Maurice Blackburn Pty Limited
ABN 21 105 657 949
Level 10
456 Lonsdale Street
Melbourne VIC 3000
PO Box 523
Melbourne VIC 3001
DX 466 Melbourne
T (03) 9605 2700
F (03) 9258 9600

20 October 2017

Mr Jim Minto
Chair
Insurance in Superannuation Working Group

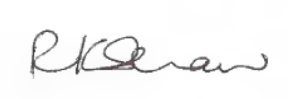
By email: ISWG-PMO@kpmg.com.au
By email: jminto@bigpond.com

Dear Mr Minto,

We welcome the opportunity to provide feedback in relation to the ISWG Consultation Paper *Insurance in Superannuation Code of Practice*.

Please do not hesitate to contact me and my colleagues on (03) 96052700 or at kshaw@mauriceblackburn.com.au if we can further assist with the Working Group's important work.

Yours faithfully



Kim Shaw
Principal
MAURICE BLACKBURN
Accredited Specialist Personal Injury Law

SUBMISSION IN RESPONSE TO THE CONSULTATION PAPER *Insurance in Superannuation Code of Practice*

October 2017

Table of Contents

Page

Introduction

Maurice Blackburn Pty Ltd is a plaintiff law firm with 32 permanent offices and 29 visiting offices throughout all mainland States and Territories. The firm specialises in personal injuries, medical negligence, employment and industrial law, dust diseases, superannuation (particularly total and permanent disability claims), negligent financial and other advice, and consumer and commercial class actions.

Maurice Blackburn employs over 1000 staff, including approximately 330 lawyers who provide advice and assistance to thousands of clients each year. The advice services are often provided free of charge as it is firm policy in many areas to give the first consultation for free. The firm also has a substantial social justice practice.

Our Superannuation business

Maurice Blackburn assists more Australians every year in making TPD and other insurance claims under their Superannuation policy than any other law firm. At any one time, we represent approximately 3000 claimants.

Through the hundreds of clients we assist, we see the best of intentions and the best of performance from superannuation funds and their insurers. We unfortunately also see the worst of culture and behaviour that has real and profound consequences for their members and our clients at a time they can least cope with such difficulty. Many of these poor experiences have been reflected by media coverage of the wider life insurance industry. This has included unethical behaviour by certain insurers such as disputing claims using out-of-date medical definitions, and delay tactics to avoid claims.

Default TPD in superannuation is a critically important resource for fund members. It is the means by which a disabled member can top up the shortfall in their superannuation retirement savings caused by the premature end to their career.

We know the personal story behind each of the claims we assist with each year, and the difference the financial assistance through superannuation based insurance makes in difficult personal and family circumstances.

Our contribution to this inquiry

Given the large volumes of disabled superannuation members that Maurice Blackburn represents, we have a unique perspective on the needs and pressures on superannuation members during times of injury, illness, disease, disability and the associated social dislocation that comes with it.

We have advocated and agitated for a binding Code of Practice (Code) for all participants in the processing of claims for insurance in superannuation. As such, we broadly welcome the draft document that has been developed by the Working Group.

We also note that the Working Group itself articulates the limitations on its work: the ability to respond to industry issues and having access to information. Our priority is that this Code is not constrained by a lack of ambition and insight and a lack of concern for members.

We fight for fund members every day to ensure they have dignity when they are incapacitated. We hope that funds would join us in that commitment for reasons set out in this submission.

Overall feedback

The ISWG has attempted to define the objective and positioning of insurance in superannuation as

> "*providing a measure of financial support to members and/or their families if the member is prevented from working, either temporarily or permanently, to retirement age by death, terminal illness, injury or ill-health. This objective has to be balanced with the broader purpose of superannuation being the provision of retirement benefits for those that do have a full working life, recognising that insurance premiums will erode those sums to some extent. The challenge for superannuation funds is managing these competing objectives and making sure that the balance between meeting needs and affordability is appropriately established and managed into the future."*

We support this proposed objective but we also believe the wider responsibilities of funds and insurers should also be formally articulated.

While it is important that member entitlements are not overly eroded, it is also critical that funds do not overreact to this objective and undermine insurance benefits such that members will not have adequate financial support in the event that they cannot work due to injury or illness. It is also critical that members not be unduly disadvantaged by any proposed changes recommended by this process.

