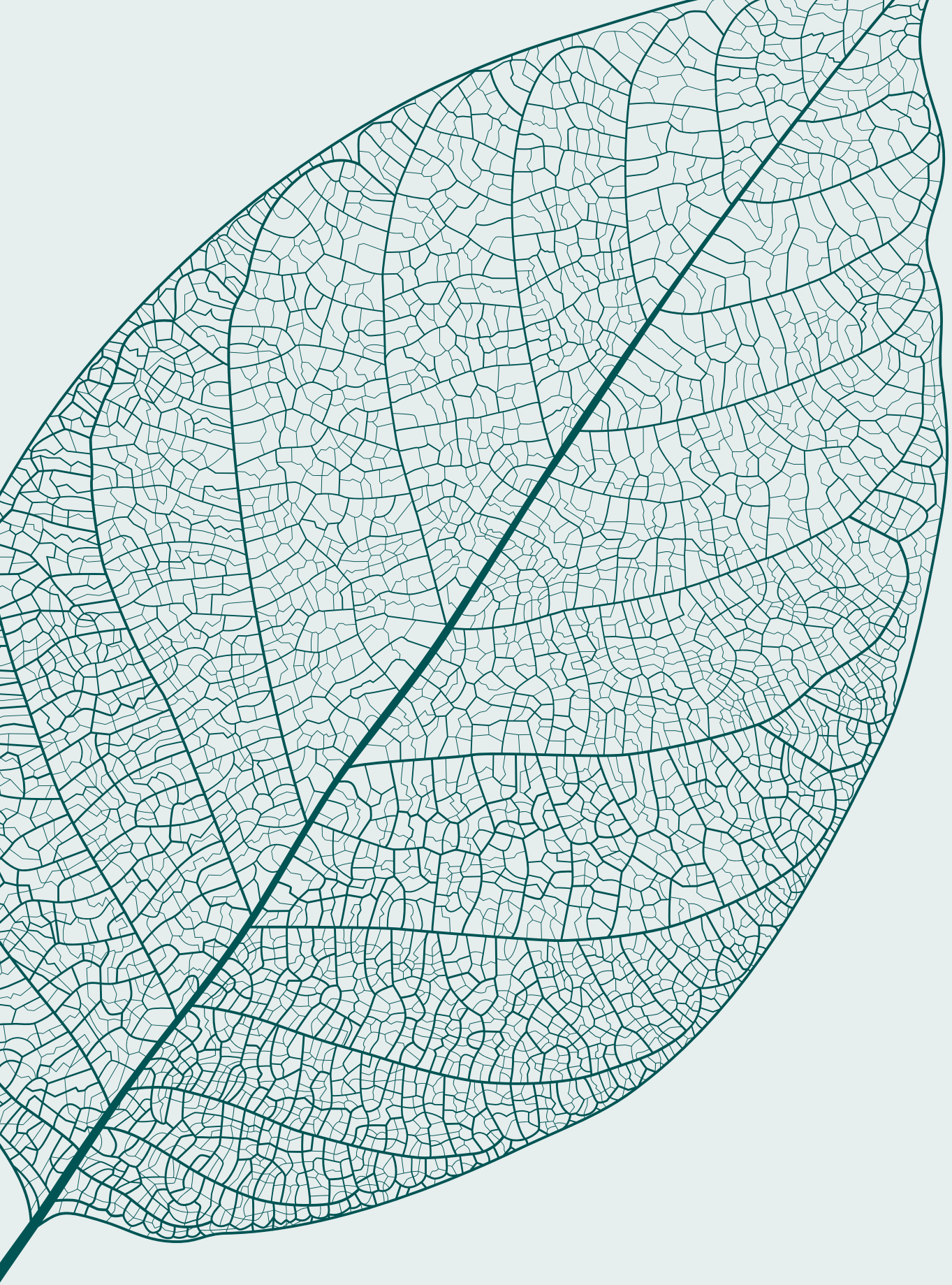

Life Insurance
Code of Practice

FSC FINANCIAL SERVICES COUNCIL

Contents

In this document

The Life Insurance Code of Practice

Subscribers to the Code make 10 key promises

The Financial Services Council (**FSC**) has voluntarily developed the Code to protect you, the customer. The FSC also promotes the Code to customers through its members, and we will work with the FSC to do this. The 10 promises are:

1. We will be honest, fair, respectful, transparent, and timely when we communicate with you, and we will use plain language unless medical or other technical terminology is needed.
2. We will ensure our staff and Authorised Representatives use appropriate sales and retention practices.
3. We will offer extra support if you have trouble with the process of buying insurance or claiming.
4. If we find that a sale was made using unacceptable sales practices, we will fix it, for example by issuing a refund or replacement policy.
5. When you make a claim, we will explain the process and keep you informed about our progress assessing it.
6. We will decide on your claim within the Code's timeframes. But if we cannot, we will explain why and tell you how to make a Complaint.
7. If we decline your claim, we will explain why in writing and let you know what to do if you disagree.
8. We will restrict the use of investigators and Surveillance to preserve your right to privacy.
9. The independent Life Code Compliance Committee (**Life CCC**) will monitor our compliance with the Code.
10. We will be accountable for Code requirements, and the Life CCC can sanction us.

1 This Code of Practice

Aims of the Code

The Code protects life insurance customers

1.1 We are bound by the Code and its goal is to ensure that we:

a) deliver a high standard of customer service throughout your relationship with us
b) continuously improve the services we offer you
c) communicate with you in plain language unless medical or other technical terminology is needed
d) seek to increase consumer trust and confidence in the life insurance industry.

1.2 The Code also outlines our obligations during the life insurance process, including when:

a) you buy a policy, make a claim, or deal with us
b) we deal with claims, Complaints, and requests for information, or help you if you experience financial hardship or need extra support.

1.3 We will make sure you know about the Code by including details on our Website, and tell you how you can access the Code if we receive a claim or Complaint from you.

1.4 This version of the Code will take effect no later than 1 July 2023 and replaces the previous version. It applies to all interactions we have with you – including about an existing claim or Complaint – from that date or the date we are bound by the Code, whichever is later. But it does not apply to interactions we had with you before we were bound by this version of the Code.

1.5 The Code does not limit your rights under any existing laws and regulations. We acknowledge that a contract of insurance is based on the principle of utmost good faith which requires both us and you to act honestly and fairly towards each other, and for us to have due regard for your interests.

Seven key principles apply to products and services under the Code

1.6 Seven principles apply to the products and services the Code covers. These inform the key promises on page 1 of the Code:

a) clarity
b) transparency
c) fairness
d) respect
e) honesty
f) timeliness, and
g) plain language.

Scope of the Code

The Code applies to Australian life insurance

1.7 The Code covers Life Insurance Policies issued in Australia, including policies commonly called:

a) term life or death and terminal illness insurance
b) total and permanent disability (TPD) insurance
c) trauma or critical illness insurance
d) disability insurance
e) income protection or salary continuance insurance
f) business expenses insurance
g) Funeral Insurance and funeral expenses insurance, and
h) consumer credit insurance (CCI), if issued by a life insurer.

Other insurances and circumstances are not covered

1.8 The Code does not cover:

a) whole-of-life and endowment insurance products
b) products issued by general insurers
c) health insurance products issued by health insurers, or
d) annuities and investment life products, as defined in sections 9(1)(c), (d), (f) and (g) of *the Life Insurance Act 1995* (the Act).

1.9 It also does not cover other products issued by an entity that is not:

a) registered as a life insurance company with the Australian Prudential Regulation Authority (APRA) under the Act, or
b) authorised to issue Life Insurance Policies under the Act.

1.10 The Code does not apply to the following entities, unless they have adopted it:

a) superannuation fund trustees
b) financial advice companies or financial advisers, or
c) other industry participants.

1.11 Sections of the Code that do not apply to certain parties will be clearly stated.

Insurers and third parties

Insurers will follow the Code

1.12 The FSC Website lists the organisations that subscribe to the Code (see www.fsc.org.au/policy/life-insurance/code-of-practice). The FSC works with the Life CCC, regulators and stakeholders to encourage all life insurers, Reinsurers, and relevant industry bodies in Australia to adopt it.

1.13 The Code binds:

a) FSC members who are registered life insurance companies issuing Life Insurance Policies
b) other FSC members who are authorised to issue Life Insurance Policies, and
c) any other industry entity that formally agrees with the FSC and Life CCC to adopt the Code.

1.14 The Code also sets responsibilities for the Life CCC, which monitors and enforces our compliance with the Code.

1.15 As we have adopted the Code, we will ensure that our staff and Authorised Representatives comply with it when they are acting for us, for example through appropriate monitoring and asking for evidence of compliance. Certain standards also apply to Distributors, and these can be found at clauses 2.13 and 2.21.

1.16 FSC members who are Reinsurers are bound by the principles in clause 1.6. They will comply with the Code if they:

a) comply with these principles, and
b) help us meet our commitments under the Code.

1.17 Before we enter an agreement with a Reinsurer who is not an FSC member and has not formally adopted the Code, we will take reasonable steps to satisfy ourselves that they will:

a) follow the principles in clause 1.6, and
b) help us meet our commitments under the Code.

Independent Service Providers will meet Code conditions

1.18 We may use Independent Service Providers to help us underwrite, administer policies, and manage claims. If we do, any service agreements we enter or renew after we are bound by the Code will meet the Code's standards relevant to the services they provide.

1.19 This means we will require Independent Service Providers to:

a) follow the principles in section 1.6 when dealing with you and us
b) get our approval before subcontracting their services
c) tell us within 5 Business Days if you make a Complaint about their services, such as an application for cover or a claim they are involved in, and
d) keep your information confidential, and only use that information for the purpose of the service they are providing.

1.20 If the Independent Service Provider is a medical assessor or examiner, we will require them to be registered by the Australian Health Practitioner Regulation Agency (or an appropriate professional body) and to comply with the Australian Medical Association's Ethical Guidelines on Independent Medical Assessments, or an equivalent international guideline for providers overseas[1].

1.21 If you make a Complaint about an Independent Service Provider, we will follow our internal Complaints process unless we are satisfied they have a comparable process of an equivalent standard. We will tell you whether we or the Independent Service Provider is dealing with your Complaint.

1.22 We will only enter contracts with Independent Service Providers who:

a) reasonably satisfy us of their expertise, experience, qualifications, and integrity, and
b) hold any required federal, state, territory, or industry licences or a reasonable equivalent.

1.23 Our contracts with our Independent Service Providers will refer to the relevant state or territory Expert Witness Code of Conduct.

1.24 We will seek impartial and objective medical reports from treating doctors, allied health professionals or Independent Service Providers and we will take all details in the report into account.

1 The Australian Medical Association's Ethical Guidelines on Independent Medical Assessments can be found on the AMA's website at ama.com.au.

