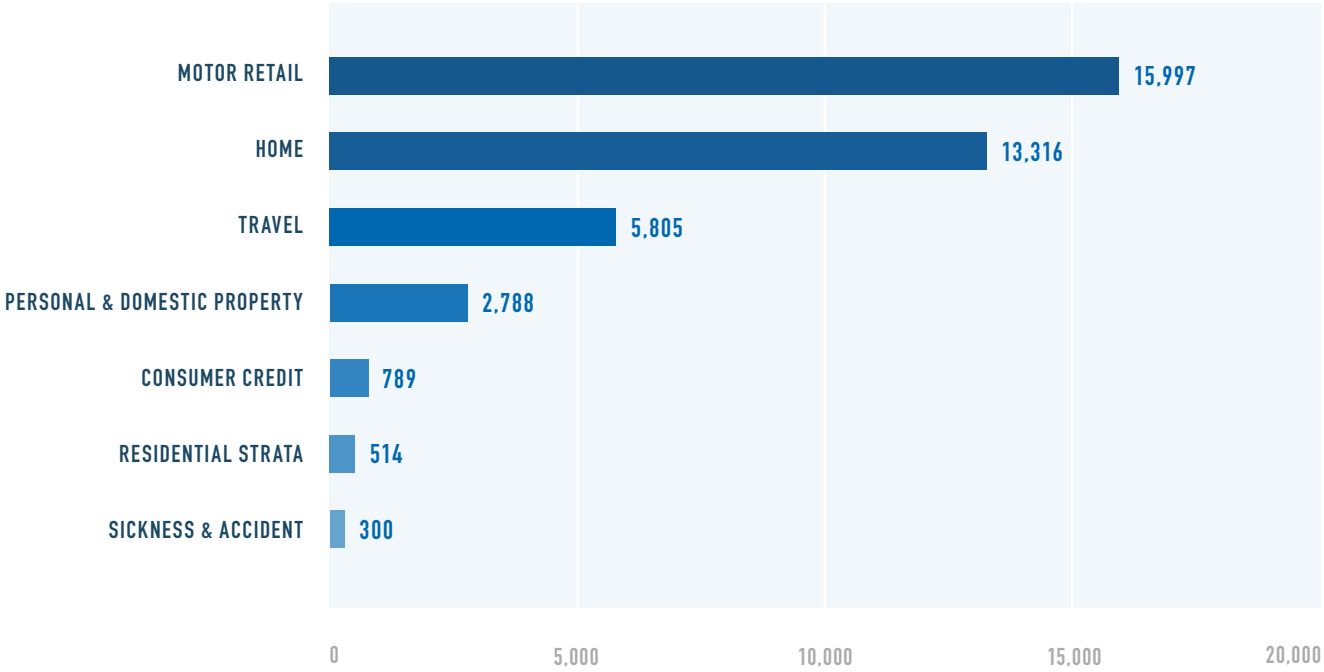
FIGURE 6: INTERNAL COMPLAINTS RECEIVED (STAGE TWO) IN THE PAST FIVE YEARS



Source: Code Governance Committee annual general insurance Code subscriber data collection, 2015-16, 2016-17, 2017-18, 2018-19 & 2019-20

10 See section 10 of the Code.

FIGURE 7: COMPLAINTS BY RETAIL INSURANCE PRODUCT 2019–20



Source: Code Governance Committee annual general insurance Code subscriber data collection, 2015-16, 2016-17, 2017-18, 2018-19 & 2019-20

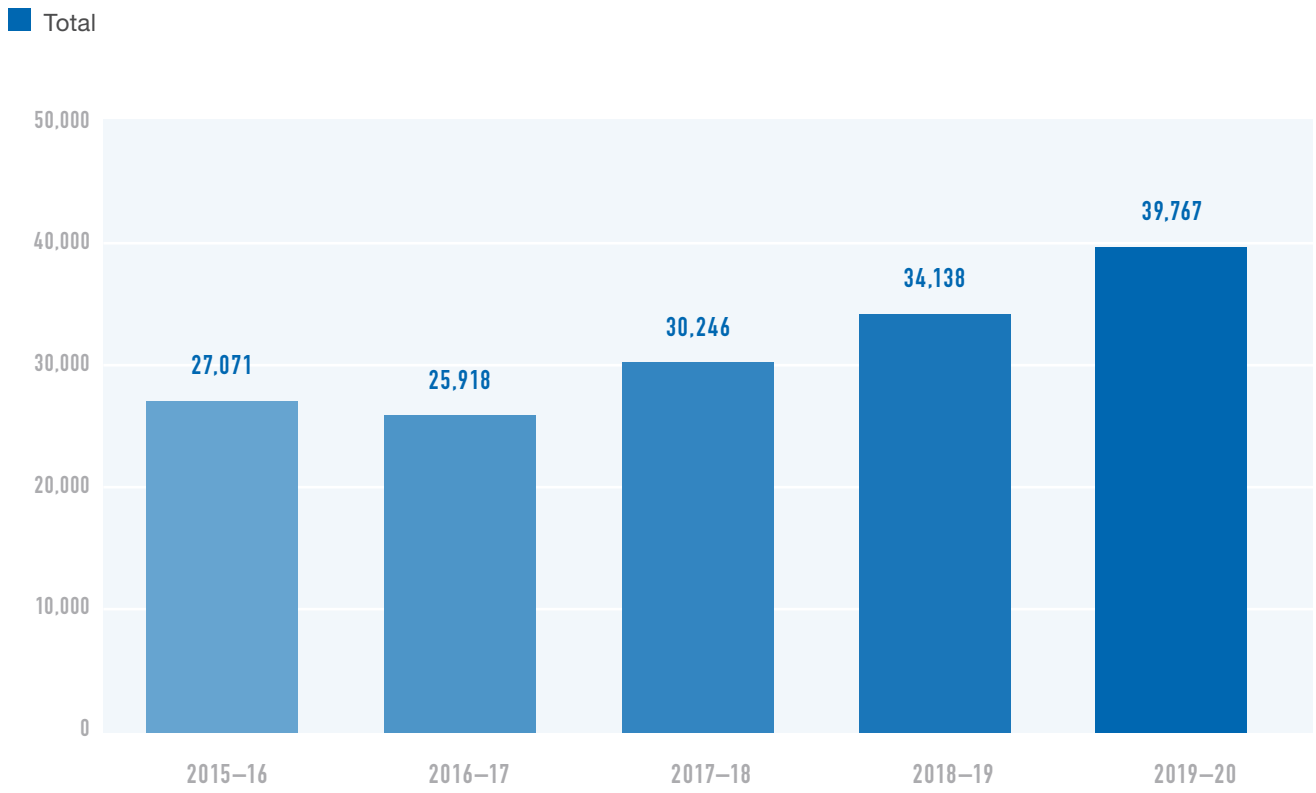
Complaints finalised by subscribers

Subscribers reported that 39,767 complaints were finalised in the year.

Finalised complaints found in favour of subscribers totalled 24,168, while those found in favour of consumers made up the remaining 15,599.

Finalised complaints relating just to retail insurance accounted for 37,800 of all finalised complaints in the year. Of these, 22,709 were found in subscribers' favour and the remaining 15,091, or 40%, in favour of the consumers.

FIGURE 8: COMPLAINTS FINALISED (STAGE TWO) IN THE PAST FIVE YEARS



Source: Code Governance Committee annual general insurance Code subscriber data collection, 2015-16, 2016-17, 2017-18, 2018-19 & 2019-20

As noted above, if consumers are unhappy with a subscriber's final decision about a complaint, they may refer their complaint to AFCA. AFCA provides consumers with fair, free and independent dispute resolution for financial complaints, including complaints about general insurance products.[11]

In 2019–20, AFCA received 19,103 general insurance complaints from consumers[12] mostly involving:

- motor insurance products – 5,293 complaints
- home insurance products – 4,562 complaints
- travel insurance products – 3,168 complaints.[13]

The most common issues consumers complained to AFCA about were:

- a decision to decline a claim – 5,369 complaints[14]
- a delay in claim handling – 3,521
- the amount paid under a claim – 3,171 complaints.

AFCA closed 17,564 general insurance complaints in 2019–20, with 70% of these resolved by agreement, or in favour of complainants.

11 AFCA determines whether a complaint it has received is within the scope of its Rules.

12 AFCA Annual Review 2019–20 – 'General insurance complaints – Between 1 July 2019 and 30 June 2020', pages 34 to 37.

13 We have combined the AFCA data for Home and Motor complaints – see 'Top five general insurance complaints received by product', p. 34, AFCA Annual Review 2019–20.

14 We have combined the AFCA data for 'Denial of claim – exclusion/condition' and 'Denial of claim' products – see 'Top five general insurance complaints received by issue', p. 34, AFCA Annual Review 2019–20.

Code compliance

Breaches

Subscribers reported 32,870 breaches of the Code in 2019–20 and a further 112 significant breaches of the Code. The Committee has sought to address its breach reporting concerns with subscribers and promote strong and robust internal breach reporting mechanisms through increased guidance and engagement. This has included individual subscriber meetings, quarterly meetings with the ICA's National Code Committee (NCC)[15] and the publication in June 2020 of *Living the Code: Embedding Code obligations in compliance frameworks (Living the Code)*[16].

Almost two-thirds (63%) of all breaches were attributed to just five subscribers:

- Subscriber P reported 8,004 breaches and 11 significant breaches
- Subscriber X1 reported 4,992 breaches and eight significant breaches
- Subscriber I1 reported 2,911 breaches and nine significant breaches
- Subscriber W reported 2,826 breaches and five significant breaches
- Subscriber O1 reported 2,009 breaches and 10 significant breaches.

Although Subscriber P reported fewer breaches this year than it did in 2018–19, it was still responsible for almost one-quarter of all the breaches reported in 2019–20. Subscriber P has indicated that it has improved its monitoring activities, which include checks for legislative, regulatory and Code requirements, as well as enhancing its internal procedures and conduct. Subscriber P has stated that it is committed to achieving positive customer outcomes while maintaining compliance with the Code.

Some Code subscribers advised the Committee that their response to the disruption caused by Covid-19 included the use of subsection 7.21 which provides for timeframes not being met under specific circumstances. While this does not require Subscribers to record a breach of the Code, the Committee advised subscribers to document their processes and be able to explain and demonstrate that their conduct and timelines were reasonable in all the circumstances.

FIGURE 9: BREACHES AND SIGNIFICANT BREACHES BY MARKET SHARE

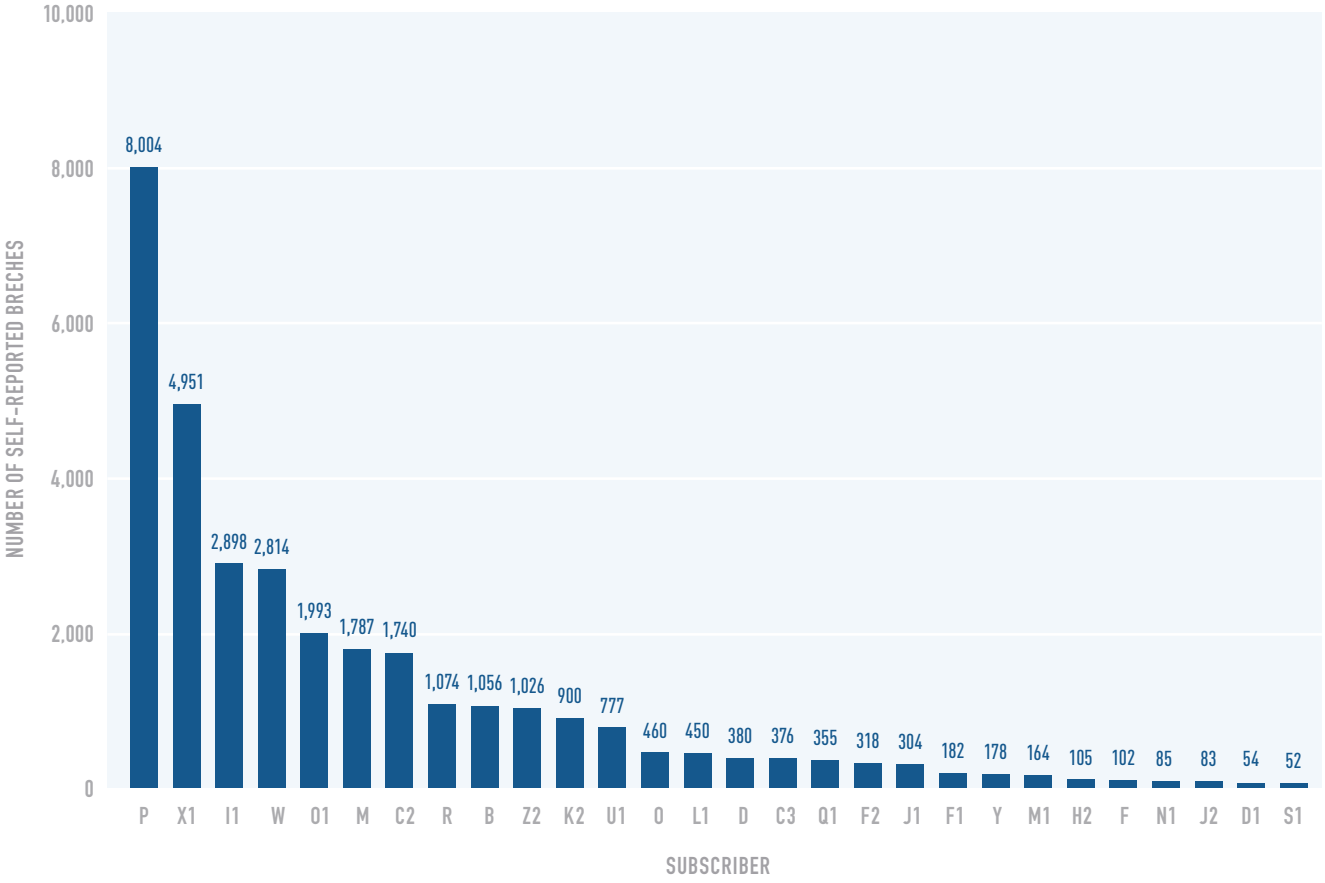
Subscriber	Self-Reported breaches total	Self-Reported Breaches per 10,000 policies	% of total breaches	Significant Breaches	% of total significant breaches
Subscriber P	8,004	10.54	24%	11	10%
Subscriber X1	4,951	7.18	15%	8	7%
Subscriber I1	2,898	29.34	9%	9	8%
Subscriber W	2,814	4.96	9%	5	4%
Subscriber O1	1,993	9.48	6%	10	9%

Source: Code Governance Committee annual general insurance Code subscriber data collection, 2019-20; KPMG *General Insurance Industry Review 2020*

15 The NCC is an industry advisory Committee to the ICA comprised of representatives from ICA member companies that provides the industry's perspective and recommendations to the ICA on Code matters.

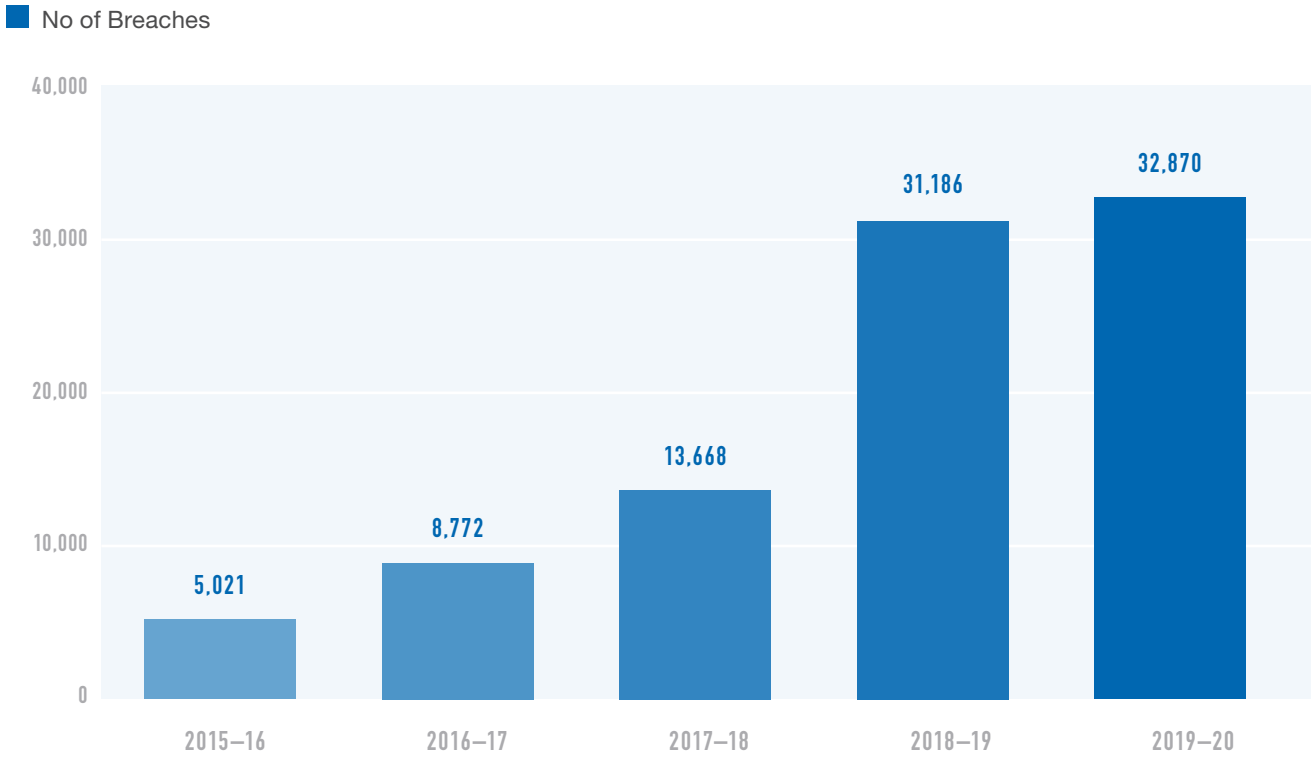
16 https://insurancecode.org.au/resource/living-the-code/

FIGURE 10: SELF-REPORTED BREACHES 2019–20 BY SUBSCRIBER



Source: Code Governance Committee annual general insurance Code subscriber data collection, 2019-20

FIGURE 11: BREACHES REPORTED BY SUBSCRIBERS IN THE PAST FIVE YEARS



Source: Code Governance Committee annual general insurance Code subscriber data collection, 2015-16, 2016-17, 2017-18, 2018-19 & 2019-20

Significant breaches

Subscribers must self-report significant breaches to the Committee. Significant breaches can have a considerable consumer impact – many significant breaches affect multiple consumers and can involve direct financial detriment or cause delays in handling consumers' claims or complaints. Significant breaches are an important warning sign for subscribers as they tend to flag systemic problems that need to be addressed.

Code subscribers self-reported 112 significant breaches during 2019–20. As stated in the previous year's *Annual Report: General Insurance in Australia 2018–19 and current insights (Annual Report 2018–19)*,[17] high levels of significant breach reporting may indicate that subscribers are paying closer attention to their compliance obligations.

Subscribers informed us that the significant breaches affected around 1.9 million consumers and involved remediation payments of more than $157 million.

DEFINITION OF A SIGNIFICANT BREACH

A significant breach is defined under section 15 of the Code as:

… a breach that is determined to be significant by reference to:

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

A breach does not need to meet all five criteria in the definition to be considered significant; if it meets only one of the criteria, it counts as a significant breach.

Subscribers have an obligation to report significant breaches to the Committee within 10 business days, as per subsection 13.3 of the Code:

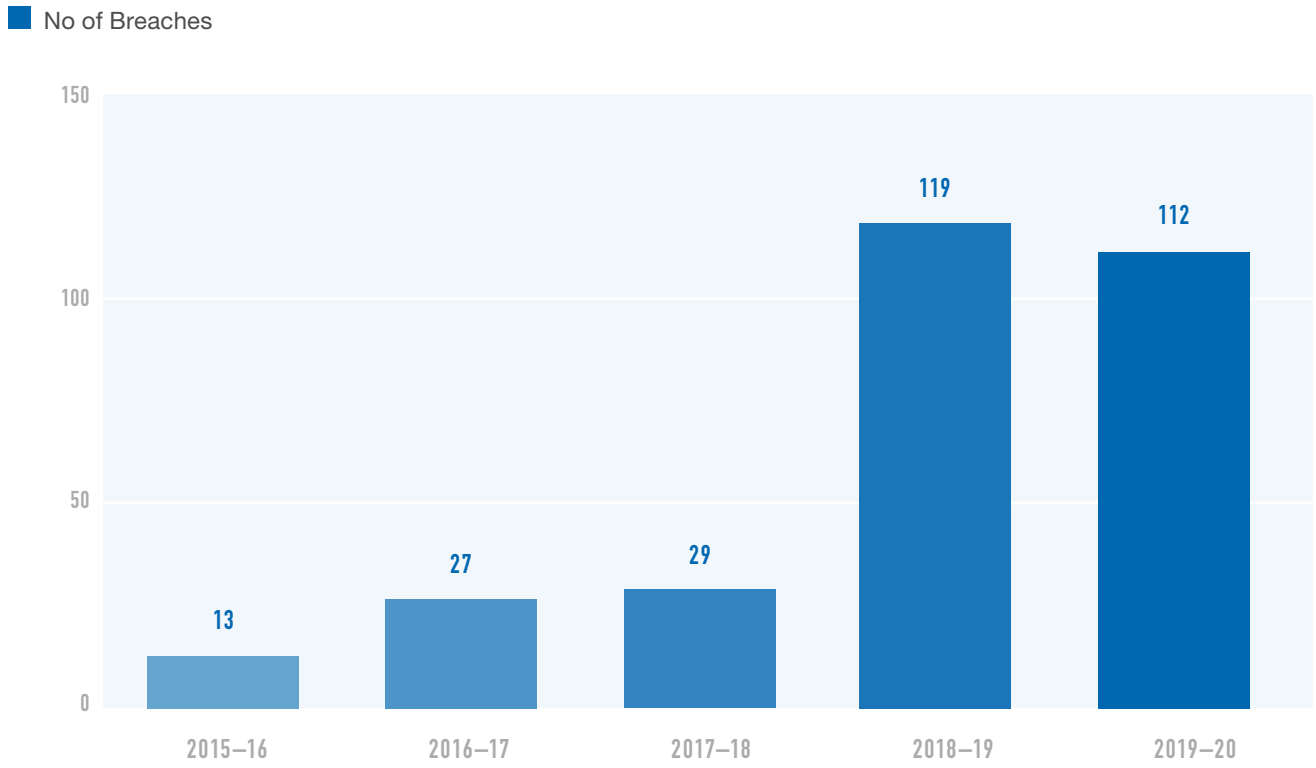
13.3 If we identify a Significant Breach of this Code, we will report it to the CGC within ten business days.

