FINANCIAL OMBUDSMAN SERVICE

2014 General Insurance Code of Practice

Preliminary transition tips – a guide for Code Participants.

FOS Code Compliance and Monitoring Team

April 2014

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1 Why you should read this guide

On 1 July 2014, a new General Insurance Code of Practice comes into effect. As a Code Participant, you have 12 months – until 30 June 2015 – to ensure your business's standards of practice and service meet the new obligations outlined in the Code.

This guide will help you by providing preliminary tips on transition, arising from the *Financial Ombudsman Service's General Insurance Code of Practice: Overview of the Year 2012–2013*. The Guide includes:

- An overview of what's new and what has changed in the new Code.
- Information on Code sections to watch based on Code Participants' performance in 2012–2013.
- A focus on the top five causes of non-compliance – and how to remedy them.
- A preliminary checklist for successful transition.

Your ongoing collaboration with the FOS Code team has helped us to develop consensus on issues and areas where we can work together to improve standards of practice and service, share our experience of Code compliance and showcase areas of good industry practice.

This guide has been informed by our work with you over the past year, which has placed us all in a strong position to transition smoothly from the current Code to the new Code.

We look forward to helping your business transition to the new Code during 2014–2015.

2 The new Code – what you need to know

On 10 February 2014 the Insurance Council of Australia (ICA) announced the release of a new General Insurance Code of Practice (the new Code),[1] effective from 1 July 2014 with a 12-month transition period for Code Participants.

2.1 Key changes and features

The application of the new Code's standards to general insurance products is dependent on whether the product is a **Retail Insurance** product or **Wholesale Insurance** product.

While all of the standards apply to **Retail Insurance** products only some standards apply to **Wholesale Insurance** products. We have outlined the standards that apply only to **Wholesale Insurance** in **Table 1**.

Some of the key features and changes introduced by the new Code are summarised in **Table 1** and we have highlighted several aspects in further detail here.

Retail Insurance and Wholesale Insurance

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

(a) a motor vehicle insurance product (Regulation 7.1.11);

(b) a home building insurance product (Regulation 7.1.12);

(c) a home contents insurance product (Regulation 7.1.13);

(d) a sickness and accident insurance product (Regulation 7.1.14);

(e) a consumer credit insurance product (Regulation 7.1.15);

(f) a travel insurance product (Regulation 7.1.16); or

(g) a personal and domestic property insurance product (Regulation 7.1.17),

as defined in the Corporations Act 2001 and the relevant Regulations.

Small Business is defined as a business that employs:

(a) less than 100 people, if the business is or includes the manufacture of goods; or

(b) otherwise, less than 20 people.

Wholesale Insurance means a general insurance product covered by the 2014 Code which is not **Retail Insurance**.

[1] 2014 Code and ICA's media release are available from **www.insurancecouncil.com.au/media-centre**.

The definition of **Retail Insurance** and the selective application of the standards to **Wholesale Insurance** are significant for Code Participants who are also members of the Financial Ombudsman Service's (FOS) External Dispute Resolution (EDR) scheme.

For Code Participants who are members of FOS's EDR scheme

Section 10 of the new Code prescribes the standards applicable to complaints and disputes. The standards apply only to complaints and disputes about **Retail Insurance** as defined by the new Code.

Broadly, the standards describe a Code Participant's obligation to provide consumers with access to its internal complaints process and to notify a consumer of their right to take their complaint to FOS's EDR scheme, if dissatisfied with the Code Participant's final decision.

If a Code Participant is a member of FOS's EDR scheme, the Code Participant has an overriding obligation to provide individuals, small businesses and third party beneficiaries (these terms are defined by FOS's Terms of Reference) with access to its internal complaints process.

The Code Participant is also required to refer a consumer to FOS's EDR scheme where the complaint or dispute arises from a general insurance product within FOS's Terms of Reference.

However, the range of general insurance products covered by FOS's Terms of Reference is much wider than those covered by section 10 of the new Code.