2 Policy design, advertising, and sales standards

Policies we design will be clear, easy to understand and up to date

2.1 We will design new products which:

a) are designed to meet a genuine need of consumers in the target market
b) do not incorporate a blanket exclusion specific to mental health in the general terms and conditions[2] of the standard form contract, and
c) are likely to be consistent with the typical objectives, financial situation and needs of consumers for whom the product is designed (known as the target market).

2.2 We will review the target market at least every 3 years so that policies are designed for the relevant class of consumers to meet a genuine need.

2.3 When we design and introduce new Life Insurance Policies, we will:

a) use plain language in our sales and policy information unless medical or other technical terminology is needed
b) consumer-test the plain language information required in clauses 3.5 and 3.10 which deals with policy documentation and yearly statements, and
c) provide clear information to help customers make informed decisions, especially for policies that are available for new customers to buy without a financial adviser, planner, or Group Policy Owner, and
d) design products with a view to meet a genuine need of consumers in the target market, and which are likely to be consistent with the likely objectives, financial situation and needs of consumers of the target market.

2.4 When we design and introduce new policies that depend on the amount you earn when you make a claim, where we increase your benefit each year to match inflation, we will link the increase to an index that broadly reflects wage or price inflation in Australia.

2.5 We will tell you that you can opt out of these increases.

2.6 Clauses 2.1 to 2.5 do not apply to products which are a Group Policy.

Updating Medical Definitions

2.7 For policies available to new customers where benefits are payable after a defined medical event, we will review all medical definitions at least every 3 years with help from relevant medical specialists.

2.8 We will review these medical definitions to ensure that they do not include a method of diagnosis or treatment which is obsolete and will update these medical definitions if needed. We will tell you when we do.

2.9 In cases where your policy has a medical definition which specifies an obsolete method of diagnosis or

2 This does not apply to the ability to exclude mental health conditions following underwriting, or offer products designed to cover specific conditions or circumstances which do not include cover for mental health conditions, such as trauma products.

treatment that is no longer used in mainstream medical practice in Australia, we will assess your claim, including whether it meets the required degree of severity defined in your policy, using a current method of diagnosis or treatment approved for use in Australia.

2.10 Clauses 2.7 to 2.9 do not apply to cover under a Group Policy.

Advertising and sales practices

Advertising will meet certain standards

2.11 When we advertise and market our Life Insurance Policies, we will ensure that:

a) our advertising is clear and not misleading
b) any images we use do not detract from or reduce the prominence of any statements
c) any price or Premium we refer to is consistent with what members of the campaign's target audience will likely pay
d) any specific circumstances a benefit depends on are clear
e) any phrases like 'free' or 'guaranteed' are not likely to mislead
f) short-term incentives that are not part of the policy, such as gift cards or reward points, do not encourage customers to buy the policy solely for these incentives
g) we comply with the relevant laws, ASIC regulations and guidance on advertising financial products and services, and on unsolicited sales, and
h) any information in our advertising campaign is consistent with the product design and the target audience for whom the product has been designed to meet their genuine consumer needs and the disclosures in any corresponding Product Disclosure Statement.

Staff and Authorised Representatives will follow good sales practices

2.12 We will have clearly documented sales rules to ensure our salespeople and Authorised Representatives sell our policies in accordance with the law and do not use unacceptable sales practices such as Pressure Selling.

2.13 We may use a Distributor to sell our policies. If we do, we will take reasonable steps to ensure that they do not use unacceptable sales practices such as Pressure Selling.

2.14 Our sales rules will include:

a) what information we or our Authorised Representatives will give you about the policy's Premium (including how stepped and level Premiums work, if applicable), features, benefits, exclusions, limits and Cooling-Off Period
b) how to identify if you are unlikely to ever be eligible to claim any of the policy's primary benefits (including processes that are designed to prevent the sale of a policy if we are aware you are unlikely ever to be eligible to claim) and, if so, not sell you the policy
c) when we or our Authorised Representatives must stop selling if you indicate you do not want a Life Insurance Policy, and
d) how to keep records that you agreed to buy the policy.

2.15 We will monitor our staff's compliance with these rules through:

a) quality assurance measures such as call monitoring, mystery shopping or post-sale customer surveys
b) analysis of and reports on key data, such as sales results, lapses, declined claims and Complaints.

2.16 We will agree with our Authorised Representatives their sales approach, staff training requirements, and monitoring and reporting framework so we are satisfied that their staff and businesses meet:

a) their agreed commitments
b) our sales rules, and
c) the Code's requirements.

2.17 We will also monitor our Authorised Representatives' conduct through arrangements such as:

a) mystery shopping
b) independent audits, or
c) analysis of key data, such as sales results, lapses, declined claims and Complaints.

Insurers will provide appropriate sales training

2.18 Our staff and the staff of our Authorised Representatives who sell our policies will receive ongoing role-appropriate training, as well as extra training to correct any shortcomings we find.

2.19 The training will cover:

a) the customer perspective
b) our Life Insurance Policies and the characteristics of customers in the target audience
c) acceptable and unacceptable sales practices
d) the legal duties owed to customers that they have when they provide personal advice, and
e) the Code's relevant standards.

2.20 We will ensure our salespeople's remuneration is consistent with good customer outcomes (such as by deterring unacceptable sales practices, including Pressure Selling) and complies with relevant laws. This includes having compliance performance measures in any staff sales incentive programs, with consequences for unacceptable sales practices, such as Pressure Selling or inappropriately using deferred Premiums or Cooling-Off Periods.

2.21 If we use a Distributor, we will ensure that their processes and procedures are consistent with good customer outcomes and the Code's relevant obligations that apply to the activities we have contracted them to do.

Insurers will investigate concerns about sales practices

2.22 We will investigate any concerns raised or identified about the sales practices of our staff, any Authorised Representative, or any Distributor.

2.23 If we find out that any of our staff, Authorised Representatives or Distributors have engaged in an unacceptable sales practice, how we fix it will depend on the circumstances, but will include us taking one or more of the following steps:

a) saying sorry
b) cancelling your policy with your agreement
c) refunding your Premiums
d) paying you interest on the refunded Premiums
e) adjusting your cover or arranging for more suitable cover with your agreement
f) correcting information
g) honouring a claim, and/or
h) another measure appropriate to the circumstances.

2.24 If we find out that any of our staff, Authorised Representatives or Distributors have engaged in (or attempted to engage in) an unacceptable sales practice, we will also correct the practice, including where appropriate with further education and training.

2.25 Where we contact you about an unacceptable sale and how we will fix it, we will consider the method you prefer where practical, in line with clause 3.1.

2.26 Where we propose a remedy to fix an unacceptable sale, we will tell you:

a) that you can ask us to review any remedy we propose, and
b) if you are unhappy with the outcome of our review, we will treat this as a Complaint.

Insurers will have rules for Direct Sales

2.27 Where a Direct Sale is made verbally or face to face, we will have sales rules that state we will:

a) periodically, as appropriate, ask if you understand the information the salesperson has given you
b) allow you time to ask questions
c) give you information to help you decide how much cover you want
d) if applicable, explain to you that Premiums may change over time and provide an example
e) tell you at the start of the application process that you are now applying to buy a Life Insurance Policy, and ask for your explicit agreement to proceed
f) not sell you the policy or take your payment details if you ask for time to think about the policy before applying or purchasing, and offer to set up a call or meeting to discuss it later, and
g) never take advantage of vulnerable customers and know when to stop selling.

2.28 If you are not eligible for the policy and we offer a different policy instead, we will give you details about it including the Product Disclosure Statement and offer to set up a call or meeting to discuss it later.

Funeral Insurance will be clearly explained

2.29 If we offer you a Funeral Insurance Policy, we will clearly explain in plain language unless medical or other technical terminology is needed:

a) that it is an insurance policy not a savings plan, and what this means
b) the benefits you are entitled to
c) how your beneficiaries can claim these benefits when you die
d) any pre-existing medical condition exclusions and how they apply
e) any period during which your policy only pays out if you die in an accident
f) that you can cancel at any time and what happens if you do so after the Cooling-Off Period, including if we will refund Premiums
g) level and stepped Premiums, and an illustration of how they might go up if stepped
h) that the total Premiums you pay could be more than the benefits we pay, if applicable, and
i) what happens if you stop paying your Premiums.

2.30 If you purchase a Funeral Insurance Policy from us, we will explain that you may choose level or stepped Premiums if stepped Premiums are offered. Along with the key facts sheet which we will provide to you, we will explain:

a) If you purchase a Policy with stepped Premiums, how stepped Premiums may increase, along with a warning about future affordability if your income changes, such as when you retire or enter aged care, and
b) what will happen if you allow the policy to be cancelled.

2.31 Some Funeral Insurance Policies require little or no Premium to be paid initially. In these cases, we will:

a) tell you before the policy starts what the first full Premium is, or we estimate it will be
b) give you 10 to 20 Business Days' notice of when we will collect the first full Premium
c) not collect the first full Premium until we provide such notice, and
d) provide you with a Cooling-Off Period from the day you pay your first full Premium.
e) Insurers will clearly explain consumer credit insurance (CCI)

In some cases, you may purchase a CCI Life Insurance Policy together with a credit product. If you do, unless there is an exemption, we will not offer or sell to you the CCI Life Insurance Policy until 4 days after you have purchased the credit product. This is known as the 'deferred sales period' which is required by law in certain instances[3].

2.33 Before you buy CCI with us or through our Authorised Representative or Distributor, we or they will give you clear information to help you make an informed decision. This will include:

a) the cost, as well as any interest you will pay on the Premium
b) the monetary limits on the key benefits payable
c) the period you would be insured for, and
d) the date your insurance ends, if different from the date the underlying credit product ends.

3 Further information about the deferred sales model can be found on the ASIC website at asic.gov.au, for example at 21-189MR ASIC releases guidance and customer information requirements to implement the new add-on insurance deferred sales model | ASIC- Australian Securities and Investments Commission

2.34 We will only sell you CCI if you give us your explicit consent to do so. If we do, we will allow you to change your mind and get a full refund within 30 calendar days in line with Clause 4.28 and 4.29.

2.35 If the CCI Life Insurance Policy is an add-on to a loan and you can pay the Premium through the loan, we will give you at least 1 non-financed payment option, such as a monthly direct debit.

2.36 If the CCI Life Insurance Policy is an add-on to a loan and the Premium is paid through the loan, we will tell you that you will pay interest on the Premium, and your initial loan repayments will be shown with and without the Premium to compare.

2.37 Clauses 2.34 and 2.35 do not include CCI that protects a credit card, line of credit facility or overdraft where the Premium is charged regularly to that card, credit facility or overdraft. In these cases, the information we give you in Clause 2.32 may not include the cost or any interest you will pay on the Premium.

