Guidance Note No. 3

Varying claims handling timeframes

Subsection 7.21 of the 2014 Code and Paragraph 84 of the 2020 Code

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GENERAL INSURANCE
Code Governance Committee

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Purpose

1. This Guidance Note applies to the 2014 General Insurance Code of Practice (2014 Code) and the 2020 General Insurance Code of Practice (2020 Code). Claims lodged before 1 July 2021 are subject to the 2014 Code, and claims lodged on or after 1 July 2021 are subject to the 2020 Code.
2. The Code Governance Committee (CGC) has developed this Guidance Note in response to Code subscribers' queries about when they can use these provisions. The CGC expects a Code subscriber to ensure that it understands when subsection 7.21 of the 2014 Code (subsection 7.21) or paragraph 84 of the 2020 Code (paragraph 84) may be applied.
3. The CGC expects this Guidance Note will help Code subscribers meet their Code obligations and adhere to the core principles underpinning the applicable Code. These include the importance of Code subscribers meeting claims handling timeframes.
4. Both the 2014 Code and the 2020 Code state their objectives as:
   a) to commit the organisation that has adopted the Code to high standards of service;
   b) to promote better, more informed relations between the organisation that has adopted the Code and an insured or third-party beneficiary;
   c) to maintain and promote trust and confidence in the general insurance industry;
   d) to provide fair and effective mechanisms for resolving complaints an insured or third-party beneficiary makes against the organisation that has adopted the Code; and
   e) to promote continuous improvement of the general insurance industry through education and training.

Subsection 7.21 and paragraph 84

5. Section 7 of the 2014 Code and Part 8 of the 2020 Code set out the claims handling obligations of Code subscribers. Both the 2014 Code and 2020 Code require Code subscribers to deal with claims in a timely manner and within the stated timeframes. Table 1 and Table 2 in **Appendix A** outline the claims handling timeframes under the 2014 Code and the 2020 Code, respectively.
6. Subsection 7.21 and paragraph 84 (hereinafter collectively referred to as 'the claims handling timeframes variation provisions') recognise there may be circumstances where a Code subscriber agrees to an alternative timeframe or cannot meet the timeframe for a reason recognised by the Code, and this would not be a breach of the Code's claims handling timeframes. The CGC expects each instance to be considered on its own

circumstances and does not expect either of the claims handling timeframes variation provisions to be applied across a group of claims unless the same factors impact the Code subscriber's ability to meet claim timeframes. Even where this is the case, the CGC expects Code subscribers to ensure supporting records are kept at the individual claim level.

Subsection 7.21 of the 2014 Code:

7.21 **We** must comply with the timetables in this section, unless:

a) **our** conduct complied with an alternative timetable agreed with you; or

b) **our** conduct and the timetable were reasonable in all the circumstances; or

c) the cause of the non-compliance was a delay in the supply of a report from an **External Expert** and **we** had engaged the **External Expert** in accordance with this section, and used our best endeavours to obtain the report in time.

Paragraph 84 of the 2020 Code:

84. We must comply with the timeframes in this part of the Code, unless any of the following apply:

a. we have complied with an alternative timetable to which you agreed;

b. our conduct, and the actual timeframe, were reasonable in all the circumstances;

c. the reason we did not comply with the timeframe was that a report from an External Expert was delayed, even though we used our best endeavours to obtain the report in time.

7. The CGC expects Code subscribers to use the claims handling timeframes variation provisions rarely and judiciously and assess each instance individually. Code subscribers should be proactive and keep good records when using the relevant provisions.

8. The CGC does not expect Code subscribers to rely on these provisions in the ordinary course of handling claims. As a matter of good governance, the CGC expects Code subscribers to regularly review and update their business continuity plans to reflect any anticipated changes in operating conditions.

9. Where a Code subscriber decides that the circumstances warrant a variation from the standard claims handling timeframe in the Code, it does not need to seek pre-approval from the CGC to apply the claims handling timeframes variation provisions. However, a Code subscriber should maintain records as outlined in this Guidance Note and be prepared to provide them to the CGC if and when requested.

