



Member forum

Life insurance

17 March 2023

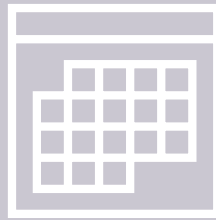
Presenters

- **Emma Curtis** – Lead Ombudsman, Insurance
- **Andrew Weinmann** – Senior Ombudsman, Life Insurance

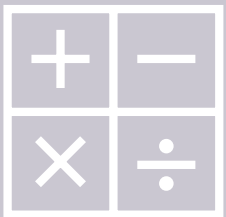
Today's session includes



**What the
complaints data
tells us**



**Claims delay complaints
– our expectations and
typical outcomes**



**How we calculate
interest**



Case studies

Life insurance complaints (1 January to 31 December 2022)



Complaints received

2,474 complaints received.
Up 30% from last year.

35% resolved at Registration and Referral stage
Up 5% from last year

Complaints closed

1,588 complaints closed.
Down 10% from last year.

Average time to close a complaint:
108 days
Down 19% from last year

Top five life insurance complaints received by product ¹

Product	Total
Funeral plans	1,038
Income protection	558
Term life	286
Whole of life	257
Total and permanent disability	222

Top five life insurance complaints received by issue ¹

Issue	Total
Misleading product/ service information	650
Interpretation of product terms and conditions	244
Incorrect premiums	232
Delay in claim handling	207
Service quality	191

Stage at which life insurance complaints closed

Stage	Total
At registration	551
At case management	458
Rules review	170
Preliminary assessment	180
Decision	229

Average time taken to close life insurance complaints

Time	Total
Closed 0-30 days	211
Closed 31-60 days	412
Closed 61-180 days	666
Closed 181-365 days	249
Closed more than 365 days	50

¹One complaint can have multiple products/ issues

Our expectations in claims delay cases

- > We get a lot of complaints about claims delays
- > Persistently in top 5 issues in life insurance complaints at AFCA
- > 221 life insurance complaints received with this issue in the last 12 months
- > Most insurers have a large proportion of complaints on this issue



Our expectations in claims delay cases



Many different causes of claims delays

- > Delays caused by complainants
 - not co-operating with reasonable requests for information/ evidence/ records
 - late notification of claims
- > Delays caused by insurers
 - not requesting relevant information/ evidence/ records at the start
 - requesting unnecessary material
 - staff changes
- > Delays caused by third parties
 - Doctors, accountants, government agencies taking a long time to provide docs

Our expectations in claims delay cases



We expect insurers to:

- > Continue to assess claims while a complaint is at AFCA
- > Give updates to AFCA on ongoing assessment
- > If some further information is required, clearly explain
 - what it is
 - why it is required
 - what efforts have been made to get it
- > Meet LICOP standards
- > Request information early, rather than ‘on the drip feed’

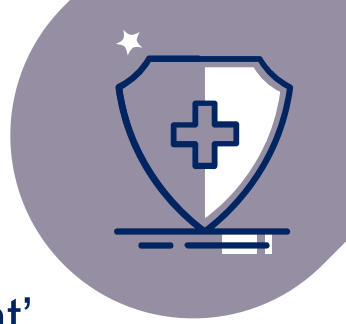
Our expectations in claims delay cases



We expect complainants to:

- > Cooperate with insurers' reasonable investigations:
 - provide medical records
 - provide income records
 - provide tax records
 - attend medico-legal assessments
 - EXCEPT where unnecessary or unreasonable

Types of outcomes AFCA can deliver



- > AFCA can require an insurer to ‘undertake a course of action to resolve the complaint’ (AFCA Rule D.2.1), e.g.:
 - make a decision within a set period of time
 - make a decision after certain information is received.
- > AFCA can require the insurer to pay the claim, but will not do this unless the parties have had a proper chance to make their case on the merits of the claim
- > AFCA can award interest and compensation for non-financial and indirect loss
- > Where a claimant is not co-operating, AFCA can find that an insurer is not required to continue assessing a claim

AFCA's approach to interest



- > AFCA awards interest calculated in accordance with s57 of the *Insurance Contracts Act*
- > Interest runs from the date on which it was unreasonable for the insurer to withhold payment
- > That date is worked out objectively allowing the insurer a reasonable time to assess a claim; AFCA will allow a longer time to assess a complex claim
- > When assessing interest, time an insurer spends investigating an unsuccessful or abandoned defence will be disregarded

Case studies

Case study – 843100 (Trauma claim)



- > lodged 29 March 2021, AFCA determination 29 August 2022, 17 months with no decision
- > AFCA referred to LICOP timeframes – 6 months, or 12 where there are ‘unexpected circumstances’
- > Some of delay not insurer’s fault – doctors not providing reports, COVID delays to medico-legal assessment
- > Insurer caused some delays – delay in re-booking medico-legal assessment, not providing medico-legal report for months, no claim updates for months after medico-legal assessment

Case study – 843100 (Trauma claim)



Outcome

- > Timetable set for a decision
- > Insurer to send its medicolegal report to treating doctor within 3 days
- > Insurer to determine claim within 30 days of getting treating doctor response
- > Complainant to cooperate with reasonable investigations until then
- > Insurer caused several months of delay, with moderate impact on complainant – \$1,500 compensation for non-financial loss awarded

Case study – 724306 (IP claim)



- > Income protection claim accepted and paid up to 4 April 2021
- > Insurer did not pay further benefits up to AFCA determination on 26 October 2021
- > Insurer requested ongoing claim forms, medical reports, medical authority and tax records, complainant refused to provide them

AFCA found:

- > *The duty of utmost good faith goes both ways. The complainant must comply with the insurer's reasonable requests (see *Shuetrim v FSS Trustee Corporation* [2015] NSWSC 464, at pars 168-171 in particular), and the insurer will not breach the duty by making reasonable requests.*
- > Insurer not required to continue assessing the claim if complainant did not cooperate.

Thank you