3 Communicating with you

Documents and notices

Who we communicate with will vary depending on the policy type and owner

3.1 We will use the communication method you prefer where practical, unless we are required by the Code, law, or regulation to communicate with you in writing. We will comply with the requirement to communicate if we communicate with the Applicant, Policy Owner, Group Policy Owner, Life Insured, Third Party Beneficiary or Representative. This may be:

a) verbal, such as face to face or by phone, or
b) in writing, such as by mail, email, text message or any other way the law or a regulation allows.

3.2 If you are not the Policy Owner, we will not share your personal information with the Policy Owner without your consent, except to the extent necessary to deal with an application, policy or claim. If we share your personal information this will be in line with privacy and confidentiality requirements.

3.3 If an employer or superannuation fund trustee owns the Life Insurance Policy, we will communicate with them as appropriate. They will communicate with you as needed.

Insurers will provide policy information and notices in writing

3.4 Our Product Disclosure Statement for on-sale products will be available online or you can ask us to send you a copy. But if the new Life Insurance Policy is related to a Product Disclosure Statement we did not prepare, we will refer you to the relevant party for a copy – such as a superannuation fund trustee or other Group Policy Owner.

3.5 After you buy a Life Insurance Policy[4], before the end of the Cooling-Off Period, we will give you documentation including the following information:

a) the types of cover we insure you for
b) how much you are insured for, if there is a fixed amount assigned to your cover, and the Premium you will pay
c) how the Premiums you pay are structured with an explanation of how Premiums change as you get older, for instance whether the cover has stepped or level Premiums or a single Premium
d) the Cooling-Off Period
e) any exclusions or waiting periods that apply
f) the impact a claim could have on other benefits in your policy
g) our claims and Complaints processes
h) if benefits are payable after a defined medical event, and
i) whether benefits are payable when a medical condition is diagnosed or after you meet extra criteria.

3.6 We will produce information to support advisers explain how Premium structures work.

4 This provision does not apply to Group Policies. If it is a group policy, the employer or trustee may provide details about your cover.

3.7 If you are buying direct, we will make information available about Premium structures and tell you how to access it.

3.8 Once you own a policy, we will send the Policy Owner a copy of your policy documents if you ask us to. But we will first meet any legal requirements for releasing them.

3.9 If we automatically upgrade your policy, we will tell the Policy Owner about any key changes, unless your policy is a Group Policy.

3.10 Before each policy anniversary, we will send the Policy Owner a notice in writing outlining:

a) what and how much we insure you for
b) an explanation for any increase in your Premiums
c) information about how Premiums could change in future depending on the Premium structure
d) how to claim
e) the risks of cancelling and replacing your policy, and
f) how to contact us if you want to change the policy or are having trouble paying your Premiums.

3.11 We will also remind you in the notice in writing, if applicable, at least once a year whether the maximum you can claim depends on how much you earn at the time of claim.

3.12 Clauses 3.10 and 3.11 do not apply to CCI or Group Policies. For a CCI policy, the notice in writing we send before each policy anniversary will show:

a) the period of cover
b) the types of cover, and
c) our contact details for questions or claims.

Insurers will tell you if they cannot provide information

3.13 We will tell you if we cannot meet or have not met a deadline in the Code for giving you information because we are waiting for a third party to let us release it. This will not be a Code breach if we tell you within 3 Business Days after the deadline.

3.14 If we decide not to disclose information you ask us for, we will:

a) do so reasonably
b) give you a list of the items we have not disclosed
c) explain our reasoning, for example where privacy laws allow us to withhold it, and
d) give you details of our Complaints process.

Insurers will tell you about errors, omissions, or inconsistencies when they impact you

3.15 If we find that we have made an error, omission or inconsistency that disadvantaged you, we will tell you within 10 Business Days. We may need extra information to address it. These timeframes will not apply if the error is identified as part of a broader remediation program affecting multiple customers.

Insurers will give you a chance to explain

3.16 Before we make a decision to vary or avoid your cover pursuant to the Insurance Contracts Act, we will send you a 'Show Cause' letter that:

a) includes copies of any information that may be relevant to our decision
b) sets out the inconsistencies between the information you provided to us when you applied for cover and the information we subsequently obtained
c) gives you a chance to explain and provide any further information or documents you would like us to consider
d) explains the impact our decision may have on your cover under the Life Insurance Policy, and
e) includes a timeframe for you to respond to us.

3.17 In line with the Code's fairness principle, we will consider any response you provide to the Show Cause letter before we make our decision.

Insurers will confirm variations or avoidances in writing

3.18 If we decide to vary or avoid your cover, we will then write to you to:

a) explain our decision and reasoning, including the decision being applied
b) confirm what impact our decision has on your cover under the Life Insurance Policy
c) tell you that you can ask us for copies of the information about you that we relied on, that we will give these to you within 10 Business Days of your request, subject to any legal requirements
d) tell you that you can ask us to review our decision, and
e) tell you how to make a Complaint.

Communicating certain medical or health information

3.19 Throughout your engagement with us, some information we have about your health may be better communicated to you by your doctor instead of us. If so, we will meet our obligations in the Code by providing this information to your doctor rather than to you directly.

4 Buying a Life Insurance Policy

Underwriting decisions

Insurers can seek more information about your health

4.1 We will only apply clauses 4.2 to 4.32 if we underwrite your application for cover.

4.2 We will only ask for information about your health that we reasonably need to assess your application, such as by asking:

a) you about your health
b) a third party, such as your doctor, for a report, or
c) you to undergo a medical exam from an Independent Service Provider we choose.

4.3 If the information we have is enough to make our decision, we will let the Applicant know the outcome within 5 Business Days of receiving the information.

4.4 We will require that independent medical assessors or examiners will meet the standards set out in Clause 1.20. While we will choose the provider referred to in clause 4.2 c), we will tell you that you can choose the gender of the examiner where this is possible.

4.5 If we ask you to have a medical exam with an Independent Service Provider, we will pay for:

a) the appointment, but not any fees if you miss it without a good reason
b) any reports, and
c) any reasonable travel costs and out of pocket costs we agree in advance.

4.6 We will ask the Independent Service Provider to give us their report within 10 Business Days of your appointment.

4.7 If we ask an Independent Service Provider for a report that does not require you to attend an assessment, we will ask them to send it within 20 Business Days of our request.

4.8 If the Independent Service Provider does not meet the deadlines in clauses 4.6 and 4.7, we will tell you and periodically update you on our progress getting the report.

4.9 We will ask for any extra information to assess your application as early as possible and keep our requests to information we reasonably require. We will also explain why we need information and that you can ask us to review our request. If you are unhappy with the outcome of our review, we will treat this as a Complaint.

Insurers will ask you for consent

4.10 We will ask for your consent to access any information about your health using the wording that the FSC and the Royal Australian College of General Practitioners agreed. You can find this wording on the FSC Website at www.fsc.org.au.

4.11 We will tell you each time we use this consent, the reason for the request and who we have asked to provide this information to us. We will contact you by phone, SMS, email or similar when possible, unless you tell us you have a different preference.

Mental health, family medical history and genetics

4.12 If you have or have had a diagnosed mental health condition, or symptoms of a mental health condition, we will:

a) not decline to insure you before you have had the opportunity to provide information about the history, severity or type of condition before making our decision about whether to insure you and, if so, the terms we offer you, and
b) take into account your circumstances such as the history, severity, or type of condition, when deciding whether we can offer you cover.

4.13 If you tell us about a past or current mental health condition, we will determine whether we can provide you with cover by managing any additional risk through higher Premiums, exclusions, limits, and caps rather than not provide cover at all.

4.14 If we offer you alternative terms, such as a higher Premium or cover subject to an exclusion, we will explain to you why in line with Clause 4.22. We will tell you:

a) how long the alternative terms will apply to the policy, and
b) that you can ask us to consider removing or amending the alternative terms and the process for asking us to do so.

4.15 If we ask you about any family history of illness, we will only ask you to tell us about:

a) the family history that you know about
b) your first-degree blood relatives (parents, children, and siblings), without giving their names or dates of birth, and
c) their illness and age at diagnosis and/or death.

4.16 When we assess your application, we will not consider any family medical information about your family that relatives have given us about themselves, for example when they took out their own policies with us.

4.17 If you have had a genetic test, we will comply with the Moratorium on genetic tests at Appendix A. It explains what we can ask you about the results and how we can use that information.

Underwriters will have appropriate skills

4.18 We will ensure our underwriters have the appropriate skills and training, including for mental health where applicable. They will not make decisions for us until they have shown technical competency and an understanding of relevant laws (including anti-discrimination laws), Code requirements, and FSC standards and guidance.

a) While assessing an application, our underwriters will access professional advice and support in relevant disciplines – such as from medical specialists and accountants – when needed.

Offering insurance

Insurers will explain any alternative terms and the reasons for them

b) We will tell you if we accept your application and, if so, on what terms within 5 Business Days of:
c) receiving all the information we reasonably need, and
d) completing all reasonable enquiries, including to any Reinsurer.

4.19 If we issue temporary insurance during the Underwriting process, we will let you know what it does and does not cover, and when it will end.

4.20 If we offer you alternative terms, we will explain in plain language unless medical or other technical terminology is needed:

a) the alternative terms
b) how long the alternative terms are intended to apply
c) that you can ask us to review any alternative terms we offer now or in the future if circumstances change, and how to do so, and
d) that if you agree to buy the policy, we will take this as your agreement to the alternative terms.

Insurers will explain the general risks of replacing an existing policy

4.21 If you are applying for a Life Insurance Policy with us and you tell us that you are replacing an existing Life Insurance Policy, we will tell you that you shouldn't cancel any existing cover until we accept your application.

4.22 We will also explain the general risks of replacing an existing Life Insurance Policy, including, where relevant, the:

a) loss of any accrued benefits
b) possibility of waiting periods starting again, and
c) implications of any errors or omissions in your new application.

Insurers will share information they relied on to make decisions

4.23 If we do not offer you insurance, we will explain to you in plain language unless medical or other technical terminology is needed:

a) the reasons for our decision having regard to what you told us and the risk of us providing insurance to you
b) that you can ask us for the information about you that we relied on to make this decision
c) that you can contact us if you think the information we relied on about you is incorrect or out of date
d) that you can ask us to review our decision or give us extra information to consider, and
e) our Complaints process.

4.24 We may sometimes learn information about you that could be significant to your health or that you may not know about. If this is the case, we may give this information to your treating doctor to explain to you.

4.25 If you ask us for the information about you that we relied on in clause 4.25, we will give it to you or your doctor within 10 Business Days. But the considerations we refer to in Clauses 3.13 and 3.14 may apply.

Policy cancellations

Customers can cancel policies they do not want

4.26 We will tell the Policy Owner about the Cooling Off Period when you take out a Life Insurance Policy.

4.27 In line with the policy terms, we may owe the Policy Owner a refund when they cancel the policy. If so, we will send them any money we owe within 15 Business Days.