Funds generally work hard in the best interests of their members and trustees have very clear fiduciary duties. But on any reading of their specific responsibilities, and by extension the objectives of this consultation paper, there are critical issues that need to be dealt with as a priority - the tightening of definitions, the barriers to making claims, the emergence of junk insurance policies, the eroding of benefit value amounts, and general downward pressure on consumers' insurance cover in super.

In relation to the consultative process established by the Working Group, we do note that there has been some limited consultation with one consumer rights legal centre and one individual private/plaintiff lawyer. However, we do not believe that consumers and their representatives have been adequately consulted.

Maurice Blackburn represents more members/clients in their claims than any other firm. The Australian Lawyers Alliance (ALA) is the peak group for lawyers working in the sector. Neither Maurice Blackburn nor the ALA were formally included in any of the consultation structures, despite initial guidance that we would be.

The submissions made by Maurice Blackburn have not been presented on the relevant websites.

We are concerned that the process has not genuinely been transparent and that the structure lacks accountability. We are also concerned that the outcomes are a lowest common denominator exercise where consumer interests are secondary to finding a compromise across diverse private/fund interests. We fear the failure of the Working Group to deal with definitions is reflective of this malaise.

In relation to transparency, we would also welcome the reporting of any profit sharing of funds with their insurance provider. We note section 8 of the draft code. There is obviously a potential conflict between trustee obligations to the member and any profit share arrangements with an insurer. Such conflict needs to be carefully managed and this reporting would clearly assist.

Notwithstanding the weaknesses of this process, we welcome the industry's broad commitment to introducing a comprehensive code that will improve compliance and improve the experience of consumers.

In relation to the suggestion that the superannuation industry work with legal representative bodies to develop protocols for the engagement of legal practitioners in claims, we would welcome this opportunity. We have publicly advocated as such for over two years and engaged directly with a majority of the ISWG founders on the same basis.

The ALA and Law Societies – as legal representative bodies – have also advocated the development of such protocols and would be willing to do this in the future.

In relation to the behaviours set out in the draft code and the version promoted by Maurice Blackburn and the ALA, we have complied with the internal review processes, have not issued court proceedings prematurely and only do so in the event of excessive delay, a claim denial, or to protect a limitation expiration, where we believe there is reasonable prospects of success. As such, we would be well prepared to meet any standards in the Code.

Lawyers are subject to very comprehensive regulation regarding behaviour, standards of practice and particularly in relation to legal costs. To meet such proposed protocols would be consistent with the operating framework and approach to date.

We note that section 9 "Promoting our Insurance cover" in the draft code is silent in supporting members in accessing legal representation. There needs to be a clear, constructive point made - for instance "…not actively discourage members from engaging a representative of their choosing".

Furthermore, a further section (ie a new 9.5) should be incorporated that sets out the responsibilities to clearly explain any changes to cover and definitions; whether the cover is increased or decreased and why; whether the definition has been tightened and why; or limits or reduces circumstances in which you will be covered and why.

B.1 Feedback questions – Scope of the Code

1. How should the ISWG ensure that all trustees are bound by the Code*?*

Our response:

Consistent with the public advocacy of the ALA and Maurice Blackburn over the past two years, all participants in the claims process should be bound by the code. This includes lawyers and financial advisers submitting claims.

The ASIC Regulatory Guide 183 sets out the requirements for a Code to be endorsed by ASIC. RG 183.20 States:

> *As such, a code should satisfy the following criteria:*
> *(a) the rules contained in the code must be binding on (and enforceable against) subscribers through contractual arrangements;*
> *(b) the code must be developed and reviewed in a transparent manner, which involves consulting with relevant stakeholders including consumer representatives; and*
> *(c) the code must have effective administration and compliance mechanisms.*

However, the draft Code states that "the Code does not apply once you commence proceedings in any court, tribunal or external alternative dispute resolution process (with the exception of the SCT and AFCA)." (paragraph 3.17).

By contrast, RG 183 sets out the specific interaction between EDR process and Codes and states (paragraphs 65 and 66) that Codes must reflect the operation of dispute resolution processes and vice versa.

RG 183 sets out in paragraph 20 that:

> *As such, a code should satisfy the following criteria:*
> *(a) the rules contained in the code must be binding on (and enforceable against) subscribers through contractual arrangements;*
> *(b) the code must be developed and reviewed in a transparent manner, which involves consulting with relevant stakeholders including consumer representatives; and*
> *(c) the code must have effective administration and compliance mechanisms.*

It is unclear how these two requirements – paragraph 3.17 of the Code and paragraphs 20, 65 and 66 of RG 183 - will be reconciled.

