INSURANCE IN SUPERANNUATION VOLUNTARY CODE OF PRACTICE

1 February 2021 v.4[1]

What is the Insurance in Superannuation Voluntary Code of Practice?

The Code is the superannuation industry's commitment to high standards when providing insurance to members of superannuation funds.

Insurance in superannuation provides a safety net of cover for Australians. Insurance in superannuation is usually provided automatically when a member joins a fund. Members may reduce or cancel their cover at any time, and this process will be made straight-forward and transparent. Members may also apply to increase their cover to meet their individual needs.

TABLE OF CONTENTS

1. Introduction 2
2. Objectives 2
3. Scope of the Code 2
4. Appropriate and affordable cover 4
5. Helping members to make informed decisions 8
6. Supporting vulnerable consumers 10
7. Handling claims 12
8. Premium adjustments 16
9. Promoting our insurance cover 16
10. Changes to cover 17
11. Refunds 19
12. Staff and Service Providers 20

[1] Previous versions:
1 March 2020 v.2 (PYS and PMIF)
1 July 2020 v.3 (Restarting of cover)

13. Making enquiries and complaints 21
14. Promoting, monitoring and reporting on the Code 23
15. Definitions 24

1. Introduction

1.1 The Insurance in Superannuation Voluntary Code of Practice (**Code**) contains standards that we will uphold on an "if not, why not basis" when providing insurance benefits to you.

1.2 "We" are superannuation fund trustees that have adopted the Code.

1.3 "You" are members of our fund who are insured through cover that we arrange, and your beneficiaries.

1.4 We will ensure that you are aware of your rights under the Code, by making the Code available to you on our website, and explaining our Code commitments in relevant communications and marketing materials.

1.5 Definitions for important terms are in bold and can be found at the end of the Code.

2. Objectives

2.1 The overarching objective of the Code is to improve the insurance in superannuation offered to you, and the processes by which we provide insurance benefits to you.

2.2 In carrying out our commitments under the Code, we will be:

a) transparent
b) fair
c) respectful
d) honest
e) timely.

2.3 Insurance offered on an automatic basis in superannuation must be appropriate and affordable, and must not **inappropriately erode** retirement income.

2.4 Our communications to you will be clear, timely and in plain language, to assist your understanding of the role of insurance in superannuation and the details of your insurance cover.

2.5 We will play a visible role in the claims process, and ensure you receive regular updates as well as a decision on your claim in a reasonable timeframe.

3. Scope of the Code

Who is bound by the Code?

3.1 The parties bound by the Code are superannuation fund trustees who have adopted the Code.

3.2 We will ensure our staff and our **Service Providers** comply with the Code when they are acting on our behalf.

What products are covered by the Code?

3.3 The Code covers insurance products held by superannuation funds. These are commonly referred to as:

a) death cover, which pays on the death of an insured member, or if they are diagnosed as terminally ill with a life expectancy less than a specified period (generally 12 or 24 months)
b) total and permanent disability (TPD) cover, which pays if an insured member becomes disabled and is unable or unlikely to ever work again, or unable or unlikely to look after themselves ever again
c) income protection cover, which is designed to provide a replacement income of a specified amount for members who are unable to work due to illness or injury. Depending on the policy, payments may continue up to a specified age if the disability is ongoing or permanent, or may be payable for a specified maximum period.

3.4 The Code does not cover insurance products held outside superannuation funds, including health insurance products issued by health insurers.

When does the Code apply from?

3.5 The Code starts on 1 July 2018, and we will state on our website by 31 March 2018 our intention to adopt the Code. By 31 December 2018, we will publish on our website our transition plan for how our funds will become compliant with the standards of the Code.

3.6 Our transition plan will include when and how we will comply with the following sections (which can have different dates of compliance):

a) benefit design and premiums (sections 4.1 to 4.9)
b) automatic cessation of cover and reinstatement (sections 4.20(e) and (f), 4.27, 4.28 and 4.29)
c) the rest of the Code.

We will comply with the Code as early as we can, and no later than 1 January 2022, to allow for our existing contractual arrangements to be adjusted.

3.7 For applications for insurance, claims or complaints that already exist on the date we transition to the Code, if the Code commits us to do something within a specified timeframe, that timeframe begins on our date of transition.

Our relationship with insurers

3.8 We will work closely with our insurers who issue the cover that applies to you, to ensure you have a consistent end-to-end experience.