4.28 We will not pressure you to keep a policy you no longer want.

4.29 If we cancel a policy because the Policy Owner has not paid the Premiums, we will let them know if there is an option to reinstate the policy. If this reinstatement is at our discretion, we may ask for extra information.

4.30 Clauses 4.28 to 4.31 do not apply to cover under a Group Policy, as the Group Policy Owner is responsible for communication about changes.

5 Claims

Communication during a claim

Insurers will work with you throughout the claims process

5.1 We acknowledge that claims time is difficult for you and that each situation is unique. We will treat you with empathy, compassion, and respect throughout the claims process.

5.2 We will not discourage you from making a claim.

5.3 If you tell us that you are having trouble providing the information we need, we will work with you to take steps to find a solution. This may include endeavours to collect the information on your behalf, with your permission.

5.4 If you make an income-related claim, we will ensure you have an assigned claims assessor throughout the claims process and, if we consider it appropriate, we will also:

a) identify and act upon ways to support your recovery during the claim
b) identify and act upon ways to encourage best practice rehabilitation and return to work programs, and
c) work with your doctor, other healthcare providers and your employer to support your recovery, rehabilitation and return to work.

Insurers will keep in regular contact about claims

5.5 Within 10 Business Days of the Claim Received Date, we will tell you:

a) how you can access the Code, in line with Clause 1.3
b) about your cover and any waiting periods that may apply
c) about all the relevant benefits under the Life Insurance Policy you are claiming on, and
d) about the claims process and how to contact us for more information.

5.6 We will update you on your claim's progress at least every 20 Business Days, unless you, the Group Policy Owner or your Representative agrees to a different timeframe. We will do this until:

a) we have made a decision, or
b) issued a Show Cause or Procedural Fairness letter.

5.7 If you ask us for information about your claim at any point, we will respond within 10 Business Days.

5.8 If your benefit period for income-related payments is expiring, we will tell you at least 3 months before your last payment is due to be made.

5.9 If there is a change in the definition under which you will be assessed after a stated period of time, we will also:

a) give you at least 3 months' notice, and

b) offer you the opportunity to commence the assessment before the change takes effect so your income is not disrupted if you are still eligible.

5.10 If the benefit you are insured for is going to reduce (except for where offsets or partial payments reduce your benefits), we will give you at least 3 months' notice.

5.11 If you make a claim that is covered by a Group Policy, we or the owner of the Group Policy will contact you to tell you who will help with your claim and who you can contact for more information. We will agree with the owner of the Group Policy what communication to send them.

Required information

Insurers will ask you to provide information or agree to it being collected

5.12 Every time you make a new claim, we will ask for your consent for us to collect information about you, such as about your finances, job, or health. We may ask you to consent to us requesting information from more than 1 source. Unless you tell us you do not want us to, we will tell you each time we use your consent by phone, SMS, email or similar where possible, to ensure you know quickly. If you do not agree that we need some of this information, we will review our request.

5.13 We will ask for the information we reasonably need from you and third parties as soon as possible and will minimise multiple information requests .

5.14 When we assess your claim, we will respect your privacy by only asking for information we reasonably need to make our assessment. We can fully investigate the history of any condition you are claiming for. We will only try to verify the information you gave us when you applied for cover about conditions that are not related to your claim if we have reasonable grounds. We will explain those grounds and how you can make a Complaint.

5.15 You can ask us to review whether the grounds are reasonable. We will tell you the outcome of our review and if you are unhappy with the outcome of our review, we will treat this as a Complaint.

5.16 From time to time, we may use information that is available online about you. We will obtain any information in accordance with the relevant laws and regulations and only rely on information that is in the public domain.

5.17 For income-related claims, such as for income protection or business expense cover, we:

a) may need medical and financial information regularly to assess if you are entitled to ongoing benefits or calculate your benefit payments
b) will not ask you for a statement from your doctor more often than we reasonably need to assess your condition
c) will not ask your doctor for a statement solely to process your regular benefit payment,
d) will only request financial information if we need it to assess if you are entitled to benefits or confirm the amount, and
e) may ask your doctor for information every 6 months, even if your condition is stable.

Medical exams

5.18 If we ask you to have an independent medical examination, we will tell you that you can ask us:

a) for a list of doctors to choose from, and
b) to include at least 1 doctor of each gender on the list where practical.

5.19 Clause 1.20 refers to the standards that independent medical examiners will meet and refers to an online link for further information. We will require independent medical examiners to meet the standards outlined at Clause 1.20.

5.20 If the doctor you choose has limited availability, we will tell you and note that this may delay your claim.

5.21 If we ask you to have a medical examination, we will pay for:

a) the appointment, but not if you miss it unless we are satisfied you had a good reason for missing it
b) any reports, and
c) any reasonable travel and out of pocket costs we agree in advance (which may include the costs of a family member or support person if we agree this is necessary).

5.22 We will avoid asking for more than 1 medical examination from the same type of specialist within 6 months, where possible. But if we do, such as for a claim for terminal illness or where superannuation law requires, we will tell you why.

5.23 We will ask the doctor to give us a report within 20 Business Days after our request or your appointment, if you need to attend one. You can ask us for a copy, and we will send it to you or to your doctor if we think that is more appropriate. If the doctor fails to meet this timeframe, we will inform you of this and keep you informed of our progress in obtaining the report.

Interviews

5.24 If we want to interview[5] you, we will document our reasons for this and ask a senior member of our team to review and approve the interview before it proceeds. We will not interview anyone under the age of 18 unless we believe there is no alternative.

5.25 We will monitor interviewers who conduct interviews on our behalf and take action in response to any poor behaviour we identify, for example, by no longer asking them to act on our behalf.

5.26 If we ask you to be interviewed (not an independent medical examination) to establish some facts, we will check our records before we hire an interviewer to see if you need one who speaks your preferred language, or if you need a support person or interpreter to attend. If you do need an interpreter, we will arrange and pay for it.

5.27 We will arrange an interviewer that:

a) is a certain gender, if you ask and a person of that gender is reasonably available

5 By interview, we mean a meeting with you and a third-party interviewer appointed by us, conducted either face-to-face or remotely, the purpose of which is to ask you questions and receive your replies in real time.

b) we are satisfied has the appropriate training and experience to discuss a claim involving a mental health condition, if relevant
c) can help if you have limited English, or
d) can help if you have known decline, disability or other impairment of a cognitive nature.

5.28 If you have asked us to communicate with your Representative, we will tell the interviewer to contact your Representative before arranging the interview with you.

5.29 We will tell you that you can ask us to be interviewed at a place and at a time we both agree to outside your home, unless interviewing you at your home is essential to establishing your entitlement to a benefit. If it is, we will explain why. If it is not essential to interview you at your home, we will suggest possible convenient locations you can be interviewed outside your home.

5.30 Before the interview, you will receive a key information sheet that explains the process and your rights, including:

a) that we will provide a summary of the interview
b) that you can have a Representative or support person with you
c) your rights and responsibilities during the interview
d) our contact details and any additional contact details of the person conducting the interview
e) if an interviewer is appointed, confirmation that they are acting on our behalf
f) that you have the right to decline an audio recording of the interview being made. If you consent and an audio recording is made, we will give you a free copy of the recording, and
g) how to make a Complaint.

5.31 At the start of the interview, the interviewer will:

a) tell you who they are, what the interview is for, how long it should take and what it will cover, and
b) explain that they are acting for us.

5.32 We will ensure that all interviews are conducted respectfully and take no more than 90 minutes, unless you agree in writing to an extension. We will explain the reasons why this extension is needed.

5.33 We will offer you a 5-minute break at least every 30 minutes during the interview, and you can ask for more breaks or to end the interview early.

5.34 We will not allow the interviewer to make any allegations of fraud without our prior authority.

5.35 The interviewer will end the interview right away if it becomes clear that you need a support person or interpreter and do not have one.

5.36 We will arrange another interview if we reasonably need it, but not within 24 hours of the first one unless you agree.

5.37 We will explain why we need to arrange another interview.

5.38 If we need to interview you more than once, before the second or any later interview, we will offer to give you a copy of the summary or recording of your previous interview, if one is available.

5.39 If you withdraw your claim after an interview, a person other than the interviewer will contact you to discuss your reasons and ask if you would like to restart your claim.

Restricting the use of Surveillance

5.40 If we have reason to believe that the information we have about your claim is inconsistent with other information available to us, we will try to resolve those inconsistencies without using Surveillance by an investigator.

5.41 If we cannot resolve these inconsistencies, we will document them and ask a senior member of our team (or someone specialising in this area) to review and either resolve these inconsistencies without Surveillance or approve Surveillance.

5.42 If Surveillance is approved, we may appoint an investigator to help us with your claim. If we do, we will give them written instructions about the investigation and require that they:

a) are a licensed private investigator
b) comply with relevant state or territory laws, and Clauses 1.19 and 1.22
c) only collect information that is relevant to the assessment of your claim
d) confirm any changes to our instructions
e) get our consent before they exceed their existing instructions
f) uphold the Code's standards for Surveillance (Clauses 5.40 to 5.43)
g) keep an up-to-date record of all investigation activities in line with the *Privacy Act 1988*, and
h) do not continue the Surveillance for longer than 4 months, use illegal methods, threaten anyone, make any promise or offer, or cause anyone to do anything they wouldn't have done otherwise during the Surveillance.

5.43 If we appoint an investigator, we will require them:

a) not to conduct Surveillance in any court or judicial facility, medical or health facility, bathroom, changing or lactation room, in a business premises - unless it is open to the public - or inside your home
b) not to intentionally film your family members, neighbours, friends, acquaintances, or colleagues with you
c) if filming them cannot be avoided, to pixelate or blur any video they appear in before giving it to any external party such as a court or External Dispute Resolution Body
d) not to communicate with your family members, neighbours, friends, acquaintances, or colleagues in ways that might reveal the Surveillance, and
e) to stop the Surveillance if we receive evidence from a doctor, psychologist or other person we consider appropriate (such as a family member or support worker) that it is negatively affecting your health, including your mental health. This evidence will not be used by us against you in the evaluation of your claim and will be treated in line with privacy laws.

5.44 We will monitor investigators who conduct Surveillance on our behalf and take action in response to any poor behaviour we identify, for example, by no longer asking them to act on our behalf.

Claim decisions

Training and remuneration for claims assessors

5.45 We will ensure our claims assessors have the appropriate skills and training (including for mental health where applicable) to make objective decisions. They will not make decisions for us until they have shown technical competency and an understanding of all relevant laws, Code requirements, and FSC standards and guidance.

5.46 We will ensure our claims assessors' remuneration, including their entitlement to any bonuses:

a) is consistent with the principles set out in clause 1.6, and
b) is not directly based on financial targets for claims outcomes.

