General Insurance Open Forum

11 October 2019

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Australian Financial Complaints Authority

Todays agenda

- AFCA update
  - A snapshot on complaints numbers
  - Complaint statistics for General Insurance
  - Public reporting
  - Legacy complaints
- Code Update
- Fairness Project
- Open discussion
- Q&A

Slide 2

AFCA Financial Fairness Roadshow

77+ Locations across Australia

September – November 2019

- Tasmania
- Victoria
- Canberra
- Regional NSW

February – April 2020

- Sydney
- Queensland
- Western Australia
- South Australia
- Northern Territory

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AFCA update

Jacinta Ryan, Senior Manager -
Investment and Insurance

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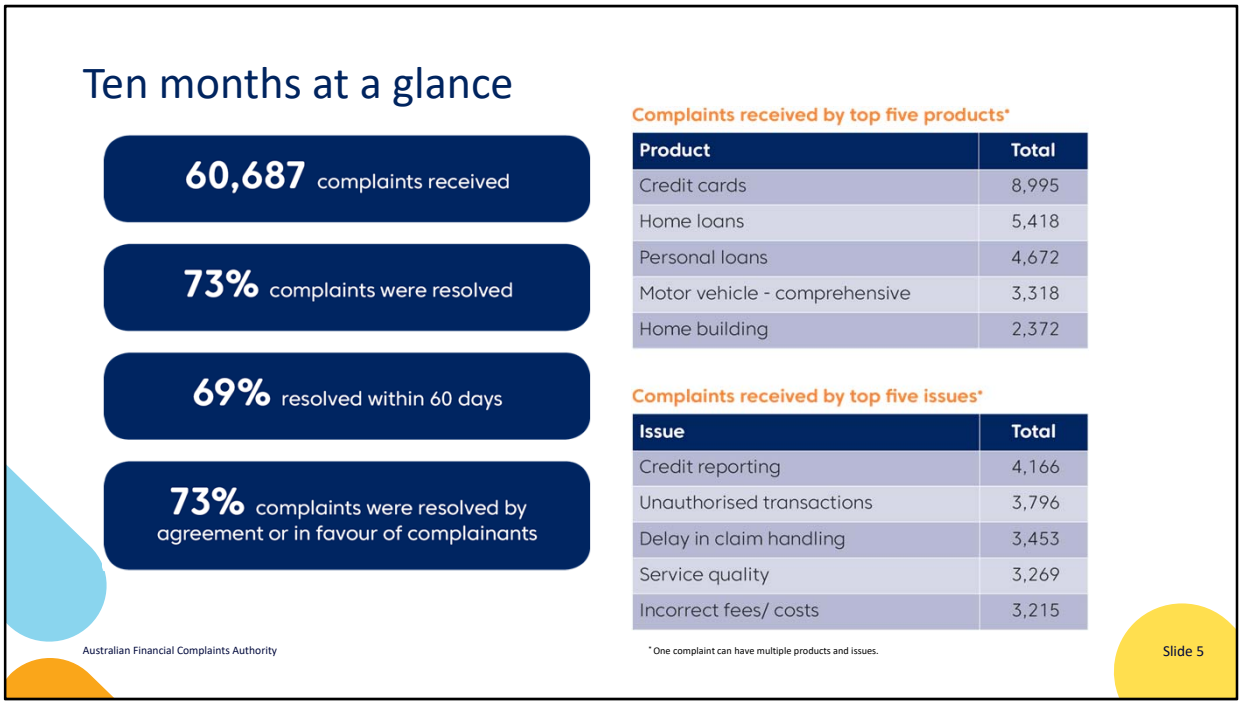
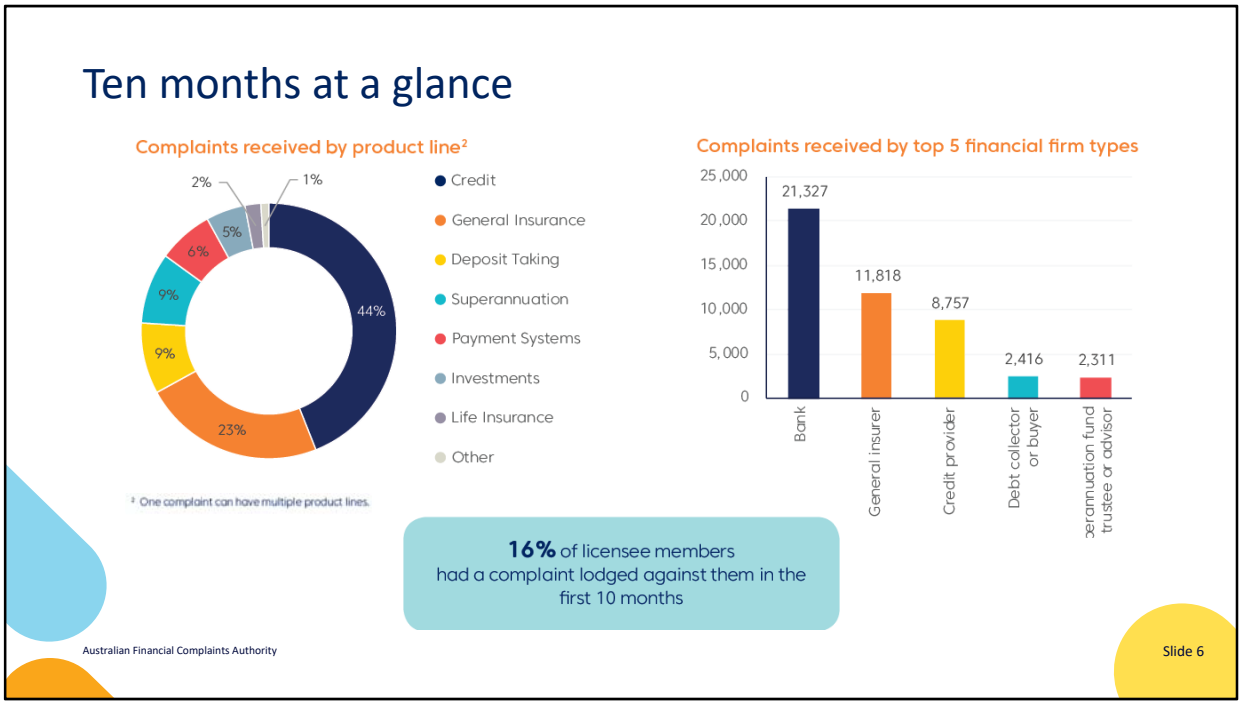


In its first ten months AFCA has received over 60,000 complaints with more than 73% of those already resolved, most within xx days of lodgement.



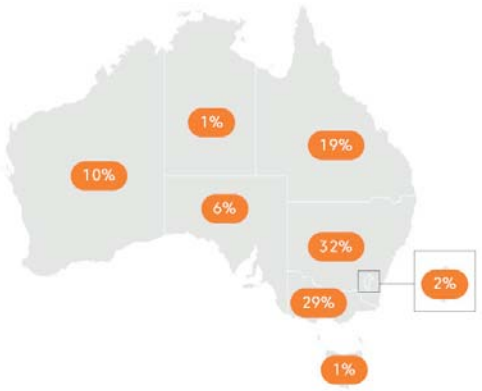
Data and transparency: Our priority is to provide information to consumers, small businesses and financial firms in a way that is accessible and useful.

Working with members: We provide clarity and certainty around the complaint resolution processes and support members to develop and strengthen their own internal processes.

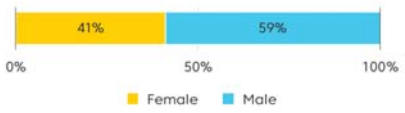
AFCA recognises that we have a significant role in rebuilding trust in the Australian financial services sector.

