Adviser use only

Adviser Guide - Claims

Delivering on our promise to honour the spirit of the policy

14 October 2022

MetLife

Navigating life together

Contents

About this document

This document is part of the **MetLife Adviser Guide**, which is made up of the following documents:

- Adviser Administration
- Claims
- Commissions
- Product, MetLife Protect and MetLife Protect Super
- Policy Administration
- Underwriting

Together, these documents provide the information you need to help you understand and manage your customers' MetLife insurance policies.

Important terms

In this Guide, we have used specific terms to refer to the Product, Policy Owners and Customers. The following table outlines how and when they will be used.

Product	Potential policy owners	The term 'Customer' refers to
MetLife Protect Super	Equity Trustees Superannuation Limited (ETSL)	Life Insured
MetLife Protect	SMSF, individual(s), a corporate entity	Policy Owner(s)

* To have cover in MetLife Protect Super, the Life Insured must be a member of the MetLife Australia Superannuation Fund.

Our claims philosophy

We deliver on our promise to look after your customers when it matters most.

Our business is about being there for your customers when they need us most. So, we aim to pay every legitimate claim we receive, quickly with compassion and care.

We pride ourselves on delivering exceptional customer experiences and guiding your customers through some of the most difficult moments in their lives. It's what makes us different in the market and what drives us to keep improving the claims service we provide.

We strive to be the most caring and easiest to deal with life insurer in Australia – and claim time is our moment of truth. So we've created a process that puts your customer at its very heart – with claims handled expertly, sensitively and ethically.

Our approach

Our claims teams have the authority, training and experience to manage claims efficiently – so your customers can start receiving their benefits as soon as possible. They will also deal with your customers with empathy and care, supporting them through a difficult time.

If a customer needs to make a claim, they'll be assigned a dedicated Case Manager, who will be supported by a team of experts. They'll manage the claim throughout the entire process – so your customer always deals with someone who knows their story and can keep them informed.

Should your customer make a claim, we will get in touch with them to identify all the information we need up-front to make a decision. We'll only ask for, and rely on, information and assessments that are relevant to the claim and will explain why we're requesting these – in plain and simple language.

We will deal with all issues raised by the information and will always seek clarification of inconsistencies or gaps. We'll also protect the interests of all our customers by not paying claims which are not covered under the policy, so we can keep insurance cover as affordable and accessible as possible.

Our commitments

To help us provide the best claims experience, we've put high standards in place for our claims teams and work hard to meet them every time.

Here's how we commit to dealing with claims:

Fairness

We are committed to delivering on the contractual promises in our policy. We aim to be fair, transparent and efficient – and explain our decision to customers in language that's easy to understand.

Timeliness

We deal with every claim as fast as possible, so your client is not kept waiting for a decision.

We work towards the following standard timelines and continue to deliver a market leading service:

- **Up to 10 business days** for initial assessment and to explain the claims process (after receiving the claim)
- Progress updates — at least **every 20 business days**
- Claim decision — **within 10 business days** of getting all the information we need.

This can sometimes take longer depending on when your client, their doctor or another party sends through the information. Our service delivery can be impacted by the timeliness of their response.

Communication

We treat every customer as an individual. That means being sensitive to the fact that they're experiencing a difficult time. It's about providing the easiest and most caring claims experience we can, whether that means helping with information or with filling in a form – or dealing sympathetically with a concern or complaint.

Lifestyle support

We believe that being healthy and able to earn a living through work are important to your customers' overall wellbeing. So we provide Return to Health services to help them recover to wellness and good health.

Privacy

We take your customers' privacy very seriously and have robust processes in place to protect it at all times.

Read our Privacy Policy.

Feedback and complaints

We aim to get it right every time — and we have Quality Assurance to review the claim assessment and Customer Relations to continually monitor customer feedback so we can improve the service we provide.

If your customer has a complaint, we'll deal with it immediately. And if we can't sort it out straight away, you or your customer can access internal and external dispute resolution committees to make sure it's reviewed and resolved in a fair and impartial way.