Timeframes apply for handling claims

5.47 The following timeframes in 5.48 to 5.58 apply unless there are Circumstances Beyond Our Control. See 5.59 below.

5.48 If your claim is for income-related benefits, we will obtain all the information we reasonably need, complete all reasonable enquiries, and make a decision on your claim[6] within 2 months of:

a) the Claim Received Date, or
b) if later, the end of the waiting period your policy specifies.

5.49 If your claim is for a lump sum benefit, we will obtain all the information we reasonably need, complete all reasonable enquiries, and make a decision on your claim[6] within 6 months of:

a) the Claim Received Date, or
b) if later, the end of any waiting period your policy specifies.

5.50 Once we have received all the information we reasonably need, including any response to a Show Cause or Procedural Fairness letter, and completed all reasonable enquiries, we will tell you our decision in writing within 15 Business Days.

5.51 We will make a decision on your claim by admitting, declining, or closing your claim.

5.52 If we have issued a Show Cause or Procedural Fairness letter, we will tell you how long you have to respond. We will give you a reasonable period of time to respond to our letter before we make a decision to admit, close or decline your claim.

5.53 Depending on your policy and the benefit you are claiming, we may tell you that you may be required to do rehabilitation or retraining before we can make a decision on the claim.

5.54 If we accept a death claim, we will tell you if we may be unable to pay the benefits until the Life Insured's Representatives confirm that they have obtained probate or letters of administration.

5.55 If we need a medical or financial report to assess your claim, we will ask the provider to give us their report within 20 Business Days of our request or the appointment, if relevant. If they do not meet this deadline, we will tell you and update you on our progress getting the report, in line with Clause 3.13.

5.56 Before we close your claim because we have not received outstanding information, such as from you or your doctor, we will follow up with the person we are waiting for at least twice, using different methods of communication where available.

6 Making a decision on your claim includes all internal sign-offs we reasonably require.

5.57 If we close or decline your claim, you or the Policy Owner can ask us to reopen or reassess it. If you do, we will treat it as a new claim with a new Claim Received Date, and the timeframes under the Code will restart from the date the request to reopen or reassess the claim is received. We will not ask for information we already have or take steps that have already been taken when assessing a reopened or reassessed claim unless we have reasonable grounds to do so. We will explain those grounds to you and explain how you can make a Complaint if you disagree.

5.58 If we decline your claim, we will tell you in writing:

a) our reasons and a summary of the information about your claim that we relied on
b) where a pre-existing condition is the reason for declining your claim, we will explain the medical connection between the pre-existing condition and your claim
c) that you can ask us for copies of the documents about your claim that we relied on, which we will send to you, or to your doctor if we think that is more appropriate in line with privacy laws. We will send these copies within 10 Business Days of your request
d) that you can ask us to review our decision, or give us additional information to consider, and
e) about our Complaints process.

Circumstances Beyond Our Control may affect our claims timeframes

5.59 Where we cannot comply with a timeframe in the Code due to Circumstances Beyond Our Control, we will not have breached the Code. If we believe the Circumstances Beyond Our Control are likely to continue, meaning we will not be able to make our decision within 2 months of the Claim Received Date for income-related benefits or within 6 months of the Claim Received Date for lump sum benefits we, or the Group Policy Owner, will:

a) let you know what the Circumstances Beyond Our Control are in writing before the end of the 2 months or 6 months, as applicable
b) update you on your claim's process at least every 20 Business Days, unless we have agreed a different timeframe with you, and
c) tell you about our Complaints process.

5.60 If we believe the Circumstances Beyond Our Control are likely to continue beyond 12 months, meaning we will not be able to give you a final decision on your claim within 12 months of the Claim Received Date we, or the Group Policy Owner, will:

a) refer your claim to a senior member of our team or review committee to review the circumstances and let you know the outcome of our review in writing
b) let you know what the Circumstances Beyond Our Control are in writing before the end of the 12 months
c) update you on your claim's progress at least every 20 Business Days, unless we have agreed a different timeframe with you, and
d) tell you about our Complaints process.

Insurers may suggest independent advice for some benefits and payments

5.61 For a claim that is not income related, if we accept it and the amount is at least $25,000, we will suggest you consider obtaining independent financial advice to help manage your payment, unless the benefit is payable to a superannuation trustee.

5.62 If we accept an income-related claim and offer you a lump sum settlement instead of future income payments, we will suggest that you obtain independent financial and legal advice before you make a decision. But we will not do this for lump sum payments that do not require you to make a decision, such as when we make advanced or back payments.

Paying you promptly

5.63 For any ongoing income-related benefits, we will pay you any benefits we owe you by the later of:

a) the due date, or
b) within 5 Business Days of when we have all the information we reasonably need to make a decision to pay you.

5.64 For any ongoing income related benefits we owe you, if we find out that your payment will be late due to unforeseen circumstances, we will tell you within 5 Business Days of us finding out.

5.65 We will not stop or withhold any income-related benefit payment during a non-disclosure, misrepresentation or duty to take reasonable care investigation, unless we reasonably believe we have evidence that will lead to your claim being declined, or your policy being cancelled or avoided.

Specific definitions apply to medical trauma and critical illness claims

5.66 The definitions in the 'Medical definitions' section apply to the first $2 million of trauma or critical illness cover for Life Insurance Policies we issued or group schemes that started on or after 1 July 2017. But they do not apply:

a) to such cover that we reinstate after a claim
b) where the amount we pay varies based on how severe the condition is, or
c) to benefits included with income protection or TPD.

5.67 Where your trauma/critical illness cover includes cover for certain cancers, heart attacks or strokes (but not the exclusions listed in the 'Medical definitions' section) and you make a claim, we will assess your claim against the 2 following definitions so that you get the better of the 2 definitions:

a) the applicable definition in our Product Disclosure Statement/policy document linked to the full benefit amount
b) if different, the definition in the 'Medical definitions' section that is current at the time of the insured event.

6 Supporting customers experiencing vulnerability or financial hardship

Customers experiencing vulnerability

A range of circumstances can cause vulnerability

6.1 We recognise that some customers may experience vulnerability due to age, disability, injury, a mental health condition, physical health condition, language barriers, literacy barriers, cultural background, remote location, Aboriginal or Torres Strait Islander status, family violence, suicidality or suicidal behaviours or financial distress. We are committed to taking extra care to support vulnerable customers. We acknowledge that we may be unable to identify some customers experiencing vulnerability unless they tell us.

6.2 We will treat you (and your family, carer, or support person as applicable) with empathy, compassion, and respect.

6.3 Given the cultural practice known as 'Gratuitous Concurrence', we will take additional care when dealing with people of Aboriginal or Torres Strait Islander status about Funeral Insurance or other Life Insurance Policies to ensure their consent is genuine.

6.4 We will keep a record of any ongoing support or assistance you require.

6.5 We understand that some customers may also have unique needs which makes them vulnerable because of their circumstances and this makes it harder to access our products and services.

6.6 We will have a publicly available policy on our website about how we will support you if you are affected by family violence.

6.7 We will arrange relevant training for our staff who are likely to be involved in communications requiring an interpreter.

6.8 On our website there will be an easy-to find link to:

a) information on interpreting services
b) teletypewriter services (TTYs)
c) any information on our products that we have translated into other languages
d) any other relevant information for people with language barriers, and
e) any supports targeted towards culturally and linguistically diverse individuals, Aboriginal and Torres Strait Islander peoples and individuals who may have difficulty understanding certain health issues.

Supporting customers experiencing vulnerability

6.9 If you tell us or we identify that you need extra support to access our services due to vulnerability, we will work with you to find a suitable, sensitive, and compassionate option. We will do this as early as practical.

6.10 We encourage you to tell us about your vulnerability and if you need extra support, we can arrange support or help you to access our services.

6.11 We will protect your right to privacy.

6.12 Where appropriate, we will tell you what types of additional support and services we can provide to help you.

6.13 If you tell us that you need extra support from someone else or if we identify that you need extra support – such as a lawyer, consumer representative, interpreter, family member, carer or friend – we will recognise this and allow it in all reasonable ways. We will arrange for and pay for an interpreter if you tell us that you need one or if we identify that one is required. We will make sure our processes are flexible enough to recognise the authority of your support person where possible.

6.14 If you need support to meet verification and identification requirements, we will take reasonable steps to support you, especially if you are from an Aboriginal or Torres Strait Islander community, a non-English speaking background or impacted by family violence. Our approach will be flexible in line with AUSTRAC guidance, while still meeting our legal obligations.

6.15 We will have internal policies and role-appropriate training to help our staff:

a) identify and understand if you are vulnerable
b) consider your unique needs or vulnerability
c) decide how we may be able to help you engage with us and to what extent, and
d) engage with you with empathy, compassion, and respect, not least to avoid exacerbating any mental health condition you have.

6.16 We will provide cultural awareness training to staff who regularly help customers in remote Indigenous communities.

6.17 We recognise that people living in remote and regional communities may have trouble meeting the timeframes we set to give us documents or to take part in assessments. We will consider this in our Underwriting and claims processes.

Financial hardship

Customers experiencing financial hardship

6.18 If you tell us or we identify that you are having trouble paying or can no longer afford your Premium due to financial hardship, we will contact you to tell you about our range of flexible support options to help you maintain cover. Some of these options may include:

a) changing your benefits or the amount we insure you for to reduce your Premium
b) Prioritising your claim for an illness or injury your policy covers, in line with Clauses 6.24 to 6.27, and/or
c) not collecting your Premium for a short time, noting that you may not be able to claim for anything that happens, is diagnosed or becomes apparent during this time.

6.19 If you take up one or more of our flexible support options, we will explain the effect on your Life Insurance Policy, including as applicable, any reduction in the amount you will be insured for and how long the support will last.

6.20 We will contact you before a flexible support option we have offered you comes to an end to explain the implications for your Life Insurance Policy.

6.21 We will periodically review and refine our flexible support options, taking into account changes in the community and any Government support measures and consider the most appropriate ways to ensure our customers are aware of the flexible support options we offer.

6.22 We will let you know what help we can offer based on reasonable evidence we ask you to give us. We will only ask for evidence we reasonably need to assess your request for extra support due to financial hardship. This could include:

a) your Centrelink statements if you are a Centrelink client
b) your bank statements or other financial documents, or
c) a statement showing your employment ended.

6.23 Clauses 6.18 and 6.22 do not apply to cover under a Group Policy, as the Group Policy Owner is responsible for changes.

Customers can ask for help when making a claim

6.24 If you tell us or we identify that you need help with the claim process, in understanding what is required of you, completing claim forms or providing requested claim information, we will work with you to find a solution. This may include endeavours to collect the information on your behalf, with your permission.

6.25 If you tell us or we identify that you urgently need the benefits of your Life Insurance Policy due to a condition that your policy covers, we will assess your request for urgent access to your benefits. We may ask you for evidence of this urgent need.

6.26 We will let you know what help we can offer you within 5 Business Days of receiving all the evidence we need. We will let you know that you can ask us to review our decision and give you details about our Complaints Process.

