General Insurance in Australia

2017–18 and current insights

March 2019

Contents

Chair's message ... 3
The general insurance industry ... 9
Financial landscape ... 9
About this report ... 13
Culture and leadership ... 14
The Financial Services Royal Commission ... 14
Inquiry into the adequacy of subscribers' compliance frameworks ... 17
Enforcement and sanctions power ... 18
Selling insurance ... 20
A picture of insurance coverage trends in Australia ... 20
Improving how insurance is sold ... 24
Claims ... 28
A picture of claims activity in the Australian insurance industry ... 28
Improving how claims are handled ... 40
Financial hardship ... 47
Monitoring financial hardship compliance ... 47
Guiding compliance improvement ... 48
Strengthening the Code ... 51
Internal disputes ... 53
A picture of internal disputes in the Australian insurance industry ... 53
Improving how internal disputes are handled ... 57
Committee activities 2017–18 ... 62
Considering Code breaches ... 62
Engaging with stakeholders ... 63
Publications and submissions ... 64
Decision-making ... 65
Committee members ... 66
Committee's Secretariat ... 67
Appendix 1: Code subscribers as at March 2019 ... 69
Appendix 3: Five-year data overviews ... 74
Appendix 4: Aggregated Code breach data 2017–18 ... 77
Appendix 5: Comparative data ... 85
Appendix 6: Glossary of terms ... 94

Chair's message

I am pleased to present the Code Governance Committee's report on the general insurance industry. The report presents a snapshot of trends and service standards in the general insurance industry in 2017−18 and into the first half of 2018–19, with a focus on retail general insurance products and services.

Financial Services Royal Commission

Throughout the period covered by this report, the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry loomed large. What came out of the Royal Commission has been shocking to us all. Through seven rounds of public hearings and over 10,000 submissions, the industry's problems were laid bare, as ordinary consumers, small businesses, executives, regulators and experts exposed misconduct that often went unpunished.

The Commissioner, the Honourable Kenneth Hayne AC QC, released the Royal Commission's final report in February 2019, making 76 recommendations. Of these recommendations, 75 were accepted by the Commonwealth Government. One of the important messages underpinning the Royal Commission's findings and recommendations was that to be fair, honest and transparent in dealings with customers, the financial services industry needs to go beyond bare minimum requirements to act in the spirit of the law. The rules are a baseline, but industry needs to go much further.

Going further is, in large part, a matter of culture. It's about the shared values and norms within an organisation that shape how people think and what they do – including what they do when no-one is watching. Commissioner Hayne identified six principles that provide the necessary foundation for a strong organisational culture that discourages misconduct:

- obey the law
- do not mislead or deceive
- act fairly
- provide services that are fit for purpose
- deliver services with reasonable care and skill, and
- when acting for another, act in the best interests of that other.

Commissioner Hayne correctly noted that culture cannot merely be prescribed. Instead, each financial services entity is responsible for developing, embedding and sustaining a healthy organisational culture. The tone from the top is crucial to this endeavour: culture must be established by leadership in order to permeate the organisation.

This report contains commentary about the Royal Commission. The commentary includes historical breach data, identifying subscribers by name, from my now public witness statement to the Royal Commission.

The opportunity for industry

In the wake of the Royal Commission, the general insurance industry now has the opportunity to step up and shape the future. Businesses can accept the challenge of embedding a strong culture of fairness, honesty and transparency, or risk being forced out of business.

The Code Governance Committee acknowledges that Commissioner Hayne's recommendations to strengthen the General Insurance Code of Practice (the Code) – in particular, through enforceable Code provisions and extension of the Committee's sanctions power – have profound and far-reaching implications for industry, and the role of the Code and Code Governance Committee.

Nevertheless, we encourage the Insurance Council of Australia and industry to fully leverage Commissioner Hayne's endorsement of codes by taking decisive action at the earliest opportunity – to implement changes that are effective and will provide consumers and small businesses with better outcomes. In particular, we support the early introduction of Code amendments to facilitate the application and levying of sanctions on subscribers.

For general insurers ready to embrace the challenge, the Code is an invaluable tool. Commissioner Hayne's fundamental cultural principles are the lenses through which the general insurance industry should be viewing and applying the Code. Several of the Code's standards directly address culture, describing how subscribers will conduct sales, handle claims and complaints and manage outsourced service suppliers. More generally, the Code commits subscribers to openness, fairness and honesty in all dealings with consumers and small businesses.

The Code Governance Committee has oversight of subscribers' culture through its Code monitoring and investigation functions and responsibilities. There is evidence, however, that not all subscribers are taking the Code and its obligations as seriously as they might.

In some instances, subscribers are reverting to black letter law in response to the Royal Commission. The Committee does not consider that approach to be in the spirit of the Code. Of particular concern is that weaknesses in some subscribers' compliance and reporting frameworks point to an insufficient grasp of the scope and understanding of the meaning of the Code. Some of these weaknesses include a poor understanding of standards that contain elements of honesty, fairness and transparency, the meaning of "significant breach" and the related obligation to report significant breaches to the Code Governance Committee within 10 business days of identification.

Appropriate compliance monitoring and governance arrangements do not exist in all subscriber organisations. In light of the evidence coming out from the Royal Commission, and the outcome of APRA's prudential review of CBA's accountability, culture and governance frameworks, some subscribers need to question whether they have shown good faith in the past. Industry now needs to step up, improve its game and take the Code more seriously. Compliance failures need to be addressed; not just given lip service. Subscribers have end-to-end responsibility for their products, including the actions of their external sellers and service providers.

A common and worrying theme has emerged through the Committee's investigations. Some subscribers, including legal firms they engage, attempt to interpret the Code's financial hardship standards as narrowly as possible. Subscribers have argued that certain standards do not apply in particular circumstances, or, more broadly, suggest that the Code is merely a guideline that does not confer any enforceable rights on a consumer or small business. This is contrary to the Committee's expectations and the purpose and spirit of the Code.

The Code is part of the broader consumer protection framework. Its purpose is to improve standards of service provided by subscribers, which means that subscribers are expected to go beyond the 'black letter of the law'.

By subscribing to the Code, insurers and their service suppliers agree to be bound by its higher standards. Subscribers should take a broad view when interpreting the Code's standards, guided by the purpose and spirit of the Code, rather than seeking to limit their application or downplay their importance.

Openness and transparency when dealing with consumers and small businesses is a critical demonstration of good faith. Subscribers also demonstrate good faith when they develop and commit to a strong culture that supports the Code and doing the right thing.

A starting point is our own motion inquiry into the adequacy of subscribers' compliance frameworks, currently in progress. Boards and executive management of subscriber companies must review the effectiveness of their compliance frameworks and oversight so that they can satisfy themselves that these arrangements are operating as required and that they are acting within the spirit of the Code. Governance is important and should be reviewed in light of the six principles.

Following the own motion inquiry, the Code Governance Committee will reflect further on how we can contribute to the cultural change that needs to occur.

Targeted monitoring work, publications and submissions

The Code Governance Committee provided a submission to the Insurance Council of Australia in December 2017 in response to its interim report on the review of the Code. The submission addressed several priority issues and the Code Governance Committee's top priority was that the Insurance Council should extend the Code's standards to all external sellers of general insurance products covered by the Code.

In March 2018 the Code Governance Committee released its report "General insurance in Australia 2016–17" on industry practice and Code compliance. This was the first time that the Code Governance Committee brought together insights about its work, and information and data about the insurance industry and its compliance with the Code, to present an integrated picture of general insurance in Australia.

Also in March 2018, the Code Governance Committee released its first guidance note "Financial hardship obligations – General Insurance Code of Practice" to help subscribers improve compliance with the Code's important financial hardship standards. The guidance note set out the Code Governance Committee's expectations of subscribers to ensure the timely assessment of requests for hardship assistance, communication with an individual's authorised representative, access to internal complaints processes and compliance by subscribers' employees and service suppliers.

The Code Governance Committee commenced an in-depth examination of subscribers' compliance with the Code's important complaint handling standards in May 2018. This work grew out of increasing numbers of complaints, a growth in complaints-related breaches and the Code Governance Committee's work that highlighted concerns with subscribers' complaints processes. In January 2019 the Code Governance Committee outlined the outcomes of its work in the report "How insurers handle consumer complaints", including 18 recommendations to improve subscribers' compliance with complaints handling standards. One of the report's key recommendations (recommendation 14) was that all subscribers should prioritise complaints based on their urgency. This also applies to complaints from vulnerable individuals, including those experiencing financial hardship, where swift resolution is likely to improve the individual's situation.

In June 2018 the Code Governance Committee released its report "Who is selling insurance?" following the completion of its own motion inquiry into the sale of add-on insurance which it had begun in November 2017. The own motion inquiry was launched to better understand add-on insurance sales – which occur mainly through external sellers who are not always covered by the Code – and recommend improvements to both industry practice and the Code. The Code Governance Committee made 22 recommendations aimed at improving how add-on insurance is sold by subscribers, including that the Insurance Council should extend the Code's buying insurance and related standards to cover all add-on insurance sales by external sellers.

Overview of the general insurance industry

The general insurance industry is a very large business with $42.7 billion in gross written premiums and profit of $5 billion in 2017–18. The largest sectors are motor insurance and home insurance with two thirds of retail insurance policies in play at any one time.

In 2017–18, the general insurance industry directly employed 45,173 people and externally engaged a further 47,363 people and entities to sell its insurance products. It also entered into arrangements with 9,517 service suppliers to provide claims handling and related services.

Subscribers issued 40.4 million retail insurance policies to consumers and small businesses. Of these retail insurance policies, there were 39.7 million individual policies and 759,062 group policies. The trend toward more group travel policies continued in 2017–18: the number of group travel policies almost tripled to 733,989 policies and individual travel policies fell 28% to 4 million policies. Subscribers estimated that group travel policies covered 16.9 million people, more than double the number in 2016–17. There was a similar trend in sickness & accident cover with a 23% increase in group policies covering some 6.5 million people, compared with 24,607 people covered under individual policies.

Subscribers received 4.1 million retail claims from consumers and small businesses in 2017–18 and half (51%) of these were made by consumers and small businesses against motor insurance policies. Home insurance claims and personal & domestic property insurance claims accounted for 20% and 18% each.

The level of declined claims remained stable with subscribers declining 164,477 retail claims. Historically, home insurance accounted for the majority of declined claims year on year. However, for the first time personal & domestic property insurance, which accounted for 60,922 (37%) of declined retail claims in 2017–18, has overtaken home insurance.

The numbers of withdrawn retail claims increased by 5% to 298,043 – almost double the number of declined retail claims – and reflected increases across motor, home, travel, residential strata and sickness & accident. Some claims were withdrawn by consumers and small businesses because they believed that their insurers would not cover the claims, while other claims were withdrawn because they did not understand what they were insured for.

The real issue here is about whether consumers and small businesses understood what they had bought and were covered for, or even if they remember these details. Insurers need to ensure that they understand what is driving consumers and small businesses to withdraw their claims.

Disputes about motor insurance products and services accounted for 43% of the 29,187 internal retail disputes raised by consumers and small businesses. Claims issues remain the main drivers of consumer dissatisfaction and accounted for 84% of all internal retail disputes. Just over half of claims-related internal retail disputes were made about an insurer's decision to refuse a consumer's or small business's claim.

Subscribers reported that they had breached the Code 11,663 times in 2017–18. The Code Governance Committee's investigations and monitoring work led to the identification of a further 89 breaches and it dealt with an additional 22 significant breaches. Overall there were 11,774 breaches, 32% more than in 2016–17. Of these breaches, 6,593 (56%) were related to the Code's claims handling standards. However, there was a substantial increase in breaches of the Code's complaints handling standards, with 4,087 breaches (35%), up from 1,167 in the previous year.

Since 1 July 2018, the Code Governance Committee has experienced a substantial upswing in significant breaches reported by subscribers, compared with previous years, including 2017–18. In the first 8 months of 2018–19, the Code Governance Committee opened 27 new significant breach matters covering 56 individual significant breaches. This trend reflects a failure in subscribers' controls, processes and systems and raises concerns about fairness and transparency in their dealings with consumers and small businesses.

Thanks

The Insurance Council has continued to make an important contribution to the Code Governance Committee's achievements this year. I would like to thank the President of the Insurance Council of Australia, Richard Enthoven, and Rob Whelan, the ICA's Executive Director, for their support in 2017–18.

Once again, the support of the Code team at the Australian Financial Complaints Authority has been invaluable. I thank Sally Davis, our General Manager, Compliance Manager Rose-Marie Galea and the rest of the Code team staff for their dedicated work this year.

And finally, I would like to thank my fellow Committee members. Julie Maron ended her term as Consumer Member on 31 March 2018. Over four years, Julie made an outstanding contribution to the Code Governance Committee, driving our increased engagement with consumer representatives and consumer issues. Ian Berg also stepped down from his role as Industry Member in June 2018, having made a tremendous contribution to the Code Governance Committee's work over the last four years. Ian leaves behind a lasting legacy for all stakeholders in the general insurance industry.

Julie was initially replaced by Brenda Staggs before Philippa Heir assumed the role of Consumer Member in February 2019. Andy Cornish commenced as Industry Member in July 2018. I welcome Philippa and Andy to their new roles on the Code Governance Committee.

Closing remarks

This report, as with the Code Governance Committee's previous reports and other publications, includes several recommendations to assist subscribers to comply with their Code obligations. The data and information, including that around current significant Code breaches, provides subscribers with valuable insights into emerging risk areas.

The Code Governance Committee expects subscribers to distribute this report to all levels within their organisations, including their boards, and highlight and implement the recommendations to improve Code compliance.

Lynelle Briggs AO
Independent Chair, General Insurance Code Governance Committee
March 2019

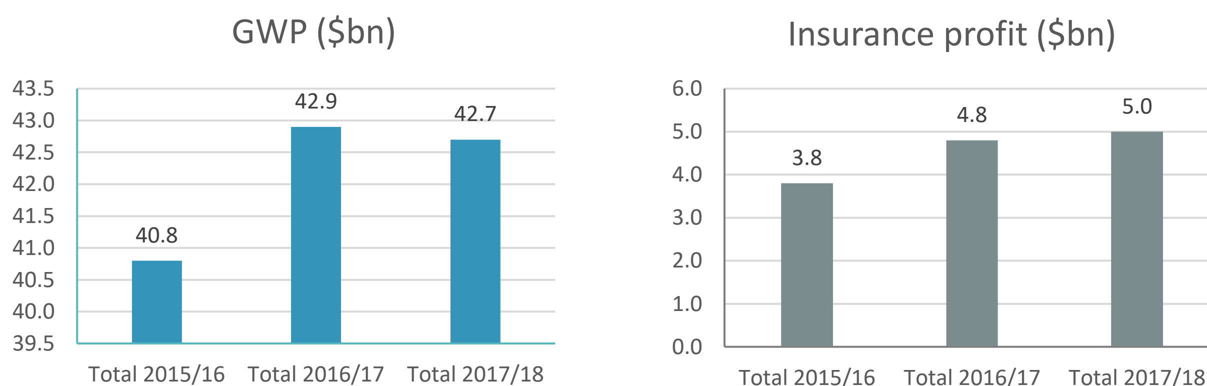
The general insurance industry

General insurance in Australia is a vast, complex and profitable industry. It is also a dynamic and changing industry that is being transformed by new technologies. The report examines how Code subscribers sold insurance to consumers and small businesses, handled claims, worked with people in financial hardship, and managed complaints and disputes in 2017–18. It also looks at more recent major industry and Code developments prompted by the Financial Services Royal Commission. With this wide-ranging and in-depth review, the Committee's aim is to highlight areas where industry can do better, lifting service standards and improving the relationship with customers.

Financial landscape[1]

Over the last three years, insurance profits have grown steadily as improved cost disciplines of insurers reduced expense ratios. Contributing to reduced expense ratios have been more cost-effective solutions for sales and administration – such as automation, outsourcing and different distribution channels. After three years of growth, profit reached $5 billion in 2017–18 (**Chart 1**). A small dip in gross written premium to $42.7 billion in 2017–18 followed strong growth the previous year.

Chart 1: Gross written premium (GWP) and insurance profit, 2015–16 to 2017–18



Source: KPMG (2018) *General Insurance Industry Review 2018*, based on APR[2]A General Insurance Performance Statistics.

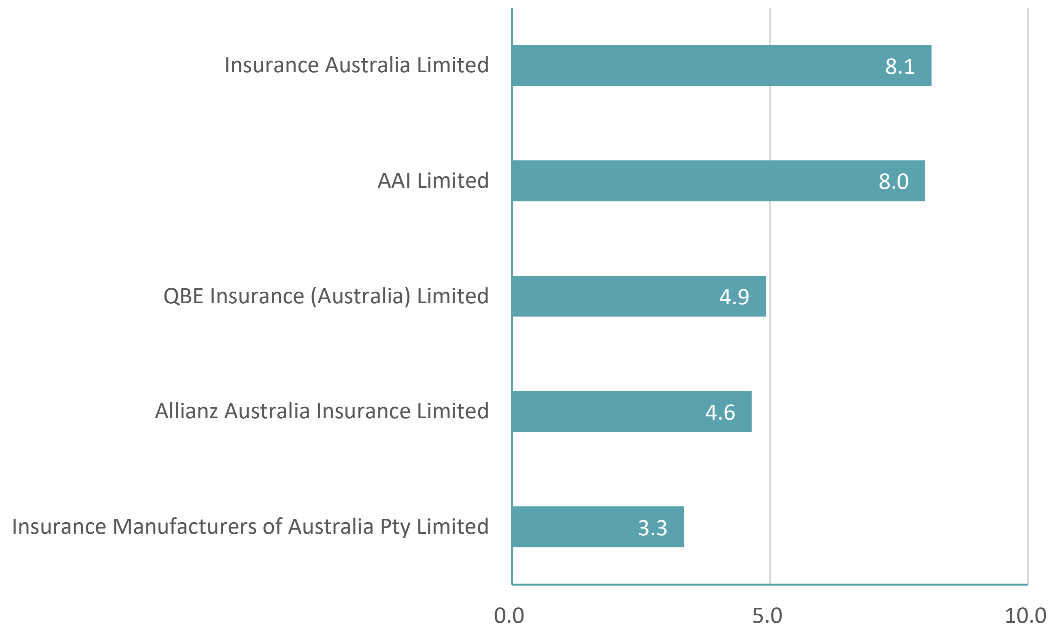
In 2017–18, the top five direct insurers of insurance, including retail insurance products for consumers and small businesses, were valued at $29 billion. Suncorp (AAI Limited) and Insurance Australia Group (comprising Insurance Australia Limited and Insurance Manufacturers of Australia Pty Limited), had the largest direct insurance market shares, worth $11.5 billion and $8 billion respectively (**Chart 2**).

---

[1] This data includes retail and insurance products, including products that are outside the scope of the Code, as well as entities that do not subscribe to the Code.

[2] APRA defines "Direct insurers" as "those insurers who predominantly undertake liability by way of direct insurance business

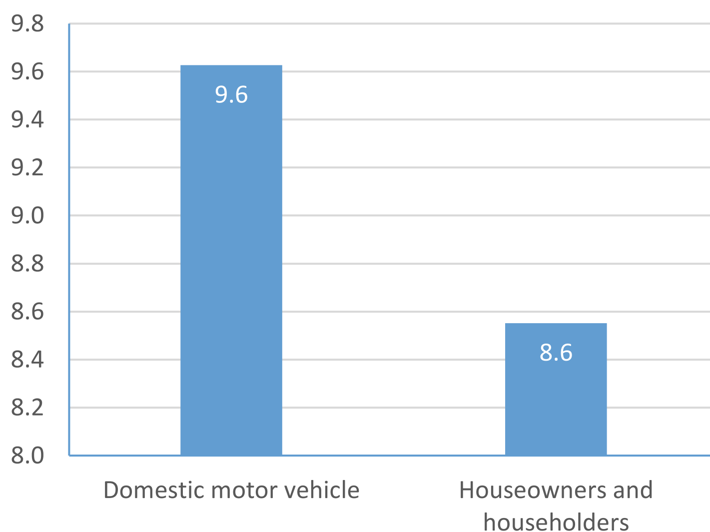
Chart 2: Top 5 Direct insurers gross written premium (GWP) ($bn) for 2017–18



Source: [APRA general insurance general insurance institution level statistics June 2018 database]

The motor and home insurance sectors account for two thirds of retail insurance policies in play at any one time. In 2017–18, motor insurance and home insurance, which have some of the highest exposure levels to consumers and small businesses, were worth $18.2 billion in gross written premium – $9.6 billion for motor, closely followed by home, worth $8.6 billion (**Chart 3**).

Chart 3: Domestic motor and home gross written premium (GWP) ($bn) for 2017–18



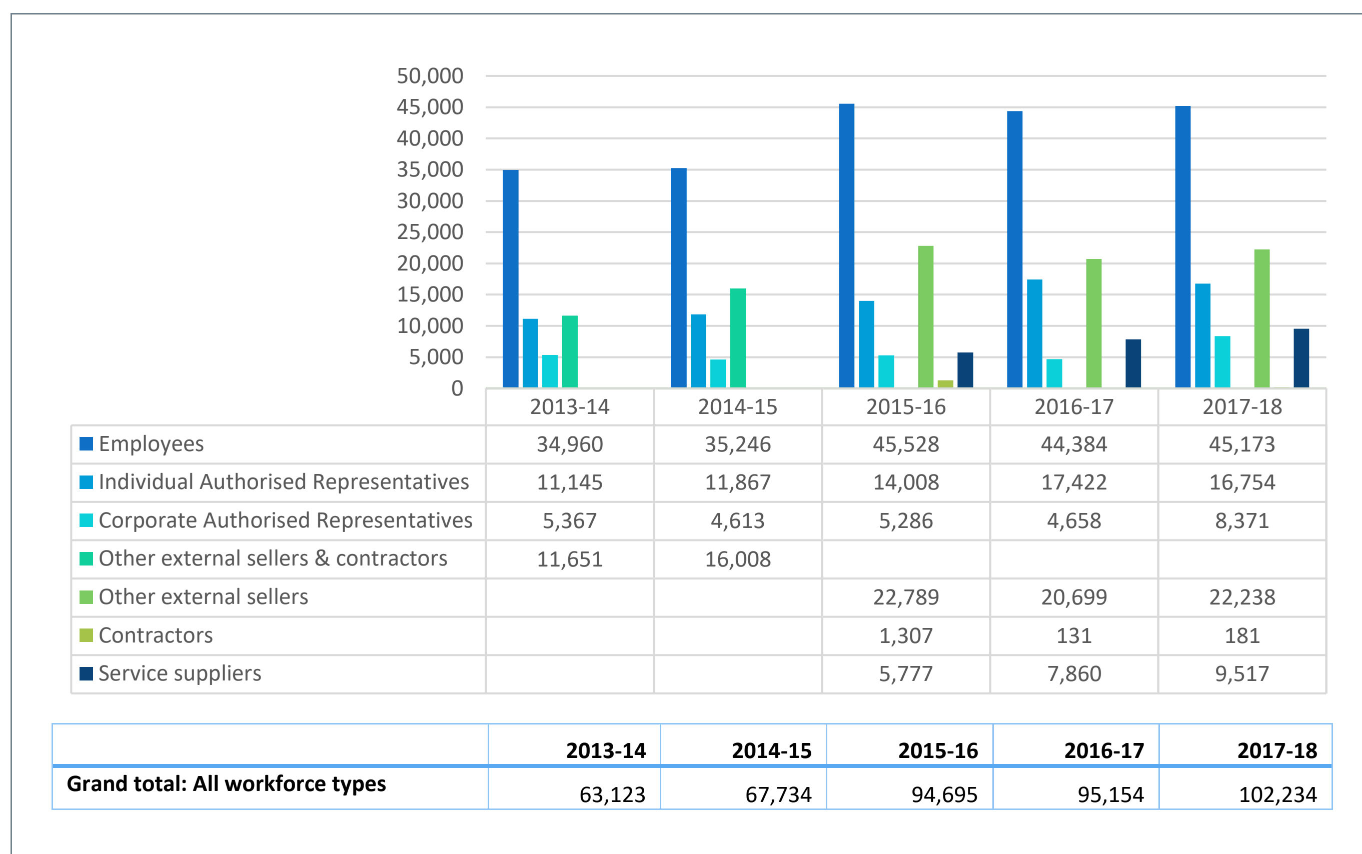
Source: [APRA quarterly general insurance performance statistics database – December 2018]

Workforce

The general insurance workforce comprises both Code subscribers' employees and other workers, not all of whom are currently captured by the Code (**Chart 2**). In 2017–18, employees of Code subscribers and related entities made up close to half (44.2%) of the general insurance workforce. Individual and corporate authorised representatives accounted for a further 24.6% of the workforce. Authorised representatives are external to Code subscribers. They play a major role in the sale of insurance and must comply with the Code's requirements. Also covered by the Code are service suppliers, who are engaged in claims and related functions and they contributed 9.3% of the general insurance workforce in 2017–18.

Other external sellers, which include entities such as banks, credit unions and insurance brokers, made up 21.8% of the workforce, consistent with 22% in 2016–17. Finally, contractors, who perform a range of mostly claims-related functions, accounted for less than 1% of the workforce.