What's more, if your customer doesn't agree with a claim decision, we'll conduct a fair and transparent internal review or we will help them obtain an independent review by external bodies.

Life Insurance Code of Practice

In addition to these promises, we also follow the industry standards set out in the Life Insurance Code of Practice (Code), which sets out specific service standards, turnaround times and complaint handling processes. The standards set out in the Code are the minimum requirements for life insurers, and we seek to exceed them as far as possible.

Who can lodge a claim?

A Policy Owner, financial adviser or an authorised third-party can lodge a claim. For MetLife Protect Super, the Life Insured can also notify us of a claim.

Life Cover claims

For Life Cover claims, you can lodge the claim. However, we'll need a policy beneficiary or an authorised legal representative of the estate to participate in the claims process.

Before we can disclose policy details or information about the claim, we'll need proof of identification for the Life Insured and the person lodging the claim (the 'claimant').

Once we've been notified of a claim, we'll speak to the claimant over the phone to determine the most effective pathway for their claim. If we need more information to assess the claim, we'll ask for it on that phone call.

All other claims

Once the claim has been lodged, we'll speak to the Life Insured over the phone to determine the most effective pathway for their claim. This may be by completing a Tele-Claim interview or a claim form, and/or providing the required information so that we can assess the claim. If we need more information to assess the claim, we'll ask the Life Insured, the claimant or an authorised third party.

See also **How to lodge a claim** on page 8.

How to lodge a claim

Let us know of a customer's claim as soon as possible, even during the Waiting Period or if you are unsure on potential eligibility.

We'll review and confirm:

- The policy is in force; and
- All premiums are paid up to date.

The information that will be required when lodging a new claim will include; policy number(s), condition claimed for and date of claim event.

The customer will then be contacted to initiate the collection of required information. This information will assist MetLife to deliver a tailored claim experience that is fast, easy and caring to the needs of the customer.

To notify of a claim event contact us:

Phone **1800 523 523**.

@ Email auclaims@metlife.com

Making a complaint

If your customer has a complaint in relation to their claim process or outcome, MetLife will work closely with them to address their concerns promptly, fairly and transparently. We aim to resolve most complaints within 15 business days from the receipt of each complaint. In cases where a customer's complaint will take longer to resolve, we will explain the reasons why and keep them updated progressively.

To raise a complaint, contact your claim professional directly by phone or email. Alternately you can raise your concern via aucomplaints@metlife.com

Internal review of disputes and decisions

If your customer is not satisfied with a solution offered, you or your customer can have their complaint reviewed by MetLife's Customer Relations Team. Certain complaints, including those about claim decisions or benefit amounts, will be sent directly to the Customer Relations Team. This free service provides an independent review of the complaint. MetLife's internal review process aims to resolve their dispute within 45 calendar days of initial complaint lodgement.

If your customer's insurance is held inside a superannuation product, the internal review process aims to resolve their dispute within 90 calendar days, which permits communication with their superannuation fund trustee, as required by certain superannuation laws.

The MetLife Customer Relations Team can be contacted at:

MetLife Insurance
GPO Box 3319
Sydney NSW 2001

1800 523 523

External review of disputes

If your customer isn't satisfied with MetLife's final response to their complaint, or the complaints process itself, you or your customer can contact the Australian Financial Complaints Authority (AFCA) on the below details:

- Online: www.afca.org.au
- Email: info@afca.org.au
- Phone: 1800 931 678
- Mail: Australian Financial Complaints Authority, GPO Box 3, Melbourne VIC 3001

Please note that before the Australian Financial Complaints Authority can investigate your customer's complaint, they generally require them to have first provided MetLife with the opportunity to address their complaint.

Policy management during a claim

When we receive a claim, we'll suspend all policy premiums from the date benefits commenced (except for trauma claims).