10. A Code subscriber does not have to report variations from the standard claims handling timeframes in the Code as a breach unless a subsequent investigation by the CGC finds it was not entitled to use it. The CGC will assess the Code subscriber's documented reasons justifying its entitlement to rely on subsection 7.21 or paragraph 84.

11. Rare but significant events can affect resourcing and claims handling arrangements which impact a Code subscriber's ability to meet its claims handling Code obligations. For example, national and international emergencies, including pandemics, may present significant challenges for a Code subscriber in terms of its ability to meet Code claims handling timeframes. Factors such as changing border arrangements, assessors and repairers being unable to attend a site, staffing shortages due to staff isolating or becoming unwell and needing time to recover, temporary closures of overseas calls centres due to staff illness and shortages and interruptions to the worldwide supply chain for building materials and car parts can all significantly challenge Code subscribers' ability to meet Code timeframes.

12. Despite any challenges, it is important Code subscribers do not disregard their Code obligations, especially at times when consumers and small business may be vulnerable and have greater need for assistance. During times of crisis, Code subscribers' core obligations under the applicable Code still apply and it is still important Code subscribers comply with the Code as far as reasonably practicable.

13. As a matter of good governance, a Code subscriber should have adequate catastrophe plans, including business continuity arrangements or other risk mitigation measures in place to ensure that it can anticipate the higher demands on their resources and respond to catastrophes efficiently, professionally and practically. This includes meeting claims handling timeframes under the Code as far as reasonably practicable.

Using the claims handling timeframes variation provisions

Overarching expectations

14. When a Code subscriber is considering whether a departure from one or more of the claims handling timeframes in the Code is warranted based on the circumstances set out in subsection 7.21 and paragraph 84, the CGC expects a Code subscriber's conduct to be reasonable in all the circumstances and to:

    a) use all reasonable efforts to meet claims handling Code timelines wherever possible;

    b) use subsection 7.21 or paragraph 84 rarely and judiciously, and regularly review the need to rely on these provisions in respect of a claim. This includes continually monitoring and reviewing the needs of the specific claim and taking steps to ensure it is complying with the Code subscriber's policies and practices. Circumstances and their impact on a Code subscriber's ability to deliver services in a timely manner can change rapidly;

    c) use subsection 7.21 or paragraph 84 on a 'case by case' basis, considering the specific circumstances of each impacted claim or claims at a portfolio level;

    d) use subsection 7.21 or paragraph 84 only when necessary, when the Code subscriber will not be able to comply with their Code obligations due to circumstances outside their control and the Code subscriber has no reasonably practicable alternative available;

    e) fast-track urgent claims for consumers in urgent financial need in accordance with the obligations contained in Section 7: Claims of the 2014 Code or Part 8: Making a claim of the 2020 Code;

f) implement suitable support measures for vulnerable consumers as early as practicable in accordance with the obligations in paragraph 97 of Part 9: Supporting customers experiencing vulnerability of the 2020 Code; and

g) have good record keeping practices. Further information about this is set out below.

Subsection 7.21(a) of the 2014 Code and paragraph 84(a) of the 2020 Code

15. Subsection 7.21(a) of the 2014 Code and paragraph 84(a) of the 2020 Code require an organisation that has adopted the Code to comply with the timeframes in that section or part of the Code unless it has complied with an alternative timetable agreed with the insured or third-party beneficiary. This may include circumstances where an insured or third-party beneficiary requests an alternative timetable.

16. In addition to the above seven overarching expectations, where a Code subscriber is seeking to use either subsection 7.21(a) or paragraph 84(a), the CGC expects the Code subscriber to:

    a) ensure it mutually agrees to any timetable change with the insured or third-party beneficiary and not make changes unilaterally. The 2014 and the 2020 Code set out timeframes for, amongst other things, informing the insured about the progress of their claim and making a decision to accept or deny a claim. The Code subscriber's records should clearly show how alternative timeframes have been mutually agreed; and

    b) proactively monitor and review whether any alternatively agreed timeline can be achieved. If not, the CGC expects Code subscribers to revise and mutually agree on any timetable changes with the insured.