Furthermore, if some form of contractual arrangements will be pursued; we advocate that such arrangements are critical.

Finally, the draft Code has been developed "closely" following RG 183 but it does not specifically state that the code will be submitted to ASIC for approval. It is important for the Working Group to formally state whether the Code will be submitted to ASIC for approval and when.

2. What are the practical implications of the transition arrangements*?*

Our response:

The timelines and transition for existing policy arrangements are reasonable, striking a balance between protecting consumer interests and effective implementation.

3. **What flags will be required to be built into a trustee's (or their administrator's) system as a result of the Code requirements (for example, whether a member is an Automatic Insurance Member, whether they have chosen to retain their cover even when not making contributions, whether they require assistance as a vulnerable consumer)*?***

No response.

B.2 Feedback questions – Premium Limits

4. **Are there alternative proposals for setting maximum premium levels that the ISWG should consider*?***

5. **Are there particular measures of earnings that the ISWG should include in Good Practice Guidance*?***

Our response:

The priority is to allow us to strike the right balance in sufficiently insuring members, whilst avoiding unreasonable account balance erosion. Modeling should be completed to demonstrate the actual death and TPD cover (or range of cover) a member could expect to get automatically based on the premium cap proposal across a range of scenarios such as age, occupation class and income. We have not seen any data regarding the premium percentage of Superannuation Guarantee Contribution currently being paid by trustees on behalf of their members. Without that data, the consequences of 1% or .5% cap cannot be appreciated in real terms.

6. **For superannuation funds – how would you approach the design principles, including the premium limits*? Do your current premiums fall within or outside of the maximum limits provided? (Note that this information will be treated confidentially).***

7. **What impacts are the premium limits likely to have on benefit design and premiums*? Are there financial impacts that the ISWG should take into account?***

No response to the above.

8. **To what extent will the premium limits achieve the goal of targeting inappropriate account erosion for low income earners, particularly women and younger members*?***

Our response:

We support selective targeting of inappropriate erosion amongst particular cohorts of members. As the Working Group may or may not be aware, we articulated that support in our previous submissions to the ISWG.

Premium limits are a logical method of achieving this for those specific groups as long as the tools are not blunt or unduly undermining the important role group insurance plays.

These sorts of life events are typically reasons for consumers to think about whether to have insurance cover or not.

It is also important that fund systems provide adequate flags to ensure policies are updated when circumstances change. For example, members' birthdays. When a member turns 25 then they should become automatically incorporated in to the opt out insurance cover system.

Furthermore, discussion in the sector has suggested that funds may remove income protection (IP) from the policies and/or TPD benefit values would be reduced. Either outcome would be to the detriment of members' interests.

9. What are the likely impacts of a trustee reducing cover for some segments of its membership in order to reduce premiums*?* How would the trustee manage a member who wanted to retain their original cover*?* Could this member remain an Automatic Insurance Member*?*

Our response:

We have previously advocated a transparent, consistent structure to compare the quality of insurance products. At present, there is significant confusion and a lack of understanding of the quality of group insurance products due to the likes of draconian definitions, barriers to access, and supplementary physical tests for eligibility, work hour tests and occupational prohibitions.

Some form of categorisation and comparison between policies would then enable effective engagement with members over these issues.

To date, reductions in cover have come without reference to any form of benchmark or standard and on occasions have been described as a change rather than any specific diminution of benefit.

With an established benchmark, members could make an informed choice to shift from a (say) 1% cap to a 2% or 3% cap with the accompanying benefits clearly articulated on an opt out basis and not subject to individual underwriting. If they are comfortable with the greater amount being taken from their account balance, and they know what that amount is, then they should be able to choose.

Cancellation and Cessation of Cover

10. What are your views on the proposed cessation and reinstatement mechanisms*?*

Our response:

In relation to paragraph 4.20 (b) of the draft Code, where cancellation is undertaken over the phone, we advocate that this must be confirmed immediately by the fund in writing with an accompanying cooling off period to ensure the full consequences are understood by the member.

In relation to paragraph 4.22, we suggest that a further element of information be added:

> "We will tell you the value of the insurance cover that you are cancelling and important life events to take in to account before cancelling insurance cover such as family/ financial commitments/ occupation/age/ or if their employer provides insurance cover."

This will ensure the full consequences of opt out/cancellation are clear.

