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# INTRODUCTION

Legally, our activities as an AFS Licence holder are controlled by The Act. (Chapter 7 of the Corporations Act 2001 and the Corporations Regulations) and by the Insurance Contracts Act 1984 and Regulations.

Commercially, an AFS Licence holder should trade as a professional, thus avoiding the possibility of an errors and omissions claim due to professional negligence. These Policy and Procedures are a “work in progress” and will be updated from time to time to include additional content specifically designed to be compliant with The Act requirements.

These Policy and Procedures are not a substitute for training and it is the responsibility of the Management Team to ensure that staff receive appropriate instruction and are competent in their function.

The purpose of these Policy and Procedures is to provide guidelines and clear documentation for insurance broking practice and set standards in order to ensure we always act in a professional manner and provide fair and honest advice to our clients.

It is imperative that the procedures and systems detailed in this manual are always adhered to ensure compliance by the company to the various legislative requirements we are bound by.

# UPDATES

These Policy and Procedures are updated on a regular basis. Any material changes to these Policy and Procedures will be advised by management either via Email or at our regular Staff meetings.

This document and associated forms etc. are accessible in soft copy via our computer network. We do not store these documents in hard copy. All information can be immediately accessed on the computer network and will always be guaranteed to be up to date.

When you see an opportunity to improve a procedure kindly make a suggestion to your manager/supervisor as we all have a responsibility to improve our standards, individually and as a Company.

# ERRORS AND OMMISSIONS

## Introduction

As an AFS Licensee our business is to provide financial services advice and service to our clients. But, in doing this we incur an onerous duty of care and are required to exercise skill and competence of a high degree.

Our exposure to circumstances which might give rise to allegations of professional negligence makes us extremely vulnerable in this consumer-oriented age. Throughout these procedures constant reference is made to recording details of conversations and instructions in writing including the time and the date. This is necessary to prove when events took place in case there is a dispute with one of our clients.

Any situation, no matter how minor that may develop into an errors and omissions dispute must be immediately brought to the attention of your manager/supervisor so that he/she can authorise appropriate action. Any complaints received will be handled in accordance with our Complaints Policy and Procedures ([Complaints Policy and Procedures](http://www.msmlm.com/msm-mission-control/complaints-policy-and-procedures/)).

The typical causes of Professional Indemnity claims can be put into 6 categories:

1. Failure to act on client instructions regarding insurance coverage and also claims handling.
2. Failure to affect any insurance on behalf of the client when requested.
3. Failure to effect covers for all the risks expected to be covered by the client.
4. Failure to effect adequate cover/ sums insured for insurance covers.
5. Failure to effectively advise the client of their duty of disclosure obligations.

By adhering to the following essential do’s and don’ts costly mistakes will be reduced.

## The Basic “Musts”

|  |  |  |
| --- | --- | --- |
| Always | Advise your Manager immediately of any matter (regardless of size) with possible professional negligence implications. | |
| Always | Consider any limitations in your knowledge and seek the expertise of your colleagues. | |
| Always | Know Your client. This means that you must take the time to gain a strong understanding of their requirements and expectations by way of specific and open-ended questions. | |
| Always | Match the Client Needs to the Product. Once you have gained an understanding of the client’s needs and understand the coverage provided by the available insurance products ensure that the most appropriate product is always recommended to the client, regardless of the cost. | |
| Always | Remember that our Duty of Disclosure and that of the insured is a continuous requirement and not something to be left until renewal. | |
| Always | Be aware of our responsibilities under legislation, for example, the Insurance Contracts Act, Insurance Contracts Act Regulations and The Act. | |
| Always | Record all verbal instructions and confirm verbal advice in writing. Use of a Daybook / Client Instruction Sheet or notes on the client file are mandatory. | |
| Always | Obtain covers immediately upon request. | |
| Always | Make effective use of a diary follow up system. | |
| Always | Act on computer generated outstanding/follow up reports within a reasonable timeframe. | |
| Always | Query ambiguous instructions/advice by any or all parties to the insurance contract, particularly be aware of fax quotations – do not repeat parrot fashion, always check for anomalies. |
| Always | Record in writing to the client those risks which are uninsured, discussed and declined by the client. |
| Always | Know your product. Do not guess the coverage and limitations within a product that you are recommending. You must ensure that whenever you are discussing policy coverage issues with the client you are providing them with accurate and factual information. |
| Always | Ensure the client has the original policy documents, including all subsequent endorsement documents, along with a copy of the original proposal form. |
| Always | Keep file notes of conversations in your Daybook or Client Instruction Sheet and place a copy on the client file. |
| Always | Report claims to insurers promptly. |
| Always | Be clear and accurate with instructions from clients and to the insurers – do not use industry jargon. |
| Always | Put the interests of the client in front of the interests of the business. Treat the client in the same way that you would like to be treated and provide the level of service and information that you would expect if you were the client. |
| Never | Complete and/or sign proposal forms or claim forms for a client. |
| Never | Intimate or confirm cover to client until it is 100% bound and confirmed from the insurer. |
| Never | Accept policies from insurers without first checking and ensuring that they agree with our original instructions, proposal forms and placement slips. |
| Never | Confirm that any claim is covered without confirmation from the insurer(s). |
| Never | Forget to date, sign and record the caller’s name of any telephone/verbal instruction and ensure this is documented in your Daybook or Client Instruction Sheet and copies placed on the client file, where necessary. |
| Never | Delay instructions from client to insurers &/or insurers to clients. |
| Never | Provide the client with sweeping statements regarding the extent of cover provided by a policy. Also request the client to read the Policy Wording to ensure they understand the extent and limitations of cover provided. |
| Never | Over emphasise the coverage provided without including details of the major exclusions in the same communication process. |

# NATIONAL INSURANCE BROKERS ASSOCIATION (NIBA)

The National Insurance Brokers Association of Australia was established in 1982. It represents around 500 member firms and 2,000 individual Qualified Practicing Insurance Brokers (QPIB).

NIBA member firms are subject to strict screening. They also agree to an enforceable code of conduct and practice. One requirement of membership is that they employ and encourage QPIB's who meet professional and technical competencies.

**NIBA provides the following services to its members:**

* educational services, including distance learning
* professional certification
* strong representation at state and federal government levels to protect members against potentially onerous regulation
* a voice to the insurance buying public to promote the many ways in which NIBA brokers add value
* services to help manage and improve business practices and technical support

NIBA members must comply with any NIBA rules and regulations.

# INSURANCE BROKERS CODE OF PRACTICE

As an overlay to the requirements set out under legislation if we are NIBA member or have separately subscribed or have publicised that we follow the Insurance Brokers Code of Practice we must adhere to the Code. The latest NIBA Code applies from November 2022 ([Insurance Brokers Code of Practice 2022](http://www.msmlm.com/msm-mission-control/insurance-brokers-code-of-practice-2022/)).

The Code can be summarised as follows:

* It promotes good relationships between our clients and ourselves.
* It promotes efficiency of service to our clients.
* It applies to general insurance, life insurance, claims management, risk management and premium funding activities.
* It promotes effecive dispute resolution between clients and ourselves.
* Requires clients to be made aware of the provisions of the Code.
* Discharge all responsibilities and duties diligently,competently, fairly and with honestly and integrity
* Advice the client when we are acting under a binder or not primarily in the interests of our client.
* Act in the clients best interests and provide appropriate advice.
* Assist clients to make informed decisions on risk and insurance protection
* Promptly advise clients of coverage being cancelled, lapsed etc.
* Promptly provide all relevant policy documentation.
* Ensure our staff are appropriately trained for the insurance services they provide.
* Advise the client of any fees payable prior to providing the service.
* Advise Retail Clients of the commission we will be paid by the insurer / premium funder prior to providing the service.
* Agree with the client on fee and/or commission retention prior to the inception of the cover.
* Provide clients with Terms of Engagement (TOE) when commencing to provide them with services. This will typically be done by including a generic TOE as a link in all emails and supplying a hard copy of the TOE to clients that do not have email facilities.
* Contact all clients at least 14 days prior to renewal. Contact can include email / phone/ sms / hard copy correspondence.
* In the event of a claim, take every step necessary to ensure prompt and fair settlement.
* Ensure complaints are handled in accordance with our Complaints Policy and Procedures.
* Support industry education and inform clients on relevant insurance information etc.
* Be aware of other relevant codes such as the General Insurance Code of Practice ([[General Insurance Code of Practice 2020](http://www.msmlm.com/msm-mission-control/general-insurance-code-of-practice-2020/)](file:///C:\Documents\MSM%20Operational%20Resources\MSM%20Operational%20Resources\MSM%20FSRA%20RESOURCES\General%20Insurance%20Code%20of%20Practice%202014.pdf)), ([General Insurance Code of Practice Overview](http://www.msmlm.com/msm-mission-control/general-insurance-code-of-practice-overview/)) and the Guidance for Hardship ([General Insurance Code of Practice - Guidance Hardship Cases (March 2018)](http://www.msmlm.com/msm-mission-control/general-insurance-code-of-practice-guidance-note-on-financial-hardship-march-2018/) )which applies to insurers and AFS Licensees acting under Binder.
* Non NIBA members who wish to subscribe to the Insurance Brokers Code of Practice are able to apply by contacting NIBA. An application fee and ongoing annual fee apply.

# OTHER INSURANCE LEGISLATION

Please refer to the Staff Policy and Procedures ([Staff Policy and Procedures.](http://www.msmlm.com/msm-mission-control/staff-policy-and-procedures/)) for an overview of the various pieces of legislation that impact our business and the insurance industry generally.

In relation to the above Acts and Codes, wordings and reference material can be sourced from the Internet as shown.

All notifications received from NIBA, the Insurance Council of Australia, and the Australian Financial Complaints Authority (AFCA) and other relevant authorities are circulated throughout the office by way of e-mail or at our regular Staff meetings.

# NOTICES AND DISCLOSURES

## Introduction

When dealing with clients (or potential clients), various pieces of Federal and State Government legislation require that certain notices and information must be provided to the insured. Whilst the Insurance Contracts Act applies to insurers, where an insurance broker is involved in the transaction, then it is the broker that must give the notices.

An explanation of the notices and the legal requirements follow. They have been broken up into the various Acts that they emanate from.

## Insurance Contracts Act 1984 and Regulations

### Utmost Good Faith

Utmost good faith is an implied term in every contract to which the Insurance Contracts Act applies. An implied term does not have to be actually printed in a policy. It is imposed by law and has the same effect as if it was printed.

The provision requires the parties to an insurance contract to act towards each other with the utmost good faith at all times.

The Act does not define what “utmost good faith” is but it has to do with questions of fairness, integrity and generally acting in a way that protects and furthers the interests of the other party.

Breaches of insurance law such as non-disclosure and unconscionable conduct ([ASIC Act 2001](http://www.msmlm.com/msm-mission-control/asic-act-2001/)) would also be breaches of the duty of utmost good faith,

However, because utmost good faith addresses the more general issue of maintaining a moral relationship in the insurance contract, it can include issues of fairness that fall outside other specific provisions of the various Acts.

For example, an insurer who seeks to rely on a policy provision to deny a claim might meet all the formal requirements of pre-contract notification, but still breach the duty of utmost good faith if the notification was too difficult to understand.

### Duty Of Disclosure

Sections 20 and 21 of the Insurance Contracts Act require that before the contract of insurance is entered into, that the insured be clearly informed in writing of the general nature and effect of a duty to either provide answers to questions or disclose specific information to the underwriter.

When a client requests that we obtain an insurance quotation on their behalf, we should obtain from the client sufficient information to enable insurers to quote. During discussions the client should be reminded of their obligation to provide accurate information. The information they provide to us should be confirmed back to client in writing, including the standard Duty of Disclosure notice. This Duty of Disclosure notice should not be altered. This notice (sample below) is automatically included in the “Important Notices” or elsewhere on all of our broking system generated invoices and client quotations.

For Consumer Insurance Contracts, (Consumer Insurance Contracts are defined as insurance that is obtained wholly or predominantly for the personal, domestic or household purposes of the insured) your only duty is to take reasonable care not to make a misrepresentation when answering questions asked of you by the underwriter

In all other situations you must tell the underwriter about anything that you know, or could be reasonably expected to know taking into account the nature and extent of the insurance cover to be provided and the class of persons who would ordinarily be expected to apply for such insurance cover. You do not need to tell the underwriter anything that reduces the risk of the underwriter, that is of common knowledge; that the underwriter knows or, in the ordinary course of business, ought to know or that the underwriter has waived your duty to tell them about.

### Misrepresentation

The Contracts Act significantly affects the Insurer’s right to a legal remedy based on misrepresentation. The Act does not consider an insured’s disclosure to be misrepresentation if:

* A question on the proposal is ambiguous- that is, it is open to more than one interprtation – and as a result the insured’s answer doesn’t provide the information the insurer is after.
* An insured genuinely believes a statement to be true when he or she completes the proposal form (and a reasonable person in the circumstances would also believe it)
* An insured fails to answer, or gives an obvioulsy incomplete or incorrect answer, to a question in a proposal.

### Prescribed Contracts

“Prescribed Contracts” as referred to in Section 34 of the Insurance Contracts Act 1984 are:

* Private Motor Vehicle
* Home Building
* Home Contents
* Accident & Sickness
* Consumer Credit
* Travel
* Please note that these are similar but not identical definitions to those insurance classes referred to as Retail Products under The Act. For further information refer to the Insurance Contract Act Regulations (1985) ([Insurance Contracts Act Regulations (1985)](http://www.msmlm.com/msm-mission-control/insurance-contracts-act-regulations-1985/))

The Act specifies the standard cover and minimum amounts that must be provided by insurers under the six prescribed classes of business. The cover is set out in the Act’s Regulations.

An insurer can give less than the standard cover, but under S35 it must inform the insured in writing of any variations before the contract is entered into. Failure to provide the information means that standard cover prevails for claims purposes.

For Prescribed Contracts we must therefore provide the insured with a copy of the Policy at the time of or before arranging cover, otherwise the insurer will be required to provide a minimum level of cover. The only exception to this is where we have advised the client that the sum insured was less than the prescribed sum insured; and details of where the policy coverage is different to the prescribed coverage Section 35 (1) Insurance Contracts Act

### Claims Made Policies

Section 40 of the Insurance Contracts Act contains provisions concerning advice to the insured in writing before the contract of insurance is entered into about the effects of the claims made provisions. This notice applies to classes such professional indemnity, directors & officer’s liability, trustee’s liability and employment practice liability policies. We should also advise the client that these types of policies are not renewable contracts (the same applies to Fidelity Guarantee policies). This notice is either included in the “Important Notices” on our invoices or included in the text on relevant invoices and other documentation.

### Average

Section 44 of the Insurance Contracts Act provides that before the contract of insurance is entered into, that the insured be clearly informed in writing of the nature and effect of the average provision. This must include whether the provision is based on indemnity or on replacement value of the property to be insured.

Our confirmation of cover and invoice documents should specify the basis of cover i.e. indemnity or replacement and specify the percentage factor that applies in the average condition. This notice is included in the “Important Notices” or in the text section of our invoices.

### Subrogation

Section 68 (1) of the Insurance Contracts Act provides that before the contract of insurance is entered into, that the insured be clearly informed in writing of the effect of any provision in the contract that has the effect of excluding or limiting the insurer’s liability by reason that the insured has entered into a contract with another party that excludes or limits the insurer’s right to recover damages from that party. This notice is included in the “Important Notices” or in the text section of our invoices.

### Unusual Terms And Conditions

Where an insurer is dealing direct with an insured, the insurer must, in accordance with Section 37 of the Insurance Contracts Act 1984, clearly inform the insured of any unusual terms, conditions or provisions included in the contract of insurance, if the contract varies from the standard contract or prescribed contracts. Such notice must be given before the contract is entered into and applies to quotations, cover notes, interim contracts of insurance and policies of insurance.

### Flood Cover

The Insurance Contract Act includes a standard definition of Flood as follows:

‘Flood’ means the covering of normally dry land by water that has escaped or been released from the normal confines of any of the following:

(a) a lake (whether or not it has been altered or modified);

(b) a river (whether or not it has been altered or modified);

(c) a creek (whether or not it has been altered or modified);

(d) another natural watercourse (whether or not it has been altered or modified);

(e) a reservoir;

(f) a canal;

(g) a dam.

The definition applies to House / Contents / Strata Title and Small Business property covers. Small business being defined as businesses with up to 5 full time equivalent staff or turnover below $1M per annum.

If an insurer is to provide Flood Cover to the above policies, then it must use the standard definition.

When a policy is arranged by an insurance broker, there is no obligation on the insurer to provide cover under the above standard definition as it is expected that the broker will assess the scope of flood cover provided and inform the client accordingly.

This creates a professional obligation on the broker to ensure we inform the client of the status of flood cover especially where it varies from the standard definition.

### Key Fact Sheets

The Insurance Contracts Act Regulations 1985 ([Insurance Contracts Act Regulations (1985)](http://www.msmlm.com/msm-mission-control/insurance-contracts-act-regulations-1985/)) require an insurer to provide a consumer with a one page Key Facts Sheet (KFS) for insurance contracts containing certain home building and/or home contents insurance that meets specific content requirements.

The aim of the KFS is to enable consumers to easily access key information about, and compare, similar insurance contracts.

A KFS must be provided by the insurer when the consumer seeks information about the relevant contract and when a consumer enters into a contract.

It need not be provided where the customer is represented by an insurance broker. The changes affect insurers and their agents, not insurance brokers acting for an insured.

Overview of Obligations

The KFS requirements apply to Home Building and Contents policies and products such as Strata Title/Landlords and Farm policies may also be impacted by this obligation.

As with PDSs, insurers may choose to issue a KFS if there is a risk an insured risk may in limited cases be caught. Others may avoid doing so by restructuring the policy or underwriting acceptance criteria. While technically the whole contract is caught, the KFS is only intended to apply to the relevant home buildings and/or home contents cover and not to other covers in the contract.

A KFS must contain the information, and be completed, in the way specified in the Forms attached in Schedule 3 to the regulations.

The KFS is subject to set specific criteria regarding presentation.

The regulations set out when and how it can be provided as well as certain exceptions. Subject to the exceptions noted below, it must be provided as soon as reasonably practicable, but not later than 14 days, after the consumer first requests information about the contract; and enters (including renewals) into the contract or potential contract with the insurer (but excluding any extension, variation or reinstatement of the contract).

This means a KFS should be provided at the time of giving a PDS where a PDS is required to be provided. In some situations, a customer may have already been provided with the PDS for a contract and they only require the KFS in which case it should be provided as soon as practicable and within 14 days.

An insurer (or an agent of the insurer) may provide the KFS by electronic means, including by a link sent in an email to the customer’s email address at the consumer’s request.

Provision of the KFS by electronic means must be at the customer’s request. Where delivery is requested by electronic means, the safer option will be to ‘provide the KFS via a link sent by email to the consumer’s email address (as explained in the Explanatory Statement).

Alternatively, providing a copy of the KFS as an attachment to an email will also meet the requirement to provide the KFS as long as the document is in the format prescribed by the regulations. It is possible that a KFS may be provided by electronic means other than by email, for example access to a secure website or other electronic communication mechanisms.

If an insurer (or an agent of the insurer) has a website that is accessible by members of the public, the insurer (or an agent of the insurer) must keep a copy of the most current/most recent version of each KFS for a contract on the website, in a format that may be downloaded by members of the public.

A KFS does not need to be provided if:

* the insurer has already provided the consumer with the KFS; and the KFS has not changed since then, other than any change to the date,
* the insurer believes, on reasonable grounds, that someone else has already provided the consumer with the KFS, or.
* the consumer requests information about the contract from an insurance broker; or enters into the contract through an insurance broker who is not acting as an agent of the insurer in relation to the contract; or
* the consumer does not provide the insurer with the consumer’s address (postal or electronic) to which the KFS is to be sent; or
* the consumer informs the insurer that the consumer does not want the KFS.

The requirement to provide a KFS rests with the insurer. It will need to meet the obligation directly or through its agents. There is no direct obligation on an insurance broker to provide a client with a KFS. Insurance brokers who act as agent of the insurer, for example under a binding authority, will need to provide the client with a KFS in their capacity as agent of the insurer where the relevant triggers arise (unless the insurer can practically do it for them).

## Corporations Act Disclosures

### Binding Authority

Where an AFS Licensee has authority to bind cover on behalf of the insurer, then the Licensee must advise the insured before, or if not practicable, as soon as reasonably practicable after the contract commences, that they are acting on behalf of the insurer and not on behalf of the insured.

The relevant notice should be used in respect of any placements under a binder.

Note: In order to comply with this, where we are operating under a binder, we must ensure that these notices are mentioned in writing when sending out quotations, invoices, renewal notices, policies, endorsements, claim forms and discharge forms. Similarly, where we have proposals printed, they should be on the proposal form and they should be on the policy documents if they are prepared by us.

### Details Of Insurers

We are required to inform the intending insured before the contract is entered into of the name and place of business of the proposed insurer(s).

Where the business is placed through another intermediary such as an Underwriting agency or through a Lloyd’s Broker, it is not sufficient to put the name of the Underwriting agency as the insurer. We must show the name and place of business of the ultimate insurer, as well as the Underwriting agent, on the invoice and any other documentation provided to the client regarding their insurance details. Where there is more than one insurer, we must also show the proportion of the risk placed with each Insurer.

For business which has been solely or proportionately placed with Lloyd’s of London the identity of the syndicate should be shown on our invoice, except where commercial considerations apply.

This information should be shown on any quotations, cover confirmations or invoices issued by our office.

### Multiple Insurers

Where the business is placed with more than one insurer, we must include the following notice:

“The subscribing insurers’ obligations under contracts of insurance to which they subscribe are several and not joint and are limited sole to the extent of their individual subscriptions. The subscribing insurers are not responsible for the subscription of any co-subscribing insurer who for any reason does not satisfy all or part of its obligations.”

Where all or part of the business is placed into Lloyds, we must give notice to the effect that:

“The risk or proportion of risk placed at Lloyd’s is placed with a number of syndicates and each syndicate’s obligation under this policy is limited solely to the extent of their individual subscription. The subscribing syndicates are not responsible for the subscriptions of any co-subscribing syndicate who for any reason does not satisfy all or part of its obligations.”

### Unauthorised Foreign Insurers (UFI’s)

The Act requires that we inform clients if all of a risk or any part thereof is to be arranged with a UFI (previously referred to as a Direct Offshore Foreign Insurer- DOFI). The notice must be given if practicable before the contract is arranged, and it is recommended that an acknowledgment based on our UFI Notice ([UFI Notice](http://www.msmlm.com/msm-mission-control/ufi-notice/)) be obtained from the insured. Lloyds Underwriters are regarded as authorised under the Insurance Act in Australia.

The notice must be used whenever we deal with UFI’s. Staff having any doubt about the status of a particular insurer should refer the matter to management.

We PROHIBIT the use of any facilities that contain a component of cover provided by a UFI, except with the written authorisation of a Responsible Manager.

## NIBA Suggested Notices

### Interests Of Other Parties

NIBA have included in their member’s practice manual a notice advising the insured that many policies restrict cover to named insureds only. This notice may be included in our notices where required.

## Insurance Brokers Code Of Practice

### Complaints Policy

The Code requires us to advise clients of our Complaints policy and how clients may access it. A standard notice is included in our invoices. We must also advise the client of our membership of the Australian Financial Complaints Authority (AFCA) and of the Insurance Brokers Code of Practice and again a standard notice is included on our invoices. For further information please refer to our Complaints Policy and Procedures ([Complaints Policy and Procedures](http://www.msmlm.com/msm-mission-control/complaints-policy-and-procedures/)).

## Privacy Act

This act requires us to provide information to individuals about our approach to Privacy and how they may get information about our Privacy Policy. A standard notice is included in our FSG and may also be included on all our invoices. For further information please refer to our Privacy Policy and Procedures ([Privacy Policy and Procedures](http://www.msmlm.com/msm-mission-control/privacy-policy-and-procedures/))

## NSW Emergency Services Levy

Under the Emergency Services Levy Act 2017 (ESLA) [NSW Emergency Services Levy Act 2017](https://www.msmlm.com/msm-mission-control/nsw-emergency-services-levy-act-2017/), the NSW State Government requires insurers to collect an Emergency Services Levy and to pay this across to the NSW government. Additional obligations imposed on insurers and their agents/representatives require disclosure of the amount of the levy to clients.

## Suggested Cancellation Warning

Following several disputes referred to Australian Financial Complaints Authority (AFCA), it is recommended that a warning involving the financial consequences of cancelling a policy mid-term be provided on all invoices. An example of this notice is included in the Important Notices Template [Important Notices Template](http://www.msmlm.com/msm-mission-control/important-notices-template/).

# CONFLICT OF INTEREST

## Introduction

Please refer to our Conflict of Interest Policy and Procedures ([Conflict of Interest Policy and Procedures](http://www.msmlm.com/msm-mission-control/conflict-of-interest-policy-and-procedures/)) and Conflict Identification Table for guidance on how we manage the conflicts of interest that arise on a daily basis within our business.