Some of the general insurance products FOS's EDR scheme has jurisdiction to deal with include residential strata title insurance products and small business/farm insurance products such as commercial property, fire/accidental damage or livestock insurance products.

We recommend that you refer to **www.fos.org.au/about-us/terms-of-reference/** for more information about FOS's Terms of Reference.

Table 1: New Code – key features and changes

Code Sections	Is Retail Covered?	Is Wholesale Covered?	Some Key Features and Changes Terms in highlighted in **bold** text are defined by the new Code.
Section 4 – Buying Insurance	Yes	No	• Applies to an **Insured** but *not* to a **Third Party Beneficiary**. • Code Participants (CP) must conduct their sales processes & services efficiently, honestly, fairly & transparently. • CP communications with an Insured to be in plain language. • CP must give written notices to an Insured about non-payment of premium instalment & cancellation of instalment policy.
Section 5 – Employees and Authorised Representatives	Yes	Yes	• **Employees** & **Authorised Representatives** must be trained on the Code. • Other training & education must be appropriate for professional & competent delivery of services.
Section 6 – Service Suppliers	Yes	No	• **Service Suppliers** must provide their services efficiently, honestly, fairly and transparently. • CP contracts with **Service Providers** must reflect Code standards relevant to the services that they provide.
Section 7 – Claims	Yes	No	• Applies to an Insured including a Third Party Beneficiary & they may make a **Complaint** about any aspect of claims process. • Cannot discourage an **Insured** from lodging a claim & must inform them that coverage will be fully assessed if asked whether loss is covered. • Timeframes apply to claims handling & must be conducted honestly, fairly, transparently & in a timely manner. • Decision to deny a claim must be in writing with reasons & disclosure of right to access Complaints process & information underlying decision.
Section 8 – Financial Hardship	Yes	Yes	• Continues to apply to third party debtors & now applies to an Insured or a Third Party Beneficiary who owes money. Standards to *not* apply to payment of premiums. • CP must follow ACCC & ASIC debt collection guidelines & recovery action to be put on hold if hardship assistance is requested. • Consumers may ask for release, discharge or waiver of debt/obligation & they are entitled to access **Complaints** process if hardship assistance is refused.
Section 9 – Catastrophes	Yes	No	• Applies to an Insured including a Third Party Beneficiary. • CP must respond to **Catastrophes** efficiently, professionally, in a practical and compassionate manner. • Timeframe for review of a catastrophe property claim extended to 12 months.
Section 10 – Complaints and Disputes	Yes	No	• Applies to an Insured including a Third Party Beneficiary. • CP must conduct complaints handling fairly, transparently & in a timely manner. • CP must publish information about its Complaints process on its website & in relevant communications. • Specifies timeframes applicable to each stage of Complaint process. • CP must provide consumers with a written response to their **Complaint** with reasons for its final decision and consumers' right to take the matter to FOS & the timeframe for doing so.
Section 11 – Information and Education	Yes	Yes	• Increased focus on Code promotion and initiation. • CP are asked to actively promote the new Code and to try to initiate & facilitate programs to actively improve financial literacy & knowledge of the general insurance industry.

2.2 Code sections to watch

Most of the breaches we finalised in 2012–2013 related to claims handling standards, while Code Participants reported an almost equal number of breaches of standards relating to buying insurance and claims handling. These standards require extra scrutiny as you transition to the new Code.

Buying Insurance

Section 2 of the 2012 Code – to become section 4 and section 5 in the new Code – describes various standards that apply to the initial enquiry and buying of insurance, the renewal of cover and the selling of insurance products by Code Participants' employees and Authorised Representatives.

In 2012–2013, 41% of breaches (2,560) identified by Code Participants and 5% of breaches (4) that we closed, including 3 significant breaches, arose from the standards of section 2 of the current Code.

19% of breaches (1,157) identified by Code Participants arose from section 2.1.4 and a further 117 breaches (2%) from section 2.4.1. Both sections describe standards of fairness, honesty and transparency in the insurance sales process. Three of the four breaches of section 2 that we closed were recorded against section 2.1.4 and were significant breaches.