In a similar sense, we also suggested adding to 4.22 information regarding insurance with other superannuation funds. For instance:

> "If you are cancelling insurance in another fund you should ensure that you have adequate cover elsewhere. If we identify you have insurance in another fund we will undertake to ensure you are at no disadvantage in cancelling your insurance in another fund."

We believe it is critical that any regret of consumers and members be minimalized, and that full information is provided to those making the decision to opt out.

Duplicate Insurance Cover

11. What more could the Code do more to help members identify whether they have duplicate insurance, and determine whether this is appropriate for them*?*

Our response:

There needs to be a mechanism to ensure members can make an informed choice to rationalize their insurance. The current draft Code does not do that, and the lack of consistent definitions is only one reason why the draft is inadequate.

We advocate that there needs to be standard benchmarks of comparison.

For instance, an ATO or Government mandated comparison website between insurance policies could be established.

We have previously advocated for the establishment of a five star system where stars are reduced where (a) there are deviations from SIS Act standards, (b) excessive barriers are created for clients and members making a claim, (c) junk clauses based on hours worked, (d) exclusions based on occupation, and (e) unreasonable medical and physical tests are required.

It is only through a like to like comparison that members can be sure they are not switching into a policy with reduced benefit amounts and tougher eligibility rules and definitions.

It is also critical information in rationalising superannuation policies, where multiple policies are held by an individual and they chose to rationalise. It forms the basis of a "no disadvantage test" for any rationalisation.

But members are not necessarily disadvantaged by multiple policies or choosing not to rationalize.

The underlying characterization of multiple policies of the Working Group process has been negative but we have witnessed the transformative effect on consumers of having multiple insurance memberships.

We submit three specific case studies involving our clients as to the benefits of multiple policies.

Case Study A

Our client was a maintenance worker at a winery in South Australia. He had always worked full time in a heavy manual capacity. On 5 February 2014 he suffered a stroke and lost the use of the right side of his body, as well as suffering from memory loss, difficulty with speech and numbness/tingling over his entire body.

Because he did not suffer with a work-related injury, he did not think he could claim any benefits. He was struggling on a Disability Support Pension (DSP) and was not aware that he had any superannuation entitlements until he sought our assistance.

Our client was found to have the following several fund memberships and insurance policies that were of significant benefit to him:

- Fund A membership: Income Protection - $3,000per month, payable for two years and TPD benefit - $61,304.20
- Fund B TPD benefit - $186,160.87
- Fund C TPD benefit - $86,594.04
- Fund D Super TPD benefit - $40,806.66
- Fund E Super TPD benefit - $113,011.19

These claims meant that rather than relying on the DSP and living a meek existence, he and his family are now able to live a life of dignity. These claims have changed his life and he was very appreciative of our work.

Case Study B

Our client is aged 50 years old and was a truck driver all of his life. The client injured his shoulder in a truck accident and had surgery, but has never been able to drive again.

Again, this client was found to have several policies that were of significant benefit to him:

- Fund A TPD - $69,600 and Income Protection: $3,000/month
- Fund B - $78,380
- Fund C - $107,600

Case Study C

Our client is in his late forties and a mechanic with a bad lower back injury; he had been a mechanic and storeman all of his working life. He has subsequently had to have surgeries to his back.

Upon investigating his claim we found several insurance policies this client was entitled to, again which were of significant benefit to him:

- Fund A - $239,000
- Fund B - $279,143
- Fund C - $65,460
- Fund D - $20,900

This client has used the money he has received to pay off his house and to support his family, together with ongoing medical bills.

B.3 Feedback questions – Helping members to make informed decisions

12. Which parts of the Code require particular attention for consumer testing*?*

Our response:

We submit that the following aspects require consumer testing:

- Appropriate and Affordable cover
- Vulnerable consumers
- Premium adjustments – and why
- Changes to Cover
- Changes to Definitions
- Complaints process

13. How could the Key Facts Sheet template better assist members to understand and compare their cover*?*

Our response:

The Key Facts Sheet is an important initiative and we support it, consistent with our past advocacy of such a reform. It demonstrates the complexity of the system that we deal with on a daily basis for our clients.

In relation to specific aspects of the proposal, we offer the following feedback:

- Under “Why this is important” it would add value to insert after “to help protect what’s important to you” the phrase “if you have to stop work due to unexpected illness or injury.” We do not believe “life changing events” is adequately clear.

- The TPD definition is misleading – it says “pays a lump sum payment if not able to work again due to illness or injury” and as a result, (and contrary to our experience) most people would assume that they would not qualify reading it in its present form. It also fails to note any hours of work or occupational requirements.