Subsection 4.4 of the Code continues to elicit the highest number of significant breaches. This subsection requires Code subscribers to conduct their sales processes in an efficient, honest, fair and transparent manner. During the year, there were 37 individual significant breaches of subsection 4.4 reported by subscribers, which affected more than 1.4 million consumers and resulted in remediation of more than $155 million. Significant breaches of this subsection accounted for one-third of all significant breach files opened by the Committee in 2019–20.

Forty-one of the 112 significant breaches related to the Code's claims handling standards (section 7). These 41 significant breaches affected 397,000 consumers and required remediation payments of more than $2 million. Most of these were due to subscribers breaching the Code's claims management timeframe obligations. Subscribers reported that these delays were due to the COVID-19 pandemic which saw a large influx of customer claims and enquiries in the area of travel insurance. Subscribers also pointed to the operational challenges associated with transitioning workforces to remote working arrangements and moving the responsibility for some processes from offshore offices to Australian-based offices.

17 Annual Report 2018–19

FIGURE 12: SIGNIFICANT BREACHES REPORTED BY SUBSCRIBERS IN THE PAST 5 YEARS



Source: Significant breaches reported to the Code Governance Committee, 2015-16, 2016-17, 2017-18, 2018-19 & 2019-20

The Committee is not surprised by the trend towards higher numbers of self-reported significant breaches in recent years. The uptick is likely to have been prompted by the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry (the Royal Commission)[18] and the Committee's work to sharpen subscribers' attention to compliance following its own motion inquiry into the adequacy of subscribers' compliance frameworks.

Having established through an own motion inquiry that Code breaches were being significantly underreported, the Committee has focused much of its attention over the past two years on preparing and providing resources to help subscribers better understand their Code compliance obligations and to identify breaches and significant breaches.

These resources include *Living the Code* which includes five specific recommendations for improving the way breaches and significant breaches are identified, reported, reviewed and analysed.[19] In addition to this, in June 2020 the Committee released *Guidance Note No. 2 Significant breach obligations*[20]. This sets out the Committee's expectations of subscribers when reporting significant breaches, including how to appropriately review all breaches and to correctly determine whether they should be classified as significant.

Some Code subscribers have told us that they have responded to this guidance by sharpening their focus on identifying, reporting and analysing breaches and significant breaches of the Code. The resulting breach and significant breach numbers reported are a more accurate reflection of what the Committee would expect to see, given the size and complexity of the Australian general insurance industry.

The Committee anticipates that significant breach reporting will remain high, if not increase, in the future. Indeed, for the first four months of the 2020–21 reporting year, there were 25 significant breach matters reported by 11 different subscribers, involving 53 individual significant breaches of the Code.[21]

18 The Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry was established on 14 December 2017. The Commissioner, the Honourable Kenneth Hayne AC QC, submitted his Final Report to the Governor-General on 1 February 2019 and the report was tabled in Parliament on 4 February 2019.

19 Living the Code: Embedding Code obligations in compliance frameworks, June 2020, p. 8.

20 Guidance Note No. 2 Significant breach obligations, June 2020.

21 For the period 1 July to 31 October 2020.

Significant breaches by Code section

Almost 93% of all the significant breaches self-reported in 2019–20 related to just five Code sections (Figure 13), with the majority of those (72%) relating to the Code's standards around claims handling and buying insurance.

FIGURE 13: TOP FIVE CODE SECTIONS FOR SIGNIFICANT BREACHES 2019–20

Code section	Significant breaches
7 – Claims	41
4 – Buying insurance	40
10 – Complaints and disputes	11
13 – Monitoring, enforcement and sanctions	8
5 – Standards for employees and authorised representatives	4

Source: Significant breaches reported to the Code Governance Committee, 2019-20

Significant breaches by Code subsection

Almost two-thirds of all significant breaches were spread across eight different Code subsections.

FIGURE 14: SIGNIFICANT BREACHES 2019–20 – MAIN SUBSECTIONS BREACHED

Code subsection	Significant breaches
4.4 – Sales processes and services of employees/AR must be efficient, honest, fair and transparent	37
7.2 – Claims handling fair, transparent and timely	12
7.11 – Claim assessed on basis of facts, policy terms and law	8
13.3 – Report within 10 business days to the Committee any significant code breach	7
7.10 – Within 10 business days notify consumer of further info/assessment required	3 each
7.13 – Inform consumer about claim progress every 20 business days	
7.14 – Respond to routine requests within 10 business days	
7.16 – Decision made once all info/enquiries received/completed and notification within 10 business days of decision	

Source: Significant breaches reported to the Code Governance Committee, 2019-20

Section 4 – Buying insurance

There were 40 significant breaches relating to the Code's buying insurance standards (section 4) in 2019–20, of which approximately 93% related to a breach of subsection 4.4. This is one of the key consumer protection provisions of the Code requiring subscribers and their authorised representatives to conduct their sales processes in an efficient, honest, fair and transparent manner.

This subsection was also the leading significant breach issue in 2018–19 and, while there were fewer significant breaches of subsection 4.4 this year (37 compared to 49 in 2018–19), the impact on consumers was substantially greater. Code subscribers paid remediation in excess of $155 million to more than 1.4 million consumers, with one subscriber alone paying remediation of $120 million to more than half a million consumers impacted by a significant breach of subsection 4.4.

The 37 significant breaches spanned a range of insurance classes, with the majority being home or motor policies.

The most common reason for significant breaches of this subsection continues to be subscribers calculating premiums incorrectly, resulting in consumers being overcharged, provided with incorrect refunds or not benefiting from discounts for which they were eligible. In some cases, this had occurred for several years before the subscriber detected the breach.

Subscribers listed a range of root causes for their non-compliance with subsection 4.4, most of which related to errors in the operation of IT systems used for pricing and, in some cases, to 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.

Systems-related issues and human error were also cited as the root cause of many significant breaches in 2018–19. It is disappointing to note that these issues persist despite being flagged by the Committee as an area of major risk for the industry in the Committee's *Annual Report 2018–19.*

Concerningly, subscribers remain on track to record high levels of non-compliance with subsection 4.4 during 2020–21. Of the 53 significant breaches reported to the Committee in the four months to 31 October 2020, 15 related to this subsection.

Corrective actions undertaken by subscribers in relation to significant breaches have included:

- customer remediation programs involving interest-accrued refund payments and communications to affected consumers
- system fixes to ensure that premiums are calculated correctly
- enhanced monitoring of sales and pricing systems
- increased testing for future system changes.

The Committee is concerned at the persistently high number of significant breaches of subsection 4.4 in recent years. This indicates that subscribers' monitoring of the operation of their pricing systems is inadequate and this is leading to financial detriment for many consumers. To stem the tide of significant breaches relating to the fair and efficient sale of insurance the Committee urges subscribers to review and test sales processes.

RECOMMENDATION

The Committee recommends that subscribers test sales processes and address any problematic areas – including the competency of their sales staff and the operation of their pricing systems.

CASE STUDY

A SUBSCRIBER REPORTS A SIGNIFICANT BREACH AFTER FAILING TO CORRECTLY APPLY POLICY DISCOUNTS TO ELIGIBLE CUSTOMERS

The subscriber reported a significant breach of subsection 4.4 of the Code after discovering that it was not correctly applying policy discounts to a group of eligible customers.

The subscriber identified that, for certain products, its pricing algorithms applied a floor, or 'cup', to the final premium for renewing customers in certain circumstances. This had the effect of limiting the year-on-year price decrease certain customers receive. The application of the cup (to the final premium, after discounts have been applied) led to certain customers receiving a smaller discount than they had been promised in the subscriber's policy documentation and sales and marketing materials.

The subscriber discovered that the breach existed for differing periods of time for different brands within its portfolio. For some brands, the breach had been occurring since 2014, while for others the breach had been occurring as far back as 2003.

To remediate the breach, the subscriber removed the effect of the cup for the impacted products and paid restitution of around $117 million (including interest) to approximately 557,000 customers who were affected by the breach. It has also taken action to enhance its governance procedures to prevent a recurrence of the breach.

THE 'BUYING INSURANCE' OBLIGATIONS IN THE 2020 CODE

The principles which are currently expressed in subsections 4.4, 6.2, 7.2 and 10.4 of the Code have been rolled into a single overarching obligation in paragraph 21 of the 2020 Code. Paragraph 21 requires subscribers, their employees, distributors and service suppliers to be honest, efficient, fair, transparent and timely in their dealings with consumers.

Paragraph 22 states that the Code sets out how subscribers will meet the obligation in paragraph 21. Critical to the application of the 2020 Code are several principles that are set out at the beginning, and the following principles underpin the general insurance industry's dealings with consumers who buy or are interested in buying retail general insurance products:

We will provide value, transparency and fairness of products and services by:

- *designing and selling insurance products and services that are of value to the community they are sold to;*
- *designing and selling insurance products and services in a clear, transparent and fair manner; and,*
- *continually reviewing and improving insurance products and services offered to ensure they remain of value to the changing needs of the community.*

As a result, the Committee will interpret and apply paragraph 21 of the 2020 Code widely when considering whether subscribers, their employees and distributors have dealt appropriately with consumers who buy, or are looking to buy, retail general insurance products.

Section 7 – Claims handling

Non-compliance with the Code's claims handling standards led to the highest number of significant breaches in 2019–20 (Figure 14), so it is not surprising to see section 7 feature prominently in the list of top significant breach subsections.

The 41 significant breaches of section 7 were spread across 11 different subsections but almost three-quarters of them were for significant breaches of the Code's various timeframe obligations when handling insurance claims.

Twelve of the significant breaches were the result of non-compliance with subsection 7.2, which requires subscribers to handle claims in an honest, fair, transparent and timely manner. A further 17 significant breaches were of subsections that contain timeframes that subscribers must meet when handling a consumer's claim, including timeframes for making a claim decision, timeframes for providing information to consumers, and timeframes for responding to consumer requests about their claim.

In recent years, we have seen subscribers report these types of significant breaches following catastrophes such as bushfires and extreme weather events. Such catastrophes often lead to an influx of claims, placing a strain on subscribers' resources and impeding their ability to process claims in a timely manner.

In 2019–20, the impact of the COVID-19 pandemic on subscribers' operations contributed substantially to the delays that consumers have experienced in the handling of their claims. This is particularly evident in subscribers' travel insurance operations. As well as having to transition their workforce to remote working arrangements, travel insurers received a huge influx of claims and enquiries from consumers around March and April 2020. This was followed by an increased number of complaints for many of these subscribers.

The Committee acknowledges that these unforeseen challenges have had a significant impact on subscribers' operations. However, we remind subscribers that they are in the business of unexpected challenges and claims handling is a critical pillar of the Code, designed to ensure that consumers receive a high standard of service when their claims are handled. This is especially important when consumers are dealing with the consequences of a catastrophe or experiencing financial distress. Subscribers should closely examine why they continue to report high numbers of significant breaches relating to claims handling timeframes – not just those covered in section 7 of the Code, but also

those referenced in section 6 (Standards for our service suppliers) and section 9 (Catastrophes). In addition to the 41 significant breaches of section 7, there were three significant breaches of section 6 and one of section 9.

RECOMMENDATION

Subscribers should review and address the root causes for significant breaches relating to claims handling timeframes in subsections 7.9, 7.10, 7.14 and 7.16.

CASE STUDY

A COVID-19-DRIVEN DELUGE OF TRAVEL-RELATED CLAIMS AND ENQUIRIES LEADS TO BREACHES OF THE CODE'S CLAIMS HANDLING STANDARDS

The subscriber, an underwriter and insurer of travel insurance products, identified a significant breach of the Code's standards relating to the timely processing of customer correspondence and claims decisions (covered under subsections 7.9, 7.10, 7.14 and 7.16).

Following the onset of the COVID-19 pandemic, the subscriber experienced an increase in the volume of customer correspondence and phone calls about travel insurance products, including queries about policies and cover. The subscriber also saw an increase in the volume of claims for cancelled travel and associated claims.

These factors, in addition to operational challenges such as moving to remote working and diverting resources to support other businesses in the travel industry, put pressure on the subscriber's customer service and claims functions. This resulted in the subscriber not being able to respond to customer queries and make claims decisions within the timeframes set out in the Code. The subscriber informed us that the breaches impacted 1,355 consumers.

In response to the breaches, the subscriber undertook several measures to reduce its timeframes for processing customer communications and claims. These included:

- evaluating and redeploying staff on a short-term basis to address specific bottlenecks (for example, in the registration of correspondence)
- getting staff from claims teams that were meeting Code timeframes to assist teams struggling to meet them
- redeploying staff with claims experience who worked in other areas of the company, such as operations, to assist claims staff
- increasing overtime for key claims staff members
- training and upskilling affected claims staff.

The five most breached sections of the Code

The five most breached sections of the Code reported by subscribers were section 7 – Claims, section 10 – Complaints and disputes, section 4 – Buying insurance, section 14 – Access to information and section 8 – Financial hardship. These accounted for more than 99% of the 32,870 breaches self-reported by subscribers.

When providing a reason for the cause of a breach, subscribers overwhelmingly pointed to processes and procedures not being followed. This is disappointing and suggests one or more of the following possibilities:

- subscribers' compliance frameworks (their controls, systems and processes for detecting, recording and preventing Code breaches) are still not sufficiently robust,
- subscribers are not adequately investigating the root cause of breaches, or
- subscribers may be selecting 'processes and procedures not being followed' as an easy, default option when completing their data questionnaire without looking closely at the real breach cause.

The Committee's *Living the Code* report made a considerable number of recommendations around breach identification — including the importance of analysing the root cause to prevent further breaches and significant breaches, as well as improving governance and process to strengthen compliance frameworks and encourage a culture where breaches and their causes are treated as a learning opportunity.

We encourage any subscriber who has recorded a high number of breaches caused by a failure to follow processes and procedures to reacquaint themselves with *Living the Code*, taking careful note of these recommendations, so that Code breaches can be better understood and prevented from reoccurring.

RECOMMENDATION

Subscribers should review the recommendations in *Living the Code* to ensure that the causes of Code breaches are better understood, and appropriate preventative action is undertaken.

FIGURE 15: TOP FIVE CODE SECTIONS BREACHED – TWO-YEAR COMPARISON

Code section	Identified by subscribers 2018–19	Identified by subscribers 2019–20	Difference	% Change
7 – Claims	15,552	16,730	**1,178**	**8%**
10 – Complaints and disputes	6,317	8,244	**1,927**	**31%**
14 – Access to information	5,398	3,555	**-1,843**	**-34%**
4 – Buying insurance	2,353	3,973	**1,620**	**69%**
8 – Financial hardship	257	175	**-82**	**-32%**

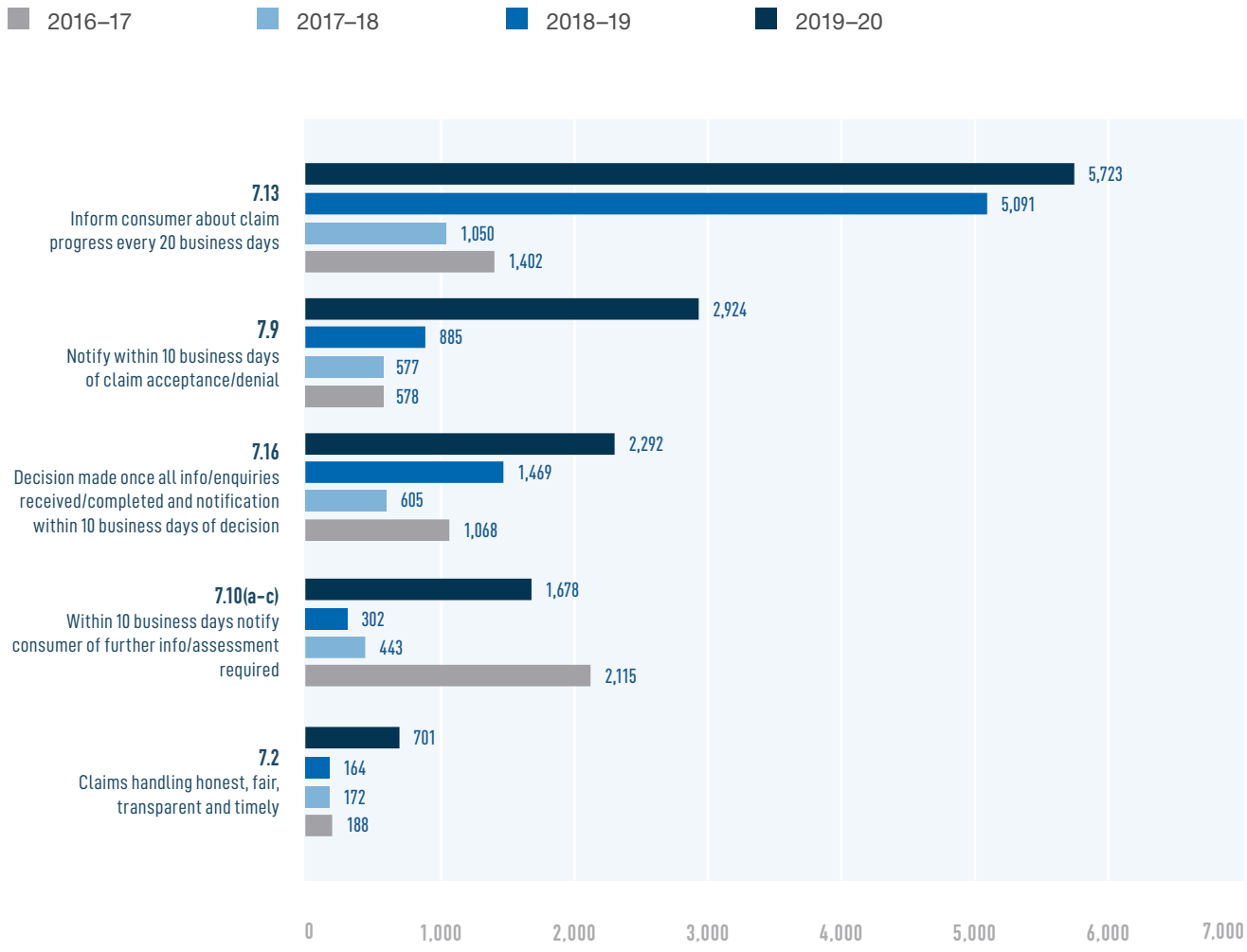
Source: Code Governance Committee annual general insurance Code subscriber data collection, 2018-19 & 2019-20

Section 7 – Claims

Subscribers self-reported 16,730 breaches of section 7 of the Code compared to 15,552 in 2018–19, an increase of 8%. This is perhaps unsurprising due to the impact of COVID-19. Lockdowns and restrictions in other countries where subscribers have claims processing operations may also have had an impact (for example, if a subscriber has a call centre located overseas). However, this ongoing non-compliance continues to be an area of concern for the Committee.

Claims handling is a major focus of the Code and the work the Committee does with Code subscribers. The standards in the Code relating to claims are crucial in making sure consumers 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.

FIGURE 16: TOP FIVE SUBSCRIBER REPORTED BREACHES OF SUBSECTIONS IN SECTION 7 – CLAIMS, WITH FOUR-YEAR DATA COMPARISON



Source: Code Governance Committee annual general insurance Code subscriber data collection, 2016-17, 2017-18, 2018-19 & 2019-20

The top four claims-related subsections breached are all standards that relate to claim timeframes – either timeframes for providing information to claimants about their claim, or timeframes for making a claim decision. The fifth most breached subsection also partially relates to timeliness.

Subsection 7.13, which requires consumers to be informed about the progress of their claim every 20 business days, has consistently been among the most breached Code standards since the 2014 Code came into effect and was the most breached subsection of 2019–20.

SUBSECTION 7.13 – KEEPING CONSUMERS INFORMED OF PROGRESS

There were 5,723 reports of non-compliance with subsection 7.13.

> Subsection 7.13 places a proactive obligation on a subscriber, their employees and service suppliers to provide consumers with updates on the progress of their retail insurance claims at least every 20 business days. This makes the claims process more transparent and lets customers know how their claims are progressing and what the next steps are. It also helps subscribers manage customers' expectations. Communicating with consumers is especially important when the subscriber has a backlog of claims.
>
> Subscribers nominated COVID-19 lockdowns and restrictions as the reason for 2,321 (41%) self-reported breaches of subsection 7.13. 'Poor processes and procedures' was nominated as the reason for 1,818 (32%) breaches, while inadequate staff numbers was given as the cause of 1,400 (24%) breaches.

The Committee has consistently stated that in order to ensure claims are managed within Code timeframes, subscribers should have adequate claims handling systems and processes in place. Claims areas should be sufficiently resourced, with individuals who have the appropriate knowledge and expertise, and who understand their organisation's commitment to the Code.

Best-practice claims management includes open and regular communication with customers. Poor communication often leads to misunderstandings and complaints. It is concerning that almost **one-third (32%) of self-reported breaches of subsection 7.13 were due to poor processes and procedures**, which meant that subscribers failed to appropriately support and equip their staff and/or service suppliers to meet the requirement of subsection 7.13.

SUBSECTION 7.9 – NOTIFYING CONSUMERS OF THE OUTCOME OF A CLAIM DECISION WITHIN 10 BUSINESS DAYS OF THE DECISION BEING MADE

> Subsection 7.9 states that if consumers make a claim that does not require further information, assessment or investigation, the subscriber will decide to accept or deny the claim and notify the consumers of the decision within 10 working days of receiving the claim.

Breaches of subsection 7.9 in 2019–20 increased 230% on the previous year. There were 2,924 reports of non-compliance with subsection section 7.9, compared to 885 in 2018–19.

Subscribers nominated COVID-19 lockdowns and restrictions as the reason for 2,106 (72%) of the breaches of subsection 7.9; the transition to remote working by subscribers' employees caused delays, negatively impacting response times. Subscribers also noted that major weather events, including the January 2020 hailstorm event and storms on Australia's east coast in February 2020 resulted in interruptions to their claims handling Code obligations as they attempted to manage the ensuing influx of claims.

Poor training, poor processes and procedures not being followed were nominated as the reasons for 442 (15%) of the breaches.

SUBSECTION 7.16 – INFORMING CONSUMERS OF CLAIMS DECISIONS

> Subsection 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.

Subsection 7.16 was the third most self-reported breach in 2019–20. There were 2,292 reports of non-compliance with subsection 7.16, an increase of 55% since 2018–19.