Here's how we treat premiums during a claim:

Policy type	Treatment of premiums
Income Cover	We'll waive premiums (and refund them if applicable) from the date the Monthly Benefit become payable, after the applicable Waiting Period has been met.
TPD Cover	We'll waive premiums from the date the Life insured meets the TPD Cover definition. Any premiums debited after will be refunded to the Policy Owner.
Life Cover	We'll suspend premiums on notification of the claim and refund any premiums from the date of death or second terminal illness certification.
Trauma Cover	We don't suspend premiums for trauma claims, since claims for other trauma conditions can still be made during this time.

If a claim is declined, we won't seek to recover any premiums that were suspended or refunded during the assessment period.

Frequently requested information at claim time

To help us process your client's claim, we may request the below information from them.

1. **Life insured information:** This information is requested through our claim forms and/or telephone interview. Includes brief condition details, restriction, occupation and duties, and details of treating doctors to contact.
2. **Medical information:** This information is requested through our claim forms and/or reports requested from treating doctors. Includes details of condition, treatment, and prognosis and restrictions.
3. **Relevant medical information:** For example, copies of medical reports.

In addition, we may also require the following information:

Income Cover claims

- Financial information on income earned prior to disablement and any income earned post disablement.
- Specific details of most recent occupation, including all duties and hours performed.

TPD Cover claims

- Details of occupational history, including roles and core duties performed for standard cover types.
- Specific details of most recent occupation, including all duties and hours performed for own occupation cover.

Trauma Cover claims

- Copies of diagnostic reports, scans or pathology relevant to the conditions diagnosed.
- We recommend your client provides all recent diagnostic information available so our claims specialists can review all available options under the policy to pay the highest benefit available.

Income claims and indemnity cover

Indemnity cover means we will be calculating the Monthly Benefits payable based on the Pre-Disability Income earned prior to Date of Disability and the calculation of the Maximum Income Replacement Amount. To calculate this we will need to obtain the financial records of the Life Insured.

Maximum Income Replacement Amount

Means the amount calculated by multiplying the relevant part of the Life Insured's Pre-Disability Income with the percentage specified in the following table.

Pre-Disability Income	%
First $20,000	70
Next $20,000	50
Next $30,000 (subject to the maximum Monthly Cover Amount of $30,000, excluding superannuation)	20

The Pre-Disability Income will be calculated based on Life Insured earning a Stable Income or Variable Income prior to their Date of Disability. Where the Life Insured was receiving a Stable Income, the Pre-Disability Income is the average Monthly Income for the 12-month period immediately prior to the Date of Disability, and for Variable Income, it is the greater of the average Monthly Income over the two years, and the most recent financial year.

The information needed will include relevant financial information such as income tax returns, profit and loss statements, payslips etc. for the individual, in addition to any entity the individual owns or part owns.

The Life Insured's Pre-Disability Income, Maximum Income Replacement Amount, Post-Disability Income and Offsets will be used towards the calculation of your Monthly Benefit.

For self employed or other non employees when calculating the Monthly Income at application, we will also review the expenses deducted from the gross income and potentially 'add-back' some of these items towards reflecting the individuals true insurable income.

We may exclude passive income not related to the individual as an employee or to their Business such as domestic rental properties, share dividends and the distribution of retained Business profit where it is demonstrated that the retained profit had been generated in a prior period.

For more information

Call 1800 523 523 Monday to Friday 9:00am to 5:00pm AEST

metlife.com.au

This document is for adviser use only and is not for public distribution. It has been prepared as a guide only - for full terms and conditions in relation to MetLife Protect and MetLife Protect Super, please refer to the MetLife Protect and MetLife Protect Super Product Disclosure Statement and Policy document (PDS).

To the extent of any inconsistency between this document and the PDS, the PDS shall prevail.

For the class of consumers whom MetLife Protect and MetLife Protect Super is likely to be suitable for, and any conditions around how the product can be distributed, please refer to the Target Market Determinations for MetLife Protect (prepared by MetLife Insurance Limited) (ABN 75 004 274 882, AFSL 238096) and MetLife Protect Super (prepared by Equity Trustees Superannuation Limited) (ABN 50 055 641 757, AFSL 229757) at www.metlife.com.au.

This document was prepared by MetLife Insurance Limited.

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