6.27 If we accept your request, we will confirm any help we offer in writing. This might be:

a) prioritising your claim assessment and our decision, and/or
b) advancing part of your claim payment.

6.28 Where you have cover under a Group Policy, we will tell you who to contact about your urgent need for benefits. The law limits access to superannuation benefits.

7 Complaints

Making a Complaint

7.1 We will not discourage you from making a Complaint.

7.2 If you make a Complaint to us and we are unable to resolve it when you first contact us, we will explain our Complaints process to you and we will tell you how you can access the Code, in line with Clause 1.3. We will acknowledge your Complaint within 24 hours (or 1 Business Day) of receiving it, or as soon as practicable.

Customers can make a complaint

7.3 If you tell us that you have a concern about someone who is not our Authorised Representative, we will tell you how to have the matter addressed.

7.4 We will give you the name and contact details of the person assigned to or dealing with your Complaint.

7.5 We will assign a person to your Complaint who will not be the person or people whose decision or conduct is the subject of your Complaint.

7.6 We will only ask for and rely on information relevant to our investigation into your Complaint and our response.

Complaints about declined or closed claims

7.7 When we give you our final decision in respect of your Complaint about a declined claim, or about the value of a claim, we will tell you what we will do regarding your claim which will be one of the following:

a) Reopen or reassess your claim
b) maintain our original decision, or
c) overturn our original decision.

7.8 When we have given you our final decision regarding your Complaint, we will then close your Complaint.

7.9 If our final decision about your Complaint is that we will reopen or reassess your claim, we will also confirm the name and contact details of the claims assessor assigned to liaise with you.

Handling your Complaint

Insurers will respond directly to some Complaints

7.10 We will only close your Complaint within 5 Business Days of receiving it, if we have:

a) resolved your Complaint to your satisfaction, or

b) give you an explanation and/or apology where we cannot take further action to reasonably address the complaint.

7.11 If we do this, Clauses 7.13 to 7.19 below do not apply, as long as:

a) your Complaint is not about hardship, a declined insurance claim, the value of an insurance claim or a superannuation trustee's decision, or
b) you have not asked for a response in writing.

7.12 We will provide a written response to your Complaint, even if we resolve your Complaint within 5 Business Days, if:

a) your Complaint is about hardship, a declined insurance claim, the value of an insurance claim or a superannuation trustee's decision, or
b) you have asked for a response in writing.

7.13 We will give you our final written response to your Complaint in writing within 30 calendar days, unless your Complaint is about a Life Insurance Policy or Group Policy a superannuation fund trustee owns, in which case Clauses 7.16 to 7.19 apply. Our final response will include:

a) the action taken to resolve the Complaint or the reasons for our decision
b) identifying and addressing the issues raised in the Complaint with a summary of the information relied on
c) that you can ask us for a copy of documents and information relied on in assessing your Complaint, and
d) that you have the right to take your Complaint to an External Dispute Resolution Body if you are not satisfied with our decision, along with how to contact them and any time limit for doing so.

7.14 If you ask for the documents and information relevant to your Complaint that we relied on, we will send them to you within 10 Business Days, in line with Clauses 3.13 and 3.14.

7.15 We may not be able to respond within 30 calendar days if the Complaint is complex and/or there are Circumstances Beyond Our Control causing a delay. If we cannot respond to your Complaint within 30 calendar days, before this time is up, we will tell you:

a) why there is a delay
b) that we will keep you regularly updated about progress, and
c) that you may have the right to take your Complaint to an External Dispute Resolution Body if you are not satisfied with our explanation, along with how to contact them and any time limit for doing so.

Superannuation fund trustees will respond to other Complaints

7.16 If you make a Complaint about a Life Insurance Policy a superannuation fund trustee owns, you can complain to us or to the trustee.

7.17 Where possible, the trustee must give you a final written response to your Complaint within 45 calendar days of us or them receiving the Complaint. This will include:

a) the action taken to resolve the Complaint or the reasons for their decision
b) identifying and addressing the issues raised in the Complaint with a summary of the information relied on
c) that you can ask for a copy of documents and information relied on in assessing your Complaint, and

d) that you have the right to take your Complaint to an External Dispute Resolution Body if you are not satisfied with their decision.

7.18 If you tell us that the trustee has not responded within 45 calendar days, we will tell you that you can ask them to explain the delay in writing.

7.19 Unless otherwise agreed with the trustee that we will give our final decision to you, we will give our final decision in writing to the superannuation fund trustee so that they can give it to you. This will include everything referred to in Clause 7.13 and, where relevant, Clause 7.7.

8 Code governance

The FSC and the Life CCC

The Financial Services Council develops the Code

8.1 The FSC develops this Code. It will:

a) consult with the Life CCC, External Dispute Resolution Bodies, consumer and industry representatives, regulators, and other stakeholders about the content, and
b) commission formal independent reviews as needed starting in 2025, and at least every 3 years after that.

The Life Code Compliance Committee monitors governance

8.2 The FSC also developed the Life CCC charter, which sets out the Life CCC's functions and powers. The Life CCC is made up of:

a) an independent chair
b) a consumer representative, and
c) an industry representative.

8.3 The Life CCC will regularly report to the FSC's Life Board Committee on industry issues and Code compliance. It may recommend:

a) improvements to the Code to address weaknesses or non-compliance, and
b) that the Life Board Committee review the Code if it could better meet its goals.

8.4 The Life CCC also publishes an annual report with consolidated, de-identified analysis on compliance.

8.5 The Life CCC may outsource its functions to an appropriate body, but not its powers to sanction.

Breaches and sanctions

Entities will comply with both the law and the Code

8.6 The Code only creates legal or other rights between the entities bound by it and the FSC. It does not create rights for any other parties.

8.7 If there is a conflict or inconsistency between the Code and any law or regulation, the law or regulation prevails. But where the Code has higher standards than the law, entities will comply with both the law and the Code.

8.8 Life insurance companies may agree with a Group Policy Owner to service standards that are higher than the Code standards.

8.9 Only the Life CCC can determine a breach of the Code. But External Dispute Resolution Bodies, such as Australian Financial Complaints Authority, may consider if we have met our obligations under the Code when they Determine disputes.

8.10 None of the provisions of the Code can be the subject of proceedings in a court or tribunal[7].

Insurers will ensure compliance with the Code

8.11 Any organisation bound by the Code (see Clause 1.12) will meet Code standards for all products and services it provides. We will:

a) have appropriate systems and processes to enable compliance
b) report to the Life CCC yearly about our compliance, and
c) have a governance process to report to our Board of Directors or executive management about our compliance.

8.12 We will be in breach of the Code if our staff or our Authorised Representatives do not comply with the Code.

8.13 If we find a Significant Breach in our organisation, we will report it to the Life CCC within 30 Business Days of discovering it. But we will not do this if we have already reported (or will report) a Significant Breach to the relevant regulator, and they know the matter may also involve a Code breach. If so, the relevant regulatory timeframes will apply.

8.14 Anyone – including you and External Dispute Resolution Bodies – can report an alleged Code breach to the Life CCC. The Life CCC may then:

a) tell us about the allegation and give us a chance to respond
b) investigate as it sees fit
c) decide if there was a Code breach
d) decide if we should deal with the allegation through our internal Complaints process, and refer you to us if so
e) agree with us to any fair and reasonable corrective actions we will take and the relevant timeframes (considering any related actions that a regulatory body has imposed), and
f) monitor our actions and decide if they are effective and on time.

8.15 The Life CCC may also impose sanctions, in line with Clauses 8.18 to 8.21.

8.16 We will cooperate with the Life CCC's reviews of our compliance with the Code, investigations of alleged Code breaches and reasonable requests at any time. For any Code breach they find, we will also take fair and reasonable corrective actions in agreed timeframes. But any corrective actions that a regulatory body imposes on us will take precedence.

8.17 In line with FSC Standard No. 1, the FSC Board can discipline us if we do not correct a Code breach. This includes if we do not comply with a Life CCC sanction, which is regarded as a breach of an FSC Standard.

7 To be updated once ASIC and FSC agree any enforceable code provisions.

The Life CCC can sanction insurers for significant code breaches

8.18 If the Life CCC finds a Significant Breach or if we cannot agree on corrective actions, it will:

a) tell our Chief Executive Officer (CEO) in writing
b) give us 15 Business Days to respond
c) consider our response before making a final decision and imposing any sanctions, and
d) tell our CEO and the FSC its decision in writing.

8.19 The Life CCC's decisions are binding on us.

8.20 When deciding any sanctions for a Significant Breach, the Life CCC will consider:

a) the Code's principles and goals
b) if the sanction is appropriate, and
c) any related actions that a regulatory body has imposed on us.

8.21 A sanction for a Significant Breach may mean giving a formal warning or may require us to do one or more of the following, depending on the severity of the breach:

a) take steps to fix the Code breach in a set timeframe, considering any related actions that a regulatory body has imposed on us
b) audit our Code compliance
c) put out corrective advertising
d) write to customers affected by the Code breach
e) make a Community Benefit Payment of up to $100,000 to a charity
f) publish our non-compliance on our Website and the FSC Website
g) agree to the Life CCC publicly identifying us as having made a Significant Breach of the Code.

9 Definitions

General definitions

These acronyms appear throughout the Code

Acronym	Meaning
APRA	Australian Prudential Regulation Authority
ASIC	Australian Securities and Investments Commission
CCI	Consumer Credit Insurance
FSC	Financial Services Council Limited
Life CCC	Life Code Compliance Committee
TPD	Total and Permanent Disability

These definitions apply to the Code (but not to Appendix A: Moratorium on Genetic Tests in Life Insurance)

Term	Meaning
Applicant	A person who applies for a Life Insurance Policy with us to become a Policy Owner or Life Insured.
AFS licence	Australian Financial Services licence
Authorised Representative	A person, company, or other entity we authorise to provide financial services on our behalf under our AFS licence, and acting as our representative, in line with the *Corporations Act 2001*. It does not include a person, company or entity that is an Authorised Representative of any other holder of an AFS licence, including a holder of an AFS licence that is a related company to us.
Business Day	Monday to Friday, except public holidays.

