GENERAL INSURANCE
Code Governance Committee

General Insurance Industry Data and Compliance Report

2022–23

Introduction

The **General Insurance Code Governance Committee's** (Committee or CGC) Annual Industry Data and Compliance Report presents analysis of compliance with the **General Insurance Code of Practice** (the Code) for the 2022–23 reporting year.

It also includes aggregated data from the general insurance industry, as well as guidance and recommendations for subscribers that will help them improve their compliance with the Code.

Methodology

As part of the 2022-23 annual industry data collection, 49 insurers that subscribed to the Code provided data on breaches, policies, claims, complaints and workforce.

The 49 insurers were:

- AAI Limited
- AIG Australia Limited
- AIOI Nissay Dowa Insurance Company Australia Pty Ltd
- Allianz Australia Insurance Limited
- Ansvar Insurance Limited
- ANZ Lenders Mortgage Insurance Pty Ltd
- Arch LMI Pty Ltd
- Assetinsure Pty Limited
- Auto & General Insurance Company Limited
- Berkshire Hathaway Specialty Insurance Company
- Catholic Church Insurance Ltd
- Chubb Insurance Australia Limited
- Credicorp Insurance Pty Ltd
- Defence Service Homes Insurance Scheme
- Eric Insurance Limited
- Factory Mutual Insurance Company
- Great Lakes Insurance SE
- Guild Insurance Limited
- Hallmark General Insurance Company Ltd
- HDI Global Speciality SE - Australia
- Helia Insurance Pty Limited
- Hollard Insurance Company Pty Ltd (The)
- Hollard Insurance Partners Limited
- Insurance Australia Limited
- Insurance Manufacturers of Australia Pty Limited
- LawCover Insurance Pty Limited
- LFI Group Pty Ltd
- Lloyd's Australia Limited
- Mitsui Sumitomo Insurance Co Ltd
- nib Travel Services (Australia) Pty Ltd
- NTI Limited
- Open Insurance Pty Ltd
- Pacific International Insurance Pty Limited
- Petsure (Australia) Pty Ltd
- QBE Insurance (Australia) Limited
- QBE Lenders Mortgage Insurance
- RAA Insurance Limited
- RAC Insurance Pty Limited
- RACQ Insurance Limited
- RACT Insurance Pty Ltd
- Sompo Japan Insurance Inc.
- Southern Cross Benefits Limited
- Swiss Re International SE
- The North of England Protecting and Indemnity Association Limited t/a Sunderland Marine
- Tokio Marine & Nichido Fire Insurance Co., Ltd
- Virginia Surety Company, Inc
- XL Insurance Company SE
- Youi Pty Ltd
- Zurich Australian Insurance Limited

We acknowledge the traditional custodians of the different lands across Australia and pay respect to elders past and present.

Contents

Chair's message

It was another challenging year for the general insurance industry, as it continued to navigate the impacts of severe weather events across the country.

An effective industry response to increasingly frequent events is crucial and shapes public confidence in insurers. In these times, adhering to the promises in the Code takes on even greater importance.

Pleasingly, in the 2022–23 reporting period, we saw that many insurers succeeded in reducing the number of breaches related to claims handling timeframes. This is a welcome result and demonstrates the ability of insurers to adapt and improve in response to changing circumstances. This commitment to Code compliance ultimately leads to better customer outcomes.

"However, there is still more work to be done, particularly on addressing the root causes of breaches across the board."

Insurers indicated that most breaches were the result of inadequate resourcing, insufficient training and monitoring, and under-investment in technology. To make meaningful and sustainable improvements in Code compliance, insurers must continue to look at the root causes of breaches and address underlying issues.

Given the findings of this data report, we expect insurers to review and improve procedures for handling claims and updating consumers on the progress of claims as priorities. In this regard, we encourage investing in appropriate technological solutions while still ensuring customers receive meaningful communications and updates.

Our observations support the findings and recommendations previously published by **Deloitte**, **the Australian Securities and Investments Commission (ASIC)** and **the Australian Financial Complaints Authority (AFCA)**. We understand that insurers are seeking to integrate these recommendations into their operations, and we expect to see tangible improvements in the next reporting period.

"We are concerned about the increase in reported complaints in the 2022–23 reporting period – the fourth year in a row of such increases."

There is likely to be a range of factors behind this increase, including claims handling and communication delays, as well as ASIC's broader definition of a complaint. This data provides a great opportunity for insurers to gain insights into where they can improve their practices.

With the increased volume of complaints, insurers clearly struggled to meet their Code obligations in the 2022–23 reporting period. However, the increase in complaints handling breaches can only be partially explained by the increased volume of complaints.

To manage complaints effectively, within the stipulated timeframes, insurers must have adequate resourcing, swift scalability, knowledgeable staff and streamlined processes supported by technology. As insurers expand teams responsible for complaints handling, they need to ensure there is comprehensive training and monitoring to accompany it.

When we see insurers falling short of their Code obligations, we will continue to engage with them to understand the issues and ensure that they take appropriate action. However, where we identify significant or sustained non-compliance, especially where there is no adequate plan or commitment to improve, we will take further action, including issuing sanctions where appropriate.

There were encouraging signs of progress in the 2022–23 reporting period, and we expect this trend to continue expeditiously.

We remain committed to working with insurers to build a culture of compliance, transparency and accountability that benefits both consumers and the industry.