Chart 2: Composition of the general insurance workforce, 2013–14 to 2017–18



	2013-14	2014-15	2015-16	2016-17	2017-18
Employees	34,960	35,246	45,528	44,384	45,173
Individual Authorised Representatives	11,145	11,867	14,008	17,422	16,754
Corporate Authorised Representatives	5,367	4,613	5,286	4,658	8,371
Other external sellers & contractors	11,651	16,008			
Other external sellers			22,789	20,699	22,238
Contractors			1,307	131	181
Service suppliers			5,777	7,860	9,517

	2013-14	2014-15	2015-16	2016-17	2017-18
Grand total: All workforce types	63,123	67,734	94,695	95,154	102,234

Industry developments

Globally, digital disruption is transforming the insurance industry. Fast, adaptive new technologies are changing how insurance business is done, allowing for increased efficiencies and smarter, more personalised solutions that can improve customer interactions and experiences.

Australia's insurance industry is considering and adopting new technologies. As this process unfolds, insurers need to think about how new technologies might impact their ability to comply with legislation and the Code. Regulators, as well as the Committee, also need to think through the compliance risks associated with new technologies.

Code coverage

The General Insurance Code of Practice (the Code) is a voluntary industry code that promotes high standards of service and better customer relationships in the general insurance industry. Developed by the Insurance Council Australia (ICA) and introduced in 1994, the Code has since undergone significant revisions to ensure its continued relevance and effectiveness.

The current version of the Code came into effect on 1 July 2015 and applies primarily to retail (rather than wholesale) general insurance products. It contains standards on a range of areas of general insurer practice, among them buying insurance, claims, financial hardship and complaints and disputes. As insurers increasingly focus on customer-centric strategies for driving growth and increasing value[3], the Code is a valuable tool for guiding practical improvements.

Members of the ICA, which represents the general insurance industry, must subscribe to the General Insurance Code of Practice if they offer insurance products covered by the Code. The ICA also encourages all other general insurers, as well as other entities that provide services covered by the Code, to adopt the Code. The Code covers 97% of Australia's general insurance industry[4] and has 178 subscribers (a list of Code subscribers is in **Appendix 1**). Code subscribers range from small, specialised insurers to large national and multinational organisations offering a wide range of products.

The Royal Commission has recommended that the Code becomes a mandatory Code for all industry participants.

The Code Governance Committee

The Code Governance Committee (the Committee) is the independent body responsible for monitoring Code subscribers' compliance with Code standards. The Committee's Code monitoring program assesses how well Code subscribers are complying with the standards in the Code, guiding improvement by highlighting both best practice as well as areas where improvement is needed and guidance on how this might be achieved. The results of this work are fed back to Code subscribers to guide their practice and are reported publicly, raising community awareness of the industry's performance.

During the year, Julie Maron and Brenda Staggs resigned as the Committee's Consumer Members and were replaced by Philippa Heir. Ian Berg completed his term as Industry Member and was replaced by Andrew Cornish.

---

[3] KPMG (2017) *General Insurance Industry Review 2017*, p. 26.

[4] The proportion of the general insurance industry covered by the Code is based on total general insurance gross earned premium and was provided by the ICA.

About this report

This report presents contextual data about trends in the general insurance industry, complemented with data on Code subscribers' compliance with the Code. All aggregate data is sourced directly from Code subscribers or from the Committee's compliance monitoring work in the year ending on 30 June 2018.

The industry data on the number and type of policies, claims and disputes is supplied by Code subscribers in response to a data request from the Committee. Detailed industry data, including the compliance data, is presented in **Appendices 2 to 5** and a glossary of key terms is in **Appendix 6**. The combined compliance data comes from three sources:

- Self-reported breaches: Each year, the Committee asks Code subscribers to self-report Code breaches that they have identified through their own internal monitoring. In 2017–18, Code subscribers self-reported 11,663 such breaches.
- Significant breaches: Some breaches of the Code's standards are considered more serious[5]; these are labelled significant breaches. When a Code subscriber identifies a significant breach, it must report it to the Committee within ten business days. This year, 22 significant breaches were finalised, and all of them were self-reported by Code subscribers.
- Committee-identified breaches: The Committee has the ability to identify Code breaches through its work investigating Code breach allegations brought by customers, third parties and the Australian Financial Complaints Authority (AFCA). The Committee investigates such allegations, determines whether any breaches have occurred, and works with Code subscribers to agree on any corrective measures that Code subscribers should apply. The Committee can also identify breaches through other monitoring activities such as own motion inquires, desktop audits, or media monitoring. This year, 89 breaches were identified by the Committee.

[5] A breach is classified as significant depending on characteristics of the breach itself – its duration, the potential or actual financial loss caused, and how it affects the Code subscriber's ability to provide its services; as well as the number and frequency of previous similar breaches and whether the breach suggests that compliance arrangements are inadequate.

Culture and leadership

The Financial Services Royal Commission, which concluded in February 2019, has been a watershed process for the general insurance industry and the Code. For the Committee, it prompted deep reflection on the Code, the Committee's work and how both need to change. After the hearings, the Committee took immediate action, launching an inquiry into the adequacy of subscribers' compliance frameworks. Realising that the balance had tipped too far towards education at the expense of discipline, the Committee also advocated for strengthened sanctions powers.

The Financial Services Royal Commission

In response to increasing public and media scrutiny of the financial services industry, the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry (the Royal Commission) was established in December 2017. The Royal Commission conducted seven rounds of public hearings and received some 10,323 public submissions. The final report from Commissioner the Hon Kenneth Hayne AC QC was tabled in Parliament in February 2019.

The Committee's witness statement

As part of its investigations into the operation and effectiveness of self-regulation in the financial services industry, the Royal Commission asked the Committee to provide data on the numbers of Code breach allegations, self-reported breaches and significant breaches in recent years, including an analysis of any trends in the Code provisions most commonly breached. The Committee was also asked to explain its sanctions powers and activities and how it works with Code subscribers to identify and monitor the actions subscribers take to correct breaches.

In September 2018, the Committee Chair, Lynelle Briggs, provided a witness statement to the Royal Commission on behalf of the Committee. In line with the Royal Commission's request, the statement included the data on the breaches and significant breaches reported by subscribers identified by name over the four years to 2017–18 (**Tables 1** and **2**).

Table 1: Self-reported significant breaches, 2014–15 to 2017–18

	2014–15	2015–16	2016–17	2017–18
Reports	2	7	13	8
Significant breaches	4	17	28	25

Table 2: Table 1J from L Briggs' witness statement to the Royal Commission – self-reported breaches by Code subscriber for the period 2014–15 to 2017–18[6]

	2014–15	2015–16	2016–17	2017–18 **Note: Numbers are indicative only**[7]
AAI Limited	98	1127	1503	4925
ACE Insurance Limited[8]	176	62		
AIG Australia Limited				74
Allianz Australia Insurance Limited	127	115	12	30
Ansvar Insurance Limited	2	2	2	
ATC Insurance Solutions Pty Ltd		2		
Auto & General Insurance Company Limited	101	70	89	56
Beazley Underwriting Pty Ltd	27			
Berkshire Hathaway Specialty Insurance Company		1	2	2
Calliden Insurance Limited	12			
Cerberus Special Risks Pty Ltd	443	421	330	
Chubb Insurance Australia Limited[9]			152	293
Chubb Insurance Company of Australia Limited[10]	1	38		
Claims Services Network		15		
Coffre-Fort Pty Ltd			121	
Commonwealth Insurance Limited	112	172	293	3249
Corporate Services Network	7			
Credicorp Insurance Pty Ltd	1		5	3
Cunningham Lindsey Australia Pty Ltd			2	
Defence Service Homes Insurance Scheme	30	5	19	7
Eric Insurance Limited		4		5
Fullerton Health Corporate Services			22	
Gallagher Bassett Service Pty Ltd	56	7	18	
Great Lakes Insurance SE	14			
Guild Insurance Limited			1	3
Hallmark General Insurance Company Limited	73	70	210	152
Insurance Australia Group (IAG)[11]	631			

[6] Some entities names in the original Table 1J were incomplete and have been completed for this version of the table. Some of the footnotes for this table have been updated. Where reference is made to changes to certain entities in the table's footnotes, this has not been independently verified and is based on the limited information the Code Governance Committee held regarding the Code subscription status of those entities.

7 The deadline to submit data for the general insurance industry data report was 31 August 2018. Some Code Subscribers had not completed their data submission by the due date. As at 6 September 2018 a total of 40 Code Subscribers had completed their submissions. The Code Subscribers that reported breaches are shown in the table in the relevant column. The data is indicative only because its integrity has not been checked or fully collated.

8 In 2014–15 and 2015–16 ACE Insurance Limited was a separate entity. It merged with Chubb Insurance Company of Australia Limited and after the 2015–16 reporting period and from 2016–17 onwards both entities deregistered their licences and formed a new company called Chubb Insurance Australia Limited.

[9] Refer to footnote 8.

[10] Refer to footnote 8.

[11] In 2014–15 Insurance Australia Group (IAG) submitted the data for their respective entities in a consolidated format. At the time, IAG consisted of the following entities: CGU Insurance Limited (CGU); HBF Insurance Pty Ltd; Insurance Australia Limited (IAL); Insurance Manufacturers of Australia Pty Limited (IMA); Mutual Community General Insurance Proprietary Limited; Swann Insurance (Aust) Pty Ltd (Swann); and WFI Insurance Limited (WFI).

	2014–15	2015–16	2016–17	2017–18 **Note: Numbers are indicative only**[7]
Insurance Australia Limited (IAL)[12]		669	345	345
Insurance Manufacturers of Australia Pty Limited (IMA)[13]			345	345
Lloyd's Australia Limited[14]	2	4		679
Mitsui Sumitomo Insurance Company Limited	1			
Morris Group Investments Pty Ltd			2	
MTA Insurance Limited[15]	1			
NTI Limited	1			1
OnePath General Insurance Pty Limited				2
Pantaenius Australia Pty Ltd	4			
Pen Underwriting Pty Ltd		1		
Progressive Direct Insurance Company	1			
QBE Insurance (Australia) Limited	609	835	3184	1458
RAA Insurance Limited	3	14	32	47
RAC Insurance Pty Limited	3	15	22	33
RACQ Insurance Limited	53	406	521	414
RACT Insurance Pty Ltd	34	106	58	44
Southern Cross Benefits Limited	29	47	34	40
Sportscover Australia Pty Ltd	305	42	51	
Swann Insurance (Aust) Pty Ltd[16]	26	19		
The Hollard Insurance Company Pty Ltd	134	351	753	529
The Tokio Marine & Nichido Fire Insurance Co Ltd			3	2
Trident Insurance Group Pty Ltd		4	2	
Westpac General Insurance Limited	51	155	475	628
WFI Insurance Limited[17]	318			
XL Catlin Australia Pty Ltd	39	10	9	
Youi Pty Ltd	172	91	90	92
Zurich Australian Insurance Limited	103	141	65	118
Grand Total	**3800[18]**	**5021**	**8772**	**13576**

[12] IAL is part of IAG – see footnote 11. In August 2017 the operations of CGU, Swann and WFI were transferred to IAL after cancellation of their insurance and AFSL licences.

[13] IMA is part of IAG – see footnote 11.

[14] The 2017-18 breach data for Lloyd's Australia Limited (Lloyd's) is an aggregate of data from Lloyd's and Lloyd's coverholders and claims administrators. A breakdown of the data was not available at the time this table was produced for the Royal Commission.

[15] In 2014–15 MTA Insurance Limited (MTA) was a separate entity but was part of the Suncorp group (AAI Limited). In later years MTA consolidated its data with AAI's data.

[16] In 2014–15 and 2015–16 Swann Insurance (Aust) Pty Ltd (Swann) was a separate entity under IAG – see footnote 11. In August 2017, Swann transferred its operations to IAL after cancellation of its insurance and AFSL licence – see footnote 12.

[17] In 2014–15 and 2015–16 WFI Insurance Limited (WFI) was a separate entity under IAG – see footnote 11. In August 2017, WFI transferred its operations to IAL after cancellation of its insurance and AFSL licence – see footnote 12.

[18] This total number is different from that recorded in the 2014–15 general insurance industry data report, which under-reported the number of breaches for that year by 27. This was due to an error made by Beazley Underwriting Pty Ltd (Beazley) when entering its data for that year. The correct total for 2014–15 is 3800, as reflected in this table. Beazley is a coverholder of Lloyd's Australia Limited.

Compliance concerns

Compiling and analysing this data gave the Committee an opportunity to reflect on subscribers' Code compliance and reporting over the past four years. The Committee observed that overall, subscribers appear to be under-reporting breaches of the Code. With close to 180 subscribers (ranging from around 150 to 200 from year to year), the Committee would expect to see higher numbers of breaches. Each year, breaches are self-reported by only around 30 subscribers – typically larger general insurance companies that have more resources to invest in robust compliance frameworks and monitoring frameworks. Even so, many larger insurers with a wide range of retail products and high consumer and small business exposure reported only low numbers of breaches, with some inconsistent and questionable numbers being reported in each year.

A large group of subscribers – ranging from between 90 to 140 from year to year – are smaller entities that specialise in wholesale insurance. Because the current version of the Code has only limited application to wholesale products, lower breach numbers from these entities are to be expected. Nevertheless, the level of breach reporting from these entities is still less than we would expect – typically, only a handful of these entities report any breaches in any given year. Moreover, few breaches were reported under previous Code versions that applied more widely to wholesale products.

These inconsistent, fragmented and questionable breach numbers were indicative of weaknesses in subscribers' compliance monitoring and governance frameworks. While the Committee had previously assumed that the industry was acting in good faith, the evidence suggests that some subscribers were not taking the Code and their obligations seriously, and that they did not have appropriate Code compliance governance and monitoring arrangements in place.

Since 1 July 2018, the Committee has also seen a very marked increase in the number of self-reported significant breaches, which subscribers have an ongoing obligation to report within 10 business days. During the period 1 July 2018 to 1 March 2019, the Committee opened 27 new significant breach files covering 56 individual significant breaches.[19] This sudden increase raises questions about earlier levels of self-reporting and about why the increase has occurred.

Inquiry into the adequacy of subscribers' compliance frameworks

Under the Code, all subscribers must have appropriate systems and processes to monitor Code compliance, as well as a governance process for reporting on Code compliance to the Board or executive management. It is time for industry to take these commitments seriously and improve compliance monitoring and governance. In the wake of the Royal Commission it is timely for Boards and executive management of subscriber companies to review the effectiveness of their compliance frameworks and oversight so that they can satisfy themselves that these arrangements are operating as required and that they are acting within the spirit of the Code.

[19] In addition, during the same period the Code Governance Committee opened 13 matters investigating conduct which may possibly constitute significant breaches.

To begin this process, in October 2018 the Committee launched an inquiry into the adequacy of subscribers' compliance monitoring and reporting frameworks, encompassing 45 subscribers. The Committee has received and begun analysing subscribers' responses to the inquiry.

Some responses to the inquiry reveal weaknesses in compliance and reporting frameworks linked to an insufficient grasp of the scope and spirit of the Code. Some subscribers do not have a clear understanding of what constitutes a significant breach or of their obligation to report significant breaches. Nor are subscribers always correctly interpreting and applying Code standards that refer to honesty, fairness and transparency.

In some instances, subscribers are reverting to black letter law, interpreting Code standards narrowly in an effort to limit the way in which they comply and how they apply the standards in their dealings with consumers and small businesses. This approach is not in the spirit of the Code, the fundamental purpose of which is to address gaps in the law, raise standards of practice above bare minimum legal obligations and require subscribers to conduct their dealings fairly, honestly and transparently. As Commissioner Hayne makes clear in the final report on the Financial Services Royal Commission, rules are merely a baseline; financial services industries should be trying to go much further to be fair, honest and transparent in their dealings with customers.

Encouragingly, however, some subscribers are proactively reviewing the way they interpret the Code, their processes, systems, and compliance and reporting frameworks, including how they determine whether a breach is significant. Two subscribers, in particular, are leading the way by reviewing their compliance frameworks to ensure alignment with the Code and they are recording much higher numbers of breaches.

All subscribers should take this step now before new laws to regulate conduct are introduced. Subscribers can use the Australian Prudential Regulatory Authority (APRA) initiated self-assessment of governance, culture and accountability as a mechanism to review compliance and reporting frameworks against the Code's requirements and to independently verify that these are operating as required.

The Committee will publish a report on its inquiry findings, outcomes and recommendations later in 2019.

Enforcement and sanctions power

Reflecting on breach reporting trends also prompted the Committee to realise that it needs to increase its focus on enforcement. If all subscribers are to take the Code seriously, the Committee cannot focus exclusively on education without a parallel emphasis on discipline.

In its earlier May 2017 submission to the ICA on the review of the Code, the Committee recommended that its sanctions power be expanded to include formal warnings, reporting to ASIC and suspension or termination of subscription to the Code.

The Financial Services Royal Commission has reinforced the Committee's position on the need for increased sanctions powers. While the final report shows that Commissioner Hayne recognized the benefits of industry codes, he also highlighted their limitations, including monitoring and enforcement that can be inadequate and limited consequences for Code breaches.

Accordingly, the final report made a number of recommendations for strengthened enforcement of industry codes. Commissioner Hayne recommended that the law be changed so that industry codes of conduct, approved by the Australian Securities and Investments Commission (ASIC), can include 'enforceable code provisions' of which a breach will also constitute a breach of the law. Remedies for these breaches are to be modeled on those in part VI of the *Competition and Consumer Act 2010* (Cth). A further recommendation specifically directs the ICA and ASIC take the necessary steps to designate as enforceable code provisions those General Insurance Code of Conduct standards that relate to contract terms.

With regard to sanctions, the final report was critical of the Committee's limited sanction powers, specifically, its inability to impose sanctions in response to a breach except where a subscriber then fails to correct the breach. Commissioner Hayne recommended that the ICA amend section 13.11 of the Code to empower the Committee to impose sanctions on subscribers that breach the Code. The Committee supports this recommendation and will continue to liaise with the ICA on these issues.

Selling insurance

To provide context for interpreting developments across the general insurance industry, the Committee collected and collated data from Code subscribers about the number and type of insurance policies they issued in 2017–18.

The Code requires subscribers to be efficient, honest, fair and transparent when selling insurance, and sets out a range of standards for the sale of insurance. In monitoring compliance with these standards, the Committee has worked with Code subscribers to improve how insurance is sold to Australian consumers and small businesses.

A picture of insurance coverage trends in Australia

As a result of the Committee and industry's ongoing efforts, the quality of subscribers' data has continued to improve. This year, some errors in previous years' data were also identified and corrected, resulting in a more complete and accurate picture of insurance coverage in Australia.[20] Although there was a small decrease in the number of policies issued in 2017–18, the growing role of group insurance meant that coverage of people and assets continued to grow.

Policies issued

The number of insurance policies issued decreased again this reporting year. In 2017–18, Code subscribers issued 43,206,830 general insurance policies – down 2.2% from 44,189,399 in 2016–17. Although this decrease was smaller than the 7.0% drop in general insurance policies from to 2015–16 to 2016–17, it represented the continuation of a downwards trend.

The decrease of 982,569 in policies issued between 2016–17 and 2017–18 was largely the result of a 757,435 (1.8%) drop in the number of retail policies, although wholesale policies also decreased – and at a faster rate, down 7.5% (**Table 3**).

This report concentrates on retail insurance, which accounts for the vast majority of policies issued (94% in 2017–18) and is the focus of the Committee's work.

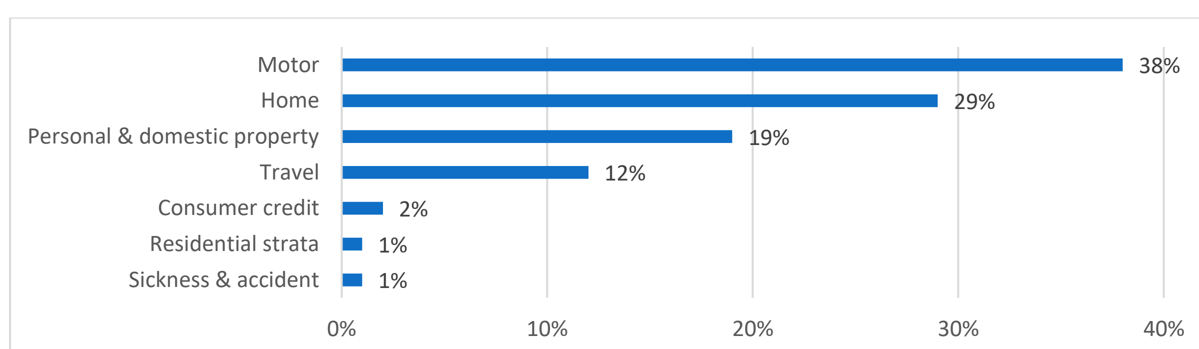
[20] The policy data refers to policies that were issued (new or renewed policies) during the reporting period. The Committee does not currently collect data about policies which were issued in an earlier reporting period but remain in force as at 30 June 2017. For example, some policies such as Consumer Credit Insurance have a policy period that exceeds 12 months.

Table 3: Wholesale and retail policies issued, 2016–17 and 2017–18

All insurance classes	2016-17	2017-18	Change	
			No.	Percent
Retail	41,193,616	40,436,181	–757,435	–1.8%
Wholesale	2,995,783	2,770,649	–225,134	–7.5%
Total	**44,189,399**	**43,206,830**	**–982,569**	**–2.2%**

The main classes of retail insurance are shown in **Chart 3**. Motor continued to be the largest class of retail insurance, comprising 38% of policies in 2017–18. Home was the next largest class, making up more than a quarter (29%) of policies, followed by personal & domestic property (19%) and travel (12%).

Chart 3: Retail policies (individual and group) by class, 2017–18



Decreases in four classes accounted for the overall downwards trend in retail insurance policies issued (**Table 4**). In particular, the number of travel insurance policies issued fell by 974,785, or 17.1%. Decreases were also recorded for consumer credit (17.3%), home (1.0%) and sickness & accident (13.5%) insurance. Despite the overall decrease in the number of retail insurance policies issued, increases were recorded for three insurance classes: personal & domestic property (5.1%), motor (0.9%) and residential strata (8.3%).

Table 4: Individual and group retail policies by class, 2016–17 and 2017–18

Class	2016-17	2017-18	No. (Change)	Percent (Change)
Motor	15,158,680	15,293,803	135,123	0.9%
Home	11,793,921	11,671,384	-122,537	-1.0%
Personal & domestic property	7,202,947	7,573,806	370,859	5.1%
Travel	5,695,318	4,720,533	-974,785	-17.1%
Consumer credit	810,244	669,791	-140,453	-17.3%
Sickness & accident	320,137	276,774	-43,363	-13.5%
Residential strata	212,369	230,090	17,721	8.3%
Total	**41,193,616**	**40,436,181**	**-757,435**	**-1.8%**

Group and individual policies issued

The vast majority of retail insurance policies are individual rather than group policies. In 2017–18, Code subscribers issued 39,677,119 individual retail insurance policies, making up 98.1% of all retail insurance policies issued that year. The remaining 759,062 policies were group policies – that is, 'master' policies, held by an insured, that provide cover for numerous people or assets within a defined group.

Last year, the balance of retail individual and group insurance policies shifted, as the number of individual policies issued decreased by 7.7%, while group policies more than quadrupled. This shift intensified between 2016–17 and 2017–18. Subscribers issued 1,304,032 fewer individual policies, a fall of 3.2% (**Table 5**).

Table 5: Retail individual policies issued by class, 2016–17 and 2017–18

Insurance class	2016-17	2017-18	No. (Change)	Percent (Change)
Motor	15,158,665	15,293,777	135,112	0.9%
Home	11,793,921	11,671,384	–122,537	–1.0%
Personal & domestic property	7,202,779	7,573,371	370,592	5.1%
Travel	5,503,298	3,986,544	–1,516,754	–27.6%
Consumer credit	810,164	669,786	–140,378	–17.3%
Sickness & accident	300,058	252,167	–47,891	–16.0%
Residential strata	212,266	230,090	17,824	8.4%
Total	**40,981,151**	**39,677,119**	**-1,304,032**	**-3.2%**

This decrease was largely the result of a marked 27.6% drop in the number of individual travel insurance policies issued, which followed a percentage decrease of the same magnitude from 2015–16 to 2016–17. In part, the decrease seen in 2017–18 reflected improved reporting by one subscriber, which had previously included add-on insurance products sold with travel policies in this category. However, most of the decrease was the result of substantive changes, such as the run-off of travel policies, the loss of distribution partners, and lower sales due to price increases or reduced marketing activity.

Consumer credit insurance also saw another substantial decrease, with 140,378 (17.3%) fewer policies issued in 2017–18 than the previous year. Subscribers attributed this decrease to a range of factors, including decreased commissions resulting in fewer sales; cessation of motor car and motorcycle dealer distribution; policies being closed for new business; and reductions in lending due to increased regulatory scrutiny of add-on insurance, including consumer credit insurance.

Set against the overall decrease in individual policies issued, personal & domestic property policies increased by 370,592 (5.1%) to total 7,573,371 in 2017–18. Subscribers variously attributed this increase to the launch of a new mass market product; the approval of a new subscriber that writes pet insurance; and an increase in new business and retention rates.

At the same time as subscribers reduced the number of individual policies issued, retail group policies more than tripled, increasing 257.3% to 759,062 (**Table 6**). The main contributor to this increase was ongoing growth in the number of group travel policies issued, which increased 282.2% from 192,020 in 2016-17 to 733,989 in 2017–18. The number of group travel policies issued each year has spiked dramatically over the last three years, rising from just 21,219 in 2015–16. As noted in last year's report, the increase in group travel policies issued (and thus in group policies overall) is partly an artefact of improved reporting capabilities, as subscribers are increasingly able to differentiate group from individual travel policies. One subscriber, however, explained that its increase in group travel policies occurred because retail travel was a new area of business for it.