Term	Meaning
Circumstances Beyond Our Control	Any of the following: a) We have not received or had a reasonable time to assess reports, records, evidence or other information we reasonably requested from you, the Group Policy Owner, an Independent Service Provider, your doctor, a government agency, or another person or entity (but not a Reinsurer). b) You or the Group Policy Owner have not responded to our reasonable enquiries or requests for documents in a reasonable timeframe. c) We have not had a reasonable opportunity to complete our assessment of your claim and make a decision after we issue a Show Cause or Procedural Fairness letter. d) We have been unable to contact you about your claim. e) You are, or will be, undergoing rehabilitation, retraining or further treatment, which means we are unable to make a final decision about your claim. f) You or the Group Policy Owner have asked for a delay or extension to part of the claims process. g) We reasonably suspect there was non-disclosure, misrepresentation or a failure to take reasonable care before the cover or policy started that we believe may impact your claim, and we need further investigation, evidence and/or information. h) We reasonably suspect that your claim is fraudulent and need further investigation, evidence and/or information.
Claim Received Date	The date a life insurer records it has received the first piece of information, but not necessarily all information, to allow it to commence the assessment of a claim.
Code	This Life Insurance Code of Practice.
Complaint	An expression of dissatisfaction made to or about an organisation about its products, services, staff or handling of a Complaint, where a response or resolution is: a) explicitly or implicitly expected, or b) legally required.
Community Benefit Payment	A payment for a Significant Breach up to a maximum of $100,000. The size of the payment must be in proportion to the gross in force premiums of the relevant insurer and the number of customers affected. The Life CCC must take into account any compensation awarded by the Australian Financial Complaints Authority or an enforcement agency. The Life CCC must also take into account any impending or ongoing investigation by the Australian Securities and Investments Commission and any penalties that they could impose.
Cooling Off Period	The period of at least 30 calendar days from the day we issue your product when you can change your mind and get a full refund, unless the duration of cover is designed to be 3 months or less, in which case the refund will be in line with the terms of the policy.
Determine	When an External Dispute Resolution Body makes a final decision.
Direct Sale	A sale where a consumer contacts us to buy a Life Insurance Policy.
Distributor	A person or entity we appoint to distribute our policies on our behalf, excluding independent financial advisors and platform operators.

Term	Meaning
External Dispute Resolution Body	An external organisation that is relevant to your Complaint, which may include the Australian Financial Complaints Authority or a Complaints handling process that legislation mandates.
Funeral Insurance Policy	A Life Insurance Policy which is issued for the purpose primarily to cover funeral, burial, or cremation expenses for the Life Insured or their family members.
Gratuitous Concurrence	Where a person appears to assent to propositions put to them even when they do not agree. For many Indigenous people, using gratuitous concurrence during a conversation is a common cultural practice, and is used to build or define the relationship between the people who are speaking. It may also be used to show respect towards a person, cooperation between people, or acceptance of a particular situation.
Group Policy	A Life Insurance Policy owned by an employer, superannuation fund trustee, or another person or entity that: a) covers a group of eligible Life Insured, and b) includes any extra cover purchased at the request of the Life Insured. And a **Group Policy Owner** means an owner of such a Life Insurance Policy.
Independent Service Provider	A person or entity we enter an agreement with to help with Underwriting, administration or claims management, such as a/an: a) independent medical assessor b) allied health professional c) rehabilitation provider d) accountant e) investigator, or f) claims management service. A Reinsurer is not an Independent Service Provider.
Life Insurance Policy	Any of the following issued in the Australian market, but not a contract of reinsurance: a) An insurance contract that provides for the payment of money on the death of a person or on the happening of a contingency dependent on the ending or continuation of human life (Section 9(1)(a), *Life Insurance Act 1995*). b) An insurance contract that is subject to payment of Premiums for a term dependent on the ending or continuation of human life (Section 9(1)(b), *Life Insurance Act 1995*). c) A continuous disability policy (Section 9(1)(e), *Life Insurance Act 1995*). d) Another insurance contract, if we carry on life insurance business (other than annuity business) by issuing or undertaking liability under such a contract due to a declaration by APRA under section 12A of the *Life Insurance Act 1995*.
Life Insured	A person insured under a Life Insurance Policy covered by this Code, whether or not they are a party to the policy. A Third-Party Beneficiary is not a Life Insured.
Mental Health Condition	A broad range of disorders, illnesses, and syndromes including mood or anxiety disorders, bipolar disorder, schizophrenia, and personality disorders.

Term	Meaning
Plain Language	A communication is in plain language if its wording, structure, and design are so clear that the intended audience can easily find what they need, understand what they find and use that information. Plain language can include technical terms where these words are the most relevant or precise.
Policy Owner	Any person, company or entity that owns a Life Insurance Policy covered by this Code, including joint Policy Owners. A Third-Party Beneficiary is not a Policy Owner.
Premium	The amount you pay, or another person or entity pays for your insurance cover.
Pressure Selling	Using certain techniques to pressure, compel or otherwise encourage someone to buy a policy they do not want. Pressure selling includes: a) using the Cooling-Off Period or a deferred payment arrangement to conclude a sale when the person has not reached a final decision that they want to buy the policy b) refusing to provide a written quote and policy information the customer asks for unless they agree to take out the policy c) not ending a sale when the person states clearly that they do not want to buy the policy.
Procedural Fairness letter	A letter where we write to you with our preliminary view on your claim and which gives you an opportunity to respond before we make a decision.
Reinsurer	An entity that provides insurance to issuers of Life Insurance Policies (known as reinsurance). A Reinsurer does not have a contract of insurance with you.
Representative	Someone you choose or who is authorised to communicate with us on your behalf, such as a: a) lawyer or person with power of attorney b) financial adviser or planner c) Group Policy Owner d) interpreter, or e) family member or guardian.
Show Cause letter	A letter we will send you before we make a decision to vary or avoid your cover, that gives you an opportunity to respond.
Significant Breach	Any Code breach that we or the Life CCC reasonably determine to be significant by referring to the: a) number and frequency of previous similar breaches b) actual or potential financial loss it causes c) impact it has on our ability to provide our services, or d) extent to which it suggests that our arrangements to ensure compliance with Code obligations are inadequate.
Surveillance	When an investigator watches or films your activities in public.

Term	Meaning
Third Party Beneficiary	Any person or entity who is entitled to benefits from a claim but is not a Life Insured or Policy Owner. This may include someone: a) a Life Insurance Policy covered by the Code specifies or refers to, by name or otherwise, as someone who may receive the benefit of the insurance, or b) seeking the benefits of the insurance.
Underwriting	The process we use to decide whether to offer you insurance and the terms that should apply to that insurance when you apply for cover. Underwriting requires medical and other personal information from you, which we will consider.
We, us, our	A life insurance provider that is bound by the Code. This includes its Authorised Representatives. 'Us' means the Code subscribers acting individually and independently, not collectively.
You, your	Means, as the context may require: a) the Applicant, Life Insured or Policy Owner b) a person authorised to act on your behalf, such as a named Representative, adviser, parent, guardian, or a person with power of attorney, or c) a Third-Party Beneficiary, if relevant.

Medical definitions

Three medical terms have specific definitio

Term	Meaning
Cancer, excluding certain early stage cancers	Cancer, excluding certain early stage cancers means any malignant tumour diagnosed with histological confirmation and characterised by: ▪ the uncontrolled growth of malignant cells; and ▪ invasion and destruction of normal tissue beyond the basement membrane. The term malignant tumour includes leukaemia, sarcoma and lymphoma. The following are not covered: ▪ All tumours which are histologically classified as any of the following: a) pre-malignant; b) non-invasive; c) high-grade dysplasia; d) borderline or low malignant potential. ▪ Carcinoma in situ except carcinoma in situ of the breast where a total mastectomy with full removal of the breast has been undertaken and was considered by treating doctors to be the appropriate and necessary treatment. ▪ All cancers of the prostate unless: a) histologically classified as having a Gleason score of 7 or above; or b) having progressed to at least clinical stage T2bN0M0 on the TNM clinical staging system; or c) where a total prostatectomy has been undertaken where the procedure was specifically to arrest the spread of malignancy and was considered by treating doctors to be the appropriate and necessary treatment. ▪ All cancers of the thyroid unless: a) having progressed to at least TNM classification T2N0M0; or b) where a total thyroidectomy has been undertaken and was considered by treating doctors to be the appropriate and necessary treatment. ▪ All cancers of the bladder unless having progressed to at least TNM classification T1N0M0. ▪ Cutaneous lymphoma confined to the skin. ▪ Chronic lymphocytic leukaemia unless having progressed to at least Rai stage I. ▪ All non-melanoma skin cancers unless having spread to the bone, lymph node, or an other distant organ. ▪ All melanoma skin cancers unless having progressed to at least TNM classification T2bN0M0.

Term	Meaning
Heart attack, with evidence of severe heart muscle damage	Heart attack, with evidence of severe heart muscle damage means the death of a portion of the heart muscle as a result of inadequate blood supply, where the diagnosis is supported by the detection of a rise and/or fall of cardiac biomarker values with at least one value above the 99th percentile upper reference limit (URL) and with at least three of the following: a) Symptoms of ischaemia. b) New significant ST-segment–T wave (ST-T) ECG changes or new left bundle branch block (LBBB). c) Development of new pathological Q waves in the ECG. d) Imaging evidence of new regional wall motion abnormality present at least six weeks after the event. If the tests specified in a) to d) above are inconclusive or unable to be met, then the definition will be met if at least three months after the event the insured's left ventricular ejection fraction is less than 50 per cent. The following are not covered: a) A rise in biological markers as a result of an elective percutaneous procedure for coronary artery disease. b) Other acute coronary syndromes including but not limited to angina pectoris.

Term	Meaning
Stroke in the brain resulting in specified permanent impairment	Stroke in the brain resulting in specified permanent impairment means death of brain tissue caused by one of the following: a) Ischaemic infarction of brain tissue. b) Intracranial haemorrhage (cerebral, intraventricular or subarachnoid). The diagnosis must be supported by both of the following: a) Evidence of permanent neurological deficit with persisting symptoms confirmed by a specialist physician as a definite result of the stroke at least six weeks after the event. b) Findings on MRI, CT, or other reliable imaging evidence consistent with the diagnosis of a new stroke. The following are not covered: ▪ Transient ischaemic attacks. ▪ Brain damage due to an accident, injury, infection, or non-vasculitic inflammatory disease. ▪ Vascular disease affecting the eye or optic nerve. ▪ Ischaemic disorders of the vestibular system. ▪ Strokes caused by or related to illicit drug use or substance abuse. ▪ Migraine. ▪ Hypoxic events. Words within the stroke definition that have special meaning. *"Permanent neurological deficit with persisting symptoms"* means dysfunction in the nervous system that is present on clinical examination and expected to last throughout the insured person's life. It includes outcomes such as: numbness, hypertonicity, hemiplegia, monoplegia, hemiparesis, monoparesis, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, coma and objectively documented significant loss of cognitive function. The following do not constitute "permanent neurological deficit with persisting symptoms": ▪ An abnormality seen on brain or other scans without definite related clinical symptoms. ▪ Neurological signs occurring without symptomatic abnormality, such as brisk reflexes without other symptoms. ▪ Symptoms of psychological or psychiatric origin.