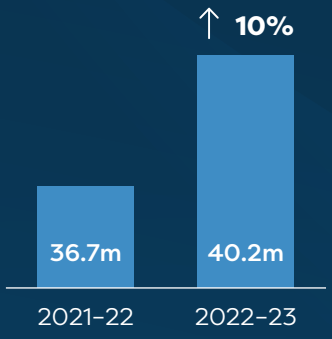
Veronique Ingram PSM

Independent Chair
General Insurance Code Governance Committee

Snapshot 2022–23

49
Code subscribers
as at 30 June 2023

40.2m
Policies issued during the year



5.1m
Claims lodged – up 5%

4m
Claims accepted – up 6%

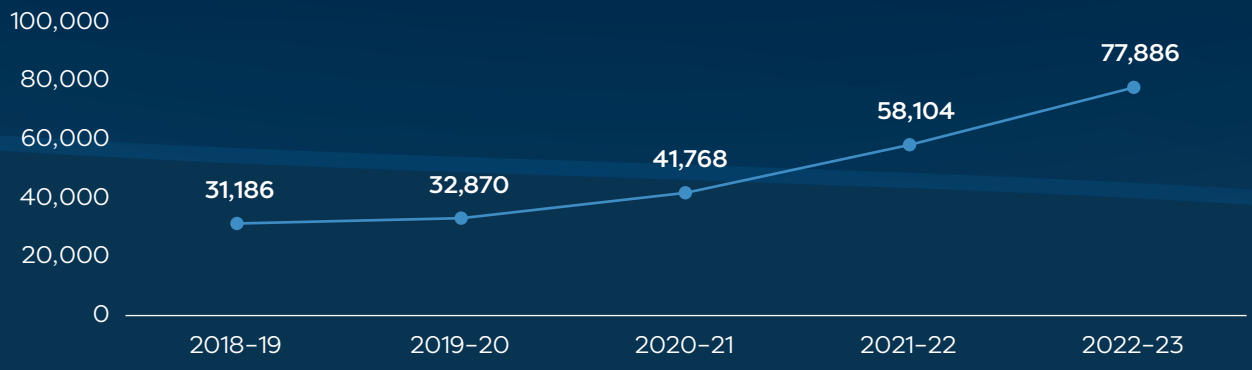
307,482
Claims declined – up 25%

106,918
Claims partially accepted – up 6%

422,457
Claims withdrawn – up 14%

Over **$20b**
Paid out in claims – up 36%

Reported breaches



77,886

Breaches reported by insurers, up 34% from last year

185,796

Consumers impacted

$2,137,492

Financial impact

45,331

Breaches of claims handling obligations – up 16%

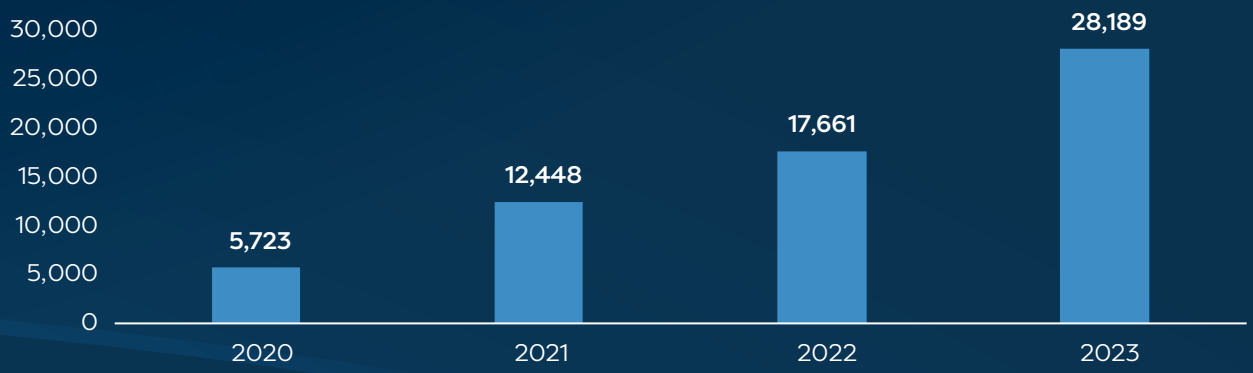
17,238

Breaches of complaints handling obligations – up 82%

The **most breached obligation** continues to be:

"We will tell you about the progress of your claim at least every 20 business days." (Paragraph 70 of the Code)

Breaches of Paragraph 70



Complaints insurers received

1,176,814 complaints received – up 61% from last year

567,406 complaints about buying insurance – up 99%

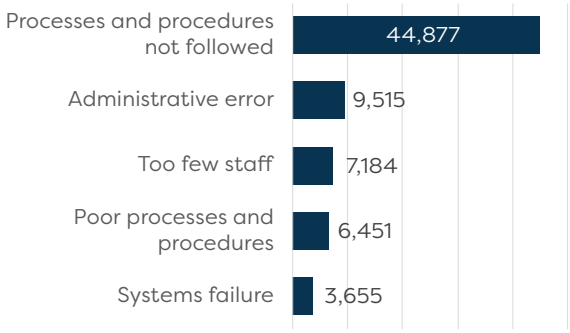
429,913 complaints about claims – up 30%

General findings

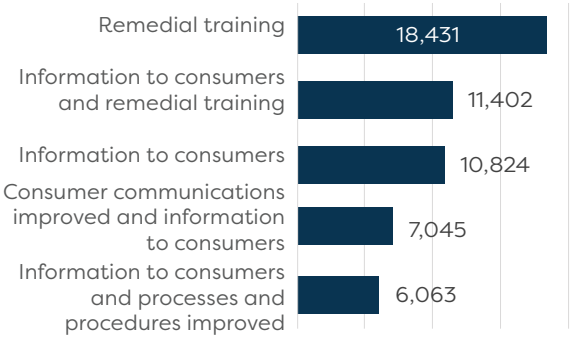
Top five Code breaches

Code paragraph	Obligation	Number of Breaches
70	We will tell you about the progress of your claim at least every 20 business days	28,189
146	We will keep you informed about the progress of your complaint at least every 10 business days	6,453
160	We comply with the Privacy Act 1988 and other requirements when we use your personal information	5,706
76	Once we have all the relevant info, we will make a decision and tell you within 10 business days	4,788
142	When we receive your complaint, we will acknowledge that we have received it	4,436
	Total	**49,572**

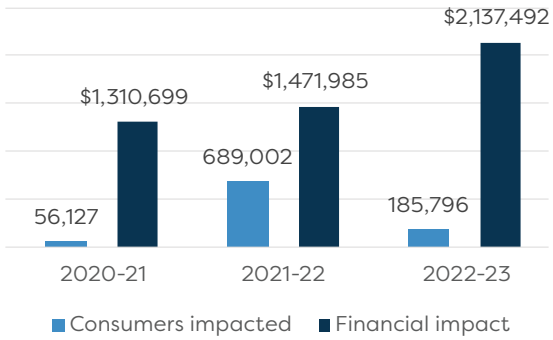
Causes of breaches



Corrective action



Impact of breaches



Notable increases in breaches

Code paragraph	Obligation	Breaches		Changes
		2021–22	2022–23	
70	We will tell you about the progress of your claim at least every 20 business days.	17,661	28,189	▲59%
146	We will keep you informed about the progress of your complaint at least every 10 business days, unless it is resolved earlier, or you agree to a different timeframe.	3,130	6,453	▲106%
142	When we receive your complaint, we will acknowledge that we have received it.	1,844	4,436	▲141%
147	We will make a decision about your complaint within 30 calendar days. If we cannot make our decision within this timeframe, then before this deadline passes, we will tell you, in writing, the reasons for the delay and about your right to take your complaint to the Australian Financial Complaints Authority, and its contact details.	1,984	4,224	▲113%
36	If you make a complaint to one of our service suppliers about either us or their conduct, then the service supplier will tell us about the complaint within two business days. Your complaint will be handled under the Code's complaints process.	41	349	▲751%
97	If you tell us, or we identify, that due to a vulnerability you need additional support or assistance, we will work with you and try to find a suitable, sensitive and compassionate way for us to proceed. We will do this as early as practicable, and we will protect your right to privacy.	330	641	▲94%

Notable decreases in breaches

Code paragraph	Obligation	Breaches		Changes
		2021–22	2022–23	
71	We will respond to your routine enquiries about your claim's progress within 10 business days.	5,578	3,253	▼42%
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.	7,810	4,788	▼39%
77	Our decision will be made within four 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.	1,114	709	▼36%
140	We will make readily available information about: a. your right to make a complaint; b. our internal processes for dealing with complaints; and c. our external dispute resolution provider. This will be published on our website, other digital platforms and in our relevant written communications.	269	51	▼81%
141	Our complaints process will comply with the Australian Securities and Investments Commission's guidelines.	520	272	▼48%
55	Your insurance policy may allow you to cancel it and obtain a refund. If you are entitled to a refund and you cancel your policy, then we will return the amount within 15 business days.	1,324	837	▼37%

Key observations

In the 2022–23 reporting period, we saw concerning increases in breaches of obligations related to claims handling and complaints handling.

Our analysis indicates three main areas that are major contributing factors to the increases in breaches:

1. **Inadequate resourcing of key functions:** Insurers that experienced increases in breaches cited resourcing issues in their claims and complaints handling functions. Insufficient resources meant employees failed to follow processes and procedures, breaching obligations to update consumers.
2. **Insufficient training and development:** The high percentage of workforce without training specific to Code obligations indicates a critical gap in knowledge and understanding of requirements. Insufficient training and a lack of ongoing monitoring resulted in errors, non-compliance, and inadequate communication with consumers.
3. **Underinvestment in technology:** Legacy systems, lack of integration between systems, and manual processes, can lead to delays, errors, and difficulties in tracking and updating claims and complaints. Technological solutions could streamline claims processing, automate updates to consumers, and facilitate efficient complaints resolution.

We note that these findings align with those contained in the **report from Deloitte** commissioned by the Insurance Council of Australia (ICA), and ASIC's **report on its review of home insurance claims**, and that insurers are working to remedy these issues.

Claims handling

By subscribing to the Code, insurers commit to keep consumers adequately informed about the progress of their claims.

It is reasonable for consumers to expect proactive communication from their insurers about the status of their claims; they do not expect to have to initiate contact themselves to receive updates and information.

The obligation to provide regular updates on the progress of a claim at least every 20 business days (paragraph 70 of the Code) has been the most breached obligation for the past four years.