17. Subsection 7.5 of the 2014 Code and paragraph 83 of the 2020 Code enable a Code subscriber to agree on a reasonable alternative timetable with an insured or third-party beneficiary when the claims handling timeframes are not practical. Both the 2014 Code and 2020 Code reference the complex nature of a claim as an example of when a Code subscriber may seek to rely on either subsection 7.5 or paragraph 83. If a Code subscriber cannot reach an agreement on an alternative timetable, it should provide details of its Complaints process to the insured or third-party beneficiary.

Subsection 7.21(b) of the 2014 Code and paragraph 84(b) of the 2020 Code

18. Subsection 7.21(b) of the 2014 Code and paragraph 84(b) of the 2020 Code require an organisation that has adopted the Code to comply with the timeframes in that section or part of the Code unless the organisation's conduct was reasonable in all the circumstances.

19. Where a Code subscriber seeks to rely on these provisions to vary the from claims handling timeframes, the CGC expects a Code subscriber to be able to demonstrate that its conduct and the actual timeframe was reasonable in all the circumstances if it is unable to comply with the timetables in this part or subsection of the Code. What is reasonable will depend on the specific circumstances of the claim. The onus is on the Code subscriber to demonstrate it has acted reasonably.

Subsection 7.21(c) of the 2014 Code and paragraph 84(c) of the 2020 Code

20. Subsection 7.15 of the 2014 Code and paragraph 74 of the 2020 Code require an organisation that has adopted the Code to ask an External Expert it has engaged to provide it with a report it needs to assess a claim within 12 weeks of the organisation engaging the expert. If the External Expert does not meet this timeframe, the organisation must tell the insured or third-party beneficiary and keep them informed of their progress in obtaining the report from the External Expert.

21. Subsection 7.21(c) of the 2014 Code and paragraph 84(c) of the 2020 Code require an organisation that has adopted the Code to comply with the timeframes in that section or part of the Code unless the reason the organisation did not comply with the timeframe was that an External Expert report was delayed, despite the organisation's best endeavours to obtain the report in time.

22. Where delays outside the Code subscriber's control occur, the overarching obligations relating to communication with the insured, and the record keeping associated with this, are particularly relevant.

Record keeping

23. Each time a Code subscriber uses either of the claims handling timeframes variationprovisions, the CGC expects the Code subscriber to record the steps taken to meet the normal timeframe and the reason or reasons it is unable to meet the normal timeframe.

24. The Code subscriber should transparently explain, demonstrate and document the specific reasons its conduct was reasonable and practicable under the circumstances and why it had no reasonably practicable alternative available. The CGC expects the Code subscriber to be able to produce these records if asked to do so in the future.

25. The Code subscriber should keep good records justifying the action it took was reasonable and practicable under the circumstances.

26. Given the importance of documenting the reasons for a subscriber's decision to rely on either of the claims handling timeframes variation provisions, the CGC considers it best practice for a Code subscriber to keep a separate and clearly drafted file note as a specific appendix to the claim notes on these matters when it seeks to rely on these variation provisions, rather than including the reasons in the claim notes.

27. At a minimum, a Code subscriber should have written records that clearly show the attempts it has made, and is making, to meet the Code's claims handling timeframes as well as attempts to contact the insured or third-party beneficiary, the nature of the contact and any agreed outcome. This includes any agreed variation to the normal timeframes required under the Code. In addition to keeping written records, some Code subscribers may have sound recordings of phone calls or call transcripts.

28. Where a customer is unresponsive or uncontactable, the Code subscriber must record reasonable attempts of contact. In a catastrophe situation, a Code subscriber should anticipate that the insured may be harder to contact than would ordinarily be the case. The threshold for proving reasonable attempts of contact may be higher in a catastrophe situation. The Code subscriber may need to be able to demonstrate they attempted to contact the insured more than they would for an ordinary claim. For example, if a subscriber's normal internal policy is to attempt to phone and/or email a customer a

certain number of times before they classify the customer as uncontactable, in a catastrophe situation, they may need to be able to demonstrate they did more than that.