3.9 Life insurers who are members of the Financial Services Council are bound by service standards, set out in the Financial Services Council's Life Insurance Code of Practice

(**Financial Services Council Insurer Code**). Any contract that we enter into with an insurer will require both parties to comply with the code to which they subscribe.

Legal status of the Code

3.10 The Code operates alongside and is subject to existing laws and regulations. Where there is any conflict or inconsistency between the Code and any law or regulation, that law or regulation prevails.

3.11 We have a legal requirement to perform our duties and exercise our powers in the best interests of our beneficiaries. We will comply with our commitments in the Code to the extent that they are in the best interests of beneficiaries and consistent with our other legal duties. However, we cannot comply with anything in the Code that limits our ability to comply with our statutory and general law duties, and our trust deed. This may require us to alter our Code commitments, which we will publish in our annual Code compliance report. We will use our discretion when making decisions about the insurance benefits that we provide.

3.12 The Code does not limit your rights under any law or regulation.

3.13 The Code does not apply if you start proceedings in any court, tribunal or external alternative dispute resolution process (with the exception of the **External Dispute Resolution** organisation that is relevant to your complaint).

4. Appropriate and affordable cover

4.1 For the purposes of sections 4.2 to 4.9, “you” refers to members who have been provided automatic insurance cover but does not include you if:

- you have voluntarily selected your level of cover;
- you have varied your automatic insurance cover;
- you are a defined benefit member; or
- your insurance premiums are wholly paid for by your employer (whether through contributions to your superannuation account or otherwise) or not paid by deduction from your account

Automatic insurance cover or default cover is cover that we provide on behalf of our membership to provide members with automatic protection against unexpected events,

illness or accidents. Automatic insurance cover is not tailored to individual needs and circumstances.

You are considered to have automatic insurance cover in circumstances where you elect to take out or maintain the default insurance cover that we provide automatically even if:

- you are under the age of 25 years;
- you have a super account balance that is less than $6,000; or
- your account has become inactive.

Benefit design

4.2 Insurance in superannuation is often provided automatically. We will design automatic insurance cover with the objectives that they are appropriate and affordable for our membership.

4.3 We will publish our insurance strategy on our website. This will include an explanation of how we have designed our automatic insurance cover including the types and levels of cover, to help **you** decide whether the automatic insurance cover is appropriate for **you**.

4.4 If a benefit design is determined by a party other than us, for example a sponsoring employer that is paying the premiums, we will review the design to ensure it is appropriate and affordable.

4.5 When we design insurance benefits, we will assess our members' likely insurance needs, including considering the following characteristics of our membership where we know them and believe them to be relevant:

a) age distribution
b) gender
c) industry and occupation
d) work status (for example, full-time, part-time, contract, casual)
e) salary
f) employer contribution levels
g) claims history
h) insurability outside automatic arrangements
i) member feedback based on member research and attitudes to insurance.

4.6 As well as determining the automatic insurance needs of our membership we will design cover that is affordable and does not **inappropriately erode** retirement savings.

4.7 We will adjust cover levels or other factors impacting cost such as terms and conditions or definitions (subject to legislative, regulatory and Code constraints) so that we are satisfied that our automatic insurance cover is affordable.

4.8 As part of determining affordability, premiums for automatic insurance cover will be set at a level that does not exceed 1% of an estimated level of salary for our membership generally, and/or for segments within the membership, subject to 4.8(c) below.

We will document and publish:

a) our basis for determining an affordable level of cover within the 1% of salary limit(s) for our membership generally and/or for segments within the membership
b) the measures of salary and timeframes we have used to apply the 1% of salary limit for our membership
c) the rationale for instances in which premiums for automatic insurance cover exceed 1% due to particular circumstances relating to the membership generally and/or segments within the membership.

Categories of our membership

4.9 We will not automatically include you in a division of our fund that is higher risk than the membership generally due to smoker status or occupation (where such a designation exists) without relevant evidence. We will set out and publish the basis for determining any such default settings for our membership in a manner that is easily accessible to **you**.

Reviews and changes to benefit design

4.10 We will review and update as necessary the benefits we offer and the policy details at each insurance contract renewal (and our review will occur no later than every 3 years), to ensure they remain appropriate and affordable.