In the 2022–23 reporting period, breaches of this obligation increased by 60%, rising from 17,661 in 2021–22 to 28,189, affecting 28,117 consumers. This significant increase came despite the number of retail claims rising by only 6%.

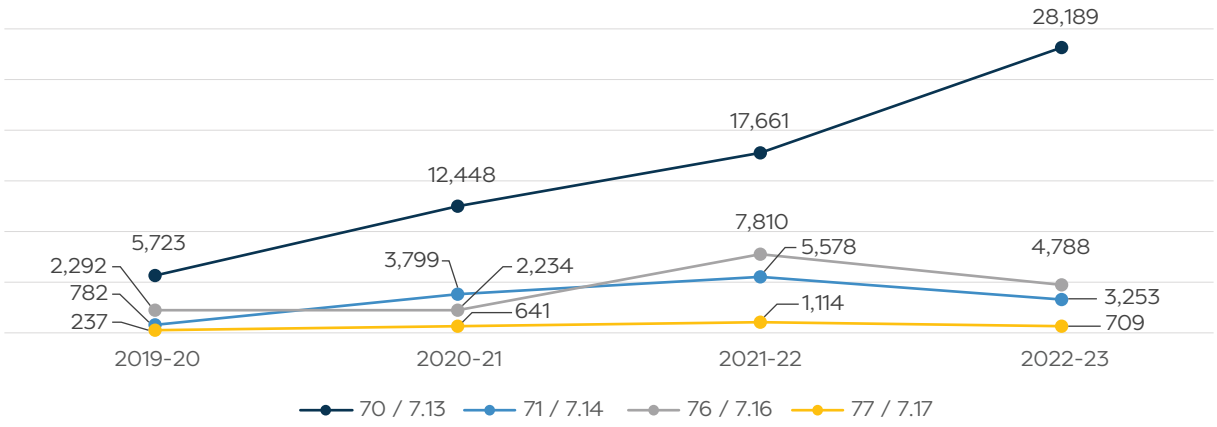
Insurers also reported 12 significant breaches of paragraph 70 that affected an additional 38,168 consumers.

Most breaches of this obligation (92%) were reported by just five insurers. Of the 29 insurers that reported breaches of paragraph 70, 16 reported an increase. Pleasingly, 13 insurers reported a decrease.

Breaches of claims handling timeframe obligations

Paragraph / Subsection	Obligation	19-20	20-21	21-22	22-23
70 / 7.13	We will tell you about the progress of your claim at least every 20 business days.	5,723	12,448	17,661	28,189
71 / 7.14	We will respond to your routine enquiries about your claim's progress within 10 business days.	782	3,799	5,578	3,253
76 / 7.16	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.	2,292	2,234	7,810	4,788
77 / 7.17	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.	237	641	1,114	709
	Total	**9,034**	**19,122**	**32,263**	**36,939**

Breaches of claims handling timeframe obligations - four-year trend



While breaches of the obligation to provide updates on the progress of a claim increased, breaches of other claims handling timeframe obligations decreased. This is a positive result.

However, despite the improvements, the prevalence of these breaches remained high.

Breaches of the obligation to communicate the claim decision within 10 business days (paragraph 76) still ranked fourth in total breaches and breaches of the obligation to respond to enquiries about a claim within 10 business days (paragraph 71) ranked seventh overall.

Causes of claims handling breaches

Insurers attributed the root cause of breaches of paragraph 70 to:

- processes and procedures not followed (61%)
- poor processes and procedures (12%)
- insufficient staff (7%)
- systems failure (4%)
- administrative errors (3%).

Insurers also cited issues with resourcing, and high volumes of claims due to catastrophes and other severe weather events as major contributors to the increase in breaches.

Crucially, this indicates that the reasons behind processes and procedures not being followed were that claims handling functions were under-resourced – employees were unable to provide regular updates due to the volume of claims they were handling.

In addition, insurers reported 13% of the total workforce did not receive training on the Code and its obligations. And among direct employees of insurers, 15% lacked Code training. This indicates a consequential gap in understanding of compliance and regulatory obligations.

In part, this may be a residual effect from the rapid increase in staff to meet demand following the major floods in New South Wales and Queensland in 2022 (CAT221).

However, it is important to note that breaches of this obligation predate CAT221; they have consistently topped the list of breaches over the past four years. Given this, we hold concerns that insurers' onboarding and training, particularly regarding Code obligations, may be insufficient.

Exacerbating these issues are concerns with a lack of technology investment and inadequate processes.

Insurers cited staff not following processes and procedures and poor processes and procedures as the main root causes of the breaches.

This indicates a lack of investment in technological solutions and process improvement. If the main root cause is staff not following procedures, insurers reveal a concerning reliance on manual intervention and lack of available technology to assist staff.

Working on improvements

The **report from Deloitte commissioned by the ICA**, the **report from ASIC on its review of home insurance claims** and ASIC's **follow-up letter to insurers** highlighted the quantum and quality of resourcing as a critical area for improvement. We expect insurers to be assessing and responding to these communications accordingly, and to see that reflected in the coming reporting period.

It is clear that insurers must do more to allocate adequate resources to handle claims, and reinforce knowledge and capability through training and monitoring, to bring down breaches, ensure compliance and uphold consumer expectations.

This necessitates initiatives to improve claims handling functions.

Our analysis links decreases in breaches among insurers to greater resources, training initiatives, improved compliance functions, and system enhancements.

Given the identified root causes of these breaches, it is imperative that insurers review their procedures and processes for updating consumers on the progress of a claim and ensure they have enough staff who are adequately trained to follow them properly.

We encourage insurers to explore technological solutions to streamline processes, such as preventative controls like automated flags and system-generated reminders prior to deadlines. While acknowledging that some insurers may contend with budget constraints, investing in such solutions is vital to sustainable compliance and better outcomes in the long term.

We also urge insurers to explore the feasibility of implementing automated updates direct to consumers via email or SMS. However, such updates must go beyond minimum requirements of paragraph 70 and offer consumers meaningful information about their claims.

We have engaged with the insurers that are driving the increase in claims handling breaches to understand their remediation efforts. If we observe sustained non-compliance, without commitment to improve and implement changes, we will consider further action, including sanctions where appropriate.

Case study

Insurers have an obligation to report significant breaches of the Code as they are identified during the year. Our investigations of significant breaches give us insights into the root causes of large numbers of breaches, and the actions insurers are taking in response.

One significant breach matter involved the insurer breaching the obligations to update consumers about their claims every 20 business days (paragraph 70), and to make a claim decision within ten business days (paragraph 76).

This breach impacted 6,313 consumers across its home and motor portfolios. The insurer identified the root causes as insufficient resourcing, system limitations and process deficiencies.

A contributing factor was the increase in claims received due to severe weather events, which exacerbated the above issues in the insurer's operations.

The insurer took remedial action by recruiting an additional three home claims teams, and ten additional staff for handling motor claims. Challenges in recruiting skilled claims handling staff meant that the insurer conducted a more comprehensive training and onboarding process for new hires.

The insurer also streamlined processes and improved efficiency, including implementing a new claims management system.

With the enhanced functionality of the new system and the increase in well-trained employees, the insurer will be better able to keep consumers regularly informed about their claims and make claims decisions in a timely manner.

Complaints handling

Insurers reported a surge in complaints in 2022–23, ranging from issues with premium increases to significant grievances about poor claims handling and delays.

The increase in complaints was exacerbated by inadequate communication with consumers regarding their claims.

Our findings and observations align with the findings on general insurance complaints outlined by AFCA in its **2022–23 Annual Review**.

In the 2022–23 reporting period insurers received 1,176,814 complaints, an increase of 61% compared to the previous reporting period.

Of these complaints, 567,406 were about 'buying insurance', with insurers attributing this mainly to grievances regarding premium increases. To reduce such complaints, insurers should provide a transparent breakdown of the components of the premium, so it is clear to consumers why their insurance premiums are increasing.