Who lodged complaints

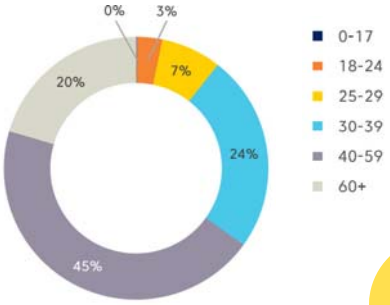
Complaints received by location



Complaints received by gender



Complaints received by age



Areas of concern

- Growing number of financial difficulty cases
- Ensuring awareness of AFCA
- Systemic issues and serious misconduct
- Members slow to respond to complaints when referred back – timeliness in response to AFCA
- Members failing to ensure customers know about EDR (only 1 in 5 are informed at IDR about the ombudsman)
- Firm remediation programs – design, reach, approach

General insurance

13,771 general insurance complaints received. 23% of all complaints received

62% general insurance complaints were resolved

77% general insurance complaints resolved within 60 days

78% complaints were resolved by agreement or in favour of complainants

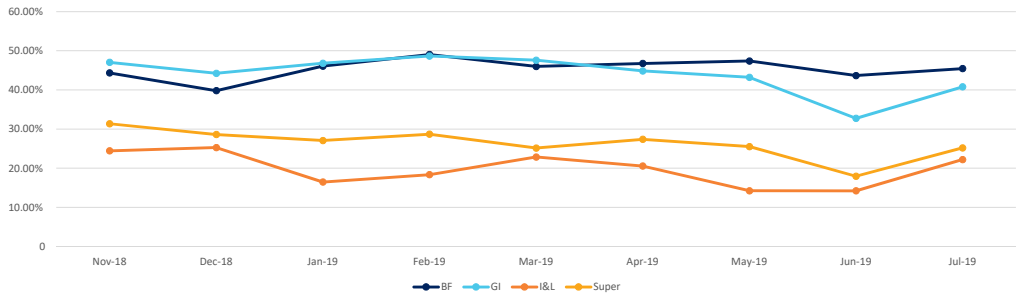
Top five general insurance products

Product	Total
Motor Vehicle- Comprehensive	3,318
Home Building	2,372
Travel	1,324
Motor Vehicle- Uninsured Third Party	992
Home Contents	611

Top five general insurance issues

Issue	Total
Delay in claim handling	2,539
Claim amount	2,527
Denial of claim-Exclusion/ condition	2,060
Denial of claim	1,801
Service quality	855

Known closure rate at registration and referral



	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun -19	Jul-19
BF	44.30%	39.80%	46.10%	49.00%	46.00%	46.80%	47.40%	43.70%	45.40%
GI	47.00%	44.20%	46.80%	48.70%	47.60%	44.90%	43.20%	32.70%	40.80%
I&L	24.40%	25.30%	16.50%	18.30%	22.90%	20.60%	14.20%	14.20%	22.20%
Super	31.40%	28.60%	27.10%	28.70%	25.10%	27.40%	25.50%	17.90%	25.20%
Total	42.20%	38.40%	42.00%	44.70%	42.90%	43.10%	41.80%	36.20%	41.20%

Australian Financial Complaints Authority

Slide 10

Known closure rate has a one month lag because closures are no finalized for the latest month at time of reporting

Accepted complaints & non-response rate

General Insurance - First 10 months

	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun -19	Jul-19	Aug-19	Total
No response received	71	62	72	67	97	69	65	92	87	115	**797**
Response received	641	611	536	620	643	690	697	624	741	724	**6527**
Total accepted complaints	712	673	608	687	740	759	762	716	828	839	**7324**
% of no response	10%	9%	12%	10%	13%	9%	9%	13%	11%	14%	**11%**

Complaints closed by status

General Insurance - First 10 months

	Number	Percentage
Closed Registration & Referral	4942	60%
Closed Case Management Level 1	1276	16%
Closed Rules review	840	10%
Closed Preliminary View	574	7%
Closed Decision	319	4%
Closed Case Management Level 2	198	2%
Closed Before Referral	72	1%
Grand Total	**8221**	

Complaints closed by outcome

General Insurance - First 10 months

	Number	Percentage
Resolved by FF (at Registration and Referral)	5265	64%
Outside Rules	800	10%
Negotiation	755	9%
Discontinued	519	6%
Resolved by FF	323	4%
Preliminary Assessment in Favour of FF	278	3%
Decision in Favour of FF	240	3%
Preliminary Assessment in Favour of complainant	111	1%
Assessment	109	1%
Conciliation	86	1%
Decision in Favour of complainant	57	1%
Outside Terms of Reference	1	0%
Grand Total	**8221**	

Complaints closed by stream at CM1 and CM2 status

General Insurance - First 10 months

	FastTrack	Standard	Complex	Total
Closed Case Management Level 1	1,033	198	45	1,276
Closed Case Management Level 2		51	147	198
Total	**509**	**212**	**422**	**1,474**

Public reporting

AFCA is making changes to its public reporting

- In line with the broader changes arising from the Royal Commission and regulatory changes, including ASIC regulatory guide 165.
- ASIC has approved changes to the AFCA Rules to allow the scheme to name financial firms in published determinations.

From 2019/2020:

- AFCA will be naming firms in published decisions.
- Changes to reporting on definite systemic issues – naming of firms involved
- Changes to AFCA comparative reporting (requirement under RG237)
  - Complaints received numbers
  - Publish every 6 months
  - Come into effect for our AFCA 18-19 comparative reporting.
  - Published in October 2019

Legacy complaints dating back to 1 January 2008

From 1 July 2019 until 30 June 2020, Australian consumers and small business can lodge complaints that would normally fall outside AFCA's time limits.

- AFCA will follow our usual process to investigate these complaints which are known as Legacy complaints
- Process begins with AFCA referring complaints back to financial firms to resolve
- It is our expectation that firms will engage proactively with their customers to resolve these legacy matters themselves where possible, as part of their commitment to justly remediate the misconduct of the past and meet the community's expectations of fairness
- Where firms are unable to satisfactorily resolve the complaints, AFCA will start investigating these matters from **1 October 2019**

Legacy complaints at a glance

520 legacy complaints received

58% Banking and Finance

21 % Investments

8% Superannuation

7% General Insurance

5% Life Insurance

Top issues	Percentage
Denial of claim	23%
Delay in claim handling	11%
Claim amount	9%

> 32% of GI legacy complaints received are closed

Our approach to Legacy complaints

- AFCA will have regard to the relevant law, codes, industry practice that were in place (and decisions made) at the time of the disputed conduct
- Approaches to assessing loss will reflect the current AFCA approach
- We will be constantly reviewing our approaches to provide further guidance to members

What is the same?

AFCA will

- Apply its Rules in accordance with the Operational Guidelines to assess jurisdiction
- Apply 912A of the Corporations Act - Require the financial firm to provide information
- Apply the appropriate decision making test including what is fair in all the circumstances
- Make a decision based on the weight of information

AFCA may where appropriate

- Refer a matter to conciliation, provide a preliminary assessment or expedite to determination
- Require a firm to provide a statutory declaration where material documents are not provided
- Apply the free decision rebate policy to Legacy complaints

What is different?

- When a complainant became aware of the loss is not relevant in a Legacy complaint to assess jurisdiction
- You can request that AFCA reconsider it's classification of the complaint as a Legacy complaint
- 45 day IDR timeframe for non superannuation complaints whether or not it has been through IDR
- Legacy complaint costs have a different funding structure;
  - fees will be higher, and
- Complaints are likely to be complex and relate to matters raised in the Royal Commission
- All Legacy complaints will be considered as standard or complex

GENERAL INSURANCE
Code Governance Committee

Update from the Code Governance Committee

Sally Davis, General Manager
Code Compliance and Monitoring

11 October 2019

Overview

- The review of the General Insurance Code of Practice
- CGC's expectations about Code compliance in the current environment
- Emerging issues
- CGC's current and upcoming work
- Closing remarks

Review of the General Insurance Code of Practice

- The Code Governance Committee (CGC) has been engaging with the Insurance Council (ICA) and National Code Committee (NCC), by providing feedback and recommendations on how the new Code could be improved.
- Recent feedback to the ICA and NCC has focused on key areas that include: consumers experiencing vulnerability, financial hardship, complaints handling, consumer credit insurance, enforcement, sanctions and compliance.
- You can find the CGC's public submissions on the ICA's review of the Code at http://www.codeofpracticereview.com.au/submissions

Key feedback to ICA/NCC included:

- The Role of the CGC: the various standards that describe the CGC's responsibilities, functions and powers should be merged into a single standard in the Code, be clear and consistent with similar provisions in the Charter. Note: the latest version of the new Code shows that the ICA has grouped the two key standards together (two consecutive standards) and the ICA has informed us that it will work with the CGC to ensure that the Code and Charter align.
- Family violence guidance: the ICA will attach a guide to the Code for industry about helping customers affected by Family Violence. The uptake of the guide is voluntary and not mandatory. The CGC said that the guidance should be mandatory or at the very least that certain parts of the guidance should be imported into the Code as mandatory standards. Note: No change to the latest version of the Revised Code.
- Consumers experiencing financial hardship - making a complaint: The ICA proposed limiting access to the Code's complaints standards to complaints related to retail insurance. The CGC said that if consumers are experiencing financial hardship they should have unfettered access to the Code's complaints standards. The latest version of the Revised Code shows that the ICA has now accepted this but some work remains to clarify the wording around this.
- Consumer credit insurance: if the new Code were to include standards that apply to subscribers' intermediaries offering CCI for credit cards or personal loans, the standards should apply widely without exception - no carve outs for motor car dealers or refinanced loans. Note: The CA has dropped the proposed standards from the latest version of the Revised Code, given ASIC/Treasury is working on deferred sales model.

