Member forum
Life insurance

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Presenters

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Today’s session includes

- **What the complaints data tells us**
- **Claims delay complaints – our expectations and typical outcomes**
- **How we calculate interest**
- **Case studies**

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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

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**

Complaints closed

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

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

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**

[1]One 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’

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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

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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

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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

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Case studies

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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

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