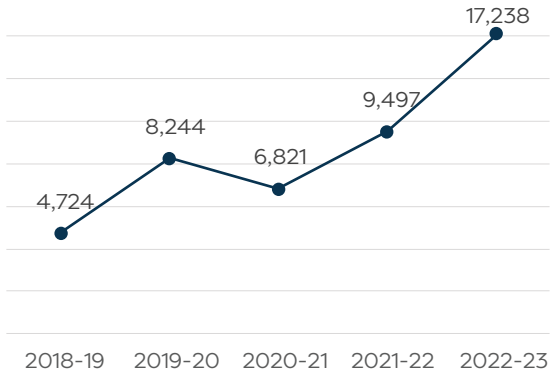
Additionally, insurers received 429,913 complaints related to claims handling, marking a 30% increase from the previous reporting period.

In its Annual Review 2022–23, AFCA highlighted a 50% increase in general insurance complaints, rising to 27,924. The reported primary issue driving these complaints was delays in claims handling. Notably, complaints to AFCA regarding claims handling delays increased by 66% in the same period.

These complaint volumes were predominantly associated with regular claims rather than claims arising from catastrophes and other severe weather events.

Various factors, including the reallocation of resources to handle claims from significant weather events and supply chain disruptions due to international events, contributed to claim delays. This led to more complaints to insurers about their services, particularly regarding ineffective communication.

Breaches of complaints handling obligations



Breaches of the Code's complaints handling obligations (Part 11 of the Code) rose by 82% in 2022–23, reaching an all-time high of 17,238. These breaches impacted 19,604 consumers, and accounted for 22% of all breaches reported in the 2022–23 period.

This increase at the industry level was largely driven by a small cohort of five insurers, which accounted for 79% of complaints handling breaches for the year. Three of these five insurers also ranked among the top five for breaches of the obligation to provide updates on claims at paragraph 70 of the Code.

The top three complaints handling obligations breached in 2022–23 were:

- Keeping consumers informed about their complaint every ten business days (Paragraph 146)
- Acknowledging a complaint when received (Paragraph 142)
- Making a decision about the complaint within 30 calendar days (Paragraph 147).

Each of these three obligations had significant increases in breaches compared to the 2021–22 reporting period. They were also the top three complaints handling breaches in 2021–22, which underscores the need for improved performance and compliance in these areas.

The increase in breaches of the obligation to acknowledge a consumer's complaint upon receipt is particularly concerning.

Failing to acknowledge complaints undermines consumer trust in the complaints resolution process and risks further disillusionment with insurers.

The increase in breaches of this obligation is indicative of issues insurers have in managing complaints effectively and must be addressed as a priority.

Complaints handling breaches 2022–23 – Top six obligations breached

Code paragraph	Breaches 2021–22	Breaches 2022–23	Change
146. We will keep you informed about the progress of your complaint at least every 10 business days, unless it is resolved earlier or you agree to a different timeframe.	3,130	6,453	▲106%
142. When we receive your complaint, we will acknowledge that we have received it.	1,844	4,436	▲141%
147. We will make a decision about your complaint within 30 calendar days. If we cannot make our decision within this timeframe, then before this deadline passes we will tell you, in writing, the reasons for the delay and about your right to take your complaint to the Australian Financial Complaints Authority, and its contact details.	1,984	4,224	▲113%
144. Your complaint will be handled by a person with appropriate authority, knowledge or experience. This will not be the person whose decision or conduct is what your complaint is about.	70	516	▲637%
143. We will tell you the name and relevant contact details of the person assigned to liaise with you about your complaint.	496	494	▼0.5%
148. When we have made a final decision about your complaint we will respond to you in writing.	146	279	▲91%

Causes of complaints handling breaches

Insurers attributed complaints handling breaches mainly to:

- processes and procedures not being followed (53%)
- insufficient staffing levels (18%)
- administrative errors (14%).

These issues mirror the challenges we observed in claims handling and can be attributed to the same underlying issues: under-resourcing of complaints handling functions, underinvestment in technology and inadequate processes and procedures.

Insurers indicated that the sharp increase in claims received during 2022, following CAT221 and other severe weather events, placed considerable strain on claims handling processes.

This led to delays, ineffective communication, and other deficiencies, resulting in a surge in consumer complaints regarding claims handling.

Additionally, insurers reported that part of the response to the large volume of claims included transferring staff to claims handling teams from other areas, including from complaints handling teams.

For many, this appears to have influenced complaints handling operations, as they were left under-resourced to deal with the increase in complaints. Consequently, we saw a significant increase in breaches of Code obligations for complaints handling.

Another contributing factor is the increased awareness of consumers of their rights to challenge organisations, including insurers, with consumers utilising various channels, including social media, to voice their concerns. This heightened consumer awareness is reflected in the escalating number of complaints received by insurers.

Working on improvements

It is important to note the correlation between resourcing issues and increases in breaches.

Insurers that reported decreases in breaches of complaints handling obligations did not report issues with resourcing to the same extent as the insurers that saw their breaches increase.

Insurers must work to ensure that their complaints handling departments are adequately resourced to manage the volume and complexity of complaints they receive. This includes the ability to swiftly scale up resources as needed, employing staff with the requisite knowledge and expertise, empowering employees to make decisions on complaints, implementing appropriate processes and technological assistance or solutions.

Furthermore, when expanding complaints handling teams with new employees, insurers must prioritise comprehensive training and monitoring.

New employees are more likely to make mistakes and errors that may lead to breaches of Code obligations. This highlights the importance of investing in training and development, as well as ongoing monitoring of performance and quality assurance to ensure compliance.

We will engage further with the insurers responsible for the most significant increases in breaches of complaints handling obligations to gain insights into their challenges. Once again, if we observe sustained non-compliance without commitment to improve and implement changes, we will consider further action, including the possibility of using sanction powers.

Case study

Insurers reported eight significant breaches related to complaints handling in 2022–23, impacting 3,070 consumers.

One insurer experienced an increase in complaints because of delays in finalising claims.

The insurer was under-resourced to handle the volume of complaints received and was unable to keep consumers informed about their complaints every ten business days (paragraph 146). It also failed to make decisions about complaints within 30 days (paragraph 147).

The breach impacted 1,127 consumers over a seven-month period.

In response, the insurer increased the resourcing in its internal dispute resolution (IDR) function, and re-allocated caseloads to specialist teams to manage the volume of complaints.

It implemented a range of preventative controls within its complaints management system, which proactively alerted employees to upcoming time-bound obligations.

Ongoing monitoring has shown a marked reduction in breaches in recent quarters following the increase in resourcing and system enhancements.

This monitoring now includes a weekly detective report to promptly identify any increases in breaches of complaints handling timeframes.

The insurer expects to see further improvements in complaints management as staff become more familiar with the enhancements to its system, and newer employees gain more experience.

Spotlight – insurer brands

Many insurers offer their products in the market under different brand names. We know that different brands are targeted at different market segments and that for many consumers, it is an insurer's retail brand that is familiar and from which they purchase a policy.

We wanted to understand, from a Code compliance perspective, whether consumer outcomes differed across brands, despite the brands being underwritten by the same insurer.

To get an insight into the compliance of insurers' different brands and their consumer outcomes, we asked insurers to provide a breakdown of policies, claims, complaints, and breaches segmented by brands for the 2022–23 reporting period.

It was disappointing to see that some insurers were unable to provide the information we requested in full, including some of the larger insurers by market share. We have written to those insurers and expect more comprehensive responses in the next reporting period.

A brand is a marketing name that insurers use to interact with consumers. Broadly, a brand will be one of two types:

- **Proprietary brand:** a brand that is owned by the insurer. These brands are completely administered by the insurer.
- **Distributor brand:** a brand that is owned by another company that sells insurance underwritten by the insurer. This practice is sometimes referred to as 'white labelling'. Distributors include banks, supermarkets, motor dealerships and airlines.

Of the 49 insurers that subscribe to the Code, 31 reported operating under retail brand names – proprietary brands and/or distributor brands. We believe the data is informative and should be used by insurers to understand where their compliance frameworks can be improved or where there may be systemic issues that need to be addressed.