CGC's expectations about Code compliance

1. **Comply with the spirit of the Code** – avoid black letter law approach.
2. **Do the right thing** – honesty, fairness and transparency in all interactions.
3. **Raise board awareness of CGC recommendations** – roadmap to culture.
4. **Apply s4.4 widely** – underpins buying/administration of insurance products.
5. **Financial hardship assistance** – must decide entitlement even if person has not provided more info; can't use court-based process to assess financial position if person has asked for hardship assistance under the Code.
6. **Significant Code breach** – turns on facts and five defined criteria: if one criterion has been met this is enough to deem the issue significant and reportable to CGC.

1. Complying with the spirit of the Code: Reverting to black letter law when applying the Code is inconsistent with its spirit. Some subscribers have a poor grasp of "honesty, fairness and transparency".

2. Doing the right thing: interactions with consumers must be underpinned by honesty, fairness and transparency - Transactions with consumers should occur within the context of honesty, fairness and transparency – these themes appear throughout the Code and underpin all interactions with consumers. The themes of honesty, fairness and transparency appear throughout the Code and underpin all interactions between subscribers and consumers. Those Code standards provide a foundation for a strong and healthy organisational culture.

3. Raise board awareness of CGC's recommendations to improve Code compliance: a roadmap to enhancing culture and compliance The findings from the Committee's current inquiry into the adequacy of compliance frameworks show that most subscribers' boards have low if any awareness of the Committee's work including recommendations made to improve compliance. Subscribers must increase board and executive awareness of the CGC's recommendations to improve Code compliance – they are a roadmap to enhancing culture and compliance.

4. Approach to subsection 4.4: Subscribers must take a broader approach to interpretation and application of subsection 4.4 of the Code. The standard captures all conduct that is related to or arises from the products themselves (their suitability) through to the way in which they are sold or offered for sale. Utmost good faith applies across dealings with customers and that captures whether a product is fit for purpose. Further, all conduct must be carried out in a fair, transparent and honest manner. It's not good enough to say that the organisation was operating

on a no advice model if the products that are being sold have little or no value as an insurance product or if sold to people who were ineligible and therefore not entitled to make a claim: this does not lead to fair outcomes for consumers.

5. Financial hardship assistance: Taken from investigation – CGC determined that the subscriber had breached multiple financial hardship standards. Of concern was the subscriber's view that:
•it did not need to decide whether the consumer was entitled to financial hardship assistance if they did not provide requested information, and
•it did not need to suspend recovery action even though it had not decided the consumer's request for assistance, and it proceeded with a summons for oral examination of the consumer's financial position through the court system.

CGC's expectations about Code compliance

7. Matters reportable to/identified by other regulators including AFCA – subscribers must also consider whether the issue is a significant Code breach.

8. Timeframe for remediation of significant breach – unless exceptional circumstances apply, CGC expects a subscriber to correct a significant breach within six months.

9. New approach to closure of significant breach matters: CGC will close its file provided a subscriber is taking appropriate corrective actions within an agreed timeframe and if notifies the CGC immediately if it can't/hasn't done this.

10. CGC publications and recommendations to improve compliance: Data and information in publications and commentary provide subscribers with valuable insights into emerging risk areas.

7. **Matters reportable to/identified by other regulators:** If a subscriber is:

- considering if an issue is reportable to ASIC or another regulator, it must also consider whether the issue is reportable to the CGC as a significant breach.
- an AFCA member, then if AFCA has identified a definite systemic issue, serious contravention, or other reportable breach, it must also consider if the issue is reportable to the CGC as a significant breach.

8. **Timeframe for remediation of significant breach:** CGC will consider if a longer timeframe is appropriate on a case by case basis. If a subscriber anticipates a period of longer six months, then it must provide the CGC with the following information for consideration:

- comprehensive reasons for a timeframe exceeding six months, and
- interim measures to ensure that the significant breach does not continue to have an impact during the period of rectification.

9. New approach to closure of significant breach matters: CGC will close its file if a subscriber is taking appropriate actions to resolve the significant breach within an agreed timeframe, and provided that it notifies the CGC immediately:

- if it has not met the agreed timetable – Code team will escalate to CGC to consider and decide next steps.
- if it is unlikely to complete implementation by the agreed date – Code team will consider extending timeframe or if appropriate escalate to CGC,

CGC may audit the subscriber – randomly or on a periodic basis – to verify that it has implemented all actions within agreed timeframes across all significant breach matters.

10. CGC publications and recommendations to improve compliance: Data and information in the CGC's publications and commentary provide subscribers with valuable insights into

emerging risk areas. The CGC:

- includes recommendations in its publications to assist subscribers to comply with their Code obligations
- expects subscribers to distribute publications to all levels within their organisations, including their boards/risk committees, and highlight and implement the recommendations to improve Code compliance, and
- conducts follow up work to assess the extent to which subscribers have taken up its recommendations.

Insights on Code subscribers' compliance with the Code: Significant breaches

7-fold increase in significant breach reports in the past year: 65 significant breach reports from subscribers plus 26 files in response to ASIC media releases and definite systemic issues identified by AFCA. About 90% of significant breaches relate to three areas:

- Subsection 4.4: such as overcharging of premiums, incorrect premium calculations due to IT errors, failure to apply no claims discounts or multi policy discounts, breaches of Insurance Contracts Act, breaches of disability and anti-discrimination laws.
- Section 7: claims handling issues due to spikes in claims following severe weather events, failing to meet timeframes for claim decisions, not keeping consumers informed of progress, failing to inform consumers about rights when claims are denied.
- Section 10: complaints handling issues such as failing to provide written responses to consumer complaints or exceeding timeframes for responding to complaints.

Insights on Code subscribers' compliance with the Code: Current top 10 emerging issues

1. subsection 10.13 - Respond to complaint in writing
2. subsection 7.2 - Claims handling fair, transparent and timely
3. subsection 7.19 - Denial of claim
4. subsection 10.10 - Stage 1 & 2 of complaints process cannot exceed 45 days
5. subsection 10.4 - Complaints handling fair/transparent/timely
6. subsection 10.11 - Respond to Stage One complaint within 15 business days
7. subsection 10.12 - Respond to complaint within 15 business days
8. subsection 7.13 - Notify within 10 business days of claim acceptance/denial
9. subsection 10.16 - Inform of progress every 10 business days
10. subsection 7.21 - Must comply within timetables

The CGC Priority Framework:

- Is a tool that operates similar to a risk framework to help the Committee identify and determine the areas it should focus on for its monitoring and investigation activities, including how it should prioritise this work in its annual workplan.
- Uses data and information from various sources to identify and assess known or emerging issues, records, assesses and tracks information from a wide variety of sources including regulators.

We are continuing to develop the qualitative component of the Framework which will enhance our ability to identify emerging trends and make recommendations to the Committee regarding future targeted monitoring work. Our goal is to formalise this wider approach through incorporating additional data such as:

- outcomes of monitoring and breach remediation activities,
- other external information that might indicate emerging issues affecting subscribers' compliance with the Code, such as reports from regulators and AFCA, and previous monitoring activities.

CGC's upcoming work

Key work:

Culture, governance and adequacy compliance and reporting frameworks: Inquiry into compliance frameworks is being merged into a larger piece on the spirit of the Code, culture and governance. CGC has sent additional questions to ten subscribers for deeper insights into breach identification and reporting frameworks, and changes made since the Royal Commission.