4.11 We will assess the premiums for automatic insurance cover at each policy renewal (and no later than every 3 years) to ensure premiums remain consistent with section 4.8 above.

4.12 If we decide to change any of the benefits offered (including the definition of the benefits) as part of your cover, we will provide you with details of the changes and any options available to you to change or cancel the new cover.

4.13 If the impact on your cover or premiums is material,[2] we will let you know **in writing** at least 30 days before the changes take effect.

Cancelling your insurance cover

4.14 You can cancel or reduce the insurance cover which we arrange for you at any time, and the associated premiums will no longer be deducted from your superannuation account. You can cancel part of your cover and keep some of it, provided this is permitted under our fund rules and the insurance policy. We will make the process straight-forward. You can cancel or reduce your cover in the following ways, subject to appropriate member identification: [3]

a) via our website, the insurer's website or our digital application
b) over the phone
c) **in writing** by email or post.

4.15 We will include clear instructions on how to cancel or reduce your insurance cover in your insurance welcome pack, our disclosure information, your annual statement, and on our website. If you request a cancellation form, we will send it to you within 5 **business days**.

4.16 As part of the cancellation process, we will tell you that:

[2] In line with the requirements of section 1017B of the *Corporations Act 2001*.
[3] The cancellation standards in the Code do not apply to members of a defined benefit fund, in which the value of the retirement benefit is defined by the fund rules, or where the insurance arrangement with an employer does not allow for member cancellation.

a) you will not be able to make a claim for insurance benefits for events or conditions that arise after your cover has cancelled
b) we will no longer deduct insurance premiums from your account
c) your ability to restart your cover may be subject to health assessment and acceptance by the insurer, and you may not be able to get cover
d) if you are replacing your cover with alternative cover, you should not cancel until the replacement cover is in place
e) you can get independent financial advice to help you to make a decision on cancellation.

4.17 We will confirm that you have cancelled your insurance cover and the date on which your cover will stop **in writing**.

4.18 If you cancel within 14 calendar days of us telling you that we have provided you with automatic insurance cover or that we have increased your level of automatic insurance cover, any premium we have deducted from your account for that insurance cover will be waived or refunded back to the cover start date or the start of the increased cover (as applicable). No cover will then apply for that period.

Communicating to you when we are required to cancel your cover

4.19 We are required by law to cancel your insurance cover in some circumstances, unless you tell us in writing that you want to keep it[4].

4.20 If we stop providing your cover because we are required to by law, in addition to the notification that law requires us to provide to you prior to this change, we will confirm this **in writing** within two weeks of the date on which your cover stopped. This communication will include the following:

a) details about the insurance cover that has stopped (sum insured, premium, etc)
b) the date the cover stopped
c) your options to restart your cover, including any terms or conditions which may apply if your cover is reinstated
d) confirmation that you may still claim insured benefits for any events or conditions that occurred before your cover was stopped
e) general information that you can get independent financial advice to help you to make a decision
f) general information about the impact of insurance premiums on retirement savings, should you choose to reinstate or recommence your cover.

Restarting of cover when we were required to cancel your cover

4.21 If your cover is stopped, we may offer you an option to restart your cover. We will clearly explain what options are available to you in our product disclosure statement, including whether you are able to continue your insurance under the same arrangement or a different arrangement.

4.22 If your cover is stopped due to termination of employment, we may offer an option for you to continue your insurance under a different arrangement.

[4] These circumstances are explained in the Superannuation Industry (Supervision) Act 1993 (principally Ss:68AAA,68AAB, 68AAC and 68AAD).

4.23 Where you apply to restart cover after if it has stopped, we may require a health assessment to determine if your cover can be restarted and any additional terms that may apply.

4.24 Restarting of cover may require you to pay unpaid premiums from your account. Should your account balance be insufficient to cover any unpaid premiums, we will provide you an opportunity to make contributions to your account to top up the balance if you wish.

Duplicate insurance cover

4.25 When you become a member of our fund, we will ask your permission to help you to determine whether you have any other insurance cover in a superannuation fund. The purpose of this is to ensure you do not unintentionally pay premiums for multiple insurance covers, or for any cover on which you may be unable to claim. If we identify that you have other insurance cover, we will let you know.

5. Helping members to make informed decisions

How we will provide you with information

5.1 We will help you to make better informed decisions by giving you appropriate and easy-to-understand information when we provide you with cover and on an ongoing basis.