Subscribers again noted that the pandemic caused an increase in breaches of subsection 7.16, nominating COVID-19 lockdowns and restrictions as the reason for 889 (39%) of breaches. Poor processes and procedures were nominated as the reason for 727 (32%) self-reported breaches of subsection 7.16.

As with subsection 7.9, major weather events in early 2020 were also cited as contributing to the breaches of subsection 7.16.

The obligation in subsection 7.16 is crucial. Consumers 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 a consumer will be able to meet their financial obligations (for example, if a person has lost their job and cannot meet their loan repayments). Delays can also create unnecessary stress for consumers and their families and impact their wellbeing.

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

RECOMMENDATION

Subscribers should ensure that their claims handling operations are appropriately resourced to meet Code timeframes.

SUBSECTION 7.10 – REQUIRING FURTHER INFORMATION OR ASSESSMENT TO MAKE A CLAIM DECISION

Subsection 7.10 details standards for subscribers where a claim requires further information or assessment. Within 10 business days of receiving a claim, subscribers must:

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

There were 1,678 reports of non-compliance with subsection 7.10, a more than five-fold increase since 2018–19 when subscribers identified 302 breaches.

SUBSECTION 7.2 – HANDLING CLAIMS HONESTLY, FAIRLY AND TRANSPARENTLY AND IN A TIMELY WAY

Under subsection 7.2, subscribers have an overarching obligation to handle claims in an 'honest, fair, transparent and timely' way. Subscribers reported 701 breaches of subsection 7.2.

It is surprising that subscribers did not report more breaches of subsection 7.2 relating to the timeliness of claims handling, given the large numbers of breaches of the other timeframe-based claims standards. If subscribers are consistently missing the timeframes specified in the Code, and therefore failing to meet the expectations of consumers and the Committee, it seems doubtful that they are handling claims fairly.

The Committee is considering whether the individual subscribers reporting large numbers of breaches attributable to COVID-19 restrictions and lockdowns should have self-reported this as one significant breach rather than a number of individual breaches.

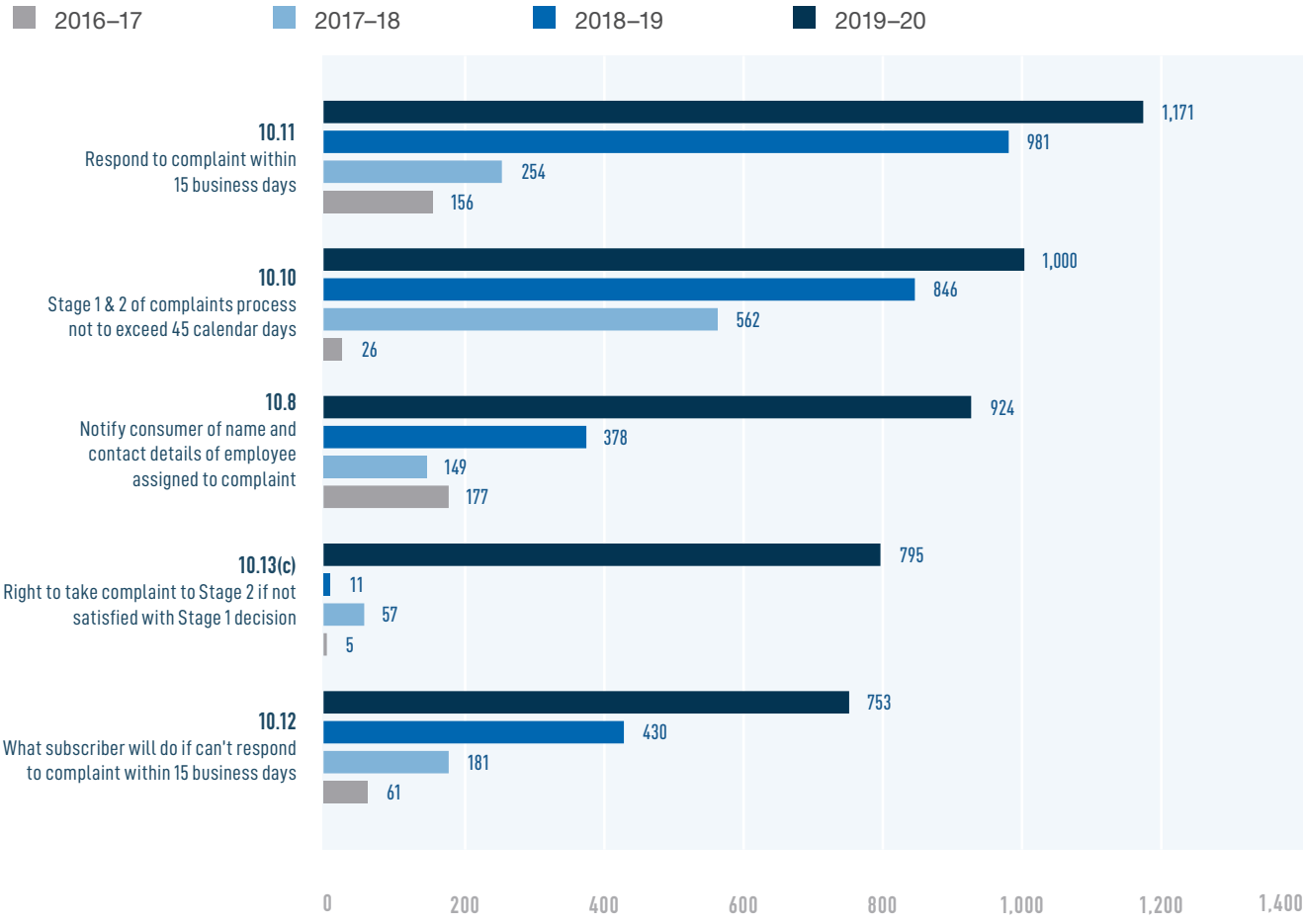
The Committee will continue to work with individual subscribers to help them self-evaluate and appropriately identify and report significant breaches and directs all subscribers to *Guidance Note No.2 Significant breach obligations*[22], which sets out the Committee's expectations of subscribers when identifying and reporting significant breaches of the Code.

Section 10 – Complaints and disputes

In 2019–20, Code subscribers dealt with almost 42,000 complaints lodged by consumers. Good handling of complaints builds consumer confidence and trust, demonstrating that Code subscribers will deal with issues in a fair, timely and transparent way.

There were 8,244 breaches of the Code's complaints and disputes standards this year – a 31% increase on last year's 6,317 breaches. This increase may be attributable to the impact of COVID-19, bushfires and extreme weather events on subscribers' ability to process claims and complaints within the required timeframes. As three of the five most breached complaints handling standards relate to timeframes for responding to consumers as part of the complaints process, this seems likely.

FIGURE 17: TOP FIVE SUBSCRIBER REPORTED BREACHES OF SUBSECTIONS IN SECTION 10 – COMPLAINTS AND DISPUTES, WITH FOUR-YEAR DATA COMPARISON



Source: Code Governance Committee annual general insurance Code subscriber data collection, 2016-17, 2017-18, 2018-19 & 2019-20

SUBSECTION 10.11 – RESPONDING TO COMPLAINTS WITHIN 15 BUSINESS DAYS

Subsection 10.11 requires the subscriber to respond to a complaint within 15 business days of receiving it, provided they have all necessary information and have completed any investigation required.

22 https://insurancecode.org.au/app/uploads/2020/06/Guidance-note-no.2-Significant-breach-obligations.pdf

There were 1,171 self-reported breaches of subsection 10.11. Between them, three subscribers accounted for 815 (or 70%) of the breaches.

Subscribers attributed the breaches to a range of causes, including administrative error, poor processes and procedures, and to delays due to COVID-19 and catastrophes. Processes and procedures not being followed was given as the cause of 902 (or 77%) of all subsection 10.11 breaches.

SUBSECTION 10.10 – COMPLETING THE COMPLAINTS PROCESS WITHIN 45 CALENDAR DAYS

> Under subsection 10.10, subscribers must complete Stage One and Stage Two of the complaints process within 45 calendar days, unless they are unable to provide a final decision within that timeframe. If a subscriber cannot provide a final decision within 45 calendar days, they must inform the consumer of the reasons for the delay as well as their right to take their complaint to AFCA. The consumer must be provided with AFCA's contact details.

There were 1,000 reports of non-compliance with subsection 10.10. Of these, 646 were reported by one subscriber (Subscriber P) and 203 by another subscriber (Subscriber X1). **Staff failing to follow processes and procedures was given as the reason for 936 (or 94%) of the breaches, with other reasons including miscommunication, administrative error and poor monitoring.** Remedial measures included improving staff training, monitoring, and changes to processes and procedures, as well as increasing resources to support staff to better manage complaints.

SUBSECTION 10.8 – PROVIDING THE NAME AND CONTACT DETAILS OF THE EMPLOYEE ASSIGNED TO HANDLE THE COMPLAINT

> According to subsection 10.8, subscribers are required to give consumers the name and contact details of the employee assigned to liaise with them at each stage of the complaints process.

Subscribers reported breaching this requirement a total of 924 times this year. As with subsection 10.10, just two subscribers accounted for the vast majority of breaches. One subscriber (Subscriber P) self-reported 680 breaches. The other subscriber (Subscriber X1) self-reported 213 breaches. **Both subscribers cited a failure to follow processes and procedures as the reason for the breaches and said they had addressed the issue by conducting remedial training and improving breach monitoring.**

SUBSECTION 10.13(C) – ADVISING CONSUMERS OF THEIR RIGHT TO ESCALATE A COMPLAINT

> Subsection 10.13(c) states that a subscriber will respond to a complaint in writing and inform a consumer of their right to take their complaint to Stage Two of the complaints process if their decision at Stage One does not resolve the consumer's complaint to their satisfaction.

Despite recording comparatively low breach numbers in the three years prior to 2019–20, subsection 10.13(c) was the fourth most breached subsection this year, with 795 breaches. This is a 72-fold increase on the 11 breaches recorded in 2018–19 but is down to one subscriber (Subscriber U1) being responsible for 777 (or 98%) of the 795 breaches.

Explaining the reason for these breaches, Subscriber U1 said they related to the offering of premium refunds/credit outside of policy terms as caused by COVID-19. In offering the refund/credit to consumers, Subscriber U1 failed to inform them of their right to take their complaint to Stage Two of the complaints process.

Although breaches of subsection 10.13(c) reveal issues with one specific subscriber rather than an emerging risk for the industry, high breach numbers are still concerning due to the impact they have on consumers. In this case, consumers may have abandoned their complaints after receiving an adverse outcome at Stage One, as they were not informed that they had a further option. They may then have missed out on an outcome they were entitled to after a further, possibly more thorough review, at Stage Two.

SUBSECTION 10.12 – WHEN THE SUBSCRIBER CANNOT RESPOND TO THE COMPLAINT WITHIN 15 BUSINESS DAYS

The fifth most breached subsection of the Code's complaints and disputes standards was subsection 10.12, with subscribers identifying 753 breaches of this subsection during the reporting period. This is 75% more than the 430 breaches recorded last year.

Subsection 10.12 is another complaints standard relating to subscriber response timeframes.

> Subsection 10.12(a) states that if a subscriber cannot respond to a consumer within 15 business days because they either don't have all the information they require or they have not completed the investigation, they will notify the consumer as soon as reasonably practicable within the 15 business days and agree a new timeframe with them. If an agreement cannot be reached, the subscriber should advise the consumer of their right to take the complaint to Stage Two of the complaints process. Subsection 10.12(b) requires the subscriber to inform the consumer of the progress of their complaint at least every 10 business days, unless the consumer agrees otherwise.

According to subscribers, poor processes and training accounted for 670 (or 89%) of all self-reported breaches of subsection 10.12 and most subscribers said they addressed these issues through improved training and monitoring processes. Several subscribers also blamed understaffing as the cause of not meeting the required timeframes for responding to complainants.

New Code and regulatory requirements for complaints and disputes in 2021

From 1 July 2021, those Code subscribers required to comply with standards in part 11 – Complaints of the 2020 Code, must ensure their complaints process complies with the guidelines issued by the Australian Securities and Investments Commission (ASIC) (paragraph 141, 2020 Code).

Moreover, from 5 October 2021 subscribers' complaints processes must comply with increased requirements set out in ASIC's *Regulatory Guide 271: Internal Dispute Resolution (RG 271)*[23]. These include an updated definition of 'complaint'[24] and the requirement that an internal dispute resolution response be provided to a complainant no later than 30 calendar days after receiving the complaint.[25]

While subscribers are enhancing their systems and processes to align with the requirements of the 2020 Code and RG 271, they must also ensure that there is adequate resourcing, training and support for employees to ensure they meet the Code's requirements, particularly around timeframes. Subscribers will have to focus on improving their complaints handling so that the numbers of breaches decrease, rather than continue to increase.

Section 14 – Access to information

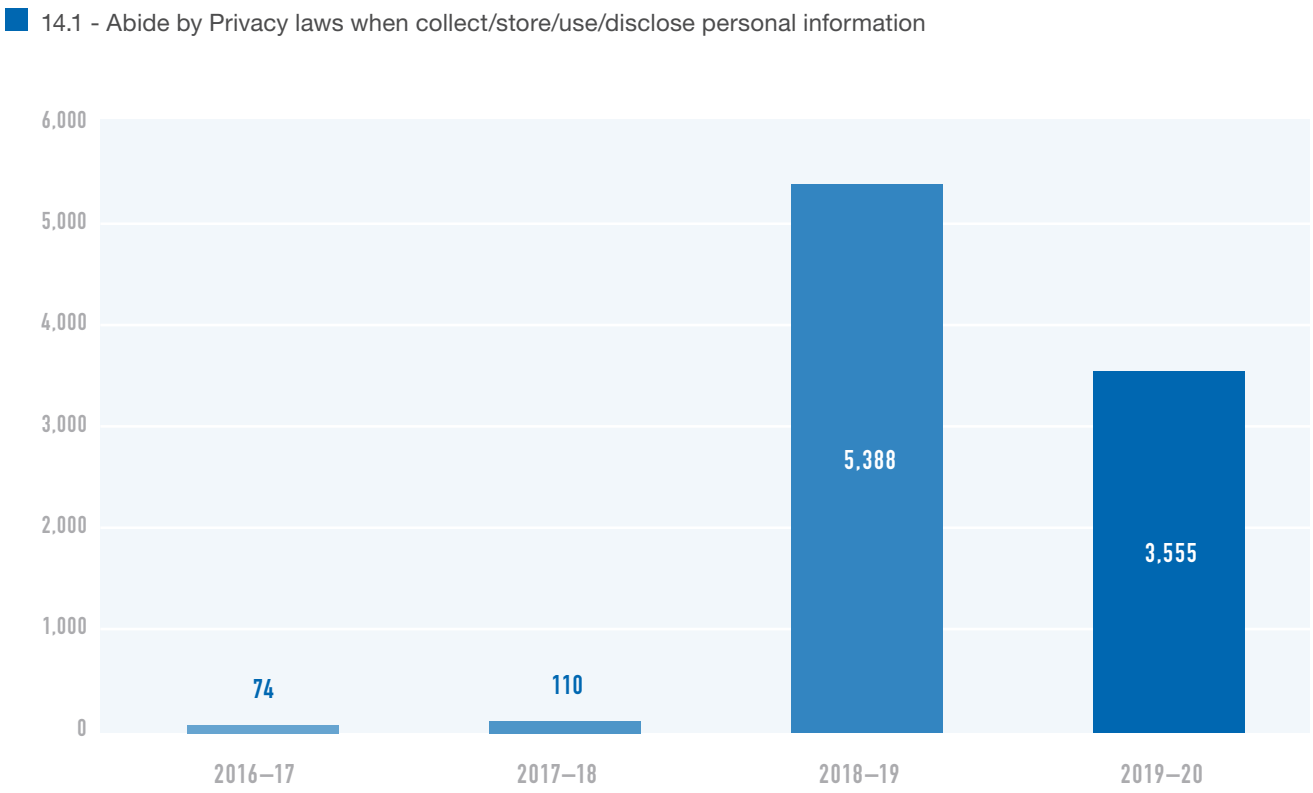
Section 14 of the Code sets out the information subscribers must make available to consumers. This includes access to the information a subscriber relies on to assess an application for insurance cover, a claim or a complaint. It also covers subscribers' legal obligations when collecting and using a customer's personal information.

While there were 3,555 self-reported breaches of section 14 of the Code, 99% were breaches of subsection 14.1, which requires Code subscribers to comply with privacy laws when collecting, storing, using and/or disclosing the personal information of their customers.

There were just 12 self-reported breaches of subsection 14.4(a), and 10 of subsection 14.2 – respectively, the second and third most breached areas of Code section 14.

23 https://asic.gov.au/regulatory-resources/find-a-document/regulatory-guides/rg-271-internal-dispute-resolution/
24 RG 271.27
25 RG 271.56

FIGURE 18: SUBSCRIBER REPORTED BREACHES OF SUBSECTION 14.1 – FOUR-YEAR COMPARISON



Source: Code Governance Committee annual general insurance Code subscriber data collection, 2016-17, 2017-18, 2018-19 & 2019-20

SUBSECTION 14.1 – ACCESS TO INFORMATION

Almost 80% of breaches of subsection 14.1 were self-reported by one subscriber (Subscriber P), with breaches attributed to a failure to follow the correct processes and procedures. Approximately 5,000 customers were affected by the breaches. Having reviewed and assessed the breaches to determine if they were significant breaches, Subscriber P reported that they were isolated and did not represent a systemic issue.

After reporting more than 6,600 privacy-related Code breaches in 2018–19 (97% of last year's total), Subscriber P has improved its monitoring activities, which include checks for legislative, regulatory and Code requirements, as well as enhancing its internal procedures and conduct.

The Committee acknowledges that Subscriber P's compliance improvements have led to an improved and consistent approach to incident reporting, enabling it to identify and report a high number of breaches this year. Considering the much lower number of privacy-related breaches reported by other subscribers, the Committee encourages all subscribers to review their processes for identifying and reporting breaches of subsection 14.1, as well as other legislative and regulatory requirements, to ensure they are being captured, reported and remediated.

The Committee reminds subscribers that a breach of subsection 14.1 is also a breach of the subscriber's legal privacy obligations to consumers. Subscribers should notify the affected consumer and the Office of the Australian Information Commissioner (OAIC) if the breach is an eligible data breach under OAIC's Notifiable Data Breach (NDB) scheme.[26]

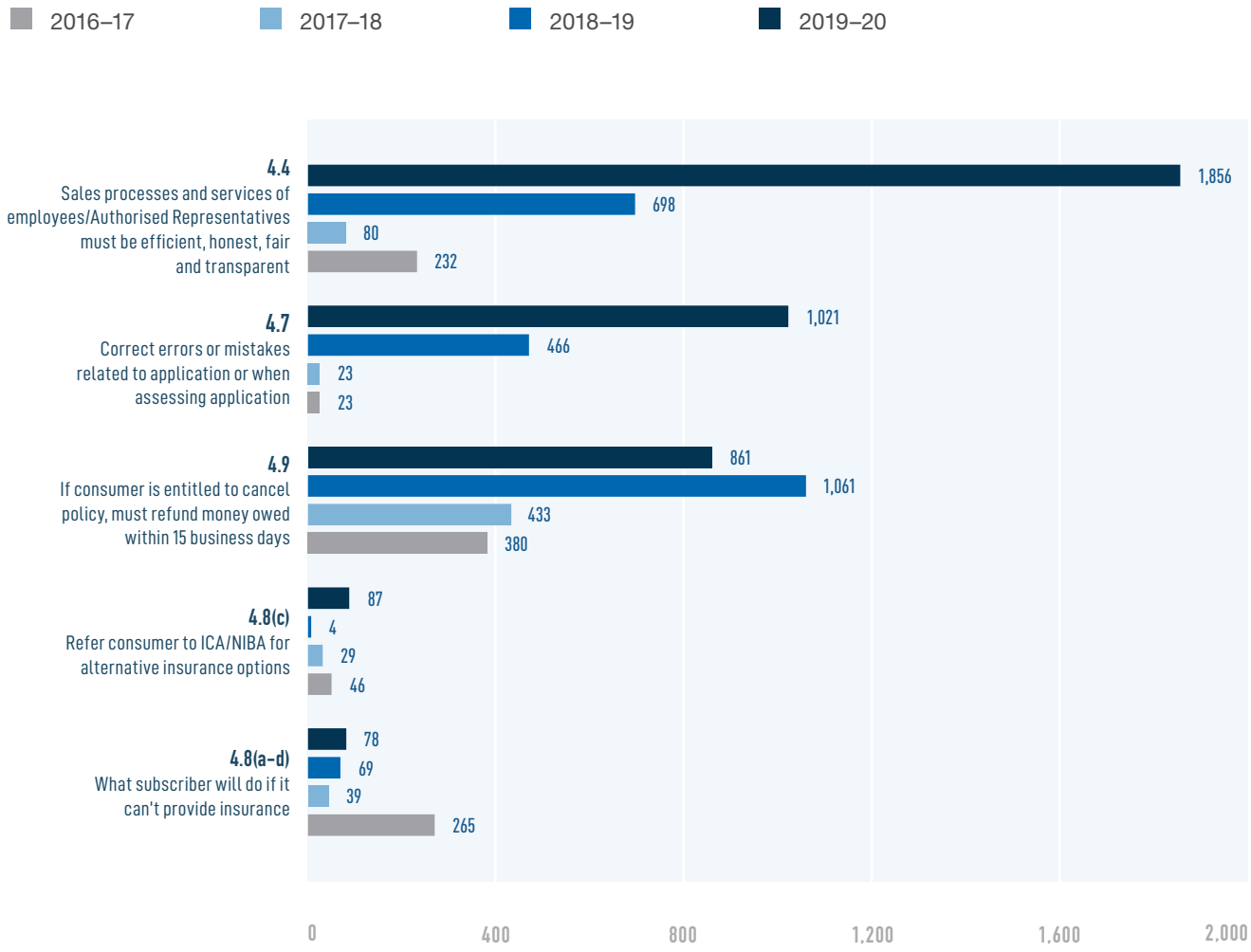
26 Notifiable data breaches — OAIC

Section 4 – Buying insurance

With consumers purchasing almost 41 million retail insurance policies during 2019–20, 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 an overarching obligation that they conduct their sales processes efficiently, honestly, fairly and transparently.

There were considerable increases in the number of breaches recorded against subsection 4.4 (efficient, honest, fair and transparent sales) and subsection 4.7 (correcting errors in a customer's insurance application). In the 12 months to 30 June 2020, subscribers self-reported 165% more breaches of subsection 4.4 and 119% more breaches of subsection 4.7 than in the previous reporting period.