Transition to a new Code: CGC will hold a mid-year strategy discussion in November about transition, including the implications of what the new Code means for the CGC's work.

New data sets: Pilot program rolled out 4/10/2019: accepted claims, partially accepted claims, premiums collected, claims paid, and additional information relating to breaches. Subscribers will have 3 months to provide data.

Claims standards: An examination of compliance with claims standards with focus on subsections 7.19 and 7.2, and some other standards that apply to decision-making and timeliness.

Travel insurance: Scoping of an own motion inquiry into Travel insurance for a possible inquiry in 2020–21.

Priorities could change depending on emerging risks and the imminent release of the revised Code.

Closing remarks

- Comply with the spirit of the Code
- Do the right thing
- Implement recommendations to improve compliance with the Code
- Emerging issues: Quality of claims handling and decision-making, quality of complaints handling and timeliness, and breaches of law

Contact the Code Team

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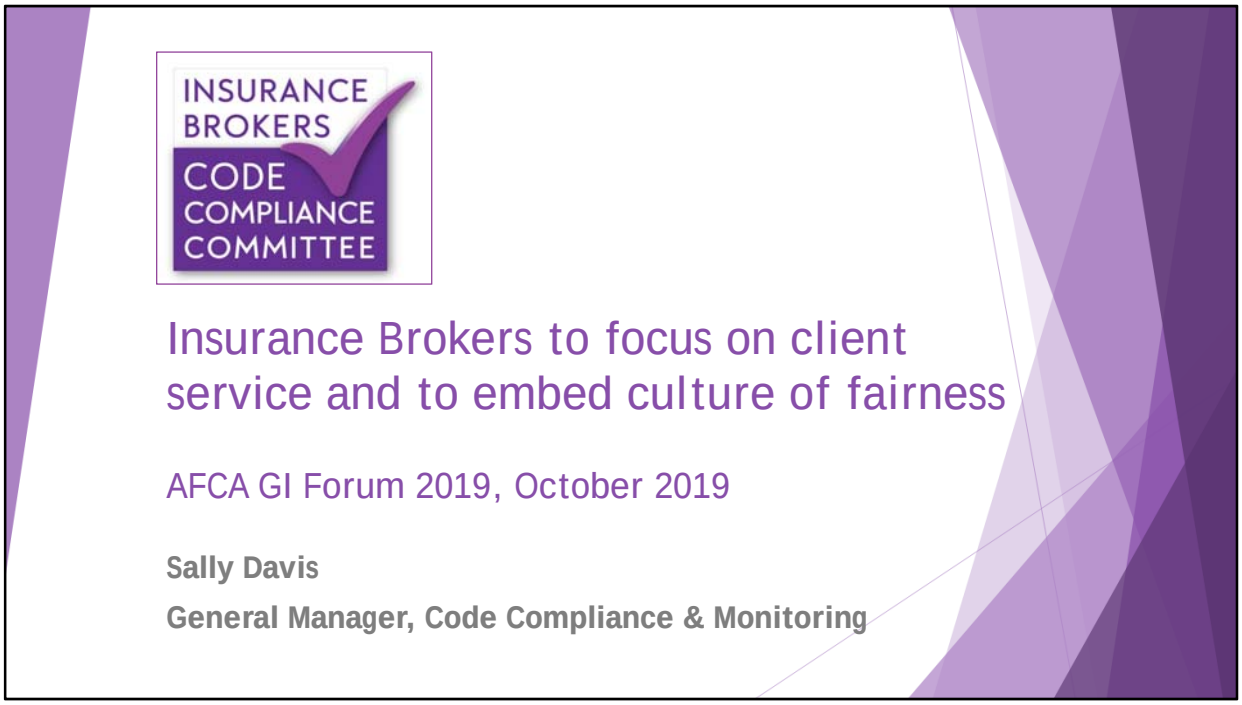
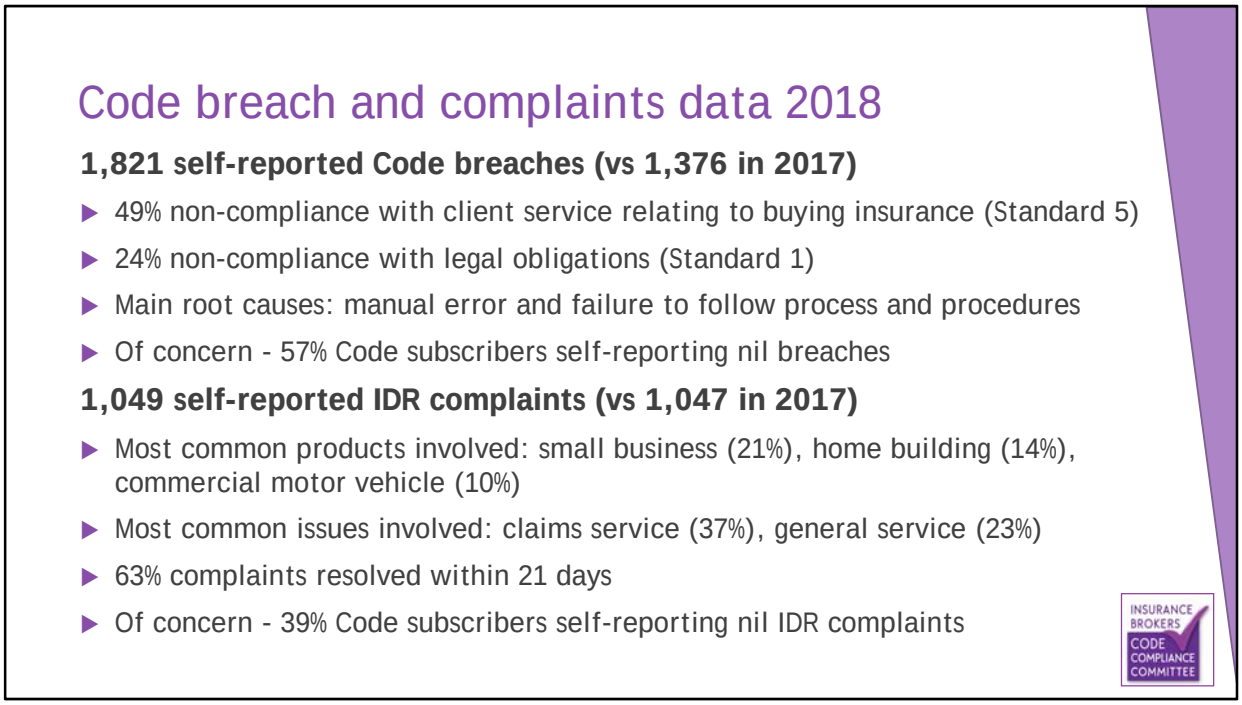


- One of the most important messages underpinning the Royal Commission's findings and recommendations was that to be fair, honest and transparent in dealings with clients, the financial services industry needs to go beyond bare minimum requirements to act in the spirit of the law.
- Insurance brokers can accept the challenge of embedding a strong culture of fairness, honesty and transparency, or risk having it forced on them.
- Improvement is needed in particular in the area of client service – the core business and point of difference of insurance brokers.



Data received via the 2018 Annual Compliance Statement (data refers to period 1 January to 31 December 2018).
Code subscribers would have received their individual benchmark report in June 2019 (followed up by telephone conference with selected subscribers to discuss data).
Annual Report 2018-19 with more detail will be published in November 2019. Check out AFCA's website.
Committee is currently developing its own website so from 2020 onwards, publications will be published there, including more guidance to Code subscribers.