- The question “Is cover provided if a claim has previously been paid under another super fund = No” has two significant shortcomings: it implies that multiple claims cannot be made even if the policies permit such a claim (as outlined earlier) when it appears its purpose is to prevent someone being declared TPD say 10 years ago and then claiming TPD again subsequently.

- The framing of the FAQ’s “you may not need a lawyer to make a claim or to have your claim reviewed” is clearly a negative frame and undermines the choice that members currently have. We would submit a neutral proposal is more appropriate, such as “You may have a representative to help you with your claim such as a lawyer, financial counsellor or advisor, or other representative. You are responsible for any fees that may be associated with representation”. This would be consistent with 13.21 of the draft Code.

A further template should be developed as to the insurance information that would be provided to members with the periodic membership statement. It should state both their entitlement and their eligibility based on their work patterns, income and occupation. Funds

will now hold that information and it should not be a prohibitive burden to provide such a report.

More generally, we continue to query why some funds continue to pursue an anti-lawyer agenda and discourage their members to accessing outside help. Trustee's duties and obligations require they act in the best interests of their members; in our submission this extends to respecting the members' choice to engage lawyers or others to assist them with the complexities of the claim process.

We should also note that we are not aware of a fund actively pursuing an insurer decision in the courts on behalf of their member. If they do not believe their obligations extend to protecting member's interests into EDR and the courts, then why would they then discourage members accessing legal representation?

14. Do the communication requirements in the Code achieve the right balance between prescription and trustee flexibility*?*

No response

15. What further steps could be taken to engage members who are making no contributions or low or infrequent contributions*?*

Our response:

Often these members are vulnerable in some way – injured, ill, complicated domestic arrangements, or their employer is failing to pay SG. In relation to this final group, the low or infrequent contributions is a wider issue and community wide issue that needs be factored in to the design of the Code.

The recent Senate Report in to Superannuation Guarantee employer non-compliance estimated that the consequence of SG noncompliance is 2.4m workers are affected and those workers lost, on average, $1,500 annually in superannuation contributions. [1]

As such, the flagging of infrequent and low contributions should also be assisted in pursuing non-compliant employers.

Specialist consumer testing of these groups of workers is critical in ensuring is design to protect their interests; that is not just consumer testing confined to "well" members.

B.4 Feedback questions – Claims Handling

16. What are the practical implications of the obligations that are placed on trustees*?* How can any practical difficulties be overcome in a way that improves members' experience of the claims process*?*

No response

17. Will the requirements at section 6.28 of the Code to provide a person claiming with information about a decline (including all documents obtained during the assessment) and the ability to provide further information in all cases cause

[1] http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Economics/SuperannuationGuarantee/Report page 13

delays and/or cost to the claims process*?* If there are concerns with these requirements, can specific examples be provided of the difficulties these requirements cause*?*

Our response:

We submit that from the members' point of view the 15 day review period of a declined claim is a positive step and will contribute to reducing delays in the process. However we submit that 6.28 e) is unnecessary and will add on further unnecessary delay. We note that once 6.28 a) to d) is complied with then members can use the internal review process set out in s101 of the SIS Act to lodge a complaint against the decision which will include further representations and submissions or further information in relation to the claim. Our current experience is that usually any further submissions or information submitted after procedural fairness documents are provided to us and our client, have little impact and the declinature is maintained. Members would be best served by going directly to the IDR process.

By contrast 6.29 is not adequate and could lead to further delay as this effectively "stops the clock" until further information is provided. It undermines the intent of resolving disputes in a timely manner.

Furthermore, paragraph 6.30 does not add value. If a fund has formed a view a decision is unreasonable then they can impose a decision, pay it themselves so the consumer is not delayed and pursue the insurer themselves without inconveniencing their member.

18. What are the implications of the requirements on trustees to oversee and review ongoing income protection payments*?*

No response.

B.5 Feedback questions – Vulnerable Consumers

19. Does the Code require more prescription as to how trustees will support vulnerable consumers*?*

Our response:

Consumer experience should be enhanced if the Code is complied with and executed well, including the experience for vulnerable consumers.

It is also important for funds and insurers to ensure their exclusions of cover for members with pre-existing mental health not offend discrimination legislation at the Federal or State level. An insurer can positively discriminate only if it meets the tests in Section 46 of the Disability Discrimination Act 1992, ie that it is based on actuarial or statistical data.[2] There is also equivalent state legislation in this regard.