FIGURE 19: TOP FIVE SUBSCRIBER REPORTED BREACHES OF SUBSECTIONS IN SECTION 4 – BUYING INSURANCE, WITH FOUR-YEAR DATA COMPARISON



Source: Code Governance Committee annual general insurance Code subscriber data collection, 2016-17, 2017-18, 2018-19 & 2019-20

SUBSECTION 4.4 – EFFICIENT, HONEST, FAIR AND TRANSPARENT SALES

Subsection 4.4 requires Code subscribers' employees and authorised representatives to conduct their sales processes in an efficient, honest, fair and transparent manner. It is one of several critical standards in the Code designed to ensure that subscribers place good consumer outcomes ahead of making profits.

Most breaches resulted from renewal notices being sent out late due to systems and/or people-related errors. Subscribers cited high work volumes for sales staff and the failure of authorised representatives to follow correct procedure as the underlying causes.

While most subscribers said they addressed these issues through remedial training, the Committee expects such training not only to refresh trainees' understanding of the processes and procedures relating to the sale of insurance, but also to remind them of their obligations under both the Code and the law – particularly if a lack of understanding of these obligations is why the Code breaches occurred.

Furthermore, subscribers who blamed a heavy staff workload for their subsection 4.4 breaches are encouraged to investigate whether additional resourcing and better forward planning would help avoid future breaches. Are sales employees adequately supported to do their job efficiently? Are more staff required? Could the high work volumes have been anticipated and better planned for before the breaches occurred?

Breaches of subsection 4.4 have risen sharply each year since 2017–18, with subscribers self-reporting two-and-a-half times more subsection 4.4 breaches this year than in the previous year.

It is concerning to see an uptick in breaches of a Code standard where non-compliance can severely impact consumers. For example, where breaches occurred as a result of renewal notices not being sent out on time, consumers are at risk of being left uninsured because they did not renew their policy on time.

At the same time, an increase in breach reporting also suggests that subscribers have taken on board the Committee's previous advice about interpreting and applying subsection 4.4. As stated in the *Annual Report 2018–19*, the Committee expects subscribers 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.

The Committee regards subsection 4.4 as having 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 1984 (Cth).

The various standards in the Code that relate to honesty, efficiency, fairness, transparency and timeliness are encompassed in a single obligation (paragraph 21) under the new 2020 Code. As with subsection 4.4 of the 2014 Code, the Committee expects subscribers to interpret and apply paragraph 21 of the new Code broadly when selling general insurance products to consumers.

The way subscribers conduct their sales processes and services has emerged as an area of major risk for the general insurance industry. Subscribers still have work to do on their compliance with the Code's buying insurance standards and the Committee once again reminds them of the need for better oversight and training of all employees and authorised representatives who sell insurance on their behalf.

RECOMMENDATION

Training on the processes and procedures relating to the sale of insurance should have a focus on subscribers' obligations under both the Code and the law.

RECOMMENDATION

Subscribers should ensure that paragraph 21 of the 2020 Code, which requires distributors and service suppliers to act honestly, efficiently, fairly and transparently, is interpreted and applied broadly when selling general insurance products to consumers.

SUBSECTION 4.7 – CORRECTING ERRORS IN A CUSTOMER'S INSURANCE APPLICATION

If a consumer's 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 1,021 breaches in 2019–20.

Breaches of subsection 4.7 have increased substantially over the past three years, growing from 23 breaches in 2017–18 to 466 in 2018–19. This year's 1,021 breaches have seen subsection 4.7 move from the 16th most breached subsection of the Code overall in 2018–19, to eighth this year.

Subscribers cited administrative errors as the primary cause of the breaches. An investigation carried out by one Code subscriber during the year identified the sale of 1,015 policies between December 2017 and September 2019 where consumers were not sent policy schedules. This was due to missing information in the data files received from the authorised representative.

Consistent year-on-year increases in breaches of subsection 4.7 indicate that subscribers' processes for identifying and resolving issues that arise when consumers purchase insurance are not sufficiently robust. It is also likely that staff are not being trained appropriately to recognise and correct errors in insurance applications. The Committee urges subscribers to review and improve their processes and training around subsection 4.7 and the corresponding sections of the new 2020 Code.

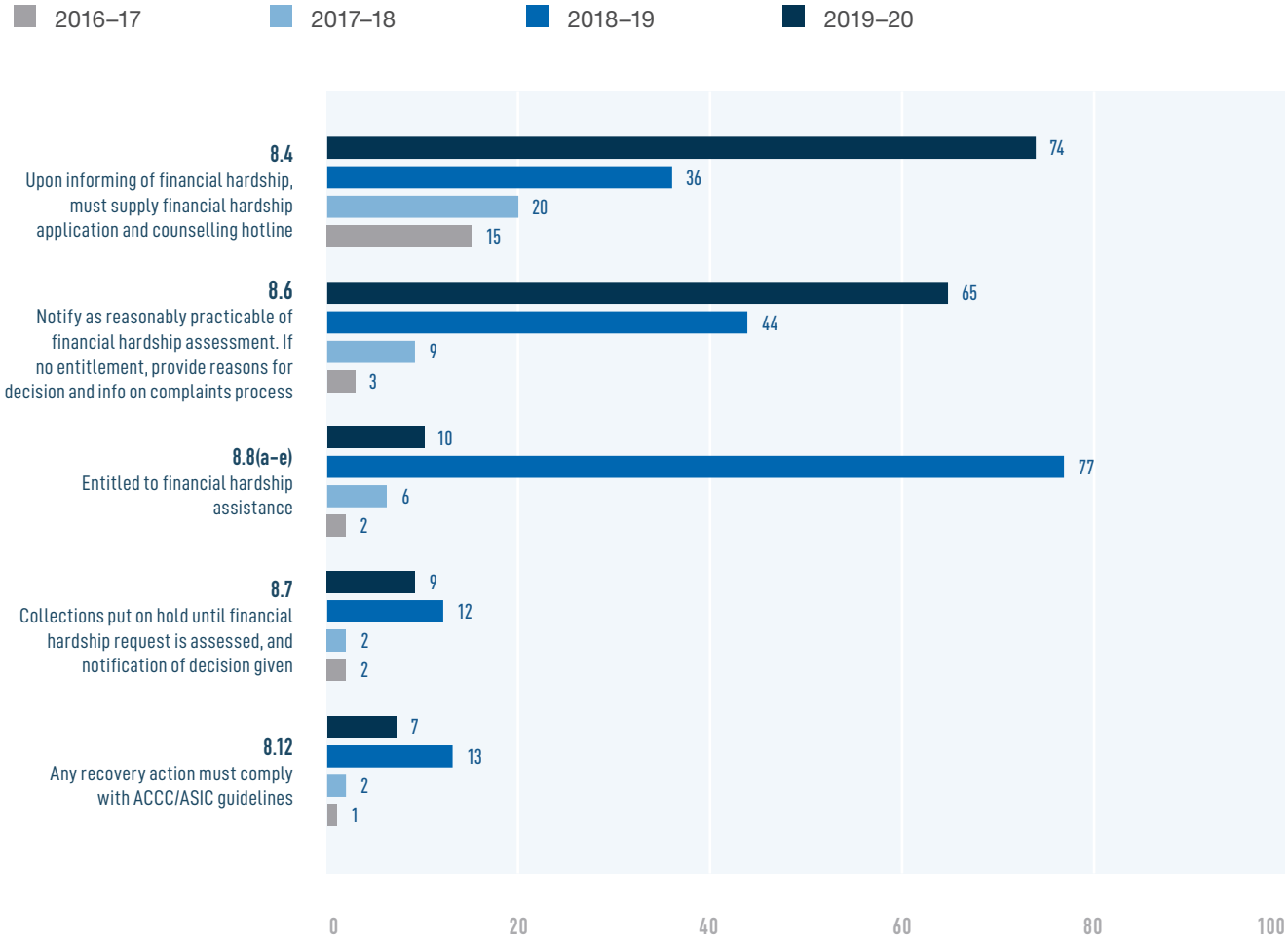
Section 8 – Financial hardship

The Code plays a vital role in helping to ensure that consumers 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.

Subscribers identified 175 breaches of section 8, compared to 257 in 2018–19. This decrease of 32% is largely explained by a significant reduction in the number of breaches of subsection 8.8, which describes how subscribers must respond to and work with consumers who are entitled to financial hardship assistance.

This reduction in breaches in subsection 8.8 may suggest that subscribers are improving the way they respond to and manage financially vulnerable consumers, resulting in increased Code compliance and better consumer outcomes. However, the Committee is concerned that subscribers may be underreporting breaches as the Committee identified through its own investigation work, 33 breaches that subscribers had not noticed and reported. This points to potential issues with the way subscribers are monitoring and capturing financial hardship breaches.

FIGURE 20: TOP FIVE SUBSCRIBER REPORTED BREACHES OF SUBSECTIONS IN SECTION 8 – FINANCIAL HARDSHIP, WITH FOUR-YEAR DATA COMPARISON



Source: Code Governance Committee annual general insurance Code subscriber data collection, 2016-17, 2017-18, 2018-19 & 2019-20

SUBSECTION 8.4 – SUPPLYING AN APPLICATION FORM AND FINANCIAL COUNSELLING HOTLINE NUMBER

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[27]. This obligation serves three important purposes:

- it provides the consumer with assurance that their financial situation has been acknowledged by the subscriber
- it lets the consumer know that financial hardship assistance is available and that they can apply to receive it
- it links the consumer to financial counselling if they have not already accessed it.

Breaches of this Code standard more than doubled in 2019–20. There were 74 breaches compared to 36 the previous year, making it the largest source of financial hardship breaches. Three-quarters of these were reported by a single subscriber (Subscriber P) and almost every one of the 74 breaches was due to established processes and procedures not being followed. Subscribers reported that the breaches were typically addressed with remedial training, improvements to processes and procedures, and communication with affected consumers.

Breaches of this subsection are concerning as these obligations effectively begin the financial hardship process and play a crucial role in the Code's consumer protection framework.

27 National Debt Hotline 1800 007 007 – ndh.org.au

In recent years, the Committee has provided clear guidance to subscribers on our expectations for complying with the Code's financial hardship obligations, particularly in relation to the treatment of consumers in financial difficulty.[28] It is therefore disappointing to note that most breaches were the result of employees and service suppliers failing to follow the correct processes and procedures for recognising and dealing with consumers who indicate they are experiencing financial hardship. The Committee is concerned that subscribers are not providing their staff and service providers with adequate training in how to identify and respond to consumers who inform them they are experiencing financial hardship.

Training in this area should be a high priority for all Code subscribers now that part 10 of the 2020 Code has come into effect.[29] Part 10 contains enhanced standards around training for subscribers' employees, as well as any collection agents or solicitors who collect money for them, on the financial hardship requirements of the new Code, including how to identify financially vulnerable consumers. Subscribers must have internal policies and training appropriate to their employees' roles to help them to determine if an individual is experiencing financial hardship and to decide how they may be able to support them.[30]

This is a significant development, as it places the onus on the subscriber to identify and offer support and assistance to a consumer in financial difficulty, rather than relying on the consumer to tell the subscriber that they are having difficulty meeting their financial obligations. Recognising financially vulnerable consumers will be increasingly important given the ongoing financial impact of COVID-19 on many individuals in the community.

SUBSECTION 8.6 – TIMELY ASSESSMENT OF APPLICATIONS FOR FINANCIAL HARDSHIP ASSISTANCE

The second most breached financial hardship standard in 2019–20 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 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.

Timely assessment of a request for financial assistance is important. A consumer who is experiencing financial hardship is entitled under the Code for their request to be assessed 'as soon as reasonably practicable', and any delay to their assessment is likely to cause them considerable stress.

The 65 breaches of subsection 8.6 this year were caused by the correct processes and procedures not being followed and were addressed via remedial training and improvements to processes and procedures.

Although the 2014 Code does not specify a timeframe for assessing requests for hardship assistance, the 2020 Code provides clear assessment timeframes, which all subscribers have been required to comply with since 1 January 2021. The timeframes set out in part 10[31] of the 2020 Code closely reflect those recommended in the Committee's Guidance Note, *Financial hardship obligations – General Insurance Code of Practice*, published in March 2018. As such, the Committee would expect subscribers' processes for the timely assessment of financial hardship applications to be robust and compliant with the provisions in the new Code.

28 In March 2018, the Committee issued its first Guidance Note, *'Financial hardship obligations – General Insurance Code of Practice'*.

29 Parts 9 and 10 of the 2020 Code came into effect on 1 January 2021.

30 Paragraph 109 of the 2020 Code: 'We will have internal policies and training appropriate to our Employees' roles to help them to identify if you are experiencing Financial Hardship and decide how they may be able to provide support to you.'

31 See paragraphs 116, 117, 121 and 122.

Breaches identified by the Committee

In addition to breach data self-reported by subscribers, the Committee also identifies breaches through the investigation of referrals of Code breach allegations. These largely consist of referrals from AFCA and allegations made by consumers, or their legal representatives, or by consumer advocate organisations. 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.

While the number of Committee-identified breaches is far lower than the number of breaches self-reported by subscribers, the Committee's investigative work plays a vital role in pinpointing issues that subscribers may not identify through their own monitoring. It can also uncover wider issues that need addressing and provide insights which help to inform decisions about the focus of the Committee's other monitoring activities.

During 2019–20, the Committee opened 255 investigation matters (20% more than in 2018–19) and closed 288 matters[32] (19% more than in 2018–19). The investigation matters opened during the year comprised of:

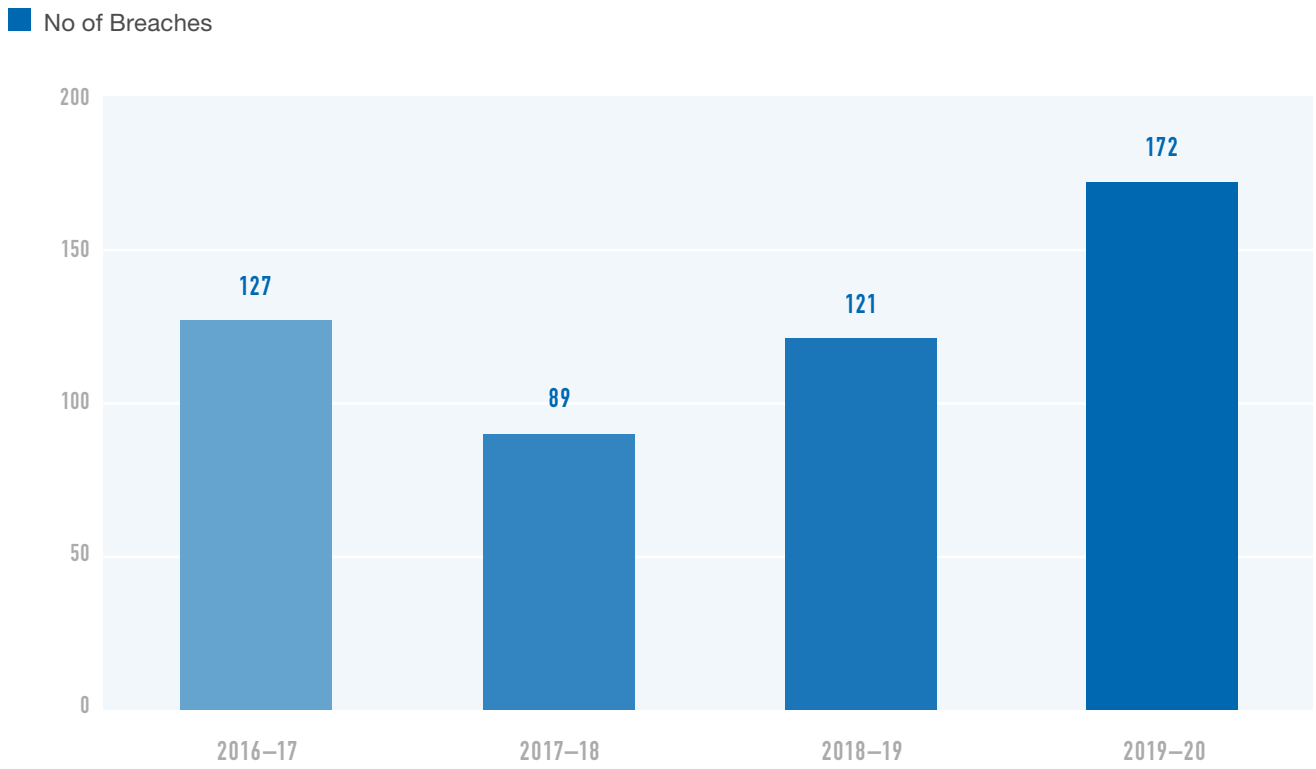
- 209 referrals of Code breach concerns from AFCA
- 33 Code breach allegations from consumers or their legal representatives
- 13 Code breach allegations from consumer advocate organisations on behalf of consumers.

The number of Code breach allegations received from consumers/legal representatives and consumer advocate groups was similar to the previous reporting year, but the Committee received 38% more referrals from AFCA during 2019–20 than in 2018–19. Not all referrals from AFCA can be investigated and actioned by the Committee as some matters fall outside the Committee's jurisdiction.

As a result of its investigations, the Committee identified 172 breaches of the Code. This is 51 more breaches than in the previous year (42% increase) and almost twice as many as the 89 identified breaches in 2017–18 (Figure 21). The number of finalised investigations increased by 20% in 2019–20 compared with the previous year.

32 Some matters closed in 2019–20 were matters that had been opened in previous reporting periods.

FIGURE 21: COMMITTEE-IDENTIFIED CODE BREACHES SINCE 2016–17



Source: Code Governance Committee additional identified breaches, 2016-17, 2017-18, 2018-19 & 2019-20

There were substantial increases in the number of Committee-identified breaches across almost all Code sections compared to 2018–19, including:

- section 7 (claims) – up 33%
- section 6 (standards for service suppliers) – up 67%
- section 8 (financial hardship) – up 70%
- section 4 (buying insurance) – up 89%.

Only two Code sections recorded a reduction in the number of breaches identified by the Committee: section 10 (complaints and disputes; down 29%) and section 13 (monitoring, enforcement and sanctions; down 100%).

In addition to receiving the highest number of subscriber-reported Code breaches in 2019–20, sections 7 and 10 were the subject of the most Committee-identified breaches (Figure 22). This was also the case in 2018–19.

FIGURE 22: COMMITTEE-IDENTIFIED BREACHES 2019–20 – TOP FIVE CODE SECTIONS

Code Section	Breaches
7 – Claims	77
10 – Complaints and disputes	35
8 – Financial hardship	33
4 – Buying insurance	9
6 – Standards for service suppliers	9

Source: Code Governance Committee additional identified breaches, 2019-20

Section 8 – Financial hardship

There was a notable difference between the proportion of section 8 (Financial hardship) breaches identified by the Committee and the proportion self-reported by Code subscribers. Where section 8 breaches accounted for 19% of all Committee-identified breaches in 2019–20, they made up just 0.5% of all self-reported breaches. In addition, there were only three significant breaches of section 8 for the year and all three were identified as a result of Committee investigations of breach allegations, rather than identified and self-reported by subscribers.

The Committee is concerned that subscribers' monitoring activities have not picked up these breaches of the Code's standards designed to protect the most vulnerable consumers. It suggests that subscribers' processes and procedures for assisting those experiencing financial hardship are inadequate or ineffective.

With many Australians continuing to face financial uncertainty due to the COVID-19 pandemic and the scheduled cessation of the JobKeeper Payment Scheme on 28 March 2021, the Code's financial hardship standards have never been more vital. 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 customers and uninsured people experiencing financial difficulty.

The Committee strongly encourages any subscriber who has self-reported a breach (significant and/or standard) of section 8 or had a section 8 breach identified by the Committee, to conduct a root cause review of these breaches – including analysing any complaints received about financial hardship – to determine why they occurred and to address any issues that might cause a reoccurrence.

CASE STUDY

A SUBSCRIBER FAILED TO FOLLOW THE CORRECT PROCESS AFTER A CONSUMER REQUESTED FINANCIAL HARDSHIP ASSISTANCE

One investigation by the Committee during 2019–20 followed an allegation directly from a consumer. A subscriber had not provided an appropriate response to his financial hardship assistance request when he was required to pay a $1,750 excess on his claim.

The Committee found the subscriber had breached subsections 8.4, 8.6 and 8.8(a) of the Code as it had not followed the correct financial hardship process. These subsections cover:

- providing the consumer with an application form for financial hardship assistance and the contact details of the national financial counselling hotline (subsection 8.4)
- the timely assessment of a consumer's request for financial hardship assistance (subsection 8.6)
- Working with the consumer to consider an arrangement for managing or repaying the debt (subsection 8.8(a)).

The subscriber carried out a claims review to establish if this was an isolated occurrence, and determined that similar breaches of subsections 8.4 and 8.8(a) had occurred on a further 80 claims. As a result, the subscriber reported a significant breach.

The subscriber has addressed the matter by reviewing and updating its financial hardship processes and providing refresher training to staff on its processes and the financial hardship obligations in the Code. The subscriber also confirmed it had several actions underway for transition to the enhanced financial hardship and vulnerability standards in the 2020 Code.

USING AGENTS TO PURSUE AN UNINSURED CONSUMER FOR DEBT

In many cases, the section 8 breaches identified by the Committee related to the recovery of money from uninsured consumers. This occurred most commonly where an uninsured driver caused damage to the vehicle of another driver who was insured by a subscriber, and the subscriber sought to recover the cost of repairs from the uninsured driver. Subscribers often used collection agents (including legal firms) in these cases to recover the debt on their behalf.

Altogether, there were 33 breaches of section 8 identified by the Committee, including 10 breaches of subsections 8.10 to 8.12, which include the requirement for debt collection agents to advise debtors that they are acting on a subscriber's behalf, and to notify subscribers when a debtor requests financial hardship assistance.

Non-compliance with section 8 as a result of the actions of collection agents authorised by subscribers has been a recurring issue over several years. The Committee is concerned that Code subscribers are still not adequately monitoring the conduct of their collection agents, including any legal firms engaged in this capacity. Although the long-term financial impact of the COVID-19 pandemic is still unknown, we are likely to see more consumers fall into debt and financial hardship in the coming months and years. Subscribers are therefore urged to remind collection agents, and legal firms acting on their behalf, of their obligations to comply with part 10 of the 2020 Code when recovering debt from financially vulnerable individuals. This includes:

- specifying the standards of the Code that apply to services provided by collection agents and legal firms, including the financial hardship standards, in contracts with them
- ensuring that collection agents are made aware of their obligations under the Code, and
- proactively monitoring collection agents' compliance with these obligations.