## Conflicted Remuneration

Conflicted Remuneration only relates to Personal Advice provided to Retail Clients and is banned. Conflicted Remuneration does not apply to General Insurance and Life Insurance. (sold outside of Superannuation).

Conflicted Remuneration is defined as:

A benefit given to an AFS Licensee / Representative who provides financial product advice to Retail Clients that, because of the nature of the benefit or the circumstances in which it is given, could reasonably be expected to influence:

* The choice of financial product recommended to clients by the AFS licensee or representative; or
* The financial product advice given to clients by the AFS licensee or representative.

Both ourselves and our representatives are banned from either receiving or paying Conflicted Remuneration.

ASIC’s view is that Conflicted Remuneration includes “Volume Based Benefits” and may also include “Performance Benefits”. Specifically, Asset Based Fees on borrowed amounts and Shelf Space fees are considered to be Conflicted Remuneration.

The following remuneration is specifically excluded from Conflicted Remuneration.

* Wholesale Client services.
* All General Insurance
* Life Insurance (outside of Superannuation)
* Soft dollar items under $300
* Genuine education and training payments.
* Banking staff recommending basic banking products.

Further details on Conflicted Remuneration can be found in RG246 – Conflicted Remuneration [RG246 - Conflicted Remuneration](http://www.msmlm.com/msm-mission-control/rg246-conflicted-remuneration/).

# FAMILY AND DOMESTIC VIOLENCE

Please refer to our Family and Domestic Violence Policy and Procedures ([Family and Domestic Violence Policy and Procedures](http://www.msmlm.com/msm-mission-control/family-and-domestic-violence-policy-and-procedures/)) for guidance on how we assist clients affected by family and domestic violence.

# RETAIL AND WHOLESALE CLIENTS

## Why do we need to identify Retail Clients?

The Act provides added protection to Retail Clients. These Retail Clients must be given certain information and documentation prior to or at the time of receiving Financial Services. We also have additional responsibilities to Retail Client’s in relation to acting in their best interests, only recommending products for which we have a current Target Market Determination (TMD) etc.

To ensure that we always provide this information and documentation and comply with all of our responsibilities it is therefore important for the us to be able to readily identify which clients are Retail to ensure that they receive the information and documentation as and when required.

## Who Is A Retail Client?

For a client to be a Retail Client they must meet two criteria:

* They must be an individual or a small business. A small business is a manufacturer with 100 employees or less or any other business with 20 employees or less.
* Part or all of the product being discussed/sold or transacted must cover the client for one of the following:

1. Home building or contents (excluding hotels/motels/boarding houses/buildings in course of erection/caravans)
2. Motor vehicle up to two tonne carrying capacity, including Motorcycles (excluding Buses/Trams). Vehicles must be designed for road use, passenger carrying and self-propelled. Excludes CTP covers.
3. Personal or domestic property cover including valuables/caravan/Pleasure craft/pets/mobile phones
4. Personal Accident
5. Consumer Credit
6. Travel
7. Medical Indemnity (Professional Indemnity) where the insured is a medical practitioner or health care professional and is required to be licensed or registered under any law or statute of any state or territory.
8. Any other cover that the government decides in the future should be included.

N.B. There is a general Retail Client exclusion relating to any covers that the Marine Insurance Act 1909 applies to.

Therefore, in deciding whether a client is a Retail Client you must ask two questions and the answers to both questions must be "Yes":

* Is the client (the insured or part of the insured) an individual or small business?
* Does the policy or part of the policy involved provide one of the specified covers?

## Examples of Retail Clients

* Mr. Jones buying building, contents or Pleasure craft policy.
* A Body Corporate buying cover for a residential block of flats.
* Joe’s Pizza Parlour (less than 20 employees) buying a Motor Policy to cover his delivery sedan.
* Mr. and Mrs. McDonald buying a Farm Policy that included the domestic building and domestic contents.
* A large manufacturing business (with more than 100 employees) buying a Motor Fleet policy that includes the Managing Director as a name insured and covers his private vehicle.

## Who is A Wholesale Client?

A Wholesale Client is any client that does not fit the Retail Client definition. The word “Wholesale” under The Act client definition does not have the same meaning that it is does in everyday usage.

## Examples of Wholesale Clients

* Mr. Jones buying a Plumbers Liability policy.
* A Body Corporate buying cover for a commercial block of units.
* Joe’s Pizza Parlour buying a Motor Policy to cover a 3 tonne delivery vehicle.
* BHP LTD (more than 100 employees) buying a Farm Policy that included farm building and domestic covers.

## A Client can be both a Retail Client and a Wholesale Client

Please note that a client may at the same time be both a Retail Client and a Wholesale Client depending on the product purchased. They must therefore be treated differently depending on the product involved.

In such cases it is recommended that you must either have two separate clients created (One Retail and One Wholesale) or be able to flag the “Retail Client” status at the Policy Level and not at the Client Level.

## Mixed Products

Many insurance products include covers that include both Retail and Wholesale components. In such cases The Act requires the client to be treated as a Retail Client in relation to the Retail components of the product. A typical example of this is the Home Building and Contents section of a farm policy. In practice whenever any component of the policy creates a Retail Client situation, we will treat the whole policy, including commission disclosure, as Retail.

ASIC have published [Legislative Instrument – Incidental Retail Cover 2022-716](https://www.msmlm.com/msm-mission-control/legislative-instrument-incidental-retail-cover-2022-716/) ([Legislative Instrument – Incidental Retail Cover 2022-716](https://www.msmlm.com/msm-mission-control/legislative-instrument-incidental-retail-cover-2022-716/)) that clarifies that where a product is a Wholesale product and has some incidental Retail Coverage that the product can be treated as Wholesale, but only where the following applies:

* The Retail Component is not optional, it is embedded in the wholesale product.
* The Retail Component is not available as a standalone product.
* There is no premium payable for the Retail Component.

An example of the above is a Business insurance Policy that automatically provides limited cover for employee’s personal property.

# GOOD DISCLOSURE PRINCIPALS

The Act includes specific obligations on the nature and type of information provided to Retail Clients at the Point of Sale. These obligations are designed to provide our consumers with sufficient information to make informed decisions in relation to the acquisition of financial products, including the ability to compare products. These principals should be applied when dealing with Retail Clients and providing them with advice and a Financial Services Guide, a Statement of Advice or a Product Disclosure Statement.

## Timeliness

Information should be provided to the client prior to them making a decision to purchase. Where this is not practical or possible information should be provided at the time of purchase or at the first possible opportunity after purchase.

## Relevant and Complete

The information provided to the client must be relevant to the product they are considering and complete in its content. This should be based on what we believe a usual client would require, and what are the important things they would want information on.

## Promote Product Understanding

We should try and avoid industry jargon and present information in a simple and concise fashion. We should avoid communication that is confusing and complex.

## Promote Product Comparison

Where possible, information should be presented in a similar fashion across various products that we are offering to the client. This will help the client assess the validity of our recommendation and help them determine the suitability of the product for their needs.

## Highlight Important Information

The positives and negative aspects of any product should be given equal prominence. Appropriate warnings should be used where a product has special conditions that may disadvantage the client. Our information should be balanced and unbiased.

# ADVICE

## Introduction

The Act defines the concept of advice. The requirement to provide various disclosure documentation is based on the type of information or advice provided to Retail Clients. There are basically three types of communication that can be provided.

* Factual information
* General advice
* Personal advice

It is not possible for us to avoid providing advice by claiming that we are not providing advice. Further information on advice is available from ASIC RG 244 Information & Advice. ([RG244 - Information & Advice](http://www.msmlm.com/msm-mission-control/rg244-information-advice/)).

## Personal Advice Versus General Advice

ASIC have indicated in RG175 the matters that we should consider in determining whether we are providing General or Personal Advice. They include

* Did the adviser offer to provide personal advice (eg in an FSG or other material given to the client before the advice was provided)?
* Does the adviser have an existing relationship with the client where personal advice is regularly provided to the client?
* Did the client request personal advice (including requesting advice as to what decision the client should make)?
* Did the adviser request information about the client’s relevant personal circumstances?
* Was the advice directed towards a named client or readily identifiable client or clients?
* Does the advice contain or was it accompanied by a general advice warning?
* Does the advice appear on its face to be tailored to the client’s relevant personal circumstances (eg does it refer to information or assumptions specific to the client)?

This is not an exhaustive list of all relevant circumstances. None of these circumstances alone determines whether advice is general or personal advice. The presence of any one circumstance does not necessarily mean that advice is personal advice or general advice.

While giving a general advice warning to the client is a relevant circumstance, it is not determinative and does not necessarily mean that general advice (rather than personal advice) has in fact been given to that client.

If an adviser receives or possesses information about the client’s relevant personal circumstances this does not, by itself, mean that any advice given to that client is necessarily personal advice.

Whether such advice is personal advice will generally depend on whether the adviser has considered (or whether a reasonable person might expect the adviser to have considered) that information in providing the advice.

An adviser need not consider all aspects of the client’s relevant personal circumstances (e.g. the client’s objectives, financial situation and needs) for the advice to be personal advice. It is enough that either:

* at least one aspect of the client’s relevant personal circumstances was actually considered; or
* regardless of whether they were in fact considered, a reasonable person might expect the adviser to have considered at least one aspect of the client’s relevant personal circumstances.

Whether the adviser has considered at least one aspect of the client’s relevant personal circumstances depends on what the adviser actually considered (i.e. took into account or had regard to) in the process of preparing and giving the advice.

|  |
| --- |
| For further information on this topic please refer to ASIC RG175 (Advisers – Conduct and Disclosure) ([RG175 - Adviser Conduct & Disclosure](http://www.msmlm.com/msm-mission-control/rg175-adviser-conduct-disclosure/)). |

## Factual Information Versus Advice

Factual information is objectively ascertainable – its truth or accuracy cannot be reasonably questioned. When providing purely factual information we are not providing advice. When providing factual information, we are not required to provide any additional documentation apart from that which is required to communicate the factual information.

Advice is usually characterised by a recommendation or statement of opinion and some intention to influence the client in their decision making.

Therefore, once any qualitative comment or judgment is made regarding factual information that is intended to affect the decision of the client, we are likely to be providing advice.

The following examples highlight this issue

|  |  |
| --- | --- |
| Factual Information | Advice |
| The policy provides cover for Fire, Burglary and Liability. | The policy is extremely restrictive and limited cover is only available for Fire, Burglary and Liability. |
| The premium and all charges for the insurance cover is $750.00 | The premium and all charges for the insurance is $750.00 and I believe it is the best value policy available. |
| The loss of your jewellery outside the premises is not covered by your policy. Other polices are available that provide this cover. | The loss of jewellery outside the premises is not covered by your policy; however, we can arrange this cover by switching you to another product. |
| There are two different types of policy available, Defined Events and Accidental Damage. | The Accidental Damage policy provides better coverage and more peace of mind than the Defined Events cover. |

## General Advice

Where we provide advice, but we do not take into account the client’s objectives, situation or needs such advice is called General Advice.

Just because we have previously provided a client with Personal Advice, or we hold information regarding the person’s individual needs, circumstances and requirements this does not mean that all advice provided to the client must be Personal Advice. It will depend on whether we have taken such information specifically into account when developing the advice provided.

There is no specific prescribed format that the warning must take, the important point is that the warning is given at the same time as the advice and that it clearly communicates the fact that the advice is of a general nature.

### Written General Advice

Where we are only providing General Advice in writing to Retail Clients, we must provide a warning that the advice does not take account of the clients’ objectives, financial circumstances or needs. The written warning should:

* warn the client that the advice has been prepared without taking into account the client's objectives, financial situation or needs; and
* because of that, they should before acting on the advice, consider its appropriateness having regard to their objectives, financial situation and needs; and
* if the advice relates to the acquisition or potential acquisition of a product, the client should obtain a Product Disclosure Statement and consider it before making any decision about whether to acquire the product.
* A sample General Advice Warning has been developed for use on relevant invoices. ([General Advice Warning Sample](http://www.msmlm.com/msm-mission-control/general-advice-warning-sample/)).

### Oral General Advice

Where we are providing general advice in a telephone call or face to face meeting, we must also provide a warning to the client.

ASIC have released a Legislative Instrument [Legislative Instrument - General Advice Warning 2015 540](http://www.msmlm.com/msm-mission-control/legislative-instrument-general-advice-warning-2015-540/) that reduces the level of information required when providing an oral General Advice Warning as compared to a written advice.

The Class Order only requires basic information to be provided orally as per the following examples:

* This advice is general, it may not be right for you;
* This advice is not tailored, so you can't assume it will be suitable for you;
* This advice may not be suitable for you because it is general advice;
* You will need to decide whether this advice meets your needs because I haven't.

Please refer to our current Oral Disclosure Script for details of how we have structured our oral General Advice Warning.

## Personal Advice

Where we provide advice to Retail Clients and take into account the client’s objectives, situation or needs such advice is called Personal Advice. It is our expectation that we will rarely provide Personal Advice.

In order to provide Personal Advice, we must have performed the following tasks where relevant:

* Completed an analysis of any existing product compared to the product being recommended and provide a high level comparison of the differences in any Statement of Advice provided.
* Complete a comprehensive needs analysis of the clients current situation, needs and requirements and document accordingly. This information collected will be over and above Actionquote or completing on line insurer quote input screens.
* Document the research done on the various products available and why the product selected is the most appropriate for the client.

Completing routine processes such as internet-based quotations or simply collecting the required information needed by insurers to provide quotations does not meet the requirements for Personal Advice and in such cases, we should treat the advice as General Advice.

We must provide a Statement of Advice (SOA) to Retail Clients in certain circumstances when Personal Advice is given and before a “financial service” is provided or if not reasonably practicable within five business days of providing the advice.

The SOA must provide information about remuneration (including commission) or other benefits that might reasonably be expected to be or have been capable of influencing our decision to recommend a particular product to the client.

An SOA is not required for the following products:

* motor vehicle insurance products;
* home building insurance products;
* home contents insurance products;
* travel insurance products;
* personal and domestic property insurance products; and
* medical indemnity insurance products.

In such cases we may choose to provide an SOA or alternatively we must disclose any remuneration (including commission) or other benefits that we or our staff, authorised representatives, distributors, spotters/referrers etc. are to receive and any other interests, whether pecuniary or not and whether direct or indirect that we or any related party may have that might reasonably be expected to be or have been capable of influencing the us in providing the advice.

This disclosure must be made at the time of providing the Personal Advice or as soon as possible after providing the advice. We will meet this requirement by including all such disclosures on the invoice provided to the client for the transaction involved.

## Best Interests

Where Personal Advice is being provided to Retail Clients, we have a duty to act in the best interests of our clients, subject to a 'reasonable steps' qualification, and place the best interests of our clients ahead of our own when providing personal advice to Retail Clients. There is a “safe harbour” provision in the Act which we can rely on to show we have met the best interests duty. This is intended to be the minimum standard of compliance with the best interests duty.

The Act defines “Best Interest” as:

* It would reasonably be regarded as in the best interests of the client to take a step, if a person with a reasonable level of expertise in the subject matter of the advice that has been sought by the client, exercising care and objectively assessing the client’s relevant circumstances, would regard it as in the best interests of the client, given the client’s relevant circumstances, to take that step.

In plain English this means that the client should be better off by taking the advice at the time it is given.

Where we are providing Personal Advice to Retail Clients, we will need to ensure that all of our advisers act in the best interests of the client. This can be demonstrated by an objective assessment of whether the advice provided would result in the client being in a better position, if the client acts on the advice at the time the advice was provided.

The Act includes a number of steps (referred to as Safe Harbour provisions) that must be met to ensure we have satisfied the Best Interests requirement as follows:

* identified the objectives, financial situation and needs of the client that were disclosed to us by the client through instructions; and
* identified the subject matter of the advice that has been sought by the client (whether explicitly or implicitly); and the objectives, financial situation and needs of the client that would reasonably be considered as relevant to advice sought on that subject matter (the client’s relevant circumstances); and
* where it was reasonably apparent that information relating to the client’s relevant circumstances was incomplete or inaccurate, made reasonable inquiries to obtain complete and accurate information.
* For non general insurance advice areas there are the following additional obliations:
* Assess if the licensee has the expertise to provide the client advice and, if not, decline to provide the advice;
* If recommending a financial product:

conduct a reasonable investigation into the financial products that might achieve those of the objectives;

assess the information gathered in the investigation;

* Base all advice on the client’s relevant circumstances;
* Take any other step that would be regarded as being in the client’s best interests given their circumstances.

## Fee Disclosure Statement (FDS)

The obligation to send an FDS only applies where an annual fee is payable by the client and where the fee is being charged for providing Personal Advice to Retail Clients.

* Where fees are charged on a one off basis for arranging a particular policy the FDS obligations do not apply. This means the vast majority of General and Life Insurance intermediaries will not have to meet the FDS obligations.
* Commissions paid by suppliers are not usually considered “Fees”

Where the business is caught by the FDS obligations we will comply with the Act and the specific guidance included on the ASIC website - [Ongoing Fee Arrangements](https://asic.gov.au/regulatory-resources/financial-services/giving-financial-product-advice/fees/faqs-ongoing-fee-arrangements/).

This means we will be required to send clients an FDS statement setting out:

* The fees charged in the last year.
* The services they were entitled to receive.
* The services that they did receive.

The FDS is to be sent no later than 30 days from the date of last FDS sent or 12 months from date of first charging such a fee.

## Our Approach to Advice

The approach that we take on what type of advice we provide (General vs. Personal) is spelt out in our Financial Services Guide and is also further explained in our annual Business Plan.

# STATEMENT OF ADVICE (SOA)

## Introduction

When we provide initial Personal Advice to a Retail Client, we must prepare an SOA for Personal Accident and Consumer Credit products, the provision of an SOA for other Retail Products is at our discretion. The SOA must be a separate distinct document from the Financial Services Guide and Policy Disclosure Statement and any other documentation, such as Invoices, Proposals etc. that may be sent out with the SOA.

In some circumstances for subsequent Personal Advice (after the provision of the initial Personal Advice) we have the option of providing a Statement of Additional Advice (SAA) or a Record of Advice (ROA) rather than producing a full replacement SOA.

## (SOA) Content

The SOA must contain the following things:

* The Title of Statement of Advice, In other parts of the document this can be abbreviated to SOA;
* Our name, contact details, AFS Licence No. and that of the Authorised Representative or Distributor (if applicable)
* The clear and concise advice and recommendations being given.
* An explanation of how the advice and recommendations:
* are based on the client's objectives, financial situation and needs,
* address those objectives,
* address the client's original request for advice and takes into account subsequent investigation and consideration by us.
* Pecuniary or non-pecuniary benefits or advantages that We or our Authorised Representatives and Distributors (or our related bodies corporates, directors or employees or associates) obtain that may reasonably be expected to be capable of influencing the provision of advice in dollar or % amounts. All remuneration disclosures must be set out in dollars unless there is a compelling reason that we are unable to do so. For further information please refer to RG182 ([RG182 - Dollar Disclosure](http://www.msmlm.com/msm-mission-control/rg182-dollar-disclosure/)).
* Where it is not possible to quantify the benefit to be received in dollar or % terms a clear unambiguous explanation of the benefits to be received should be provided.
* This includes remuneration details such as commission we or our Authorised Representative and Distributor receives in connection with the advice and any profit/sales/volume/lapse/new business/overrider etc bonuses payable whether they are paid in monetary terms or by other means such as trips/holdays/gifts etc and regardless of when such benefits might be paid.
* Information about all remuneration and benefits that a spotter or referrer has received or is to receive from another person for referring the client to Us or the Authorised Representative or Distributor.
* Any other interests of the person or entity providing the advice that may have influenced it, including any associations between the adviser and the issuers of any financial products;
* Where advice recommends product replacement, information to allow the client to assess the cost of replacing a product and the potential financial loss or loss of benefits that may result.
* If we are recommending a policy be cancelled mid term, details of any penalties that may apply.
* Where the advice might be based on incomplete or inaccurate information a warning that the advice may be based on incomplete or inaccurate information and the client should consider appropriateness of the advice before acting.

## Statement of Advice (SOA) Presentation

When preparing an SOA please also bear in mind the following guidance provided by ASIC.

* SOA’s should be short and simple for short and simple advice.
* Extraneous information (i.e. information that the law does not actually require to be included in the SOA, such as detailed research) should not be included if it results in the SOA not being clear, concise and effective. Where extraneous information is included, it should be clearly distinguishable from the mandatory information.
* The clear, concise and effective obligation does not mean that information required by the SOA content provisions can be left out. Rather, the clear, concise and effective obligation affects the way that an adviser presents the required information. This includes trying to present the information in as brief a manner as reasonably possible, without compromising its accuracy.
* The most important information in an SOA should be highlighted, e.g. in an executive summary that summarises the most important information and indicates where more detail can be obtained. This is especially important where the SOA is long (say, more than 10 pages).
* The longer the SOA, the more important will be the inclusion of navigational aids such as a table of contents.
* Legal, industry or technical jargon should be avoided, especially where advice is provided to relatively unsophisticated clients.
* There is no one 'correct' or 'ideal' format for an SOA – the law provides flexibility in tailoring the format and presentation to the particular information needs of consumers. In this regard, consumer testing can help advisers assess the effectiveness of various disclosure formats.

## Statement of Additional Advice

ASIC have made provision for situations where we provide another SOA to a client after the initial SOA. In such cases we are not required to repeat some of the information that was provided in the initial SOA.

## Record of Advice (ROA)

An ROA will typically be a verbal advice and may be provided to a client in lieu of a full SOA in the following circumstances:

* We have previously given the client an SOA.
* The client's personal circumstances have not materially changed from those applicable to the original SOA.
* The basis on which the advice is given is not significantly different from that relied on for the original SOA.

Where we are providing an ROA, we must provide the client with the following information in writing as soon as practical after providing the ROA:

* Brief details of the advice.
* Details of all remuneration related to the ROA.
* Details of any relationships that may impact the advice provided in the ROA.

Full details of the ROA and all supporting information must be retained by us for 7 years and provided to the client upon request. Due to the complexities of this option and the minimal savings involved, we have decided to issue a complete SOA each time we provide Personal Advice to a Retail Client.

## Oral Advice and SOA’s

In situations where we are unable to provide an SOA at the time of the Retail Client acting on the Personal Advice (e.g. advice is provided over the phone) we must tell the client about the following matters at the time of providing the advice:

* any remuneration (including commission) or other benefits that we or any associates/staff etc may receive.
* any relationships that may influence our advice.
* The risks and disadvantages of switching from one product to another (if applicable)
* A script for these situations has been developed by the business and must be followed in all relevant situations.

## Electronic Delivery

We can deliver the SOA’s electronically (email / hyperlink / website) to the client where we provide the client with an easily accessible option of opting out of such delivery mechanisms within 7 days of being advised of the proposed electronic delivery system.

For further information on this please refer to RG221 – Facilitating On line Disclosure [RG221 - Facilitating Online Financial Disclosure](http://www.msmlm.com/msm-mission-control/rg221-facilitating-online-financial-disclosure/) and Legislative Instrument Facilitating Electronic delivery of Financial Services Disclosure 2015-647 ([Legislative Instrument - Facilitating Electronic Delivery of Financial Services Disclosure 2015-647.pdf](http://www.msmlm.com/msm-mission-control/legislative-instrument-facilitating-electronic-delivery-of-financial-services-disclosure-2015-647)).

## Chapter 7 (Corporations Act) Decision Tree

What Type of Client am I Dealing With ?

Is the client an individual or a small business with less than 20 employees or a manufacturer with less than 100 employees ?

Yes

Is the product Home / Contents / Motor (under 2 Tonne) / Pleasure Craft / Travel / Personal Accident ?

Yes

No – Wholesale Client

Client must be Given FSG and PDS

Factual Information

No need for Staff to have Tier 1 or Tier 2

Advice (Express or Implied)

Staff must have Tier 1 (Personal Accident) or Tier 2 (Other Classes)

Personal Advice

Provide Statement of Advice or Statement of Additional Advice and act in best interest of client

No – Wholesale Client

General Advice

Provide General Advice Warning

# FINANCIAL SERVICES GUIDE (FSG)

## Introduction

Under The Act we must provide a current Financial Services Guide (FSG) to Retail Clients when providing advisory or dealing services to clients, unless we are sure that the client has already received a current FSG. The FSG content requirements ensure that Retail Clients are given sufficient information to enable them to decide whether to obtain financial services from us.

Our approach is to provide all clients with an FSG. The reasons for this are:

* It removes the risk of failing to correctly classify the client as “Retail”.
* Our FSG includes advice that we retain all interest earned on “Client Money” held in our Trust Account. If a client is not given this advice, we would have to pass such interest back to the client.

The FSG should be provided at the time of giving advice however if this is not practical as soon as is practical after giving the advice but, in any event, no later than five business days after giving the advice.

Our representatives who are attending clients for the first time are required to provide a copy of the current FSG to the client.

Any Authorised Representatives that operate on our behalf are required to issue an FSG that provides additional information on their specific authorities and remuneration arrangements.