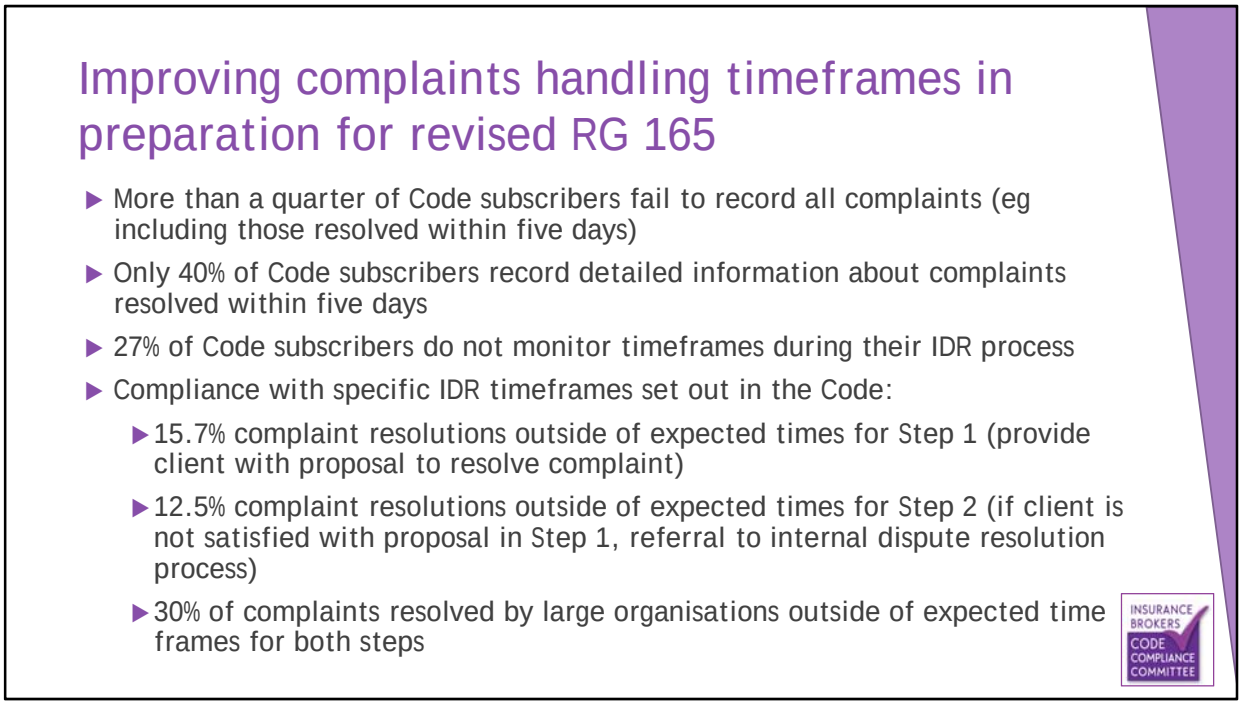
BREACHES

- In 2018, Code subscribers self-reported 1,821 breaches of the Code – an increase of 32% from the number of self-reported breaches in 2017.
- Self-reported breaches by micro Code subscribers accounted for 37% of all Code subscribers' breaches in 2018. Small, medium and large Code subscribers each accounted for around 20% of breaches. A high number of self-reported Code breaches might reflect a positive breach reporting culture but might also warrant a review of the reporting structure and framework and the effectiveness of benchmarks.
- The number of Code subscribers self-reporting nil breaches (57%) is concerning.
- Nearly half (49%) of Code breaches in 2018 related to non-compliance with required standards of client service relating to buying insurance including acting diligently, competently, fairly and with honesty and integrity, covered in Service Standard 5. Non-compliance with the legal obligations (Service Standard 1) was the second most reported breach by Code subscribers in 2018, accounting for almost a quarter (24%) of all self-reported breaches. Both areas were represented by similar percentages in 2017.
- The quality and consistency of breach data and information self-reported by Code subscribers is still a concern to the Committee.

- Subscribers named manual error and a failure to follow processes and procedures as the two main reasons for Code breaches in 2018. Paradoxically, only 2% of self-reported Code breaches concerned adherence to Service Standard 8 (‘We will ensure that we and our representatives are competent and adequately trained to provide the relevant services and will maintain this competence’).

IDR COMPLAINTS

- Number of complaints in 2018 (1,049) similar to 2017 (1,047).
- Most commonly involved products: small business insurance (21%), home building insurance (14%) and commercial motor vehicle (10%) insurance.
- Most common issues: 60% of complaints related to service levels, particularly in the area of claims (37%).
- The number of complaints resolved within 21 days remained similar to last year (63% in 2018 compared with 61% in 2017).



As part of the Annual Compliance Statement (ACS) Program in early 2019, the Insurance Brokers Code Compliance Committee conducted an own motion inquiry to develop a better understanding of how Code subscribers manage their timeframes for handling complaints based on obligations under Service Standard 10.

Service Standard 10 requires Code subscribers to establish an internal complaints and disputes handling process that meets the Code Complaints and Dispute Resolution Process standards. This requirement is imperative to the Code's purpose of promoting professional competence and building consumer trust in the insurance broking sector.

Code subscribers have to improve the way they manage timeframes for handling complaints to prepare them for ASIC's proposed changes to RG 165, due to come into effect in December 2019. ASIC research consumer experience of the IDR processes of financial firms found that consumer satisfaction was significantly affected by the length of time a firm took to conclude a complaint (see **ASIC Report 603**, December 2018).

Main findings from OMI:

- more than a quarter of Code subscribers fail to record all complaints (including those resolved within five days)
- only 40% of Code subscribers record detailed information about complaints resolved within five days
- 27% of Code subscribers do not monitor timeframes during their IDR process
- 15.7% complaint resolutions outside of expected times for Step 1 (provide client with proposal to resolve complaint)
- 12.5% complaint resolutions outside of expected times for Step 2 (if client is not satisfied with proposal in Step 1, referral to internal dispute resolution process)

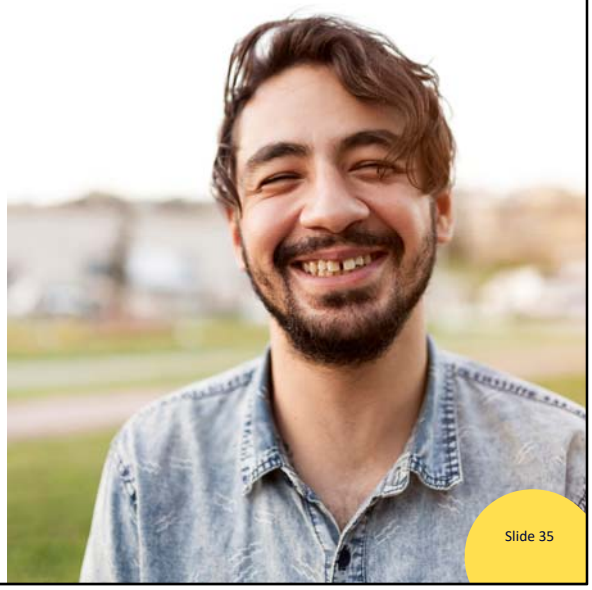
- 30% of large organisations' complaints were resolved outside of the expected timeframes for Steps 1 and 2 of the Code's Complaints and Disputes Resolution process.

I would like to acknowledge the traditional owners and custodians of the land on which we meet today. I pay my respects to Elders past, present and future, and Elders from other communities who may be here today.

[INTRODUCTIONS]

Introduction

- AFCA's purpose and values
- AFCA's decision making jurisdiction
- Fairness project

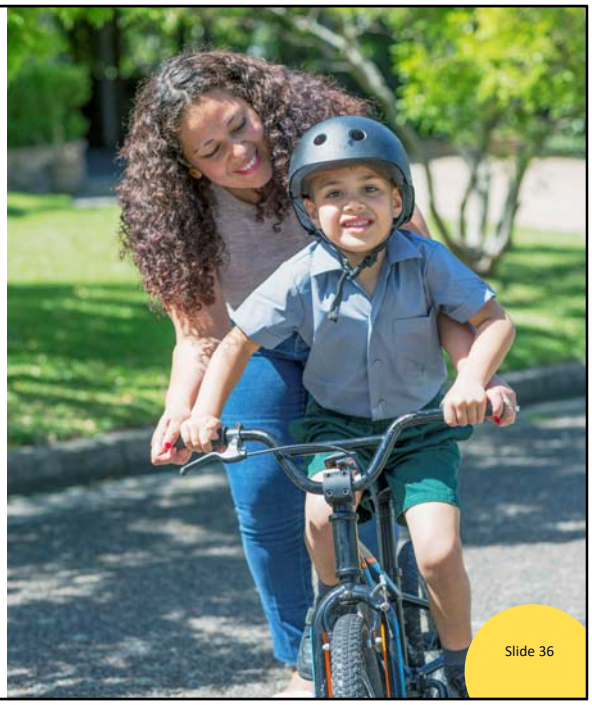


Our purpose and values

It is inherent in AFCA's purpose and values to provide fair and independent decision making.