THE FINANCIAL HARDSHIP OBLIGATIONS IN THE 2020 CODE

Part 10 of the 2020 Code contains enhanced financial hardship standards to provide increased protection to consumers. Part 9 contains new standards for supporting customers experiencing vulnerability.

While the ICA deferred the adoption of the majority of the 2020 Code by six months to 1 July 2021 due to the impact of COVID on the industry, it brought forward by six months (to 1 July 2020) the key consumer provisions in parts 9 and 10 of the new Code.

From 1 July 2020, Code subscribers were required to have their policies to support customers affected by family violence available on their websites, as set out in paragraph 95 in part 9 of the 2020 Code. Code subscribers were also required to provide support for customers who are experiencing vulnerability, including financial hardship, within the spirit and intention of the key provisions in parts 9 and 10 of the 2020 Code.

Since 1 January 2021, Code subscribers have been required to be fully compliant with parts 9 and 10 of the 2020 Code. This also means that the Committee can monitor and enforce compliance with these parts of the new Code as though they were a part of the 2014 Code and the old section 8 no longer applies.

Focus on travel insurance

While COVID-19 impacted all classes of general insurance in 2019–20, travel insurance was particularly affected by significant increases in claims, policy refunds and complaints, and significant decreases in the sale of policies. The relatively high rate of declined travel insurance claims over the past five years was one of the issues flagged by the Committee when it first considered conducting an inquiry into travel insurance. When overseas travel recommences, and insurers are selling travel insurance again, the Committee will consider whether the issues that previously affected consumers remain and whether an inquiry can assist subscribers in providing improved products and services and better outcomes for consumers.

Travel insurance policies

Many subscribers ceased selling travel insurance after the Federal Government announced a ban on overseas travel on 24 March 2020.

Overall, there was a decrease of 255,779 travel insurance policies issued in 2019–20 compared to 2018–19, a 5% decrease.

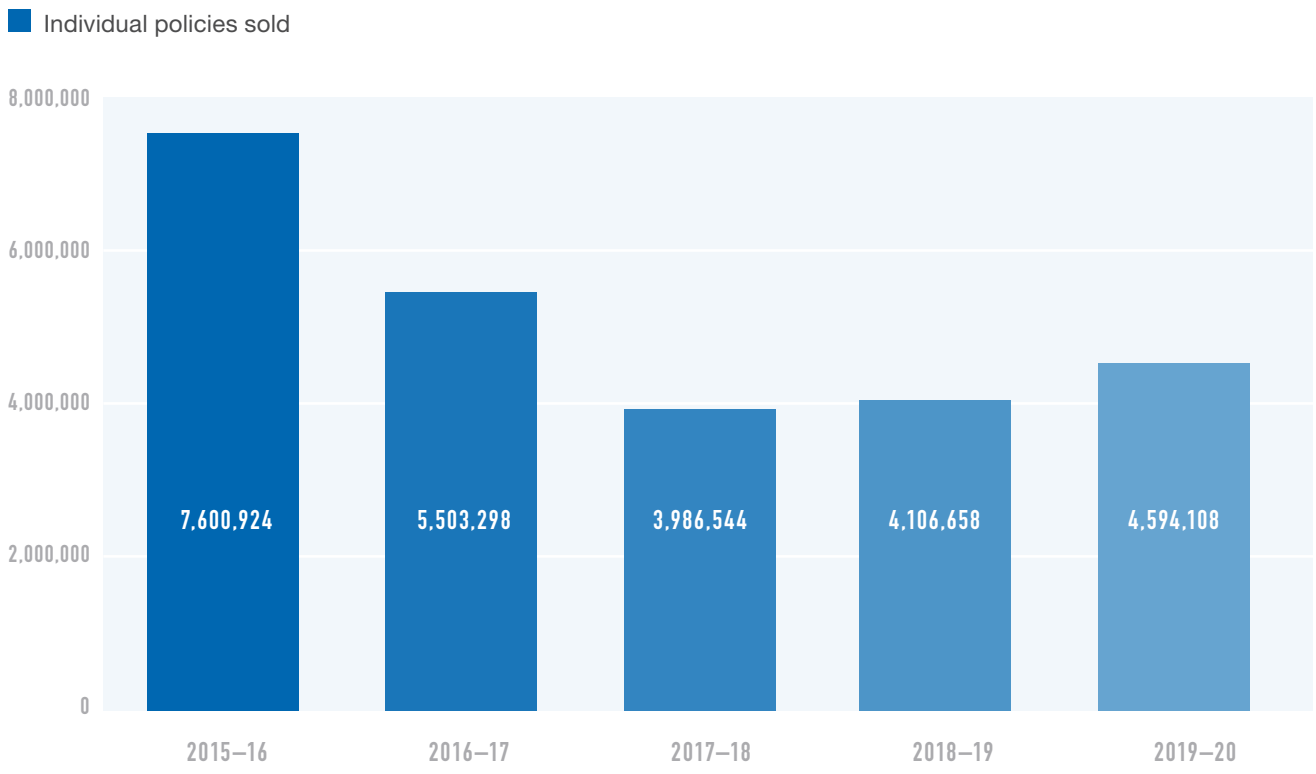
While there was an increase in individual travel policies issued by subscribers, the overall decrease was driven by a drop in the number of group travel policies issued. The decrease in group travel policies issued also resulted in a decrease of 5,611,673 (42%) in the estimated number of people covered by group travel policies in 2019–20.

FIGURE 23: TOTAL RETAIL POLICIES SOLD (INDIVIDUAL AND GROUP) – COMPARISON FOR PAST 2 YEARS

Insurance class – Retail	1 July 2018 to 30 June 2019	1 July 2019 to 30 June 2020	Change	% Change
Motor	16,146,138	16,082,095	-64,043	-0.40%
Home	11,345,303	11,188,464	-156,839	-1.38%
Personal & domestic property	8,070,461	8,110,930	40,469	0.50%
Travel	**4,979,340**	**4,723,561**	**-255,779**	**-5.14%**
Consumer credit	551,960	347,056	-204,904	-37.12%
Sickness & accident	269,567	253,318	-16,249	-6.03%
Residential strata	210,227	233,378	23,151	11.01%
Total	**41,572,996**	**40,938,802**	**-634,194**	**-1.53%**

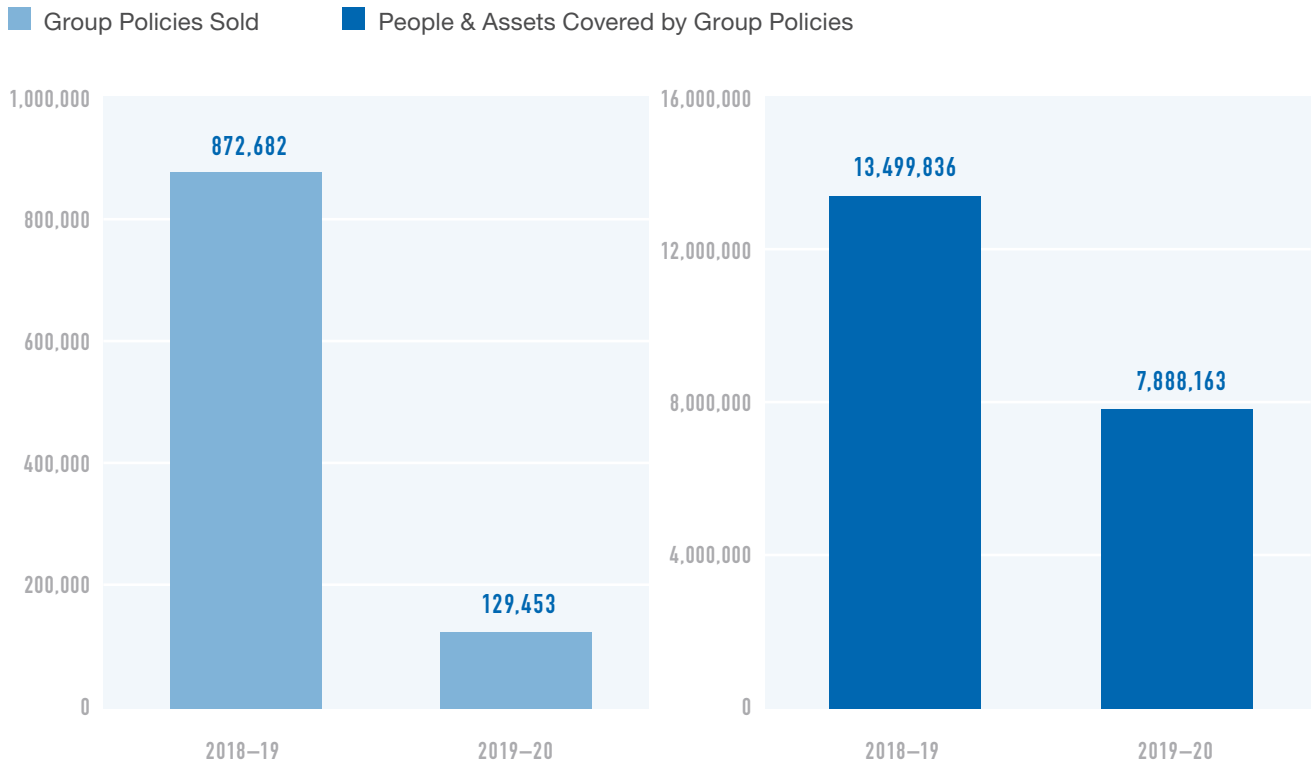
Source: Code Governance Committee annual general insurance Code subscriber data collection, 2018-19 & 2019-20

FIGURE 24: INDIVIDUAL TRAVEL POLICIES SOLD – FIVE-YEAR COMPARISON



Source: Code Governance Committee annual general insurance Code subscriber data collection, 2015-16, 2016-17, 2017-18, 2018-19 & 2019-20

FIGURE 25: GROUP TRAVEL POLICIES SOLD AND PEOPLE/ASSETS COVERED BY GROUP TRAVEL POLICIES – TWO-YEAR COMPARISON



Source: Code Governance Committee annual general insurance Code subscriber data collection, 2018-19 & 2019-20

Travel insurance claims

In relation to travel insurance, there were notable increases from 2018–19 to 2019–20 in the number of claims lodged by consumers, and in the number of declined and withdrawn claims. We understand that the increase in claims lodged is due to COVID-19, with a number of subscribers informing us of surges in claims lodged from March 2020 onwards.

Subscribers declined 16% of travel insurance claims lodged by consumers in 2019–20, which was considerably higher than for retail insurance overall (5%). In 2018–19 the percentage of travel insurance claims declined by subscribers was 12%, compared to 4% for retail insurance overall. The proportion of travel claims withdrawn in 2019–20 was 7%, compared to 8% for retail insurance overall.

FIGURE 26: RETAIL TRAVEL INSURANCE – TOP FIVE REASONS FOR DECLINED CLAIMS[33]

Reason for declined claims	Number
No coverage under policy	5,892
Policy exclusion applies	829
Pre-Existing damage/medical condition exclusion	636
Consumer did not provide requested documentation	153
Claim under deductible	124

FIGURE 27: RETAIL TRAVEL INSURANCE – TOP FIVE REASONS FOR WITHDRAWN CLAIMS

Reason for withdrawn claims	Number
Consumer self-withdrew claim	3,948
Consumer did not provide requested documentation	1,680
No coverage under policy	359
Claim amount under excess	133
Coverage under other provider	46

Source: Code Governance Committee annual general insurance Code subscriber data collection, 2019-20

FIGURE 28: 2019–20 RETAIL INSURANCE CLAIMS LODGED, DECLINED AND WITHDRAWN

Insurance class – retail	Claims lodged	Claims declined	% of claims declined	Claims withdrawn	% of claims withdrawn
Motor	1,870,331	7,933	0.42%	153,948	8.23%
Home	854,563	67,683	7.92%	115,140	13.47%
Personal & domestic property	987,516	84,606	8.57%	36,831	3.73%
Travel	**365,681**	**58,962**	**16.12%**	**26,848**	**7.34%**
Residential strata	59,339	1,978	3.33%	2,755	4.64%
Consumer credit	50,337	3,182	6.32%	1,086	2.16%
Sickness & accident	27,172	1,294	4.76%	1,330	4.89%
Total	**4,214,939**	**225,638**	**5.35%**	**337,938**	**8.02%**

Source: Code Governance Committee annual general insurance Code subscriber data collection, 2018-19 & 2019-20

33 Number derived from subscribers' completed feedback.

FIGURE 29: RETAIL TRAVEL CLAIMS LODGED, DECLINED AND WITHDRAWN – TWO-YEAR COMPARISON

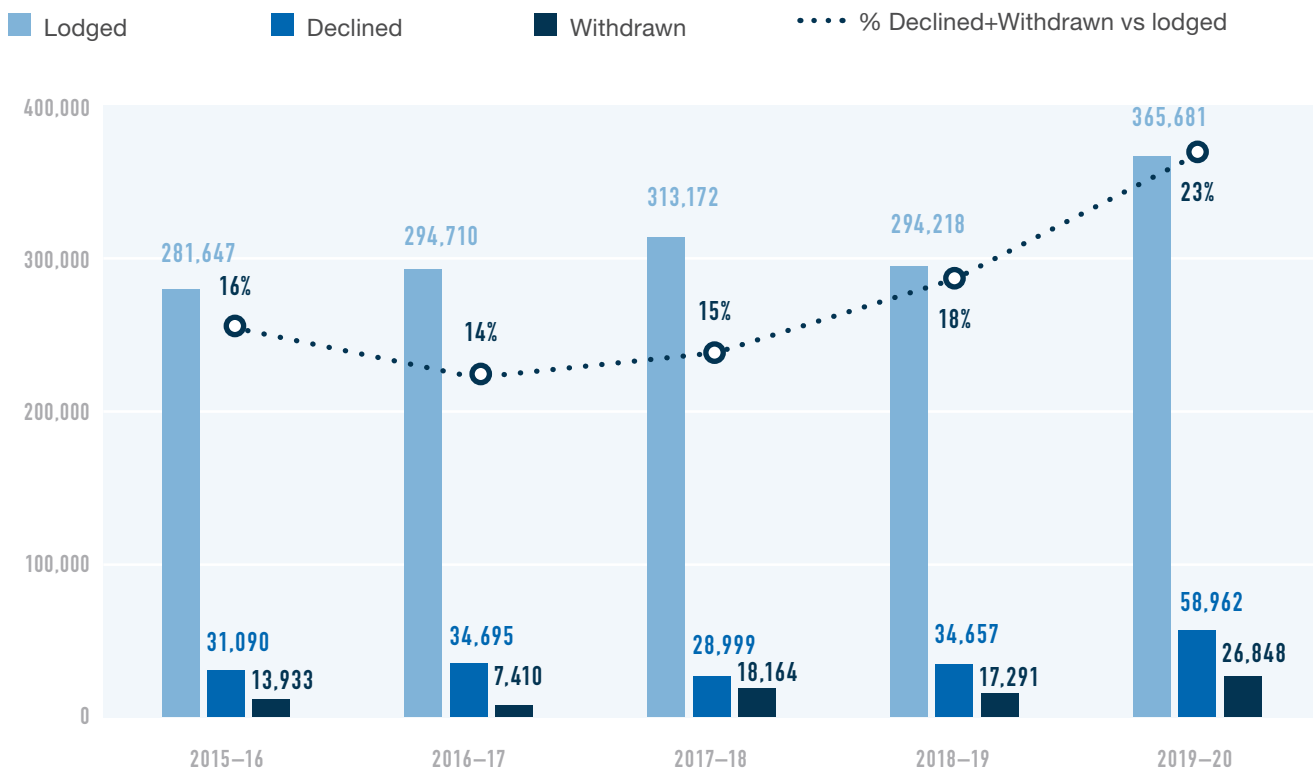
Insurance class – retail travel	1 July 2018 to 30 June 2019	1 July 2019 to 30 June 2020	Change	% change
Claims lodged	294,218	365,681	71,463	24%
Claims declined	34,657	58,962	24,305	70%
Claims withdrawn	17,291	26,848	9,557	55%
Complaints lodged	3,450	5,805	2,355	68%

Source: Code Governance Committee annual general insurance Code subscriber data collection, 2018-19 & 2019-20

Five-year trends in travel insurance

The proportion of travel insurance claims declined and withdrawn over the past five years has been increasing, with 23% of claims (nearly one in four) either declined or withdrawn in 2019–20. This trend is of concern to the Committee. The increase in declined claims suggests that consumers may not understand what the policy they have purchased covers and are claiming for items that are not covered by the policy. The increase in withdrawn claims could indicate deficiencies in subscribers' claims handling processes. The Committee encourages subscribers to review the reasons that travel insurance claims are declined or withdrawn to ensure they are meeting all Code obligations.

FIGURE 30: LODGED, DECLINED AND WITHDRAWN CLAIMS – FIVE-YEAR TREND



Source: Code Governance Committee annual general insurance Code subscriber data collection, 2015-16, 2016-17, 2017-18, 2018-19 & 2019-20

Travel insurance complaints

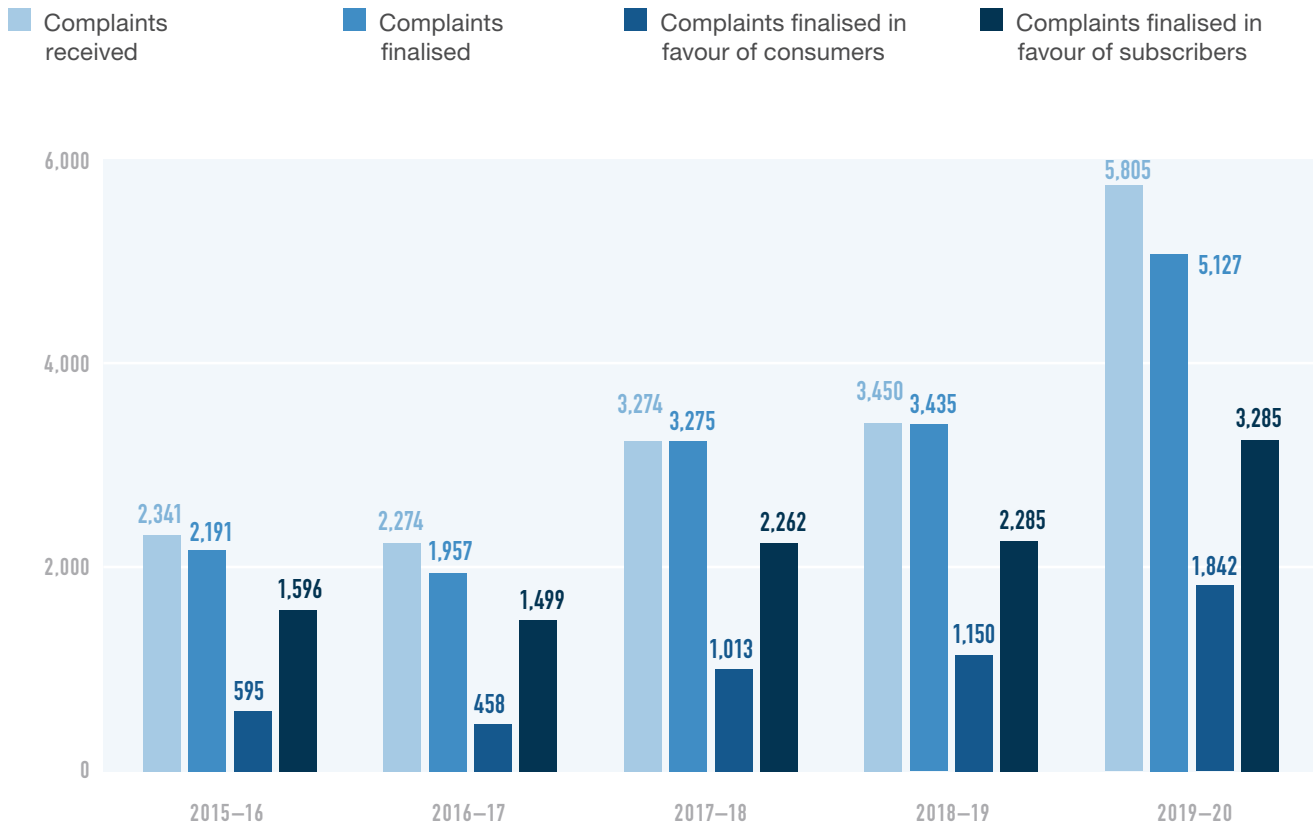
Complaints related to travel insurance have increased each year over the past five years. This is accompanied by an increased proportion of complaints being resolved in favour of consumers. The Committee is concerned this this trend may indicate that subscribers are not adequately considering the need for changes to processes and procedures to address the underlying reasons for disputes.

FIGURE 31: TOP FIVE REASONS FOR TRAVEL INSURANCE COMPLAINTS 2019–20

Reason for travel insurance complaint	Number
Declined claims and Claims handling	4,986
Claim value/Settlement	295
Buying insurance	482
Employees/Authorised Representatives	41
Financial hardship	1

Source: Code Governance Committee annual general insurance Code subscriber data collection, 2019-20

FIGURE 32: TRAVEL INSURANCE COMPLAINTS RECEIVED BY SUBSCRIBERS – FIVE-YEAR TREND



Source: Code Governance Committee annual general insurance Code subscriber data collection, 2015-16, 2016-17, 2017-18, 2018-19 & 2019-20

Transitioning to the 2020 Code

The 2020 Code comes into full effect on 1 July 2021. Parts 9 and 10 of the 2020 Code have already come into effect. The 2014 Code will cease to operate from 1 July 2021, which means all Code subscribers must comply with the obligations in the new Code from this date.

Highlights of the 2020 Code

The Code has been comprehensively updated and rewritten, taking into account the recommendations in the final report of the Royal Commission as well as most of the reform suggestions made by this Committee. Importantly, the new Code provides the Committee with enforceable powers of sanction in the event of a Code breach by a subscriber.

Critical to the application of the 2020 Code are several principles – outlined at the beginning – that underpin how the general insurance industry treats people, how it conducts itself, and its decision-making through:

- inclusiveness when designing insurance to meet the community's diversity and changing needs
- value, transparency and fairness of products and services
- promotion of trust, integrity and respect
- the provision of accessibility and additional support
- the resolution of any concerns and prevention of prevent future concerns
- adding value to the community.

Principles-based obligations in the outgoing Code have been rolled into a single overarching obligation in paragraph 21 of the new Code: subscribers, their employees, distributors and service suppliers must be honest, efficient, fair, transparent and timely in their dealings with consumers.