Table 6: Retail group policies issued by class, 2016–17 and 2017–18

Insurance class	2016–17	2017–18	No. (Change)	Percent (Change)
Travel	192,020	733,989	541,969	282.2%
Sickness & accident	20,079	24,607	4,528	22.6%
Personal & domestic property	168	435	267	158.9%
Motor	15	26	11	73.3%
Consumer credit	80	5	–75	–93.8%
Home	0	0	0	0%
Residential strata	103	0	–103	–100.0%
Total	**212,465**	**759,062**	**546,597**	**257.3%**

Coverage of people and assets

In 2017–18 the estimate of people and assets covered by retail group policies increased 74.3% to 23,932,319 (**Table 7**). This represented the continuation of a trend, after group policy coverage almost doubled between 2015–16 and 2016–17. Improved reporting contributed to the increase in coverage this reporting year, however, the growth in coverage mainly reflects substantive increases in coverage in the travel and sickness & accident classes.

Table 7. People and assets covered by retail group policies, 2016–17 and 2017–18

Insurance class	2016–17	2017–18	No. (Change)	Percent (Change)
Travel	7,948,208	16,860,956	8,912,748	112.1%
Sickness & accident	5,261,685	6,499,910	1,238,225	23.5%
Personal & domestic property	507,733	566,226	58,493	11.5%
Motor	12,341	5,227	-7,114	-57.6%
Home	0	0	0	0%
Consumer credit	0	0	0	0.0%
Residential strata	119	0	-119	-100.0%
Total	**13,730,086**	**23,932,319**	**10,202,233**	**74.3%**

Recommendation 1: Ensuring consumers and small businesses understand their travel cover.

As group policy numbers and the associated cover continues to increase, driven by the growth in group travel insurance, Code subscribers should help ensure that the consumers and small businesses covered by these policies understand their level of cover and policy terms and conditions. Subscribers can provide policy summaries and key fact sheets that describe the policies in simplified language.

Improving how insurance is sold

The high number of insurance policies purchased by consumers and small businesses each year underscores the importance of the Code's standards on buying insurance, which Code subscribers must follow when selling, renewing and administering insurance policies – as well as answering enquiries about them. In 2017–18 the Committee monitored breaches of these section 4 standards and continued to advocate for an extension of the standards to cover all external sellers.

Monitoring breaches of the Code's standards

This year, the Committee recorded a decrease in breaches of the Code's buying insurance standards, following a spike in 2016–17. In 2017–18, there were 633 breaches, including 624 breaches self-reported by subscribers, 7 significant breaches and 2 breaches identified by the Committee through its investigative work. This represented a notable decrease of 35% from the 973 breaches recorded in 2016–17. Nevertheless, with 5% of total breaches, buying insurance remained the third highest category of breach in 2017–18, after claims (6,593, 56%) and complaints (4,087, 35%). Also of note is the substantial increase in significant breaches of the buying insurance standards, up from 2 in 2016–17 to 7 in 2017–18.

Customer refunds

For the second year in a row, customer refunds were the biggest source of breaches of the Code's buying insurance standards. When a customer cancels their insurance policy, Code subscribers are required to refund any money owed to the customer within 15 business days (subsection 4.9). In 2017–18, Code subscribers reported 435 breaches of this requirement, including 2 significant breaches.

Subscribers attributed the breaches largely to poor monitoring (367 or 84.3%) and a failure to follow established processes and procedures (65 or 14.9%). To remediate the breaches, subscribers provided remedial training and made improvements to processes, procedures and monitoring.

Efficient, honest, fair and transparent sales

The Code's buying insurance provisions include a general requirement that Code subscribers conduct their sales processes in an efficient, honest, fair and transparent manner (subsection 4.4). This subsection accounted for 87 breaches in 2017–18, making it the second most-breached buying insurance requirement. Even so, such breaches decreased a substantial 63% from 235 in 2016–17.

Despite this overall decrease, the number of significant breaches of subsection 4.4 increased from 2 in 2016–17 to 5 in 2017–18. Two significant breaches closed by the Committee in 2017–18 concerned a single subscriber's failure to correctly apply premium discounts.

In the first case, the 13,553 motor policyholders were affected when the application of a minimum (cupping) mechanism to premiums prevented application of the full discount specified in customers' certificates of insurance. To address the significant breach, the Code subscriber made restitution payments totalling $2.4 million to affected customers. The Code subscriber reviewed its controls to prevent a recurrence of the problem.

The second significant breach, which also concerned motor policies, occurred when 30,867 consumers and small businesses did not receive their 'no claim' discount at renewal. The breach was the result of an error in the subscriber's no claim discount pricing function, which was then corrected to align with the product disclosure statement (PDS). To remediate the breach, the subscriber paid affected consumers and small businesses a total of $7,443,971. A further two significant breaches concerning either incorrect calculation of premiums or the failure to apply a premium reduction remained under investigation in 2017–18. As detailed in last year's report, two significant breaches in 2016–17 raised similar issues.

Moreover, an influx of significant breach reports since 1 July 2018 has also continued to highlight problems with sales processes. Of the 27 new significant breach matters opened during the first eight months of 2018–19, most related to subsection 4.4. Overall, subsection 4.4 is currently the leading significant breach issue for the Code, with 23 of the 78 confirmed significant breaches that the Committee is investigating. These 23 significant breaches of subsection 4.4 involve five different Code subscribers. Based on current estimates, the breaches affected almost 80,000 customers and involved remediation payment of close to $10 million.

The most common issue in these significant breaches is subscribers calculating premiums incorrectly and therefore overcharging customers, typically for home or motor policies. These significant breaches have occurred mainly due to errors in IT systems used to calculate premiums. Subscribers have corrected the significant breaches with customer remediation programs involving refund payments and communications to affected policyholders; system fixes to correct errors; implementation of regular reviews of pricing systems; increased testing for future system changes; increased monitoring; and process enhancements and additional controls.

Another common issue was subscribers providing incorrect or misleading information about travel and motor policies and the level of cover provided to consumers and small businesses. This occurred because subscribers had incorrect or out-of-date information on their websites, and links to incorrect PDSs. Subscribers have corrected the breaches by reviewing their websites and those of partners and authorised representatives, correcting of incorrect information and links, updating PDS wording, and increasing monitoring and testing.

The Code Governance Committee remains concerned about the robustness of subscribers' embedded controls and monitoring generally, as highlighted during the Royal Commission.

Recommendation 2: Put in place strong processes to monitor compliance with the Code's buying insurance standards.

Code subscribers must comply with the Code's important buying insurance standards, identifying compliance hotspots and acting to address them. This must include an effective compliance monitoring and reporting framework that will enable subscribers to identify and act on any problems with sales processes. Subscribers' processes should be externally and independently assessed to verify compliance.

Recommendation 3: Improve oversight of internal and external IT systems

Subscribers should closely oversee their IT systems – both internal (pricing, policy administration systems etc.) and external (websites, online sales processes etc.) – with regular and robust testing to ensure all information and functionality is up to date and correct.

Addressing a gap in Code coverage

For some time, the Committee has been concerned that when subscribers use external sellers (that are not authorised representatives) to distribute insurance products, the sales are not covered by the Code. Thus, customers buying insurance from other external sellers do not receive the same Code protections as those purchasing insurance via a Code subscriber's employees or authorised representatives. As noted in last year's report, subscribers' use of other external sellers has been increasing since 2012–13, making this an issue of growing importance.

The Committee highlighted this issue in its 2017 submissions to the ICA's review of the Code. Among the Committee's several recommendations was that the Code's standards for buying insurance should be extended to all external sellers, and should not be limited to authorised representatives.

Add-on insurance inquiry

To further illuminate some of these issues, in 2017–18 the Committee conducted an own motion inquiry into the sale of add-on insurance by subscribers and their external sellers. ‘Add-on insurance’ refers to insurance products that are sold to a consumer or small business alongside their purchase of a primary product – such as ‘add-on’ mechanical breakdown insurance sold with a car from a dealership. Drawing on subscribers’ data, the inquiry, for the first time, painted a comprehensive picture of how these products are sold.

The inquiry found that although only a minority of subscribers (13%) sell add-on insurance, the volume of sales is substantial, estimated at around two million policies per year. The data showed that subscribers sold 28 types of add-on insurance, with travel insurance and ticket event or cancellation insurance the most common. Further, the Committee found that subscribers indirectly sold 97% of add-on insurance products through external sellers, some of whom were acting under an Australian Financial Services Licence (AFSL) of another entity that did not subscribe to the Code. Given that add-on insurance products have been associated with poor sales practices, the findings of the inquiry confirmed the Committee’s view that the Code’s standards for buying insurance should be extended to all external sellers of retail general insurance products.

Code review and ICA position

The ICA also considered these issues in its review of the Code. In discussing the issues, the ICA’s final report drew a distinction between other external sellers distributing insurance products under their own AFSL and those operating under an insurer’s AFSL.

With regard to external sellers acting under their own AFSL, such as banks, the ICA’s position was that these entities are subject to enough regulation and their own voluntary codes, meaning the extension of the Code would be an unnecessary duplication.

Where other external sellers act under the insurer’s AFSL, the ICA clarified that the selling activity is already covered by the Code, which defines all such persons, companies or entities as authorised representatives.[21] This Code definition of ‘authorised representative’ is broader than that contained in the *Corporations Act*, leading to some confusion about the Code’s application. To clarify the matter, the ICA concluded that the Code’s references to ‘authorised representative’ should be changed to ‘distributor’, thereby making it clear that the Code applies to all distributors acting under the insurer’s licence.

[21] The Code defines Authorised Representative more broadly than the Corporations Act.

Claims

With more than 4.1 million retail insurance claims lodged by consumers and small businesses in 2017–18, claims handling is an area of enormous activity for Code subscribers. The Committee's data on the claims lodged, declined and withdrawn points to important trends both within individual retail classes and across the industry.

Interaction between consumers, small businesses and Code subscribers peaks when a claim is made: this is when consumers and small businesses find out how an insurance product works and what level of service the Code subscriber provides. Claims handling is therefore a major focus of the Code and of the Committee's work with Code subscribers.

A picture of claims activity in the Australian insurance industry

Code subscribers' data shows that claims activity remained fairly steady in 2017–18. Overall, the number of lodged and declined claims remained at similar levels to 2016–17. However, more claims were withdrawn in this reporting period, which some subscribers have attributed to better data collection. Some of the reasons for withdrawn claims highlight that consumers and small businesses may not have understood what they had bought or were covered for. Overall, the rate of retail claims acceptance improved to 95.7% and was above 90% for each retail class.

Lodged claims

The number of claims lodged by consumers and small businesses remained stable this reporting year. In 2017–18, Code subscribers received 4,660,014 general insurance claims. Although wholesale claims decreased 10.2% to 565,822, this was off-set by a slight growth in retail claims, which made up 88% of total claims. As a result, overall claim numbers fell by just 0.3% (**Table 8**).

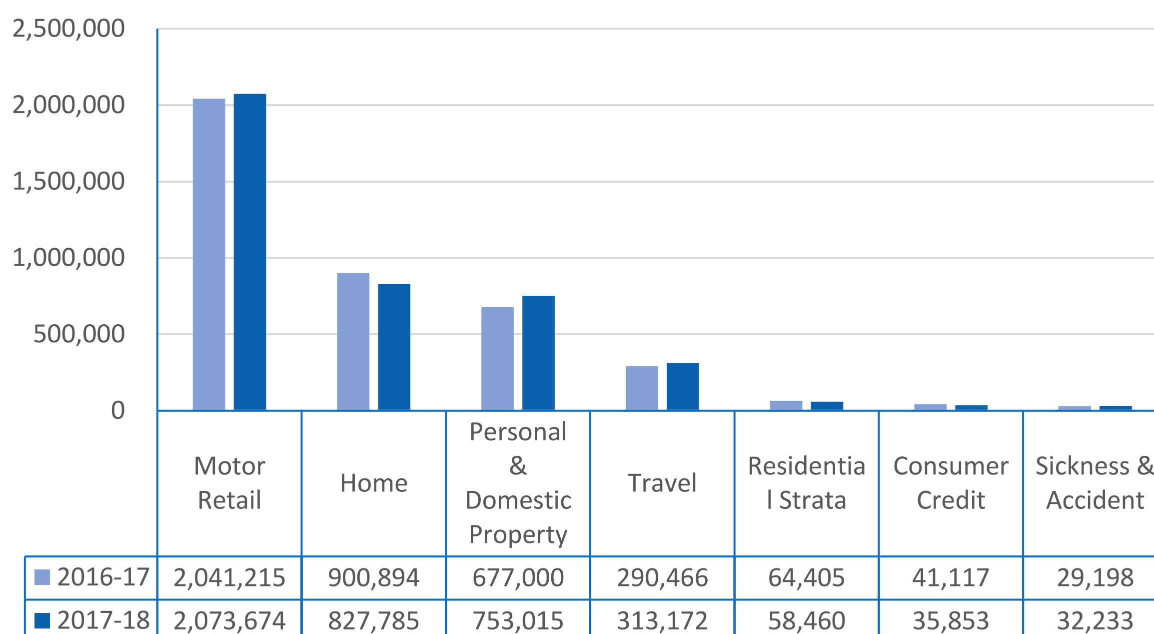
Table 8: Claims lodged, declined and withdrawn, 2017-18

	Lodged		Declined		Withdrawn	
	No.	Percent change	No.	Percent change	No.	Percent change
Retail	4,094,192	1.2%	164,477	0.2%	298,043	4.8%
Wholesale	565,822	-10.2%	5,537	-16.5%	21,734	2.7%
Total	**4,660,014**	**-0.3%**	**170,014**	**0.4%**	**319,777**	**4.6%**

Retail insurance class trends

With 2,073,674 claims lodged (up 1.3%), motor remained the largest category of retail claims, accounting for 51% of the total – similar to the previous year (**Chart 4**).

Chart 4: Retail claims lodged by class, 2016–17 to 2017–18



	Motor Retail	Home	Personal & Domestic Property	Travel	Residential Strata	Consumer Credit	Sickness & Accident
2016-17	2,041,215	900,894	677,000	290,466	64,405	41,117	29,198
2017-18	2,073,674	827,785	753,015	313,172	58,460	35,853	32,233

Home was the second largest retail claim category, accounting for 20% of the total. This was despite an 8.1% decrease in home claims, down to 827,785 in 2017–18 from 900,894 the previous year. Subscribers largely attributed this decrease in home claims to the reduced impact of catastrophe events in 2017–18. Although the ICA declared 5 catastrophes[22] in 2017–18, the same number as the previous two years, the estimated financial impact of these events was just $0.7 billion, compared with $2.76 billion in 2016–17. Industry received only 71,780 catastrophe-related claims, down 60% from 182,565 the previous year. One subscriber also said that it had improved its risk selection and monitoring after Cyclone Debbie in 2016, which led to fewer home claims.

The third largest category of retail claims was personal & domestic property, which accounted for 18% of retail claims after an 11.2% increase to 753,015 claims in 2017–18. Six subscribers attributed the increase in personal & domestic property claims to growth in sales, while one subscriber said that its claim volume increase was largely due to particular weather events.

Travel claims also increased, up 7.8% to 313,172 in 2017–18. Four subscribers noted that this growth in claims was consistent with growth in group and individual travel insurance sales.

[22] ICA Data Globe website, ICA Catastrophe Dataset.

Residential strata, consumer credit and sickness & accident insurance together made up the remaining 3% of retail claims. Consumer credit insurance claims fell 12.8%, which some subscribers attributed to lower sales (see discussion on p. 22). Residential strata claims also decreased 9.2%, again attributed to the reduced impact of catastrophe. Bucking the downwards trend, sickness & accident claims increased by 10.4%, a result of growth in policy sales and group policy coverage.

Declined claims

Following the trend in lodged claims, the number of declined claims remained steady between 2016–17 and 2017–18. 'Declined' here refers to all claims formally declined or not accepted and excludes withdrawn claims and any claims that were partially accepted. Declined claims decreased a slight 0.4% from 2016–17 levels to reach 170,014 in 2017–18. Some 96.7% of total declined claims were for retail insurance, for which declined claims increased 0.2% to 164,477 in 2017–18. In contrast, wholesale declined claims, which had increased dramatically between 2015–16 and 2016–17, this year fell 16.5% to 5,537 (**Table 8**). Subscribers provided the most frequent reasons – up to five – underlying declined claims across retail classes and their ability to capture more detailed information is improving. However, some subscribers continue to record generic reasons such as "policy condition or exclusion applied", providing little insight into why some claims were declined.

Retail insurance class trends

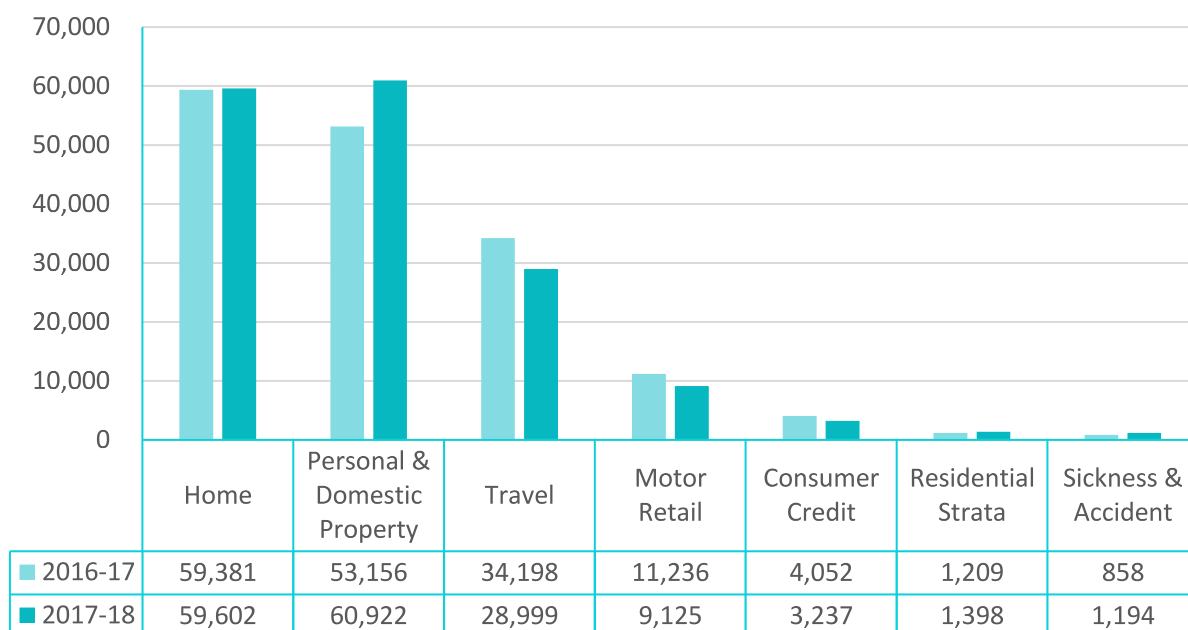
The small overall increase in declined retail claims over the last two years was largely the result of a substantial 14.6% increase in declined claims in the personal & domestic property class (**Chart 5**). This has led to personal & domestic property accounting for the majority of declined claims for the first time – historically, home had accounted for the majority. While some subscribers attributed the increase in declined personal & domestic property claims to business growth, the increase in declined claims outstripped the corresponding 11.2% increase in claims lodged. One subscriber attributed its increase in declined personal & domestic property claims to improved data collection, as well as an increased focus on fraud detection.

Declined sickness & accident claims also increased a marked 39.2% to 1,194 from a low base of 858 in 2016–17, although lodged claims grew by only 10.4% over the same period. Residential strata declined claims increased 15.6% to 1,398. Subscribers did not provide an explanation for this increase in declined sickness & accident claims, but one subscriber identified an increase in fraudulent claims as a contributor to the growth in residential strata declined claims.

In contrast, there was a noticeable 15.2% decrease in declined travel claims, which occurred despite a 7.8% increase in the number of travel claims lodged. Declined motor claims also dropped a substantial 18.8% to 9,125 in 2017–18. One subscriber attributed the decreases in both classes to changes to PDSs and claims philosophy on certain risk types, as well as the implementation of joint claims discussions among operational and complaints teams.

Other subscribers attributed the decrease in motor declined claims to system, process and reporting improvements rather than substantive changes. Declined claims for consumer credit insurance also decreased by 20.1% between 2016–17 and 2017–18, a change attributable to the reduction in sales of these products.

Chart 5: Declined retail claims by class, 2016–17 to 2017–18



	Home	Personal & Domestic Property	Travel	Motor Retail	Consumer Credit	Residential Strata	Sickness & Accident
2016-17	59,381	53,156	34,198	11,236	4,052	1,209	858
2017-18	59,602	60,922	28,999	9,125	3,237	1,398	1,194

Withdrawn claims

While the numbers of lodged and declined claims remained steady from 2016–17 to 2017–18, the number of withdrawn claims increased this reporting period, continuing a trend of year-on-year increases in withdrawn claims.

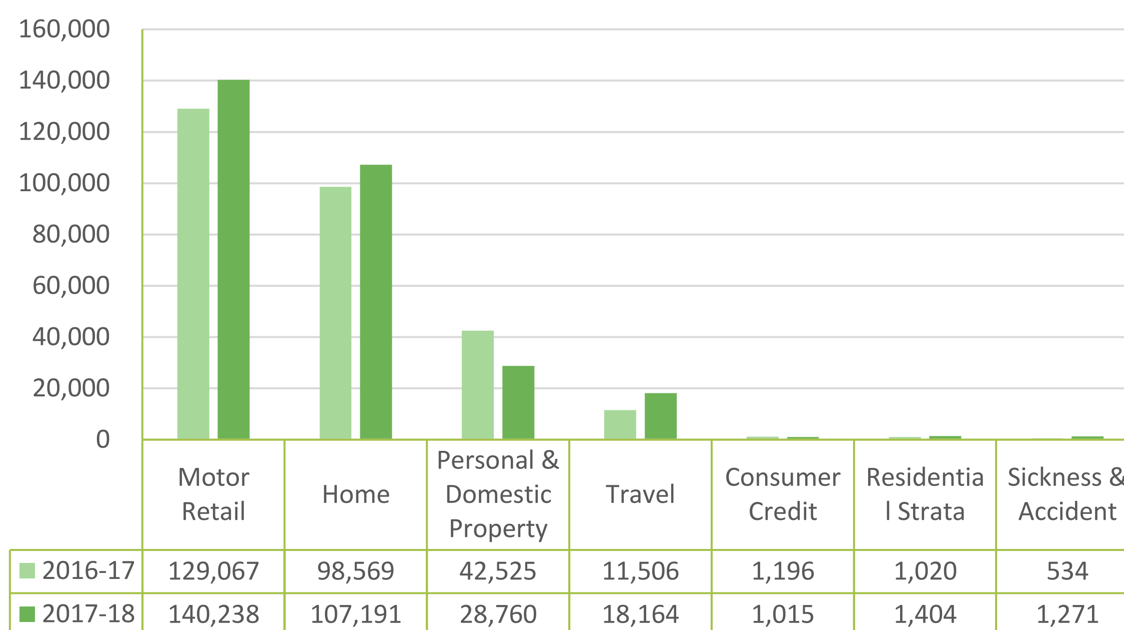
A withdrawn claim is any claim that is discontinued before a subscriber formally decides whether to accept or deny it. Withdrawal may be initiated by the subscriber or at the request (or with the agreement) of a consumer or small business. The category includes claims described variously as ‘cancelled’, ‘closed’, ‘discontinued’ or ‘withdrawn’.

In 2017–18, Code subscribers reported that 319,777 claims were withdrawn (up 4.6%), which was almost double the number of declined claims (170,014). Withdrawn retail claims made up 298,043 or 93.2% of total withdrawn claims in 2017–18, and increased more (4.8%) than withdrawn wholesale claims (2.7%) (**Table 8**).

The overall increase in withdrawn retail claims reflected increases across five insurance classes: motor, home, travel, residential strata and sickness & accident (**Chart 6**). At the same time, many more home and motor claims were withdrawn than declined. In the motor class, withdrawn claims increased 8.7% to 140,238 to make up nearly half (47%) of total withdrawn retail claims. Two subscribers attributed the increase to improved data collection, while another said it was a result of a change to the way in which its customers engaged with repairers.

Code subscribers provided the top reasons (up to five) for withdrawn claims. While more information is being captured, some subscribers continue to record generic or non-specific reasons which provide few if any insights into the drivers of withdrawn claims.

Chart 6: Withdrawn retail claims by class, 2016–17 to 2017–18



	Motor Retail	Home	Personal & Domestic Property	Travel	Consumer Credit	Residential Strata	Sickness & Accident
2016-17	129,067	98,569	42,525	11,506	1,196	1,020	534
2017-18	140,238	107,191	28,760	18,164	1,015	1,404	1,271

In percentage terms, the largest increase occurred in the sickness & accident class, with withdrawn claims up 138% to 1,271 in 2017–18. This growth in withdrawn claims was despite a 13.5% decrease in the number of retail policies issued, and far outstripped the 10.4% growth in claims lodged. One subscriber attributed the growth in withdrawn sickness & accident claims to data collection and reporting improvements.

Going against the overall increase, personal & domestic property withdrawn claims decreased 32.4% to 28,760. One subscriber attributed this to systems, processes and reporting improvements, and said that its previous reporting may have been overstated.