Some early observations included:

- One insurer that reported notably more breaches for its proprietary home insurance brand compared to its distributor brands.
- A distributor brand of one insurer had significantly higher numbers of complaints per 10,000 home and motor insurance policies compared to the insurer's other brands.
- A distributor brand for home insurance of one insurer reported notably higher percentages of claims declined and withdrawn compared to its proprietary brands.

In the upcoming reporting period, we will delve deeper into comparisons between proprietary brands and distributor brands, to gain insight into the compliance of the various brands and the impact on consumers.

Breach data

Breaches by Code part and retail insurance class

Code part	Consumer Credit	Home	Motor Retail	Personal and Domestic Property	Residential Strata	Sickness and Accident	Travel	Unknown	Total
Part 3		448	685	327	3	6	14	455	1,938
Part 4		56	51	23	1		16	66	213
Part 5		216	191	6			1		414
Part 6	6	3,348	501	65	12	3	8	635	4,578
Part 7	19	213	607	8	3	3	22	16	891
Part 8	189	21,212	14,615	1,062	4,579	373	2,540	761	45,331
Part 9	2	281	299	2	1	1	6	173	765
Part 10	1	63	200	7	1			115	387
Part 11	835	6,787	6,901	549	413	539	199	1,015	17,238
Part 12		510	1,202	216	1	144	74	3,629	5,776
Part 13		2	1					1	4
Part 14								3	3
Part 15		100	220	8				20	348
Total	**1,052**	**33,236**	**25,473**	**2,273**	**5,014**	**1,069**	**2,880**	**6,889**	**77,886**

Breaches by retail insurance class

Insurance class	Breaches 2021–22	Breaches 2022–23	Change in breaches	% change in breaches	% change in policies
Retail					
Consumer Credit	331	1,052	721	218%	-45%
Home	24,479	33,236	8,757	36%	4%
Motor Retail	19,037	25,473	6,436	34%	4%
Personal and Domestic Property	1,932	2,273	341	18%	-15%
Residential Strata	403	5,014	4,611	1,144%	-8%
Sickness and Accident	448	1,069	621	139%	1%
Travel	557	2,880	2,323	417%	161%
Insurance class not reported	10,917	6,889	-4,028	-37%	N/A
Total	**58,104**	**77,886**	**19,782**	**34%**	**11%**

Breaches of Part 3: Our obligation to you

Code paragraph	Breaches 2021–22	Breaches 2022–23
21 - Subscribers, Distributors, Service Suppliers to be honest, efficient, fair, transparent, timely	2,184	1,938
Total		**1,938**

Breaches of Part 4: Standards for us and our Distributors

Code paragraph	Breaches 2021–22	Breaches 2022–23
26 - Our Distributors must tell us about any complaint that you make to them within 2 business days	22	102
28(a) - Employees and Distributors to receive appropriate education and training to provide service	6	79
24 - Employees and Distributors will only provide services that match their expertise	6	10
23 - Policies and procedures in place for Employees and Distributors to conduct sales appropriately	31	7
25 - Our Distributors will inform you they act on our behalf and the service they are authorised for	2	3
31 - We will investigate concerns about the conduct of our Employees or Distributors	6	3
32 - If Employees'/Distributors' conduct caused harm, we will contact you to discuss remedy.	1	3
28(c) - Employees and Distributors to receive appropriate education and training about the code	14	2
30 - Policies and procedures in place to monitor performance of our Employees and/or Distributors	0	2
29 - Our Employees' and Distributors' education and training records will be kept at least 7 years	0	1
33 - If you are not satisfied with our proposed remedy, we will tell you how to make a Complaint	1	1
Total		**213**

Breaches of Part 5: Standards for our Service Suppliers

Code paragraph	Breaches 2021–22	Breaches 2022–23
36 - Our Service Suppliers will tell us about any complaint that you make to them within 2 business days	41	349
37 - Our Service Suppliers will notify us within 2 business days of any Code breaches by them	65	51
35 - Our Service Suppliers will inform you they act on our behalf and the service they are authorised for	7	7
41 - If our Service Suppliers' performance does not meet Code standards, then we will address this	0	4
39 - All contracts with Service Suppliers must reflect the relevant standards of the Code	0	2
38 - We will have measures in place to ensure that we appoint only suitable Service Suppliers.	2	1
Total		**414**

Breaches of Part 6: Buying insurance

Code paragraph	Breaches 2021–22	Breaches 2022–23
47(b) – We will tell you about your right to ask for information and will provide it to you as per Part 12 of the Code	10	1,087
47(c) - Refer you to either ICA or NIBA for information about other insurance options	26	1,070
47(d) - Give information about Complaints process if you are unhappy with decision	12	1,051
47 - Information if we cannot provide you with insurance	397	631
49 - Reminders at time of purchase and at each renewal	163	403
49(a) - Remind you about automatic renewal process	7	85
48 - Provide access to calculator that is periodically reviewed to enable estimate of sum insured	37	64
46 - Where mistakes are identified in application or information, we will immediately correct it	13	56
51 - If insurance policy has No Claims Discount, we must tell you how it works	140	52
44 - Pressure Selling of products is prohibited	270	46
45 - We will ask for and rely on information and documents only if relevant to our decision	7	13
49(b) - Remind you that you can opt-out of that process	5	8
50 - If we offer to renew products bought directly from us, we will provide comparison and calculation	28	4
49(c) - Check amount of sum insured for appropriate insurance cover	0	4
47(a) - give our reasons for decision	34	3
50(d) - motor vehicle – unless fleet of vehicles or business or other organisation	0	1
Total		**4,578**

Breaches of Part 7: Cancelling an insurance policy

Code paragraph	Breaches 2021–22	Breaches 2022–23
55 - If you cancel your policy we will refund the amount within 15 business days unless with broker	1,324	837
56 - We will send a notice of non-payment 14 days prior to cancellation of your instalment policy	41	44
57 - If notice sent under Paragraph 56, we will send a second non-payment notice in writing	3	9
57(b) - Within 14 days after cancellation, confirming our cancellation of your instalment policy	3	1
Total		**891**

Breaches of Part 8: Making a claim

Code paragraph	Breaches 2021–22	Breaches 2022–23
70 - We will tell you about the progress of your claim at least every 20 business days	15,051	28,189
76 - Once we have all the relevant info, we will make a decision and tell you within 10 business days	6,850	4,788
71 - We will respond to your routine enquiries about your claim's progress within 10 business days	4,950	3,253
73 - If we appoint an Investigator, within 5 business days we will tell you and explain their role/Investigation process will comply with Part 15 of the Code	81	1,749
59(a) - we will tell you about our claims process	46	1,713
90 - Request review of Catastrophe claim within 12 months if you think assessment was inaccurate	37	877
68 - if we need further information relating to your claim, then within 10 business days we will	415	761
77 - Decision to be made within 4 months or tell you about Complaints process unless Paragraph 78 applies	1,063	709
59 - If you make a claim, then we will tell you about process, excess, waiting periods, contact details	416	537
81 - If we deny your claim, or do not pay it in full, then we will tell you, in writing	393	502
79 - If we cash settle on your home policy, we will provide info to help you understand our decision	332	408
61 - If required we will provide information about the purpose and process of a scope of works	450	384
62 - We will take prompt action to correct any claim mistake that you tell us about or we identify	703	147
58 - We will not discourage you from making a claim and tell you we will fully assess coverage of loss	114	141
68(a) - tell you any information we need to make a decision on your claim	157	139
84 - We must comply with the timeframes in this part of the Code, unless certain circumstances apply	0	113
72 - If we appoint a Loss Assessor, within 5 business days we will tell you and explain their role	181	99
69 - We will consider relevant facts, the terms of your policy and the law when we assess your claim	272	95
81(b) - the reasons for our decision	160	79
81(a) - the aspects of your claim that we do not accept	173	77
78 - Decision made within 12 months or tell you about Complaints process	26	67
81(e) - about our Complaints process	179	61
81(c) - you have the right to ask for the info about you that we relied on when assessing your claim	149	57
81(d) - you have the right to ask for copies of Service Suppliers'/Experts' reports we relied on	148	57
59(b) - about any excess amounts you have to cover or pay in relation to your claim	63	50