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

VULNERABILITY AND FINANCIAL HARDSHIP

One of the most significant improvements to the 2020 Code is the strengthening of the financial hardship standards to ensure that vulnerable people are treated fairly. Part 10 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.

Part 9 (Supporting customers experiencing vulnerability) has 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.

BUYING INSURANCE

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

One of the key updates is replacing the term 'Authorised Representative' with 'Distributor'. This clarifies and expands the types of external sellers captured by the 2020 Code when engaged by subscribers to sell their retail general insurance products. Subscribers to the 2020 Code must ensure that external sellers they engage to act on their behalf are aware of the expanded definition of 'Distributor' and what this means in terms of Code obligations that will apply to each of them. The expanded definition of 'Distributor' was also highlighted in a report recently published by the Insurance Brokers Code Compliance Committee, which monitors insurance brokers' compliance with the Insurance Brokers Code of Practice.[34]

Part 4 (Standards for us and our Distributors) specifies the conduct consumers can expect from subscribers and their distributors when buying insurance, as well as committing subscribers to providing professional and competent sales practices, supported by appropriate education, training and monitoring of employees and distributors.

Part 6 (Buying insurance) includes obligations related to pressure selling, applying for or renewing insurance policies, premium comparison, and the sale of consumer credit insurance.

CLAIMS

Among the most important changes introduced into the 2020 Code are 43 new standards (part 15 –Claims investigation standards) that apply to the investigation of claims carried out by subscribers' employees and their external investigators. These new standards are aimed at providing greater transparency about claims investigations, interviewing consumers including minors, accessing interpreters and support persons, and investigators' conduct.

Part 8 (Claims) has been strengthened with the addition of new claims handling standards including the following:

- if an uninsured person contacts a subscriber because they wish to make a claim against one of its customers, it must tell them about its claims process and what it requires to begin the claim (paragraph 60)
- if a subscriber has accepted an uninsured person's claim under its insured's motor vehicle policy, then it must tell them about the next steps in the claims process, its complaints process, and the name and contact details of the person they may contact if they have any questions about their claim (paragraph 60)
- if a scope of works is needed for a home building claim, a subscriber must provide information to help consumers understand how it works, its purpose and what is involved (paragraph 61)
- if a subscriber decides to offer a consumer a cash settlement under a home building policy, it must provide consumers with information to help them understand how cash settlements work and how decisions are made on cash settlements (paragraph 79)
- subscribers and their service suppliers must treat consumers who have suffered a total loss with sensitivity. If a subscriber has accepted a consumer's claim for a total loss under a home building and home contents insurance policy – and the consumer can't provide proof of ownership because it was lost in or damaged by the insured event – provided that ownership of the insured property is clear, the subscriber will not require them to provide:
  - proof of ownership; nor
  - a list of insured property that was lost or damaged (paragraph 80)
- The requirement to provide specified information to a consumer in writing when a subscriber has denied their claim now also applies when it does not pay their claim in full, namely:
  - which parts of the claim it did not accept
  - the reasons for its decision
  - that the consumer has a right to ask for information about them that the subscriber relied on when assessing their claim
  - that the consumer has a right to ask for copies of reports from services suppliers or external experts that it relied on
  - about its complaints process (paragraph 81).

34 *Insurance Brokers Code Compliance Committee Own Motion Inquiry Report – Sale of add-on general insurance products*, pages 10-11. https://insurancebrokerscode.com.au/app/uploads/2020/12/IBCCC-OMI-Sale-of-add-on-insurance-Dec-2020.pdf

Timeline for Code subscribers' transition to the 2020 Code

When the ICA first released the 2020 Code on 1 January 2020, it had expected Code subscribers to implement it and be ready to run with it from 1 January 2021. No one had anticipated a global pandemic that would threaten lives and livelihoods.

The Australian Government deemed general insurance an essential service during the COVID-19 crisis, stretching the industry's operational capacity and ability to effectively comply with its obligations under the 2014 Code. This occurred at a time when the industry was already dealing with the severe consequences of the bushfire crisis and other weather events, while at the same time preparing to operate under the new 2020 Code by 1 January 2021.

The ICA sought greater certainty from us about our approach to Code compliance during this rapidly evolving period. As a result, in April 2020 we wrote to the ICA strongly emphasising that it remained essential that the industry did not disregard the Code at a time of extreme crisis when consumers needed it the most. Moreover, we highlighted that it was critical that industry prioritise vulnerable consumers, those experiencing financial hardship, and those whose damaged properties pose a risk to them or others. Consumers want and are entitled to the protections of the Code, especially during a crisis such as the global pandemic, when they are most likely to be affected by family violence and financial hardship.

We confirmed that we would maintain our focus on outcomes that constitute or are indicative of significant consumer harm and expected industry to fulfil its obligations in such circumstances in accordance with the spirit of the Code. This included an expectation that industry would continue to monitor compliance, provide timely reports of breaches to their boards and notify us of significant breaches of the Code.

On 7 May 2020, the ICA announced[35] a revised timeline for Code subscribers' transition to the 2020 Code. Under the new timeline, the implementation of some components of the 2020 Code have been postponed, while others have been prioritised and fast-tracked, with a sharpened focus on the standards that provide protections to vulnerable consumers and those experiencing financial hardship.

Overall, except for parts 9 and 10 of the 2020 Code, the ICA has delayed Code subscribers' compliance with the remainder of the 2020 Code by six months. We have outlined the key elements of the ICA's revised transition timeline below.

WHAT IS OPERATIONAL NOW?

Code subscribers were required to meet a key milestone on **1 July 2020**, namely to make publicly available on their websites policies that describe how they will support individuals affected by family violence, as set out in paragraph 95 of the 2020 Code.

In addition, the ICA required Code subscribers to provide support for individuals who are experiencing vulnerability, including financial hardship, within the spirit and intention of the key provisions in part 9 – Supporting customers experiencing vulnerability and part 10 – Financial Hardship of the 2020 Code.

Subscribers reached the next major milestone in Code implementation **on 1 January 2021**, the date that parts 9 and 10 became operational.

35 Insurance Council of Australia News Release: 'Insurance Council fast-tracks new Code of Practice vulnerability and hardship provisions', May 2020.

WHAT WILL BE OPERATIONAL ON 1 JULY 2021?

The full 2020 Code, including the following parts, will be operational by **1 July 2021** and Code subscribers must be ready to comply by then:

- **Part 3** – Our obligation to you
- **Part 4** – Standards for us and our distributors
- **Part 5** – Standards for our service suppliers
- **Part 6** – Buying insurance
- **Part 7** – Cancelling an insurance policy
- **Part 8** – Making a claim
- **Part 11** – Complaints
- **Part 12** – Your access to information
- **Part 13** – Enforcement, sanctions and compliance
- **Part 14** – Promoting, reviewing and improving the Code
- **Part 15** – Claims investigation standards.

What does phased transition mean for the Committee and Code subscribers?

The revised transition timeline means that Code subscribers are implementing parts of the 2020 Code in separate phases. This phased transition also has an impact on how the Committee can monitor and enforce some parts of the 2020 Code prior to 1 July 2021, as well as how it deals with the outgoing 2014 Code.

Prior to 1 July 2021, the transitional arrangements in place mean that the relevant parts of the 2020 Code will be binding on Code subscribers by a specified date, and therefore enforceable by the Committee, as if they were a part of the 2014 Code. Figure 33 summarises the effective dates that apply to various parts and the status of the outgoing 2014 Code.

FIGURE 33: EFFECTIVE DATES FOR 2020 CODE AND STATUS OF 2014 CODE

2020 Code provisions	Effective date of 2020 Code	Status of 2014 Code
Paragraph 95 – a Code subscriber must have a publicly available policy to support individuals affected by family violence. Sits in part 9 – Supporting customers experiencing vulnerability	No later than 1 July 2020	There is no counterpart under the 2014 Code
Part 9 – Supporting customers experiencing vulnerability	No later than 1 January 2021, but may adopt earlier if practicable	There is no counterpart under the 2014 Code
Part 10 – Financial hardship	No later than 1 January 2021, but may adopt earlier if practicable	Section 8 – Financial hardship no longer applies from 1 January 2021
Parts 1-8 and 11-15	No later than 1 July 2021 (unless adopted earlier)	Code ceases to operate from 1 July 2021, or earlier if a subscriber adopts earlier

From a Code compliance point of view, we measured subscribers' conduct against the 2014 Code during 2019–20 and worked with subscribers to implement corrective actions aimed at facilitating their compliance with corresponding obligations under the incoming 2020 Code. Moreover, we viewed subscribers' conduct through the lens of consumer vulnerability and financial hardship as subscribers were required to apply the spirit of parts 9 and 10 of the new 2020 Code in the lead-up to 1 January 2021.

The Committee's 2020 Code transition plan

WHAT IS THE COMMITTEE'S PLAN FOR TRANSITION TO THE NEW 2020 CODE?

We began work on mapping our governance requirements and operations to the 2020 Code prior to the end of 2019–20. In July 2020 we revised our transition plan, following the ICA's release of a revised timeline for implementation of the 2020 Code and with a new Chair at the Committee's helm.

Our revised transition plan has been progressing along three parallel routes, addressing the following areas:

PART A: GOVERNANCE

This incorporates a review of the Committee's governance arrangements, and amendment where required, to align them with the 2020 Code and with the anticipated revision of our governance framework. It includes the following items:

- mapping of Committee functions, powers and responsibilities
- review of delegation of existing Committee functions
- developing procedures that support the Committee's exercise of its functions, powers and responsibilities
- reporting requirements.

PART B: OPERATIONS

This incorporates a review of operational procedures across the Code team, and amendment where required, to align with the 2020 Code and the revised Committee Charter. It includes the following items:

- updating operating procedures
- developing advice/guidance for the Committee on the scope and/or interpretation of specific provisions of the 2020 Code, including in relation to the non-mandatory guidelines attached to the 2020 Code
- incorporating the new 2020 Code into the Committee's priorities assessment framework.

PART C: SUBSCRIBERS' TRANSITION

This incorporates assessing whether Code subscribers have implemented the 2020 Code in line with the phased transition plan, and providing guidance to improve their compliance. It includes the following items:

- monitoring of subscribers' compliance as they transition to the 2020 Code
- assessing subscribers' implementation of the 2020 Code following the end of each transition phase
- developing and providing guidance on the Committee's approach to imposing sanctions.

By the time we publish this annual report, many of the tasks under our transition plan will have been completed.

What work has the Committee completed or is about to undertake that will assess subscribers' 2020 Code readiness?

CHECKING IF SUBSCRIBERS HAVE PUBLISHED THEIR FAMILY VIOLENCE POLICIES ON THEIR WEBSITES

As outlined earlier, the ICA required subscribers to publish on their websites policies that describe how they will support individuals affected by family violence (paragraph 95, 2020 Code) by 1 July 2020. We assessed whether subscribers had met this key milestone by conducting a desktop audit of subscribers' websites to identify whether they had published their family violence policies and ease of accessibility.

In summary, 99 (92%) of the 108 organisations required to publish their family violence policies on their websites did so. The remaining nine (8%) organisations did not have publicly available family violence policies either because the relevant organisation did not have a website, or because it is part of a corporate group that has a group or international website. The Committee worked with each of these organisations to ensure they published family violence policies on their websites. It also recorded a significant breach of paragraph 95 for one of these organisations, and a breach for each of the remaining seven organisations.

The outcomes of this desktop audit were published in a report, *Assessment of Compliance with new Provision on Family Violence Policies* – March 2021.

CHECKING IF SUBSCRIBERS HAVE IMPLEMENTED PARTS 9 AND 10 OF THE 2020 CODE

On 1 January 2021, part 9 – Supporting customers experiencing vulnerability and Part 10 – Financial Hardship became operational.

Part 9 is an entirely new addition to Code obligations. It sets out the standards that Code subscribers must comply with to support customers experiencing vulnerability, including individuals they are seeking to recover money from. It comprises 14 subsections that apply only to retail insurance products.[36]

Part 10 builds on the standards under the outgoing 2014 Code and sets out 34 subsections that apply to Code subscribers when dealing with customers and non-customers experiencing financial hardship. It includes new Code obligations, and unlike Part 9, Part 10 applies to both retail insurance products and wholesale insurance products.[37]

We will be testing subscribers' compliance with Parts 9 and 10 through a focused inquiry which we expect to distribute during quarter 3 of 2020–21. The inquiry will enable us to:

- identify if any subscribers have not yet begun or completed their implementation of Part 9 and/or Part 10
- identify which Code subscribers we may need to work with to ensure implementation is prioritised and occurs within an appropriate timeframe
- consider any further action by the Committee, including applying a sanction, for a failure to implement Part 9 and/or Part 10 by 1 January 2021.

36 Part 16 of the 2020 Code defines "Retail Insurance" as comprising general insurance products of the following types: motor vehicle; home building; home contents; sickness and accident; Consumer Credit; travel; and, personal and domestic property.

37 Part 16 of the 2020 Code defines "Wholesale insurance" as a general insurance product covered by the Code which is not Retail Insurance.

Committee activities 2019–20

During 2019–20, 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.

Investigating Code breach allegations

Code breach allegations from consumers, third parties and AFCA (since 1 November 2018, and prior to that, the Financial Ombudsman Service) are considered by the Committee. The Code gives the Committee the power to investigate these allegations, determine whether any breaches have occurred, work with Code subscribers to agree on any corrective measures they should apply, and monitor their implementation. 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.

The Committee's work to investigate referrals to determine whether there has been a breach or significant breach of the Code is detailed above at 'Breaches identified by the Committee'.

Publications and targeted monitoring activities

The publication of the Committee's Annual Report 2018-19 attracted significant industry and regulatory interest when it was published in April 2020. During 2019-20, the Committee developed and released two further publications. It also worked with subscribers to develop a pilot data collection program to expand the Committee's data collection framework.

ANNUAL REPORT: GENERAL INSURANCE IN AUSTRALIA 2018-19 AND CURRENT INSIGHTS

Published in April 2020, the Committee's *Annual Report 2018–19* provided an overview of the general insurance industry in Australia, along with a snapshot of trends and service standards in the industry during 2018–19 and the first half of 2019–20. The report also included 17 recommendations for subscribers to improve practices and their compliance with the Code.

Articles about the report appeared in the *Australian Financial Review* and *Insurance News* and it also generated considerable industry and regulatory interest in the report. Concerned at the high number of Code breaches recorded by subscribers during 2018–19, the House of Representatives Standing Committee on Economics called the General Manager of the Committee's Secretariat as a witness on behalf of the Committee in a public hearing on the insurance sector as part of its *Review of the Four Major Banks and other Financial Institutions*.

LIVING THE CODE

In June 2020, the Committee published *Living the Code: Embedding Code obligations in compliance frameworks*. This important publication followed from an inquiry into subscribers' practices that builds on the work of the Royal Commission and provides valuable guidance on how to place the Code – and the Code's purpose of doing the right thing by consumers – at the heart of all strategy and decision-making.

The report was the result of an own motion inquiry launched in response to the Committee's concerns that an underreporting of Code breaches reflected weaknesses in subscribers' compliance monitoring frameworks, and that subscribers were not taking the Code's obligations as seriously as they should. It outlines how the Committee has been actively working with the general insurance industry to implement the Royal Commission recommendations around culture, leadership and governance at all levels.

To help subscribers achieve this, *Living the Code* contains 22 clear and simple recommendations about how to make the Code a living and successful document with valuable outcomes, such as:

- the importance of developing a consumer-centric culture that values honesty and fairness
- the need for those at the top of insurance organisations to 'set the tone'
- robust governance processes that encourage and enable everyone in the insurance organisation to 'live the Code'.

There was significant industry and media interest in *Living the Code*. Upon the release of the report, *Insurance News* published two articles about it, while the Consumers Federation published one article.

GUIDANCE NOTE ON SIGNIFICANT BREACH OBLIGATIONS

In June 2020, the Committee issued *Guidance Note No.2 Significant breach obligations – General Insurance Code of Practice*, setting out the Committee's expectations of subscribers to ensure they:

- can appropriately identify a significant breach
- report significant breaches to the Committee in an efficient and timely manner
- understand the expected timeframe for correcting a significant breach
- understand the circumstances in which the Committee will close a significant breach matter.

The Guidance Note was published in response to the Committee's inquiry into compliance monitoring and reporting frameworks and the influx of significant breach matters reported by industry since 2018–19.

The Committee's inquiries revealed that subscribers were 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. Some subscribers have historically reported a disproportionally low number of significant breaches when compared to other subscribers of comparable size and market share.

These findings suggested that subscribers were failing to understand and interpret the definition of a 'significant breach' as set out in the Code, and unwilling or unprepared to review breaches and their root causes for evidence of systemic failings and major problems.

INDUSTRY DATA SETS – A PILOT PROGRAM

The Committee has begun collecting new data from our subscribers designed to expand our industry data collection framework. This will give the Committee deeper insights into – and help subscribers identify – emerging risks and areas of poor industry practice that need to be examined more closely.

With feedback received from our subscribers and the ICA's National Code Committee, we were able to begin collection of Phase I of the new data sets. Data collected from subscribers under the pilot program included:

- 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. Subscribers completed their submissions to Phase 1 of the survey in January 2020. Part of the collection process focused on gathering information, including feedback from subscribers about implementing the new data sets and the data definitions. This feedback will enable the Committee to provide effective commentary and guidance to subscribers and encourage them to provide the necessary data consistently and accurately, now and into the future.

Engagement with stakeholders

The Committee remained committed to engaging with a range of stakeholders during 2019–20, including consumer groups, Code subscribers, regulators and AFCA.

CONSUMER ADVOCATES

The Committee and the Secretariat met with various consumer advocates throughout 2019–20.

It attended two consumer advocate conferences during the year: the annual conference of the South Australian Financial Counsellors Association in Adelaide on 27 August 2019; and the ICA's Family Violence Workshop on 20 September 2019. The ICA workshop provided an opportunity for industry, consumer representatives, AFCA and ASIC to consider in detail the issues arising from family violence and general insurance.

We delivered a presentation to representatives of Settlement Services International (SSI) in Sydney on 5 September 2019. SSI is a leading community-based not-for-profit organisation providing a range of services in the areas of refugee settlement, asylum seeker assistance, housing, multicultural foster care, disability support and employment services. The presentation focused on the Committee's work and how it can positively impact SSI's clients.

We also held meetings with representatives from various consumer advocate groups. We met with Consumers' Federation of Australia Chair, Gerard Brody, and Deputy Chair, Gordon Renouf, on 5 March 2020. We attended a meeting on 11 June 2020 with representatives of Consumer Action Law Centre, Financial Rights Legal Centre and Victorian Aboriginal Legal Service to discuss the 2020 Code, vulnerability and hardship issues, and the forthcoming own motion inquiry into travel insurance.

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 2019–20, the Committee and the Secretariat met several times with ASIC, the Australian Prudential Regulation Authority (APRA) and Treasury to share work in progress and to 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.

INDUSTRY

As part of the Committee's inquiry into the adequacy of governance, culture and compliance frameworks, 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.

The Secretariat met with 17 individual Code subscribers during 2019–20 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.

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; as well as welcoming ICA representatives to Committee meetings.

The Committee also worked closely with the ICA's National Code Committee and the ICA during the year, meeting regularly with both bodies to discuss the Committee's activities and Code matters.

AUSTRALIAN FINANCIAL COMPLAINTS AUTHORITY (AFCA)

The Committee enjoyed a close working relationship with AFCA during 2019–20. The Committee and Secretariat worked closely with AFCA meeting regularly to share insights and updates on our work.

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON ECONOMICS

The General Manager of the Secretariat appeared before the House of Representatives Standing Committee on Economics in June 2020 as part of the Standing Committee's *Review of the Four Major Banks and other Financial Institutions*.

CODE REVIEW

The Committee continued its engagement with the ICA as it finalised its review of the Code. The Committee provided comments and recommendations throughout the review process and has worked with the ICA in preparation of the new Code.

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 from various sources – its own recent monitoring, desktop audits, own motion inquiries, Code breach investigations, information on ASIC activities, issues arising in AFCA cases and input from consumer advocates – 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 Sydney in February 2020.

The Committee met a further eight times in 2019–20, 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:

- work with the ICA, the ICA's NCC and subscribers to facilitate a successful transition to the 2020 Code
- build capacity to increase resources for compliance monitoring and subscriber guidance (including Guidance Notes)
- develop subscriber compliance benchmarking
- commence the next phase of the Committee's new data sets pilot program
- proactively work with subscribers to identify, report and prevent significant breaches
- continue industry engagement to improve reporting and data accuracy.

Committee members

The Committee has three members: an independent Chair and one representative each of industry and consumers.

LYNELLE BRIGGS AO

– INDEPENDENT CHAIR (OUTGOING)

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.

VERONIQUE INGRAM PSM

– INDEPENDENT CHAIR (INCOMING)

With degrees in law and politics, Veronique Ingram has extensive experience across corporate governance and financial regulation in Australia and internationally. She has held a number of senior positions in the Commonwealth Attorney-General's Department and the Treasury.

She was the Chief Executive and Inspector-General in Bankruptcy at the Australian Financial Security Authority from 2009 to 2017. She previously served as the Australian Ambassador to the OECD in Paris from 2005 to 2008 and was Chair of its Audit Committee and Committee on Corporate Governance. Prior to that she was General Manager, Finance System Division, in the Commonwealth's Treasury Department where she had responsibility for providing advice to the Treasurer about regulatory policy issues relating to banking, insurance and superannuation. She advised the government on financial system issues during the Global Financial Crisis in 2008 and also in relation to the collapses of Ansett Australia and HIH Insurance.

She has also held the position of Chief Adviser, International, in the Treasury with responsibility for advising the government on international economic developments and financial policy issues as well as Australia's participation in the International Monetary Fund, World Bank, Asian Development Bank, OECD, Asia-Pacific Economic Cooperation and G20 meetings of finance ministers.

She was recognised in the 2016 Australia Day Honours List for outstanding public service to the financial sector in Australia and internationally in the areas of public policy, administrative initiatives and service delivery.

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, she represented and supported two clients who gave evidence at the Royal Commission about their experience with the insurance industry.

CHERYL CHANTRY

– INDUSTRY MEMBER

Cheryl Chantry is an experienced senior executive who has significant capability in Board engagement, governance and management committees, as well as not-for-profit director experience. She has worked at senior executive levels in large, complex organisations such as IAG and Suncorp. She established her own business in early 2019, focused on executive coaching, leadership development and consulting. Prior to this she was the Executive General Manager, Customer Development, at IAG. She is a passionate advocate for the development of engaging organisational cultures where employee and consumer well-being are a central focus, and a champion of the important role the insurance industry plays in the Australian economy.