Appendix A: Moratorium on Genetic Tests in Life Insurance

A.1 This Moratorium

Life insurance should not dissuade people from Genetic Testing

a) Genetic Testing has the potential to play an important role in informing people about their health and enabling them to manage their health risks through preventative actions and personalised medicine.

b) It is important that public concerns about the use of Genetic Test results in life insurance do not dissuade people from taking Genetic Tests or taking part in genetic research.

c) The objective of the Moratorium on Genetic Tests in Life Insurance (the Moratorium) is to ensure people can access a level of life insurance without being asked about the result of a previously taken Genetic Test.

d) The Moratorium covers an Applicant for individually underwritten life insurance (including individually underwritten life insurance in group insurance) with an FSC member.

e) The Moratorium starts for applications received on or after 1 July 2019 and applies until 30 June 2024.

A.2 Test results

Insurers can ask for test results in some circumstances

a) The overriding principle is that for all applications, regardless of the amount of Cover and any other clause in the Moratorium, we can ask you to disclose, and use as part of our Underwriting process, any diagnosis of a condition, even if the diagnosis resulted directly or indirectly from a Genetic Test.

b) For all applications, regardless of the amount of Cover, we will not ask or otherwise encourage you to:

   i) take a Genetic Test as part of your application and Underwriting process
   ii) disclose the result of a Genetic Test that was taken as part of a medical research study conducted by an accredited university or medical research institution where the test results have not been and will not be provided to you, or you have specifically asked not to receive them.

c) As part of the application process for the benefits listed below, we may only ask for or use the results of a Genetic Test if the total amount of Cover you would have – including both the Cover being applied for and any existing individual and group insurance Cover with all life insurers – is more than any of the following:

   i) $500,000 of lump sum death Cover
   ii) $500,000 of total permanent disability (TPD) Cover
   iii) $200,000 of trauma and/or critical illness Cover
   iv) $4,000 a month of any combination of income protection, salary continuance or business expenses Cover.

d) If your total amount of Cover exceeds any of the limits in clause A.2c), we may ask for and use the result of a previously taken Genetic Test or planned test when assessing the full amount of Cover being applied for across all types. A planned test means you have consented to a Genetic Test. We can do this provided that an evidence base shows that the test has relevance to the Cover applied for, in line with the Disability Discrimination Act.

e) We will take the following into account as part of our Underwriting assessment:
   i) a favourable Genetic Test result you choose to disclose, regardless of the amount of Cover, for example to show that you are not carrying a gene pattern associated with developing an illness that runs in your family
   ii) evidence based preventative treatment, or adherence to evidence based preventative measures, which reduce the possibility of developing an illness that runs in your family.

f) We will only ask for or use Genetic Test results as part of the process to decide the terms offered for Cover in line with clause A.2c). For example, this means that we will not ask for or use adverse Genetic Test results, even if the limits in clause A.2c) are exceeded due to an increase in Cover without Underwriting through automatic yearly increases in Cover.

g) We will ensure that Underwriting staff can consult a medical professional (such as a Chief Medical Officer) where a Genetic Test result is deemed to be relevant in the Underwriting assessment.

h) We will comply with privacy law regarding sensitive information in asking for, using, and retaining Genetic Test results in our life insurance operations.

i) For the purposes of governance and compliance, and to inform the review in clause A.3a), we will record anonymous details of all Genetic Test results received as part of the Underwriting process, whether or not we asked for them, on the FSC database of Genetic Test results.

Undisclosed results might not breach duty of reasonable care

j) When assessing claims, we will not treat the Life Insured as having breached their duty to take reasonable care not to make a misrepresentation for not disclosing the results of a Genetic Test that we were not entitled to ask for or use as part of our Underwriting process in line with the Moratorium.

A.3 Moratorium governance

The Financial Services Council (FSC) will review this Moratorium

a) During 2022, the FSC will review the Moratorium in consultation with stakeholders with a view to extending the date, taking account of its objectives and:
   i) feedback from consumer groups and expert stakeholders
   ii) the appropriateness of the amounts of Cover in clause A.2c), taking into account any cross-subsidy between customers who have a genetic pre-disposition and those who do not
   iii) the rates of participation in genetic research
   iv) advances in the field of genomics and Genetic Testing
   v) impacts of the Moratorium on the sustainability of the life insurance industry.

b) The FSC will not reduce the term of, or otherwise change, the Moratorium outside this review process.

These definitions apply to the Moratorium

c) For the Moratorium, the following terms have the associated meaning:

Term	Meaning
Applicant	A person who applies for a Life Insurance Policy with us to become a Policy Owner or Life Insured.
Cover	Any type of life insurance, including: ▪ lump sum death cover ▪ total permanent disability (TPD) cover ▪ trauma/critical illness cover ▪ income protection, salary continuance or business expenses cover.
Genetic Test	A test that examines a person's chromosomes or DNA. It does not include any non-genetic medical tests (such as blood or urine tests for proteins, cholesterol, liver function or diabetes), even if they are to test for a condition that may have a genetic origin.
Underwriting	The process we use to decide whether to offer you insurance and the terms that should apply to that insurance when you apply for Cover.
We, Us, Our	A life insurance provider that is bound by the Code. 'Us' means the entities acting individually and independently, not collectively.
You, Your	The Applicant.

Appendix B: Supporting customers experiencing a mental health condition

People with mental health conditions

This Appendix B sets out sections of the Code which we believe may be of particular interest to customers experiencing mental health conditions. In this Appendix B we also refer you to certain parts of the Code containing more detailed information which you may wish to read.

We will take extra care if you are vulnerable due to your mental health

1. We recognise that some customers may experience vulnerability due to a mental health condition. We are committed to taking extra care to support customers with a mental health condition. We acknowledge that we may be unable to identify some customers experiencing vulnerability due to a mental health condition unless they tell us. We will treat you (and your family, carer or support person as applicable) with empathy, compassion, and respect. See Clause 6.1 and 6.2 of the Code.

You can ask us for extra support

2. If you tell us or we identify that you need extra support to access our services due to a mental health condition, we will work with you to find a suitable, sensitive, and compassionate option. We will do this as early as practical. See Clause 6.9 of the Code.

3. We encourage you to tell us about your mental health condition and if you need extra support, we can arrange support or help to access our services. See Clause 6.10 of the Code.

4. If you tell us that you need extra support from someone else or if we identify that you need extra support – such as a lawyer, consumer representative, interpreter, family member, carer, or friend – we will recognise this and allow it in all reasonable ways. We will arrange for and pay for an interpreter if you tell us that you need one or if we identify that one is required. We will make sure our processes are flexible enough to recognise the authority of your support person where possible. See Clause 6.13 of the Code.

5. If you need support to meet verification and identification requirements, we will take reasonable steps to support you, especially if you are from an Aboriginal or Torres Strait Islander community, a non-English speaking background or are impacted by family violence. Our approach will be flexible in line with AUSTRAC guidance, while still meeting our legal obligations. See Clause 6.14 of the Code.

6. We will have internal policies and role-appropriate training to help our staff:
   a) identify and understand if you are vulnerable
   b) consider your unique needs or vulnerability
   c) decide how we may be able to help you engage with us and to what extent, and
   d) engage with you with empathy, compassion, and respect, not least to avoid exacerbating any mental condition you have. See Clause 6.15 of the Code.

Appendix B: Supporting customers experiencing a mental health condition

Buying a Life Insurance Policy

7. If you have or have had a diagnosed mental health condition, or symptoms of a mental health condition, we will:
   a) not decline to insure you before you have had the opportunity to provide information about the history, severity, or type of condition before making our decision about whether to insure you and, if so, the terms we offer you, and
   b) take into account your circumstances such as the history, severity, or type of condition, when deciding whether we can offer you cover. See Clause 4.12 of the Code.
8. If you tell us about a past or current mental health condition, we will determine whether we can provide you with cover by managing any additional risk through higher Premiums, exclusions, limits, and caps rather than not provide cover at all. See Clause 4.13 of the Code.
9. We will ensure our underwriters have the appropriate skills and training, including for mental health where applicable. They will not make decisions for us until they have shown technical competency and an understanding of relevant laws (including anti-discrimination laws), Code requirements, and FSC standards and guidance. See Clause 4.18 of the Code.
10. While assessing an application, our underwriters will access professional advice and support in relevant disciplines – such as from medical specialists and accountants – when needed. See Clause 4.19 of the Code.

Making a claim under a Life Insurance Policy

11. We acknowledge that claims time is difficult for you and that each situation is unique. We will treat you with empathy, compassion, and respect throughout the claims process. See Clause 5.1 of the Code.
12. We will not discourage you from making a claim. See Clause 5.2 of the Code.
13. If you tell us that you are having trouble providing the information we need, we will work with you to take steps to find a solution. This may include endeavours to collect the information on your behalf, with your permission. See Clause 5.3 of the Code.
14. If you make an income-related claim, we will ensure you have an assigned claims assessor throughout the claims process and, if we consider it appropriate, we will also:
   a) identify and act upon ways to support your recovery during the claim
   b) identify and act upon ways to encourage best practice rehabilitation and return to work programs, and
   c) work with your doctor, other healthcare providers and your employer to support your recovery, rehabilitation and return to work. See Clause 5.4 of the Code.
15. Within 10 Business Days of the Claim Received Date, we will tell you:
   a) how you can access the Code, in line with Clause 1.3.
   b) about your cover and any waiting periods that may apply
   c) about all the relevant benefits under the Life Insurance Policy you are claiming on, and
   d) about the claims process and how to contact us for more information. See Clause 5.5 of the Code.

Claim interviews will follow set rules

16. If we want to interview you, we will document our reasons for this and ask a senior member of our team to review and approve the interview before it proceeds. We will not interview anyone under the age of 18 unless we believe there is no alternative. See Clause 5.24 of the Code.

17. We will monitor interviewers who conduct interviews on our behalf and take action in response to any poor behaviour we identify, for example, by no longer asking them to act on our behalf. See Clause 5.25 of the Code.

18. If we ask you to be interviewed (not an independent medical examination) to establish some facts, we will check our records before we hire an interviewer to see if you need one who speaks your preferred language, or if you need a support person or interpreter to attend. If you do need an interpreter, we will arrange and pay for it. See Clause 5.26 of the Code.

19. We will arrange an interviewer that:
    a) is a certain gender, if you ask and a person of that gender is reasonably available
    b) we are satisfied has the appropriate training and experience to discuss a claim involving a mental health condition, if relevant
    c) can help if you have limited English, or
    d) can help if you have known decline, disability, or other impairment of a cognitive nature. See Clause 5.27 of the Code.

20. If you have asked us to communicate with your Representative, we will tell the interviewer to contact your Representative before arranging the interview with you. See Clause 5.28 of the Code.

21. We will tell you that you can ask us to be interviewed at a place and at a time we both agree to outside your home, unless interviewing you at your home is essential to establishing your entitlement to a benefit. If it is, we will explain why. If it is not essential to interview you at your home, we will suggest possible convenient locations you can be interviewed outside your home. See Clause 5.29 of the Code.

www.fsc.org.au

FSC FINANCIAL SERVICES COUNCIL