A Distributor must provide all clients with our FSG and disclose their remuneration to Retail Clients

For further information on this topic please refer to ASIC RG175 (Advisers – Conduct and Disclosure) [RG175 - Adviser Conduct & Disclosure](http://www.msmlm.com/msm-mission-control/rg175-adviser-conduct-disclosure/)

## Content of FSG

The FSG must contain information about:

* The purpose and content of the FSG;
* Include a “Lack of Independence” statement (in bold and on first page) where we receive commission from suppliers. This obligation is effective as from 1/7/21.
* Include advice that clients may receive Statements of Advice and Pproduct Discosure Statements and the purpose and contents of those documents.
* Who we are and how the client may instruct us;
* What are the financial services that we are licensed to provide;
* Details of anyone we act on behalf of when providing the financial service(s);
* How we are to be remunerated — this applies to us, a related body corporate, an employee or director of ours or a related body corporate; an associate of any of the above; or any other person specified in Regulations;
* Information regarding access to Records of Advice, access to remuneration information where an SOA is not provided.
* Any associations that we have with a product issuer that might reasonably be expected to affect the advice provided; and
* Where services are being provided under a binder, information on the binder and for whom we are acting.
* Details of our internal and external dispute resolution procedures and how the client may access these.
* Details of our Compensation arrangements

## Oral Advice and FSG Information

In situations where we are unable to provide an FSG at the time of providing advice (e.g. advice is provided over the phone) we must tell the client about the following matters at the time of providing the advice:

* How we are to be remunerated — this applies to us, a related body corporate, an employee or director of ours or a related body corporate; an associate of any of the above; or any other person specified in Regulations;
* Any associations that we have with a product issuer that might reasonably be expected to affect the advice provided; and
* Where services are being provided under a binder, information on the binder and for whom we are acting.
* A script for these situations has been developed by the business and must be followed in all relevant situations.

## Updates

Where our FSG contains information that is outdated, or that may tend to mislead or deceive, a new or supplementary FSG must be prepared and provided to clients or a replacement FSG must be issued.

A copy of the old FSG is to be retained by the business for seven years and we must keep a record of when each FSG commenced being distributed and when it became superseded.

This register will be maintained by the Compliance Officer. All old FSG stock must be destroyed and the new FSG should be issued to all Retail Clients on renewal or when next providing advice.

## Electronic Delivery

We are able to deliver the FSG electronically (email / hyperlink / website) to the client where we provide the client with an easily accessible option of opting out of such delivery mechanisms within 7 days of being advised of the proposed electronic delivery system.

For further information on this please refer to RG221 – Facilitating On line Disclosure [RG221 - Facilitating Online Financial Disclosure](http://www.msmlm.com/msm-mission-control/rg221-facilitating-online-financial-disclosure/) and Legislative Instrument Facilitating Electronic delivery of Financial Services Disclosure 2015-647 ([Legislative Instrument - Facilitating Electronic Delivery of Financial Services Disclosure 2015-647](http://www.msmlm.com/msm-mission-control/legislative-instrument-facilitating-electronic-delivery-dislosure-2015-647/)).

# PRODUCT DISCLOSURE STATEMENT (PDS)

## Introduction

When we recommend a financial product to a Retail Client, we must provide a Product Disclosure Statement (PDS) for the product at the same time, unless a limited set of exceptions applies. The major exceptions are:

* Where we have issued an Interim Contract, the PDS must be provided prior to the proposal being completed.
* Where the client has previously received the relevant PDS.

Therefore, we need to send a PDS to each Retail Client when providing them with a quotation/interim cover and at renewal where there has been a change in the PDS. We must also send out the PDS for the new product where we are recommending the client change from one insurer to another insurer or from an existing product to a new product.

The PDS’s are produced and provided by the insurer that issues the policy wording. We must ensure that we have supplies available of current PDS’s for all products on which we advise Retail Clients. If a PDS changes between the time we provide advice and the subsequent purchase of the product we must provide the client with an up-to-date PDS.

## Content

The PDS must contain information that helps a client make an informed decision including:

* The fees payable in respect of the product.
* The risks of the product
* The benefits of the product
* Any significant characteristics of the product.

## Oral Advice and Product Disclosure Statements

If we have provided a Retail Client with Personal Advice and the client wishes to purchase the product and we are unable to supply them with a copy of the PDS we must advise the client about the following matters:

* the name of the insurer (this assumes address of insurer is readily available in the public domain)
* offer the client further information about the product.
* information about the cooling‑off period.
* Advise the client that they should review the PDS.
* In such cases the PDS must be supplied to the client within five business days of purchase. A script for these situations has been developed by the business and must be followed in all relevant situations.

## Updates

Where a PDS contains information which is outdated, or that may tend to mislead or deceive, a new PDS must be provided to Retail Clients. Insurers are responsible for advising us of such changes.

A copy of the old PDS is to be retained by the business for seven years and we typically keep a record that details when each PDS commenced being distributed and when it became superseded.

All old PDS stock must be destroyed and the new PDS should be issued to all Retail Clients on renewal or the date at which it becomes applicable, whichever is the earlier.

The Document Register will be maintained by the Compliance Officer.

## Electronic Delivery

We are able to deliver the PDS electronically (email / hyperlink / website) to the client where we provide the client with an easily accessible option of opting out of such delivery mechanisms within 7 days of being advised of the proposed electronic delivery system.

For further information on this please refer to RG221 – Facilitating On line Disclosure [RG221 - Facilitating Online Financial Disclosure](http://www.msmlm.com/msm-mission-control/rg221-facilitating-online-financial-disclosure/) and Legislative Instrument Facilitating Electronic delivery of Financial Services Disclosure 2015-647 ([Legislative Instrument - Facilitating Electronic Delivery of Financial Services Disclosure 2015-647](http://www.msmlm.com/msm-mission-control/legislative-instrument-facilitating-electronic-delivery-dislosure-2015-647/)).

# NEEDS ANALYSIS (KNOW YOUR CLIENT)

A key requirement to provide professional advice is that in the provision of advice there must be a sustainable basis for that advice that can be provable to an auditor.

In fact, Chapter 7 of the Corporations Act states that the provider of personal advice must have considered the objectives, the financial situation and needs as relevant or a reasonable person might expect the provider to have considered those matters.

For example, in providing a recommendation or opinion on the purchase of a policy, a Needs Analysis of the client would be required to have been done to ascertain what the client’s situation and requirements are and that the advice given meets those requirements. The Needs Analysis would then form the basis of the advice provided to the client.

It should also be noted, that an Intermediary will be held liable at law if they fail to inform the client of any “significant terms” in a policy and the ramifications if the client fails to adhere to those terms, including that the Insurer may be able to avoid an otherwise indemnifiable claim.

We have developed a set of standard forms to be used to gather client information. Proposals and like documents can be used as a base to elicit Client Needs, however at all times it is important to remember the requirements that you must have reasonably considered. These are:

The Client’s:

* Objectives
* Financial situation
* Needs

Finally, in recommending or providing an opinion regarding Insurers or their products, there needs to be a reasonable basis of making the recommendation or providing an opinion. The Insurers’ products may also need to be independently assessed as being superior in a particular category in order to make a supported recommendation.

It is important therefore that all staff/representatives dealing with clients document the discussion and advice given in order to provide a record that will show that advice was reasonable in the circumstances.

# CONFIRMATION OF TRANSACTIONS

Confirmation of transactions for Retail Clients must be given to the client as soon as reasonably practicable after the transaction. This is the insurer responsibility. Examples of transactions include variation of the Policy after inception, such as endorsements. The confirmation must be in writing or in electronic form and:

* Identify the Insurer, the Intermediary and the Insured and
* the effective date of the transaction and
* the description of the transaction and
* any premium or other amount payable (including stamp duty or other taxes) in respect of the transaction.

One way this requirement may be met is for the Insurer to establish a telephone facility or appoint the Intermediary to provide confirmations on their behalf. In this case, a Retail Client may phone us and we must provide this information to them. In order to do this, the Retail Client must be aware of this facility by way of some initial notification to them.

We have included information on this facility in our standard Broking Letter of Engagement. ([Broking Letter of Engagement](http://www.msmlm.com/msm-mission-control/broking-letter-of-engagement/)).

# ANTI HAWKING

## Introduction

There is a restriction on selling or offering to sell financial services via unsolicited contact (“hawking”) under the Chapter 7 of The Act. The restriction only applies to Retail Clients and does not apply where Personal Advice is being provided to the Retail Client. A full coverage on this topic is available from RG38 – The Hawking Prohibitions ([RG38 - The Hawking Prohibitions](http://www.msmlm.com/msm-mission-control/rg38-the-hawking-prohibitions/)).

Unsolicited Contact means any telephone, face to face or real-time interaction in the nature of a conversation or discussion without consumer consent that involves the offering of financial products or services for issue or sale in the course of, or because of the interaction.

Text message discussions are likely to be included in the scope of real-time interactions, but emails are not considered real-time interactions.

The consumer consent must be positive, voluntary, clear and capable of being reasonably understood.

## The Do’s and Don’ts – Retail Clients Only

|  |  |
| --- | --- |
| Do’s | Don’ts |
| Before making an unsolicited call, clarify if the client is a Retail or Wholesale client. | Treat all clients the same when making outbound telephone calls |
| Limit unsolicited outbound phone calls to existing coverage and directly related coverage issues. E.g. It is OK to ask a client with contents insurance if they require building insurance and vice a versa. | Try and cross sell Retail Clients additional products during phone calls, unless the client (without prompting) specifically raises the issue / concern with you and requests coverage options for their consideration. |
| Send out emails / flyers / brochures advertising products and requesting clients to respond if interested. | Follow up Retail Clients via an unsolicited phone call that have been sent an email / flyer / brochure with the purpose / intent or outcome of selling them a product. |
| Follow up clients to ensure they received and understood information supplied above with no attempt made to initiate or finalise a sale. | Request the client to approve the unsolicited contact during the unsolicited contact. Such approval has no legal status. |
| Ensure that where a client provides consent for you to contact them about the sale of a product, contact is made within 6 weeks of the consent being provided, otherwise contact will be deemed “unsolicited”. | Send out proposal forms /emails etc after an unsolicited phone call except where client has initiated (without prompting) the coverage request. |

## Hawking Penalties

A breach of the hawking restrictions is an offence under The Act and creates the risk of the business having various fines imposed on it and also entitles the Retail Client to an full refund of any premiums paid in relation to a product sold.

# COOLING OFF PERIOD

For clients purchasing a “Retail” product the client has a right to cancel the Policy within 14 days, commencing from either the date of confirmation of cover or five business days after issuance, whichever is earlier.

The client in these circumstances will receive a refund of premium from the inception of the Policy less any administration costs which may include a pro rata premium for the Insurer in respect of time on risk.

The Cooling Off Period will not, however, apply if the client has exercised their rights under the Policy, such as making a claim before the end of the cooling off period. Additionally, if the Policy is of duration of less than 12 months and is a renewal of an existing Policy on the same terms and conditions, this will also be exempt from the Cooling Off provisions.

The Cooling Off Period does not apply to renewals where the client has already received 14 days, notice.

# APPROVED / BANNED PRODUCT LISTING

In some cases, we may maintain an Approved / Banned Product Listing that details the products that we recommend / exclude from our client advice. Any relevant listing will have been developed as part of our Product Research Policy and Procedures ([Product Research Policy and Procedures](http://www.msmlm.com/msm-mission-control/product-research-policy-and-procedures/)). All staff making product recommendations to clients must be familiar with these Policy and Procedures.

Apart from providing guidance on the relative benefits and disadvantages associated with each product the Approved Product listing will also identify any products that are impacted by preferential remuneration arrangements. When recommending products that involve significant additional commission payments, we must be careful to ensure the advice provided is appropriate and driven by the client’s needs rather than our income. For further information refer to the Commission Section of these Policy and Procedures.

# UNDERWRITER ADMINISTRATION

## Introduction

Our Product Research Policy and Procedures ([Product Research Policy and Procedures](http://www.msmlm.com/msm-mission-control/product-research-policy-and-procedures/)) provides guidance on the use of insurers.

In determining whether we wish to deal with a particular insurer, underwriting agency or wholesale broker we need to balance the requirement to ensure we have access to the broadest possible range of products for our clients with the administrative cost of maintaining a relationship with each of our suppliers.

If a new Insurer, Underwriting Agency or Wholesale Broker is to be used, full details regarding the security of the Underwriting Agency and Insurer is to be provided to the Responsible Manager(s) at the time of request.

We maintain (via our broking computer system) a list of Insurers, Underwriting Agencies and Wholesale Brokers with whom we deal. This is maintained by one of our Responsible Manager(s) or a duly authorised staff member.

Wherever possible locally authorised insurers, underwriting agencies and wholesale brokers representing local insurers are to be used and/or sourced for securing our clients business.

## Underwriting Agents and Wholesale Brokers

Where an Underwriting Agency and/or Wholesale Brokers are used full details of their insurer security must be provided to the insured at the time of quotation or binding of cover. Our computer records must be set up in such a fashion to clearly identify the company carrying the risk on all invoices etc.

It is also imperative when dealing with underwriting agencies or wholesale brokers etc. that we check in every instance that we have the name and address of the insurers involved and that they are not Unauthorised Foreign Insurers (UFI’s).

Where we are placing cover for a Retail Client via an Underwriting Agency or Wholesale Broker the agreement must include a requirement for us to provide the client with the Licensees FSG or alternatively provide the client with information on how to access the FSG of the Licensee with whom we are placing the business.

For all such underwriting agencies and wholesale brokers the following template should be used on all relevant invoices.

“This insurance is being arranged via another AFS Licensee who is not the final insurer of the cover. Should you wish to access their Financial Services Guide please contact us and we will arrange to have a copy sent out to you.”

Alternatively, we may include a similar pre-printed notice on the rear of our invoices.

## Unauthorised Foreign Insurers (UFI)

### UFI Overview

By way of background, if an insurer carries on business in Australia it will usually be authorised under the Insurance Act 1973 ([Insurance Act 1973](http://www.msmlm.com/msm-mission-control/insurance-act-1973/)) and comply with APRA’s capital and reserving requirements. Lloyds syndicates have a special authorisation under the Insurance Act 1973 so that Lloyds provides a deposit by way of guarantee instead of syndicates having to meet the capital and reserving requirements.

UFI’s are insurers based overseas that have not applied for or met the licensing requirements of the Insurance Act 1973. This lack of regulatory control of UFI’s potentially leads to a real and practical risk that the insurer may not have the financial resources to pay claims into the future. This risk is increased substantially where long tail classes such as Liability are involved.

The Insurance Act 1973 requires all insurers operating in the Australian to be authorised by APRA. The authorisation requirements are designed to ensure that Australian policyholders have the security of Australia’s strong prudential regime for general insurers and are protected from dealing with UFI’s that do not meet the standards required of an APRA-authorised insurer.

The Corporations Act 2001 requires Australian Financial Services Licence (AFSL) holders and their authorised representatives, who are licensed to deal in general insurance products, to only deal in general insurance products of Australian-authorised insurers, unless an exemption applies.

Under the Insurance Act 1973 a person is also taken to carry on insurance business in Australia (which triggers the obligation to obtain a general insurance licence) if:

* they carry on business outside Australia that would be considered to be carrying on insurance business if it was carried on in Australia, and
* they act in Australia through another person, eg an agent.

As a result, UFI’s who issue insurance to Australian customers through an agent or broker are required to hold a general insurance licence and are subject to prudential regulation, including the requirement to have a presence in Australia and to hold sufficient assets to meet their liabilities here. Limited exemptions are available under the Insurance Regulations (refer below).

* The definition of ‘insurance business’ under the Insurance Act is defined to include ‘any business incidental to insurance business’. And to expressly encompass a set of activities which, while not exhaustive, would specifically include:

1. inducing others to enter into contracts of insurance with the person as an insurer
2. publishing or distributing a statement relating to the person’s willingness to enter into a contract of insurance as an insurer, and
3. procuring the publication or distribution of a statement relating to a person’s willingness to enter into a contract of insurance as an insurer.

This definition may have the effect of including some foreign insurers who might otherwise be excluded from the new regime because their activities might not have been considered sufficient to constitute carrying on an insurance business in Australia.

Incidental activities which take place after the insurer has entered into the contract of insurance with the insured are not, however, intended to be captured by this definition. Such activities would include claims handling, operating accounts, making payments or holding records on behalf of an overseas foreign insurer.

* Where an Australian customer directly initiates contact with a UFI outside Australia, rather than acting through an Australian insurance agent or broker, the UFI will not be considered to be carrying on insurance business in Australia and will not be required to become APRA authorised even under the expanded scope of the Act (provided it did not initially induce the customer to enter into the insurance contract).
* Section 118 of the Act has been amended to allow a foreign insurer to appoint a range of different legal entities as their agent in Australia.
* The Corporations Act includes a prohibition on AFSL holders and Authorised Representatives from dealing in a general insurance product, unless it is from an authorised insurer, a Lloyd’s underwriter or an exemption applies. This prevents Australian based insurance agents or brokers directly placing insurance with foreign insurers who do not actively participate in the Australian market.

### UFI Exemptions

Some business is able to be placed with UFI’s as long as this business meets one or more of the following exemption rules outlined in the Insurance Regulations 2002 ([Insurance Regulations 2002](http://www.msmlm.com/msm-mission-control/insurance-regulations-2002/)).

* high-value insured:- This limb allows Australia's largest businesses and global companies headquartered in Australia to use UFI’s as part of their risk management frameworks and to cover their global risks. It recognises that high-value insureds are likely to be sophisticated purchasers of general insurance with complex risks that may not be able to be covered solely through authorised insurers.
* The insured and/or their Australian Financial Service Licence (AFSL) holding intermediary must "self-assess"; against these thresholds, which are set out in the Insurance Regulations 2002. If the insured meets the definition of high-value insured, the business could then be placed with a UFI without the UFI or AFSL holder being in breach of the prohibitions. High-value insureds are defined as corporations, partnerships or trusts (either as a single entity or a group of related entities that have:

1. total group gross operating revenue in Australia of $200 million or more; or
2. total group gross assets in Australia of $200 million or more; or
3. total group employees in Australia of 500 or more.

* atypical risk:- This limb recognises that there are a number of limited specific atypical insurance risks that currently cannot be placed, on a stand-alone basis, with authorised insurers. The insured and/or their AFSL holding intermediary must self-assess against this list of insurance lines. If the insured is seeking a policy that corresponds to one of these lines, the business could then be placed with a UFI without the UFI or AFSL holder being in breach of the prohibitions. The exemption applies to the following lines of insurance:
* Nuclear
* War
* Terrorism
* Satellite or space Biological risk
* Medical clinical trials
* Aviation liability
* Shipowners’ protection and indemnity other than for pleasure crafts
* Legislative:- An arrangement with a UFI that is required by the law of a foreign jurisdiction is exempt.
* Customised:- This limb recognises that there is a further range of circumstances where a business or consumer has a unique risk that cannot be placed with an authorised insurer. An assessment must be made, and documented, by Us to determine if a specific risk cannot be placed with an authorised insurer, taking into account the following criteria:

a lack of market capacity;

a material difference in price;

a difference in non-price terms and conditions bearing a material impact on the business or consumer; and

material benefits accruing from continuity of an ongoing relationship between a given insurer and the business or consumer.

If we are satisfied that the risk cannot be placed with an authorised insurer, the business could then be placed with a UFI without the UFI or ourselves being in breach of the prohibitions. Our determination would need to be based on a reasonable level of investigation and market analysis.

Assessment of the exemption must be made at the time of negotiation, inception, renewal or material change in the terms and conditions of the relevant policy.

The use of UFI’s is therefore both highly risky and potentially short term (due to the ongoing requirement to meet an exemption). The use of UFI’s to cover our client’s business is therefore only to be used as a last resort after all other avenues of arranging cover have been exhausted.

The Federal Government also requires AFS Licensees to provide statistical returns to APRA on the placement of business with UFI’s. Dealing with a UFI will therefore require us to apply for and install the APRA D2A software and lodge our 6 monthly Form 701’s via the D2A system. The application process for the D2A software and subsequent installation and maintenance of the software is expected to involve at least 2 to 3 hours per annum. This overhead should be considered when making a decision to initially use a UFI within the business.

Our professional indemnity insurance may not pay for claims against us due to an insurer going into liquidation with claims remaining unpaid. We PROHIBIT the use of any facilities that contain a component of cover provided by a UFI except with the written authorisation of a Responsible Manager.

### UFI Risks

The main risks relevant to a UFI are essentially as follows:

* the risk of insolvency and inability to pay a valid claim;
* the risk that the UFI will not administer their policy in accordance with the requirements of the Insurance Contracts Act and other Australian legislation which is designed to protect consumers; and
* the risk that the UFI will not abide by Australian law should a customer seek to claim or enforce any rights they have under the legislation or in any other dispute. As the insurer is outside the jurisdiction they are harder to chase if they decide not to co-operate. This can be an expensive process.
* The UFI cannot be a declared general insurer for the purpose of Part VC of the Insurance Act 1973, and, if the insurer becomes insolvent, the client will not be covered by the financial claims scheme provided under Part VC of that Act.
* The UFI may not follow the Australian Privacy Principles as laid out in the Privacy Act 1988 creating the risk that we may be found liable for such breaches and associated fines and penalties.

We do not seek to warrant or guarantee the solvency of an insurer (whether a UFI or not) when the policy is recommended or on an ongoing basis. A court is unlikely to find that this is the case in most circumstances unless there is a representation to the contrary. We need to ensure that we make no such representation. A notice to this effect, before or at the time the policy is entered into, is a useful way of clarifying matters. Such a notice has been incorporated in the NIBA example UFI Notice ([UFI Notice](http://www.msmlm.com/msm-mission-control/ufi-notice/)).

UFIs are neither subject to the prudential requirements of the Insurance Act nor the scrutiny of APRA. The fact that a UFI is not subject to these requirements does not automatically mean it is in any better or worse position regarding solvency than an insurer that is. However, where an insurer is subject to the Insurance Act 1973, there is some comfort that these requirements apply (including minimum capital and reinsurance requirements) and that an Australian regulator is monitoring the insurer’s situation on an ongoing basis.

APRA is typically in a much better position than us to determine the financial situation of an insurer. The fact that an insurer is authorised under the Insurance Act 1973 does not necessarily guarantee that it is or will remain solvent, but the risk of this is reduced for the client and for us.

If we arrange insurance with an insurer that is or becomes insolvent, the customer will typically seek to recover any resulting loss from us, asserting a breach of duty of care, breach of contract and/or misleading or deceptive conduct, etc.

Professional indemnity insurance is unlikely to cover such a risk, so this is a crucial matter for consideration. We will typically need to be able to establish that in arranging and/or recommending any product we have exercised a fair, reasonable and competent degree of skill in determining the financial adequacy of the insurer and its ability to pay valid claims.

In addition to the above, we can in some cases have an ongoing obligation to warn clients of any change in the insurer’s financial position during the term of the insurance contract. The extent of this obligation is something which is open to argument and will very much depend on the circumstances.

### UFI Processes

Where a UFI is used the following steps must be taken for new business and at every renewal.

Before we consider a UFI, we should follow the steps below:

* Canvas the local market for coverage, pricing, conditions etc. documenting the process.
* Ensure the placement is lawful - one of the four exemptions listed in 21.3.2 must apply. This step is to be clearly documented by the use of the UFI - Exemption Checklist ([UFI Placement Checklist](http://www.msmlm.com/msm-mission-control/ufi-placement-checklist/)) which is to be completed for every placement.
* Review the insurer’s financial position (including financial performance in the most recent financial year);
* Review the insurer’s market reputation and claims paying philosophy based on the experience of intermediaries or contacts in Australia or overseas;
* Review the insurer’s credit rating through a local or overseas credit rating agency (like Standard & Poors);
* Review the system for prudential regulation that operates in the country where the insurer is domiciled;
* Review the system for resolution of claims disputes in the country where the insurer is domiciled;
* Review the existence of a local or regional office that could assist in handling claims and other inquiries about the insurer’s products;
* If the insurer will be underwriting Retail Client products, whether a Product Disclosure Statement (PDS) exists for those products and the PDS includes a specific reference to the fact the insurer is unauthorised and also details the risks associated with dealing with a UFI..
* If a UFI option is to be put to the client this must be approved by a Responsible Manager prior to providing the client with the option.
* If a local market is located always recommend this coverage to the client, regardless of the price.
* If the client elects to use the UFI, have the client complete the relevant UFI declaration ([UFI Notice](http://www.msmlm.com/msm-mission-control/ufi-notice/)) prior to the placement of cover. Where the client is a corporate entity or business ensure that the Notice is signed by the Owner,/ Chief Financial Officer, Chief Executive Office, Director or other similar senior person within the business. This will ensure we meet our obligations to both Retail and Wholesale clients under the Corporations Act.
* Ensure a copy of the declaration is maintained on the client file.
* Include the key points from the Unauthorised Foreign Insurer Notice in relevant invoices provided to the client
* All covers placed with Unauthorised Foreign insurers should be coded accordingly to enable a review of our exposure to such business and to aid the compliance review of such covers and subsequent reporting requirements of APRA.
* To ensure compliance with all of the steps above a UFI Placement Checklist ([UFI Placement Checklist](http://www.msmlm.com/msm-mission-control/ufi-placement-checklist/) ) is to be completed for every placement and kept on the policy file.