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, she was Senior Manager of Systemic Issues at FOS and has worked at AFCA and its predecessor schemes for over 15 years. She is a graduate of the Mt Eliza Business School and an accredited mediator. She holds a Bachelor of Commerce and a Bachelor of Laws degree from the University of Melbourne and a Graduate Diploma (Arts) from Monash University.

She works regularly 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 (OUTGOING)

Rose-Marie Galea 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.

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

ELIZABETH MCNESS

– CODE COMPLIANCE AND OPERATIONS MANAGER

Elizabeth McNess joined AFCA in November 2020 as the Code Compliance and Operations Manager to lead the team monitoring Code compliance on the Committee's behalf. Prior to this, she worked at ASIC in the Insurers stakeholder team. She has experience across regulation, financial capability, policy development and consumer advocacy, with a focus on engaging with financial firms to improve consumer outcomes. She holds a Bachelor of Economics from the Australian National University, a Masters of Social Science from the Royal Melbourne Institute of Technology and is completing a Masters of Administrative Law and Policy at the University of Sydney.

Appendix 1:
General Insurance Code subscribers as at 30 June 2020

1	AAI Limited
2	AI Insurance Holdings Pty Ltd
3	AIG Australia Ltd
4	AIOI Nissay Dowa Insurance Company Australia Pty Limited (ADICA)
5	ANZ Lenders Mortgage Insurance Pty Ltd
6	Allianz Australia Insurance Limited
7	Ansvar Insurance Limited
8	Assetinsure Pty Ltd
9	Auto & General Insurance Company Ltd
10	Berkshire Hathaway Specialty Insurance Company
11	Catholic Church Insurance Limited
12	Chubb Insurance Australia Limited
13	Commonwealth Insurance Limited
14	Cover-More Insurance Services Pty Ltd
15	Credicorp Insurance Pty Ltd
16	Defence Services Homes Insurance Scheme
17	Eric Insurance Limited
18	Factory Mutual Insurance Company
19	Genworth Financial Mortgage Insurance Pty Ltd
20	Great Lakes Insurance SE
21	Guild Insurance Limited
22	Hallmark General Insurance Company Ltd
23	Insurance Australia Limited
24	Insurance Manufacturers of Australia Pty Limited
25	LFI Group Pty Ltd
26	Lawcover Insurance Pty Limited
27	Lloyd's Australia Limited
28	Mitsui Sumitomo Insurance Co Ltd
29	NTI Limited
30	NIB Travel Services (Australia) Pty Ltd
31	OnePath General Insurance Pty Limited
32	PD Insurance Agency Pty Ltd
33	PetSure (Australia) Pty Ltd
34	QBE Insurance (Australia) Ltd
35	QBE Lenders' Mortgage Insurance Limited
36	RAA Insurance Limited
37	RAC Insurance Pty Limited
38	RACQ Insurance Limited
39	RACT Insurance Pty Limited
40	Sompo Japan Insurance Inc.
41	Southern Cross Benefits Limited
42	Swiss Re International SE
43	The Hollard Insurance Company Pty Ltd
44	The North of England Protecting and Indemnity Association Ltd t/a Sunderland Marine
45	The Tokio Marine & Nichido Fire Insurance Co Ltd
46	Virginia Surety Company Inc.
47	Westpac General Insurance Limited
48	XL Insurance Company Ltd
49	Youi Pty Ltd
50	Zurich Australian Insurance Ltd

For current list of General Insurance Code Subscribers, see https://insurancecode.org.au/about/code-subscribers/.

Appendix 1(a):
Lloyd's Coverholders and Claims administrators as at 30 June 2020

1	1Cover Pty Ltd
2	360 Accident and Health Pty Ltd
3	360 Farm and Regional Pty Ltd
4	360 Financial Lines Pty Ltd
5	360 Underwriting Solutions Pty Ltd
6	A.I.S Insurance Brokers Pty Ltd
7	About Underwriting Pty Ltd
8	Agile Underwriting Services Pty Ltd
9	AJ Gallagher t/a Offshore Market Placements Limited
10	Amazon Underwriting Pty Ltd
11	AON Risk Services Australia Ltd
12	Arch Underwriting at Lloyd's (Australia) Pty Ltd
13	Argenta Underwriting Asia Pte Ltd
14	ASG Insurances Pty Limited
15	ASR Underwriting Agencies Pty Ltd
16	ATC Insurance Solutions Pty Ltd
17	Australian Insurance Agency Pool t/a Fairways Agencies
18	Australian Warranty Network Pty Ltd
19	AWIB Pty Ltd ATF AWIB Unit Trust t/a Alan Wilson Insurance Brokers
20	Axis Underwriting Services Pty Ltd
21	BMS Risk Solutions Pty Ltd
22	Canopius Asia Pte Ltd t/a Canopius Australia & Pacific
23	Catalyst Consulting (Aust) Pty Ltd
24	Catlin Australia Pty Ltd
25	Cerberos Brokers Pty Ltd
26	Chase Underwriting Pty Ltd
27	Coffre-Fort Pty Ltd
28	Columbus Direct Travel Insurance Pty Ltd
29	CoverLink Pty Ltd
30	Coversure Pty Ltd
31	Downunder Insurance
32	Downunder Worldwide
33	Dual Australia Pty Ltd
34	East West Insurance Brokers Pty Ltd
35	Eclipse Business Insurance Pty Ltd
36	Edge Underwriting Pty Ltd
37	Edgewise Insurance Brokers
38	Edmund Insurance Pty Limited
39	Elkington Bishop Insurance Brokers Pty Ltd
40	Emergence Insurance Pty Ltd
41	Ensurance Underwriting Pty Ltd
42	Enterprise Underwriting Solutions Pty Ltd
43	Epsilon Underwriting Agencies Pty Ltd
44	Evari Insure Pty Ltd
45	Fitton Insurance (Brokers) Australia Pty Ltd
46	FTA Insurance Pty Ltd
47	Fusion Specialty Insurance Pty Ltd
48	Gard Insurance Pty Ltd
49	Genesis Underwriting Pty Ltd
50	Glenowar Pty Ltd t/a Fenton Green & Co
51	Go Unlimited Pty Ltd
52	Gow Gates Insurance Brokers Pty Ltd
53	High Street Underwriting Agency Pty Ltd
54	Holdfast Insurance Brokers Pty Ltd
55	Hostsure Underwriting Agency Pty Ltd
56	HQ Insurance Pty Ltd
57	HW Wood Australia Pty Ltd
58	IBL Ltd t/as Focus Underwriting

For current list of Lloyd's Coverholders and Claims administrators, see https://insurancecode.org.au/about/code-subscribers/.

59	Imalia Pty Ltd
60	Inglis Insurance Brokers Pty Ltd
61	Insurance Geeks Pty Ltd
62	Insurance Investment Solutions Pty Ltd
63	iTrek Pty Ltd
64	JUA Underwriting Agency Pty Ltd
65	Keystone Underwriting Pty Ltd
66	Liberty Specialty Markets Australia Pty Ltd
67	Lion Underwriting Pty Ltd
68	Lockton Companies Australia Pty Ltd
69	Logan Livestock Insurance Agency Pty Ltd
70	London Australia Underwriting Pty Ltd
71	Mainstay Underwriting Pty Lltd
72	Marsh & McLennan Agency Pty Ltd
73	Marsh Advantage Pty Ltd incl Victor Insurance
74	McLardy Mcshane Partners Pty Ltd
75	MiCover Pty Ltd
76	Millennium Underwriting Agencies Pty Ltd
77	Miramar Underwriting Agency Pty Ltd
78	MJW Langston Pty Ltd as trustee for the Wallis Family Trust t/a Aspect Underwriting
79	Newline Australia Insurance Pty Ltd
80	Nova Underwriting Pty Ltd
81	One Underwriting Pty Ltd (part of AON Risk Services)
82	Pacific Underwriting Corporation Pty Ltd
83	Pen Underwriting Pty Ltd (part of Pen Underwriting Group Pty Ltd)
84	Petcover Aust Pty Ltd
85	Petplan Australasia Pty Ltd
86	PI Direct Insurance Brokers Pty Ltd
87	Platinum Placement Solutions Pty Ltd
88	Point Underwriting Agency Pty Ltd
89	Precision Underwriting Pty Ltd
90	Procover Underwriting Agency Pty Ltd
91	Professional Risk Underwriting Pty Ltd
92	PSC NFIB Markets Pty Ltd t/a Skyline Underwriting
93	Quanta Insurance Group Pty Ltd
94	Quantum Underwriting Agencies Pty Ltd
95	Red Sky Insurance Pty Ltd
96	Specialist Underwriting Agencies Pty Ltd
97	Sportscover Australia Pty Ltd
98	Starr Underwriting Agents (Asia) Limited
99	Hostsure Underwriting Agency Pty Ltd
100	Miramar Underwriting Agency Pty Ltd
101	Procover Underwriting Agency Pty Ltd
102	Platinum Placement Solutions Pty Ltd
103	Sterling Insurances Pty Ltd
104	SURA Pty Ltd
105	SURA Film & Entertainment Pty Ltd
106	SURA Hospitality (formerly Guardian Underwriting)
107	SURA Labour Hire Pty Ltd
108	SURA Professional Risks Pty Ltd
109	SURA Speciality Pty Ltd
110	SURA Construction Pty Ltd
111	Trinity Pacific Underwriting Agencies Pty Ltd
112	Insurance Investment Solutions Pty Ltd
113	SureSeason Australia Pty Ltd
114	Tego Insurance Pty Ltd
115	The Barn Underwriting Agency Pty Ltd
116	Timark Casualty Solutions
117	Topsail Insurance Pty Ltd
118	Trident Insurance Group Pty Ltd
119	Wellington Underwriting Agencies Pty Ltd
120	Windsor Income Protection Pty Ltd
121	Woodina Underwriting Agency Pty Ltd
122	Wymark Insurance Brokers Pty Ltd
123	YourCover Pty Ltd
124	*Broadspire by Crawford & Company
125	*Claims Management Australasia
126	*Corporate Services Network Pty Ltd
127	*DWF Claims (Australia) Pty Ltd
128	*Employers Mutual Ltd t/a EML
129	*Gallagher Bassett Service Pty Ltd
130	*Insurx Pty Ltd
131	*Proclaim Management Solutions Pty Ltd
132	*Sedgwick Australia Pty Ltd

* Claims administrators

For current list of Lloyd's Coverholders and Claims administrators, see https://insurancecode.org.au/about/code-subscribers/.

Appendix 2:
Aggregated industry data 2019–20

Policies and claims

Insurance class	Individual policies	Group policies	Total policies	Lodged claims	Declined claims	Withdrawn claims
Retail	**40,781,359**	**157,443**	**40,938,802**	**4,214,939**	**225,638**	**337,938**
Wholesale	**2,630,482**	**215,223**	**2,845,705**	**505,785**	**5,842**	**28,643**
Grand total	43,411,841	372,666	43,784,507	4,720,724	231,480	366,581
Retail						
Motor retail	16,080,761	1,334	16,082,095	1,870,331	7,933	153,948
Home	11,186,304	2,160	11,188,464	854,563	67,683	115,140
Personal & domestic property	8,110,370	560	8,110,930	987,516	84,606	36,831
Travel	4,594,108	129,453	4,723,561	365,681	58,962	26,848
Consumer credit	347,045	11	347,056	50,337	3,182	1,086
Sickness & accident	229,422	23,896	253,318	27,172	1,294	1,330
Residential strata	233,349	29	233,378	59,339	1,978	2,755
Retail total	**40,781,359**	**157,443**	**40,938,802**	**4,214,939**	**225,638**	**337,938**
Wholesale						
Business pack	1,127,346	64,002	1,191,348	92,074	2,654	6,390
Liability	570,737	42,283	613,020	36,372	749	2,876
Primary industries pack	282,826	3,959	286,785	58,076	736	2,285
Motor wholesale	200,436	87,731	288,167	242,242	265	12,576
Business	154,762	11,547	166,309	34,655	1,010	2,345
Other	176,801	610	177,411	7,699	58	212
Contractors all risks	38,880	111	38,991	4,814	45	197
Industrial special risks	52,567	4,967	57,534	28,347	310	1,633
Primary industries	26,127	13	26,140	1,506	15	129
Wholesale total	**2,630,482**	**215,223**	**2,845,705**	**505,785**	**5,842**	**28,643**

Source: Code Governance Committee annual general insurance Code subscriber data collection, 2019-20

Received internal complaints (Stage Two complaints received by subscribers)

Insurance class	Access to information	Authorised representatives	Buying	Catastrophes	Claims	Employees	Financial hardship: Customers	Financial hardship: Recoveries	Total
Retail	**82**	**33**	**5,027**	**3,037**	**29,213**	**865**	**1,245**	**7**	**39,509**
Wholesale	**14**	**0**	**138**	**120**	**1,766**	**46**	**15**	**0**	**2,099**
Grand total	**96**	**33**	**5,165**	**3,157**	**30,979**	**911**	**1,260**	**7**	**41,608**
Retail									
Motor retail	46	7	2,568	638	11,531	220	980	7	15,997
Home	23	4	1,472	1,428	9,820	317	252	0	13,316
Travel	7	4	482	920	4,361	30	1	0	5,805
Personal & domestic property	6	0	245	12	2,506	10	9	0	2,788
Consumer credit	0	0	246	3	274	266	0	0	789
Residential strata	0	0	7	26	473	6	2	0	514
Sickness & accident	0	18	7	10	248	16	1	0	300
Retail total	**82**	**33**	**5,027**	**3,037**	**29,213**	**865**	**1,245**	**7**	**39,509**
Wholesale									
Motor wholesale	1	0	6	4	422	8	3	0	444
Business pack	0	0	51	62	597	30	1	0	741
Liability	1	0	22	21	175	4	2	0	225
Business	0	0	8	3	122	1	0	0	134
Primary industries pack	0	0	11	22	189	1	0	0	223
Other	12	0	33	1	120	2	9	0	177
Primary industries	0	0	1	6	53	0	0	0	60
Industrial special risks	0	0	5	1	75	0	0	0	81
Contractors all risks	0	0	1	0	13	0	0	0	14
Wholesale total	**14**	**0**	**138**	**120**	**1,766**	**46**	**15**	**0**	**2,099**

Source: Code Governance Committee annual general insurance Code subscriber data collection, 2019-20

Finalised internal complaints (Stage Two complaints finalised by subscribers)

Insurance class	Complaints category	Resolved in favour of consumer: finalised disputes 2019–20	Resolved in subscribers' favour: finalised disputes 2019–20	Total finalised disputes 2019–20
Retail		**15,091**	**22,709**	**37,800**
Wholesale		**508**	**1,459**	**1,967**
Grand total		**15,599**	**24,168**	**39,767**
Retail	Access to information	25	41	66
Retail	Authorised representatives	17	15	32
Retail	Buying	2,396	2,291	4,687
Retail	Catastrophes	1,262	1,554	2,816
Retail	Claims	10,133	18,157	28,290
Retail	Employees	280	372	652
Retail	Financial hardship	978	279	1,257
Retail total		**15,091**	**22,709**	**37,800**
Wholesale	Access to information	1	8	9
Wholesale	Authorised representatives	0	0	0
Wholesale	Buying	18	94	112
Wholesale	Catastrophes	23	97	120
Wholesale	Claims	453	1,224	1,677
Wholesale	Employees	8	24	32
Wholesale	Financial hardship	5	12	17
Wholesale total		**508**	**1,459**	**1,967**

Source: Code Governance Committee annual general insurance Code subscriber data collection, 2019-20

Group policies and People and assets

Insurance class	Group policies	People and assets
Retail	**157,443**	**17,372,671**
Wholesale	**215,223**	**7,914,385**
Grand total	**372,666**	**25,287,056**
Retail		
Travel	129,453	7,888,163
Sickness & accident	23,896	8,397,772
Personal & domestic property	560	1,043,236
Motor retail	1,334	20,308
Home	2,160	23,192
Consumer credit	11	-
Residential strata	29	-
Retail total	**157,443**	**17,372,671**
Wholesale		
Business packs	64,002	237,602
Liability	42,283	6,280,174
Motor wholesale	87,731	1,336,149
Business	11,547	44,981
Primary industries pack	3,959	7,015
Industrial special risks	4,967	4,019
Other	610	2,051
Contractors all risks	111	98
Primary industries	13	2,296
Wholesale total	**215,223**	**7,914,385**

Source: Code Governance Committee annual general insurance Code subscriber data collection, 2019-20

Appendix 3:
Aggregated Code breach data 2019–20

The aggregated breach data presented in Appendix 3 comprises data from all sources: breaches and significant breaches identified by the Committee, and breaches and significant breaches reported by Code subscribers.

Breaches by Code section and source

Code section	Identified by Committee	Significant breaches	Identified by subscribers	Total
4 – Buying insurance	9	40	3,973	4,022
5 – Standards for employees and authorised representatives	5	4	37	46
6 – Standards for service suppliers	9	3	38	50
7 – Claims	77	41	16,730	16,848
8 – Financial hardship	33	3	175	211
9 – Catastrophes	0	1	114	115
10 – Complaints and disputes	35	11	8,244	8,290
11 – Information and education	0	0	0	0
13 – Monitoring, enforcement and sanctions	0	8	4	12
14 – Access to Information	4	1	3,555	3,560
Grand total	**172**	**112**	**32,870**	**33,154**

Source: Code Governance Committee annual general insurance Code subscriber data collection, 2019-20

Top five areas of non-compliance

Code subsection	Breaches
7.13 – Inform on claim progress every 20 business days	5,735
14.1 – Abide by privacy laws when collect/store/use/disclose personal information	3,526
7.9 – Notify within 10 business days of claim acceptance/denial	2,926
7.16 – Decision made once all info/enquiries received/completed and notification within 10 business days of decision	2,301
4.4 – Sales process/services of employees/AR's efficient/honest/fair/transparent	1,902
Total	**16,390**

Source: Code Governance Committee annual general insurance Code subscriber data collection, 2019-20

Breaches by Code section and subsection

4 – Buying insurance Note: 'AR' means "authorised representatives"	Identified by Committee	Significant breaches	Identified by subscribers	Total
4.4 – Sales processes and services of employees/AR must be efficient, honest, fair and transparent	9	37	1,856	1,902
4.5 – Communications in plain language			4	4
4.6 – Ask for and rely on relevant information or documents only in assessing application			41	41
4.7 – Correct errors or mistakes related to application or when assessing application		1	1,021	1,022
4.8(a) – Provide reasons why insurance cannot be provided			20	20
4.8(a-d) – What subscriber will do if can't provide insurance			78	78
4.8(b) – If consumer asks, supply requested information underlying assessment of application				0
4.8(c) – Refer consumer to ICA/NIBA for alternative insurance options			87	87
4.9 – If a consumer business is entitled to cancel policy, must refund money owed within 15 business days		2	861	863
4.10(a-b) – Provide written notice of instalment non-payment at least 14 calendar days prior to cancellation			2	2
4.10(b) – within 14 days after cancellation by us, confirming our cancellation of your Instalment Policy			3	3
Grand total	**9**	**40**	**3,973**	**4,022**

Source: Code Governance Committee annual general insurance Code subscriber data collection, 2019-20

5 – Standards for employees and authorised representatives (AR)	Identified by Committee	Significant breaches	Identified by subscribers	Total
5.1(a) – Education and training of employees/AR to ensure competent and professional services		2	8	10
5.1(a-e) – Education, training and monitoring of employees/AR	4	2	23	29
5.1(b) – Employees/AR provide only services with expertise			4	4
5.1(c) – Monitoring performance of employees/AR to measure training effectiveness				0
5.1(d) – Education and training to correct employees/AR shortcomings				0
5.1(e) – Keep training records min. five years	1			1
5.2 – AR to notify subscriber of complaints and must handle these under its complaints process			2	2
5.3 – AR to inform consumer/small business of subscriber's identity and services provided on its behalf.				0
5.5 – AR to comply with Code when selling products on our behalf				0
Grand total	**5**	**4**	**37**	**46**

Source: Code Governance Committee annual general insurance Code subscriber data collection, 2019-20

6 – Standards for service suppliers	Identified by Committee	Significant breaches	Identified by subscribers	Total
6.2 – Service suppliers must provide their services honestly, efficiently, fairly and transparently	5	1	27	33
6.3(a) – Must use qualified service suppliers to provide competent and professional service				0
6.4 – Service supplier contracts reflect code standards		1		1
6.5 – Service suppliers must obtain approval before subcontracting their service				0
6.6 – Service suppliers to inform of insurer's identity and services provided on their behalf			1	1
6.7 – Service suppliers to notify subscriber of complaints and these must be handled under its complaints process	4	1	10	15
Grand total	**9**	**3**	**38**	**50**

Source: Code Governance Committee annual general insurance Code subscriber data collection, 2019-20

7 – Claims	Identified by Committee	Significant breaches	Identified by subscribers	Total
7.2 – Claims handling fair, transparent and timely	31	12	701	744
7.3 – Ask for and rely on relevant information only when deciding claim	1		91	92
7.4 – Correct errors or mistakes in dealing with claim		1	78	79
7.5 – Reasonable alternative timeframe			46	46
7.6 – Complaints process available to policy holders			4	4
7.7(a) – Fast track claim assessment/decision process			9	9
7.7(a-c) – Urgent financial need of benefit under policy			36	36
7.7(b) – Advance payment within five business days to alleviate hardship			7	7
7.7(c) – Provide details of complaints process			2	2
7.8 – Prior to lodging claim consumer can ask if policy covers loss. Will not discourage claim lodgement	1		216	217
7.9 – Notify within 10 business days of claim acceptance/denial		2	2,924	2,926
7.10(a) – Notify of any information required to make decision	1		88	89
7.10(a-c) – Within 10 business days notify consumer of further info/ assessment required	1	3	1,678	1,682
7.10(b) – Appointment of loss assessor/adjuster			11	11
7.10(c) – Provide initial estimate of timetable/decision making process			10	10
7.11 – Claim assessed on basis of facts, policy terms and law	5	8	130	143
7.12 – Notify within five business days of loss assessor/adjuster/ investigator appointment			63	63
7.13 – Inform consumer about claim progress every 20 business days	9	3	5,723	5,735
7.14 – Respond to routine requests within 10 business days	3	3	782	788
7.15 – Provide External Expert report to consumer within 12 weeks of engagement or inform of report progress/delay			16	16
7.16 – Decision made once all info/enquiries received/completed and notification within 10 business days of decision	6	3	2,292	2,301