Code Participants also identified 863 breaches (14%) of section 2.2, which requires a Code Participant to refund a premium to a customer within 15 business days (where a customer's policy permits them to cancel it has permission under a policy to cancel it).

Claims handling

Section 3 of the current Code – to become sections 5, 7 and 8 in the new Code – covers the conduct of claims handling including:

- Decision-making.
- Disclosures that must be made to a customer when their claim has been refused.
- The conduct of external Service Providers and financial hardship experienced by a customer or third party debtor.

In 2012–2013, the Code's claims handling standards accounted for 78% of breaches closed by us and 41% of breaches identified by Code Participants.

24 breaches – more than a third of all breaches of section three closed by us – involved the standards in part (b) of section 3.5.5 of the current Code. In addition, 27% of the breaches identified by Code Participants also related to section 3.5.5(b).

The standards introduced in 2012 require a Code Participant to notify a customer about their right to:

- Ask for copies of information that the Code Participant relied on in denying the claim.
- Request a review of any decision to refuse to release such information.

The breaches of section 3.5.5(b) occurred because:

- A template used as a framework for communicating a claim denial to consumers was not updated to include the disclosures specified by section 3.5.5(b).
- Alternatively, an outdated claims denial template was used, even though an updated template had been provided to claims staff.

Code Participants reported that 70% of section 3 breaches (1,779 breaches) arose from a failure to comply with section 3.2.3. This standard requires a Code Participant to provide updates to a customer about the progress of the claim at least every 20 business days. We closed five breaches of section 3.2.3, including one significant breach which a Code Participant identified and reported to us.

Of the 1,779 breaches identified by Code Participants, 1,000 breaches were due to insufficient staff resources, which meant that claims staff were unable to comply with the 20 business day timeframe. The remaining breaches were due to claims staff not adhering to the requirement to provide an update to customers, contrary to internal processes.

The standards of sections 3.5.1 and 3.7.1 describe the standards that must be applied to claims handling by Code Participants and their employees and Service Providers. Both standards have in common elements of fairness and transparency as essential components of effective claims handling.

Key learnings: fairness and transparency obligations

More than 91% of the reporting by Code Participants against the claims handling standards was focused on meeting benchmarks for timeliness of actions in the course of claims processing. Whilst timeliness is important in claims handling, it represents only one aspect of effective claims handling.

Based on our analysis of breach data, we recommend that Code Participants strengthen their breach reporting and Code compliance frameworks by:

- Analysing internal and external dispute resolution complaints and disputes data, and outcomes of disputes determined by FOS's EDR service, to identify issues relating to conduct requirements. The results may lead to enhanced claims and internal decision-making and fewer disputes overall.

- Extending external and internal claims file audits to assess the quality of claims handling and decision-making to ensure that the interests of customers are being appropriately balanced with the interests of the Code Participant.

We encourage Code Participants to continue to find ways to identify and report on their fairness and transparency obligations in claims handling.

3 The top five causes of non-compliance and how to remedy them

Causes of non-compliance

In 2012–2013, the top five causes of non-compliance aggregated across all 6,263 breaches[2] were as follows:

Causes	Total (% of all breaches)
Process not followed	3,202 (51%)
System error or failure	1,530 (24%)
Insufficient staff resources	1,337 (21%)
Miscommunication	87 (1%)
Administrative error	39 (1%)

Key learnings: remedying non-compliance and how to minimise its risk

Rectification of a breach must address the results or impact of a breach, in addition to the underlying cause. For example, a breach may have occurred as a result of using a non-compliant template document and to address this a Code Participant would be expected to:

1. Amend the template document to ensure that it is compliant.
2. Remove the old template document from circulation.
3. Identify customers who may have been misinformed as a result of the use of the old template document.
4. Provide each affected customer with the requisite information.