### UFI Taxation Issues

An unauthorised foreign insurer may or may not issue a contract of insurance which is subject to Australian taxation laws. This means Withholding Tax, GST, stamp duty and other taxes or charges in various states might apply (such as Insurance Protection Tax in NSW, fire services levy in various States and terrorism levies).

Check with the insurer or intermediary to ensure that they have arrangements in place to remit taxes and charges that apply because the liability may fall to us and our client if they are not met. We need to protect the business against liability for payment of taxes, charges, fines and penalties.

If the insurer does not have suitable arrangements, we may need to cease dealing with them. Otherwise, we may need to make arrangements to remit tax etc. on their behalf. Usually if a local broker or underwriting agency is appointed to bind cover for the UFI they will attend to these matters – but check to make sure they are handling this.

### UFI – Retail Clients and Product Disclosure Statements

An unauthorised foreign insurer that underwrites insurance for Retail Clients must prepare a PDS. The PDS needs to explain the features of the insurance, the rights of the insured and access to dispute resolution processes amongst other information required under The Act.

It also needs to include a statement:

A That the product issuer is an unauthorised foreign insurer, is not authorised under the Insurance Act 1973 to conduct insurance business in Australia and is not subject to the provisions of the Insurance Act 1973, which establishes a system of financial supervision of general insurers in Australia.

B That the insurer cannot be a declared general insurer for the purpose of Part VC of the Insurance Act 1973, and, if the insurer becomes insolvent, the person will not be covered by the financial claims scheme provided under Part VC of that Act.

The PDS should also advise the client to consider whether to obtain further information, including:

* the country in which the product issuer is incorporated, and whether the country has a system of financial supervision of insurers; and
* the paid up capital of the product issuer; and
* which country's laws will determine disputes in relation to the financial product.

Make sure the insurer we deal with has a compliant PDS for Retail Clients – otherwise we risk breaching The Act because it is our obligation to give the PDS to the client.

## Hold Covered Facilities

Unless we have a written contract or agreement with an insurer, underwriting agency or wholesale broker that includes Hold Covered provisions all covers including renewals must be confirmed with the underwriter prior to cover commencement.

Where possible we will endeavour to arrange Hold Covered facilities with our suppliers. These arrangements do not replace Credit Terms or provide automatic cover extension except in specific circumstances.

The usual trigger for Hold Covered facilities to become operative is an instruction or clear indication from the client that renewal of a cover is required, usually pending additional or further information.

Where payment is not expected to be received from a client by the Due Date of a renewal we must confirm and document the insured’s clear intention and instruction to renew the cover to ensure we provide the client with the possible protection of a Hold Covered Agreement.

## Commission And Credit Terms

For each underwriter we deal with we have agreed various commission rates and credit terms. These are entered into our Computer System to facilitate automatic commission calculations and payment of premiums. The Responsible Manager(s) or a duly authorised staff member can only alter these.

It is good business practice to advise all staff when changes are made to the commission or credit terms of any underwriter. This will usually be done during our Staff Meetings.

## Insurer Incentive Schemes

In some cases, we may also enter agreements with insurers where they agree to pay us additional benefits based on the volume of premium, premium growth or profitability of the business that we place with them. In such cases we need to ensure that:

* We have included such arrangements in our Conflict of Interest processes.
* Where the conflcit is considered materal, include an appropriate advice on or with all invoices to clients. This may be based on the Insurers Incentive Scheme Disclosure Sample ([Insurer Incentive Scheme Disclosure Sample](http://www.msmlm.com/msm-mission-control/insurer-incentive-disclosure-sample/)).
* We include an appropriate reference in our FSG and Oral Disclosure Script where considered necessary.
* We formalise and document the approach staff are to take in deciding to recommend the insurer.

## Agreements

For all insurers, underwriting agents and wholesale brokers we should have a signed agreement that spells out the details of our relationship with them. Most insurers and underwriting agents have standard agreements that they will supply on request.

We have developed a Wholesale Broking Agreement ([Wholesale Broker Agreement Template](http://www.msmlm.com/msm-mission-control/wholesale-broker-agreement-template/)) to be used as the basis for agreements where we are wholesaling to other brokers.

All agreements are only to be signed by a Responsible Manager and must be carefully read prior to signature.

It is important when signing these documents that the following issues are checked:

* The agreement does not include an indemnity clause that our Professional Indemnity cover will not respond to.
* The agreement spells out hold covered arrangements clearly and unambiguously.
* The agreement spells out Credit Terms.
* The agreement ensures that we retain control over the client.
* The agreement includes a relevant clause that ensures there is no secondary service being provided as part of the relationship. (Refer Below)

The agreements are to be filed centrally and our Computer System records updated to show a current agreement is in place.

## Secondary Service

If we provide a financial service to a Retail Client via another AFS Licensee, we must put into place a number of processes to ensure that we are not deemed to be providing the services to the Retail Client ourselves.

If we are deemed to be providing a service (referred to as Secondary Service) then we are required to provide the client with all documentation as if we were dealing directly with the client. This is impractical on a day-to-day basis, confusing for the client, involves a significant amount of additional work and creates a compliance risk for the business.

The processes that we must have in place when wholesaling business via another broker are:

* We expressly prohibit the broker from passing on our advice to the client.
* We include a prominent statement in our advice (invoice) to the broker that any advice contained in the invoice is only intended for use by the broker and is not to be directly made available to the client.
* We have a reasonable basis to believe that the broker will comply with our express prohibition in point 1 above.
* We have a signed agreement ([Sample Wholesale Broker Agreement](http://www.msmlm.com/msm-mission-control/wholesale-broker-agreement-template/)) with the placing broker stating that where the service we are providing is being provided to an end Retail Client that the placing broker will either provide our FSG to the client or provide the Retail Client with details of how they may access the FSG directly from us.

The wording that is to be used on our invoices where we are wholesaling to other brokers is to be based on the following:

“Please note that any advice involved with this transaction is intended solely for the use of the placing broker and is not intended to be provided directly to the client. The placing broker is expressly prohibited from passing any of our advice directly to the end client.”

## Insurer Ratings

Many of the insurers that we deal with are rated by Credit Ratings Agencies (CRA’s) such as Standard & Poors etc. Due to the way in which such CRA’s are typically licensed under the Corporations Act, they may not be licensed to provide advice to “Retail Clients”, this is likely to include information on an insurer's Credit Rating.

Similarly, most CRA’s require any business quoting or using their Rating’s to be authorised by the CRA to do so.

Due to the above issues we will not promote or publish the Credit Ratings of any insurers that we deal with to any of our clients. Any requests received from clients for information on the Credit Rating on any insurer are to be handled on a case by case basis by researching the publicly available information at that time on the relevant insurer and passing this information on to the client.

This also means that we should not refer to an insurer’s Credit Rating in any PDS that we may be involved in developing without gaining the CRA’s written consent and that the CRA is licensed to provide advice to Retail Clients.

We are not to actively promote or recommend any insurer on the basis of the Credit Rating they may have from any particular CRA.

## GST on Overseas Placements

The general rules applicable to GST when placing business with an insurer (directly or via their foreign intermediary) who is not registered for GST in Australia are as follows:

1. Where business is placed under a Lloyd’s Coverholder arrangement or under a Binder, GST is applicable to all premiums.
2. Where business is placed on an Offer and Acceptance basis:
   1. GST is applicable on the premium if the end client is not registered for GST.
   2. GST is not applicable on the premium if the end client is registered for GST.

Where we are using another AFSL intermediary to place the business with the insurer who is not registered for GST it will be that AFSL Intermediary’s responsibility to ensure these GST rules are correctly applied. In such cases we are likely to be unaware of the GST status of the insurer involved and also unaware of whether the business is being placed on an Offer and Acceptance basis or via a Lloyd’s Coverholder facility or Binder.

Where we are the business placing the insurance with the overseas insurer (directly or via their foreign intermediary) we must ensure these rules are followed and register for GST (a separate GST registration from our business) as agent for the Overseas Insurer and remit GST collected as per standard GST reporting and payment obligations.

For further information on this please refer to the Lloyd’s GST Guidance Ref Y5099 [Lloyd's GST Guidance Ref Y5099](http://www.msmlm.com/msm-mission-control/lloyds-gst-guidance-ref-y5099/)

# BINDERS

## Introduction

When we act under a Binder we will generally be required to comply with the requirements of the General Insurance Code of Practice ([[General Insurance Code of Practice 2020](http://www.msmlm.com/msm-mission-control/general-insurance-code-of-practice-2020/)](file:///C:\Documents\MSM%20Operational%20Resources\MSM%20Operational%20Resources\MSM%20FSRA%20RESOURCES\General%20Insurance%20Code%20of%20Practice%202014.pdf)) and the Guidance on Hardship Assistance ( [General Insurance Code of Practice - Guidance Hardship Cases (March 2018)](http://www.msmlm.com/msm-mission-control/general-insurance-code-of-practice-guidance-note-on-financial-hardship-march-2018/) ). Any significant breaches of the Code are required to be reported to the Financial Ombudsman Service within 10 business days of their identification. Staff operating a binder should also review the General Insurance Code of Practice Overview ([General Insurance Code of Practice Overview](http://www.msmlm.com/msm-mission-control/general-insurance-code-of-practice-overview/)).

## Binder Operation

Staff are to ensure that they are fully aware of the authority, limits and exclusions applicable to respective Binder Agreements, specifically –

* Underwriting and Acceptance Guidelines
* The scope of cover
* Terms and conditions
* Limits of financial delegation
* Authority to bind cover
* Authority to settle/pay claims
* We should only ask for and take into account relevant information when assessing a prospective clients application for insurance cover. Clients should also be given access to information that we have relied on in assessing the application and an opportunity to correct any mistakes or inaccuracies.
* When decling cover we should provide the reasons to the client in writing and also refer them to alternative markets should we not be able to find cover for them. If no alternative markets are identified we whould advise them that they may contact NIBA or the Australian Financial Complaints Authority (AFCA) who hold lists of insurers for various classes of insurance.
* It is a requirement of the Code that any monies payable under a Policy that we administer under a Binder will be refunded by the insurer to the client within 15 business days.

## Reporting Requirements And Time Limits

It is the responsibility of the Responsible Manager(s) to: -

* Give authority in writing to those staff that are permitted to grant cover under any particular binder
* Ensure that authorised staff are fully informed and hold copies of any Procedures Manuals supplied by the Insurers
* Advise/bring to authorised staff’s attention any changes in Binder Operations.
* Ensure Quotations, Statements of Advice, Invoice Text etc and all oral representations contain the notification that we are acting as agent of the insurer and not the insured.

## Binder Disclosure

When we arrange a cover under a binder, we will be acting on behalf of the insurer for that cover and must give the client a notice along the following lines:

“In arranging this contract of insurance, we will be acting under an authority given to us by the insurer to bind cover on their behalf. This means that we are required to act in their best interests in arranging the insurance. For this contract of insurance, we are therefore not acting on your behalf and your interests will be secondary to those of the insurer.”

This notice should be included in all documentation and promotional material relating to the Binder as well as in our invoices and quotes. It must also be included in our oral disclosure where the client requires cover prior to receiving the relevant disclosure documentation.

When we propose to deal with a claim under a binder, we will be acting on behalf of the insurer for that claim and we must give the client a notice saying that:

“In dealing with and/or settling this claim, we will be acting under an authority given to us by the insurer to deal with and/or settle the claim, and we will be dealing with and/or settling the claim on behalf of the insurer and not for you, the intending insured.”

We should also have included the operation of the Binder in our Conflict of Interest documentation.

# FEES AND COMMISSIONS

## Commissions

The business receives commission from the insurers with whom we place business. For most classes of insurance, the commission rates payable are agreed and are built into our computer system and are automatically calculated. The commission is payable on the base premium (before charges) and is typically between 5% and 25 % of the premium.

Where a change from the standard commission provided by the insurer is to be used, the insurer must be specifically advised to ensure that our accounting records reconcile.

Where a lower commission is to be taken, please note that the shortfall is to be included in the Broker Fee charged on the transaction.

In most cases the commission received from all providers for a particular product type is similar. Where we receive significant preferential commission levels for a product, we have a legal obligation that the advice being provided to our clients is not driven by the preferential commission. Where we are replacing one product with another in such cases of preferential remuneration, we must be especially careful that the client is not disadvantaged by such a replacement.

Details of any preferential remuneration situations will be documented in our Approved Product List and addressed in our Conflict of Interest Policy and Procedure ([Conflict of Interest Policy and Procedures](http://www.msmlm.com/msm-mission-control/conflict-of-interest-policy-and-procedures/)).

## Fee For Service (FFS) – Brigade/Services Levy (FSL)

In some parts of Australia, the state fire brigade authorities charge a levy on certain classes on the premium collected from the client to help fund the fire brigade services. In some cases, we may decide to provide some or all of services on a Fee For Service (FFS) model. This means we agree with the client to charge an FFS and accept no commission from the insurer(s) on some or all of their policies.

This will generate a reduction in the premium payable by the client, with a flow on effect that the FSL payable on the premium is similarly reduced.

To ensure that any such arrangements are not seen as being “Net Rating” it is critical that we follow the guidelines (where relevant) issued by the various state-based Fire Brigade Services. A policy that is deemed to be “Net rated” will potentially attract the Fire Brigade Services levy on the notional commission component of the cover and the insurer may seek to recover this cost at some time after the contract has been entered into.

## Broker Fees

Broker Fees are charged to cover the cost of our additional services. They are needed to cover items such as after hour’s availability, claims assistance, insurance endorsements, monitoring and review of cover.

Various factors including the work involved, the client, the size of premium etc. determine the size of the fee. If unsure, please refer to the Responsible Manager(s).

Broker Fees are to be charged in accordance with our Broking Fees Table. Staff duly authorised to do so as documented in each staff members Position Description can only amend broker fees.

Where the usual commission on a policy has been reduced or removed the value of the commission forgone must be added onto the Broker Fee.

## Miscellaneous

As a general rule of thumb where a cover is cancelled at any time after it has been issued, we do not refund any of the Broker Fee that was initially paid for the cover. The vast majority of work involved in managing a cover occurs at the commencement of the cover. The client may receive up to 100 % of the pro rata commission paid, when a cover is cancelled dependent on the circumstances involved.

In addition, a fair and reasonable fee is also to be charged for cancellations and endorsements to assist in covering costs associated with processing, administration and other costs relating to mid-term changes. The minimum fee for this type of transaction is shown in our Broking Fees Table.

NIBA by-law 3 (2.1) and (3.1) provides that in the event of cancellation a broker will refund a proportionate part of the brokerage and no fee or penalty will be charged. These restrictions may be avoided by the inclusion of a specific provision in our Letter of Appointment / Letter of Engagement where we do not wish to refund commission. Such a clause may also be included on all invoices should we not wish to refund commission in any circumstances.

## Disclosure of Fees And Commission

There are specific requirements to disclose commissions and fees to Retail Clients under the Corporations Act 2001 and associated regulations. Fee and Commission information is required to be shown in the Financial Services Guide and Statement of Advice (Personal Advice only) provided to Retail Clients.

The Insurance Brokers Code of Practice requires fees to be disclosed prior to performing a service regardless of whether the client is Retail or Wholesale.

## Terms Such As “Independent / Impartial / Objective”

Under The Act (S923A) a business is not able to use words such as “Independent”, “Unbiased”, “Objective” or “Impartial” in circumstances where it is receiving commissions from the supplier. Therefore, where we receive commissions we require staff to not use such terms or similar when communicating with our clients whether this is in writing or verbally. In addition, we are unable to use the words Independent etc. to describe the status or ownership of the business.

## Use of words - Financial Adviser / Financial Planner

Under proposed changes to The Act a new Section 923C is to be introduced which bans the use of the words Financial Planner and Financial Adviser in situations where:

* The Licensee is not authorised to provide Personal Advice or.
* The Licensee Is only authorised in one or more of General Insurance / Consumer Credit Insurance or Basic Deposit Products.

# INVOICING

## General

All client invoicing must be raised through the computerised broking system. No “non-system” invoices are permitted to be raised. All invoices must show details of Broker Fees; however there is no legal requirement to disclose commission on our invoices when we are providing General Advice.

Company standard coverage summaries must always be used for the purpose of producing standard invoicing text.

Invoice documents must be forwarded to the client within 24 hours of being printed.

New Business & Endorsement - invoices are to be raised as soon as instructions are received from the client.

Renewal - invoices are to be raised and mailed at least 16 days prior to renewal date.

The computer system automatically date stamps all processing, therefore providing a computerised record of when the closings were printed.

The only exemption to this rule would be where certain Sunrise and binder agreements do not require any closing instructions to be issued by the broking office.

## Common Expiry Date (Optional)

If a Common Due Date Policy has been implemented in the business, new covers are to be completed so as to expire on nominated dates. Pay particular attention to this when invoicing, as the computer will default to an expiry date that is 12 months from inception.

## Special Clauses

There are numerous standard clauses that are automatically included by the computer, which are generated by a combination of the insurer selected and the product class involved. These can be created and maintained as templates in the broking system.

## Government Charges

When calculating the premium, it will also be necessary to calculate (where applicable) the fire services levy and stamp duty. The rates applicable will depend upon the location of the risk. The NIBA member’s practice manual contains schedules of the applicable rates that NIBA update for any changes during the year. The charges are also accessible from the various State Revenue Office Websites and Fire Authorities.

GST applies to premiums, commission and broker fees. An example of a premium calculation follows:

Premium $1,000

Fire Services Levy (if applicable) $ 400

Subtotal $1,400

GST 10% $ 140

Subtotal $1,540

Stamp Duty (Varies by state) $ 154

Total $1,694

Broker Fee (including GST) $ 55

# Australian Financial Complaints Authority (AFCA)

Please refer to our Complaints Policy and Procedures ([Complaints Policy and Procedures](http://www.msmlm.com/msm-mission-control/complaints-policy-and-procedures/)) for further details of how we handle complaints.

# DO NOT CALL REGISTER

There is government legislation and Industry Standards that impose restrictions on who we can contact, when we can contact them and obligations on the information we must supply at that time.

There is a federal “Do Not Call Register” where individuals (not businesses) are able to register their phone numbers to stop unwanted telephone calls. Individuals are able to have their home phone and mobile phone number details included on the register. Full details are available from [www.donotcall.gov.au](http://www.donotcall.gov.au)

It is an offence for any business (not just professional telemarketers) to make an unsolicited call to such phone numbers. If we do, there are penalties, ranging from a formal warning to a fine. The minimum fine is $1,100, and the maximum (for repeat offenders) is $1.1 million.

The basic rule is that we cannot call a phone number listed on the “Do Not Call Register”. There are some exceptions including appointment rescheduling, chasing bills and where we have consent.

Where we have an existing relationship with the client, we are deemed to have implied consent for us to make calls that would otherwise be banned. The issue of consent however is unclear where we may contact an existing client to cross sell another product or service.

Therefore, we may include in our FSG and on our invoices specific notices advising existing customers that they provide consent for us to contact them in regard to all products and services that we offer.

Where we wish to contact prospective new clients (individuals) via phone we will need to first check that the phone number is not on the “Do Not Call Register” and also familiarise ourselves with the relevant Industry Standards.

Prior to commencing any such contact we must review the Do Not Call website and ensure we are complying with both the letter and the intent of the legislation and associated Industry Standards.

# PRIVACY

For general details on how we approach the issue of Privacy please refer to our Privacy Policy and Procedures ([Privacy Policy and Procedures](http://www.msmlm.com/msm-mission-control/privacy-policy-and-procedures/)).

Client documents/information are to be thoroughly checked and reviewed upon receipt, with the document being initialled and dated to confirm the data has been checked.

Client supplied information shall be handled in such a manner as to preserve its confidentiality and shall be stored in a suitable safe environment.

Clients are entitled to confidentiality in relation to their affairs. Staff should never discuss our clients’ affairs (including information which has come to the staff member’s attention while attending to any matter on behalf of the client) with parties other than as authorised by the client.

Breach of client confidentiality will be viewed very seriously by our Management and may result in disciplinary action against the staff member involved.

Release of client information to other than relevant Underwriters, Insurers and Loss Adjusters requires the approval of the Privacy Officer.

Any loss or damage to client documents/information is to be reported to our Management and then to the client as soon as the loss or damage has been detected.

It is the responsibility of the employee to ensure all waste containing client information and/or personal data has been destroyed in accordance with the company’s procedures.

All unsolicited outbound contact with clients not directly related to the provision of Financial Services already requested by the client must include an advice that the client can be placed on our No Contact register.

Where clients advise us that they do not wish to receive any unsolicited contact from us we must ensure their name is added/checked in the No Contact field within our broking software.

Please refer to the Staff Policy and Procedures ([Staff Policy and Procedures](http://www.msmlm.com/msm-mission-control/staff-policy-and-procedures/)) and Privacy Policy and Procedures for further details on the procedure.

# CLIENT SEGMENTATION AND SERVICING ALLOCATION

## Client Segmentation (Optional)

To ensure that our services meet the varying expectations of our client base we have the facility to segment our clients into categories. Client Income means the total annual fees and commission earned from the client and associated (closely connected) clients.

Where we have only part of a client’s insurance portfolio the client should generally be allocated to the category that reflects the total size of the client’s portfolio. This is especially the case where we believe that we have a real opportunity to take over the balance of the portfolio.

The Client record on our computer system can be used to identify which category each of our clients is allocated to. For the definition of each Category and the relevant codes please refer to our Broking Service Standards.

## Servicing Allocation (Optional)

All of our clients can be allocated to a particular Staff Member or Team. This allocation can usually be done by the Responsible Managers based on the matching the needs of the client with the skills and expertise of the staff or teams involved whilst also ensuring a balanced workload across the business.

The allocation of a client to a servicing arrangement ensures that a person or area becomes responsible for the management of the client. This approach also facilitates measurement of performance within the business and enables exception reports and tasks to be accurately allocated to the relevant staff or team.

In the Client Record on our computer system are provisions to record the Client Segment that a Client belongs to and the Service Staff member or Team for the client. Where used, these fields must be accurately allocated when a new client is created on the system and kept up to date to ensure that our staff are aware of the expected level of service to be delivered and the person or area responsible for the delivery.

# INSURANCE PREMIUM QUOTATIONS

## Information & Exposure Review

At the interview/telephone conversation stage of quotation, in addition to the normal information regarding existing insurance’s, it is necessary to consider possible exposures of which the potential client may not be aware, in order to allow us to include them in our report as a means of complying with our professional duty. Clients should be advised of their Duty of Disclosure prior to requesting any insurance related information from them.

It is imperative that clear, concise and unambiguous notes are taken of the interview conversation. Misunderstandings relating to the coverage required by the client are common at this stage and clear and comprehensive notes of discussions will minimise the risk of this happening.

Under some circumstances it is sufficient to use the proposal form provided by the Insurer to gain information on that specific risk.

For all potential Commercial and Corporate Clients (where possible) our own specially prepared documentation is to be used:-

* Survey Report - including photo of the site (using digital cameras available upon request)
* Insured Risk Checklist [Insured Risk Checklist](http://www.msmlm.com/msm-mission-control/insured-risk-checklist/)
* Class Questionnaires

## Quotation Slip Preparation

Quotation slips are to be prepared on the basis of a Policy Summary for existing covers plus any additional covers as identified in the quotation checklists. If an additional cover is a variation on an existing cover, it is better to display it separately as specific inclusions.

Where possible, the quote slips available in the computer system are to be utilised. The main advantage of this is that the insurer and the client are both receiving the same documentation, which is also in the same format as the invoice / closing. Quotations can also be upgraded to policies, removing the need to re-key the entry to produce the final invoice / coverage summary.

Quotation slips to include:-

* Type of cover
* Form required (nominate standard form plus extensions/restrictions required)
* Location of subject matter / geographical limits
* Description of subject matter
* Sums Insured / Limit of Liability (Schedule of Assets)
* Sub-limits
* Deductibles required
* Period of Insurance
* Claims
* Underwriting information (from Survey Reports and Questionnaires) including protection procedures, management and housekeeping.
* Any special instructions and date by which quotation is required.

Standard company form Quotation / Placement Slips are available for all frequently used classes and should be used in every case.

Separate page / identification is to be provided for each type of cover / type of policy, with the exception being “package policies”

Any claims information supplied must be certified as correct by the current or past insurer and any underwriting information verbally supplied by the client must be confirmed back to the client in writing to verify its accuracy.

Quotations from insurers must be received in writing. Verbal quotations must be confirmed.

For certain classes of insurance (e.g. Professional Indemnity, Directors and Officers) a completed signed proposal should accompany the quotation / placing slip in all cases.

Placing slips must be duly signed, dated and stamped by the insurer before effective date.

## Domestic quotations

Complete Household/Motor quotation form to obtain relevant details

If available process quote using internet-based quotation systems while client is on the phone and advise client of quotation details. Details should always be saved for new clients or to the existing in case of need for future referral.