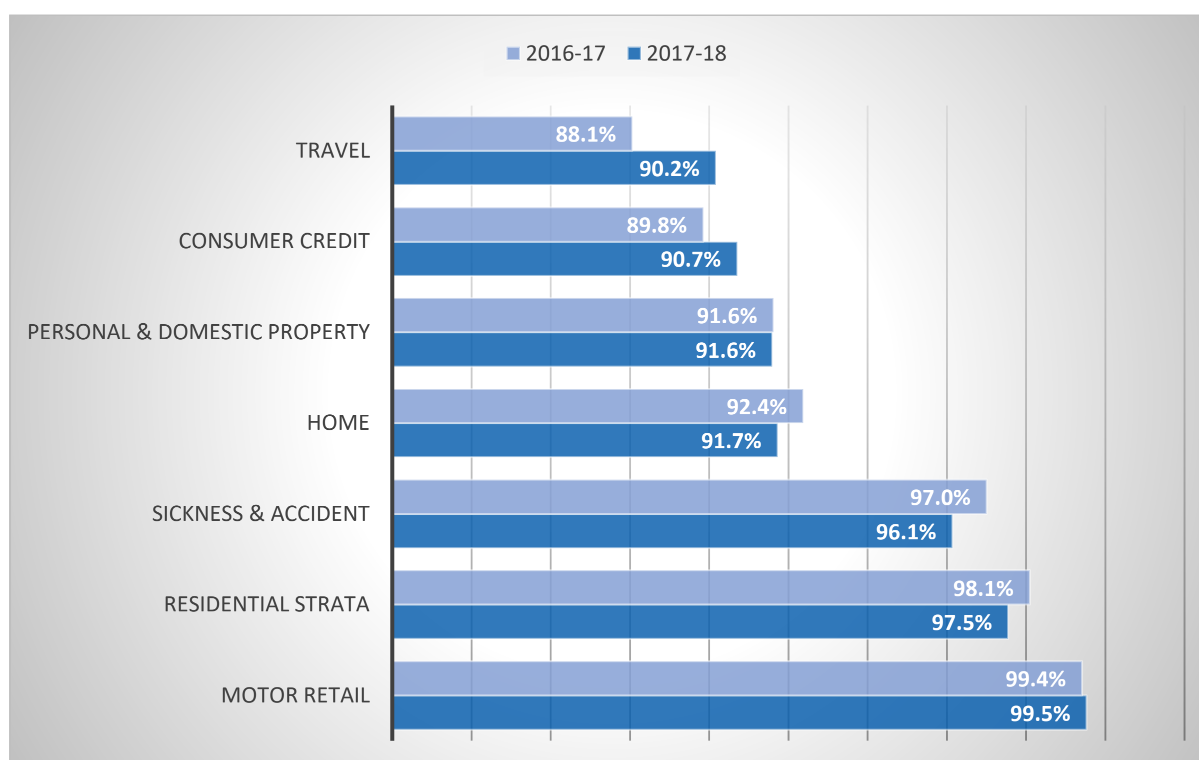
Claims acceptance rate

In 2017–18, the retail claims acceptance rate – that is, the percentage of claims lodged (less claims withdrawn) that were not declined – improved marginally to 95.7%, compared to 95.6% in 2015–16. Acceptance rates improved or remained stable in four classes: travel, consumer credit insurance, personal & domestic property and motor retail (**Chart 7**). Acceptance rates decreased in three classes, most notably sickness & accident, but remained above 90% for all classes.

The Committee has previously highlighted that the interpretation of claims acceptance rates is complicated by gaps in the collection of claims-related data.[23] The actual number of accepted claims and partially accepted claims are unknown. Further, the proportion of withdrawn claims that would have been accepted or declined – had they proceeded to a decision – is also unknown. Withdrawn claims are growing year-on-year and for motor and home, more claims are withdrawn than are declined. The Committee is working with the ICA and industry to collect accepted claims and partially accepted claims data, to obtain a clearer picture of claims acceptance and insights into consumer expectations and understanding of product coverage.

[23] See the Committee's *General Insurance in Australia 2016-17* report at page 27.

Chart 7: Retail claims acceptance rates by class, 2016–17 and 2017–18



Motor claims

Motor continues to have the highest claim acceptance rate, with 99.5% acceptance in 2017–18. Subscribers reported that 9,125 claims were declined, however there were 140,238 withdrawn motor claims – 15 withdrawn claims for every declined claim.

Where possible, Code subscribers provided information about the main reasons claims were declined (**Table 9**). For almost half of declined motor claims (4,207 or 46%), subscribers reported only that a policy exclusion or condition applied, but were not able to specify which.

Table 9: Top reasons motor claims were declined, 2017–18

Reason	Declined claims
Non-specified policy exclusion or condition applied.	**4,207**
Specified policy exclusion or condition applied, including: • Non-disclosure or misrepresentation – **1,381** • Non co-operation – **1,035** • Fraud – **494** • Driver was affected by alcohol or drugs – **76** • Damage caused by wear and tear/lack or maintenance or mechanical breakdown – **53** • Driver's age excluded from cover – **15**	**3,275**
No policy in place or outside cover period.	**969**

Subscribers also provided detail on why motor claims were withdrawn (**Table 10**). The majority of these (78,791 or 56%) were withdrawn by a consumer or small business, most often without a reason being provided.

Table 10: Top reasons motor claims were withdrawn, 2017–18

Reason	Withdrawn claims
Withdrawn by consumer/small business including: • Decided not to proceed with the claim and did not give a reason – **54,329** • Claim under excess – **8,548** • Client decided not to claim for their damage – **4,900** • No damage – **4,804** • Damage claimed through the other driver's insurer – **3,152** • Client unable to claim for their own damage because they do not hold comprehensive cover – **2,909** • Suspicion of fraud, driver affected by alcohol or drugs, or non-cooperation – **149**	**78,791**
No response or supporting information from consumer/small business	**11,278**
Other	**8,300**

Of note, 2,909 claims were withdrawn by a consumer or small business because they did not hold comprehensive cover and were therefore unable to claim their own damage, suggesting that they may not have understood the cover they held. A lack of response or supporting information from consumers or small businesses accounted for the withdrawal of 11,278 claims.

Recommendation 4: Monitor trends to understand why withdrawn motor claims are increasing.

Subscribers should investigate withdrawn motor claims trends more deeply to determine whether factors other than improved data capture are contributing to an increase and should then act in response to emerging risks.

Home claims

Code subscribers accepted 91.7% of home claims in 2017–18, a slight deterioration of the acceptance rate, which was 92.4% in 2016–17. The frequency of withdrawn home claims was almost double that of declined home claims. Code subscribers were able to provide some information about the reasons home claims were declined (**Table 11**).

Table 11: Top reasons home claims were declined, 2017–18 Make all these tables blue.

Reason	Declined claims
Specified policy exclusion or condition applied including: • Damage caused by wear and tear/lack or maintenance – **17,639** • Damage due to defects, structural/design faults or faulty workmanship – **3,110** • No storm-created opening – **3,062**	29,085

• Non-cooperation – **158** • Non-disclosure or misrepresentation – **96** • Fraud – **12**	
Non-specified policy condition or exclusion applied	13,107
No valid policy at time of loss	192
Other/unclassified	297

Code subscribers also provided details on the top reasons claims were withdrawn (**Table 12**). There were 42,344 (39.5%) claims withdrawn by a consumer or small business, most often because they decided not to proceed and without giving a reason.

Table 12: Top reasons home claims were withdrawn, 2017–18

Reason	Withdrawn claims
Claim withdrawn by or with the knowledge of consumer/small business, including: • Decided not to proceed with claim and did not give a reason – **20,284** • Claim under policy excess – **9,690** • No cover including due to application of a policy exclusion or condition – **7,080** • No longer wanted to proceed with the claim and gave reasons – **5,290**	42,344
Claim cancelled/other	7,162
No response or supporting information from consumer/small business	4,346
Other, including: • Duplicate claims – **2,070**	3,118

Personal & domestic property claims

For the first time most declined claims were related to personal & domestic property cover. Nevertheless the acceptance rate for personal & domestic property claims was 91.6% in 2017–18, with no change from 2016–17, despite the 15% increase in declined claims. Subscribers provided data on the top reasons claims were declined (**Table 13**). Where subscribers specified the reason for non-acceptance of claims, they most often related to claims under pet cover: 20,112 (33%) claims were refused because a pet's condition was not covered, pre-existing or within the waiting period under the policy.

Table 13: Top reasons personal & domestic property claims were declined, 2017–18

Reason	Declined claims
Non-specified policy exclusion or condition applied	29,745
Specified policy condition or exclusion applied including: • Diagnosis of pet's condition not covered, pre-existing or within waiting period – **20,112** • Defect, wear and tear, faulty workmanship or mechanical breakdown – **837** • No forced entry – **120** • Non-cooperation – **39**	21,821

No policy at time of loss	2,572

Subscribers also provided their top reasons for the withdrawal of claims based on 26,744 personal & domestic property claims (**Table 14**). Some 15,839 (55%) personal & domestic property claims were recorded as withdrawn by subscribers because consumers or small businesses did not respond to requests for supporting or further information.

Table 14: Top reasons personal & domestic property claims were withdrawn, 2017–18

Reason	Withdrawn claims
Claim not pursued or no response	15,839
Recorded as cancelled or other, including: • Duplicate claims – **540**	3,120
Withdrawn by consumer/small business & no reason given	3,088
Withdrawn for specified reasons applied including: • Consumer/small business did not intend to make a claim – **1,703** • Claim under excess – **904** • Avoid a formal claim denial – **118** • Claim settled privately – **77**	4,697

Travel claims

With 15% fewer declined claims this year alongside a 58% increase in withdrawn claims, the travel claims acceptance rate improved from 88.1% in 2016–17 to 90.2% in 2017–18. At least 7,942 claims were declined because there was no cover or because an exclusion or condition applied – however for most such claims, subscribers were not able to specify the exclusion or condition involved.

Table 15: Top reasons travel claims were declined, 2017–18

Reason	Declined claims
No cover or non-specified policy exclusion or condition applied	5,323
Specified exclusion or condition applied including: • Pre-existing medical condition – **374** • Luggage/personal effects left unsupervised in public place – **234** • No evidence of ownership or failed to report loss to police – **148**	2,619
Claim under excess	367

The top reason for claim withdrawal (4,790 claims) was a consumer's or small business's failure to respond to requests for further information (**Table 16**).

Table 16: Top reasons travel claims were withdrawn, 2016–17

Reason	Withdrawn claims
No response or supporting information from consumers/small business	4,790
Withdrawn, reasons specified including: • Unable to substantiate claim – 1,530	2,719

• Following investigation of claim – 940	
Claim not pursued - no reasons given	2,518
Opened in error	1,496
Claim under excess	793
Other	680

Residential strata

The claim acceptance rate fell from 98.1% to 87.5% in 2017–18, consistent with the 16% increase in declined claims. Subscribers reported their top reasons for declining Residential Strata claims, including 475 claims that were declined due to “no cover” without specifying the reason. They declined 130 claims for a specified reason, including 71 due to wear and tear or lack of maintenance (**Table 15).**

Table 17: Top reasons residential strata claims were declined, 2017–18

Reason	Declined claims
No cover - reason not specified	475
Specified policy exclusion or condition applied, including: • Wear and tear or lack of maintenance – **71**	130
Claim under excess	11
Other – legal action taken with no reasonable prospect of success	1

Subscribers also reported the top reasons for withdrawal of residential strata claims, however, most were withdrawn for ‘other’ reasons and not specified (**Table 18**).

Table 18: Top reasons residential strata claims were withdrawn, 2017–18

Reason	Withdrawn claims
Other	711
Claim not being pursued	229
Under excess	190
No response from consumer/small business	71

Consumer credit insurance

In 2017–18, the consumer credit insurance claim acceptance rate improved from 89.8% to 90.7%, in line with the 20% drop in declined claims.

Code subscribers provided their top reasons for declining consumer credit insurance claims. There were 1,715 claims declined due to a specified exclusion or condition, including 581 excluded because the price item was not covered. Unspecified exclusions or conditions led to 179 claims being declined.

Table 19: Top reasons CCI claims were declined, 2017–18

Reason	Declined claims
Specified policy exclusion or condition applied, including: • Price item not covered – 581 • Pre-existing medical condition – 288 • Outside of policy limit – 269	1,715

Reason	Declined claims
• Voluntary unemployment – 115 • Non-disclosure or misrepresentation – 105 • Wilful misconduct – 80 • Fraud – 2	
Non-specified exclusion or condition applied	179
Event not covered or no cover	84
Other	15

The top reason for withdrawal of consumer credit insurance claims was a consumer or small business deciding not to proceed, without any further reason being given – this applied to 560 claims. A further 231 claims were withdrawn because consumers or small businesses did not respond or provide supporting documents.

Table 20: Reasons CCI claims were withdrawn, 2017–18

Reason	Withdrawn claims
Consumer/small business decided not to proceed - no reasons given	560
No response or supporting information from consumer/small business	231
Other	210

Sickness & accident

The acceptance rate for sickness & accident insurance decreased from 97.0% to 96.1% in 2017–18, coinciding with a 39.2% increase in declined claims for this class. Most often, claims were declined due to the application of an exclusion or condition, however, subscribers were usually unable to specify further (**Table 21**).

Table 21: Top reasons sickness & accident claims were declined, 2017–18

Reason	Declined claims
Specified policy exclusion or condition applied including: • Outside period of cover – 62 • Pre-existing medical condition – 52	311
Non-specified exclusion or condition applied	526
Other	13

Similarly, the top reason for withdrawn claims was that the claim was withdrawn by the consumer or small business, with no further detail (**Table 22**).

Table 22: Top reasons sickness & accident claims were withdrawn, 2017–18

Reason	Withdrawn claims
Withdrawn by consumer/small business	845
Specified policy exclusion or condition applied including: • No response or supporting information from consumer/small business – 169	189
Error lodging claim	115

Other	12
Below excess	10

Data quality

In previous reports, the Committee has highlighted concerns with the quality of Code subscribers' claims data, and has made recommendations for improvement. Positively, subscribers are continuing to strengthen both their internal reporting capability and their capacity to gather data from external providers. Achieving this has required investment in systems and specialist staff.

Some subscribers are also improving their data capture and analytics tools, as well as working to decommission and replace or consolidate disparate legacy systems. As a result, one subscriber is now capturing withdrawn claims data for some retail classes for the first time. Over time, these changes should lead to more consistent and granular reporting.

As a result of data capture and reporting improvements, seven subscribers this year made corrections to previously submitted data on claims, declined claims and withdrawn claims in 2016–17. This report uses these corrected figures.

However, despite the efforts of the Committee and Code subscribers, data quality issues have not yet been fully resolved. Some subscribers continue to report that the quality of their data has been affected by system changes, disparate legacy systems with different functionality, and different methodologies used to extract data.

At least three Code subscribers reported that year-to-year variations were influenced by different individuals coordinating data collection over time, without a consistent, documented process for extraction and reporting. These ongoing issues should be borne in mind when interpreting the data in this chapter.

Recommendation 5: Improve data capture, extraction and reporting.

Subscribers should improve data quality by:

- developing and documenting a consistent methodology for recording and extracting data, ensuring consistency year-to-year
- mapping consistent data sets across insurance brands, and
- scrutinising data carefully before submitting it to the Committee, minimising errors and identifying trends that may require explanation.

There are also ongoing limitations on subscribers' capacity to record and report on why claims are declined or withdrawn.

Often, as the above discussion shows, subscribers are only able to provide very general reasons for a claim decline, such as that the claim incident was not covered. For example, in the motor class, 50% of claim declines were due to a policy condition or exclusion that the subscriber could not specify.

Recommendation 6: Contribute to trend identification and product design with more granular data on declined and withdrawn claims.

Code subscribers should improve their capacity to record the specific reasons claims are declined and withdrawn. This would enable subscribers to monitor trends concerning specific policy conditions and exclusions to ensure that:

- insurance products are operating as intended, with no gap between the product's benefits and the consumers and small businesses that are buying it, and
- claims decisions are consistent with the policy terms and conditions, relevant facts and the law.

Improving how claims are handled

Claims handling is a central focus of the Code's standards and of the Committee's work monitoring and promoting improvement to practice in the general insurance industry. In 2017–18, claims-related breaches made up 57.6% of all Code breaches. In the first half of 2018–19, the Committee has also seen a major influx of significant breach matters, many of them concerning the Code's claims standards. The Committee's monitoring of breaches and investigation of significant breaches highlights areas where Code subscribers can focus their compliance efforts, improving the claims service they offer consumers and small businesses.

Monitoring breaches of the Code's claims standards

The Code's claims-related standards play a critical role in ensuring that consumers and small businesses receive high standards of service in claims handling, especially when they are experiencing financial hardship or the consequences of a catastrophe.

The relevant standards are contained in three Code sections. Extensive claims standards are set out in section 7, which describes Code subscribers' obligations when receiving claims, assessing and investigating them and making claims decisions, as well as obligations concerning workmanship and materials.

Focused on Code subscribers' use of service suppliers, section 6 includes standards for how service suppliers provide services; their competency and suitability for this; their contracts with Code subscribers; and how they must respond to complaints. Section 9 sets out specific standards that apply to claims related to catastrophes.

Claims breaches increased slightly

There were 6,780 breaches of these claims and claims-related standards in 2017–18, a slight 2.5% increase from 6,613 such breaches in 2016–17. By far, the majority of claims-related breaches in 2017–18 were of the specific claims standards in section 7 of the Code – these accounted for 97.2% of all claims-related breaches (**Table 21**).

The number of section 7 breaches remained about the same as in 2016–17 (6,561); however, breaches of section 6 fell from 44 to 15, while breaches of section 9 increased dramatically from 8 to 172.

Table 23: Claims-related breaches by Code section, 2017–18

Code Category	Breaches
7 Claims	6,593
6 Standards for Service Suppliers	15
9 Catastrophes	172
Total	**6,780**

Looking at specific subsections, the top contributors to claims-related Code breaches in 2017–18 (**Table 24**) were different to 2016–17. Breaches of subsection 7.19 increased sharply to become the largest contributor, while section 7.21 became the fourth-largest source of claims breaches in 2017–18 after zero such breaches the previous year.

Table 24: Top contributors to claims-related Code breaches, 2017–18

Code standard	Breaches
7.19: If a subscriber denies the claim, it must give the claimant reasons in writing including information about their right to access information about them and service suppliers' and external experts' reports related to the decision, and internal and external complaints resolution processes.	1,932
7.13: A subscriber must keep the claimant informed about the progress of their claim at least every 20 business days.	1,053
7.10: If a subscriber requires further information or assessment then within 10 business days of receiving the claim it must notify the claimant of any required information, appoint a loss assessor/adjuster if needed, and provide an initial timeframe for making a claim decision.	694
7.21: A subscriber must comply with claims handling timeframes in s7 unless one or more of 3 exceptions apply.	691
7.16: Once all relevant information has been obtained and enquiries completed, a subscriber must decide whether to accept or deny the claim and notify the claimant of the decision within ten business days.	607
Total	4,977

The same subsections figure in the influx of significant breaches the Committee is investigating in 2018–19. During the first eight months of 2018–19, there were 30 open and confirmed significant breaches concerning claims standards and the top contributors are summarised in **Table 23**.

Table 25: Top claims-related significant breaches in first half of 2018–19

Code standard	Open significant breaches
7.13: A subscriber must keep the claimant informed about the progress of their claim at least every 20 business days.	6
7.10: If a subscriber requires further information or assessment then within 10 business days of receiving the claim it must notify the claimant of any required information, appoint a loss assessor/adjuster if needed, and provide an initial timeframe for making a claim decision.	3
7.2: A subscriber must conduct claims handling in an honest, fair, transparent and timely manner.	3
7.9: A subscriber must decide to accept or deny a claim within 10 business days if no further information or assessment are needed.	3
7.14: A subscriber must respond to routine claimant requests for information within 10 business days.	3
7.16: Once all relevant information has been obtained and enquiries completed, a subscriber must decide whether to accept or deny the claim and notify the claimant of its decision within ten business days.	3

Informing consumers and small businesses about declined claims

Under subsection 7.19, when a Code subscriber decides that it will not accept a consumer's or small business's claim, it is required to communicate its decision to the consumer or small business in writing. Together with the decision, Code subscribers must communicate the reasons the claim was denied and information about the consumer's or small business's rights – information it relied on in reaching its decision including reports supporting its decision and information about its complaints (internal and external) process. This standard is critical for consumers and small businesses whose claims have been declined – it provides them with a means to understand the basis of the Code subscriber's decision and how it can be disputed.

Breaches of subsection 7.19 increased a dramatic 452% in 2017–18, up to 1,932 from just 350 in 2016–17. This trend is of concern because it cannot be attributed to growth in claims. Claim numbers changed very little between 2016–17 and 2017–18, increasing by just 1% (an additional 49,897 claims). Thus, the rate of subsection 7.19 breaches per 10,000 claims increased from just 0.87 in 2016–17 to 4.2 in 2017–18.

The bulk of subsection 7.19 breaches (1350 or 70%) were reported by a single subscriber. Most were caused by an administrative error and addressed with strengthened processes and procedures and refresher training for claims staff. A further 434 breaches were reported by another subscriber, which addressed the non-compliance in a similar way. The Committee will work with both subscribers to ensure that they have appropriately addressed the underlying cause of the breaches.

Other Code subscribers who breached this standard rectified the breaches by providing information to affected consumers or small businesses and requiring the responsible staff to do further training.

Complying with claims handling timetables

Subsection 7.21 requires subscribers to comply with various claims handling timetables. However, subscribers do not have to comply with these timetables where otherwise agreed with the consumer or small business; where a longer timetable is reasonable given the circumstances; or where an External Expert was the cause of the delay.

The subsection 7.21 timetables are critical in ensuring that subscribers manage the end-to-end claims process and the steps within it in an honest, efficient, fair, transparent and timely way. There are timetables that apply to decision-making – whether to accept or deny a claim – and others that trigger a critical contact with the consumer or small business, which may include informing them of their right to access internal and external dispute resolution.

Whereas there were no reported breaches of subsection 7.21 in 2016–17, subscribers reported 691 such breaches in 2017–18. Increased auditing, monitoring and review activities, sometimes focused on new staff, may have boosted awareness of Code obligations and thus reporting of non-compliance. Nevertheless, for the Committee, this new trend is concerning.

Almost all the breaches (664 or 95.7%) were reported by one subscriber that had breached subsection 7.21 multiple times. The subscriber reported that the breaches were caused by an administrative error and addressed it by improving monitoring and providing refresher training to employees. The Committee will look into this with the subscriber to ensure that it has appropriately addressed the underlying cause of the breaches. Subsections 7.17 and 7.18 also concern the timeliness of claims decisions, focusing on timeframes for a decision where there are exceptional circumstances that apply to the claim. Together, these subsections accounted for three significant breaches opened in the first eight months of 2018–19.

Significant breaches of these subsections are particularly important because of their substantial customer impact. The significant breaches were caused by backlogs following high claim volumes, IT system issues, failure to receive or process emails, and misunderstanding of Code obligations resulting in a failure to provide information to affected consumers and small businesses. These types of failures point again to the adequacy of subscribers' embedded controls and monitoring generally.

Recommendation 7: Ensure sufficient resourcing to comply with claim handling timeframes.

Subscribers should ensure they have both:

- adequate claims handling systems and processes, and
- enough appropriately trained staff with the required knowledge and expertise to handle consumers' and small businesses' claims within Code timeframes, particularly the timeframes for making a decision on a claim.

Keeping consumers and small businesses informed of progress

Once a consumer or small business makes a claim, a Code subscriber must keep them informed about the claim's progress at least every 20 business days (subsection 7.13). This proactive and positive obligation facilitates transparency about the claims process and helps Code subscribers to manage their customers' expectations about the claims, including how they are tracking. Communication with affected consumers and small businesses becomes especially important during claims backlogs.

Subsection 7.13 was the second-biggest contributor to claims breaches in 2017–18. Even so, breaches of subsection 7.13 decreased 25% to 1,053 from 1,407 in 2016–17. Looked at another way, breaches per 10,000 claims decreased by 26% from 3.48 to 2.57. In 2016–17, the Committee observed the spike in breaches of subsection 7.13 (as well as 7.10 and 7.16, discussed below) may have related to a sharp increase in claims volumes following severe weather events, which would have placed pressure on claims staff and service suppliers, making it difficult to maintain compliance with timeframe-based claims handling standards.

However, it is noteworthy that, as detailed in the Committee Chair's witness statement to the Royal Commission[24], subsection 7.13 has consistently been among the most-breached sections of the Code over the past four years, and was the single top source of breaches in both 2014–15 and 2015–16. This highlights a persistent inability to keep consumers and small businesses informed of the progress of their claims – part of a more general difficulty meeting claims standards that involve timeframes and communication with consumers and small businesses, such as the requirements in subsections 7.9, 7.10 and 7.16. More needs to be done to work out why subscribers have been consistently failing in this area and what can be done to improve regular communication with consumers and small businesses.

Notifying consumers and small businesses of additional information needs

The Code imposes timeframes on Code subscribers that seek more information or assessment before a claims decision is made. Under subsection 7.10, a Code subscriber has ten business days from receipt of the claim to explain any extra information it needs from the consumer or small business; engage a loss assessor or adjuster, if needed; and give the consumer or small business an initial estimate of the time it will need to make a decision on the claim.

The costs to consumers and small businesses of processing delays can range from minor inconvenience to major emotional and financial detriment. This important standard is meant to ensure that claims are processed in a timely way, in turn allowing timely claims decisions and minimising detriment to affected consumers and small businesses.

Breaches of subsection 7.10 decreased even more sharply than breaches of subsection 7.13, falling 70% from 2,283 in 2016–17 to just 694 in 2017–18. The percentage decrease was the same on a breaches per 10,000 claims basis, down from 5.64 to 1.69.

[24] See Witness statement of Lynelle Jann Briggs, Rubric 6-75 and Rubric 6-78, dated 14 September 2018, page 15.