Almost half of the breaches closed by us – 38 of 78 breaches – were addressed by Code Participants providing remedial training either alone or together with other means, and either on a one-on-one basis or across an entire team. Code Participants also used remedial training solely or with other rectification tools in response to 1,345 of the 6,185 breaches (22%) they identified.

The dominant rectification tool used by Code Participants to address internally identified breaches consisted of enhancing or improving existing processes and/or systems, either alone or in combination with other tools. This approach was used by Code Participants in response to 3,049 breaches (49%).

To ensure compliance with the new Code's service standards, we recommend Code Participants:

1. Provide ongoing training to employees and Authorised Representatives in the processes they are expected to follow and the role they play in achieving compliance with service standards.
2. Monitor a new process to ensure that it is effective, has been understood by those who will be using it, and that the process is being applied.
3. Build key performance indicators into service level agreements with Service Providers who act on their behalf during claims handling.
4. Monitor the performance of employees, Authorised Representatives and Service Providers against Code obligations.
5. Review template documents on a regular basis to identify areas that require amendments to ensure continuing compliance.
6. Remove outdated documents from circulation.
7. Ensure that key areas of the business are adequately resourced to enable Code Participants to deliver their Code commitments to their customers.

[2] 6,263 breaches in total comprising 78 breaches closed by FOS Code and 6,185 breaches identified and reported by Code Participants as part of their Annual Return for 2012–2013.

4 How to assess significant breaches of the Code

Code Participants are required to monitor their compliance with the Code and identify and report significant Code breaches to us within 10 business days.[3]

The Code defines "significant breach" as a breach that is determined to be significant by reference to one or more of the following factors:

- the number of similar previous breaches
- the adequacy of arrangements to ensure compliance with the Code
- the extent of any consumer detriment, and
- the duration of the breach.

In 2012–2013 we found that sometimes Code Participants:

- did not identify significant breaches of the Code when they should have done so
- identified significant breaches of corporations law but not of the Code, and
- did not conclude correctly that a breach of the Code was significant.

Key learnings: assessing significant breaches

During transition we encourage Code Participants to review their breach incident identification and reporting mechanisms. To that end, we have highlighted the factors we take into account when assessing a significant breach. The General Insurance Code Compliance Committee also considers these factors when reviewing our reports of significant breaches.

1. The nature of the significant breach and its duration.

2. Was there any consumer detriment? What was its nature and extent and how was the detriment established?

3. Did the Code Participant identify the significant breach and report it within the required 10 business days? If not, why not?

4. Whether the factors that led to the breach may have additionally led to other separate instances of non-compliance with Code obligations.

5. Was the incident also reported to ASIC as a significant breach of the Code Participant's Australian Financial Services Licence?

6. The relevant compliance history of the Code Participant and whether similar breaches had occurred previously.

7. Whether FOS EDR has received any complaints from consumers arising from the significant breach matter.

8. The effectiveness of the Code Participant's breach and incident reporting and management system.

9. The nature of the corrective action proposed and timeframes for completion.

10. Whether there were any other factors that FOS Code considered relevant to the significant breach.

[3] The Code, Section 7.3 and Section 7.11.

5 Declined claims

A declined claim is one where a Code Participant has made a decision to deny indemnity having had regard to the terms and conditions of the particular policy. It excludes partially accepted claims and withdrawn claims data.

A claim that has been declined during 2012–2013 may have been lodged during an earlier reporting period.

Code Participants declined 98,920 claims comprising 94,058 personal insurance claims and 4,862 commercial insurance claims.

When assessed against the 3,770,454 claims lodged during 2012–2013, the number of claims declined by Code Participants represented 2.6% of all claims lodged.

The number of declined claims for personal insurance classes increased 3% between 2011–2012 and 2012–2013.

The overall increase in declined personal insurance claims is due to **Personal & Domestic Property**, which recorded a 218% increase in declined claims. This is against a background of an equally significant growth in claims of 97% and a 2% increase in policy numbers.