20. What more can be done to ensure that members who are granted release of funds for terminal illness do not lose their insurance cover*?*

No response

[2] http://www6.austlii.edu.au/cgi-bin/viewdoc/au/legis/cth/consol_act/dda1992264/s46.html

B.6 Feedback questions – Premium Adjustments

21. Are the premium adjustment arrangements sufficiently transparent*?*

Our response:

The proposal set out in section 8 of the draft Code is an important step in delivering transparency. However, this reporting could take place today, or on the first date of the effective operation of the Code rather than waiting 12 months.

We would also advocate that any hospitality and gifts to trustees and managers, other forms of payment to the fund or support in kind offered by insurers also be reported.

22. What further detail could the Code include*?*

Our response:

We have long advocated for consistent definitions in policies; the draft Code obviously fails to deal with this issue. Maurice Blackburn has been particularly concerned with the change of definition from “unlikely” to “unable”.

“Unlikely” has been interpreted by Australian courts to require a consideration of “the real world”, namely market conditions, in assessing whether the person is unlikely to return to work given their injuries or illness.

By contrast, “unable” is a medical assessment without consideration of the “real world”. For instance, it is possible to argue that even a quadriplegic is theoretically capable of work and may not satisfy an “unable’ definition”. As a consequence, the insurance effectively becomes junk insurance.

In 2014, a major fund with over a million members changed its TPD definition to remove the word “unlikely”. It now requires claimants to demonstrate that they are “incapable of ever engaging in any occupation for which [they are] or may become reasonably suited by education, training or experience”.

The industry generally considers that the threshold “incapable of ever engaging” is much higher than “unlikely” as found in the regulations, hence their policy change to limit their liability to pay claims. Further, the standard of work that is considered appropriate is lower than that provided for in the regulations. Ultimately this means that claimants can have claims rejected, even if it is unlikely that they will engage in employment similar to that which they were performing before the accident.

The NSW Court of Appeal considered the “unlikely” TPD test and found that “a real chance that a person will return to relevant work, even if it is less than 50%, will preclude an Insured Person being unlikely ever to return to relevant work.” We advocate that such a test is sufficiently onerous.

It is pleasing to see that some other major funds have resisted pressure from insurers to depart from the ‘Permanent Incapacity’ test and have kept the “unlikely” definition. The fact that such definitions are being retained by some confirms the viability for doing so across all insurers.

B.7 Feedback questions – Promoting our Insurance Cover, Changes to Cover

23. What are the practical implications of the Code obligations for trustees*?*

No response

B.8 Feedback questions - Refunds

24. What are the practical and administrative implications of the refund requirements provided*?*

No response

25. Are there any issues with the maximum time limits for the duration of refunds*?*

No response

26. For superannuation funds – what are your current practices for refunding premiums, and the duration of any refunds*?*

No response.

B.9 Feedback questions – Staff and Independent Service Providers

27. Do the standards for training and monitoring staff require further detail*?*

No response.

28. What are the practical implications of requiring trustees to ensure Independent Service Providers comply with the Code*?*

No response.

B.10 Feedback questions – Enquiries and complaints

29. Do the processes for making enquiries and making complaints require further detail*?*

Our response:

The proposed contents of 13.5 and 13.6 of the draft Code have significant implications for consumers. The right to access of information is less than what is accessible under FOI regimes around Australia. If there is a true commitment to transparency, then the standards of FOI should be reflected in the Code.

B.11 Feedback questions – Governance, Enforcement and Sanctions

30. Is the governance framework appropriate, taking into account ASIC's requirements for approval of the Code, and the governance provided by existing financial services codes*?*

Our response:

Our initial analysis is that the self-reporting and self-regulation in the draft Code is similar to other sector codes. We believe the arrangements would be enhanced if there was an audit function committed to by the Code Administrator in 14.3 – indeed this is likely a requirement of RG183 - see RG183.22(d).

We suggest the addition of a 14.3(j) that is….

> …*ensuring there is a regular external audit of Claims function of Trustees conducted to satisfy itself that self-reporting, claims handling, training, education, data management, adequate cover and communications are all compliant with the Code, RG 183 and industry standards.*

The draft Code is clearly a comprehensive attempt to ensure consistency with RG 183 and consumer confidence will be further enhanced if the Code is registered with ASIC.

In relation to reporting of key data sets, we have advocated that mandated reports be developed as a matter of urgency including the number of claim enquiries, lodgments, acceptances, declines and acceptances after internal or external review, and the average time taken for each category.