Notifying consumers and small businesses of claims decisions

When a Code subscriber has completed gathering the information it needs to assess a claim and form a view about its liability, it must decide to accept the claim or deny it and inform the consumer or small business of its decision within 10 business days.

This obligation, contained in subsection 7.16, is crucial. Consumers and small businesses are entitled to have their claims promptly assessed and paid in accordance with the relevant policy, and delays can have serious adverse consequences for them. This is especially so where a claim is made for significant damage to a home (for example, as a result of a catastrophic event) or where the claim's outcome will determine whether a consumer or small business will remain able to meet their financial obligations (for example, where a person has lost their job and is no longer able to meet their loan repayments).

There were 607 breaches of this requirement in 2017–18, making it the fifth-largest contributor to claims-related breaches. This represented a drop of 43% from 1,070 breaches in 2016–17. The rate of breaches per 10,000 claims basis decreased from 2.64 to 1.48.

Responding effectively to catastrophes

When a disaster prompts a large number of claims to multiple insurers, the ICA declares the event a catastrophe, triggering the application of the Code's catastrophe provisions.

While it is important that Code subscribers handle catastrophe-related claims expeditiously, they must also maintain oversight to ensure that the Code's standards are being met. Catastrophes often place consumers and small businesses in highly stressful situations, while the volume of claims can also put pressure on insurers.

To assist customers in catastrophes, Code subscribers need adequate resourcing and the right processes. For this reason, the Code places special obligations on Code subscribers to respond to catastrophes in an efficient, professional, practical and compassionate manner. The standards that apply when the ICA declares a catastrophe are contained in section 9 of the Code.

Breaches of these catastrophes standards increased from 8 to 172 in this period (see **Table 23** on p.40). All 172 of these breaches were of the special requirements, set out in subsection 9.3, for catastrophe-related property claims that are finalised within one month of the catastrophe. In this circumstance, consumers and small businesses have 12 months after claim finalisation in which they can check whether the settlement of their claim included everything that was lost or damaged, and, if not, to ask the Code subscriber to review the claim – even if they previously signed a release.

Subsection 9.3 also requires Code subscribers to tell consumers and small businesses about this entitlement when a claim is finalised. This is an important protection for consumers and small businesses with catastrophe-related claims, which are typically settled quickly, often with a cash settlement. This has the important benefit of minimising inconvenience to customers, allowing them fast access to funds and the flexibility to manage repairs or rebuilding.

However, the expeditious handling of these claims can mean some aspects are overlooked, while consumers' and small businesses' precarious positions can make it difficult for them to fully assess their loss and coverage of it. It is important that Code subscribers carefully assess all relevant benefits under a policy, addressing these in settlements that are consistent with the policy wording and the principle of fairness. Where something is missed, subsection 9.3 provides additional protection for consumers and small businesses.

Recommendation 8: Proactively contact consumers and small businesses whose claims were finalised within one month of a catastrophe.

Before the 12-month review period under subsection 9.3 expires, subscribers should proactively contact affected consumers and small businesses to ensure that no aspect of their claim was overlooked during settlement.

In 2017–18, all 172 breaches of subsection 9.3 occurred because claims staff did not follow subscribers' processes and procedures. Of these 172 breaches, 169 were reported by one subscriber. This subscriber addressed the breaches largely through refresher training of claims staff.

In view of the spike in breaches of subsection 9.3, it is worth repeating our observation from 2016–17 and reiterating it here as a recommendation to guide subscribers in improving compliance with this critical standard.

Recommendation 9: Inform consumers and small businesses of their right to have their claim reviewed.

Subscribers should inform consumers and small businesses affected by catastrophes of their right to have their claim reviewed. Subscribers should also closely monitor compliance with their processes to ensure that the standards in subsection 9.3 are met.

Financial hardship

One of the key contributions of the Code is the higher standard of protection it offers for customers and uninsured persons experiencing financial hardship. Subscribers have now had three years to adapt to the Code's enhanced financial hardship standards, including those relating to financial hardship assistance, the process of applying for it, and how Code subscribers seek to collect money they are owed. In 2017–18, the Committee's expectation was that Code subscribers should have mature processes both for handling financial hardship and monitoring compliance with the standards.

Monitoring financial hardship compliance

In 2017–18, breaches of the financial hardship standards in section 8 were a comparatively small source of recorded Code breaches. With 94 breaches, financial hardship ranked sixth as a source of breaches, contributing only a fraction of the number of breaches of claims (section 7) and complaints (section 10) standards.

Although the number of financial hardship breaches remained comparatively small, it continued to increase, rising a marked 40.3% from 67 in 2016–17 to 94 in 2017–18. This increase followed a previous 116.1% increase from just 31 recorded breaches in 2015–16.

Using agents to pursue a third party for debt

It is common practice for Code subscribers to use a collection agent when pursuing an uninsured person for a debt owed as a result damage they caused to an insured's property. The Code requires, under subsection 8.10, that when a Code subscriber uses an agent to communicate with a person about money they owe, the communication must identify both the subscriber the agent is acting for and the nature of the claim against the person.

This year, there was a spike in breaches of this subsection. Of the ten financial hardship subsections breached in 2017–18, subsection 8.10 was the source of the most breaches (35, or 37.2% of the total). In 2016–17, just two breaches of subsection 8.10 were recorded.

The vast majority (33 or 94.3%) of subsection 8.10 breaches in 2017–18 concerned a single Code subscriber. Investigating a Code breach allegation from a community legal centre on behalf of an uninsured person, the Committee found the subscriber breached subsection 8.10 when the debt collection letter its agent sent to the uninsured person did not identify the subscriber or explain the basis of the claim against them. After the Committee found this breach and informed the subscriber, the subscriber reviewed its files and found 32 similar breaches.

The investigation found that the breaches were caused by a non-compliant template letter being used by the subscriber's collection agent. The subscriber addressed the issue by developing a new template letter for its collection agent. The subscriber also told the Committee that it was transitioning to a new collection agent and had developed a similar compliant template letter for it.

The Committee's investigation work has uncovered several instances where legal firms engaged by subscribers to conduct debt recovery were seemingly unaware of their obligation to comply with the Code when acting on behalf of a subscriber. Legal firms, like collection agents and other service suppliers, are bound by the requirements in section 8 of the Code, including the requirement to comply with the ASIC and ACCC *Debt collection guideline for collectors and creditors*.

Recommendation 10: Make service suppliers aware of their Code obligations and monitor their compliance with debt recovery obligations.

Service suppliers, including legal firms, acting on behalf of Code subscribers to recover debt are bound by the Code's standards including the financial hardship standards. This means that Code subscribers need to:

- specify the standards of the Code that apply to services provided by their service suppliers, including the financial hardship standards, in contracts with them
- ensure that service suppliers are made aware of their obligations under the Code, and
- proactively monitor service suppliers' compliance with these obligations.

Supplying an application form and financial counselling hotline number

When a person tells a subscriber that they are in financial hardship, subsection 8.4 of the Code requires the subscriber to give them an application form for financial hardship assistance and the contact details of the national financial counselling hotline. This obligation is particularly important as it begins the financial hardship assistance process and links persons in hardship to financial counselling if they have not already accessed it.

Subsection 8.4 was the second-largest source of financial hardship breaches in 2017–18, accounting for 24 breaches: 20 self-reported by subscribers and 4 identified through the Committee's monitoring. This represented a 33.3% increase from 2016–17, when there were 16 recorded breaches of subsection 8.4.

Subscribers attributed most of these breaches to a failure to follow established processes and procedures. They reported that the breaches were typically addressed with remedial training, improvements to processes and procedures, and communication with affected persons.

Guiding compliance improvement

Part of the Committee's role is to provide guidance, to subscribers and other interested parties, on compliance with the Code. In 2017–18, the Committee elaborated on interpretation of the Code's financial hardship standards and how to comply in both its determinations and its first Guidance Note, 'Financial hardship obligations – General Insurance Code of Practice' (financial hardship guidance note).

Assessing applications for assistance on the information available

One issue addressed in the Committee's guidance note was the timely assessment of requests for financial hardship assistance, which the Committee expects should meet the requirements in the *National Credit Code*.

The Committee recently issued an important determination on this point. Acting on behalf of an uninsured person, a community legal centre alleged that the subscriber had breached multiple financial hardship subsections. Among the issues in the case was that when the uninsured person did not supply information that was requested, the subscriber failed to make a decision on their request for financial hardship assistance.

While acknowledging that the financial hardship process was drawn out, the subscriber argued that it was not obliged to tell the uninsured person the outcome of his financial hardship application because he had not provided the requested documentation and it was unable to assess his financial position. However, the Committee's view, having regard to subsection 8.6 of the Code, was that the subscriber was nevertheless required to assess the uninsured person's application based on the information available (or lack thereof) and notify him of its decision as soon as reasonably practicable. Therefore, the Committee determined that the subscriber breached subsection 8.6 of the Code. The Committee is currently investigating a second Code breach allegation in which the same issues arose.

The Committee's financial hardship guidance note provided guidance for subscribers on the timeframe for assessing applications for assistance, including where a subscriber asked a person to provide additional information but did not provide it.

Recommendation 11: Assess hardship application on available information and provide written decision if person has not provided requested additional information.

If a subscriber has asked a person for more information to support their application for financial hardship assistance but has not received it within 21 calendar days, the subscriber:

- should assess the application on the information available, and
- inform the person of the decision in writing no later than 28 calendar days after it first requested the additional information.

Placing debt recovery action on hold

Another important issue that arose in the completed investigation was that when the uninsured person said he was experiencing financial hardship, the subscriber did not have its collection agent put recovery action on hold while it assessed the financial hardship request (required under Code subsection 8.7). Instead, when the uninsured person did not provide requested documentation, the subscriber instructed its lawyers to proceed with a summons for oral examination of the uninsured person in the Magistrates' Court. The Committee determined that by doing this, the subscriber had breached subsection 8.7.

Once again, the Committee is now investigating similar issues raised in a second Code breach allegation. In this matter, the subscriber's lawyers wrote to the uninsured person saying that if the debt was not settled, they would apply to the Court for an instalment order. However, this was after the uninsured person, through his representative, had informed the lawyers he was experiencing financial hardship and asked for the debt to be waived. The subscriber's lawyers failed to initiate the financial hardship process, and incorrectly told the uninsured person that the subscriber was not bound by the ACCC and ASIC Debt Collection Guideline, and that the uninsured person was not eligible to use the subscriber's internal complaints process. The Committee's investigation of this matter is ongoing.

Interpreting the Code's financial hardship standards

A common theme in these and other Committee investigations is that some subscribers, alongside legal firms they engage, attempt to interpret the Code's financial hardship standards as narrowly as possible. For example, by arguing that certain standards do not apply in particular circumstances, or, more broadly, by suggesting that the Code is merely a guideline that does not confer any enforceable rights on a consumer or small business.

This is contrary to the expectations of the Committee and the purpose of the Code. The Code is part of the broader consumer protection framework. Its purpose is to improve standards of service provided by subscribers, which means that subscribers are expected to go beyond the 'black letter of the law'. By subscribing to the Code, insurers and their service suppliers agree to be bound by its higher standards.

Recommendation 12: Interpret the Code's standards with good faith.

Guided by the purpose and spirit of the Code, subscribers should take a broad view when interpreting the Code's standards, rather than seeking to limit their application or downplay their importance.

Focusing on financial hardship

In striking contrast to other Code standards, most recorded financial hardship breaches are identified by the Committee through its monitoring work, rather than by Code subscribers themselves. In 2017–18, the Committee identified 52 financial hardship breaches (55.3%), while Code subscribers self-reported 42. The split was similar in 2016–17, when the Committee identified 61.2% of recorded financial hardship breaches.

When the Committee investigates Code breach allegations relating to financial hardship, almost invariably it identifies problems with subscribers' understanding of their obligations. These issues are evident across the range of subscribers, small and large.

Combined, the paucity of self-reported financial hardship breaches and the issues uncovered in investigations lead the Committee to believe that Code subscribers need to intensify their focus on financial hardship. On the whole, the industry lacks an adequate understanding of financial hardship issues and is deficient in monitoring its compliance with financial hardship obligations.

Similarly, among the issues highlighted by the Financial Services Royal Commission has been the way insurers deal with vulnerable persons. Clearly, the expectations of vulnerable persons and the community are not being met. The Committee expects the Financial Services Royal Commission to have a major impact on how general insurers conduct their business and engage with vulnerable persons.

Recommendation 13: Improve understanding of the Code's financial hardship standards as well as the compliance monitoring framework.

To meet the expectations of vulnerable persons and the community, subscribers need to strengthen their focus on the Code's financial hardship standards. This means subscribers should:

- review the way in which they interpret and apply the financial hardship standards
- ensure that subscribers' employees and service suppliers clearly understand the financial hardship standards and how they operate in practice, and
- put in place more robust compliance monitoring to ensure that subscribers and their service suppliers are meeting their obligations.

Strengthening the Code

One focus of the Committee's input into the ICA's review of the Code was strengthening the financial hardship standards to ensure that vulnerable persons are treated fairly.

In its interim report on the Code review, the ICA set out proposals for strengthening the Code's standards on vulnerable persons. The Committee, in its submission on the ICA's interim report, strongly supported these proposals, and provided further feedback on these and the Code's financial hardship standards in section 8.

The Committee's submission addressed:

- **the scope of the financial hardship standards**—The Committee agreed that it should be made clear that section 8 applies to situations where a subscriber's customer cannot pay their excess, and that the options for financial hardship assistance in section 8.8 should include deduction of the excess from the claim payment.
- **identifying persons in financial hardship**—The Committee agreed that service suppliers should be trained in their financial hardship obligations and how to identify financial hardship when engaging with persons who owe money to a subscriber. Debt recovery letters should include information about the financial hardship process.
- **processing applications**—The Committee agreed that applications for financial hardship assistance should be processed in line with the timeframes in the *National Credit Code*.

- **communicating with consumer representatives**—The Committee recommended that when a subscriber who is contacted directly by a person in hardship and is aware they have a representative, the subscriber should always be required to notify the representative that such contact has occurred.
- **allowing payment by instalments**—The Committee recommended that the Code specify that if a person experiencing financial hardship can pay their debt in instalments, the insurer should not refuse this.
- **handling complaints and disputes**—The Committee recommended that it be made clearer that all persons within the scope of section 8 should have access to the complaints and disputes process under section 10 of the Code, for issues about or related to the recovery of money under a retail insurance product or a wholesale insurance product. The Committee also agreed that financial hardship complaints should have a 21-day complaint handling timeframe, in line with RG 165.

In its final report, the ICA affirmed many of these changes, making it likely that the next iteration of the Code will significantly strengthen financial hardship standards.

Recommendation 14: Review and improve existing financial hardship processes.

Subscribers should review their existing financial hardship processes and make any necessary improvements.

Internal disputes

In 2017–18, Code subscribers dealt with more than 30,000 internal disputes lodged by consumers and small businesses. Good handling of such disputes builds customer confidence and trust, showing that Code subscribers will deal with issues in a fair, timely and transparent way. As well as monitoring breaches and significant breaches of the complaint standards during 2017–18, in 2018 the Committee focused on internal disputes with a desktop audit of 20 subscribers.

A picture of internal disputes in the Australian insurance industry

The Code permits a Code subscriber to operate a two-stage internal complaints process. Stage one is an initial review of a consumer's or small business's complaint. The consumer or small business, if unhappy with the Code subscriber's decision, may escalate their complaint to stage two. The review of a complaint in stage two should be conducted by a different person who was not involved in the stage one decision.

If the consumer or small business is unhappy with the Code subscriber's stage two decision, they have a right to refer the dispute to AFCA for external dispute resolution (EDR). Code subscribers must inform consumers and small businesses of this right during and at the end of the internal disputes process.

Each stage of the internal complaints process must be completed within 15 business days. At the end of each stage, a Code subscriber must respond to the consumer's or small business's complaint in writing and provide information about their rights in the event they are unhappy with the outcome. A Code subscriber must provide its final decision in response to a consumer's or small business's complaint within 45 calendar days of receiving it. This chapter focuses on complaints that have reached stage two of this internal process; these have been labelled 'internal disputes'.

Internal dispute trends

Code subscribers received 30,898 internal disputes in 2017–18 (**Table 24**), 4.4% more than the 29,604 received in 2016–17. Internal dispute numbers have remained relatively stable over the past three years, fluctuating from around 27,000 to 31,000.

Table 26: Internal disputes received and finalised, 2017–18

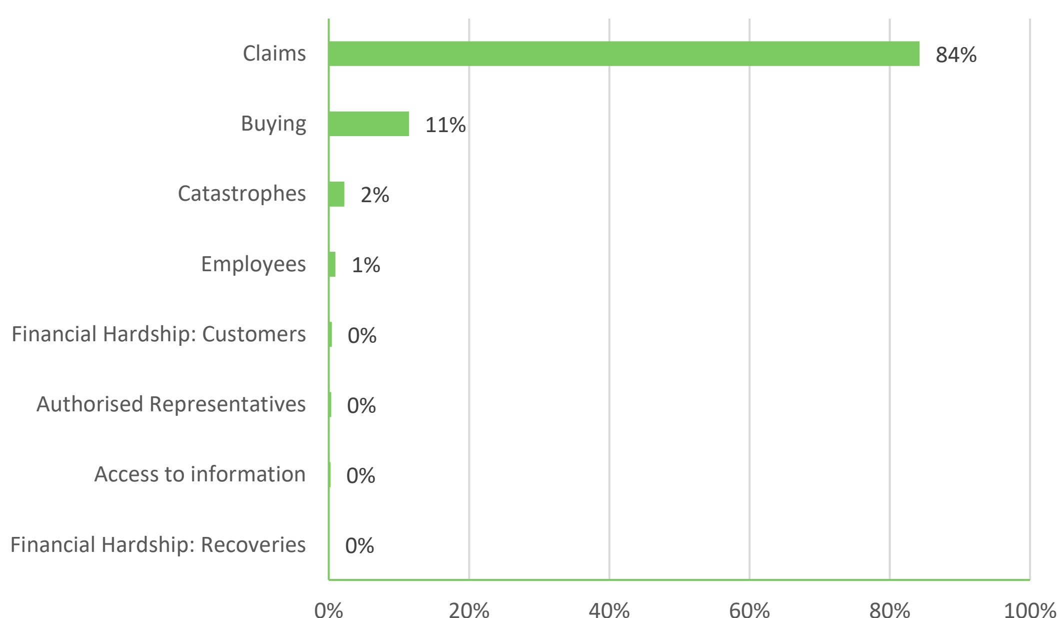
	Internal disputes in stage two			
Insurance class	**Received by Code subscribers**		**Finalised by Code subscribers**	
	Received	**% Variance from last year**	**Finalised**	**% Variance from last year**
All Classes	30,898	4.4%	30,246	9.5%
Retail	29,187	4.5%	28,660	9.5%
Wholesale	1,711	1.5%	1,586	9.7%

Once again, the vast majority of the internal disputes (29,187 or 94.4%) received in 2017–18 related to retail rather than wholesale insurance products. Retail insurance internal disputes increased 4.5% between 2016–17 and 2017–18 and accounted for all of the increase in total internal disputes. At the same time, AFCA received 8% more disputes about general insurance in in 2017-18[25] to 14,252 disputes up from 13,200 disputes in 2016–17.

Internal disputes about claims

Claims are a key issue in internal disputes, reflecting the fact that interactions between Code subscribers and consumers and small businesses peak when a claim is made. In 2017–18, 84% of all retail internal disputes received concerned claims (**Chart 10**). A similar pattern was observed in 2016–17 when claims accounted for 87% of all retail internal disputes.

Chart 8: Retail internal disputes by Code section, 2017–18



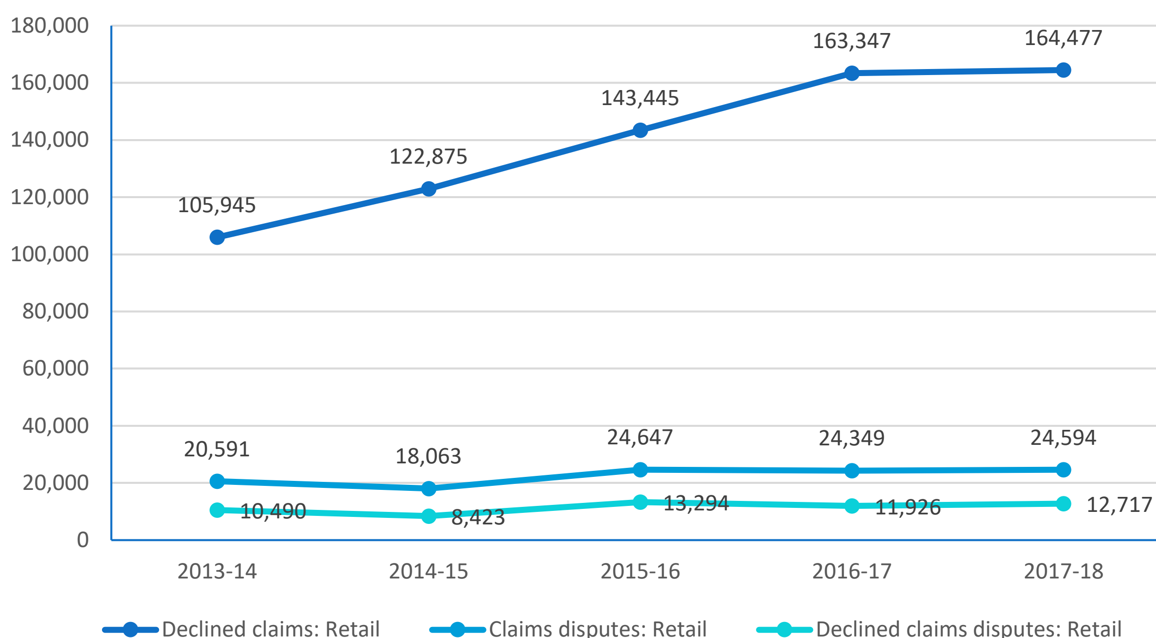
Just over half (52%) of the internal disputes about claims concerned declined claims. Around one-quarter (26%) fell into the category of ‘other disputes about claims’, which includes disputes relating to service delays, the application of an excess and disputes about liability for motor collisions. The remaining 22% of claims disputes concerned the claim value, up from 12% in 2016–17, while disputes about the refusal to re-open a claim make up less than 1% of claims disputes.

While the number of retail claims lodged and declined has risen year-on-year for the past five years, the numbers of claims-related disputes and disputes specifically about declined claims have remained steady, with only minor fluctuations from year to year (**Chart 9**). The number of declined claims rose sharply from 2013–14 to 2016–17, then levelled off.

---

[25] See FOS’s 2017–18 Annual Review, available at https://www.fos.org.au/publications/annual-review/.

Chart 9: Retail declined claims and related internal disputes, 2013–14 to 2017–18



Internal disputes by retail insurance class

In 2017–18 increases in motor, home and travel insurance disputes were largely offset by decreases in the four other retail insurance classes: personal & domestic property, consumer credit, residential strata and sickness & accident (**Table 27**). Even so, retail internal disputes increased 4.5%, mainly because of increased travel and home disputes.

Table 27: Retail internal disputes (Stage 2) by class, 2017–18

Insurance class	No. 2017-18	% Change from 2016–17
Motor	12,518	1.5%
Home	10,374	6.4%
Travel	3,274	44.7%
Personal & Domestic Property	2,095	-7.9%
Consumer Credit	376	-33.9%
Residential Strata	288	-26.7%
Sickness & Accident	262	-22.3%
Total	**29,187**	**4.5%**

In 2017–18, motor products again contributed the highest proportion of internal disputes, accounting for close to half (43%) of all internal disputes. Motor-related internal disputes increased a slight 1.5% from the previous year. This increase coincided with small increases in the number of motor policies sold (up 0.9%) and claims lodged (up 1.6%) in the same year. Explaining the small increase in motor disputes, some Code subscribers also cited factors such as service delays; liability disputes; offshore partners' training and skilling issues; team restructuring; and changes to product features.

Most (80%) motor-related internal disputes had to do with claims. Between 2016–17 and 2017–18, there was a 7.8% decrease in the number of motor disputes about declined claims, corresponding with a 19% decrease in the number of declined motor claims over the same period. Conversely, disputes about the value of a claim more than doubled, up 113%, while disputes about buying motor insurance increased 49.4%. A subscriber attributed increases in its motor vehicle disputes to the introduction of an optional cover which incurs an extra premium, where previously this cover was included as standard.

Home made up 36% of retail disputes received and 84% of home disputes related to how claims were handled. Despite decreases in the numbers of policies sold (down 1.1%) and claims lodged (down 5.6%) in 2017–18, disputes about retail home insurance increased 6.4%. One subscriber attributed the increase in the number of its home disputes to reporting improvements. Other subscribers cited continuing flow-on effects from Cyclone Debbie, which may account for the 108.5% increase in home disputes specifically about catastrophes. Disputes about declined home claims increased by 17.9%. One subscriber said that it received more disputes about declined home claims was related to the use of offshore operations to process claims. Disputes about the value of home claims increased 60.2%.

The third largest source of disputes was travel insurance. Travel represents 11% of all retail disputes received and 98% of travel disputes were about claims. Travel disputes increased by 44.7% to 3,274 in 2017–18. Interestingly, although declined travel claims decreased 13.3% between 2016–17 and 2017–18, the number of disputes about declined travel claims increased a marked 36.4%. There were also increases in other disputes about travel claims (up 114.8% and the value of a claim (up 92.6%).

Some 7% of disputes concerned personal & domestic property insurance and 94% of these were about claims. Although the number of policies sold increased 5.1% from 2016-17 to 2017-18, there was a 7% decrease in the number of related disputes. Despite the overall decrease in personal & domestic property disputes, some specific types of dispute increased: disputes about the value of a claim increased 355.6%; disputes about buying insurance increased 59.5%; and other disputes about claims increased 51.8%.