29. There may be circumstances where a Code subscriber is specifically requested not to contact a consumer to provide ongoing updates in relation to a claim under paragraph 70 of the 2020 Code or in accordance with an alternative timetable agreed under subsection 7.5 of the 2014 Code. The CGC also acknowledges that there may be practical limitations to being able to contact consumers in certain situations. For example, telecommunication infrastructure networks may be damaged as a result of a Catastrophe or consumers may request that Code subscribers do not contact them.

30. For subsection 7.21(a) and paragraph 84(a), the CGC expects the Code subscriber to record how the insured or third-party beneficiary agreed to a variation of any of the timeframes set out in Section 7 and Part 8 of the 2014 and 2020 Codes respectively.

31. Although subsections 7.21(b) and (c) and paragraph 84(b) and (c) are silent on it, the CGC considers it good practice for a Code subscriber to keep the insured or third-party beneficiary regularly informed of any challenges it is having meeting the Code's claims handling timeframes due to circumstances beyond its control and what it is doing to overcome these challenges. A Code subscriber's written records should clearly explain how and when it communicated or attempted to communicate with the insured or third-party beneficiary.

32. If a Code subscriber seeks to rely on subsection 7.21(c) or paragraph 84(c), the CGC expects the Code subscriber's records to show the reason the subscriber did not comply with the timeframe because the External Expert was delayed and that it used its best endeavours to obtain the report in time. At a minimum, the CGC expects written records that clearly show the Code subscriber attempted to obtain the report from the External Expert within the Code's claims handling timeframes and the challenges faced in doing so. The onus is on the Code subscriber to show its conduct is reasonable in all the circumstances.

Examples to illustrate how the CGC would assess if circumstances justify reliance on subsection 7.21(b) or paragraph 84

These case studies have been written to illustrate the factors that determine whether subsection 7.21 or paragraph 84 applies. All case studies have been modified from what was reported to the CGC.

Case study 1

A Code subscriber sought to rely on subsection 7.21(b) after claims handling delays due to the impact of the COVID-19 pandemic

The Code subscriber received an unprecedented level of travel insurance claims and complaints from March 2020 onwards due to COVID-19 related travel restrictions in Australia and worldwide, resulting in delays to its handling of claims.

The Code subscriber implemented several measures to remediate these delays. These included offering travel credits and premium refunds to affected customers, implementing additional resources, fast-tracking claims of vulnerable customers, increased consumer communication and ceasing the sale of new travel insurance policies to consumers.

The CGC reviewed whether the Code subscriber could rely on subsection 7.21(b) of the 2014 Code in the circumstances. The CGC concluded that reliance was not justified on the basis of the following factors:

- The claims handling breaches occurred over a long period (March to October 2020). During this time, the Code subscriber should have been proactively monitoring its breaches and whether subsection 7.21(b) may apply, but it did not do so. It only decided five months later to retrospectively rely on subsection 7.21(b).
- In handling each claims case, the Code subscriber failed to proactively record the steps taken to meet the normal claims handling timeframes specified in the Code and the reason or reasons it is unable to meet the normal timeframe. These steps were only revealed and recorded retrospectively.
- A large number of consumers (several thousand) were impacted by claims handling delays.
- The Code subscriber failed to implement support measures for vulnerable consumers ‘as early as practicable’. Customer support measures were not implemented until May 2021.

Case study 2

A Code subscriber notified the CGC it sought to rely on subsection 7.21(b) after claims handling delays due to the impact of the COVID-19 pandemic

The Code subscriber’s customer and claims enquiries increased by more than 100% due to operational disruptions during the COVID-19 pandemic. Many customers experienced significant delays with their claims process. The Code subscriber sought to rely on subsection 7.21(b) citing the impact of COVID-19 on its workforce and business operations.