If referral to underwriter required prior to providing quote, refer to underwriter and make contact with the client

## Quotation Submission to client

Details of any unusual terms or special conditions should be confirmed to the client together with the Duty of Disclosure Notice and other notices. Any broker fees should be disclosed at this stage. Credit terms should be advised and depending on the level of premium, funding of the payment can be offered. If a client has specifically requested details of the quotation to be conveyed by telephone, these details must then be confirmed in writing and can take the form of a fax or email.

We must confirm to commercial clients details of any insurable risks that are not presently insured. A list of these is to be included with the Insurance submission provided to the client.

When presenting a quotation to a client always –

* Confirm details as advised by client
* Confirm insurance’s NOT quoted / required
* Advise credit terms
* Use company standard submission forms, which are available for most classes. A Letter of Appointment should be included in all cases.

## Placing Cover

The client’s instructions may be in writing, or if received verbally should be recorded in our Day Book or on Client Instruction Sheets.

When we are appointed to handle the insurance, we must immediately (before all other tasks) place cover with the insurer by phone or e-mail and obtain confirmation of acceptance by the insurer in writing, within 24 hours. If using a fax provide a space and headings for the insurer to stamp and sign acceptance before faxing it back to our office as evidence. (Sunrise transactions are placed electronically and confirmed instantaneously.)

Immediately the insurer confirmation has been received we should confirm to the client in writing that the risk has been placed. If there are any difficulties in getting the risk placed, the client must be kept informed.

## Following Cover Placement

The premium invoice should be raised within three working days and sent to the client with premium funding documents (if applicable – refer Premium Funding Procedures) along with a standard new business letter (amended where appropriate) and a Letter of Appointment or Broking Letter of Engagement ([Broking Letter of Engagement](http://www.msmlm.com/msm-mission-control/broking-letter-of-engagement/)) where considered appropriate. The notice should include a clause whereby the client acknowledges that they have appointed us as brokers to act on their behalf.

For Prescribed Contracts under the Insurance Contracts Act a copy of the Policy Wording must be sent with the invoice documentation.

## Signing Of Proposals

If the insurer requires a completed proposal form, the form should be sent to the client for completion. All proposal forms should ideally be fully completed in detail, signed and dated by the client.

In situations where it is unavoidable for us to complete some of the basic information on the proposal, the following paragraph or similar must to be included on the proposal.

|  |
| --- |
| I confirm I have checked all the information contained in this document, some of which may not be in my own handwriting, and hereby verify the truth and accuracy of the information contained in this document.  Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_ |

Under no circumstances are proposal or claim forms to be signed by staff.

Where a proposal form is subject to a specific wording, e.g. (description of interest covered) it should be attached to the proposal before the client signs it.

## New Business Administration

A regular computer system report can be used to track unpaid new business. It is also a requirement that the follow up system is also used to follow up proposals. A 14-day follow up process is to be used.

If the client returns their payment but without the completed proposal, the payment should be returned to the client together with a request for the completed proposal and replacement payment.

Once the client has returned the completed proposal form the Service Manager / Office Staff must:

* Check and verify the proposal;
* Note receipt of the proposal on our records;
* Place a photocopy of the proposal on the policy file noting the date it was sent to the insurer;
* Send original proposal to the insurer (if required by insurer), along with our closing instructions, with a request for a policy in duplicate;

If there is an exchange of correspondence supplementary to the proposal form, make sure such correspondence is clear and carefully worded as it may contain a material fact and be crucial in the event of a claim.

A proposal form should never be destroyed (unless in accordance with an archive file destruction program duly sanctioned by Management in accordance with Statutory Requirements).

Remember that the proposal form is a vital document and we must be extremely careful when dealing with it.

Where we have approved standard policy wordings and specifications they must be used and any amendments to it should be approved by a Responsible Manager.

It is the responsibility of the Office Staff to ensure the policy document or endorsement is issued within a reasonable time but no later than 8 weeks from inception of cover. All policy documentation must be checked for accuracy when received and sent to the client without delay, together with a covering letter.

If the policy is incomplete, inaccurate or ambiguous, an email or letter must be sent to the insurer immediately requesting a correction. This has the effect of providing proof of intent, should anything happen before the correction is received.

The computer system is to be updated with the Policy No. once the correct and complete Policy has been received from the insurer.

We produce a regular computer report on Outstanding Policies or use other follow up systems to chase insurers for missing documentation on an ongoing basis.

The original policy schedule and wording is to be forwarded to the insured, with a copy of the schedule and attachments being retained for our files

# ENDORSEMENTS

## Introduction

An endorsement is a material change or amendment to an existing policy.

All alterations advised by telephone or verbal advice should be clearly and comprehensively documented, actioned and placed on appropriate policy file.

Alterations advised to our office in writing do not require additional recording.

## Automatic Coverage

Where a policy contains a condition that allows automatic coverage in the event of amendments to the subject matter, no immediate advice or cover note is necessary. HOWEVER, CHECK THE POLICY BEFORE ASSUMING THIS, and create invoice to client to confirm same.

## Advice to Insurer

Where there is a material change that is not automatically covered, we must immediately advise the Insurer in writing or e-mail, irrespective of whether they have been advised verbally.

The correspondence must:-

* Provide full details of the amendments
* Request confirmation by written acknowledgment
* Request advice (or confirmation) of additional or return premium
* Request advice of any variations in terms of cover from the existing policy

E-mails should be followed up if no reply is received from the insurer.

Sunrise transactions are input into the computer system without advice to the insurers unless an authority code is required.

## Debiting / Crediting

When the endorsement has been bound with the insurer, a debit/credit invoice should be issued as soon as possible. Where there is no premium charge a NIL premium invoice is to be raised to record the changes.

All transactions that might create a credit to the client of over $100,000 must be treated with special care. In such situations we should request the insurer involved to draw a cheque direct to the client or EFT etc. for the amount involved.

## Changing Client Codes

If the endorsement involves a change of name which makes the existing Debtors Code illogical, the Debtors Code should be changed, a notation made accordingly and the Hard Copy file reference updated accordingly.

## Follow Up

Regular follow-ups of significant policy changes should be instituted with the Insurer, until the endorsement is received and checked for accuracy.

# CERTIFICATES OF CURRENCY

## Introduction

Staff should be fully aware of the risks we face when using Certificates of Currency. Under no circumstances are staff to issue Certificates of Currency or Certificates of Insurance, unless when authorisation has been obtained from the insurer (i.e. when operating under a binder agreement or other arrangements are in place). The only exception to this is where the document issued includes a clear statement that we have “arranged” the insurance.

### Background

There is a possibility that parties, other than the parties directly involved in the contract of insurance, can rely on the Certificate of Currency (Insurance) to provide them with protection. Should the policy be lapsed, cancelled or altered and the protection no longer be there, it may be possible for the parties relying on the Certificate of Currency (Insurance) to seek indemnity from whoever issued the Certificate of Currency (Insurance).

Unless we have written authority from the insurer to issue Certificates of Currency (Insurance), such certificates are not legally binding. In the event of a dispute, the insurer will be entitled to repudiate our Certificate of Currency (Insurance) issued without their approval, thus potentially exposing us to a Professional Indemnity claim.

### Issuing of Certificates

Hence, it is a Company policy that Certificates of Currency (Insurance) shall be obtained from Insurers and are not to be issued by our office. As Insurance Brokers we negotiate the contract, we are not a party to the contract and therefore have no right to issue any Certificates unless we are doing so on behalf of the insurer when acting under a Binder Agreement.

### Procedure

When we are acting under a Binder Agreement and have the authority in writing from the insurer to issue Certificates of Currency (Insurance), the Certificate should be dated and show the name and address of the party to whom it is issued. A copy should be retained on file.

The top of the Certificate should include the following statement:-

“This document certifies that the policy referred to below is currently intended to remain in force until 4.00 p.m. on the expiry date shown and will remain in force until that date, unless the policy is cancelled, lapsed, varied or otherwise altered in accordance with the relevant policy conditions or the provisions of the “Insurance Contracts Act 1984”.

The Certificate must also show the full name and address of the insurer and at the bottom show the following IMPORTANT NOTICE and DISCLAIMER.

“IMPORTANT NOTICE”

This certificate has been arranged by us in our capacity as agents for the insurer named above. It does not reflect in detail the policy terms or conditions and merely provides a very brief summary of the insurance that is, to the best of our knowledge, in existence at the date we have issued this certificate. If you wish to obtain details of the policy terms, conditions, restrictions, exclusions or warranties, you must refer to the policy contract.”

“DISCLAIMER”

“In arranging this certificate, we do not guarantee that the insurance outlined will continue to remain in force for the period referred to as the policy may be cancelled or altered by either party to the contract at any time in accordance with the terms and conditions of the policy or in accordance with the terms of the “Insurance Contracts Act”. We accept no responsibility or liability to advise any party who may be relying on this certificate of such alteration to or cancellation of the policy of insurance.”

## Confirmation Of Cover

If it is absolutely necessary for us to issue some form of cover Confirmation, care should be taken with the format and only our standard “Confirmation of Cover” document should be used. This document should include an appropriate disclaimer as shown below.

Because only an insurer can certify the currency of a policy if a certificate is issued on our letterhead the document should be headed “Confirmation of Cover” and contain the following disclaimer:

PLEASE NOTE:

This confirmation of cover is not intended to replace the effect of the policy. Please refer to the policy document for full details of cover, terms and conditions.

This Confirmation does not guarantee that the Insurance outlined will continue to remain in force for the period as the policy may be cancelled by either party to the contract at any time, in accordance with their terms and conditions of the policy and we accept no responsibility or liability in advising any party who may be relying on this Confirmation of such alteration or cancellation to the policy of insurance. If a Certificate of Currency or Insurance is required, this can be obtained from the Underwriter.

# RENEWALS

## Introduction

Renewals are the lifeblood of the business and the effective, efficient and timely management of this function is paramount to our success. Income received on renewals account for over 80 % of the income of the business. Renewal business is generally far less expensive to administer than New Business and therefore far more profitable.

In considering what action should be taken as part of the renewal process we must bear in mind:

* The Broking Service Standards applicable to the client. This can be ascertained by accessing the Service Segment that the client is allocated to on the computer and cross-referencing to the relevant Broking Service Standards. The relevant Segment Code and Servicing Arrangement codes should be updated to reflect any changes in the Clients relationship with us.
* Changes in the client’s business
* Claims and service experience from current underwriter.
* Is underwriter still on our acceptable or preferred listings.
* Will the client be obtaining alternative quotes?
* The current insurer’s attitude to renewal.
* The need to remarket the cover as per our Broking Service Standards.
* Exposures created by changing insurers or products.

## Computer Reports

### A Client Pre-List Report

This lists current policies and is run on a fortnightly basis detailing all policies due for renewal at least 4 to 6 weeks in advance.

### Client Renewal List

This report shows each policy in full detail and is to be used in the review process.

A team meeting will be held upon receipt of the report to determine responsibility for the renewal management of clients, which clients will receive a pre renewal visit prior to receipt of renewal terms and which will receive a visit to review renewal terms once received at least two weeks prior to expiry where possible.

## Common Monthly Renewal Dates (Optional)

If a Common Due Date Policy has been implemented in the business, we try to operate on twenty four (24) renewal dates (16th and first day of each month) throughout the year and irrespective of the inception of a cover the expiring date should be brought to the nearest common due date. Any policies which are being renewed and which do not already comply with this procedure should be corrected.

## Review

Notwithstanding that client reviews may have been done during the past twelve months, specific reviews of the renewal cover is essential.

The review of renewal cover can be divided into the following areas: -

* Collection of updated figures, business risks, changes in operations/occupations etc;
* Review of cover, change in material facts;
* Collection of digital photographs / survey reports
* Review of covers not already in place, by using company standard Insurance’s Available
* All covers placed with a Unauthorised Foreign Insurer (UFI) are to be remarketed to the Local insurance market to confirm the unavailaibility of cover or the pricing and terms available. In every case the client is to be recommended any terms received from authorised insurers over those provided by a UFI.

## Corporate Clients (Major)

### Preliminary Work

When the renewals listing is produced it is the responsibility of the Office Staff to ensure distribution to Service Manager’s etc. for renewal purposes. The distribution of reports is to take place immediately upon production.

It is the responsibility of the Service Manager to identify and prepare a suitable renewal timetable. The timetable will initially decide where a servicing renewal visit is required or whether the renewal can be satisfactorily handled by way of telephone and mail.

Should any concerns arise with the coordination of the renewal meeting, the Service Manager is to bring these concerns to the attention of the Responsible Manager(s).

### Pre-Renewal

At least 2 to 5 weeks prior to renewal date the client should be contacted by the Service Manager to discuss the client’s needs and a renewal meeting arranged where required. It is recommended that an agenda (or report) highlighting the proposed discussion points is produced and distributed to the client prior to the renewal meeting.

The client should be made aware of the current renewal market climate and should be informed of any “problem areas” that are foreseen in the marketing of the insurance portfolio.

Review the client’s business activities for any likely changes and agree the description to be used on the policies. A completed survey report and supporting digital photos should be produced at this first meeting if relevant.

A completed “Insurance’s Available” or “Insurances Not Taken” should be completed, with confirmation of risks not insured / not required being forwarded to the client immediately after completion.

* Establish/re-emphasise client’s renewal philosophy on:
* - Remarketing
* - Deductible quotations
* - Extended cover quotations
* - Indemnity limits
* Obtain insurer’s claims experience for each policy, and prepare claims summary for client.
* Be aware of any changes to policy terms and conditions.
* Obtain from client estimated asset values, turnover figures, etc if not already provided.
* Establish with client the requirements, if any, for the format of the renewal report.

As soon as the renewal information is received it should be collated and a submission to insurers prepared by the Service Manager. The renewal submission must be with insurers in sufficient time to allow deadlines to be met for reporting to the client.

When renewal terms and/or alternate premium quotations are received and carefully checked, prepare a renewal report for the client and deliver it within the time frame agreed. Consideration in the report should be given to the following: -

* Premium comparisons;
* Claims experience and trends;
* Clear definition of changes to terms and conditions;
* Recommendations on each policy;
* Risk Management options/recommendations i.e. increased deductibles;
* Credit terms;
* Any relevant new legislation;
* Uninsured types of insurance’s and a brief description of cover provided by such insurance (refer to Insured Risk Checklist - [Insured Risk Checklist](http://www.msmlm.com/msm-mission-control/insured-risk-checklist/)).
* Declaration forms for completion;
* Service plan for ensuing twelve months.

Do not blindly issue a renewal report based simply upon the previous year. Seek ways to improve the contents and style in order to retain clarity and moreover the interest of our client.

When we receive the client’s renewal instructions either verbally or in writing:

* Confirm proposed action by way of correspondence
* Confirm clients renewal instructions to the respective insurers
* Prepare invoices for immediate dispatch to client along with confirmation of credit terms, and agreed payment method
* Send closing instructions to insurers.

### Post Renewal

* Place insurer confirmation of renewal acceptance on client file.
* Prepare an updated insurance manual where applicable and make it available to the client within 28 days of renewal.
* Follow up Renewal Certificates/Schedules from insurer if required.

## Commercial Clients (Non-Major)

Follow the procedural steps as outlined for Corporate Clients and as included in our Broking Service Standards. It is the responsibility of the Service Manager to determine the extent of the renewal process dependent upon the style of client, and whether a re-marketing exercise is required.

## Small/Domestic/Private Policies

Policies with no accommodating business can be sent to client without such a detailed review, unless special circumstances exist such as unfairly increased premium, fault in cover etc. Again, refer to our Broking Service Standards for guidance.

The Service Manager will evaluate the extent of renewal service required and give an instruction to the Office Staff based on the type of insurance involved, client connection, value etc., but at no time must we leave ourselves open to criticism.

Small business clients should also receive an “Insurance Available” or “Insurances Not Taken” for their consideration.

## Renewal Administration

### Insurer Obligations and Remedies

The Insurance Contracts Act requires that the insured receive notice of expiry at least fourteen days prior to renewal date. The insurer has a responsibility at this stage to advise whether they are prepared to offer renewal or will not be renewing the policy. There is no obligation on the insurer to provide specific terms and conditions for the renewal.

Where the insurer has failed to notify their approach to renewal at least fourteen days prior to renewal date we must do the following:

Advise the insured that we have not yet received renewal terms and advise them that cover automatically continues where the policy is renewable.

Follow up the insurer to get the renewal terms.

Where an insurer fails to provide renewal terms no less than 14 days prior to expiry Section 58 of the Insurance Contract Act provides the insurer with the obligation to cancel the cover in writing providing 14 business days’ notice (with no premium charge). The other option is for us to reach mutual agreement with the insurer on cover extension to the next renewal date.

Failure by the insurer to provide renewal terms 14 days prior to expiry ***does not***:

* Allow us to renew the policy at last years terms.
* Allow us to renew the policy for no premium.
* Allow us to decide on what are reasonable terms and conditions.

### Follow Up

Follow-ups should be instituted for the issue of the renewal by the insurer, until it is received and checked for accuracy.

Follow up with Insurers any renewal notices that have not been received within 3 weeks of policy expiry date

### Renewal Terms Review and Process

Once terms received, evaluate whether:

* Alternative quote required (this should have been considered prior to this time however)
* Quotes for increased liability limits are obtained.
* Discussion required with existing Insurer re changes to cover and premium
* What standard letters/individual letter are required
* New wordings are to be forwarded
* Insurer documentation to be forwarded with renewal
* Premium funding option should be given
* Process renewal with any changes through computer system
* Link invoices with documentation (prelist and Insurer renewal notice)

### Client Advice

In all cases we have a professional obligation to give the client at least 14 days’ notice of the expiry of their policy. This will usually be by way of an invoice for the renewal.

However occasionally this is not possible due to the late notification of terms from insurers or in circumstances where complex renewal negotiations are required. In all such circumstances we must contact the client to explain the situation and document discussions accordingly.

Any declarations to be completed by the client and renewal notices must be accompanied by the statutory notices.

Where required in our Broking Service Standards renewal should be confirmed to the client in writing together with details of uninsured risks Insured Risk Checklist [Insured Risk Checklist](http://www.msmlm.com/msm-mission-control/insured-risk-checklist/)

### Insurance Documents

Where there is a policy document/endorsement attached to the insurer renewal invitation it must be forwarded with our renewal invoice and an appropriate notation put into our invoice text. A copy of the insurer policy document/endorsement must be placed in the policy file.

### Overdue Renewals

The Computer System produces lists of Outstanding Renewals for referral to the Service Manager and Office Staff to make sure that held covered terms have been arranged and are in place.

Hold Covered facilities will only apply in situations where we have received and documented clear instructions from the client of their intention to renew the policy. Without such instructions cover ceases as from the Expiry Date.

### Non-Renewal

When a policy is to lapse, either following the client’s instructions or lack of instructions to renew, written confirmation/email must be sent to the client and just as importantly insurers must also be advised.

### Debiting

When renewal terms have been agreed our renewal invoice should be issued as soon as possible. Invoice text should state when premium is due and payable which is usually fourteen days from invoicing.

### Claim Made Wording

A similar wording to the following should be provided to all clients where we are proposing to change the insurer on a Claims Made coverage wording.

Warning – Claims Made Policy

By electing to change your Professional Indemnity (PI) insurer you will be creating the risk that any PI claims that are deemed to have been notified to You prior to the inception of the replacement PI policy and which have not been notified to your existing PI insurer prior to the expiry of your existing policy will not be covered by either your previous or your proposed insurer. It is therefore imperative that any matters that you and or your employees/agents etc. are aware of that might give rise to a PI claim are notified to your existing insurer prior to the expiry of your existing cover.  We only recommend that you elect to change PI insurers where:

* You are satisfied, after making all reasonable and appropriate enquiries, that all matters that might give rise to a PI claim have been notified to your current insurer, and
* The combination of the premium and coverage terms of the proposed new PI insurer are substantially better than the terms offered by your existing PI insurer, and
* You accept the risk that a failure to notify a matter to your current PI insurer will in all likelihood result in any such PI claim being uninsured.

### Insurer Advice

If during the renewal discussions the client wants to vary the insurance program, the amendments should be placed immediately or in accordance with the client’s instructions.

Insurers must be advised in writing that renewal is required either by way of our closing instructions or a separate fax or email. Ideally this should be done at the same time as invoicing the client or prior to expiry where our invoicing is delayed. If the policy is transacted electronically, we should “close” the renewal to the Underwriter as part of the invoicing process. We should not be relying upon hold covered agreements.

A Renewal Checklist ([Renewal Checklist Template](http://www.msmlm.com/msm-mission-control/renewal-checklist-template/)) has been developed to provide guidance on this process

# CANCELLATIONS

## Introduction

The incorrect and inappropriate handling of cancellations is one of the most common causes for disputes between brokers and their clients. It is therefore important that the following guidelines are strictly adhered to.

The overriding rule with cancellations is that only the insurer or the insured can cancel a policy. We cannot make that decision.

In the unlikely event that the insurer cancels the contract, we should take care to establish that the terms of cancellation are in accord with Insurance Contracts Act (ICA) and/or the policy terms and conditions, including the notice period. We should inform the client immediately any such notice is received.

If the client wishes to cancel the contract, we should insist that the client confirm their request in writing signed by all parties to the contract together with instructions on who is to receive any refunded premium. Only in exceptional circumstances should cancellations be acted upon without a signed authority by all parties.

For clients well known to the servicing staff it maybe more practical in circumstances (where the client refuses to confirm the cancellation in writing) to make a comprehensive file note regarding the cancellation advice, including the person’s name, time and date of call/conversation, reason for the cancellation, the handling of any refund etc. and confirm the instruction to the client in writing.

Any request from the insured to cancel a policy from inception should be managed carefully to ensure the client understands the ramifications of the decision, including in respect of claims.

We must also confirm with the client how they wish any refund to be handled. Our preferred approach is to use EFT, however the client may wish to receive a cheque. This should also be documented. Refund cheques should only be made out to the name of the insured and any EFT processes should include receiving proof of the name of the Bank Account that the funds are to be transferred to matches the Insured Name, especially where the refund amount is over $500.

Return premiums are normally received by deducting the relevant premium from the Insurers monthly remittance advice. Should we be unable to take the return premium in this fashion, we should follow through receipt of any return premium from the insurer and forward the return premium to the insured within 7 days of receiving it from the insurers.

All transactions that might create a credit to the client of over $100,000 must be treated with special care. In such situations we should request the insurer involved to draw a cheque direct to the client or EFT the funds for the amount involved.

Always check that the client does not have any other amounts owing to us prior to sending a refund out. Where premium funding arrangements are in place the premium refund will usually be paid to the Premium Funder. The agreed arrangements with both the client and the Premium Funder need to be documented.

The return premium should be accompanied by the relevant return premium invoice or with a Compliments Slip if the invoice has been previously forwarded.

## Insurer Cancellation Rights

Insurers have limited grounds for cancelling policies as set out by S63 of the ICA.

Insurers can only cancel a policy under the following circumstances:

* A breach of the duty of utmost good faith by the insured.
* A breach of the insured’s duty of disclosure.
* The insured has misrepresented information to the insurer.
* A breach of a provision of the policy contract, including any provision regarding payment of the premium.
* Where the insured has made a fraudulent claim.
* Where the policy contract requires the insured to advise the insurer of a specific act or ommission (e.g. change of risk) and the insured advises the insurer of the change and the insurer decides to cancel due to its underwriting guidelines.
* Where a policy (renewal) is in force due to S58 of the ICA.

Interim contracts are able to be cancelled by the insurer at any time.

Insurers are only able to cancel retrospectively in cases of fraudulent non-disclosure or fraudulent misrepresentation that occurred before the contract was effected. In all other cases an insurer can only cancel prospectively.

Cancellations attempted by insurers in contravention of the ICA are void and the insurer remains on risk until the insured effects alternative insurance or the insurer cancels correctly.

An insurer must normally give its reasons for cancelling a policy when requested in writing to do so.

## Insurer Cancellation Rights – Instalment Policies

There are different cancellation rules for an instalment contract of general insurance (where the premium is payable by 7 or more instalments in a year).

An insurer can cancel the policy if at least 1 instalment is unpaid for at least 1 month and the insured was informed in writing before the contract was entered into of the effect of the provision of S62(2) of the ICA. Usually, the policy terms will include notice about this right for contracts that can be paid by instalment.

## Cancellation Notification

The insurer’s notice of cancellation can be sent to the broker but must be given in writing and takes effect at the earlier of:

1. 4:00 pm on the third business day from the date the notice is received,
2. when the insured arranges alternative insurance.
3. For a policy (renewal) in force due to Section 58 of the Insurance Contracts Act, 4:00 pm on the fourteenth business day from the date the notice is received.

In some cases, these cancellation periods may be extended either by specific provisions within the policy contract or by the insurer.

## Mid Term Cancellations

Where a client wishes to cancel a policy mid-term, they often receive significantly less than the pro-rata amount they may be expecting. This can be caused by:

* Insurer refunds based on monthly or quarterly apportionments or the impact of minimum premiums.
* Interest charges and other penalties applied by Premium Funders.
* Our decision to retain commission and broker fees.