Code paragraph	Breaches 2021–22	Breaches 2022–23
67 - When assessing your claim we will only ask for and rely on information that relates to our decision	91	40
64 - If you urgently need the benefits you are entitled to under the policy we will do the following	18	31
86 - We will accept responsibility for work of our authorised repairer and handle Complaints	11	29
59(d) - how to contact us regarding your claim	36	26
82 - We will give you that info or report in 10 business days, as set out in Part 12 of the Code	187	26
59(c) - any waiting or no cover periods that need to end prior to paying you under the policy	28	23
74 - We will ask Expert to provide a report in 12 weeks and tell you if they don't meet that time	81	20
63 - You may make a Complaint about your claim handling through our Complaints process	16	15
83 - If we cannot agree on alternative timetable, we will inform you of our Complaints process	4	15
66 - We will tell you about our Complaints process if you are unhappy with our response to your urgent financial need	0	12
88 - We will respond to Catastrophes efficiently, professionally, practically and compassionately	1	12
60 - If contacted by an uninsured person, we will tell them about our claims process	7	9
68(c) - provide our estimate of the likely timeframe and process for us to make a decision	30	7
68(b) - if necessary, appoint a Loss Assessor or Loss Adjuster to assess your claim	29	4
75 - We will engage an Expert only if we believe they have the expertise to provide the opinion	3	4
80 - When you have suffered a total loss, we will treat your claim with sensitivity	2	2
60(b) - about our Complaints process	0	1
64(b) - Within 5 business days pay you an advance amount to help ease your urgent financial need	3	1
84(a) - we have complied with an alternative timetable to which you agreed	0	1
87 - If required, we will arrange a hire car or accommodation and cover the reasonable costs	0	1
Total		**45,331**

Breaches of Part 9: Supporting customers experiencing vulnerability

Code paragraph	Breaches 2021–22	Breaches 2022–23
97 - Work with vulnerable consumers to give timely support or assistance and protect privacy	330	641
101 - Provide access to an interpreter if required, record use or reasons if unable to arrange	242	30
96 - Have internal policies and provide appropriate training to Employees on consumer vulnerability	14	27
98 - Allow for and recognise authority of vulnerable consumer's support person	71	26
91 - Committed to taking extra care with customers who experience vulnerability	37	17
100 - Provide support or assistance to meet identification requirements	3	11
99 - Additional support includes easier way to liaise, financial or community support services	25	6
104 - Develop internal processes and procedures to take account of mental health conditions	0	2
92(f) - Vulnerability due to language barriers	0	2
92(a) - Vulnerability due to age	0	1
92 - A person's vulnerability may be due to a range of factors	1	1
96(a) - Help Employees understand if a consumer may be vulnerable	7	1
Total		**765**

Breaches of Part 10: Financial hardship

Code paragraph	Breaches 2021–22	Breaches 2022–23
111 - Type of information given to a person in Financial Hardship	57	145
121 - Give written decision on support request within 21 calendar days unless more info needed	100	118
120 - Action on hold until application for support is assessed & have notified person of decision	20	20
122 - If more information is needed under paragraph 116	49	15
111(b) - If appropriate give contact details for the National Debt Helpline	45	11
118 - Place recovery action on hold if identify Financial Hardship or person asks for support	40	11
109 - Have internal policies and train Employees to identify person in Financial Hardship	12	9
111(a) - Provide details about how to apply for Financial Hardship support	49	8
112 - Contact person about their application using their preferred communication method	7	8
123 - If entitled to Financial Hardship support work with person to implement an arrangement	4	6
131 - Comply with ACCC and ASIC Debt collection guideline for collectors and creditors	31	6
116 - When more information is needed about Financial Hardship before a decision can be made	2	5

Code paragraph	Breaches 2021–22	Breaches 2022–23
129 - Notify person of reasons for declining Financial Hardship application	16	4
106 - Consumer has right to ask for fast-tracking of claim if in urgent financial need	2	3
124 - Confirm the agreed arrangement in person's preferred method of communication	2	3
113 - Update person's representative about request for Financial Hardship support unless told not to	2	2
115 - Request reasonably necessary info to assess an application for Financial Hardship support	2	2
119 - Contact Collection Agent or solicitor and tell them action is on hold	8	2
127 - Agreement to release, discharge or waive a debt or obligation will be confirmed in writing	3	2
107 - Individuals entitled to Financial Hardship support	3	1
114 - When assessing a person's request for Financial Hardship consider all reasonable evidence	2	1
117 - 21 calendar days to provide information unless a different timeframe has been agreed	16	1
122(a) - If all info received give written decision on Financial Hardship support within 21 calendar days	6	1
130 - Person may re-apply for Financial Hardship support if circumstances change	0	1
132(a) - Understand the Financial Hardship requirements in the Code	0	1
133 - First communication about money owed must include info to show amount is fair and reasonable	1	1
Total		**387**

Breaches of Part 11: Complaints

Code paragraph	Breaches 2021–22	Breaches 2022–23
146 - We will keep you informed about progress of your Complaint at least every 10 business days	3,130	6,453
142 - When we receive your Complaint, we will acknowledge that we have received it	1,844	4,436
147 - We will make a decision about your Complaint within 30 calendar days and advise of options	1,984	4,224
144 - Your Complaint will be handled by person with appropriate authority, knowledge or experience	70	516
143 - We will tell you contact details of person assigned to liaise with you about your Complaint	496	494
148 - When we have made a final decision about your Complaint we will respond to you in writing	146	279
141 - Our Complaints process will comply with ASIC guidelines	520	272
150 - If Complaint resolved within 5 business days, we will not respond in writing unless required	194	260
139 - You may complain to us about any aspect of your relationship with us	66	117

Code paragraph	Breaches 2021–22	Breaches 2022–23
149 - Our written response will include reasons for decision and details about AFCA process	84	89
140 - We will publish information about Complaints process on website, digital platforms and written communications	210	49
152 - If we made a mistake when handling your Complaint, then we will take action to correct it	35	21
145 - We will only ask for and rely on information that is relevant to our decision	11	13
151 - We must give information relied on in making decision on Complaint within 10 business days	47	9
140(b) - our internal processes for dealing with Complaints	27	2
154 - You can take Complaint to AFCA and if complaint not resolved within 30 Calendar Days	51	2
156 - AFCA's decisions are binding on us in the way set out in its Rules	1	2
Total		**17,238**

Breaches of Part 12: Your access to information

Code paragraph	Breaches 2021–22	Breaches 2022–23
160 - We comply with Privacy Act 1988 and other requirements when we use your personal information	2,635	5,706
161 - On request, we will give you information we relied upon within 30 calendar days free of charge	40	62
163 - If we refuse to give info, will not do so unreasonably, give reasons and complaints process	6	3
162(b) - copies of your product disclosure statement and insurance	5	2
162(d) - copies of any recordings and/or transcripts of any interaction we had with you	0	1
162(c) - copies of any reports from Service Suppliers or External Experts that we relied on	0	1
162(a) - documents and information we relied on to deny your claim	0	1
Total		**5,776**

Part 13: Enforcement, sanctions and compliance

Code paragraph	Breaches 2021–22	Breaches 2022–23
179 - Subscribers will report to their Board or executive management, about compliance with the Code	0	2
178 - The Code Governance Committee's decisions and sanctions are binding on subscribers	0	1
180 - Appropriate systems and processes to monitor Code compliance and provide annual compliance report	0	1
Total		**4**

Breaches of Part 14: Promoting, reviewing and improving the Code

Code paragraph	Breaches 2021–22	Breaches 2022–23
186(a) - We will have Information about the CGC on our websites, in product info and other places	3	3
Total		**3**