Together, disputes about consumer credit insurance, residential strata insurance and sickness & accident insurance made up 3.2% of retail disputes in 2017–18. Disputes about claims in each of these classes respectively were:

- Consumer credit – 47%
- Residential strata – 92%, and
- Sickness & accident – 79%.

Disputes about consumer credit insurance decreased 33.9% – potentially the result of substantial decreases in policies sold and claims lodged and declined. Disputes about residential strata products also decreased, down 26.7% to 288 in 2017–18, as did sickness & accident disputes, which dropped 22.3%.

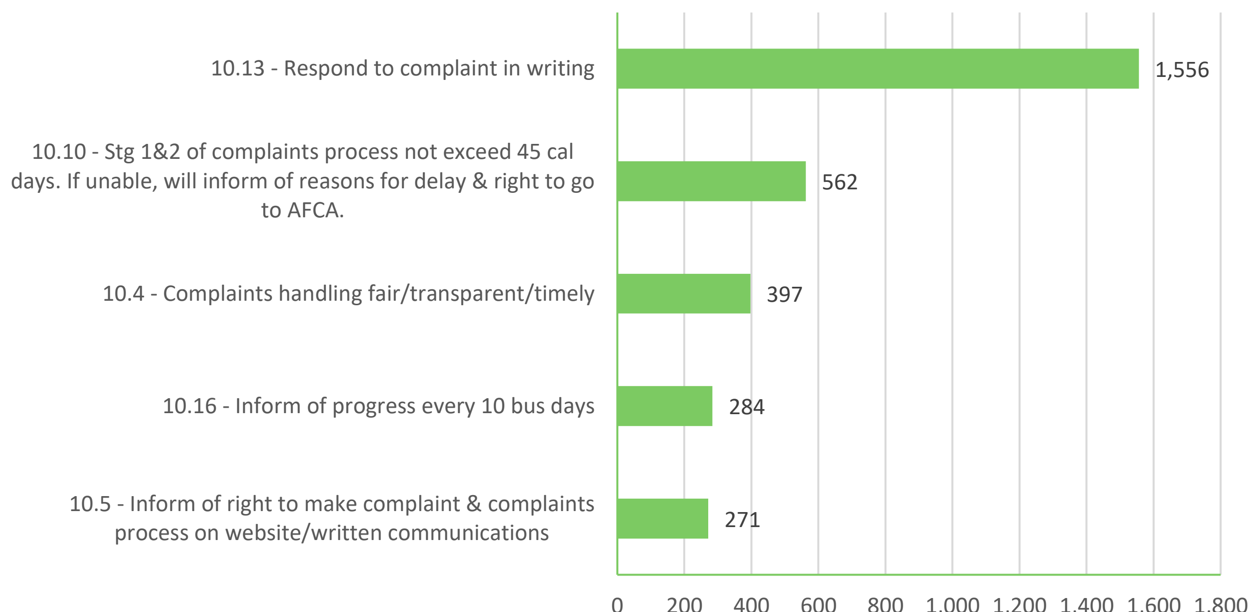
Improving how internal disputes are handled

The Code requires that Code subscribers have an internal complaints process to deal with complaints and disputes, and sets out, in section 10, various standards that this complaints and disputes process must meet. The Committee via its compliance monitoring work has identified areas in which Code subscribers can improve the way they handle complaints and disputes. The Committee also initiated a desktop audit into subscribers' complaint handling and continued to advocate for a shift to a simpler, single-stage internal complaints process.

Monitoring breaches of the Code's standards

Recorded breaches of the Code's complaints standards more than tripled this reporting period, rising from 1,167 in 2016–17 to 4,087 in 2017–18. This increase followed an earlier 219.8% surge between 2015–16 to 2016–17. The 4,087 breaches in 2017–18 included 4 significant breaches and 4,076 other self-reported breaches – which make up the vast majority of recorded section 10 breaches – as well as 7 breaches identified by the Committee through its monitoring work. Together, breaches of the Code's complaints and disputes standards made up over one-third (35%) Code breaches in 2017–18, ranking second only to breaches of the claims standards. Chart 10 shows the top five internal dispute breach areas in 2017–18.

Chart 10: Complaints and disputes breaches, top five subsections, 2017–18



The number of reports of significant breaches from subscribers increased in 2018–19, resulting in 78 open significant breaches by 28 February 2019. With 14 significant breaches involving 4 subscribers, the complaints handling standards were the third-largest contributor to significant breaches, after claims and selling insurance.

As with claims, a central theme in these significant breaches of the complaint handling standards is the failure to meet the timeframes specified in the Code, including failures to complete the complaints process within 45 days (subsection 10.10); to respond to complaints within 15 business days (subsections 10.11, 10.12, 10.17 and 10.18); and to keep consumers and small businesses informed every 10 business days (subsection 10.16). These significant breaches occurred across a range of products and insurance classes.

The significant breaches were caused by IT system issues (incorrect receipt and processing of emails); high claim volumes after severe weather events causing correspondence backlogs leading to higher complaints volumes; misunderstanding of Code obligations; inefficient processes for escalating complaints and workflow and resourcing issues.

To address these breaches, subscribers have taken corrective actions such as communicating with affected consumers and small businesses; enhancing processes and IT systems; training staff; introducing daily reviews of open complaints and weekly QA reviews of closed complaints; recruiting; and outsourcing of tasks to law firms.

Responding in writing

Code subscribers are required to respond to a complaint in writing, telling consumers and small businesses the decision and reason for it and informing them of their right to escalate the complaint internally and, after that, to take their complaint to AFCA (subsection 10.13). These are vital protections, giving consumers and small businesses a clear understanding about how and why a decision was made and the availability of EDR if they do not agree. It also serves as a record of the decision and enables consumers and small businesses to escalate the matter to AFCA if they are still dissatisfied.

As in 2016–17, subsection 10.13 was the top source of complaints breaches in 2017–18. Breaches of subsection 10.13 increased sharply this year, up 648% to 1,556 – an alarming development considering the importance of this standard. Subscribers reported that almost all (1,547) breaches of subsection 10.13 were caused by processes not being followed. Administrative errors accounted for 9 breaches. Most breaches were rectified by providing remedial training to staff (1,458 breaches), improving communications with affected consumers and small businesses and/or enhancing monitoring.

Timely response to complaints

Code subscribers must ensure that combined, stages one and two of the complaint process do not exceed 45 calendar days (subsection 10.10). If a subscriber cannot provide a decision within this timeframe, it must tell the consumer or small business – before the end of the period – why the delay has happened. They must also inform the consumer or small business of their right to take the complaint to AFCA, and provide AFCA's contact details.

With 562 breaches, subsection 10.10 was the second biggest source of complaints breaches. Breaches of this subsection increased dramatically in 2017–18, up 1,907% from just 28 breaches in 2016–17.

This is a concerning development. When a subscriber fails to make a decision on complaints in a timely way, consumers and small businesses experience stress and are left without finality. While they await a decision, they may be unable to take action to mitigate their loss. IDR delays also delay the consumer's or small business's opportunity to take their complaint to EDR to try to obtain their desired outcome.

The majority of subsection 10.10 breaches (557) were caused by processes not being followed; 4 breaches occurred because there were too few staff, and 1 breach occurred because there was no process or procedure in place. To address the breaches, Code subscribers provided remedial training to staff (555 breaches) or improved processes and procedures.

Recommendation 15: Ensure sufficient resourcing to comply with complaint handling timeframes.

Subscribers should ensure they have both adequate complaint handling systems and processes, and enough staff with the required knowledge and expertise, to handle consumers' and small businesses' complaints within Code timeframes.

Handling complaints fairly and transparently

Code subscribers must handle complaints in a fair, transparent and timely manner (subsection 10.4) – this principle underpins all standards in section 10. With 397 breaches, subsection 10.4 ranked third as a source of complaints breaches in 2017–18. Breaches of this kind more than doubled, up 170% from 147 in 2016–17.

Most breaches this year were caused by processes and procedures not being followed (276). Too few staff (113) and administrative errors (6) also contributed. Most often, subscribers addressed the breaches with remedial training. The also provided information to affected consumers and small businesses, and improved their processes, monitoring and communications.

Recommendation 16: Test training to ensure its effectiveness.

Complaints breaches are typically caused by staff failing to follow processes and procedures. The frequency of such issues suggests that there are deficiencies in how subscribers train staff to follow processes and procedures. Subscribers should look at ways to test the effectiveness of training to ensure that staff understand and can locate the processes they are required to apply.

Keeping consumers and small businesses informed about complaint progress

Under section 10.16, subscribers are required to keep consumers and small businesses informed about the progress of their stage two complaint every 10 business days. These updates develop and build consumer confidence and trust. Consumers and small businesses need to be reassured that subscribers are doing what is required to assess their concerns and make a fair decision.

Breaches of subsection 10.16 nearly quadrupled this year, rising from 72 in 2016–17 to 284. Almost all of the breaches (283) were primarily caused by a failure to follow processes and procedures; 1 resulted from an administrative error. Once again, subscribers primarily resolved the breaches with remedial training (236).

Informing consumers and small businesses of the right to make a complaint

Under subsection 10.5, Code subscribers must make available to consumers and small businesses information about their right to make a complaint and complaints processes, including the timeframe for providing a final decision, on their websites and in relevant written communications. Giving consumers and small businesses accessible information about a Code subscriber's complaints process is extremely important: consumers and small businesses need to know that they have the right to complain about any aspect of their relationship with their insurer and how to do this. Given continuing growth in the use of online communications and social media, Code subscribers must make information about their complaints processes easily available online.

There were 271 breaches of subsection 10.5 this year, up from 146 in 2016–17. Almost all of these breaches (269) were caused by processes not being followed; 2 were caused by administrative error. Most were addressed by providing remedial training (262), improving processes and informing consumers and small businesses.

Internal dispute resolution desktop audit

In light of sharp increases in the number of complaints-related breaches, in 2018, the Committee conducted a desktop audit of 20 subscribers to assess how they were meeting their Code obligations when handling internal complaints. The Committee's report on its findings, released in January 2019, made 18 recommendations in the IDR report, including important recommendations about meeting Code timeframes and providing decisions in writing.

Positively, the desktop audit found that almost all subscribers audited respond to complaints in writing. Through the audit, however, one subscriber identified a significant breach of subsections 10.13 and 10.19. Recommendation 10 highlighted that under the Code, subscribers must respond to all stage one and stage two complaints in writing and within the required timeframes. The Committee also noted that if a subscriber's written response provides any complaint information in an attached brochure, this must be clearly highlighted, and that any verbal response must be followed up with a written response.

With regard to complaint handling timeframes, the desktop audit found that 7% of audited subscribers' stage one complaint responses exceeded 15 business days, and some 20% of stage two complaint responses exceeded the 15-business day timeframe.

Simplifying the internal disputes process

An internal complaints process should work simply and effectively for consumers and small businesses. Current arrangements under the Code require a consumer or small business to, in effect, complain twice to a Code subscriber before they can take an unresolved complaint to AFCA.

The Committee believes that this process places too much onus on consumers and small businesses and can be difficult for them to navigate. In its investigations, the Committee has seen that consumers often struggle with the two-stage process. Increases in declined claims generally do not cause a corresponding increase in stage two complaints and this may also suggest that consumers and small businesses are not navigating the process effectively.

Consumer groups have argued that the two-stage approach is confusing and fatiguing for consumers and small businesses. These concerns have been supported by recent ASIC research, which found that only 56% of financial services complainants feel confident in their ability to navigate IDR processes.[26]

The Committee previously raised these concerns in its initial submission to the ICA review of the Code. The Committee argued that a simple one-stage process should be put in place to improve complaint handling timeframes, reduce complexity for consumers and small businesses, and simplify complaints data collection. The Committee reiterated this position in a subsequent submission responding to the ICA's interim report on the review of the Code.

In its final report on the review of the Code, the ICA acknowledged stakeholders' concerns about the two-stage internal complaints process. However, it also noted insurers' views that the two-stage process provides better outcomes for most consumers and small businesses and is simpler and less expensive to operate. The ICA stopped short of recommending a move to a single-stage process, but said that it would work with insurers and stakeholders to plan changes to the two-stage process that address stakeholder concerns. The Committee will contribute to these discussions.

---

[26] ASIC, December 2018, *The consumer journey through the Internal Dispute Resolution process of financial service providers*, report 603.

Committee activities 2017–18

During 2017–18 the Committee monitored Code subscribers' compliance with Code standards. Under an outsourcing agreement, the Code team at AFCA acts as Code administrator, with responsibility for monitoring Code compliance on the Committee's behalf.

Considering Code breaches

In 2017–18, the Committee finalised 111 breaches, including 22 significant breaches, by 11 Code subscribers – these have been included together with self-reported breaches in the totals given throughout this report. Breaches finalised by the Committee decreased 26% from 149 breaches closed in 2016–17.

Investigating Code breach allegations

Code breach allegations from customers, third parties, AFCA since 1 November 2018, and prior to that FOS, are sources of the Code breaches considered by the Committee. The Code gives the Committee the power to investigate these allegations, determine whether any breaches have occurred and work with Code subscribers to agree on any corrective measures they should apply. As well as informing the Committee's work with individual Code subscribers, the insights from these investigations help to inform decisions about the focus of the Committee's other monitoring activities.

This year, the Committee received 190 matters for investigation. Most (60.5%) of these were referrals from FOS; 22.6% were from consumers or private lawyers; and 16.8% came from consumer advocates. By the end of 2017–18, the Committee had closed 173 investigations.

Significant breaches

Some breaches of the Code's standards are considered more serious; these are labelled significant breaches. A breach is classified as significant depending on characteristics of the breach itself – its duration, the potential or actual financial loss caused, and how it affects the Code subscriber's ability to provide its services – as well as the number and frequency of previous similar breaches and whether the breach suggests that compliance arrangements are inadequate. When a Code subscriber identifies a significant breach, it must report it to the Committee within ten business days.

The Committee dealt with 13 self-reported significant breach matters during 2017–18, capturing 22 significant breaches.

Half (11) of this year's significant breaches concerned the Code's claims handling standards and 31.8% (7) involved the standards that apply to how insurance is sold. The remaining four significant breaches (18.2%) concerned the Code's complaints and disputes standards.

Engaging with stakeholders

Engagement remained a Committee focus in 2017–18. The Committee continued to draw on intelligence from consumer advocates to inform its strategic direction. Alongside the Committee's ongoing work addressing breaches with Code subscribers, it kept in close communication with the ICA, with a focus on improving the Code via the ICA's Code review.

Consumer advocates

In 2017–18, the Committee focused on building on the encouraging results from the previous year's efforts to build our engagement with consumer advocates.

During the year, the Committee met with a number of consumer advocates including the Consumer Action Law Centre, the Financial Rights Legal Centre, the Financial and Consumer Rights Council, Western Community Legal Centre, Legal Aid Queensland and Legal Aid New South Wales. These discussions provided us with new insights into consumer issues including product comparison, misleading advertising, travel policy exclusions and service suppliers' failure to refer complaints back to subscribers.

Government and regulators

Throughout 2017–18, the Committee Secretariat continued to hold quarterly and ad hoc meetings with ASIC, sharing the Committee's work on activities such as the add-on insurance own motion inquiry. In March 2018, the Secretariat participated in ASIC's forum on fraud investigation.

Industry

Much of the Committee's engagement with individual Code subscribers revolved around Code breach investigations and Code subscribers' self-reports of significant breaches. These meetings were an opportunity to progress investigations, identify where breach acknowledgements were appropriate, discuss the interpretation of Code standards, and check that Code subscribers' remedial actions adequately addressed the underlying causes of Code breaches.

At the industry level, the Committee stayed in close communication with the ICA, providing quarterly reports on its work to the ICA Board; briefing ICA meetings and welcoming ICA representatives to Committee meetings; and holding ad hoc discussions with ICA staff.

The ICA's review of the Code was a major focus of the Committee's engagement with the ICA throughout much of the year. The Committee made a submission on the ICA's interim report and attended three ICA workshops on specific areas of Code improvement. The Committee and Secretariat also attended the ICA's 2018 Annual Forum, with Industry Representative, Ian Berg, contributing to a panel discussion on the Royal Commission and consumer expectations. In March 2018 the Committee Secretariat met with the ICA Code Reference Group to discuss strategy, data collection, and the Committee's financial hardship guidance note.

FOS

During 2017–18, the Committee continued its close engagement with FOS as it prepared for the transition to AFCA in 2018–19. FOS Chief Ombudsman, Shane Tregillis, attended the Committee's October 2017 meeting to discuss the transition. In September 2017, the Committee Chair also met with the chairs of other Code Governance Committees supported by FOS, which cover the financial services sector.

Publications and submissions

The Committee released two publications and a guidance note during 2017–18. The Committee also made two submissions and began developing a new Committee website.

Who is selling insurance?

In June 2018 the Committee released its report on an own motion inquiry into the sale of add-on insurance, making a major contribution to Australian's understanding of add-on insurance and how and by whom they are sold. The report drew on data from 23 general insurers that sell add-on insurance, complemented with case studies and other input from consumer advocates.

The report revealed that the add-on insurance business was much larger than previously recognised, with around two million add-on insurance products sold in 2017. The report also illuminated the role of external sellers in the add-on insurance business, showing that only 3% of add-on insurance was sold directly by Code subscribers. Authorised representatives sold two-third of add-on insurance (66%), while other external sellers - who are not covered by the Code - contributed just under one-third (31%) of sales.

The report made 22 recommendations aimed at improving how insurance is sold by employees, authorised representatives and other external sellers. Most importantly, the Committee recommended that the Code be extended to cover all external sellers.

General insurance in Australia 2016–17: Industry practice and Code compliance

Released in March 2018, the Committee's *General insurance in Australian 2016–17* report brought together data collected from Code subscribers about their activities – including policies, claims, financial hardship and complaints – and their compliance with the Code.

The report highlighted consumers' growing reliance on group travel policies. An eight-fold increase in the sale of group travel policies meant that for the first time, consumer exposure to travel insurance exceeded motor or home cover for the first time. However, the report revealed, the acceptance rate for travel claims was low and decreasing. The report also drew attention to growth in claims and associated breaches, which accounted for three-quarters of all non-compliance with the Code. The report included 14 Committee observations about how subscribers could improve their service standards and compliance with the Code.

Once again, the report was well-received by stakeholders. Its major findings were reported in *The Australian* and the *Australian Financial Review*, and cited by ASIC Deputy Commissioner, Peter Kell, in a speech to the Insurance Council 2018 Annual Forum.

Guidance note 1: Financial hardship obligations

In March 2018 the Committee released its first guidance note, on financial hardship. The Guidance note provides practical advice on how with the Code's financial hardship standards, as well as related complaint standards. It addresses:

- the timely assessment of requests for financial hardship assistance
- communication with a person's authorised representative
- access to internal complaints processes.

Submission on the ICA's interim Code review report

During 2017–18 the ICA continued and concluded its review of the Code, begun the previous year. In December 2017 the Committee provided its submission responding to the ICA's interim report. The submission addressed a range of issues, but focused, as a top priority, on the extension of the Code's standards to all third-party sellers.

Joint submission to the Treasury on industry codes in the financial sector

Together with the Committee Chairs for four other financial services codes, the Committee made a submission to the Treasury's review of ASICs enforcement regime.

Decision-making

Each year the Committee convenes a strategy meeting to consider its aims and where it will focus its monitoring efforts. The Committee examines the intelligence gleaned through its own recent monitoring, including desktop audits, own motion inquiries and Code breach investigations; information on ASIC activities; issues arising in FOS cases; and input from consumer advocates, all of which build a picture of industry trends, consumer experience and possible areas of emerging risk. This picture informs the Committee's strategic decisions. In This year, the strategy meeting took place in Wagga Wagga in February.

Additionally, the Committee met 11 times in 2017–18, in line with its Charter and Deed obligations. Meetings were held in Sydney, Melbourne and Wagga Wagga, and via teleconference.

Workplan priorities

For the coming year, the Committee's workplan priorities are to:

- enhance its value-add to industry
- continue to work proactively with industry to improve data collection and reporting
- focus on new emerging issues, such as claims handling timeframes and travel insurance
- continue to work proactively with industry to introduce reforms arising from the ICA's Code review and the Committee's recommendations to improve compliance
- manage the outcomes of the ICA's Code review, including ongoing monitoring during transition to a new Code
- elevate Code awareness and communications through the development and implementation of an independent website
- continue to develop the relationship with consumer advocates.

Committee members

The Committee comprises three members: an independent chair and one representative each of industry and consumers.

Lynelle Briggs AO – Independent Chair

Lynelle Briggs is a Royal Commissioner into Aged Care Quality and Safety. She was the Chairperson of the NSW Planning Assessment Commission. She serves on the Boards of Maritime Super, the Aid Governance Board and Goodstart Early Learning. She was formerly a member of the Council of the Royal Australian College of General Practitioners and of the Australian Rail Track Corporation Board. She was also Chairperson of the Australian Security Intelligence Organisation's Audit and Risk Commission and Chairperson of the Jigsaw Theatre Company Board. She has chaired the Shipping Workforce Development Forum, the Inquiry into Compliance, Work Health and Safety Laws in the ACT Construction Industry, and the Catholic Development Fund Steering Committee. She was the Independent Project Facilitator for the Millers Point Accommodation Project. During her executive career, she was Australia's Public Service Commissioner and Chief Executive of Medicare Australia.

Philippa Heir – Consumer Member

Philippa Heir is currently the Managing Lawyer – Insurance at the Consumer Action Law Centre in Melbourne. Having started her career in private practice acting for insurers, for the last four years, she has been advising and advocating for consumers experiencing insurance issues. She is also involved in insurance campaigns at Consumer Action, including the Stop Selling Junk campaign, which involved the development of a self-help web tool, DemandARefund.com, to help people seek refunds for add-on insurance. In 2018, Philippa represented and supported two clients to give evidence at the Financial Services Royal Commission about their experience with the insurance industry.

Andrew Cornish – Industry Member

Andy Cornish has more than 40 years' experience in the insurance industry in Australia and overseas. He is an Independent Non-Executive Director of MLC Limited, Chair of the Risk Committee and a member of the Audit Committee, is a Member of the Board of Career Trackers Pty Ltd, Larapinta Connect Pty Ltd and Australia New Car Assessment Programme (ANCAP), and is a Responsible Manager of Asurion Pty Ltd. Andy, who has an MBA from Ashridge Management College, consults and advises various insurers in Australia.

Prior to retiring from executive life in June 2016, Andy was Chief Operations Officer at IAG and prior to that was Chief Executive Officer, Personal Insurance, IAG. He has also served as Chairman and President of the Insurance Council of Australia.

Ian Berg – Industry Member (from 1 July 2014 to 30 June 2018)

Ian retired from FM Global Australia's operations in March 2014 after 35 years with the group. He was Vice President and Operations Manager for Australia, Chief Executive Officer for FM Global in Australia and a director of FM Insurance Co. Ltd. Ian spent five years as a director on the ICA Board. Starting his career as a loss prevention engineer, Ian has worked in engineering, business development, marketing, underwriting and management positions for FM Global in Australia, the UK and the US. Ian is a qualified engineer and a Member of the Australian Institute of Company Directors.

Julie Maron – Consumer Representative (from 1 July 2014 to 31 March 2018)

Julie has been a practicing solicitor since 2001, having worked in private practice and government legal departments in Canberra, before moving to her current role as a senior consumer lawyer for Legal Aid NSW, based in Wagga Wagga in regional NSW.

Julie has assisted hundreds of consumers with insurance matters after natural disasters, including the 2010–2011 Queensland floods, the 2010 and 2012 Riverina floods and the 2013 Warrumbungles bushfire. Julie was the consumer adviser to the Independent Review of the General Insurance Code of Practice.

Brenda Staggs – Consumer Member (from 1 April 2018 to 13 December 2019)

Brenda has been a practicing solicitor since 2001. While studying law, Brenda worked as a senior claims officer with (then) CU Insurance, and then practiced insurance litigation, specialising in major and catastrophic claims. In 2009, she followed her passion for social justice and joined the Redfern Legal Centre, running the centre's TAFE branch for six years. Following that, Brenda joined Legal Aid NSW, combining her passion for justice with her insurance knowledge. Brenda is currently acting as Legal Aid's disaster response coordinator and insurance specialist. Legal Aid NSW has a long history of providing client-centred legal information, advice and assistance to victims of natural disasters. They have a team of over 30 specially trained lawyers on standby to help people solve their problems after a disaster.

Committee's Secretariat

Under an outsourcing agreement, the Code team at AFCA acts as Code administrator, with responsibility for monitoring Code compliance on the Committee's behalf.

Sally Davis – General Manager

Sally Davis began her role as General Manager of the Code team and CEO of the Code Compliance and Monitoring Committee on 1 September 2015. Prior to her appointment to this role, Sally was Senior Manager of Systemic Issues at FOS and has worked at FOS and its predecessor schemes for over 15 years. Sally is a graduate of the Mt Eliza Business School and an accredited mediator. She holds a Bachelor of Commerce and a Bachelor of Laws degree from the University of Melbourne and a Graduate Diploma (Arts) from Monash University.

Sally regularly works with all relevant stakeholders to enhance the knowledge and effectiveness of Codes of Practice in the financial services industry and provides support to the Committees in their monitoring of those Codes, shares insights from monitoring activities and adds value back to industry and consumers.

Rose-Marie Galea – Compliance Manager

Rose-Marie has worked with FOS and its predecessor schemes since 2001 and has been involved in Code compliance monitoring within the general insurance industry since 2003.