Whenever a client is cancelling mid-term, we should immediately ascertain the impact of these factors on any refund payable and advise the client accordingly.

It is also requirement of the Insurance Brokers Code of Practice that we agree with the client beforehand if we are to retain our Commission and Fees on any return premiums. A notice regarding this is typically included in our Financial Services Guide and is also recommended that a standard notice (Refer Notice and Disclosures Section) be included on our invoices to cover such situations.

## Cancellation Due to Non-Payment

A broker cannot cancel the contract due to non-payment as the broker is not a party to the contract, unless they have been provided with specific authority by the insured to do so.

Where the client has not paid a premium within our credit terms and we believe that the insured does not intend to pay we should advise the insurer accordingly. Where the client has advised us that they will be paying the premium at some date in the future we should use our best endeavours to have the insurer extend credit terms to the expected payment date. In either situation we should clearly communicate in writing with the client the actions that we have taken and the impact to the client’s ongoing policy coverage.

When advising the insurer of non-payment of the premium we should not request cancellation as part of the advice. The insurer will then decide whether they will cancel the cover and on what date the cover is to be cancelled from. The following wording is recommended to be used when advising insurers of non-payment:

As per our credit terms we advise that the premium (or part thereof) for the above / attached / following policies has not been received by us. As we have not received a cancellation notice from you, these policies remain in force until such time as we receive a notice from you that complies with Sec. 59 of The Insurance Contracts Act 1984. If this should be incorrect, please advise us immediately.

Cancellations made due to non-payment can only be effective from the date notified by the insurer. They cannot be back dated to the commencement of the cover except where the policy contract specifically includes terms to that effect which the insurer is able to legally rely upon. Where the broking system requires us to enter the inception date as the cancellation date – e.g. Sunrise transactions, we should manually enter the effective date of the cancellation into the relevant invoice and /or include reference to the effective cancellation date in our covering letters/emails or telephone calls.

## Cancellation – Premium Funders

Typically, all funding contracts include a provision that the client irrevocably assigns or grants the Premium Funder a right to cancel the policy contract if the funding contract is breached – usually due to non-payment.

Where we receive instructions from the Premium Funder to cancel the contract due to non-payment, we should immediately contact the client and discuss the situation with them. At this time it is imperative that we calculate the refund amounts applicable, who they will be paid to and ensure the client is in agreement with the policy cancellation and discuss possible alternative coverage approaches.

Where there is any issue between the funder and the client in relation to the amount of the refund or who the refund is to be paid to we should use our best endeavours to resolve such issues and gain documented agreement from the client on the course of action to be taken.

## Cancellation Good Practice Checklist

| Good Practice | Unacceptable Actions |
| --- | --- |
| Obtain written advice from the client to cancel policy and obtain written instructions on who is to receive the Return Premium. (if there is more than insured under the policy.) | Request the insurer to cancel the policy if we do not have written advice from the client. |
| Where the insurer is cancelling, ensure the insurers cancellation notice is in writing and the insurer has the right to cancel the policy and the notice period under the ICA has been complied with. | Cancel a policy at the request of an insurer without receiving a valid cancellation notice. |
| Exercise appropriate risk management if affecting cancellation for the Premium Funder, by ensuring the client is aware of and accepts the validity of the cancellation and that replacement policy options have been fully canvassed. | Cancel a funded policy at the request of the client without liaising with the Premium Funder. |
| Refund any premium as per client instructions or to the Premium Funder once the insurer has sent you a credit note. | Retain any amount of refunded premium on account of “lost” commission. |
| Inform the client as soon as possible after you receive insurer notification of cancellation, including the reason for the cancellation and the date that the cancellation takes effect. Discuss with client options to arrange alternative cover. | Cancel the policy without instructions from the client unless we are acting under a binder for the insurer. |
| With any cancellation advise the client of any premium to be refunded and any amounts to be deducted from the refund, including commission and fees payable. | Cancel the policy on instructions from the Premium Funder unless we have an obligation to do so and have also discussed the cancellation with the client. |
| If an interim contract of insurance is being cancelled and the insurer does not want to cover the risk, ensure 3 business days’ notice of cancellation has been given. | Direct the insurer to cancel the policy if we have not been paid. Only the insurer/insured can cancel a policy. |
| If acting under a binder send the insured a notice of cancellation as agent for the insurer if at least one of the circumstances in S60 of the ICA applies, e.g. insured has not paid premium and the notice specifies when the cancellation will take effect. Cancel the policy once the time specified in the notice has expired. | Cancel a policy retrospectively – that is do not back date the cancellation. |
| Cancel the policy on instructions from a Premium Funder if there is an obligation to do so. | Obstruct a Premium Funder in a cancellation of the policy that is allowed by the funding agreement. |

# CLAIMS

## Introduction

The way a claim is handled by our Company is often an important test of the value we can add to the services we provide. For this reason is in imperative that we handle claims situations with empathy and understanding and provide assistance to clients wherever possible and appropriate.

Consider the client’s needs when handling a claim. The person on the other end of the phone may not always understand what the next step is when they have been involved in a loss.

It is our job to explain what the next steps are, to reassure the client, and importantly to demonstrate empathy toward the client in every case. We should advise the client of the usual timing involved in the processes however be conservative to ensure that the client does not have false expectations.

Do not procrastinate! If a claim is clearly not covered advise the client immediately.

If a claim is doubtful, do not build up the client’s hope. Clearly advise that we will try, but that there are no guarantees.

## Claim Notification Procedures

### New Claim Steps

The outcome of a claim is largely determined by the initial client contact and action. If the client is comfortable and confident with a process and clearly understands our role the claim is much more likely to proceed without problems. In the event that the client notifies a claim the following steps should be followed:

* Take brief details and record on an internal file note or Claims Action Sheet.
* Advise the client to take whatever steps are necessary to reduce the loss. If in doubt the client should act as if they were uninsured. Actions might include temporary shuttering, security guards, removing valuable items from exposed location (ensure insurer advised and agrees), hire of replacement equipment,
* Advise the client to keep any damaged items wherever possible and to take photos of any damage etc that is required to be immediately repaired or of goods that must be immediately removed or destroyed.
* Check insurance coverage to establish that the claim appears to be covered. If the loss would appear not to be covered, due to our failure in any respect, refer the matter to the Responsible Manager(s). They will determine if special consideration can be obtained from the insurer. Do not admit fault or liability in the first instance.
* If we are handling the claim under a Binder arrangement advise the insured that we will be handling the claim on behalf of the insurer and not on their behalf. This must be also communicated to the client in writing and included in any further written documentation that we send to the client. For further information please refer to the Section Below – Binder Claims
* Arrange for a claim form to be sent to the insured.
* Advise the insured of any excess or other contribution/limitation that the policy involves.
* Explain to the client in simple non-technical terms the steps, processes and likely time frames involved in the claims handling process.
* Enter the claim onto our computer system or other recording systems against the relevant policy. The claims advice should be printed and sent to the Insurer as our notification in writing. It is important to ensure this written notification is forwarded in every instance.
* Where an assessor is appointed they will contact the client, establish the detailed circumstances of the claim and report to insurers. Unless we have specific authority from an insurer we should not appoint assessors ourselves except in extenuating circumstances.

### Claim Forms

If a claim form is required the client should complete it. We should never complete or sign a claim form on behalf of the client.

If the claim form is received in our office a copy should be taken for our file and the original sent to insurers and the file noted to this effect.

It is good claims management practice to ensure we have immediate access to most claim forms required by our clients. Where forms are not available on the Internet we must ensure we have adequate supplies on hand in our office.

### Reinstatement of Cover

The issue of reinstatement of cover should also be addressed at this stage and referred to the relevant Service Officer where action is required. Failure to appropriately address this issue is one of the common causes of disputes between brokers and their clients.

## Claims Handling

### The Client

For most clients, a claim is a traumatic experience. They have suffered a loss that may have stopped their business from operating, or involved them in a collision.

When faced by a stressful situation, human beings act in a variety of ways. The following list covers some common situations and provides some suggestions for the broker.

| Reaction | Situation | Your Response | Never |
| --- | --- | --- | --- |
| Stunned | Our client may be in a state of shock. In this condition they will find it difficult to take in information and may repeat themselves. They may have forgotten where their policy is, the site of the accident and other important details. | Understanding is very important. Don’t expect a rational conversation. You need to be sympathetic to the experience that the client is having. You must also be patient and very clear about what you want the client to do. If the client sounds really stunned, phone back later to confirm the details. | Get impatient or try to push the client too much. It won’t help you get information, and you are simply creating more stress for your client. |
| Angry | Another very human reaction to a loss is to be angry and blame or attack the nearest person available. This could be you, so be prepared. | Learn how to defuse angry people. One way of doing this is listening sympathetically, letting them vent their anger. Recognise that the anger is a sign of stress and has nothing to do with you. | Buy into the client’s anger. If you respond in any way to the anger or accusations, you will fuel the client’s anger and can end up in an argument. |
| Defensive | The client feels bad about what has happened and may think you won’t really help them. In their anxiety, some people blame themselves when something goes badly wrong. It’s a normal human reaction, but it can make a client guarded and suspicious. | Again, sympathy lets the client know that you are on their side and committed to providing them with a professional service. Get the facts from them and let them know that you are committed to helping them. | Buy into the client’s self-blame. It’s a temporary state of mind. If you agree, yes, the client should have checked the locks twice; the client will feel even more defensive and become angry with you. |

### The Insurer

The insurer is ultimately responsible for the swift settlement of claims lodged by our clients. The relationship that we have with the insurer can be an important factor in the outcomes received by our clients.

The following are examples of the simple things that we can do to work with the insurer for our client’s benefit.

* Respond promptly to all requests for information etc from the insurer.
* Ensure that claims forms submitted to the insurer have all of the necessary information and detail on them.
* Develop a rapport and professional relationship with the claims staff. Give praise where it is due.
* Try to keep up to date with the roles and responsibilities of key staff within the insurers claims department.
* Where possible and practical follow the systems and processes required by the insurer.

In the event of a claim being rejected in part or in total demand that the insurer advise us prior to telling the client.

### What Role Do We Play?

Our role in the handling of the claim is to help the client receive their rightful entitlements under the policy as quickly as possible.

This is best done by ensuring that the client and insurer have all of the necessary information to progress the claims settlement process. Acting as the middleman for all communication only delays the process and can lead to misunderstandings.

As a rule of thumb, apart from the initial claims notification we should advise the client to communicate directly with the insurer or assessor and not via ourselves. Where the client requests us to become involved in the communication process, we should explain the potential problems and delays that this may cause, however where the client still insists, we should meet their request.

It is our responsibility to follow up settlement of the claim with insurers. Do not be put off. Go to the source of the information or problem. Be persistent. Chase the assessor or claims officer. If you do not get a satisfactory response from your follow up escalate your query to the next level of management. Make it happen.

Keep the client informed on the progress of any claims matters that you are attending to on their behalf. Confirm everything. If the client does not know what we are doing they will presume we are doing nothing.

Whenever an insurer rejects part or all of a claim it is our responsibility to carefully review the decision on behalf of the client. Where the circumstances warrant the insurer reviewing the decision, we must request this is done immediately. Where applicable we should also ensure the client has been clearly been made aware of the Insurers Internal Dispute facility and the Australian Financial Complaints Authority (AFCA).

How we handle our client’s claims can make or break our relationship with them. Claims are why our client’s purchase insurance. Pro-active diligent performance on claims is expected of us from our clients and we can never do enough to expedite satisfaction.

### Key Players in the Claims Process

|  |  |
| --- | --- |
| Legal Professionals: | Complex or litigated claims will usually involve legal professionals such as solicitors and barristers. Usually, when clients are sued, a Statement of Claim, Summons or Writ will be issued that starts legal proceedings against them. If the client receives such a document, it needs to be forwarded to the insurer without delay and the insurer will appoint a legal professional to handle the defense of the client. Insurers also use legal professionals in recovery proceedings against other parties. |
| Accountants: | May sometimes be engaged in more complex claims where the amount of the claim may be difficult to quantify. This may occur for example, in business interruption claims arising from a fire covered by the policy. |
| Engineers: | May be engaged to provide advice for a range of claims, including finding out the cause of complex claims. For example, their expertise may be required where there has been a mechanical breakdown of complex machinery. The engineer will provide advice of the cause of the breakdown and possibly recommend the best way to repair it. |
| Claims Consultants | May be involved to assist the client in preparing the business end of the claim. They can be used to obtain extensive risk reporting information, or to work out the best way to get the business operational again. |
| Valuers | May be involved where there are questions regarding the value of insured property that has been damaged or lost. Insurers may need their expert assistance if a valuation cannot be otherwise easily obtained. |
| Risk Managers | For larger clients, insurance and risk management may be delegated to a risk manager. The risk manager’s job is usually to identify all risks that may affect the client organisation (whether capable of being insured or not) and determine whether those risks can be eliminated, reduced or transferred to an insurer or other party. |
| Surveyors | May be required on certain marine cases to ascertain the extent of damage to property that is covered under a policy. |
| Specialist Technical Experts | May be used in complex matters to determine either the cause or extent of a loss. For example, university experts may be called upon to provide an expert opinion on a claim in a highly specialist and unique situation. |
| Medical Practitioners | Are used on a variety of cases, including personal accident, liability and workers compensation policies where there are elements of personal injury in the claim. They provide both cause and extent of loss (injury) information to insurers. |
| Loss Adjusters | Are used on many cases in insurance to provide factual information and expert advice about the cause and extent of loss. They may or may not be employed directly by insurers |
| Underwriters | The person employed by the underwriting company to assess the risk that is covered by an insurance policy. In a claims situation you would usually be dealing with the claims staff of an underwriting company. These staff would refer to the underwriter of the policy where needed. |

### The Privacy Act and Claims

| PRIVACY RULE | WHAT IT MEANS TO YOU |
| --- | --- |
| Personal information can only be obtained where it is necessary for and in relation to the claim | You can’t collect any information about a client (e.g. give a client a claim form or ask questions) unless there is a good reason for doing so, and it is related to the claim |
| Information must be collected lawfully and fairly | When you collect information, the clients must be aware of what you will do with it |
| The broker cannot disclose client information to anyone else unless that disclosure could be reasonably expected | Check that claim forms and correspondence get agreement from the client that you can give their personal information to the underwriter |
| The broker must ensure that the information collected is accurate and complete to the best of their knowledge or could be reasonably be expected to know | Make sure you get accurate information and keep file information up to date |
| The client must ensure that information obtained is properly stored to protect it from misuse or loss | Files with personal information must be secure so that nobody outside your company can get hold of your client information. You must also keep files safe from damage, and have a fully functional back-up system |
| The broker must generally allow an individual access to their own personal information file | If a client wants to see their file, your company must give them access to it. This has implications for your company’s file management systems |
| “Sensitive information” such as someone’s political opinions, religion, business or trade memberships, sexual preferences or state of health may not be collected without the consent of the person to whom it relates | Any requests (such as forms) that ask clients for sensitive information must include a section where the client signs their consent |

### Claims Management Success Drivers

Those who are effective in claims management have four key attributes:

* They are able to deal effectively with all of the people involved in the claims
* They understand the legal environment and the rights of the client.
* They maintain excellent records
* They get the claim settled as quickly as possible.

## Claims Payments

Ideally arrange for electronic funds transfer of the claim payment direct into the insured’s bank account and forward either a letter or email to the insured to confirm the transaction has been completed.

If electronic funds transfer is not possible and a cheque (including those from co-insurers) must be issued, it must be sent to the client on the day that it is received in our office.

Claim cheques for $10,000 or more should be hand delivered where the client is in relatively close proximity to the office.

## Claim Denials

If the insurer denies liability for the claim, we should advise the client immediately and confirm the advice in writing. Before this happens, the denial must be referred to the relevant account executive.

They will need to consider whether the denial is correct and take appropriate steps to negotiate with the Insurers if they feel the denial is unreasonable. Circumstances of the denial, which may arise from any negligence on our part, must be referred to management who will need to immediately advise our professional indemnity insurer.

## Fraud

### Insurance Fraud

Insurers take fraud very seriously. Where in the past an insurer may have only refused to pay a claim, if fraud is now proven, the insurance company may hand over its evidence to the police and request criminal prosecution.

### Prejudice generally

The remedies available to an insurer following breach of one of the insured's duty such as utmost good faith, disclosure or as to misrepresentations generally are covered in the Insurance Contracts Act 1984.

Fraudulent claims are dealt with separately. However in general terms, an insurer cannot refuse to pay a claim either in whole or in part by reason of some act or omission of the insured, but only reduce its liability to pay the claim by the amount that fairly represents the extent to which the insurer's interests were prejudiced.

If an insurer could show, other things being satisfied, that it would not have written an insurance policy had it received notice of certain information, it would be entitled not to avoid the policy as such, but could anyway reduce the claim payment to nil.

### Fraud

In the Act it is clearly stated that where a claim is made fraudulently the insurer may avoid payment of the claim, but if the fraud is held by the Court to be only at minimal or insignificant part of the claim and that non-payment of the remainder of the claim would be harsh and unfair, the Court may order the insurer to pay such amount (if indeed any) as considered just and equitable in the circumstances.

For example, in the case of a theft claim in the order of $20,000 the insured may only have committed a fraud in describing a stolen bottle of alcohol as being full, whereas in fact it was only quarter-full. In that case it may well be considered by the Court that payment in respect of the alcohol should be denied but the rest of the claim should be paid. As it is naturally difficult to prove fraud in law and also simply as a matter of producing sufficient evidence to prove it, some insurers consider this provision unreasonable.

The Court must however specifically refer to the need to deter fraudulent conduct in relation to insurance in making its decision, in addition to any other matter it considers relevant.

## Binder Claims

When we handle or settle claims arising out of a policy that we have issued under a binder or where we have a claims settlement authority from the insurer we will be typically expected to act in the best interests of the insurer and not those of the client. We will also typically be expected to meet the obligations of the General Insurance Code of Practice ([[General Insurance Code of Practice 2020](http://www.msmlm.com/msm-mission-control/general-insurance-code-of-practice-2020/)](file:///C:\Documents\MSM%20Operational%20Resources\MSM%20Operational%20Resources\MSM%20FSRA%20RESOURCES\General%20Insurance%20Code%20of%20Practice%202014.pdf)) in regard to our claims work.

The key issues and requirements to be considered when we have claims settlement authority are:

* Ensure all staff involved in the claims settlement process are aware of the claims limits provided by the insurer.
* Within 10 business days of receipt of the clients claim, we will decide to accept or deny the claim and notify the client of our decision, if we have received all necessary information at the time the claim is lodged and no assessment or investigation is required.
* Within 10 business days of receiving your claim, we will:
* notify the client of the detailed information we require to make a decision on their claim;
* if necessary, appoint a loss assessor/loss adjuster; and provide an initial estimate of the time required to make a decision on the claim.
* If we decide to appoint a loss assessor/loss adjuster and/or investigator, we will notify the client within 5 business days of appointing them.
* We will keep the client informed of the progress of their claim, at least every 20 business days except where longer timeframes have been agreed with the client.
* We will respond to the clients routine requests for information within 10 business days.
* When we have all necessary information and have completed all investigation that was required to assess your claim, we will decide to accept or deny your claim and notify you of our decision within 10 business days.
* We will conduct claims handling in a fair, transparent and timely manner.
* We will only ask for and take into account relevant information when deciding on a claim.
* We will give the client access to information about them which we have relied on in assessing the claim and an opportunity to correct any mistakes or inaccuracies. In special circumstances or where a claim is being or has been investigated, we may decline to release information and reports but we will not do so unreasonably. In these circumstances, we will give the client reasons and they will have the right to request a review of our decision through our complaints handling procedures. We will provide our reasons in writing upon request.
* Where an error or mistake in dealing with your claim is identified, we will immediately initiate action to correct it.
* If we deny your claim, we will provide written reasons for our decision to deny the claim and information about our complaints handling procedures; and on request, other than in the circumstances referred to above, copies of reports from our service providers which we have relied on in assessing the claim.
* Our Employees and our Service Providers will conduct their services in an honest, efficient, fair and transparent manner.
* Our Service Providers will notify us of any complaint they receive against them when acting on our behalf.
* Our Service Providers will inform you of the services they have been asked to provide and the identity of the Insurer for whom they are acting.
* Our Employees or our Service Providers will not perform functions that do not match their expertise.
* Our Employees and Service Providers will have and maintain a current license if required under legislation; and membership of a relevant professional body or sufficient expertise.
* Our Employees will receive adequate training to carry out their claims handling tasks and functions competently.
* Training of our Employees will include the principles of general insurance and any relevant consumer protection law; what to do in the event of a claim; product knowledge; and the requirements of the General Insurance Code of Practice.
* We will keep our Employees training records for at least five years and on request shall make those records available for examination by the Australian Financial Complaints Authority (AFCA).
* We will measure the effectiveness of training by monitoring the performance of our Employees; and require additional or remedial training to address any identified deficiencies.
* Our Service Providers will obtain our approval before subcontracting their services.
* We will handle complaints relating to or received by our Service Providers under our complaints handling procedures, when they are acting on our behalf.
* Where the client satisfactorily demonstrates to us that they are in urgent financial need of the benefits they are entitled to under their policy as a result of the event causing the claim, we will fast-track the assessment and decision process of your claim; and/or make an advance payment to assist in alleviating their immediate hardship within 5 business days of them satisfactorily demonstrating their urgent financial need.
* We will notify any financial institution that you have told us has an interest in your policy.
* If the client is unhappy with our decision, we will inform them of our complaints handling procedures.
* We and our Service Providers will comply with the ACCC & ASIC Debt Collection Guideline: for Collectors and Creditors, which require us to act fairly and in a considerate manner.
* If a person is experiencing difficulty repaying a debt due to illness, unemployment or other reasonable cause, and they reasonably expect to be able to discharge the debt if repayment terms are arranged, we will consider one of the following options:
* extending the period of repayment and reducing the amount of each payment due accordingly;
* postponing payments for an agreed period; or
* extending the period of repayment and postponing payments for an agreed period.
* If we are unable to reach an agreement with the person about the repayment of the debt, we will provide information to them about:
* our complaints handling procedures; and
* the existence of the Australian Financial Counsellors and Credit Reform Association for a referral to a not for profit, free financial counselling service.
* Where we have selected and directly authorised a repairer, we will
* Accept responsibility for the quality of workmanship and materials; and
* Handle any complaint about the quality or timeliness of the work or conduct of the repairer as part of our complaints handling process.

## Claims and Risk Management

A key service provided as part of our Claims Management process is to work with the client in identifying claims trends. All claims reported should be reviewed to identify the type of loss and the cause and prior loss history.

Where the review indicates potential for future losses, we should discuss the issue with the client and agree a plan to reduce such losses into the future.

Actions to be taken may include:

* Arranging for a risk inspection and report to be done by a staff member or external provider.
* Altering business procedures to reduce the risk or quantum of loss.
* Improving physical systems and procedures.

Each situation is different and often the client will already have considered taking corrective action. Our professional support in this process is one that will hopefully reduce the losses, both insured and uninsured that are suffered by our clients.

## Dissatisfied Customers

Please refer to our Complaints Policy and Procedures ([Complaints Policy and Procedures](http://www.msmlm.com/msm-mission-control/complaints-policy-and-procedures/)) when unable to satisfactorily resolve an issue with a client.

# GENERAL PROCEDURES

### Telephone Enquiries/Discussions

All telephone enquiries and face to face discussions from whatsoever source must be recorded in detail, dated and timed in our Day-book or Client Instruction Sheets, with the original copy being placed into the Client File. They must then be actioned accordingly. Service staff must be made aware of any relevant developments regarding their clients.

With an after-hours telephone conversation involving a request for cover, Brokers are to advise that immediate cover is NOT available and note their Day-book or Client Instruction Sheet accordingly

Telephone messages should always be relayed via email or message pads to ensure a trace of the call can be made if required.

Further information on Telephone issues can be found in the Staff Policy and Procedures ([Staff Policy and Procedures](http://www.msmlm.com/msm-mission-control/staff-policy-and-procedures/))

### Understanding What is Required

Establish exactly what it is the client requires and confirm in writing the action taken. Inform the client of any likely timetable and make use of the diary or follow up system when follow up action is required.

Where you give a client advice or offer an improvement to their cover and the client for whatever reason does not agree thereto, ensure that you immediately confirm in writing that they did not wish to proceed with your recommendation.

### Verbal Instructions

A file note or entry in your Day-book or Client Instruction Sheet must be created to record important information or instructions received verbally about a client or insurer. Ensure the message is clear and self-explanatory (i.e. not too cryptic or personalised). Remember a file note may be vital in a coverage dispute. After appropriate action, place the file note in the client policy or correspondence file.

Where appropriate/relevant such notes can be entered onto the Client records on the broking system.

### Confirming Verbal Instructions

We must confirm all verbal instructions regarding coverage inception or changes in writing, either by letter/email. Be particularly careful that verbal instructions from insurers are reported clearly to clients. Do not transfer the information in parrot fashion, and do not merely quote the client price only. All terms, conditions, exclusions and excesses are to be advised to the insured. If the message, terms, conditions etc., are not clear do not interpret them yourself but refer back to the insurers for clarification and follow up promptly. Do not hesitate to involve your supervisor or manager.