The CGC reviewed whether the Code subscriber could rely on subsection 7.21(b) in the circumstances and concluded that it could. The CGC concluded that reliance was appropriate and that the Code subscriber had not breached the relevant claims handling timeframes based on the following factors:

- The Code subscriber proactively identified the impact on claims handling and considered the application of subsection 7.21(b). It acted quickly to manage its response to the COVID-19 catastrophe.
- The Code subscriber assessed all impacted claims and determined that all delays were due to the impact of the COVID-19 catastrophe, rather than operational deficiencies.
- The Code subscriber had taken reasonable steps to re-establish compliance through the efficient implementation of business continuity and crisis management plans.
- The Code subscriber implemented operational changes to re-establish compliance as efficiently as possible - it quickly redeployed many employees to support customer contact operations and reduce response delays, and it transitioned its operations to remote working to deal with service and claims enquiries.
- The Code subscriber implemented a specialist health and emergency assistance team for travellers who required COVID-19 medical and non-medical health support.

Case study 3

A Code subscriber received a significant influx of home building property and motor vehicle claims within a couple of months due to the Queensland and New South Wales floods in early 2022

On 28 February 2022, the Insurance Council of Australia (ICA) extended the insurance Catastrophe declaration for the South-East Queensland floods between 23 February 2022 to 7 April 2022 to include impacted areas of New South Wales (Catastrophe 221).

Many Code subscribers may have experienced a surge in their claims volumes under CAT-221 and the CGC acknowledges that timeframes for scheduling assessments and repairs may be affected by supply chain issues.

If a Code subscriber were to rely on paragraph 84(b) to explain claims handling timeframe delays, the CGC would expect it to:

- Proactively review and record its eligibility to rely on subsection 84(b) at the time a claim is assessed on a case-by-case basis rather than across a wide range of claims.
- Fast-track urgent claims from affected policyholders and triage claims to direct urgent assistance to customers experiencing urgent financial need including emergency support payments in accordance with paragraph 64 of the 2020 Code.
- Implement customer support measures as early as possible including emergency repairs, temporary accommodation and cash payments to make emergency purchases.
- Employ robust business continuity and Catastrophe plans that are adequate for managing Code subscribers' response to major flood events.

- Record reasonable attempts to re-establish Code compliance including re-deploying staff to establish a surge workforce or recruiting claims and complaints staff.
- Unless otherwise agreed in accordance with paragraph 70 of the 2020 Code or for a reason permissible under the Code, keep any affected customers or third-party beneficiaries regularly informed of any challenges it is having in meeting any Code timeframes due to circumstances beyond its control and let them know what it is doing to overcome these challenges.
- At a minimum, have written records of all attempts it has made, and is making, to meet any Code timeframes at an individual claims level, as well as attempts to contact the insured or third-party beneficiary, the nature of the contact and any agreed outcome. If the Code subscriber and the insured or third-party beneficiary agree on an alternative timeframe other than in Part 8 of the 2020 Code, the Code subscriber should ensure it has written records which confirm the insured or third-party beneficiary has agreed to the variation.

Case study 4

Two consumers lodged a claim for home property damage resulting from the 2019-20 Australian bushfires. They experienced significant claims handling delays in finalising the cash settlement for contents items and the home building scope of works.

On 8 November 2019, the ICA declared a Catastrophe event in relation to a series of bushfires affecting Victoria, New South Wales, South Australia and Queensland (Catastrophe 195). The bushfires resulted in over 38,936 claims across industry and incurred more than $2,319,164,486 billion dollars loss.

Throughout the Catastrophe event, the ICA and Code subscribers deployed resources to impacted towns and cities. Code subscribers experienced significant demand on the supply chain, accessibility issues and staff resourcing due to the sheer number of claims.

In 2020, the Consumers lodged a claim with the Code subscriber under their home and contents insurance policy after their property was damaged during the 2019-20 bushfire season. The Consumers were experiencing vulnerability due to the loss of their home and the delays in the processing of their insurance claim added to their financial distress.