Central to this is that all decisions are balanced, considered…

…and fair.



Australian Financial Complaints Authority

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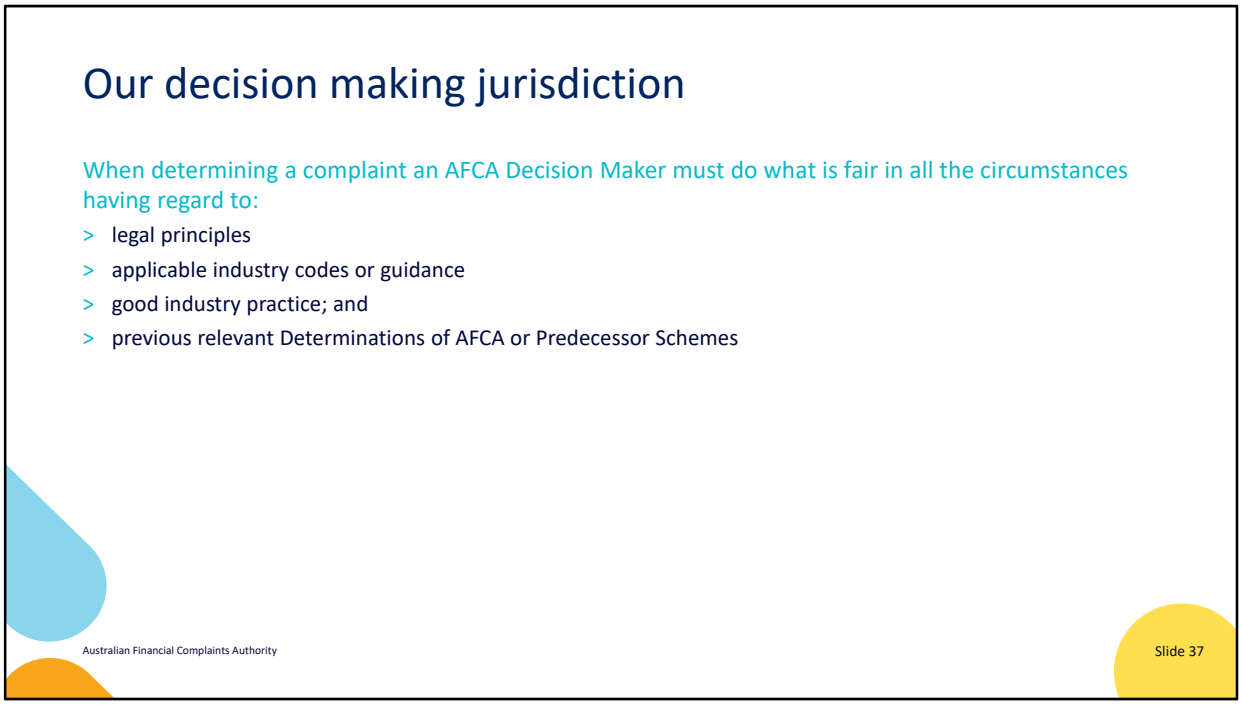
AFCA's Jurisdiction

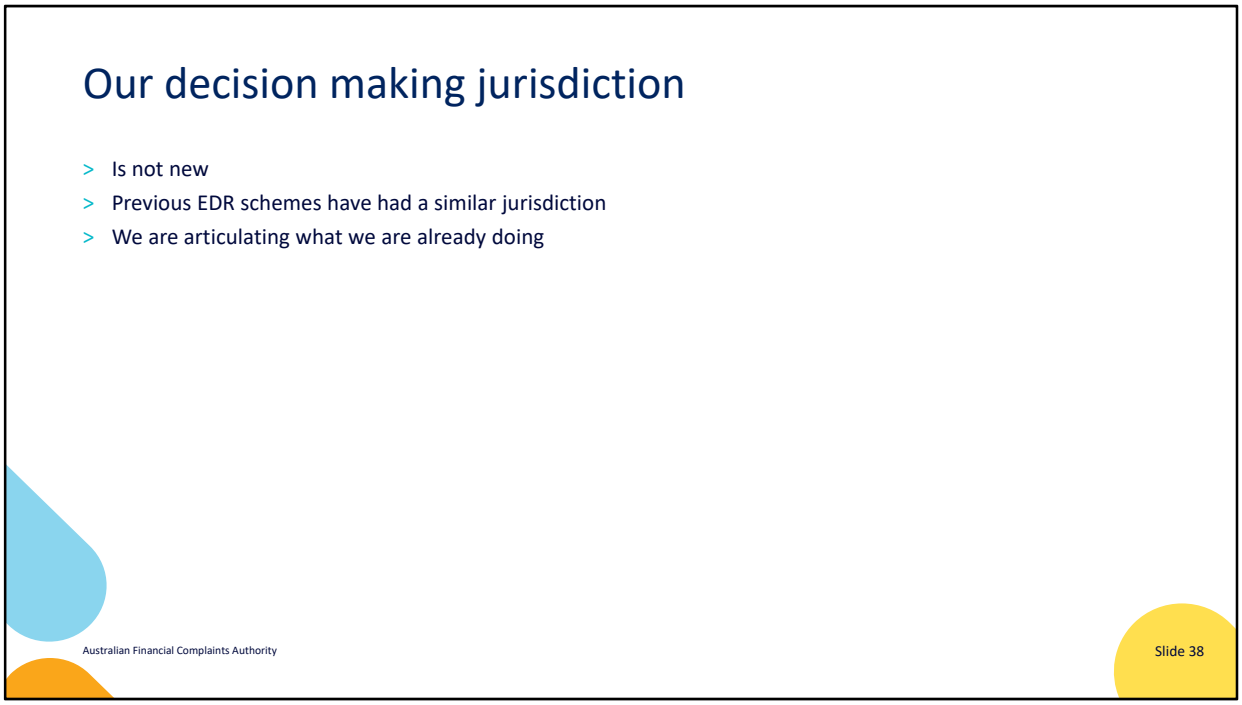
The *AFCA Complaint Resolution Scheme Rules* (2018) set out AFCA's jurisdiction
These Rules provide that when determining a complaint an AFCA Decision Maker must do what is fair in all the circumstances having regard to:

- legal principles
- applicable industry codes or guidance
- good industry practice; and
- previous relevant Determinations of AFCA or Predecessor Schemes



In its superannuation division, AFCA is required to make decisions having regard to the conduct of a fair and reasonable trustee.

The University of Melbourne Law and Business School has done some research for us and a literature review about this type of jurisdiction and it is broad.
That research helps to articulate how our jurisdiction operates.