Code Participants have reported that in their view the principal reason underlying their decline of **Personal & Domestic Property** claims was that the events giving rise to the claims fell outside the scope of the applicable policies.

We believe the increase in declined claims is significant and requires further assessment by industry to identify contributory factors. As a result, we will continue to monitor this trend during 2014–2015 by increasing our focus on compliance with the Code obligations underlying decision-making.

6 Internal dispute resolution

Code Participants are required to have an internal process for dealing with complaints and disputes received from their customers and from third parties in defined circumstances.[4]

The Code defines “complaint” and “dispute” as follows:

"Complaint" means an expression of dissatisfaction made to us related to our products or services or to our complaints handling process where a response or resolution is explicitly or implicitly expected.

"Dispute" means an unresolved complaint.

Customers lodged 31,894 internal disputes during 2012–2013, an increase of 10% on 2011–2012. This figure comprises:

- 30,296 internal disputes about personal classes of insurance accounting for 95% of all internal disputes, and
- 1,598 internal disputes regarding commercial classes of insurance.

Overall, internal disputes about personal insurance claims increased 12% and internal disputes about buying personal insurance products increased 10%. This included an increase in the number of internal disputes in relation to **Personal & Domestic Property** products or services from 27 internal disputes in 2011–2012 to 775 internal disputes in 2012–2013.

The increase in internal disputes about **Personal & Domestic Property** products or services was not unexpected given an increase in declined claims for this class. However, the overall number of internal disputes is lower than we would have expected given the number of declined claims seen in 2012–2013. We will continue to monitor developments during 2014–2015.

According to Code Participants, a number of factors contributed to increases in internal dispute numbers including:

- **Home** and **Motor** claims made after the significant weather events of 2011–2012 being closed during 2012–2013.
- Premium issues due to the inclusion of flood cover in **Home** policies.
- Greater transparency about complaints processes.
- Decisions by Code Participants not to renew **Home** policies due to revised underwriting guidelines regarding flood risk.

The data also showed that most internal disputes resulted in outcomes in favour of Code Participants, which is consistent with IDR data reported in previous years.

We encourage industry to examine internal resolution outcomes across all classes of business, together with information associated with FOS EDR outcomes, and monitor trends carefully. The results may lead to enhanced internal decision-making, not only in relation to disputes, but also in relation to claims outcomes, and may reduce the number of disputes customers refer to IDR and EDR.

[4] Code sections 3.11 – 3.13.

7 Checklist: top ten transition tips

KEY ACTIVITY	☑
Mapping	
1. Undertake a mapping exercise of the new Code against the current Code to identify what is new, what has changed and what remains the same.	☐
Communications with consumers and consumer documents	
2. Review and revise all consumer communications, consumer marketing and disclosure documents, including template documents and material on websites. Ensure that outdated material and templates are removed from circulation.	☐
Training	
3. Plan and schedule training in the new Code for employees and/or Authorised Representatives, and ensure it has been completed to a competent standard.	☐
4. Review and revise other training of employees and/or Authorised Representatives, including continuing training requirements, to ensure content is appropriate and that they are able to provide competent and professional services.	☐
5. Provide appropriate training to employees and/or Authorised Representatives about any changes to procedures, processes and/or systems.	☐
Contracts with Authorised Representatives and Service Suppliers	
6. In relation to Authorised Representatives, review and revise contracts to ensure consistency with the new Code and that Authorised Representatives are aware of their Code obligations.	☐
7. In relation to Service Suppliers, review and revise contracts to ensure that they reflect the standards of the new Code as they apply to their services.	☐
Procedures, processes and systems	
8. Review and revise all procedures, processes (including template documents) and systems to ensure compliance with the new Code's standards.	☐
Monitoring compliance	
9. Monitor compliance by employees, Authorised Representatives and/or Service Suppliers to ensure new Code's obligations are being adhered to; that procedures are being applied consistently; and to identify areas that may require further development and/or education and training.	☐
10. Review and revise compliance and monitoring frameworks and tools to enable effective Code compliance monitoring.	☐

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