The CGC reviewed whether the Code subscriber could rely on subsection 7.21(b) of the 2014 Code in the circumstances. The CGC concluded that the Code subscriber could not rely on the exemption on the basis of the following:

- Although the Code subscriber knew it would not be able to meet the claims handling timeframes specified in the Code, it failed to proactively monitor and review whether an alternative agreed timetable could be achieved.
- The Code subscriber did not agree on a reasonable alternative timetable with the Consumers.
- The Code subscriber did not use all reasonable efforts to meet the claims handling timeframes in the Code.
- It was unreasonable for the Code subscriber to require the Consumers to provide lengthy lists of contents items that exceeded the sum insured. This contributed to

further delays in assessing the Consumers' claims. It was clear from the circumstances the bushfire destroyed everything the consumers owned.

- The commencement of repairs was unnecessarily delayed as the Code subscriber failed to inform the Consumer that there were alternative builders available to complete repairs other than the Code subscriber's preferred builder.
- Despite the Consumers' vulnerabilities, the Code subscriber failed to implement support measures 'as early as practicable' and failed to treat the claim with any particular urgency.

Appendix A: Claims handling timeframes under the 2014 Code and 2020 Code

Table 1: The 2014 Code contains the following obligations in relation to claims handling timeframes under Section 7 'Claims':

Subsection	Code obligation
7.4	Where **we** identify, or **you** tell **us** about, an error or mistake in dealing with **your** claim, **we** will immediately initiate action to correct it.
7.5	If any of the timeframes in this section are not practical due, for example, to the complex nature of **your** claim, **we** will agree a reasonable alternative timetable with **you**. If **we** cannot reach an agreement on an alternative timetable, **we** will provide details of **our Complaints** process.
7.7	Where **you** reasonably demonstrate to **us** that **you** are in urgent financial need of the benefits **you** are entitled to under **your** insurance policy as a result of the event causing the claim, **we** will: (a) fast-track the assessment and decision process of **your** claim; and/or (b) make an advance payment to assist in alleviating **your** immediate hardship within five **business days** of **you** demonstrating **your** urgent financial need; and (c) provide details of **our Complaints** process, if **you** are not happy with **our** decision.
7.9	If **you** make a claim and **we** do not require further information, assessment or investigation, **we** will decide to accept or deny **your** claim and notify **you** of **our** decision within ten **business days** of receiving **your** claim.
7.10	If **you** make a claim and **we** require further information or assessment, within ten **business days** of receiving **your** claim **we** will: (a) notify **you** of any information **we** require to make a decision on **your** claim; (b) if necessary, appoint a loss assessor or loss adjuster; and (c) provide an initial estimate of the timetable and process for making a decision on **your** claim.
7.12	If **we** appoint a loss assessor, loss adjuster or investigator, **we** will notify **you** within five **business days** of their appointment.
7.13	**We** will keep **you** informed about the progress of **your** claim at least every 20 **business days**.
7.14	**We** will respond to routine requests made by **you** about **your** claim within ten **business days.**
7.15	If **we** engage an **External Expert** to provide a report which is necessary to assess **your** claim, **we** will ask them to provide their report to **us** within 12 weeks of the date of their engagement. If the **External Expert** cannot meet

Subsection	Code obligation
	or fails to meet this timeframe, **we** will inform **you** of this, and keep **you** informed of **our** progress in obtaining the report.
7.16	Once **we** have all relevant information and have completed all enquiries, **we** will decide whether to accept or deny **your** claim and notify **you** of **our** decision within ten **business days**.
7.17	**Our** decision will be made within four months of receiving **your** claim, unless **Exceptional Circumstances** apply. If **we** do not make a decision within four months, **we** will provide details of **our Complaints** process.
7.18	Where **Exceptional Circumstances** apply, **our** decision will be made within 12 months of receiving **your** claim. If **we** do not make a decision within 12 months, **we** will provide details of **our Complaints** process.
7.19	If **we** deny your claim, **we** will: (a) give **you** reasons for **our** decision **in writing**; (b) inform **you** of **your** right to ask for the information about **you** that **we** relied on in assessing **your** claim, and supply the information within ten **business days** if **you** request it, in accordance with section 14 of this **Code**; (c) inform **you** of **your** right to ask for copies of any **Service Suppliers'** or **External Experts'** reports that **we** relied on in assessing **your** claim, and supply the reports within ten **business days** if **you** request them, in accordance with section 14 of this **Code**; and (d) provide details of **our Complaints** process.