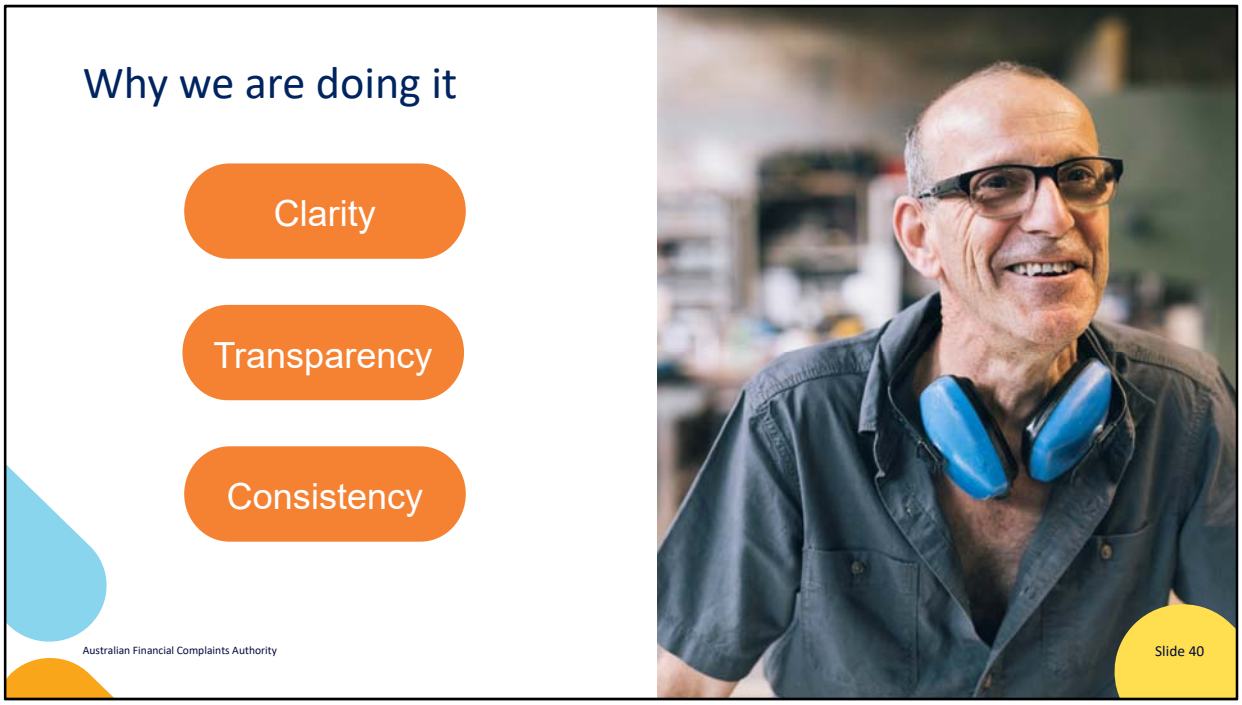


We are assessing financial firm conduct against existing legal and ethical obligations and calling out how those obligations speak to community expectations.

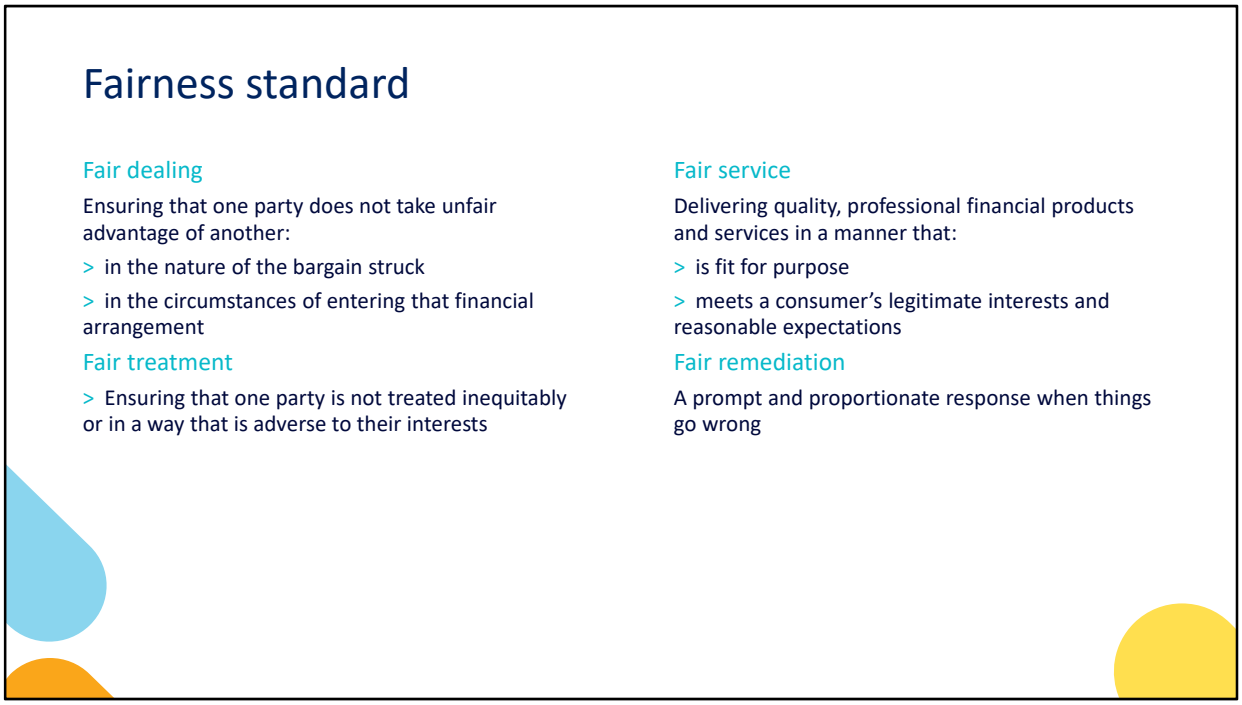
We are trying to be more transparent about how we made decisions.

We are creating a framework and to encapsulate the essential elements against which AFCA will assess financial disputes in accordance with our jurisdiction.

We are articulating how we assess financial firm conduct against existing legal and ethical obligations and calling out how those obligations speak to community expectations.



- We want to be more transparent about how we exercise our fairness jurisdiction and provide a clearly articulated framework of how and when we will exercise it in our decision making
- We want to ensure consistency in decision making, considering the organisation's recent rapid growth, expanding jurisdiction and the number of case handlers involved, including Ombudsmen and Adjudicators



AFCA believes:

- principles of fairness should be central to both the design and assessment of financial products and services and
- Fairness should be reflected in the relationship between financial firms and consumers before, during and after a financial product or service is provided.

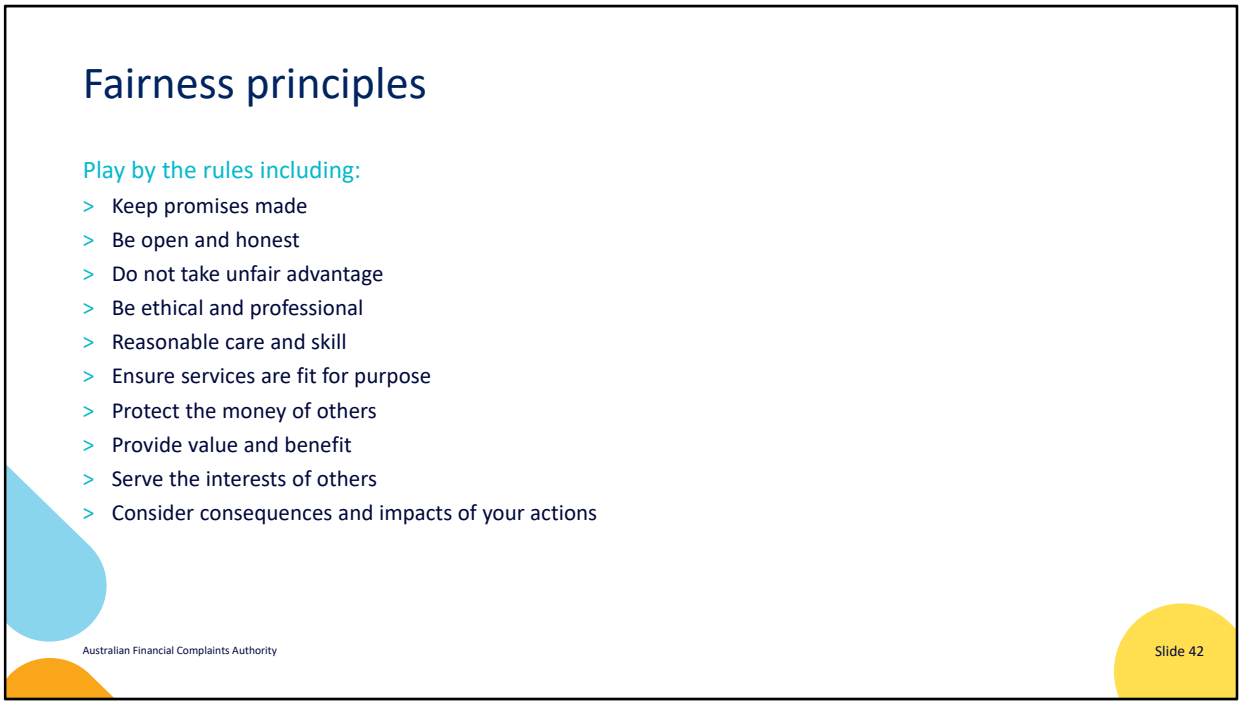
With this in mind, we have identified a standard which can be mapped to existing ethical and legal standards.

There are four key components to the fairness standard set out in this slide:
Fair dealing, fair treatment, fair service and fair remediation.

These components have come from our work with University of Melbourne which outlined that what is fair in all the circumstances can be usefully considered across a 'fairness lifecycle' reflecting the course of a relationship between consumers and financial firms.