5.2 We will seek to understand the characteristics of our members, so that we can tailor our communications.

5.3 We will use plain language in our insurance communications, and will limit the use of jargon and acronyms. If acronyms or jargon are used, plain language definitions will be provided. We will ensure that the wording of key insurance concepts has been consumer tested for comprehension.

5.4 We will regularly review the insurance communications that we provide to ensure they are appropriate and consistent.

5.5 We will publish a Key Facts Sheet for our automatic insurance cover in a standard industry format on our website.

5.6 The purpose of the Key Facts Sheet is to provide high-level, fund-specific insurance information in a format that is consistent across the industry, to help you to better understand your cover and to compare cover across different superannuation funds.

5.7 We will also provide you with clearly identifiable insurance-specific information in a welcome pack when we provide you with automatic insurance cover. This may be provided as part of a broader welcome pack about our superannuation fund.

5.8 The purpose of the insurance welcome pack is to give you greater awareness and better information about the automatic insurance cover that you receive from us.

5.9 The insurance information in our welcome pack will contain the following:

a) a copy of the Key Facts Sheet
b) how much you are insured for
c) the premiums you will pay

d) any other information specific to you that is not included in the general information on the Key Facts Sheet
e) that you should consider whether you hold cover elsewhere, either within another fund or outside superannuation, and the impacts of holding multiple insurance covers
f) a link to the Code
g) a link to the product disclosure statement and other relevant insurance information on our website.

5.10 We will make the following information easily accessible on our website, and provide you with hard copies upon request:

a) the Key Facts Sheet
b) the product disclosure statement for our automatic insurance cover
c) information about the benefits and costs of insurance in superannuation
d) information on how to cancel your insurance and the consequences of cancelling
e) how to make a claim
f) how to make a complaint.

Explaining our definitions

5.11 We will clearly explain on our website and in our product disclosure statement our intention in providing total and permanent disability and income protection cover, and how the definitions that we use will be applied in practice.

5.12 We will agree on the interpretation and application of our definitions with our insurers to ensure a consistent approach.

5.13 We will undertake a regular review to ensure the interpretation and application of our definitions are consistent with any changes in our policy terms, and our insurers' approach.

5.14 We will use the following standard headings that are relevant to our total and permanent disability cover:

a) Total and permanent disability – [unable/unlikely] to do a suited occupation ever again
b) Total and permanent disability – [unable/unlikely] to do your own occupation ever again
c) Total and permanent disability – [unable/unlikely] to look after yourself ever again
d) Total and permanent disability – [unable/unlikely] to do basic activities associated with work ever again
e) Total and permanent disability –permanent loss of intellectual capacity
f) Total and permanent disability – loss of limbs and/or sight
g) Total and permanent disability – suffering a specifically defined medical condition and permanently unable to work because of it
h) Total and permanent disability – significant impairment to your whole body.

5.15 If the total and permanent disability definition that we use has more requirements than those listed above, we will ensure they are described in similar plain language terms to the descriptions above.

5.16 If the total and permanent disability definition that we use is different from the standard definition which allows superannuation benefits to be released under legislation,[5] we will explain the differences in plain language.

Communication during the term of your cover[6]

5.17 We will provide you with an annual statement which includes the following information:

a) the types of cover you hold and how much you are insured for
b) your current premium
c) an explanation for any change in your premiums
d) the policy's standard exclusions and benefit limitation terms that may impact your entitlement to insurance benefits
e) about the impact of insurance premiums on retirement savings
f) information about how to contact us to discuss options if you want to change the terms of your cover
g) how you can increase, decrease or cancel your cover based on your individual needs;
h) information about the Code
i) our rules for automatic cessation of cover
j) what to do in the event of a claim.

5.18 We will contact you about your insurance cover if we become aware that:

a) a change in your employment arrangements may impact your cover
b) you are no longer covered due to the terms of the policy.

5.19 The purpose of the communications during the term of your cover is to prompt you to evaluate the appropriateness of your cover, and ensure that you are kept informed of your options to change, review or cancel your cover.

5.20 We will promote any digital tools that we provide, to help you to monitor your account and your contributions, the cost of insurance and the impact on your balance.

Lost members

5.21 We will use our best efforts to keep our members' contact details current, so that we can provide the communications required by the Code.

5.22 If we cannot contact you as we do not have your current contact details, we may be required to report to the Australian Taxation Office that you are a lost member.