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

Appendix 1: Code subscribers as at March 2019

1	1Cover Pty Ltd	90	iSure Pty Ltd
2	AAI Limited	91	Itrek Pty Ltd
3	About Underwriting Pty Ltd	92	Jardine Lloyd Thompson Pty Ltd
4	Advent Insurance Management Pty Limited	93	JMD Ross Insurance Brokers Pty Ltd
5	Agile Underwriting Services Pty Ltd	94	JUA Underwriting Agency Pty Ltd
6	AI Insurance Holdings Pty Ltd	95	LawCover Insurance Pty Limited
7	AIG Australia Ltd	96	Lloyd’s Australia Limited
8	AIOI Nissay Dowa Insurance Company Australia Pty Ltd	97	Lockton Companies Australia Pty Ltd
9	AIS Insurance Brokers Pty Ltd	98	Logan Livestock Insurance Agency Pty Ltd
10	AJ Gallagher t/a Offshore Market Placements Limited	99	London Australia Underwriting Pty Ltd
11	Allianz Australia Insurance Limited	100	Marsh Pty Ltd
12	Amazon Underwriting Pty Ltd	101	Millennium Underwriting Agencies Pty Ltd
13	Ansvar Insurance Limited	102	Miramar Underwriting Agency Pty Ltd
14	ANZ Lenders Mortgage Insurance Pty Ltd	103	Mitsui Sumitomo Insurance Co Ltd
15	AON Risk Services Australia Ltd	104	Mobius Underwriting Pty Ltd
16	Arch Underwriting Agency (Australia) Pty Ltd	105	Morris Group Investments Pty Ltd
17	Arch Underwriting at Lloyd's (Australia) Pty Ltd	106	Newline Australia Insurance Pty Ltd
18	Argenta Underwriting Asia Pte Ltd	107	NM Insurance Pty Ltd
19	ASG Insurance Pty Limited	108	Nova Underwriting Pty Ltd
20	ASR Underwriting Agencies Pty Ltd	109	NTI Limited
21	Assetinsure Pty Ltd	110	NWC Insurance Pty Ltd t/as No worries insurance
22	ATC Insurance Solutions Pty Ltd	111	One Underwriting Pty Ltd
23	Austagencies Pty Ltd	112	OnePath General Insurance Pty Limited
24	Australian Insurance Agency Pool Pty Ltd T/A Fairways Agencies	113	Online Insurance Brokers Pty Ltd
25	Australian Warranty Network Pty Ltd	114	Pacific Underwriting Corporation Pty Ltd
26	Auto & General Insurance Company Limited	115	Panoptic Underwriting Pty Ltd
27	Axis Underwriting Services Pty Ltd	116	Pantaenius Australia Pty Ltd
28	Berkshire Hathaway Specialty Insurance Company	117	PD Insurance Agency Pty Ltd
29	Bizcover Pty Ltd	118	Pen Underwriting Group Pty Ltd
30	Blue Badge Insurance Australia Pty Ltd	119	Pen Underwriting Pty Ltd
31	BMS Risk Solutions Pty Ltd	120	Petplan Australasia Pty Ltd
32	Bovill Risk & Insurance Consultants Pty Ltd	121	Petsure (Australia) Pty Ltd
33	Broadspire by Crawford & Co	122	PI Direct Insurance Brokers Pty Ltd
34	Brooklyn Underwriting Pty Ltd	123	Point Underwriting Agency Pty Ltd
35	Catalyst Consulting (Aust) Pty Ltd	124	Prime Underwriting Agency Pty Ltd
36	Catholic Church Insurance Limited	125	Proclaim Management Solutions Pty Ltd
37	Cerberos Brokers Pty Ltd	126	Procover Underwriting Agency
38	Cerberus Special Risks Pty Ltd	127	Professional Risk Underwriting Pty Ltd
39	Cheap Travel Insurance Pty Ltd	128	QBE Insurance (Australia) Limited
40	Chubb Insurance Australia Limited	129	QBE Lenders’ Mortgage Insurance Limited
41	Claims Management Australasia	130	Quanta Insurance Group Pty Ltd
42	Coastal Marine Underwriting (Pacific) Pty Ltd	131	Quantum Insurance Holdings
43	Coffre-Fort Pty Ltd	132	RAA Insurance Limited

44	Columbus Direct Travel Insurance Pty Ltd	133	RAC Insurance Pty Limited
45	Commercial and Trucksure Pty Ltd	134	RACQ Insurance Limited
46	Commonwealth Insurance Limited	135	RACT Insurance Pty Ltd
47	Coversure Pty Ltd	136	Richard Oliver Underwriting Managers Pty Ltd
48	Credicorp Insurance Pty Ltd	137	Risk Partners Pty Ltd
49	Cunningham Lindsey Australia Pty Ltd	138	RiskSmart Claims Management (part of Honan)
50	Defence Service Homes Insurance Scheme	139	Savannah Insurance Agency Pty Ltd
51	Dracko Insurance Brokers Pty Ltd	140	SLE Worldwide Australia Pty Ltd
52	Dual Australia Pty Ltd	141	Solution Underwriting Agency Pty Ltd
53	Duinsure Pty Ltd	142	Sompo Japan Nipponkoa Insurance Inc
54	East West Insurance Brokers Pty Ltd	143	Southern Cross Benefits Limited
55	Edge Underwriting Pty Ltd	144	Specialist Underwriting Agencies Pty Ltd
56	Elkington Bishop Molieaux Brokers Pty Ltd (also known as EBM Insurance Brokers)	145	Sportscover Australia Pty Ltd
57	Emergence Insurance Pty Ltd	146	Starr Underwriting Agents (Asia) Limited
58	Ensurance Underwriting Pty Ltd	147	StarStone Underwriting Australia
59	Epsilon Underwriting Agencies Pty Ltd	148	Steadfast IRS Pty Ltd
60	Eric Insurance Limited	149	Sterling Insurances Pty Ltd
61	Factory Mutual Insurance Company	150	Sunderland Marine Mutual Insurance Company Limited
62	Fitton Insurance (Brokers) Australia Pty Ltd	151	Sura Hospitality Pty Ltd
63	Fullerton Health Corporate Services	152	Sura Labour Hire Pty Ltd
64	Gallagher Bassett Service Pty Ltd	153	Sura Professional Risks Pty Ltd
65	Gard Insurance Pty Ltd	154	Surafilm & Entertainment Pty Ltd
66	Genesis Underwriting Pty Ltd	155	SureSave Pty Ltd
67	Genworth Financial Mortgage Insurance Pty Ltd	156	SureSeason Australia Pty Ltd
68	Glenowar Pty Ltd (Fenton Green & Co)	157	Swiss Re International SE
69	Go Unlimited Pty Ltd	158	Talbot Underwriting Australia Ltd
70	Gow-Gates Insurance Brokers Pty Ltd	159	The Hollard Insurance Company Pty Ltd
71	Great Lakes Insurance SE	160	The Procare Group Pty Ltd
72	GSA Insurance Brokers Pty Ltd	161	The Tokio Marine & Nichido Fire Insurance Co Ltd
73	Guild Insurance Limited	162	Topsail Insurance Pty Ltd
74	Hallmark General Insurance Company Limited	163	Travel Insurance Direct Pty Ltd
75	High Street Underwriting Agency Pty Ltd	164	Trident Insurance Group Pty Ltd
76	Holdfast Insurance Brokers	165	Trinity Pacific Underwriting Agencies Pty Ltd
77	Honan Insurance Group	166	Triton Global (Australia) Ltd
78	Hostsure Underwriting Agency Pty Ltd	167	Virginia Surety Company Inc
79	HQ Insurance Pty Ltd	168	Westpac General Insurance Limited
80	HW Wood Australia Pty Ltd	169	Windsor Income Protection
81	IBL Ltd (Planned Professional Risks Underwriting Agency)	170	Winsure Underwriting Pty Ltd
82	Imalia Pty Ltd	171	Woodina Underwriting Agency Pty Ltd
83	Inglis Insurance Brokers	172	World Nomads Group Ltd
84	Insurance Advisernet Australia Pty Ltd	173	Wymark Insurance Brokers Pty Ltd
85	Insurance Australia Limited	174	XL Catlin Australia Pty Ltd
86	Insurance Facilitators Pty Ltd	175	XL Insurance Company Ltd
87	Insurance Manufacturers of Australia Pty Limited	176	Youi Pty Ltd
88	Insure That Pty Ltd	177	YourCover Pty Ltd
89	Ironshore Australia Inc	178	Zurich Australian Insurance Ltd

Appendix 2: Aggregated industry data 2017–18

Policies & claims

Insurance class	Individual policies	Group policies	Total policies	Lodged claims	Declined claims	Withdrawn claims
Retail	39,677,119	759,062	40,436,181	4,094,192	164,477	298,043
Wholesale	2,579,865	190,784	2,770,649	565,822	5,537	21,734
Grand Total	**42,256,984**	**949,846**	**43,206,830**	**4,660,014**	**170,014**	**319,777**
Retail						
Motor Retail	15,293,777	26	15,293,803	2,073,674	9, 152	140,238
Home	11,671,384	0	11,671,384	827,785	59,602	107,191
Personal & Domestic Property	7,573,371	435	7,573,806	753,015	60,922	28,760
Travel	3,986,544	733,989	4,720,533	313,172	28,999	18,164
Consumer Credit	669,786	5	669,791	35,853	3,237	1,015
Sickness & Accident	252,167	24,607	276,774	32,233	1,194	1,271
Residential Strata	230,090	0	230,090	58,460	1,398	1,404
Retail Total	**39,677,119**	**759,062**	**40,436,181**	**4,094,192**	**164,477**	**298,043**
Wholesale						
Business Pack	974,212	112,504	1,086,716	113,484	2,012	4,967
Liability	489,872	26,118	515,990	32,672	839	1,313
Business	262,282	9,492	271,774	50,002	1,168	2,195
Motor Wholesale	210,449	36,582	247,031	267,797	190	9,558
Primary Industries Pack	230,085	0	230,085	37,881	598	2,128
Other	203,579	1,911	205,490	12,746	211	140
Primary Industries	131,358	373	131,731	20,812	78	96
Industrial Special Risks	45,616	3,772	49,388	21,506	354	1,017
Contractors All Risks	32,412	32	32,444	8,922	87	320
Wholesale Total	**2,579,865**	**190,784**	**2,770,649**	**565,822**	**5,537**	**21,734**

Group policies and people & assets

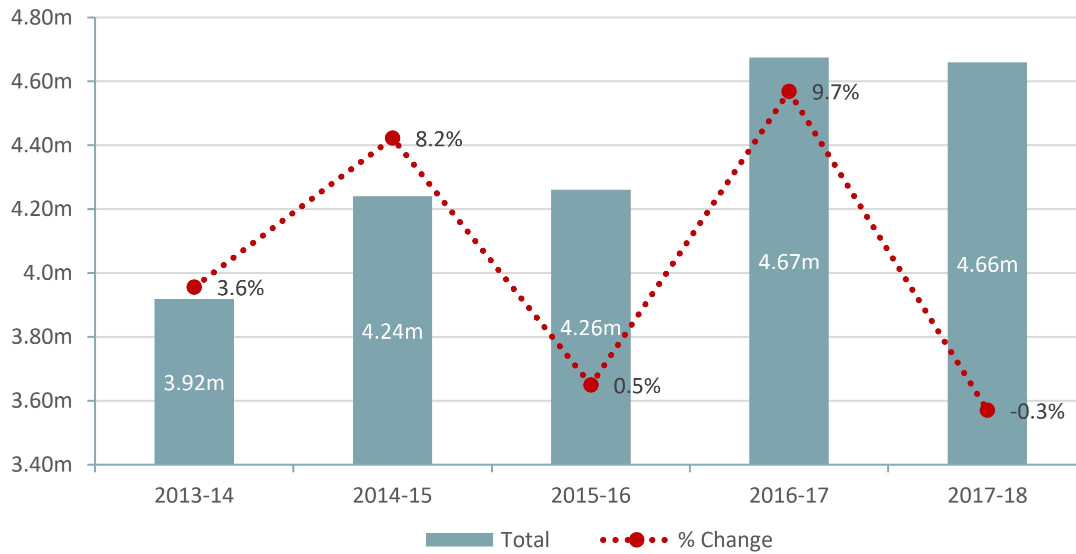
Insurance class	Group policies	People or assets
Retail	759,062	23,932,319
Wholesale	190,784	5,732,425
Grand Total	**949,846**	**29,664,744**
Retail		
Travel	733,989	16,860,956
Sickness & Accident	24,607	6,499,910
Personal & Domestic Property	435	566,226
Motor Retail	26	5,227
Home	0	0
Consumer Credit	5	0
Residential Strata	0	0
Retail Total	**759,062**	**23,932,319**
Wholesale		
Liability	26,118	4,627,516
Motor Wholesale	36,582	783,972
Business Pack	112,504	232,995
Business	9,492	75,539
Industrial Special Risks	3,772	6,810
Primary Industries	373	3,228
Other	1,911	2,365
Primary Industries Pack	0	0
Contractors All Risks	32	0
Wholesale Total	**190,784**	**5,732,425**

Received internal disputes (stage two)

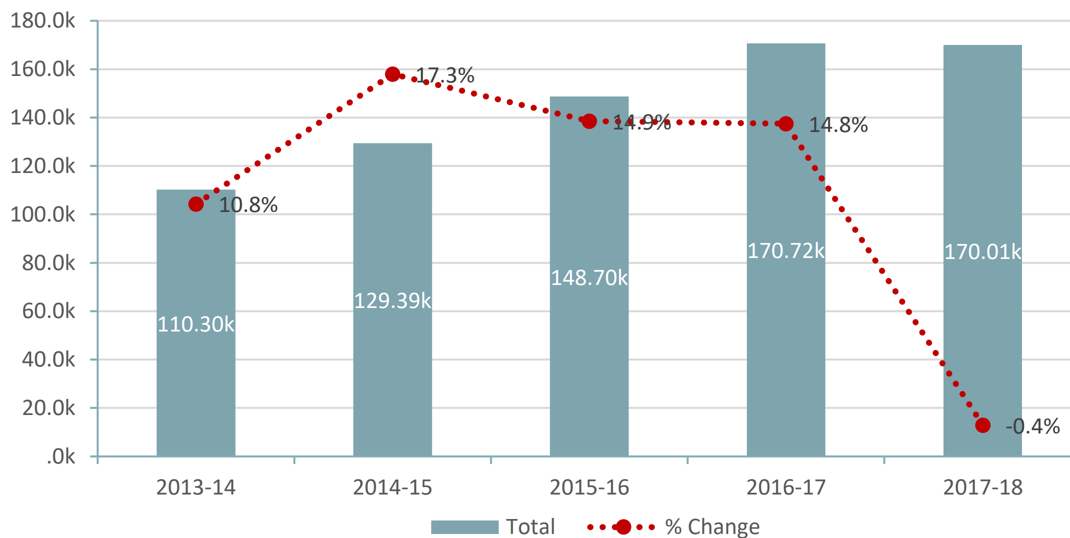
Insurance class	Access to information	Authorised Representatives	Buying	Catastrophes	Claims	Employees	Financial Hardship: Customers	Financial Hardship: Recoveries	Total
Retail	72	102	3,340	653	24,594	280	124	22	29,187
Wholesale	2	1	55	50	1,566	29	8	0	1,711
Grand Total	**74**	**103**	**3,395**	**703**	**26,160**	**309**	**132**	**22**	**30,898**
Retail									
Motor Retail	38	21	2,039	164	10,043	106	88	19	12,518
Home	31	10	955	467	8,722	156	30	3	10,374
Travel	1	2	40	8	3,221	2	0	0	3,274
Personal & Domestic Property	1	1	118	8	1,961	4	2	0	2,095
Consumer Credit	0	18	173	0	176	7	2	0	376
Residential Strata	1	0	11	6	265	5	0	0	288
Sickness & Accident	0	50	4	0	206	0	2	0	262
Retail Total	**72**	**102**	**3,340**	**653**	**24,594**	**280**	**124**	**22**	**29,187**
Wholesale									
Business Pack	1	1	31	29	486	23	2	0	573
Motor Wholesale	0	0	6	4	346	4	2	0	362
Business	1	0	2	0	240	1	1	0	245
Liability	0	0	6	4	160	1	0	0	171
Primary Industries Pack	0	0	4	11	128	0	0	0	143
Other	0	0	4	0	82	0	3	0	89
Primary Industries	0	0	2	0	64	0	0	0	66
Industrial Special Risks	0	0	0	2	55	0	0	0	57
Contractors All Risks	0	0	0	0	5	0	0	0	5
Wholesale Total	**2**	**1**	**55**	**50**	**1,566**	**29**	**8**	**0**	**1,711**

Appendix 3: Five-year data overviews

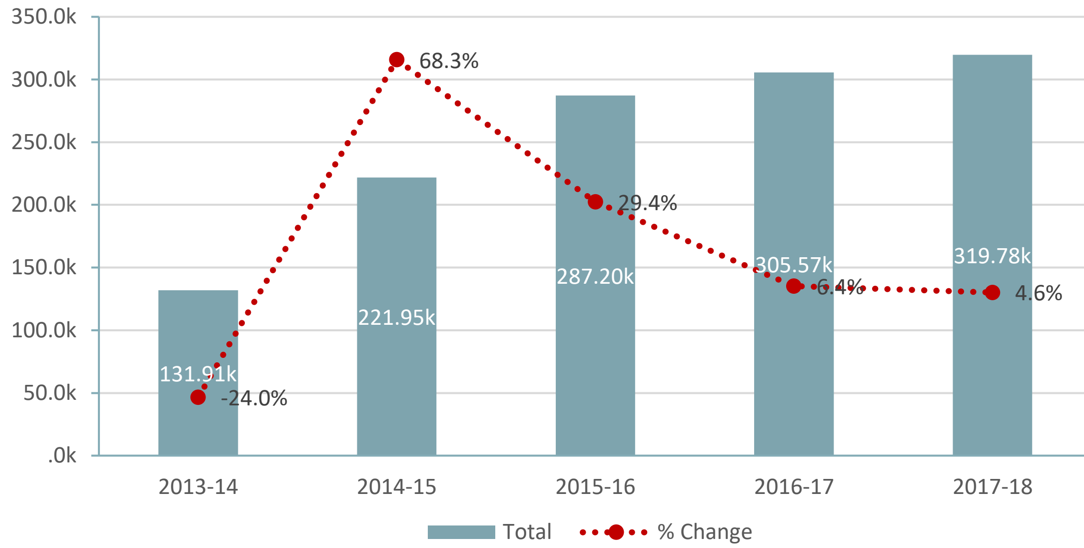
Lodged claims



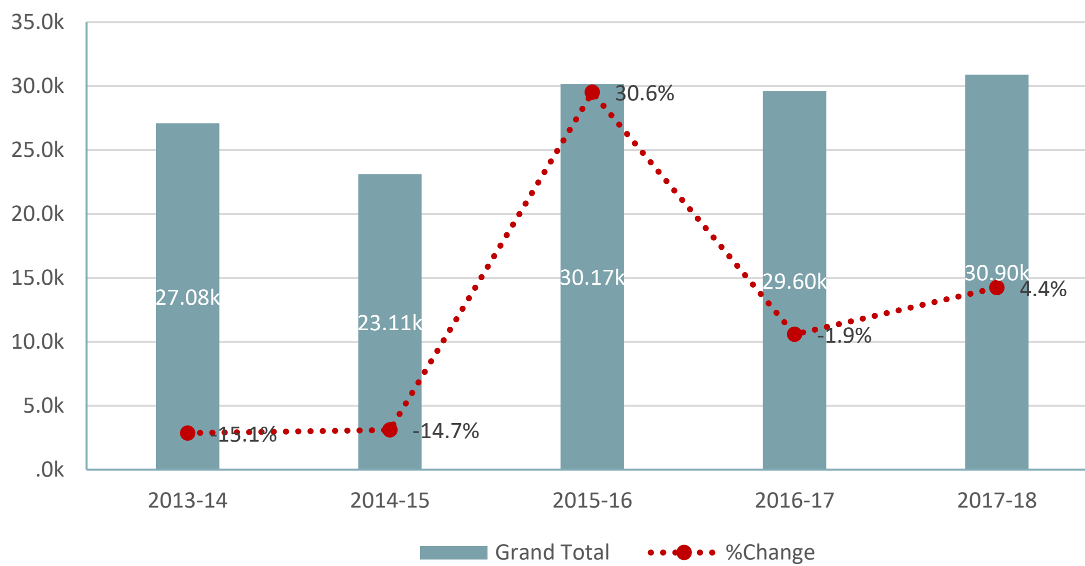
Declined claims



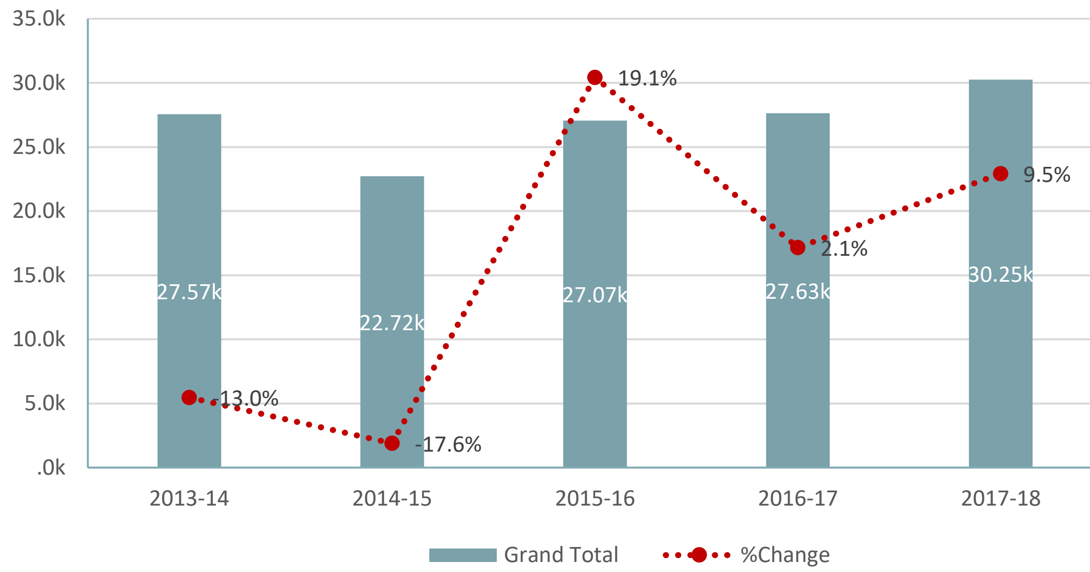
Withdrawn claims



Received internal disputes (stage two)



Reviewed internal disputes (stage two)



Appendix 4: Aggregated Code breach data 2017–18

The aggregated breach data presented in Appendix 4 comprises data from all sources: breaches and significant breaches identified by the Code Governance Committee (CGC), and breaches and significant breaches reported by Code subscribers.