These components allow us to focus on the relationship between the customer and financial firm, over time – ie entering into the contract; whilst the contract is on foot; what service was given; if things went wrong – was there fair compensation or remediation?

The elements are not discrete however they do provide a framework for guiding analysis.



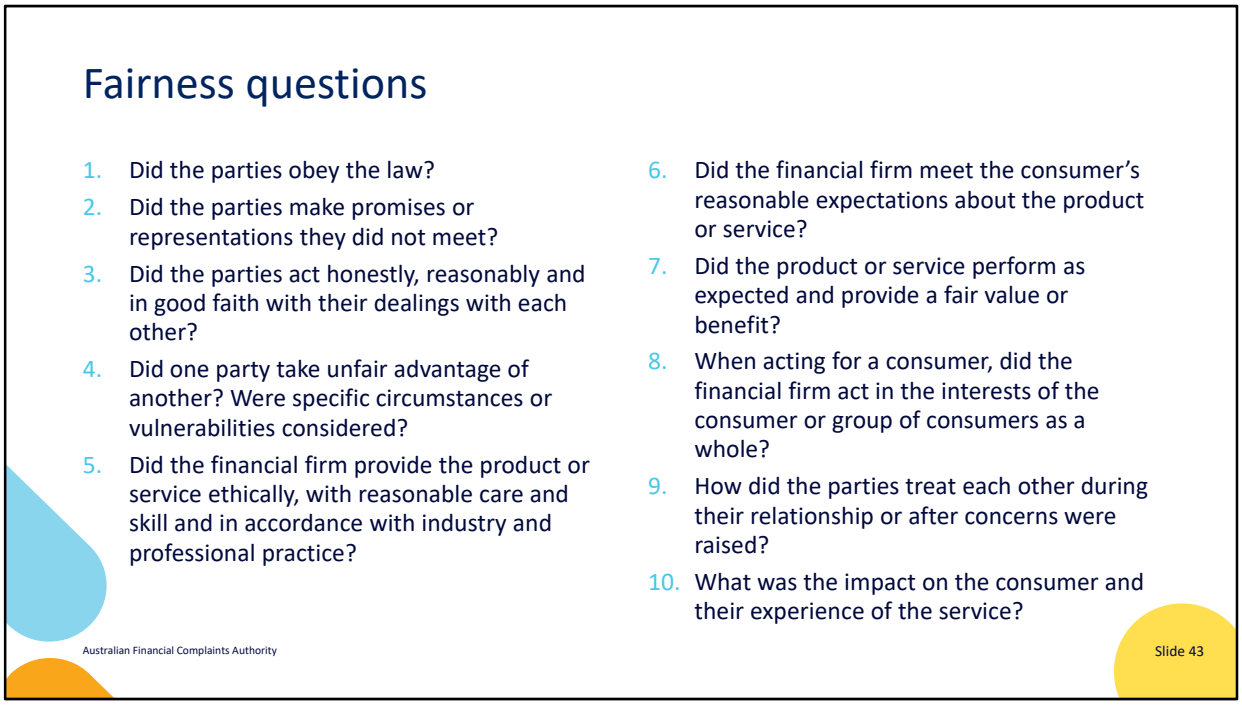
We start with something simple: Play by the rules.

Q: What do we mean by the rules?

A: The legal and ethical obligations set out in the law; industry codes of practice; good industry practice and rules that arise from community expectations.

We have created a fairness tool based on the existing legal and ethical obligations of financial firms. It is designed to guide the assessment of whether or not a firm has met the fairness standard in the delivery of products and services.

The tool comprises a series of ten questions based on the above fairness principles



The ten questions which make up the tool are intended to be used as a guide by both case officers and decision makers to assess the relationship between the parties.

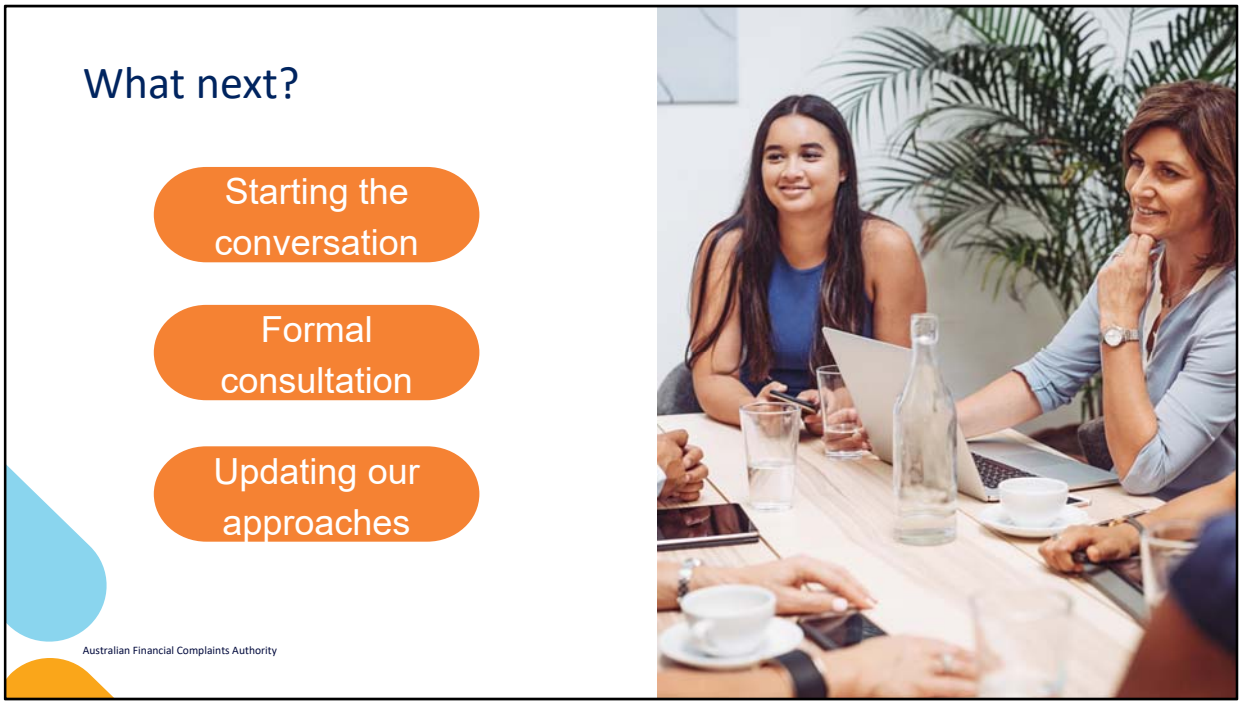
They are not intended to be a check list but are designed to assist investigation and assessment of whether or not a firm has met the fairness standard in the delivery of products and services to the consumer.

These questions encapsulate the key elements of AFCA's decision making jurisdiction including the law, relevant codes and industry standards, through a lens of fairness.

The questions each have applicability across a wide range of product areas and dispute types and we have completed detailed mapping of these questions against the existing legislative and industry specific 'rules'.

These are not new considerations for AFCA.

Q: What will be different?
A: How we articulate our decisions should be clearer. Further how we set out our inquiry of the issues may change to reflect this assessment.



This is the start of our conversation.

We will be doing a formal consultation later this year.

Look out for our consultation paper on our framework and tools.

We will of course ensure that we update our approach documents which exist to ensure that they remain of use and helpful to stakeholders; industry and consumers.

Open Discussion

Discussion Panel

- John Price, Lead Ombudsman General Insurance
- Don O'Halloran, Ombudsman
- Chris Liamos, Ombudsman
- Helen Moye, Ombudsman
- Mark McCourt, Adjudicator

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620915 and 632193

620915

- Determination in favour of complainant with 'choice of repairer' benefit
- Insurer must pay reasonable costs charged by complainant's choice of repairer
- Motor Trades Association of Australia (MTAA) and Australian Motor Body Repairers Association (AMBRA) issued a press release about the determination, calling it a "benchmark ruling" protecting consumers and repairers
- AFCA has received submissions from several complainants who seem to be quoting the determination.

632193

- Determination in favour of insurer
- Insurer entitled to assess reasonable cost of repairs
- Complainant said insurer must pay quote from complainant's choice of repairer, and was not entitled to assess the quote or get a second quote.

Wrap up and questions

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Australian Financial Complaints Authority

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Thank you

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