7 – Claims	Identified by Committee	Significant breaches	Identified by subscribers	Total
7.17 – Claim decision made within four months of receiving claim unless exceptional circumstances apply. If no decision, must provide details of complaints process	5	2	237	244
7.18 – Decision made within 12 months if exceptional circumstances apply. If no decision, provide details of complaints process	3	1	16	20
7.19(a) – Reasons for decision must be in writing	2	1	136	139
7.19(a-d) – Denial of claim	2	1	718	721
7.19(b) – Inform of right to ask for info relied on in assessing claim. Supply within 10 business days	3		234	237
7.19(c) – Inform of right to ask for copies of service suppliers or external expert reports. Supply within 10 business days	2		87	89
7.19(d) – Provide details of complaints process to consumer	2	1	99	102
7.20(a) – Accept responsibility for materials/workmanship quality			1	1
7.20(a-b) – Selection and authorisation of repairer by subscriber				0
7.20(b) – Handle any complaint re quality/timeliness/conduct of work/ repairer			16	16
7.21(a) – Comply within agreed alternative timetable			3	3
7.21(a-c) – Must comply within timetables			231	231
7.21(b) – Conduct/timetable reasonable in the circumstances			16	16
7.21(c) – Cause of non-compliance if External Expert report delay and best endeavours used to obtain report			26	26
7.22 – Timetable compliance doesn't apply if court/tribunal/EDR commenced (except AFCA)			3	3
Grand total	**77**	**41**	**16,730**	**16,848**

Source: Code Governance Committee annual general insurance Code subscriber data collection, 2019-20

8 – Financial hardship	Identified by Committee	Significant breaches	Identified by subscribers	Total
8.3 – If money owed and experiencing financial hardship, may ask if entitled to assistance	1		4	5
8.4 – Upon informing of financial hardship, must supply financial hardship application and counselling hotline	8	1	74	83
8.5(a-b) – Reasonable evidence may assist in assessing financial hardship assistance				0
8.6 – Notify as reasonably practicable of financial hardship assessment. If no entitlement, provide reasons for decision and info on complaints process	8		65	73
8.7 – Collections put on hold until financial hardship request is assessed, and notification of decision given	3		9	12
8.8(a) – Work together to consider an arrangement	1		2	3
8.8(a-e) – Entitled to financial hardship assistance	1	1	10	12
8.8(d) – If release/discharge/waiver agreed to, confirm in writing and, if requested, notify any financial institution with interest in policy				0
8.8(e) – If unable to reach an agreement, provide details of complaints process	1		3	4

8.9 – If not entitled and circumstances change, can make further request for financial hardship assistance				0
8.10 – Any communication from agent re money owed will identify insurer and specify nature of claim	3			3
8.11 – Agents notified of financial hardship required to provide details of financial hardship process	3		1	4
8.12 – Any recovery action must comply with ACCC/ASIC guidelines	4	1	7	12
8.13 – If declaring bankruptcy, work together to provide written confirmation of debt owed. If no agreement, provide details of complaints process				0
Grand total	**33**	**3**	**175**	**211**

Source: Code Governance Committee annual general insurance Code subscriber data collection, 2019-20

9 – Catastrophes	Identified by Committee	Significant breaches	Identified by subscribers	Total
9.2 – Respond to catastrophe in efficient/professional/practical/ compassionate manner			0	0
9.3(a-b) – If property claim finalised within one month of catastrophe, consumer may request a review within 12 months of decision, even if released signed		1	10	11
9.3(a) – Inform consumer of entitlement to review claim decision when property claim finalised.			52	52
9.3(b) – Inform consumer of complaints process when property claim finalised.			52	52
Grand total	**0**	**1**	**114**	**115**

Source: Code Governance Committee annual general insurance Code subscriber data collection, 2019-20

10 – Complaints and disputes	Identified by Committee	Significant breaches	Identified by subscribers	Total
10.3 – Consumer entitled to make complaint about any aspect of relationship with subscriber	1		176	177
10.4 – Complaints handling must be fair, transparent and timely	8	1	500	509
10.5 – Inform consumer of right to make complaint and complaints process on website and in written communications			72	72
10.6 – Only ask for and rely on relevant information when dealing with complaint. If consumer asks, supply information relied on within 10 business days			44	44
10.7 – Correct errors and mistakes in complaint handling			32	32
10.8 – Notify consumer of name and contact details of employee assigned to handle complaint			924	924
10.9 - Complaints process doesn't apply if complaint resolved within five business days and response not requested in writing, excluding complaints about a declined claim, claim value or financial hardship			389	389
10.10 – Stages One and Two of complaints process not to exceed 45 calendar days. If unable to provide decision must inform consumer of reasons for delay and right to go to AFCA	7	1	1,000	1,008
10.11 – Respond to complaint within 15 business days if subscriber has all necessary information and completed investigation	7	2	1,171	1,180
10.12(a) – Notify consumer 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 Two.	2	1	240	243
10.12(a-b) – What subscriber will do if can't respond to complain within 15 business days	3	1	753	757
10.12(b) – Inform consumer of progress every 10 business days unless otherwise agreed	1	1	167	169
10.13(a) – Complaint decision must be in writing			27	27
10.13(a-d) – Respond to complaint in writing	2	2	312	316
10.13(b) – Provide reasons for decision in writing			14	14
10.13(c) – Consumer has right to take complaint to Stage Two if not satisfied with Stage One decision			795	795
10.13(d) – If consumer not satisfied with Stage Two decision, notify of right to go to AFCA	2	1	15	18
10.14 – If consumer not satisfied with Stage One decision, can ask subscriber to move to Stage Two			15	15
10.15 – Stage Two complaint must be reviewed by appropriately qualified and authorised employee(s). Where practicable employee should not be same employee who handled Stage One or who was subject of complaint			11	11
10.16 – Inform consumer of progress every 10 business days			640	640
10.17 – Within 15 business days of escalation of complaint to Stage Two, subscriber must respond to complaint if it has all necessary information and completed investigation			513	513
10.18 – Notify consumer as soon as reasonably practicable within 15 business days of reasons for delay and agree on reasonable timeframe. If no agreement, advise consumer of right to go to AFCA			355	355
10.19(a) – Final decision on complaint and reasons must be in writing			5	5
10.19(a-b) – Response to complaint must be in writing		1	52	53

10 – Complaints and disputes	Identified by Committee	Significant breaches	Identified by subscribers	Total
10.19(b) – Notify consumer of right to go to AFCA including AFCA timeframe and contact details			1	1
10.22 – If not satisfied with Stage Two decision or if complaint unresolved within 45 calendar days, consumer entitled to refer complaint to AFCA			10	10
10.23 – AFCA determinations are binding on subscribers	2		11	13
Grand total	**35**	**11**	**8,244**	**8,290**

Source: Code Governance Committee annual general insurance Code subscriber data collection, 2019-20

13 – Monitoring, enforcement and sanctions	Identified by Committee	Significant breaches	Identified by subscribers	Total
13.2(a) – Have appropriate systems/processes to enable CGC compliance monitoring		1	3	4
13.3 – Report within 10 business days to CGC any significant code breach		7	1	8
Grand total	**0**	**8**	**4**	**12**

Source: Code Governance Committee annual general insurance Code subscriber data collection, 2019-20

14 – Access to information	Identified by Committee	Significant breaches	Identified by subscribers	Total
14.1 – Abide by privacy laws when collecting, storing, disclosing personal information		1	3,526	3,527
14.2 – If asked by consumer/small business, provide access to information relied on	2		10	12
14.3 – If asked by consumer/small business, give access to reports of Service Suppliers or External Experts relied on			3	3
14.4(a) – Where information is protected from disclosure by law, including Privacy Act 1988			12	12
14.5(a-c) – What subscriber will do when declining access or disclosure	1		3	4
14.5(a) – Will not deny access or disclosure unreasonably	1		1	2
14.5(b) – If not giving access or disclosing information, provide reasons			0	0
14.5(c) – Provide details of complaints process			0	0
Grand total	**4**	**1**	**3,555**	**3,560**

Source: Code Governance Committee annual general insurance Code subscriber data collection, 2019-20

Appendix 4:
Comparative data

Total policies (individual + group)

Insurance class	Total policies 2018–19	Total policies 2019–20	% difference – total policies	Absolute difference – total policies
Retail				
Motor retail	16,146,138	16,082,095	-0.40%	-64,043
Home	11,345,303	11,188,464	-1.38%	-156,839
Personal & domestic property	8,070,461	8,110,930	0.50%	40,469
Travel	4,979,340	4,723,561	-5.14%	-255,779
Consumer credit	551,960	347,056	-37.12%	-204,904
Sickness & accident	269,567	253,318	-6.03%	-16,249
Residential strata	210,227	233,378	11.01%	23,151
Total – retail	**41,572,996**	**40,938,802**	**-1.53%**	**-634,194**
Wholesale				
Business pack	1,096,652	1,191,348	8.64%	94,696
Liability	615,147	613,020	-0.35%	-2,127
Primary industries pack	278,693	286,785	2.90%	8,092
Motor wholesale	239,682	288,167	20.23%	48,485
Business	222,278	166,309	-25.18%	-55,969
Other	176,792	177,411	0.35%	619
Industrial special risks	48,804	57,534	17.89%	8,730574
Contractors all risks	46,027	38,991	-15.29%	-7,036
Primary industries	29,217	26,140	-10.53%	-3,077
Total – wholesale	**2,753,292**	**2,845,705**	**3.36%**	**92,413**
Grand total	**44,326,288**	**43,784,507**	**-1.22%**	**-541,781**

Source: Code Governance Committee annual general insurance Code subscriber data collection, 2018-19 & 2019-20

Individual policies only

Insurance class	Total policies 2018–19	Total policies 2019–20	% difference – total policies	Absolute difference – total policies
Retail				
Motor retail	16,146,112	16,080,761	-0.40%	-65,351
Home	11,341,106	11,186,304	-1.36%	-154,802
Personal & domestic property	8,069,994	8,110,370	0.50%	40,376
Travel	4,106,658	4,594,108	11.87%	487,450
Consumer credit	551,960	347,045	-37.12%	-204,915
Sickness & accident	241,072	229,422	-4.83%	-11,650
Residential strata	210,227	233,349	11.00%	23,122
Total – retail	**40,667,129**	**40,781,359**	**0.28%**	**114,230**
Wholesale				
Business pack	983,718	1,127,346	14.60%	143,628
Liability	578,969	570,737	-1.42%	-8,232
Primary industries pack	274,304	282,826	3.11%	8,522
Motor wholesale	211,670	200,436	-5.31%	-11,234
Business	209,878	154,762	-26.26%	-55,116
Other	174,990	176,801	1.03%	1,811
Contractors all risks	45,895	52,567	14.54%	6,672
Industrial special risks	44,508	38,880	-12.64%	-5,628
Primary industries	29,195	26,127	-10.51%	-3,068
Total – wholesale	**2,553,127**	**2,630,482**	**3.03%**	**77,355**
Grand total	**43,220,256**	**43,411,841**	**0.44%**	**191,585**

Source: Code Governance Committee annual general insurance Code subscriber data collection, 2018-19 & 2019-20

Group policies only

Insurance class	2018–19	2019–20	No. (Change)	% (Change)
Retail				
Travel	872,682	129,453	-743,229	-85.1%
Sickness & accident	28,495	23,896	-4,599	-16.1%
Personal & domestic property	467	560	93	19.9%
Motor retail	26	1334	1,308	5030.7%
Consumer credit	0	11	11	1100.0%
Home	4,197	2,160	-2,307	-48.5%
Residential strata	0	29	29	2900.0%
Retail total	**905,867**	**157,443**	**-748,424**	**-82.6%**
Wholesale				
Business pack	112,934	64,002	-48,932	-43.3%
Motor wholesale	28,012	87,731	59,719	213.1%
Liability	36,178	42,283	6,105	16.9%
Business	12,400	11,547	-853	-6.9%
Industrial special risks	4,296	4,967	671	15.6%
Other	1,802	610	-1,192	-66.2%
Primary industries	22	13	-9	-40.9%
Contractors all risks	132	111	-21	-15.9%
Primary industries pack	4,389	3,959	-430	-9.8%
Wholesale total	**200,165**	**215,223**	**15,058**	**7.5%**
Grand total	**1,106,032**	**372,666**	**-733,366**	**-66.3%**

Source: Code Governance Committee annual general insurance Code subscriber data collection, 2018-19 & 2019-20

People and assets

Insurance class	2018–19	2019–20	No. (Change)	% (Change)
Retail				
Travel	13,499,836	7,888,163	-5,559,470	-70.4%
Sickness & accident	7,759,352	8,397,772	638,420	8.2%
Personal & domestic property	696,935	1,043,236	346,301	49.7%
Motor retail	7,235	20,308	13,073	180.7%
Home	215,821	23,192	-192,629	-89.3%
Consumer credit	0	0	0	0.0%
Residential strata	0	0	0	0.0%
Retail total	**22,179,179**	**17,372,671**	**-4,754,305**	**-27.4%**
Wholesale				
Liability	5,455,503	6,280,174	824,671	15.1%
Motor wholesale	574,587	1,336,149	761,562	132.5%
Business pack	247,309	237,602	-9,707	-3.9%
Business	47,262	44,981	-2,281	-4.8%
Industrial special risks	3,033	4,019	986	32.5%
Primary industries	2,490	2,296	-194	-7.8%
Other	2,776	2,051	-725	-26.1%
Primary industries pack	7,770	7,015	-755	-9.7%
Contractors all risks	98	98	0	0.0%
Wholesale total	**6,340,828**	**7,914,385**	**1,573,557**	**24.8%**
Grand total	**28,467,804**	**25,287,056**	**-3,180,748**	**-12.6%**

Source: Code Governance Committee annual general insurance Code subscriber data collection, 2018-19 & 2019-20

Lodged claims

Insurance class	2018–19	2019–20	No. (Change)	% (Change)
Retail				
Motor retail	2,082,486	1,870,331	-212,155	-10.2%
Home	776,011	854,563	78,552	10.1%
Personal & domestic property	883,165	987,516	104,351	11.8%
Travel	294,218	365,681	71,463	24.3%
Residential strata	49,482	59,339	9,857	19.9%
Consumer credit	37,548	50,337	12,789	34.1%
Sickness & accident	34,334	27,172	-7,162	-20.9%
Retail total	**4,157,244**	**4,214,939**	**57,695**	**1.4%**
Wholesale				
Motor wholesale	288,864	242,242	-46,622	-16.1%
Business pack	105,618	92,074	-13,544	-12.8%
Business	35,865	34,655	-1,210	-3.4%
Primary industries pack	43,336	58,076	14,740	34.0%
Liability	37,592	36,372	-1,220	-3.3%
Industrial special risks	23,308	28,347	5,039	21.6%
Primary industries	2,566	1,506	-1,060	-41.3%
Other	8,016	7,699	-317	-3.9%
Contractors all risks	8,498	4,814	-3,684	-43.4%
Wholesale total	**553,663**	**505,785**	**-47,878**	**-8.7%**
Grand total	**4,710,907**	**4,720,724**	**9,817**	**0.2%**

Source: Code Governance Committee annual general insurance Code subscriber data collection, 2018-19 & 2019-20

Declined claims

Insurance class	2018–19	2019–20	No. (Change)	% (Change)
Retail				
Consumer credit	2,681	3,182	501	18.7%
Home	50,433	67,683	17,250	34.2%
Motor retail	9,764	7,933	-1,831	-18.7%
Personal & domestic property	79,566	84,606	5,040	6.3%
Residential strata	1,468	1,978	510	34.7%
Sickness & accident	1,153	1,294	141	12.2%
Travel	34,657	58,962	24,305	70.1%
Retail total	**179,722**	**225,638**	**45,916**	**25.6%**
Wholesale				
Business	1,276	1,010	-266	-20.9%
Business pack	2,111	2,654	543	25.7%
Contractors all risks	60	45	-15	-25.0%
Industrial special risks	340	310	-30	-8.8%
Liability	1,175	749	-426	-36.3%
Motor wholesale	241	265	24	10.0%
Other	182	58	-124	-68.1%
Primary industries	22	15	-7	-31.8%
Primary industries pack	660	736	76	11.5%
Wholesale total	**6,067**	**5,842**	**-225**	**-3.7%**
Grand total	**185,789**	**231,480**	**45,691**	**24.6%**

Source: Code Governance Committee annual general insurance Code subscriber data collection, 2018-19 & 2019-20

Withdrawn claims

Insurance class	2018–19	2019–20	No. (Change)	% (Change)
Retail				
Consumer credit	923	1,086	163	17.7%
Home	113,810	115,140	1,330	1.2%
Motor retail	157,221	153,948	-3,273	-2.1%
Personal & domestic property	34,333	36,831	2,498	7.28%
Residential strata	1,914	2,755	841	43.9%
Sickness & accident	1,699	1,330	-369	-21.7%
Travel	17,291	26,848	9,557	55.3%
Retail total	**327,191**	**337,938**	**10,747**	**3.3%**
Wholesale				
Business	1,941	2,345	404	20.8%
Business pack	6,204	6,390	186	3.0%
Contractors all risks	276	197	-79	-28.6%
Industrial special risks	1,206	1,633	427	35.4%
Liability	2,246	2,876	630	28.1%
Motor wholesale	11,802	12,576	774	6.6%
Other	224	212	-12	-5.4%
Primary industries	135	129	-6	-4.4%
Primary industries pack	2,036	2,285	249	12.2%
Wholesale total	**26,070**	**28,643**	**2,573**	**9.9%**
Grand total	**353,261**	**366,581**	**13,320**	**3.8%**

Source: Code Governance Committee annual general insurance Code subscriber data collection, 2018-19 & 2019-20

Received internal disputes (Stage Two complaints received by subscribers)

Insurance class	2018–19	2019–20	No. (Change)	% (Change)
Retail				
Motor retail	15,054	15,997	943	6.26%
Home	10,635	13,316	2,681	25.21%
Travel	3,450	5,805	2,355	68.26%
Personal & domestic property	2,632	2788	156	5.93%
Consumer credit	330	789	459	139.09%
Residential strata	342	514	172	50.29%
Sickness & accident	317	300	-17	-5.36%
Retail total	**32,760**	**39,509**	**6,749**	**20.60%**
Wholesale				
Business pack	588	444	-144	-24.49%
Motor wholesale	533	741	208	39.02%
Business	178	225	47	26.40%
Liability	221	134	-87	-39.37%
Primary industries pack	122	223	101	82.79%
Other	119	177	58	48.74%
Primary industries	62	60	-2	-3.23%
Industrial special risks	53	81	28	52.83%
Contractors all risks	17	14	-3	-17.65%
Wholesale total	**1,893**	**2,099**	**206**	**10.88%**
Grand total	**34,653**	**41,608**	**6,955**	**20.07%**

Source: Code Governance Committee annual general insurance Code subscriber data collection, 2018-19 & 2019-20

Reviewed internal disputes (Stage Two complaints finalised by subscriber)

Insurance class	2018–19	2019–20	No. (Change)	% (Change)
Retail				
Motor retail	15,124	15,655	531	3.51%
Home	10,219	12,898	2,679	26.22%
Travel	3,435	5,127	1,692	49.26%
Personal & domestic property	2,601	2,720	119	4.58%
Consumer credit	338	634	296	87.57%
Residential strata	342	475	133	38.89%
Sickness & accident	312	291	-21	-6.73%
Retail total	**32,371**	**37,800**	**5,429**	**16.77%**
Wholesale				
Business pack	553	628	75	13.56%
Motor wholesale	507	433	-74	-14.60%
Business	147	128	-19	-12.93%
Liability	210	221	11	5.24%
Primary industries pack	112	225	113	100.89%
Other	115	172	57	49.57%
Primary industries	64	58	-6	-9.38%
Industrial special risks	45	87	42	93.33%
Contractors all risks	14	15	1	7.14%
Wholesale total	**1,767**	**1,967**	**200**	**11.32%**
Grand total	**34,138**	**39,767**	**5,629**	**16.49%**

Source: Code Governance Committee annual general insurance Code subscriber data collection, 2018-19 & 2019-20

Appendix 5:
Subscriber reported breaches per 10,000 policies sold

Subscriber	Self-Reported breaches total	Self-Reported Breaches per 10,000 policies	% of total breaches	Significant Breaches	% of total significant breaches
Subscriber P	8,004	10.54	24%	11	10%
Subscriber X1	4,951	7.18	15%	8	7%
Subscriber I1	2,898	29.34	9%	9	8%
Subscriber W	2,814	4.96	9%	5	4%
Subscriber O1	1,993	9.48	6%	10	9%
Subscriber O2	1,794	19.86	5%	0	0%
Subscriber M	1,787	12.39	5%	4	4%
Subscriber C2	1,740	8.75	5%	3	3%
Subscriber B	1,056	380.92	3%	0	0%
Subscriber Z2	1,026	32.44	3%	0	0%
Subscriber K2	900	1.96	3%	25	22%
Subscriber U1	777	39.78	2%	0	0%
Subscriber O	460	10.59	1%	0	0%
Subscriber L1	450	8.19	1%	7	6%
Subscriber D	380	4.03	1%	2	2%
Subscriber Q1	355	1.88	1%	4	4%
Subscriber F2	318	2.60	1%	4	4%
Subscriber J1	304	325.31	1%	1	1%
Subscriber F1	182	1.54	1%	2	2%
Subscriber Y	178	14.21	1%	1	1%
Subscriber H2	105	0.58	0%	3	3%
Subscriber N1	85	1.78	0%	0	0%
Subscriber J2	83	3.12	0%	0	0%
Subscriber D1	54	12.59	0%	1	1%
Subscriber S1	52	0.97	0%	0	0%
Subscriber U	39	4.03	0%	3	3%
Subscriber G1	25	0.46	0%	1	1%
Subscriber L	18	1.08	0%	8	7%
Subscriber B3	16	3.05	0%	0	0%
Subscriber D2	11	0.55	0%	0	0%
Subscriber A	8	1.56	0%	0	0%
Subscriber H1	2	115.61	0%	0	0%
Subscriber C	2	0.48	0%	0	0%
Subscriber P1	1	36.50	0%	0	0%
Subscriber E1	1	0.18	0%	0	0%
Subscriber A3	1	0.15	0%	0	0%

The Committee intends to do further work to better understand the reasons for the wide variation between subscribers in their breach reporting.

Source: Code Governance Committee annual general insurance Code subscriber data collection, 2019-20

Appendix 6:
Glossary of terms

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

2020 Code means the 2020 General Insurance Code of Practice.

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, the 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) 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
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.**

GENERAL INSURANCE
Code Governance Committee

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