Breaches by Code category and source

	Identified by CGC	Significant breaches	Identified by subscribers	Total
4 Buying insurance	2	7	624	633
5 Standards for Employees & Authorised Representatives	1		54	55
6 Standards for Service Suppliers	4		11	15
7 Claims	17	11	6,565	6,593
8 Financial hardship	52		42	94
9 Catastrophes			172	172
10 Complaints and disputes	7	4	4,076	4,087
11 Information & Education			4	4
13 Monitoring, enforcement & sanctions			2	2
14 Access to Information	6		113	119
Grand Total	**89**	**22**	**11,663**	**11,774**

Top five areas of non-compliance

Code section	Breaches
7.19 (a-d) - Denial of claim	1,932
10.13 (a-d) - Respond to complaint in writing	1,556
7.13 - Inform on claim progress every 20 business days	1,053
7.10 (a-c) - Notify within 10 business days of further info/assessment required	694
7.21 (a-c) - Must comply within timetables	691
Grand Total	**5,926**

Breaches by Code category and subsection

4 Buying insurance Note: "AR" means "authorised representatives"	Identified by CGC	Significant breaches	Identified by subscribers	Total
4.9 – If consumer/small business is entitled to cancel policy, must refund money owed within 15 business days.		2	433	435
4.4 - Sales processes and services of employees/AR must be efficient, honest, fair and transparent.	2	5	80	87
4.8(a-d) – What subscriber will do if can't provide insurance.			39	39
4.8(c) – Refer consumer/small business to ICA/NIBA for alternative insurance options.			29	29
4.7 - Correct errors or mistakes related to application or when assessing application.			23	23
4.6 - Ask for and rely on relevant information or documents only in assessing application.			12	12
4.10(a-b) – Provide written notice of instalment non-payment at least 14 calendar days prior to cancellation.			6	6
4.8(b) – If consumer/small business asks, supply requested information underlying assessment of application.			2	2
Grand Total	**2**	**7**	**624**	**633**

5 Standards for Employees & Authorised Representatives (AR)	Identified by CGC	Significant breaches	Identified by subscribers	Total
5.3 - AR to inform consumer/small business of subscriber's identity and services provided on its behalf.			20	20
5.1(a) – Education and training of employees/AR to ensure competent and professional services	1		13	14
5.1(c) - Monitoring performance of employees/AR to measure training effectiveness.			9	9
5.1(a-e) – Education, training and monitoring of employees/AR.			5	5
5.1(b) - Employees/AR to provide services within their expertise.			4	4
5.1(d) – Education and training to correct employees/AR shortcomings.			2	2
5.2 - AR to notify subscriber of complaints and must handle these under its complaints process.			1	1
Grand Total	**1**		**54**	**55**

6 Standards for Service Suppliers	Identified by Committee	Significant breaches	Identified by subscribers	Total
6.2 - Service suppliers must provide their services honestly, efficiently, fairly and transparently.	2		8	10
6.7 - Service suppliers to notify subscriber of complaints and these must be handled under its complaints process.	2		2	4
6.3(a) – Must use qualified service suppliers to provide competent and professional service.			1	1

Grand Total	4		11	15

7 Claims	Identified by CGC	Significant breaches	Identified by subscribers	Total
7.19(a) - Reasons for decision must be in writing.	1		1,467	1,468
7.13 - Inform consumer/small business about claim progress every 20 business days.	1	2	1,050	1,053
7.16 - Decision made once all info/enquiries received/completed & notification within 10 business days of decision		2	605	607
7.9 - Notify within 10 business days of claim acceptance/denial		1	577	578
7.10(c) - Provide initial estimate of timetable/decision making process			443	443
7.14 - Respond to routine requests within 10 business days	1	1	303	305
7.21(c) - Cause of non-compliance if External Expert report delay & best endeavours used to obtain report			256	256
7.21(a) - Comply within agreed alternative timetable			227	227
7.21(b) - Conduct/timetable reasonable in the circumstances			207	207
7.10(a) - Notify of any information required to make decision			183	183
7.2 - Claims handling fair, transparent and timely	7	2	172	181
7.19(b) - Inform of right to ask for info relied on in assessing claim – supply within 10 business days			178	178
7.19(c) - Inform of right to ask for copies of service suppliers or external expert reports – supply within 10 business days			125	125
7.12 - Notify within 5 business days of loss assessor/adjuster/investigator appointment			103	103
7.11 - Claim assessed on basis of facts, policy terms and law	1		101	102
7.8 - Prior to lodging claim consumer/small business can ask if policy covers loss. Will not discourage claim lodgement.	2		97	99
7.19(d) - Provide details of complaints process to consumer/small business			82	82
7.19(a-d) - Denial of claim			78	78
7.17 – Claim decision made within 4 months of receiving claim unless exceptional circumstances apply. If no decision, must provide details of complaints process.		1	68	69

7 Claims	Identified by CGC	Significant breaches	Identified by subscribers	Total
7.10(a-c) - Within 10 business days notify consumer/small business of further info/assessment required		1	63	64
7.20(a-b) - Selection & authorisation of repairer by subscriber.			37	37
7.3 - Ask for and rely on relevant information only when deciding claim.			30	30
7.4 - Correct errors or mistakes in dealing with claim.			22	22
7.15 – Provide External Expert report to consumer/small business within 12 weeks of engagement or inform of report progress/delay.			21	21
7.7(a) - Fast track claim assessment/decision process			12	12
7.7(b) - Advance payment within 5 business days to alleviate hardship			12	12
7.5 - Reasonable alternative time frame		1	11	12
7.20(b) - Handle any complaint re quality/timeliness/conduct of work/repairer			8	8
7.22 - Timetable compliance doesn't apply if court/tribunal/EDR commenced (except AFCA)			7	7
7.20(a) - Accept responsibility for materials/workmanship quality	2		3	5
7.6 - Complaints process available to policy holders			5	5
7.10(b) - Appointment of loss assessor/adjuster			4	4
7.18 - Decision made within 12 months if exceptional circumstances apply. If no decision, provide details of complaints process.			4	4
7.7(a-c) - Urgent financial need of benefit under policy			2	2
7.21(a-c) - Must comply within timetables			1	1
7.7(c) - Provide details of complaints process			1	1
7.3 - Ask for/rely on relevant information only in deciding claim	1			1
7.19(c) - Inform of right to request copies of service suppliers/external expert reports, to be supplied within 10 business days	1			1
Grand Total	**17**	**11**	**6,565**	**6,593**

8 Financial hardship	Identified by CGC	Significant breaches	Identified by subscribers	Total
8.10 - Any communication from agent re money owed will identify insurer and specify nature of claim	35			35
8.4 - Upon informing of financial hardship, must supply financial hardship application & counselling hotline	4		20	24
8.6 - Notify as reasonably practicable of financial hardship assessment. If no entitlement, provide reasons for decision & info on complaints process	3		9	12
8.12 - Any recovery action must comply with ACCC/ASIC guidelines	6		2	8
8.8(a-e) - Entitled to financial hardship assistance			6	6
8.7 - Collections put on hold until financial hardship request is assessed & notification of decision given.	1		2	3
8.11 - Agents notified of financial hardship required to provide details of financial hardship process	2			2
8.3 - If money owed & experiencing financial hardship may ask if entitled to assistance			1	1
8.8(d) - If release/discharge/waiver agreed to, confirm in writing & if requested, notify any finance	1			1
8.13 - If declaring bankruptcy, work together to provide written confirmation of debt owed. If no agreement, provide details of complaints process			1	1
8.5(a-b) - Reasonable evidence may assist in assessing financial hardship assistance			1	1
Grand Total	**52**		**42**	**94**

9 Catastrophes	Identified by CGC	Significant breaches	Identified by subscribers	Total
9.3(b) - Inform consumer/small business of complaints process when property claim finalised.			87	87
9.3(a) - Inform consumer/small business of entitlement to review claim decision when property claim finalised.			81	81
9.3(a-b) - If property claim finalised within 1 month of catastrophe, consumer/small business may request a review within 12 months of decision, even if released signed.			4	4
Grand Total			**172**	**172**

10 Complaints & Disputes	Identified by CGC	Significant breaches	Identified by subscribers	Grand Total
10.13(a-d) - Respond to complaint in writing.		1	1,383	1,384
10.10 - Stage 1 & 2 of complaints process not to exceed 45 calendar days. If unable to provide decision must inform consumer/small business of reasons for delay & right to go to AFCA.			562	562
10.4 - Complaints handling must be fair, transparent and timely.	4	1	392	397
10.16 - Inform consumer/small business of progress every 10 business days.			284	284
10.5 - Inform consumer/small business of right to make complaint & complaints process on website and in written communications.			271	271
10.11 - Respond to complaint within 15 business days if subscriber has all necessary information and completed investigation.	2		254	256
10.12(a-b) – What subscriber will do if can't respond to complain within 15 business days.			181	181
10.8 - Notify consumer/small business of name and contact details of employee assigned to handle complaint.			149	149
10.9 - Complaints process doesn't apply if complaint resolved within 5 business days & response not requested in writing, excluding complaints about a declined claim, claim value or financial hardship.			108	108
10.18 - Notify consumer/small business as soon as reasonably practicable within 15 business days of reasons for delay & agree on reasonable timeframe. If no agreement, advise consumer/small business of right to go to AFCA.			103	103
10.13(a) – Complaint decision must be in writing.		1	70	71
10.13(c) – Consumer/small business has right to take complaint to stage 2 if not satisfied with stage 1 decision.			57	57
10.17 – Within 15 business days of escalation of complaint to stage 2, subscriber must respond to complaint if it has all necessary information and completed investigation.	1		43	44
10.12(a) – Notify consumer/small business as reasonably practicable within 15 business days of response delay & agree to reasonable timeframe. If no agreement, advise consumer of right to move to stage 2.			34	34
10.13(b) – Provide reasons for decision in writing.		1	26	27
10.14 - If consumer/small business not satisfied with stage 1 decision, can ask subscriber to move to stage 2.			24	24
10.19(b) - Notify consumer/small business of right to go to AFCA including AFCA timeframe and contact details.			22	22

10 Complaints & Disputes	Identified by CGC	Significant breaches	Identified by subscribers	Grand Total
10.19(a-b) - Response to complaint must be in writing.			19	19
10.13(d) - If consumer/small business not satisfied with stage 2 decision, notify of right to go to AFCA.			17	17
10.19(a) - Final decision on complaint & reasons must be in writing.			17	17
10.6 - Only ask for and rely on relevant information when dealing with complaint. If consumer/small business asks, supply information relied on within 10 business days.			14	14
10.3 – Consumer/small business entitled to make complaint about any aspect of relationship with subscriber.			13	13
10.12(b) – Inform consumer/small business of progress every 10 business days unless otherwise agreed.			12	12
10.7 - Correct errors and mistakes in complaint handling.			11	11
10.15 - Stage 2 complaint must be reviewed by appropriately qualified and authorised employee(s). Where practicable employee should not be same employee who handled stage 1 or who was subject of complaint.			6	6
10.23 - AFCA determinations are binding on subscribers.			2	2
10.22 - If not satisfied with stage 2 decision or if complaint unresolved within 45 calendar days, consumer/small business entitled to refer complaint to AFCA.			2	2
Grand Total	**7**	**4**	**4,076**	**4,087**

11 Information & Education	Identified by CGC	Significant breaches	Identified by subscribers	Total
11.6 - Provide code info on website/product info			4	4
Grand Total			**4**	**4**

13 Monitoring, enforcement & sanctions	Identified by CGC	Significant breaches	Identified by subscribers	Total
13.2(b) - Prepare annual return to CGC on code compliance			1	1
13.2(a) - Have appropriate systems/processes to enable CGC compliance monitoring			1	1
Grand Total			**2**	**2**

14 Access to information	Identified by CGC	Significant breaches	Identified by subscribers	Total
14.1 - Abide by privacy laws when collecting, storing, disclosing personal information.			110	110
14.2 - If asked by consumer/small business, provide access to information relied on.	1		2	3
14.5(b) – If not giving access or disclosing information, provide reasons.	1			1
14.5(a) - Will not deny access or disclosure unreasonably.	1			1
14.3 - If asked by consumer/small business, give access to reports of Service Suppliers or External Experts relied on.	1			1
14.5(c) - Provide details of complaints process.	1			1
14.5(a-c) – What subscriber will do when declining access or disclosure.			1	1
14.4(a-c) - May decline access in special circumstances.	1			1
Grand Total	**6**		**113**	**119**

Appendix 5: Comparative data

Total policies (individual + group)

Insurance class	2016-17	2017-18	No. (Change)	Percent (Change)
Retail				
Motor Retail	15,158,680	15,293,803	135,123	0.9%
Home	11,793,921	11,671,384	-122,537	-1.0%
Personal & Domestic Property	7,202,947	7,573,806	370,859	5.1%
Travel	5,695,318	4,720,533	-974,785	-17.1%
Consumer Credit	810,244	669,791	-140,453	-17.3%
Sickness & Accident	320,137	276,774	-43,363	-13.5%
Residential Strata	212,369	230,090	17,721	8.3%
Retail Total	**41,193,616**	**40,436,181**	**-757,435**	**-1.8%**
Wholesale				
Business Pack	1,143,225	1,086,716	-56,509	-4.9%
Liability	520,834	515,990	-4,844	-0.9%
Business	421,474	271,774	-149,700	-35.5%
Motor Wholesale	262,739	247,031	-15,708	-6.0%
Primary Industries Pack	217,874	230,085	12,211	5.6%
Other	203,253	205,490	2,237	1.1%
Primary Industries	144,055	131,731	-12,324	-8.6%
Industrial Special Risks	49,433	49,388	-45	-0.1%
Contractors All Risks	32,896	32,444	-452	-1.4%
Wholesale Total	**2,995,783**	**2,770,649**	**-225,134**	**-7.5%**
Grand Total	**44,189,399**	**43,206,830**	**-982,569**	**-2.2%**

Individual policies only

Insurance class	2016-17	2017-18	No. (Change)	Percent (Change)
Retail				
Motor Retail	15,158,665	15,293,777	135,112	0.9%
Home	11,793,921	11,671,384	-122,537	-1.0%
Personal & Domestic Property	7,202,779	7,573,371	370,592	5.1%
Travel	5,503,298	3,986,544	-1,516,754	-27.6%
Consumer Credit	810,164	669,786	-140,378	-17.3%
Sickness & Accident	300,058	252,167	-47,891	-16.0%
Residential Strata	212,266	230,090	17,824	8.4%
Retail Total	**40,981,151**	**39,677,119**	**-1,304,032**	**-3.2%**
Wholesale				
Business Pack	1,039,726	974,212	-65,514	-6.3%
Liability	495,070	489,872	-5,198	-1.0%
Business	403,843	262,282	-141,561	-35.1%
Primary Industries Pack	217,874	230,085	12,211	5.6%
Motor Wholesale	230,359	210,449	-19,910	-8.6%
Other	203,044	203,579	535	0.3%
Primary Industries	144,048	131,358	-12,690	-8.8%
Industrial Special Risks	47,733	45,616	-2,117	-4.4%
Contractors All Risks	32,896	32,412	-484	-1.5%
Wholesale Total	**2,814,593**	**2,579,865**	**-234,728**	**-8.3%**
Grand Total	**43,795,744**	**42,256,984**	**-1,538,760**	**-3.5%**

Group policies only

Insurance class	2016-17	2017-18	No. (Change)	Percent (Change)
Retail				
Travel	192,020	733,989	541,969	282.2%
Sickness & Accident	20,079	24,607	4,528	22.6%
Personal & Domestic Property	168	435	267	158.9%
Motor Retail	15	26	11	73.3%
Consumer Credit	80	5	-75	-93.8%
Home	0	0	0	0.0%
Residential Strata	103	0	-103	-100.0%
Retail Total	**212,465**	**759,062**	**546,597**	**257.3%**
Wholesale				
Business Pack	103,499	112,504	9,005	8.7%
Motor Wholesale	32,380	36,582	4,202	13.0%
Liability	25,764	26,118	354	1.4%
Business	17,631	9,492	-8,139	-46.2%
Industrial Special Risks	1,700	3,772	2,072	121.9%
Other	209	1,911	1,702	814.4%
Primary Industries	7	373	366	5228.6%
Contractors All Risks	0	32	32	0.0%
Primary Industries Pack	0	0	0	0.0%
Wholesale Total	**181,190**	**190,784**	**9,594**	**5.3%**
Grand Total	**393,655**	**949,846**	**556,191**	**141.3%**

People and assets

Insurance class	2016-17	2017-18	No. (Change)	Percent (Change)
Retail				
Travel	7,948,208	16,860,956	8,912,748	112.1%
Sickness & Accident	5,261,685	6,499,910	1,238,225	23.5%
Personal & Domestic Property	507,733	566,226	58,493	11.5%
Motor Retail	12,341	5,227	-7,114	-57.6%
Home	0	0	0	0.0%
Consumer Credit	0	0	0	0.0%
Residential Strata	119	0	-119	-100.0%
Retail Total	**13,730,086**	**23,932,319**	**10,202,233**	**74.3%**
Wholesale				
Liability	2,451,043	4,627,516	2,176,473	88.8%
Motor Wholesale	569,736	783,972	214,236	37.6%
Business Pack	208,849	232,995	24,146	11.6%
Business	114,066	75,539	-38,527	-33.8%
Industrial Special Risks	2,914	6,810	3,896	133.7%
Primary Industries	3,717	3,228	-489	-13.2%
Other	24,770	2,365	-22,405	-90.5%
Primary Industries Pack	0	0	0	0.0%
Contractors All Risks	0	0	0	0.0%
Wholesale Total	**3,375,095**	**5,732,425**	**2,357,330**	**69.8%**
Grand Total	**17,105,181**	**29,664,744**	**12,559,563**	**73.4%**

Lodged claims

Insurance class	2016-17	2017-18	No. (Change)	Percent (Change)
Retail				
Motor Retail	2,041,215	2,073,674	32,459	1.6%
Home	900,894	827,785	-73,109	-8.1%
Personal & Domestic Property	677,000	753,015	76,015	11.2%
Travel	290,466	313,172	22,706	7.8%
Residential Strata	64,405	58,460	-5,945	-9.2%
Consumer Credit	41,117	35,853	-5,264	-12.8%
Sickness & Accident	29,198	32,233	3,035	10.4%
Retail Total	**4,044,295**	**4,094,192**	**49,897**	**1.2%**
Wholesale				
Motor Wholesale	264,645	267,797	3,152	1.2%
Business Pack	127,547	113,484	-14,063	-11.0%
Business	73,748	50,002	-23,746	-32.2%
Primary Industries Pack	61,860	37,881	-23,979	-38.8%
Liability	33,994	32,672	-1,322	-3.9%
Industrial Special Risks	22,591	21,506	-1,085	-4.8%
Primary Industries	25,071	20,812	-4,259	-17.0%
Other	12,633	12,746	113	0.9%
Contractors All Risks	7,771	8,922	1,151	14.8%
Wholesale Total	**629,860**	**565,822**	**-64,038**	**-10.2%**
Grand Total	**4,674,155**	**4,660,014**	**-14,141**	**-0.3%**

Declined claims

Insurance class	2016-17	2017-18	No. (Change)	Percent (Change)
Retail				
Consumer Credit	4,052	3,237	-815	-20.1%
Home	59,381	59,602	221	0.4%
Motor Retail	11,236	9,125	-2,111	-18.8%
Personal & Domestic Property	53,156	60,922	7,766	14.6%
Residential Strata	1,209	1,398	189	15.6%
Sickness & Accident	858	1,194	336	39.2%
Travel	34,198	28,999	-5,199	-15.2%
Retail Total	**164,090**	**164,477**	**387**	**0.2%**
Wholesale				
Business	820	1,168	348	42.4%
Business Pack	2,986	2,012	-974	-32.6%
Contractors All Risks	26	87	61	234.6%
Industrial Special Risks	491	354	-137	-27.9%
Liability	775	839	64	8.3%
Motor Wholesale	287	190	-97	-33.8%
Other	210	211	1	0.5%
Primary Industries	475	78	-397	-83.6%
Primary Industries Pack	560	598	38	6.8%
Wholesale Total	**6,630**	**5,537**	**-1,093**	**-16.5%**
Grand Total	**170,720**	**170,014**	**-706**	**-0.4%**

Withdrawn claims

Insurance class	2016-17	2017-18	No. (Change)	Percent (Change)
Retail				
Consumer Credit	1,196	1,015	-181	-15.1%
Home	98,569	107,191	8,622	8.7%
Motor Retail	129,067	140,238	11,171	8.7%
Personal & Domestic Property	42,525	28,760	-13,765	-32.4%
Residential Strata	1,020	1,404	384	37.6%
Sickness & Accident	534	1,271	737	138%
Travel	11,506	18,164	6,658	57.9%
Retail Total	**284,417**	**298,043**	**13,626**	**4.8%**
Wholesale				
Business	1,075	2,195	1,120	104.2%
Business Pack	5,227	4,967	-260	-5.0%
Contractors All Risks	54	320	266	492.6%
Industrial Special Risks	1,086	1,017	-69	-6.4%
Liability	1,164	1,313	149	12.8%
Motor Wholesale	10,861	9,558	-1,303	-12.0%
Other	400	140	-260	-65.0%
Primary Industries	766	96	-670	-87.5%
Primary Industries Pack	522	2,128	1,606	307.7%
Wholesale Total	**21,155**	**21,734**	**579**	**2.7%**
Grand Total	**305,572**	**319,777**	**14,205**	**4.6%**

Received internal disputes (stage two)

Insurance class	2016-17	2017-18	No. (Change)	Percent (Change)
Retail				
Motor Retail	12,330	12,518	188	1.5%
Home	9,753	10,374	621	6.4%
Travel	2,263	3,274	1,011	44.7%
Personal & Domestic Property	2,274	2,095	-179	-7.9%
Consumer Credit	569	376	-193	-33.9%
Residential Strata	393	288	-105	-26.7%
Sickness & Accident	337	262	-75	-22.3%
Retail Total	**27,919**	**29,187**	**1,268**	**4.5%**
Wholesale				
Business Pack	454	573	119	26.2%
Motor Wholesale	316	362	46	14.6%
Business	214	245	31	14.5%
Liability	318	171	-147	-46.2%
Primary Industries Pack	211	143	-68	-32.2%
Other	101	89	-12	-11.9%
Primary Industries	7	66	59	842.9%
Industrial Special Risks	63	57	-6	-9.5%
Contractors All Risks	1	5	4	400.0%
Wholesale Total	**1,685**	**1,711**	**26**	**1.5%**
Total	**29,604**	**30,898**	**1,294**	**4.4%**

Reviewed internal disputes (stage two)

Insurance class	2016-17	2017-18	No. (Change)	Percent (Change)
Retail				
Motor Retail	11,798	12,118	320	2.7%
Home	9,082	10,291	1,209	13.3%
Travel	1,967	3,275	1,308	66.5%
Personal & Domestic Property	2,103	2,089	-14	-0.7%
Consumer Credit	553	347	-206	-37.3%
Residential Strata	353	278	-75	-21.2%
Sickness & Accident	329	262	-67	-20.4%
Retail Total	**26,185**	**28,660**	**2,475**	**9.5%**
Wholesale				
Business Pack	378	540	162	42.9%
Motor Wholesale	276	335	59	21.4%
Business	194	228	34	17.5%
Liability	264	168	-96	-36.4%
Primary Industries Pack	178	139	-39	-21.9%
Other	92	64	-28	-30.4%
Primary Industries	6	59	53	883.3%
Industrial Special Risks	57	49	-8	-14.0%
Contractors All Risks	1	4	3	300.0%
Wholesale Total	**1,446**	**1,586**	**140**	**9.7%**
Total	**27,631**	**30,246**	**2,615**	**9.5%**

Appendix 6: Glossary of terms

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

Authorised Representative means a person, company or other entity authorised by a **Code subscriber** to provide financial services on its behalf under its Australian Financial Services licence, in accordance with the Corporations Act 2001. An **authorised representative** is a type of **external seller**.

Breach means a failure to comply with a **Code** standard.

CGC or Code Governance Committee means the independent body responsible for monitoring, reporting and enforcing **Code** compliance.

Claim means a formal request from an insured or third party beneficiary for coverage of loss or damage under a general insurance policy.

Code means the 2014 General Insurance Code of Practice.

Code subscriber means an organisation that has adopted the **Code**.

Code Team means the Code Compliance and Monitoring Team at the Financial Ombudsman Service Limited (FOS) appointed as code administrator to monitor **Code** compliance on behalf of the **CGC**.

Complaint means an expression of dissatisfaction made to a **Code subscriber**, related to its products or services, or its **complaints** handling process, where a response or resolution is explicitly or implicitly expected.

Corporate authorised representative means a company authorised by a **Code subscriber** to provide financial services on its behalf under its Australian Financial Services license (AFSL), in accordance with the Corporations Act 2001. A **corporate authorised representative** is a type of **external seller**.

Data set means a collection of related sets of information.

Declined claim means a **claim** on a general insurance policy that a **Code subscriber** has declined or not accepted.

Dispute means a **complaint** that is at or has completed **Stage Two** of a **Code subscriber's internal complaints process**.

Dispute type means a category used to aggregate data about similar types of **disputes.**

Employee means a person employed by a **Code Subscriber**, or related entity, that provides services to which the **Code** applies.

External seller means a person, company or other entity that sells or offers for sale a **Code subscriber's** general insurance products.

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

Individual authorised representative means a person or partnership authorised by **a Code subscriber** to provide financial services on its behalf under its Australian Financial Services license (AFSL), in accordance with the Corporations Act 2001.

Individual policy means a general insurance policy held by an **insured** that is not a **group policy**.

Contractor means a person, company or other entity engaged by a **Code subscriber** to provide insurance-related services, excluding the distribution of general insurance products.

Industry data means data about:

1. workforce,
2. compliance,
3. policies,
4. claims,
5. declined claims,
6. withdrawn claims and
7. internal disputes.

Insurance class means a category used to aggregate data about similar types of general insurance products.

Insured means a person, company or entity seeking to hold or holding a general insurance product covered by the **Code**, but excludes a **third party beneficiary**.

Internal complaints process means a **Code Subscriber's** internal process for dealing with **complaints**, broadly defined by subsections 10.3 to 10.10 of the **Code** and comprising **Stage One** and **Stage Two**.

Lodged claim means a **claim** made on a general insurance policy.

Other external seller means a person, company or other entity that is not an **authorised representative** but is engaged in the distribution of a **Code subscriber's** general insurance products.

Policy means a contract of insurance.

Retail Insurance means a general insurance product that is provided to, or to be provided to, an individual or for use in connection with a **Small Business**, and is one of the following types:

a) a motor vehicle insurance product (Regulation 7.1.11);
b) a home building insurance product (Regulation 7.1.12);
c) a home contents insurance product (Regulation 7.1.13);
d) a sickness & accident insurance product (Regulation 7.1.14);
e) a consumer credit insurance product (Regulation 7.1.15);
f) a travel insurance product (Regulation 7.1.16); or
g) a personal & domestic property insurance product (Regulation 7.1.17), as defined in the Corporations Act 2001 and the relevant Regulations.

Service Supplier means an **Investigator**, **Loss Assessor or Loss Adjuster**, **Collection Agent**, **Claims Management Service** (including a broker who manages claims on behalf of an insurer) or its approved sub-contractors acting on behalf of a Code Subscriber.

Small Business means a business that employs:
(a) less than 100 people, if the business is or includes the manufacture of goods; or
(b) otherwise, less than 20 people.

Stage One means the first stage of a **Code subscriber's internal complaints process** and is described in subsections 10.11, 10.12 and 10.13 of the **Code.**

Stage Two means the second stage of a **Code subscriber's internal complaints process** and is described in subsections 10.14 to 10.19 of the **Code.**

Third party beneficiary means a person, company or entity who is not an **insured** but is seeking to be or is specified or referred to in a general insurance policy covered by the **Code**, whether by name or otherwise, as a person to whom the benefit of the insurance cover provided by the **policy** extends.

Withdrawn claim means a **claim** that does not proceed to a decision to accept or deny it and includes a **claim** that may be described as "cancelled", "closed", "discontinued" or "withdrawn".

Wholesale Insurance means a general insurance product covered by the **Code** which is not **Retail Insurance**.