5.23 We will not be in breach of the Code if we are unable to provide you with any of the communications required by the Code.

6. Supporting vulnerable consumers

6.1 We recognise that some people may have unique needs, such as older persons, people with mental health conditions, people with a disability, people from non-English speaking

[5] *Superannuation Industry (Supervision) Act 1993*.
[6] For defined benefits members, the requirements for communication during the term of the cover will be tailored as appropriate to the insurance arrangements in place.

backgrounds, people with low levels of literacy, people in financial distress, people in abusive relationships, and Indigenous Australians, when accessing insurance, making an enquiry, claiming on their cover, making a complaint and communicating with us.

6.2 We will have internal policies in place to help our staff to identify vulnerable consumers and to take practical steps to better assist members who may need further support. This may include referral to people or services with specialist training and experience to appropriately engage with and support them.

6.3 Where you tell us that you require support or where we identify that you require assistance from us, we will provide support or assistance to the best of our ability. We will ask for your permission to keep a record of the support or assistance you require.

Providing information

6.4 We recognise that some groups of consumers (for example, people from Indigenous communities or those from non-English speaking backgrounds) may require support in meeting identification requirements. We will take reasonable measures to assist and a flexible approach to verification and identification in line with AUSTRAC[7] guidance, while still meeting our obligations under the law.

6.5 We recognise that people living in remote and regional communities may have trouble meeting their obligations to provide us with documents and to take part in assessments in the timeframes we set. We will take this into account when going through the underwriting and claims processes.

6.6 If 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 and the insurer to find a solution. This may include endeavours to collect the information on your behalf, with your permission.

Interpreting services

6.7 We will provide access to an interpreter at your request, or where we need an interpreter to communicate effectively with you. We may use an interpreter who is a member of our staff, or an external interpreter.

6.8 We will record your interpreting needs and plan ahead to meet these needs. Where an interpreter is offered but declined, this will also be recorded.

6.9 We will provide a direct link on our website to information on interpreting services and any other relevant information for non-English speakers, including any insurance information that we have translated into other languages.

Guardianship

6.10 Where you are under the care of a State-appointed guardian or administrator or the holder of your enduring power of attorney, any communications we provide will be sent directly to your guardian, administrator or attorney, and we may only accept payment instructions from them.

[7] Australian Transaction Reports and Analysis Centre.

Release of funds

6.11 If we allow our members to receive early release of some of the money in their account on the basis of severe financial hardship or compassionate grounds, we will clearly explain the process on our website. If we do not allow this, we will explain the reasons for this on our website.

6.12 If we grant you release of your superannuation account balance (for example, due to a terminal illness), we will let you know the impact on any insurance cover you still have at the time and that you can choose to leave enough funds in your account to pay the premiums for your cover.

7. Handling claims

Principles for claims handling

7.1 We acknowledge that claim time can be difficult. We will treat you with compassion and respect. We will make the claims process as straight-forward as possible for you.

7.2 We will help you identify any cover held within our fund under which you may be entitled to claim. We will not discourage you from making a claim.

7.3 We will oversee the claims process, and help you to navigate the process.

7.4 We will be responsible for overseeing the conduct of the insurer and any **Service Provider** we engage in the claims process, in line with the standards in Section 12 of the Code. We will proactively engage with other parties in the claims process, such as any representative that you engage, to minimise delays and remove unnecessary duplication from the process.

7.5 We will put in place appropriate governance arrangements for our claims handling.

7.6 We will publish our claims philosophy on our website, and we will assess the claims philosophies of our insurers to ensure they align with our own philosophy.

The claims process

7.7 The claims process incorporates a number of steps, and there are roles for us, for the insurer and for you. You may be required to provide relevant documents and attend assessments.

7.8 The **Financial Services Council Insurer Code** places responsibilities on insurers to determine claims within specific timeframes. We will work together to ensure a consistent and efficient process for you.

7.9 You will be given contact details for the primary contact during the claim process.

7.10 We will have complied with the requirements to communicate with you in this section even if the communications are provided to you by the insurer or a **Service Provider**.

7.11 We may take responsibility for a step in the claim process that is not covered below, such as arranging an independent medical examination or an interview with you. In these cases, we will comply with the relevant standards in the **Financial Services Council Insurer Code**.