Breaches of Part 15: Claims investigation standards

Code paragraph	Breaches 2021–22	Breaches 2022–23
204 - We will update you about the investigations process at least every 20 business days	39	170
202(a) - Before investigation we will tell you verbally and in writing of our investigation process	38	36
196 - We will independently review investigations longer than four months and you will be notified	17	25
205(a) - If we need to interview you we will tell you in writing of the purpose of the interview	9	17
198 - If our review exceeds 30 calendar days we will advise in writing about our Complaints process	9	13
219 - There will be a 5 minute break every 30 minutes offered or mandated for vulnerable customers	6	12
201 - We will train our Employees to communicate to you the reason your claim is being investigated	9	10
213 - Interviews must be conducted in objective, honest, efficient, transparent and fair manner	0	7
200(a)(ii) - We will ensure that we tell you why we need to request more information or documents	0	6
223 - If we need to interview you more than once we will give you a record of the previous interview	2	6
193(b) - We will ensure our appointed Investigators or Employees act appropriately and respectfully	0	4
202(e) - Before investigation we will tell you that decisions will be made in 10 business days	4	4

Code paragraph	Breaches 2021–22	Breaches 2022–23
221 - The Investigator or Employee must record all offers of breaks and the interviewee's responses	5	4
222 - We will offer you a free transcript of the formal interview or a recording, or at your request	16	4
199 - Post review we will advise in writing why a decision is outstanding and of any details we need	0	3
193(a) - We will ensure our appointed Investigators or Employees only investigate necessary matters	2	2
200(b)(i) - We will advise Investigators and Employees that investigations are limited to the claim	1	2
202(c) - Before investigation we will tell you verbally and in writing of the roles of our staff	4	2
214 - A single interview sitting may only last for up to 90 minutes	2	2
217(a) - If an interpreter is needed the Investigator or Employee will pause the interview	1	2
231(a) - We require Investigators to collect information only if they reasonably view it relevant	0	2
195 - Our QA program includes reviews of non-genuine claims indicators reviewed annually	0	1
200(a)(i) - We will aim to ensure requests for more information or documents are made in one request	1	1
202(g) - Before investigation we will tell you verbally and in writing about our complaints process	4	1
203 - If we need your authority to access information we will explain why you should provide it	0	1
205(f) - If we need to interview you we will tell you in writing of the expected interview duration	1	1
205(h) - If we need to interview you we will tell you of your right to a lawyer or support person	1	1
210(b) - When arranging the interview we will tell you if it can be scheduled at your preferred time	0	1
217(b) - If an interpreter is needed the Investigator or Employee will reschedule the interview	1	1
218(b) - The Investigator or Employee will outline the role of the support person role at interview	0	1
220 - You can request additional breaks and stop the interview early and reschedule if needed	0	1
225(a) - If we appoint an Investigator we will provide written instructions about each investigation	1	1
226(a) - We require Investigators to record written approval requests to access personal information	0	1
226(b) - We require Investigators to provide those records to us at the end of their investigation	0	1
229(a) - Investigators must make or retain contemporaneous written records of in-person meetings	0	1

Code paragraph	Breaches 2021–22	Breaches 2022–23
231(g) - We require Investigators to obtain authority by the insurer before alleging fraud	0	1
Total		**348**

Breaches per 10,000 policies sold

As well as engaging with insurers with high breach numbers, we monitor insurers that report low numbers of breaches, or no breaches, for possible under-reporting.

There were 12 subscribers that reported no breaches for 2022–23 – largely due to their businesses being predominantly or entirely concerned with wholesale insurance. Large parts of the Code, including parts related to claims handling and complaints handling, do not apply to wholesale insurance.

Note: the aliases used to de-identify subscribers in this data are different to ones used in previous years' reports.

Subscriber	Breaches	% of total breaches	Breaches per 10,000 policies
Subscriber 73616X	20,167	25.9%	33
Subscriber 74491W	12,339	15.8%	194
Subscriber 46617C	7,326	9.4%	33
Subscriber 92067C	7,286	9.4%	48
Subscriber 59722A	6,714	8.6%	9
Subscriber 89628E	5,658	7.3%	12
Subscriber 79880R	3,816	4.9%	29
Subscriber 33502F	2,904	3.7%	12
Subscriber 97640E	2,664	3.4%	14
Subscriber 33598A	2,178	2.8%	11
Subscriber 68136D	1,255	1.6%	14
Subscriber 89381E	1,147	1.5%	9
Subscriber 42282U	946	1.2%	22
Subscriber 94376L	564	0.7%	6
Subscriber 10087T	490	0.6%	104
Subscriber 86110B	338	0.4%	7
Subscriber 95867A	211	0.3%	21
Subscriber 54405E	166	0.2%	3
Subscriber 33477D	117	0.2%	1
Subscriber 11835V	102	0.1%	31
Subscriber 94827F	82	0.1%	3
Subscriber 64287C	76	0.1%	12
Subscriber 61043I	68	0.1%	7
Subscriber 75351D	68	0.1%	1
Subscriber 60242D	63	0.1%	79
Subscriber 98601S	50	0.1%	5
Subscriber 51072V	47	0.1%	1

Subscriber	Breaches	% of total breaches	Breaches per 10,000 policies
Subscriber 90981O	47	0.1%	1
Subscriber 91390C	40	0.1%	3
Subscriber 20161V	37	<0.1%	1
Subscriber 21426H	14	<0.1%	9
Subscriber 62980C	13	<0.1%	6
Subscriber 63727K	6	<0.1%	1
Subscriber 17084K	4	<0.1%	<1
Subscriber 32992V	3	<0.1%	1
Subscriber 54704W	2	<0.1%	<1

Industry data

Policies and claims

Insurance Class	Individual Policies	Group Policies	Total policies	Lodged Claims	Declined Claims	Withdrawn Claims
Retail	36,601,022	306,729	36,907,751	4,619,370	299,497	381,151
Wholesale	3,028,836	233,339	3,262,175	494,755	7,985	41,306
Total	**39,629,858**	**540,068**	**40,169,926**	**5,114,125**	**307,482**	**422,457**
Retail						
Consumer Credit	98,600	12	98,612	38,482	1,464	512
Home	11,654,225	0	11,654,225	664,364	108,364	121,557
Motor Retail	16,950,602	68,879	17,019,481	2,160,809	11,013	190,207
Personal and Domestic Property	2,749,901	2,606	2,752,507	1,425,518	139,275	41,921
Residential Strata	219,799	0	219,799	41,189	5,780	4,846
Sickness and Accident	136,333	26,290	162,623	27,843	1,133	1,923
Travel	4,791,562	208,942	5,000,504	261,165	32,468	20,185
Retail Total	**36,601,022**	**306,729**	**36,907,751**	**4,619,370**	**299,497**	**381,151**
Wholesale						
Business	169,385	9,864	179,249	24,556	1,034	3,290
Business Pack	1,258,832	84,624	1,343,456	70,834	3,091	8,820
Contractors All Risks	39,566	707	40,273	8,005	237	732
Industrial Special Risks	54,628	5,172	59,800	20,374	509	2,183
Liability	664,796	96,823	761,619	39,017	1,240	4,789
Motor Wholesale	220,726	32,214	252,940	245,786	429	16,641
Other	287,933	983	288,916	10,041	76	494
Primary Industries	35,081	5	35,086	15,467	19	225
Primary Industries Pack	297,889	2,947	300,836	60,675	1,350	4,132
Wholesale Total	**3,028,836**	**233,339**	**3,262,175**	**494,755**	**7,985**	**41,306**

Group policies/people and assets covered by group policies

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

Insurance Class	Group Policies	People and assets covered
Retail	306,729	23,252,107
Wholesale	233,339	14,049,096
Total	**540,068**	**37,301,203**
Retail		
Consumer Credit	12	0
Home	0	0
Motor Retail	68,879	391,393
Personal and Domestic Property	2,606	2,702,179
Residential Strata	0	0
Sickness and Accident	26,290	9,778,267
Travel	208,942	10,380,268
Retail Total	**306,729**	**23,252,107**
Wholesale		
Business	9,864	11,888
Business Pack	84,624	281,162
Contractors All Risks	707	82
Industrial Special Risks	5,172	3,492
Liability	96,823	12,465,508
Motor Wholesale	32,214	1,110,870
Other	983	175,395
Primary Industries	5	699
Primary Industries Pack	2,947	0
Wholesale Total	**233,339**	**14,049,096**

Accepted claims and value of paid claims

An accepted claim is one for which an insurer has accepted responsibility for all aspects of a claim for coverage. This does not include partially accepted claims or claims paid on an ex-gratia basis.