Table 2: The 2020 Code contains the following obligations in relation to claims handling timeframes under Part 8 'Making a Claim':

Paragraph	Code obligation
62	If we identify, or you tell us about a mistake we make in handling your claim, then we will immediately take action to correct the mistake.
64	Where the event (for example, a natural disaster) that caused you to make a claim under your policy also caused you to be in urgent financial need of the benefits you are entitled to under that policy, then we will do either or both of the following: a. fast-track both our assessment of your claim and the process we follow to make a decision about your claim; b. pay you an advance amount to help ease your urgent financial need — we will do this within 5 Business Days after you demonstrate your urgent financial need.

Subsection	Code obligation
68	If you make a claim and we need further information or assessment, then within 10 Business Days of receiving your claim we will: a. tell you any information we need to make a decision on your claim. We will use our best endeavours to do that in one request; b. if necessary, appoint a Loss Assessor or Loss Adjuster to assess your claim; and c. provide our estimate of the likely timeframe and process for us to make a decision about your claim.
70	We will tell you about the progress of your claim at least every 20 Business Days.
71	We will respond to your routine enquiries about your claim's progress within 10 Business Days.
72	If we appoint a Loss Assessor or Loss Adjuster, then within 5 Business Days we will tell you that we have appointed them and what their role is. An appointed loss assessor or loss adjustor may be an Employee.
73	If we appoint an Investigator or Employee to investigate your claim, then within 5 Business Days we will tell you that we have appointed them and what their role is. When we appoint an Investigator or Employee to investigate your claim, then the investigation process will comply with the Claims Investigation Standards (see part 15).
74	If we engage an External Expert to provide us with a report that we need to assess your claim, then we will ask them to report to us within 12 weeks of us engaging them. If the External Expert does not meet that timeframe, we will tell you and keep you informed of our progress in obtaining the report.
76	Once we have all relevant information and have completed all enquiries, we will decide whether to accept or deny your claim and tell you of our decision within 10 Business Days.
77	Our decision will be made within 4 months of receiving your claim, unless paragraph 78 applies. If we do not make a decision within that time, we will tell you in writing about our Complaints process.
78	In circumstances where: a. your claim arises from an Extraordinary Catastrophe; b. your claim is fraudulent, or we reasonably suspect it is fraudulent; c. you do not respond to our reasonable inquiries or to our requests for documents or information about your claim; d. we have difficulty communicating with you about your claim due to circumstances beyond our control; or

Subsection	Code obligation
	e. you request a delay in the claims process; then within 12 months of receiving your claim we will tell you our decision in writing. If we cannot make a decision within 12 months, we will tell you in writing about our Complaints process.
82	If you ask for information or for copies of any Service Suppliers' or External Experts' reports that we relied on, then we will give you that information or report within 10 Business Days, as set out in part 12 of the Code.

Disclaimer

Examples and case studies used in this Guidance are purely for illustration; they are not exhaustive and are not intended to impose or imply particular rules or requirements.

About the General Insurance Code Governance Committee

The 2020 Code is a voluntary industry code that promotes high standards ofservice and better customer relationships in the general insurance industry.The Committee is the independent body responsible for monitoring and enforcing Code subscribers' compliance with the Code standards. See www.insurancecode.org.au

Contact the Code Governance Committee

If you have any queries about this report, please contact the Committee through its secretariat at: info@codecompliance.org.au.

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