### Summary

There must be no misconceptions or misunderstandings between parties participating in the contact. If you are in doubt on any issue, then you must clarify the matter.

* When you are asked to effect cover, do so immediately and confirm. If there is to be any delay you must inform the client.
* Confirm all cover details with clients and insurers in writing.
* Keep the client and insurer informed of all situations that might concern them.
* Maintain telephone conversation record books.
* Take file notes to summarise meetings and discussions.
* Provide clients with all Statutory Notices.

### Registered Mail

It is a requirement to use Australia Post “registered mail” for important and contentious correspondence and a record of same must be kept on the client file.

### E-mail

Please refer to the Staff Policy and Procedures for details.

### Inward Mail

Please refer to the Staff Policy and Procedures for details.

# FILING

## Client / Policy Files

Each Client has a separate hard copy file:

The name on each file is to mirror the code that is used for that client on the computer system. Where multiple clients on the computer share one hard copy file there must be an appropriate comment put on the computer system identifying the name of the relevant hard copy file.

The Hard Copy file is also to contain a note on the front or inside cover of the file of the additional Clients whose information is incorporated into the file.

The Filing of hard copy files is alphabetical.

Within the hard copy file, a separate section is to be maintained for each policy held by the client.

Where it is warranted by virtue of the size of a client’s documentation, separate files (Client Correspondence /Policy Files) can be maintained. In this case all hard copy files for the Client must include a cross-reference to each of the other hard copy files on the front or inside cover of the hard copy file.

## Policy File Layout:

The sequence of filing in each section of the hard copy file is to be in chronological order. Items of a non-policy specific nature are to be filed in the Client Section of the hard copy file. Dividers are to be used to clearly separate the various components of the file.

## Claim File Layout

Claim files should contain at a minimum: -

* Copy of claim form
* Copies of client correspondence
* Copies of insurer correspondence, including copies of claim settlement cheque / EFT and details of settlement

## File Maintenance

Files must be, at all times, kept to a standard that would enable any competent operative to pick up the file and attend to a claim or a client query or service requirement.

All documentation etc. must be permanently fixed to a binding clip and not be left loose in the file.

All files, unless in use, must be kept in the storage facilities provided.

All correspondence received from the client/insurer is to be filed in the hard copy file. The only exception to this is compliments slips/sundry attachments etc. that do not contain any relevant information. This includes copies or originals of all policy/endorsement/cancellation schedules received from insurers but does not include standard insurer printed policy wordings that are available upon request from the insurer.

Copies of all insurer standard policy wordings and endorsements are separately maintained within the office.

Copies of documentation produced from our computer system are not to be filed except where there has been a change made to the documentation and our computer system does not record the original details of the transaction. In such cases a copy of the original documentation is to be filed in the hard copy file with a note indicating that the document has subsequently been updated.

Where Electronic filing is utilised in the office there must be a scanning request form attached detailing the client code, folder to be filed and a document description starting with the date in yy/mm/dd order.

# ARCHIVING

## Introduction

It is imperative that in the event of historical documentation being required that we are able to quickly and consistently retrieve the required information. Records of whatsoever nature must not be destroyed without approval of Management.

Files for liability/workers compensation classes should be kept indefinitely (at least the policy documents and/or renewal certificates). Other files should be kept for a minimum of five years (for Tax Purposes) and ideally seven years. Refer to our privacy policy for details on how files can be destroyed.

## Archiving of Policy / Client Files

The archiving procedure adopted in the office should be based on the following guidelines as follows:

At the beginning of each Financial Year a new set of Archive Boxes/Storage Areas is to be created. The Archive Boxes/Area must be clearly marked showing the alphabetical range; period for which they relate and the Destruction Date planned. All documents that are archived during the financial year are to be placed in the relevant Archive Boxes/Area for that year.

If a whole client file is to be archived this can simply be placed in the Archive Boxes/Area in Client Code alphabetical order. Where only part of an existing Client File is to be archived a manila folder is to be used to store all client documents. The manila folder is to have the Client Code clearly marked.

The Archive Boxes/Area will be maintained on site for a period of time (usually twelve months to three years) after the year to which they relate and then be sent to permanent storage. This will be co-ordinated by the Responsible Manager(s).

When an insurance policy is cancelled or not renewed office staff should update the computer accordingly file the dead policy/client file in the archive box once all final correspondence has been filed.

At other times when handling the Hard Copy file all documentation more than two years old is to be taken out of the folder and archived. This should be part of the routine adopted when filing documentation to the hard copy folder.

Note:

Archiving of Day-books, Client Instruction Books, Diaries and any other document containing client and/or company information is subject to the above procedures.

Archive records will remain in storage for a minimum period of 7 years before being destroyed by an approved secure document destruction system. Workers Compensation and Liability files are to remain for an indefinite period.

Please also refer to our Privacy Manual for further information on the issue of access and safe storage of Client Information.

# CREDIT TERMS AND CREDIT CONTROL

## Introduction

Commercial awareness must play an important part of our day-to-day business activities, not least so in the area of Credit Control.

Investment income makes a significant contribution to our profitability. It is essential therefore that we act in a professional manner at all times, and strictly control the credit we allow our clients in order to maximise investment income and pay insurers within credit terms.

All staff have a personal responsibility to achieve and maintain a high standard of credit control.

Compliance with The Act requires payments to underwriters within agreed trading terms and in any event within 90 days of cover inception. In many cases underwriter’s terms may be 30 days, 45 days or 60 days. Regardless of the credit terms it is important that all clients are invoiced prior to inception or renewal of the policy, or within 14 days of inception or renewal.

If we fail to collect the premium from the client within the required time frames the client may find themselves uninsured. It is therefore in their best interests to pay their premiums as required.

## Terms of Credit

We must aim to collect premium settlement from our clients as near to renewal date, or effective date, as possible, but in any event within thirty days of cover inception. It is the responsibility of the Service Manager to negotiate any extension of credit and advise the Office Staff accordingly.

## Methods of Payment

There are various payment options made available to our clients. These options, where applicable, should be offered to the client at the time of distributing the invoice. The options available are spelt out in our Broking Service Standards: -

In accordance with the Consumer Credit Act, we are unable to offer premium funding to any domestic style clients except where the Premium Funder has been granted an exemption and we have supporting documentation for the funder on file within the office.

## Collection of Debts

It is the responsibility of the Office Staff to attempt collection within thirty days of effective date. The invoice text states when premium is due and payable which is usually 14 days from invoicing.

The Credit Controller produces a weekly Debtors Aging Summary showing all premiums invoiced, which is distributed to all Service Managers and Office Staff for attention. It is ultimately the responsibility of the Service Manager to monitor and action any outstanding premiums over 60 days or which are outside the insurers Credit Terms.

If the reason for non-payment relates to a dispute or an expectation of return premiums, we should obtain payment of that part of the debt that is not disputed and agree a timetable for a resolution of the dispute or the processing of the return premiums. All account queries, either emanating from clients or insurers must receive immediate attention so that they do not impact on our credit control policy.

If there is no reason for non-payment, the Office Staff responsible would normally commence a follow up by way of a telephone call backed up by a letter reiterating the essence of the conversation. The Office Staff should point out the terms of credit, the fact that they have been exceeded, and the fact that payment must be received as a matter of urgency.

In all instances, the amount of credit extended to clients is subject to restrictions placed on us by The Act, and the Licensee Agreements terms/conditions entered into between the insurers/underwriters and ourselves. We must always advice clients where the debt is outside insurer credit terms. An example of the standard letter/communication is shown below:

“We refer to the above invoice that according to our records remains unpaid. If you have made this payment in the last few days, please disregard this notice.

Please note that the debt now exceeds the credit terms provided to us by the insurer and accordingly the insurer has a legal right to have the policy cancelled due to non-payment. This will or already has left you without the insurance coverage that we believe that you require.

To ensure ongoing coverage please make immediate payment of this invoice or contact us to discuss your situation. If payment is not made immediately, you should assume that all cover related to this invoice is no longer in place. The insurer may also be entitled to seek payment directly from you for time on risk.”

Each staff member's discretion to write off Broker Fees should be included in their Position Description or Task Allocation Table.

Staff should also be aware of that we have a documented approach to assisting clients facing financial hardship. This is included in the Financial Policy & Procedures ([Financial Policy and Procedures](http://www.msmlm.com/msm-mission-control/financial-policy-and-procedures/)).

## Monthly Reporting

A report to the Responsible Manager(s) is provided each month by the Credit Controller showing all balances outstanding over sixty days with explanations as to non-payment and expected dates of receipt.

## Investment Income

It should be noted that investment income is an important contributor towards our profitability, therefore THE BETTER THE CREDIT CONTROL THE BETTER THE INVESTMENT INCOME EARNED.

# HANDLING CLIENT FUNDS AND FUNDS CONTROL

## Introduction

As a Financial Services Provider we receive funds from clients that contain various elements. These include the premium and charges that must be passed on to the underwriter, commissions and fees payable to the business.

## Trust Account

Section 981 B of The Act ([The Corporations Act](http://www.msmlm.com/msm-mission-control/corporations-act-2001/)) and Reg 7.8.02 of the Corporations Regulations ([Corporations Regulations 2001 (Combined)](http://www.msmlm.com/msm-mission-control/corporations-regulations-2001-combined/)) provide that an AFS Licensee shall maintain a separate Trust Account with an ADI, an approved foreign bank or in a cash management trust. All moneys received from an insured in connection with a contract of insurance or received from an insurer on account of an insured shall be paid into that account.

The Act and Regulations prescribes how funds shall be invested as follows:

* investment on deposit with an eligible money market dealer;
* investment on deposit at interest with an Australian ADI;
* the acquisition of cash management trust interests;
* investment in a security issued or guaranteed by the Commonwealth or a State or Territory;
* investment on deposit with a licensed CS facility.

## Receipting

All client funds must be banked to our Trust Account on the day that they are received or the next working day where this is not possible. Such payments must also be receipted through the computer system to ensure that our debtor’s information is kept up to date.

All invoices produced from the computer system provide an option for the client to request a receipt. Apart from cash transactions (where a cash receipt must always be provided) receipts are not to be issued unless specifically requested.

## Credit Cards

The business commits to complying with the spirit and intent of the Payment Card Industry Data Security Standard [Payment Card Industry Data Security Standard (PCI DSS)](http://www.msmlm.com/msm-mission-control/payment-card-industry-data-security-standard-pci-dss/) and has put into place the following processes.

* All credit card payment details are to be destroyed /de-idenitified or stored securely within 7 days of the credit card details being used.
* Documents that need to be retained by the business that include Credit Card details are to have the Credit Card details de-identified or alternatively stored securely.
* Clients are to be requested not to email / fax credit card details when paying via credit card. This is to be included on all documentation that provides for Credit Card details.
* Clients that fax / email their Credit Card details to us are to be courteously advised of the security threat such communication processes involve and requested to phone details to us or use any secure Credit Card gateways that we have available.
* We are not to pass client Credit Card details to third parties via either fax or email, including scanned attachments to emails.

## Payment of Business Income

As mentioned above the monies banked into our Trust Account are a mixture of business earnings and payments to be passed onto underwriters. On a regular basis (but no less than every 30 working days) we will draw funds out of the Trust A/C that represent the earnings and associated GST of the business and any sub agents/intermediary earnings and GST.

Any such transfer of funds from the Trust A/C to the Operating A/C of the business must have been duly authorised by the Responsible Manager(s) and supported by an Online or documented reconciliation of the Trust A/C. Such transfer requests are then to be processed accordingly.

At no time and under no circumstances are client funds that are payable to an underwriter to be transferred to the Operating Bank A/C. The Trust A/C balance must be equal to or greater than the underwriter liabilities showing on the Reconciliation.

## Funds Control

The following procedures have been put into place to reduce the risk of client funds being inappropriately used.

* All cash received by the business is to have a Cash Receipt issued, regardless of whether the client requests one.
* As part of our Compliance Policy and Procedures a random check of Cash Receipts issued and banked is performed on a regular basis.
* Wherever possible the handling of cash receipts and cash disbursements is to be carried out by staff that are not involved in the raising of invoices to clients.
* All cheques and electronic transfers from the Trust A/C should require two signatories/authorisations wherever practical.
* Access to creating new Underwriter’s and altering Underwriter details is restricted to the Responsible Manager(s) and other duly authorised staff.
* Where possible there is to be a clear separation of duties between the operational staff involved in the business and the staff responsible for processing all withdrawals from the Trust A/C.
* Trust A/c’s are subject to a minimum monthly bank reconciliation and are included in the annual audit process.

## Write Off Processes

From time-to-time clients inadvertently overpay or underpay our invoices. Whenever we identify such a situation the following steps should usually be taken.

* In cases where the discrepancy is less than $5.00 the discrepancy should be written off.
* In all cases involving amounts over $5.00 the client should be contacted to confirm the amount is an error and agree with the client what action is to be taken to rectify the under/overpayment.
* Where the underpayment is in excess of $10.00 the matter should be referred to the Responsible Manager(s) for approval prior to being written off.

# PAYMENT TO INSURERS

Reg 7.8.08 (2) of the Corporations Regulations ([Corporations Regulations 2001 (Combined)](http://www.msmlm.com/msm-mission-control/corporations-regulations-2001-combined/)) provides that an AFS Licensee shall pay the premium to the insurer no later than 90 days after the day upon which cover with the insurer commenced or a lesser period if this has been agreed between the insurer and the broker.

Reg 7.8.08 (3) of the Corporations Regulations ([Corporations Regulations 2001 (Combined)](http://www.msmlm.com/msm-mission-control/corporations-regulations-2001-combined/)) provides that where an AFS Licensee has not been received payment within 90 days of the cover commencing, then within a further 7 days, the broker shall notify the insurer in writing that the broker has not received the premium.

The credit terms agreed with some insurers may be less than the period prescribed in the Act.

To ensure underwriters are paid within terms our Computer System includes provision to capture Credit terms. At a set date or dates each month; reports are to be run detailing payments due to underwriters up to the corresponding date of the next payment process. They are to be verified by the Responsible Manager(s) or other authorised staff and submitted for payment.

Computer exception reports are to be run weekly (where available) to identify other payments that become due to an underwriter and individual payments made where we are unable to wait until the monthly payment process is completed.

Most insurers are now using and accepting Electronic Funds Transfer. The setup of such information in the computer system is the responsibility of the Responsible Manager(s) or other authorised staff.

Where Underwriters are to be paid via a cheque a Cheque Requisition Form or signed Insurer Payment report is to be completed and processed.

Where business is not placed directly with an insurer but via another AFS Licensee we have a requirement when making each payment to advise the AFS Licensee that the monies being paid to them are client monies and such monies are to be banked into a designated Trust account. (Reg 7.8.02 (1A)). The wording below is to be included in such remittances.

“This note only applies to payments made to AFS Licensees other than insurers:

Please note that these monies have been withdrawn from an account maintained for S981B of the Corporations Act and should be paid into an account maintained for S981B of the Corporations Act no later than the day after they have been received.”

# PAYMENTS TO CLIENTS

## Refunds From Insurers

On a regular and ongoing basis, we will be required to make payments to clients for refunds on polices that have been cancelled etc. Under the Corporations Act we are required to make such payments to the client within 7 days of receiving the money from the insurer.

In most cases the insurer does not draw us a cheque or remit funds to us. We usually deduct the credits owing to insurers from our regular remittances. The deduction of the credit does not involve confirmation from the insurer that they have accepted the refund amount as being valid.

The date of payment from the insurer is therefore taken to be either:

* The date we receive payment from the insurer,
* The date we make a payment to the insurer that includes the deduction for the client credit.

To ensure that our client refund process both meets our legal responsibilities and does not expose the business to the risk of payments that will not be eventually funded by the insurer we have put into place the following processes.

After each payment cycle to the underwriters (as well as the weekly report) we produce a computer report or manual listing of all refunds due to clients. The relevant servicing officer within 7 days must have already or is to be requested to either:

* Confirm the payment has been approved by the insurer and the client requires payment, or
* We are awaiting approval of the refund amount from the insurer (must be noted), or
* The client has other current or pending debits that the money is to be applied to (must be noted).

If a payment is required as in Point 1 above the remittance must be sent to the client within 7 days of insurer receipt.

## Payments From Clients

Occasionally clients will send us payments for insurance covers, that for one reason or another (such as failure to submit a proposal,) do not proceed. In such cases we must ensure that we return the funds to the client within one month of the coverage involved not commencing.

## Unclaimed Monies

In circumstances where we are unable to locate the client when trying to refund monies, such monies are generally payable to the relevant state in which the business operates. For details of the requirements that apply, refer to the relevant State Treasury Department’s website for further guidance. In NSW, amounts under $100 are not required to be paid to Treasury.

ASIC are responsible only for Unclaimed Monies in relation to banking, life insurance and Corporations Act matters involving the acquisition of shares in Publicly Listed companies.

# PREMIUM FUNDING

## Introduction

Premium funding should be offered to clients as per our Broking Service Standards. The funding offer should be in writing setting out all terms, conditions, fees and interest incurred for the contract. The funding offer also must make it clear that the client is entering into a separate contract from the insurance policies being funded and also include information on how we and the premium funder deals with clients in financial difficulty.

To ensure that we meet our Conflict of Interest obligations all funding offer documentation must include specific reference to the fact that we receive remuneration for arranging premium funding from the Premium Funder together with details of the remuneration involved.

There is a Premium Funders Code of Practice ([Premium Funders Code of Practice](https://www.msmlm.com/msm-mission-control/premium-funders-code-of-practice/)) that imposes additional obligations and expectations on those funders that have adopted compliance with the Code.

## Funder Selection

When deciding on which premium funders the business is to use there are a range of factors that we need to take into account and assess. These include:

1. The ease of use and flexibility of the funder, including their software offer and integration into our Broking system.
2. The ability of the funder to handle both commercial and domestic clients.
3. The interest rate and fees to be charged to the client, client payment terms, payment dates to us and the funding commissions payable by the funder to us.
4. The funders documented policies for handling clients facing financial hardship and their willingness to work with clients when they face financial hardship.
5. Whether the funder has committed to complying with the Premium Funders Code of Practice.

## Procedures

The usual steps involved in the funding process include:

* Select an approved Premium Funder from our Approved Product Listing (where relevant).
* Quotations from Funders should be processed through the Premium Funders software based on the commission earnings as set out in our Broker Fees Table.
* Evaluate which company provides best alternative for client.
* Print contract documentation and forward to client with standard premium funding letter.
* Ensure that copy of quotations are saved in relevant client file.
* When funding paperwork is returned ensure that all required documents have been returned and completed in the correct manner.
* Update client computer records via transaction amendment menu to note that the policies in question are being funded. This will then ensure that when implementing credit control procedures the policies will show as being funded.
* Forward funding documents to the Funder.
* Confirmation of payment to be passed to relevant team member for banking
* The client should be followed up in 7 days, from when documentation was forwarded, unless premiums have been paid by the client. It is the responsibility of the Office Staff to ensure settlement is received by the end of each month.
* Should we become aware of any clients facing financial hardship we need to remind them that both ourselves and the premium funders have processes in place to assist with financial hardship
* We should liaise with the Premium Funder to look at the individual circumstances of the client and what options may be able to be presented to them. For further guidance on deaing with Financial Hardship please refer to our Financial Policy & Procedures ([Financial Policy and Procedures](http://www.msmlm.com/msm-mission-control/financial-policy-and-procedures/)).

## Client Warning

* To ensure that clients are aware of the fact that Premium Funding contracts are a separate contract to the insurance covers and the possible adverse consequences involved in a mid term policy cancellation we recommend the use of the following disclosure information be provided with all Loan Application Forms provided to clients. The provision of such a notice also meets the expectations of AFCA in regard to Premium Funding.

“Enclosed is a Premium Funding Loan Application Form. Premium funding allows you to spread out the cash flow associated with paying your insurance premiums over the next twelve months. Please note that the Premium Funding contract is a separate contract to the insurance contract(s) that it funds and interest and fees apply to the funding contract as detailed on the Loan Application Form.

Due to our relationship with the Premium Funder, you are automatically accepted for funding, simply complete the funding application including the Direct Debit authority and return it to us. We receive a commission from the funder for arranging the funding contract; full details are shown on the Application Form.

Please note that should the insurance policy be cancelled before the expiry date for whatever reason, the Premium Funder will charge you the full interest applicable to the contract, as detailed in the Loan Application Form. Typically, there will be no refund of our commission on the refund premium and no refund of any fee we may have charged you for arranging the cover. We also reserve the right to charge you a policy cancellation handling fee. In some cases, insurers also apply minimum premiums to policies, which may further reduce the refund that you might otherwise receive.

The impact of the above on you is that any refund you receive for the mid-term cancellation of your policy will usually be significantly less than a pro rata calculation would produce and in extreme cases may involve you having to make an additional final payment even though the policy has been cancelled. Therefore prior to cancelling a policy and replacing it with another cover we strongly recommend that you discuss your situation with us so that we can advise the exact extent and impact of the early cancellation provisions mentioned above.

We also take this opportunity to let you know that both ourselves and the funder are committed to assisting clients facing financial hardship. If you are facing financial hardship, please contact us to discuss your situation.”

# ANTI MONEY LAUNDERING LEGISLATION

The Anti-Money Laundering and Counter-Terrorism Financing Act 2006 (AML/CTF Act) forms part of a legislative package that will implement reforms to Australia's AML/CTF regulatory regime.

The reforms are a major step towards:

* bringing Australia into line with international standards, including standards set by the [Financial Action Task Force (FATF)](http://www.fatf-gafi.org/), and
* preventing and detecting money laundering and terrorism financing by meeting the needs of law enforcement agencies for targeted information about possible criminal activity and terrorism.

The AML/CTF Act covers the financial sector, gambling sector and bullion dealing and any other professionals or businesses that provide particular ‘designated services’. The AML/CTF Act imposes a number of obligations on businesses when they provide these designated services. These obligations include:

* customer due diligence (identification, verification of identity and ongoing monitoring of transactions)
* reporting (suspicious matters, threshold transactions and international funds transfer instructions)
* record keeping, and
* establishing and maintaining the AML/CTF program

At this stage AFS Licensees who operate as traditional general insurance brokers and who do not provide their own funding to clients, but arrange for clients to access funding from Premium Funders are not required to take any action in regard to the AML/CTF Act.

# STATIONERY

The “Standard Notices” used on our invoices must also be readily available to be used for other correspondence with the client. On the reverse of or in the text section of the invoice should be printed the Important Notices with a note on the bottom of the facing page “Please refer to the Important Notices overleaf” where relevant. Any requests for stationery/printing should be made to the relevant staff member.

# SERVICE STANDARDS

## Minimum Standards

It is essential that standards be observed in managing our accounts if we are to maintain, and strive to improve, the service we offer our clients.

Our standards are clearly documented in our Broking Service Standards. As a general rule we do not wish to amend our Service Standards on a client by client basis as the practical requirements of monitoring and managing such situations are almost impossible to consistently achieve, leading to a failure to meet the clients’ expectations.

## Golden Rules Of Service

We have a business responsibility and legal duty of care to our clients to take reasonable care in the provision of financial services. We are expected to exercise the same duty of care to our clients as would a competent insurance intermediary. All broking staff must abide by the following golden rules.

### Know your Client (Commercial & Corporate Clients)

Service Managers should personally know the executive management staff of your client, particularly the Company Secretary, Financial Manager and Insurance Officers. Be aware of changes made or contemplated in executive staff and make early contact with replacement(s). Details of all senior /or staff of the client should be recorded in the hard copy file or on computer where relevant.

Service managers should formally introduce the designated Office Staff to the client as soon as practically possible, or at renewal of the account.

### Have an Inquiring Mind

Be fully acquainted with all general aspects of your client’s activities and encourage clients to keep you informed of changes in their business activities that may have an effect on the insurance program. Continually question your clients on this.

### Attention to Detail and Look for Trouble

Be positive and give clear and concise advice to clients at all times. If you are not sure of an answer, say so, but ascertain the answer as quickly as possible and advise the client immediately by letter or email as appropriate.

Do not hesitate to involve other senior members of our company.

### Review Client’s Needs

Be Able to Live Your Client’s Business, Understand it, Read about It and Identify the Client’s Needs and Philosophy

Make service calls in line with our Broking Service Standards depending on the requirements of the client and document the calls.

Ensure all Corporate clients go through an audit / marketing strategy and pre-renewal strategy process each year and that outstanding claims reports are discussed with these clients on a regular basis.

### At all Times Have a Sense of Urgency

Keep your Supervisor/Manager informed of any problems or difficulties etc. that could arise in respect of your clients’ insurance and where a potential professional indemnity claim may occur. Give prompt action to all incoming mail relating to the client’s insurances, especially if there are complaints. Any client complaint (written or oral) must be reported to your Supervisor/Manager. For further details refer to the Complaints Policy and Procedures.