Insurance class	Number of claims accepted	Value of claims paid ($AUD)	Premiums received ($AUD)
Retail			
Consumer Credit	36,014	$20,870,231	$60,009,007
Home	547,641	$8,764,790,546	$10,967,769,877
Motor Retail	2,035,166	$9,097,035,902	$13,699,604,110
Personal and Domestic Property	1,188,701	$1,380,360,185	$1,779,274,960
Residential Strata	29,657	$621,617,188	$1,235,700,038
Sickness and Accident	23,295	$227,304,676	$448,954,116
Travel	164,549	$361,914,662	$1,512,235,271
Retail Total	**4,025,023**	**$20,473,893,390**	**$29,703,547,379**

Partially accepted claims

A partially accepted claim is one for which an insurer determines that part falls within the terms and conditions of the policy and part is not accepted. It does not include an accepted claim, a declined claim, or an ex-gratia claim. It does not include caps and limits within the policy. Claims paid to the limits and sub-limits of the policy are not deemed partially accepted and are not included as part of this data; they are recorded under accepted claims.

Insurance Class	Partially accepted due to 'No Cover'	Partially accepted due to standard policy exclusion	Partially accepted - 'Other'	Total Number of Partially Accepted Claims
Retail				
Consumer Credit	1	0	0	1
Home	1,305	5,527	25,990	32,822
Motor Retail	177	612	2,565	3,354
Personal and Domestic Property	11,093	40,810	7,953	59,856
Residential Strata	107	826	117	1,050
Sickness & Accident	229	249	895	1,373
Travel	3,172	3,199	2,091	8,462
Retail Total	**16,084**	**51,223**	**39,611**	**106,918**

Workforce and training

Workforce type	Total staff	Staff that received Code training	Staff that did not receive Code training
Claims Management Services	3,250	3,115	135
Collection Agents	973	944	29
Corporate Distributors	27,138	11,880	1,506
Employees including employees of related entities	43,755	36,882	6,444
Independent Contractors	19,727	13,811	5,916
Individual Distributors	11,098	10,551	547
Investigators	975	925	50
Loss Assessors or Adjusters	9,355	8,922	816
Other external sellers	18,946	16,424	2,705
Total	**135,217**	**103,454**	**18,148**

Complaints received

The 'Claims' category comprises complaints about 'declined claims', 'quantum/value of claim', 'refusal to re-open a withdrawn claim' and 'other complaints about claims'.

Insurance class	Access to information	Buying Insurance	Catastrophes	Claims	Distributors	Employees (incl related entities)	Financial hardship	Vulnerability	Total
Retail	44,864	559,864	23,458	416,350	45,008	56,672	2,099	785	1,149,100
Wholesale	1,432	7,542	1,477	13,563	269	3,393	35	3	27,714
Total	**46,296**	**567,406**	**24,935**	**429,913**	**45,277**	**60,065**	**2,134**	**788**	**1,176,814**
Retail									
Consumer Credit	14	11,690	1	244	7	673	0	3	12,632
Home	13,432	225,094	20,401	156,920	11,845	17,284	302	230	445,508
Motor Retail	28,764	280,225	1,784	200,371	32,463	35,363	1,167	261	580,398
Personal and Domestic Property	2,337	37,010	805	33,315	459	2,635	426	16	77,003
Residential Strata	270	3,515	146	5,693	69	592	5	0	10,290
Sickness and Accident	10	137	6	599	3	14	0	0	769
Travel	37	2,193	315	19,208	162	111	199	275	22,500
Retail Total	**44,864**	**559,864**	**23,458**	**416,350**	**45,008**	**56,672**	**2,099**	**785**	**1,149,100**
Wholesale									
Business	32	305	298	1,623	13	77	2	0	2,350
Business Pack	905	3,786	432	3,639	99	2,178	8	3	11,050
Contractors All Risks	0	0	0	23	0	1	0	0	24
Industrial Special Risks	1	6	38	326	0	14	1	0	386
Liability	185	779	6	436	90	467	2	0	1,965
Motor Wholesale	298	1,952	92	5,806	67	509	19	0	8,743
Other	8	312	85	364	0	11	0	0	780
Primary Industries	0	177	154	500	0	27	2	0	860
Primary Industries Pack	3	225	372	846	0	109	1	0	1,556
Wholesale Total	**1,432**	**7,542**	**1,477**	**13,563**	**269**	**3,393**	**35**	**3**	**27,714**

Complaints finalised

Insurance Class	Complaints resolved in consumer favour	% resolved in consumer favour	Complaints resolved in subscriber favour	% resolved in subscriber favour	Total complaints finalised
Retail	524,009	46%	619,592	54%	1,143,601
Wholesale	11,849	43%	15,516	57%	27,365
Total	**535,858**	**46%**	**635,108**	**54%**	**1,170,966**
Retail					
Consumer Credit	5,073	40%	7,757	60%	12,830
Home	215,540	49%	227,302	51%	442,842
Motor Retail	269,557	47%	307,590	53%	577,147
Personal and Domestic Property	22,166	29%	55,318	71%	77,484
Residential Strata	4,268	42%	5,992	58%	10,260
Sickness and Accident	161	21%	594	79%	755
Travel	7,244	33%	15,039	67%	22,283
Retail Total	**524,009**	**46%**	**619,592**	**54%**	**1,143,601**
Wholesale					
Business	1,058	46%	1,238	54%	2,296
Business Pack	4,924	45%	6,086	55%	11,010
Contractors All Risks	4	18%	18	82%	22
Industrial Special Risks	191	50%	192	50%	383
Liability	613	31%	1,334	69%	1,947
Motor Wholesale	3,564	42%	4,969	58%	8,533
Other	233	30%	539	70%	772
Primary Industries	524	61%	332	39%	856
Primary Industries Pack	738	48%	808	52%	1,546
Wholesale Total	**11,849**	**43%**	**15,516**	**57%**	**27,365**

About us

The General Insurance Code Governance Committee was established to monitor compliance with the Code to help encourage best practice and improve consumer outcomes.

Our **Charter** provides for us to undertake the following functions:

- Monitor compliance with the Code
- Collect and analyse data
- Identify areas for improvement
- Provide guidance
- Publish findings of inquiries
- Engage with stakeholders

We also have the power to issue determinations and impose sanctions when appropriate in the circumstances.

In addressing issues, our first step is to work with the insurer to rectify what has gone wrong, support their compliance with the Code, and pursue better outcomes for consumers.

Our work is supported by the Code Team which provides monitoring, operational and administrative services. The Code Team works within the Australian Financial Complaints Authority (AFCA) alongside four other code compliance committee teams.

This arrangement allows the Code Team to learn from other code committees and teams, share insights and information about compliance, and improve our own practices.

Our **Annual Report for 2022–23** contains further details about our work to drive better compliance with the Code and help the insurance industry improve its service to customers.

The Code

The General Insurance Code of Practice (the Code) sets out obligations that promote high standards of ethical conduct and customer service for insurers.

The Code aims to strengthen consumer protection by ensuring insurers operate with transparency, accountability and a focus on consumer interests and needs. It also helps to build a relationship of trust with consumers.

Subscribing to the Code commits insurers to good practices and service delivery that is honest, efficient, fair, transparent and timely.

The Code is owned and published by the Insurance Council of Australia (ICA) and is an important part of the national consumer protection framework and general insurance regulatory system.