### Put the Client’s Needs First

Ensure that: -

* Client files are maintained in an orderly fashion; and
* Each Corporate client receives an annual insurance register or manual

### Know People and Maintain Good Communication

The client is our “bread and butter”. You should make yourself available at all times – be prepared for the emergency. The success of the relationship depends on a clear understanding between both parties.

### Act Competitively at all Times

Although the business may have a long and very strong relationship with a client, there is no room for complacency. Unless you have received clear written instructions to the contrary you should always operate under the assumption that the client may be seeking or have already received alternative quotations for their needs.

### Client Manuals

Client Manuals should be prepared annually for all Corporate clients where required and as applicable for all other clientele. Client manuals are only to be prepared in the standard business format. A full copy of the manual must be kept in the client file.

# LETTERS OF AUTHORITY/ENGAGEMENT/RESIGNATION

## Letters of Appointment

Where a client wishes us to take over the handling of one or more of their existing policies from another broker, but wishes covers to remain with existing insurers we should have the client complete and sign a Letter of Appointment ([Broking Letter of Appointment](http://www.msmlm.com/msm-mission-control/broking-letter-of-appointment/)) confirming this.

The letter is designed to be able to forward to the insurer(s) to facilitate the transfer of business to us, whilst minimising the work required to be done by the client.

It is important to note that the letter must be on the client’s letterhead and be signed by a senior person within the firm.

This document is designed to provide a suggested form of authority that clearly sets out the scope of an appointed broker's power to request information from insurers post appointment. It may assist in avoiding confusion and disputes between insurance brokers, clients and insurers.

If an insurance broker represents the scope of their authority to insurers in a way that is broader than what the client believes it to be, the insurance broker runs the risk of an action being brought against it for misrepresentation and may also be seen to have breached its AFSL licensing obligations and duty to the client, amongst other things. Clarity on the scope of authority is crucial to avoid this risk.

From an insurer's perspective, an insurer runs the risk of breaching its privacy, confidentiality and AFSL licensing obligations, amongst other things, in passing information on the insured to an insurance broker that has not provided a written authority from the insured to do so. The insured can assert no such authority was provided and the insurer should not have passed the relevant information to the insurance broker.

In addition, it is crucial for the insurer to only pass to the insurance broker the information it is authorised to provide. The notice is designed to assist in this regard and provide some form of certainty.

## Letters of Authority

Where we are required to obtain information (including claims experience) from a client’s (prospective client’s) insurer, we should request a Letter of Review and Quotation ([Broking Letter of Review and Quote](http://www.msmlm.com/msm-mission-control/broking-letter-of-review-and-quote/)) before proceeding. Signed copies are to be retained in our files. It is important to note that the letter must be on the client’s letterhead and be signed by a senior person within the firm.

This document is designed to provide a suggested form of authority that clearly sets out the scope of the enquiring insurance broker's power to request information from insurers pre appointment. It may assist in avoiding confusion and disputes between insurance brokers, clients and insurers.

If a quoting insurance broker represents the scope of their authority to insurers in a way that is broader than what the client believes it to be, the insurance broker runs the risk of an action being brought against it for misrepresentation and may also be seen to have breached its AFSL licensing obligations, amongst other things. Clarity on the scope of authority is crucial to avoid this risk.

From an insurer's perspective, an insurer runs the risk of breaching its privacy, confidentiality and AFSL licensing obligations, amongst other things, in passing information on the insured to an insurance broker that has not provided a written authority from the insured to do so. The insured can assert no such authority was provided and the insurer should not have passed the relevant information to the insurance broker, especially where the insurer is aware that the insured has an existing insurance broker.

In addition, it is crucial for the insurer to only pass to the quoting insurance broker the information it is authorised to provide. The notice is designed to assist in this regard and provide some form of certainty.

## Letters of Engagement

As a means of minimising risk, a signed Broking Letter of Engagement ([Broking Letter of Engagement](http://www.msmlm.com/msm-mission-control/broking-letter-of-engagement/oc)) should be completed for all newly acquired and all existing major clients and other clients where practicable.

Service Managers are responsible for ensuring that: -

* The Broking Letter of Engagement is completed on or about the commencement of service to the client, or an updated Broker Letter of Engagement is obtained at renewal date for long standing clients.
* Classes of risk are identified (if not all insurances are involved) using the company standard Insurance’s Available prescribed form.
* That the client accepts the Broking Letter of Engagement.
* The Broking Letter of Engagement indicates the client’s intention that we act as their insurance broker.

## Resigning As The Clients Broker

Apart from any clause in our Engagement Letter with the client we may terminate our services to the client by giving them reasonable notice. All decisions to terminate our relationship with a client should not be taken lightly and should be signed off by a Responsible Manager.

The resignation notice should be provided verbally initially and followed up in writing with a copy of the advice retained on file.

Throughout any resignation process we should keep in mind that where commercially feasible we should endeavour to limit any potential prejudice to the client. This is especially the case where policies are due for renewal, interim covers are due to expire or other time critical processes are on foot.

The resignation documentation should include confirmation that we are no longer providing any services to the client in relation to insurance placement, insurance renewal, claims handling etc. and that the client should make alternative arrangements as a matter of urgency.

We should also provide the client with a list of all insurances currently in place with full details of all coverages and insurers etc. If we have been involved in claims handling activities a list of all open claims and their status should also be provided.

We should also advise each insurer with whom we have placed the clients’ insurances that we are no longer acting for the client and advise them of the direct contact details of the client and ask them to communicate directly with the client.

A sample Client Resignation Letter ([Broking Letter of Resignation](http://www.msmlm.com/msm-mission-control/broking-letter-of-resignation/)) is available as a basis for such written communication.

## Commercial/Corporate Clients Service Plans

As a base to your relationship with your client you should plan and structure your servicing arrangements. This is to be done by

A formalised plan based on our Broking Service Standards should be provided for all Corporate clients and other clients as required. The plan then forms the basis of the overall servicing program. This system serves as a mechanism to enable Service Managers to plan and co-ordinate activities on the account and will also enable a permanent record of service calls and reviews to be maintained.

The Service Plan should be discussed and agreed and signed off with the client. When visiting clients ensure that an agenda is prepared for the meeting and wherever possible forward the agenda to the client prior to the actual meeting. If it is not possible for the agenda to precede your visit, you should present the agenda to the client at the actual meeting. Following the meeting a short note should be written to the client summarising the points agreed.

A Service Register is to be maintained by the Service Manager and retained in the client correspondence file for all Corporate Clients

# STAFF INSURANCE

Please note that any insurance being arranged by a staff member for their own, friends or relatives’ policies must not be handled by the staff member concerned without the approval of management. As a general rule we would prefer such insurances to be arranged by another staff member.

# APRA DATA COLLECTION

## Introduction

The Corporations Regulations include an obligation (with associated penalties for non-compliance) on AFS Licensees that deal in General Insurance to provide the Australian Prudential Regulation Authority (APRA) with regular data on their insurance placements including all placements done by any Authorised Representatives of the AFS Licensee. The data collection process has the aims of enabling:

1. Ongoing monitoring of insurance business being placed with Unauthorised Foreign Insurers (UFI) under exemption arrangements and assist in the modification of those arrangements over time.
2. A better understanding of the Australian general insurance market by obtaining data on the intermediation of general insurance products
3. A greater understanding of the impact of an insurance failure on the Australian community.

## Is My Business Affected?

If we are involved in the placement of general insurance covers with insurers, then we must comply with the Regulations. The only insurance intermediaries not caught would be those that only provide advisory general insurance services and are not involved in the placement of insurance.

## Reporting Periods and Dates

The reporting periods are from 1st January to the 30th June and from the 1st July to 31st December each year. The relevant Form 701 must be lodged with APRA within 20 days of the end of each reporting period.

## Information Required

All affected Licensees will be required to collect and report on information in the form (Referred to as Form 701) ( [APRA Form 701](http://www.msmlm.com/msm-mission-control/apra-form-701/) ). Instructions on completion and further information on Form 701 are provided in the [Apra Data Collection Explanatory Note](http://www.msmlm.com/msm-mission-control/apra-data-collection-explanatory-note/) and [APRA Instruction Guide Form 701](http://www.msmlm.com/msm-mission-control/apra-instruction-guide-form-701/)

Part 1 of the form will be required to be completed for all placements.

Part 2 of the form will be required if we are placing business directly with UFIs. If cover is placed via another AFS Licensee, then we are not required to include the placement on the form.

In completing the form, premium excludes Fire Brigade Levy, Stamp Duty, GST and Broker and Survey fees etc.

## Information Source

Our Broking Software system will generate the required reports.

## Submitting Information

If we do not have any direct UFI placements to report, the Form 701 can be lodged in either hard copy / PDF or submitted via the APRA “D2A” data lodgement software. All direct UFI placement data can only be provided via the APRA “D2A” data lodgement software. We would only use the D2A lodgement facility if we are required to report on individual UFI transactions.

# ADVERTISING FINANCIAL PRODUCTS & ADVICE

## Introduction

ASIC have published Regulatory Guide 234 ([RG234 - Advertising Financial Products & Advice](http://www.msmlm.com/msm-mission-control/rg234-advertising-financial-products-advice/)) to help AFS Licensees comply with their obligations to not make false or misleading statements or engage in false and misleading conduct.

Whether a particular statement is misleading or deceptive will depend on all the circumstances of the particular case.

We must ensure that when we create advertisements / promotions and statements in letters / emails etc. that they not only meet the minimum requirement of not being misleading or deceptive but also that help consumers make appropriate decisions. This includes whether to seek further information about the financial product or advice service.

## Implications

All advertising / promotional material should be approved by a Responsible Manager and this should be either clearly documented or self-evident by the systems and processes involved in releasing such documentation. Whenever creating or signing off advertising / promotional material we must ask ourselves the following:

* Are our statements consistent with our FSG, the PDS or policy wording?
* Do they accurately portray the range of products and services that we can provide and the scope of those services?
* Have we given a realistic impression of the fees and charges for our service? A service is not free if a client pays indirectly for the service through the commission included in the premium.
* Do they create an accurate and balanced representation of our product or service, or is it confusing and unclear? Is there crucial information missing?
* When comparing products, is the information up to date, complete, accurate and fair? Will it remain that way during the ‘life’ of the advertisement?
* Have we included an advertising/general advice warning?
* As a rue of thumb, the use of words such as “Best”, “Cheapest”, “Broadest”, “Perfect”, “Lowest”, “Widest”, “Largest”, “Smallest”, “Biggest” should be avoided as it is highly unlikely such comments can be objectively proven and even where this can be proven at the time the claim is made we would need to continually test such claims to ensure that they hold true for the life of the advertisement / promotion etc.

# DEFERRED SALES MODEL OBLIGATIONS

## Introduction

The Deferred Sales Model for Add On Insurance Obligations (DSM) was one of the governments responses to the findings of the Hayne Royal Commission into the Financial Services industry.

The Commission identified numerous cases where clients were being sold financial products at the same time as buying other goods and services where the financial products were either inappropriate to the needs or requirements of the client or provided minimal economic value to the client. It was also found that in many cases clients were subject to unfair sales practices and believed that the purchase of the financial product was a mandatory part of purchasing the related goods and services.

Examples of such behaviour and products included Tyre and Rim Insurance and Consumer Credit sold via Motor vehicle dealerships.

Based on these findings the government has passed legislation to break the perceived nexus between purchasing the goods and services and purchasing the related insurance referred to as Add On Insurance. ASIC have also issued [RG275 – Deferred Sales Model For Add On Insurance](https://www.msmlm.com/msm-mission-control/rg275-deferred-sales-model-for-add-on-insurance/) that provides ASIC’s view of the way the legislation is to be interpreted and acted upon.

It must be said that there were no instances raised in the Royal Commission of general insurance brokers directly involved in the inappropriate sales of add on insurance, however the new obligations apply to brokers regardless of this.

Effectively Add On Insurance, except where an exemption applies, cannot be sold to a “Consumer” at the same time as the “Principal Service or Product”. There is a pre deferral period and a mandatory 4 day post sale deferral period that applies. This means that the financial product cannot be sold to the client until 4 clear days after the client commits to purchasing the “Principal Service or Product” and the client has been provided with a “Customer Information Sheet”.

The “pre deferral period” covers the period from when the client intends to purchase the “Principal Service or Product” and when the client commits to the purchase.

## Scope of the DSM

The ASIC Act and ASIC’s RG275 guidance paper attempt to ban all of the scenarios that unscrupulous sales people may engage into get around the deferral periods. For example:

1. If you refer a client to a third party, the third party cannot make contact with the client until 4 days post sale.
2. You cannot present the insurance as complimentary but take the clients credit card details or other information prior to the end of the 4 day deferment period and then automatically trigger coverage at a later date.

## Additional Consumer Protections

The client can opt out of being provided with any information or sales material relating to the insurance as well as opting out of any contact by any means in relation to the sale of the insurance. Once the client opts out, there can be no contact with the client.

The client can return the financial product within 6 weeks of purchase with a full refund (less any claims paid) where the product was sold within the deferment period. The seller will also be subject to potential penalties and fines in such cases.

## Exemptions

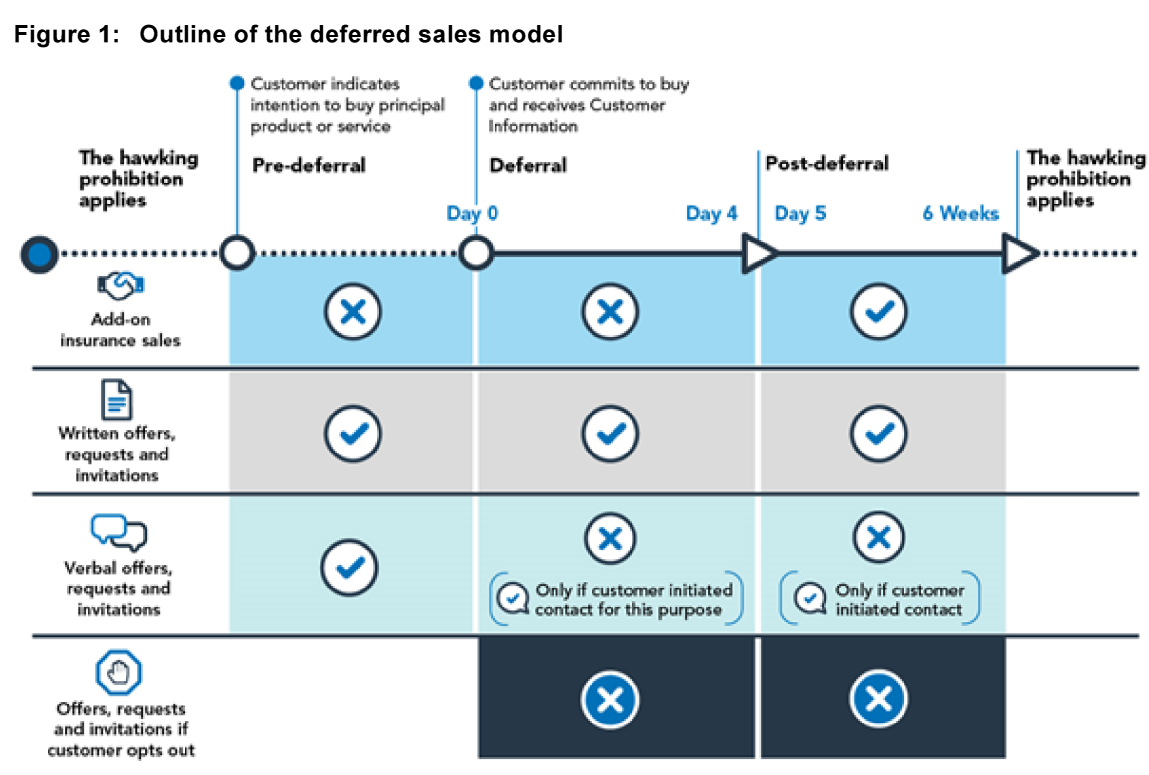
The DSM does not apply in the following situations as per [ASIC Amendment Deferred Sales Model Regulations 2021](https://www.msmlm.com/msm-mission-control/australian-securities-and-investments-commission-amendment-deferred-sales-model-regulations-2021/):

1. The purchase of the Principal Service or Product is used in a business and the cost of the insurance exceeds $1,000.
2. The insurance sale is being provided via a Personal Advice model and the Principal Service or Product is also supplied by the financial adviser/insurance broker.
3. Where ASIC have specifically granted an exemption to a product in addition to the list below.
4. Specific Financial Product Exclusions
   1. comprehensive motor vehicle or vessel insurance products;
   2. compulsory third party motor vehicle insurance products;
   3. home and / or contents insurance products;
   4. landlord insurance products;
   5. limited motor vehicle or vessel insurance products;
   6. transport and delivery insurance products;
   7. travel insurance products;
   8. superannuation‑related add‑on insurance products.

## The Deferral Periods

The conduct that is permitted and prohibited for providers of add-on insurance products changes over the distinct periods in the deferred sales model:

1. Pre-deferral period—This period starts when the customer indicates an intention to acquire a principal product or service and ends when the deferral period starts. During this period you can promote the product, provide sales and marketing information and discuss the product etc, but you cannot sell the product.
2. Deferral period—This period starts when the customer commits to acquire a principal product or service and receives the information in the manner and form prescribed by ASIC (Customer Information). It ends four clear days after the day on which the deferral period began, A person only needs to give the customer the Customer Information to initiate the deferral period if they wish to offer or sell the customer add-on insurance. During this period you can promote the product, provide sales and marketing information etc, but you cannot discuss or sell the product.
3. Post-deferral period—This period starts at the end of the deferral period and ends six weeks after the day the deferral period began. During this period you can market the product via brochures/flyers/emails etc, discuss the product but only if the customer initiated the contact and sell the product. After the period ends the anti-hawking provisions apply.



## Customer Information Sheet (CIS)

The CIS can be provided electronically, but any “in person” sales of the Principal Product or Service requires the client to be given the option of receiving the document in hard copy at that time.

The legislation spells out the type and level of information that must be provided to a client in the CIS – Legislative Instrument – Customer Information Statement for Add On Insurance 2021-632 ([Legislative Instrument – Consumer Statement for Add On Insurance 2021-632](https://www.msmlm.com/msm-mission-control/legislative-instrument-Consumer-Statement-for-Add-On-Insurance-2021-632/)). This includes statements informing the client that:

1. You can say no to being sold this insurance. It is not compulsory.
2. Salespeople must wait 4 days before selling you insurance as an ‘extra’ to your main purchase.
3. You can say ‘no’ to being contacted about the insurance.
4. You can opt-out of being contacted about any insurance as an ‘extra’ to your main purchase.
5. If you are unsure, consider your situation and ask yourself:
   1. Do I need and understand this insurance?
   2. Consider what the policy covers and what it excludes. You may already have other insurance or arrangements that will cover any potential loss or damage.
   3. Could I get a better deal somewhere else?
   4. Consider if another insurance product or company can better meet your needs. You may be able to shop around for a better deal.

# PRODUCT DESIGN AND DISTRIBUTION OBLIGATIONS (DDO)

## Overview

Product design and distribution obligations (DDO) apply to product issuers and distributors of financial products who deal with Retail Clients. These obligations create a governance framework to ensure financial products are targeted at, and then sold to the right people.

ASIC have released RG274 - Product Design and Distribution Obligations ([RG274 - Product Design and Distribution Obligations](https://www.msmlm.com/msm-mission-control/rg274-product-design-and-distribution-obligations/)) to provide practical guidance on the implementation of these obligations. An overview of the DDO requirements is detailed below.

The issuer of the product (the insurer, underwriting agency or other intermediary acting under a binder facility) has obligations that involve the identification of affected Retail Client products, the development of a Target Market Determination (TMD) for each Retail Client product and establishing systems for the management of distribution of those products including reporting, review and monitoring. We have a developed a standard template to be used when we are required to create a TMD ([Target Market Determination Template](https://www.msmlm.com/msm-mission-control/target-market-determination-template/)).

An insurance broker and its representatives have a much more limited set of legislative obligations – only the items asterisked in the table below apply. However, the issuer of the product will typically require an insurance broker that distributes their product to also provide timely information on complaints/problems etc. relating to the product. This is required so that the issuer can meet their obligations.

|  |  |  |
| --- | --- | --- |
| Design Obligations | Distribution Obligations | Monitor and Review Obligations |
| Develop TMD.  Review TMD For Appropriateness.  Keep record of decisions.  Notify ASIC of significant dealings which are not consistent with TMD.  Have a publicly available Product Development and Distribution Statement (this is a requirement of the General Insurance Code of Practice).  [Product Development and Distribution Statement](https://www.msmlm.com/msm-mission-control/product-development-and-distribution-statement/) | Supply TMD to all parties that have the ability to distribute the product.  \*Do not deal with product unless TMD exists.  \*Do not distribute product if TMD is inappropriate.  \*Take reasonable steps to ensure distribution is compliant with TMD.  Collect distribution information.  Notify significant dealing which is inconsistent with TMD. | Monitor distribution of products and appropriateness of TMD.  Review and update / replace inappropriate TMD’s. |

## Regulated Products

The DDO requirements apply to a financial product (regulated product) if it requires the issuing of a Product Disclosure Statement (PDS) (e.g. Retail Client insurances). They apply where the product is sold directly by the issuer or through an intermediary (such as an agent or insurance broker). They do not apply to wholesale clients or where the product is sold by a person following personal advice given by that person to the client.

## Design Obligations

Where we are the Product Issuer, we need to produce a TMD for each regulated product offered to Retail Clients. The TMD is a written statement about:

* Who the target market for the product is – i.e. the class (or demographic) of Retail Clients for which the product or service is appropriate and is targeted at;
* Any conditions or restrictions on dealings in the product (known as distribution conditions) including the events and circumstances that would reasonably suggest that the TMD is no longer appropriate for the target market;
* The arrangements for periodic review of the TMD for appropriateness including when trigger events occur that might necessitate an early review of the TMD (e.g. when events occur which means the product is no longer appropriate for its target market);
* The reporting obligations for anyone selling the product, including the information required to be supplied to the issuer for the purpose of identifying whether a review trigger for the TMD has occurred, and when complaints should be provided to the issuer.

A product is ‘appropriate’ if it is reasonable to conclude that, if the product were issued in the target market in accordance with the distribution conditions, the product would generally meet the likely objectives, financial situations and needs of the persons in the target market.

Product issuers must review the TMD for appropriateness at regular intervals and keep records about target market determinations. They must identify how often the TMD must be reviewed and any trigger events for an earlier review of the TMD.

A trigger event is an event or circumstance that would materially change a factor or consideration that is relevant to the TMD (e.g. substantial increase in premium, a defect in the product disclosure documents, a sale of the product that is not contemplated by the TMD and any material adverse or negative feedback from people who distribute or purchase the product).

If a trigger event occurs then within 10 business days of that event, the product issuer must cease distributing or selling the product to Retail Clients unless they have reviewed the TMD or made a new TMD or the product is issued or sold to a person who has received personal advice on the product.

Records of the decisions in relation to the TMD, including the review triggers and the review periods and the reasons for those decisions must be kept for five (5) years as ASIC may request access to them. Records must be accurate, complete and as detailed as possible.

A TMD must be prepared by the person who is responsible for preparing the PDS and it must be available to the public, free of charge in a way that is easily accessible to customers and product sellers.

The TMD must be published before the product is first offered or any advice is given on the product. The product issuer must notify ASIC about significant dealings in respect of the target market, specifically where those dealings are not consistent with the product’s TMD. There is no meaning of ‘significant’ in this context but it is likely to include any matters that would be considered significant in the context of a significant reportable breach to ASIC.

## Distribution Obligations

Where we are the product issuers of regulated products, we also have to comply with a number of distribution obligations. The distribution obligations apply where there is Retail product distribution conduct such as:

* Dealing in a financial product in relation to a Retail Client;
* Giving a PDS for the product to a Retail Client;
* Providing financial product advice in relation to the product to a Retail Client.

Under the distribution obligations, a product issuer must take reasonable steps to ensure the people distributing the product to Retail Clients do so in a way that is consistent with the TMD (i.e. to avoid mis-selling).

Distributors, including AFS licensees and authorised representatives will also have distribution obligations if they sell a regulated product. They will be required to take reasonable steps to ensure that their dealings in the product are consistent with the TMD and this will require monitoring and supervision systems and processes to allow licensees and product issuers to track compliance with the distribution obligations.

Where we are the product issuer we need to consider:

* The likelihood of a person acquiring the regulated product otherwise than in accordance with the TMD;
* The nature or degree of harm that might result if the product is issued in a manner that is inconsistent with the TMD; and
* What the product issuer knows about the risks and the ways that they can mitigate them.

Distributors must also notify the product issuer of:

* Any complaints they receive in relation to the product;
* The steps taken in relation to any complaints;
* Any information they acquired during the reporting period;
* Any significant dealings inconsistent with the TMD; and
* Any other matter the product issuer wants reported.

Where we are the product issuer, we need to have appropriate reporting systems for distributors to access and use in order to provide this information to them. We will need to evaluate the data from our distributors to ascertain whether any matters are reportable to ASIC or require changes to the TMD and whether they are required to suspend the sale of the regulated product until a new or revised TMD is prepared and published.