Making a claim

7.12 If you tell us that you wish to make a claim, we will help you provide the information for your claim, or direct you to the appropriate forms or information online or email these to you by the next **business day**. If you require hard copy forms, we will send these within 5 **business days**.

7.13 If we receive a completed claim from you,[8] within 5 **business days** we will:

a) acknowledge receipt of the claim
b) assess whether you have provided all of the necessary information and documentation
c) carry out an initial eligibility assessment to assess whether you have insurance cover based on the information available
d) provide you with a summary of the claim process (if this has not already been provided to you when you tell us you wish to make a claim);
e) either provide the claim to the insurer, or tell you that you are not eligible to make a claim based on the information available (in line with section 7.16 below).

7.14 If a claim is made via telephone, a written record or call recording will be kept and can be sent to **you** on request.

7.15 The summary of the claim process that we will give you will include:

a) an explanation of the terms of your cover, including the policy's standard exclusions and limitations
b) the steps involved in the claim process and a reasonable expectation of the end-to-end timeframe for the assessment of the claim, taking into account the timeframes in the **Financial Services Council Insurer Code** and our review of the insurer's decision
c) our role and duties and the role and duties of the insurer
d) who will be your primary contact and contact details you can use to get information about your claim
e) whether you may be required to attend ongoing assessments
f) how payments will be made if the claim is accepted
g) that there may be financial or tax implications and you may wish to get independent advice
h) the impact on the amount of the claim of receiving income from other sources including Centrelink and workers' compensation if offsets are applied
i) how we will review the insurer's decision.

7.16 If we assess that you are not eligible to make a claim, we will:

a) explain this in writing
b) give you the opportunity to provide more information so that we can review your eligibility
c) tell you that if you are not satisfied with our decision, you can make a complaint and we will explain our complaints process.

While a claim is being assessed

7.17 If you have a query about your claim while it is being assessed, we will respond:

a) with an acknowledgment by the next **business day**

[8] A completed claim requires lodgement of claim forms with **us**, or provision of requested claim information via telephone.

b) with a full response within 10 **business days**.

7.18 You will receive progress updates at least every 20 **business days** (unless a different timetable is agreed with you). If there are any issues delaying assessment of your claim, we will let you know what these are.

7.19 We will oversee the progress of the claim to minimise delays and intervene if we become aware that the insurer is not complying with the timeframes provided in the **Financial Services Council Insurer Code**.

7.20 If the insurer tells us that it cannot make a decision on your claim in the timeframes provided in the **Financial Services Council Insurer Code** because information which is necessary for assessment has not been provided, we will tell you the revised timeframes. If your medical condition has not yet stabilised to allow a decision to be made, we will tell you that your claim will be progressed further when more information is available.

7.21 If we become aware of any errors or mistakes in the claim or in the information requested, these will be addressed promptly. We may request more information to correct errors or mistakes.

Review of insurer's decision

7.22 Once the insurer has made its decision on your claim, if the insurer informs us that it intends to make a payment to us,[9] we will carry out a review within 5 **business days** to assess whether you have met the requirements for the money to be released from your superannuation account. We will also have oversight processes in place to confirm that the insurer is paying the correct amount, either to us or directly to you.

7.23 If we identify as part of our review that there are differences between the requirements for your insurance claim to be paid and the legal requirements for the release of funds from your superannuation account, we will clearly explain the differences in plain language.

7.24 If the insurer informs us that it has decided not to pay the claim, we will carry out a review within 15 **business days** of receiving the notification from the insurer. As part of our review, we will determine whether the insurer has provided you with the below, and we will provide you with any of the below that you have not yet received:

a) an explanation in plain language to enable you to understand the reasons for the insurer's view
b) an outline of the evidence relied upon in forming that view
c) a list of all documents obtained by the insurer and us during the assessment, and an opportunity to receive any documents on request
d) an opportunity to make further representations and submissions or provide further information about your claim.

7.25 Wherever possible, when we review the insurer's decision we will use information already collected during the claim assessment process, rather than asking you to provide information again, or to attend any further assessments. If we believe there is not enough information to make a properly informed decision, we will let you know. We will request any

[9] This does not refer to payments that the insurer makes to you directly (such as with some income protection payments).

further information or assessments we need as early as possible and will avoid multiple information requests where possible.

7.26 We will only ask for and rely on information and assessments that are relevant to the claim and policy, and you can ask us to give you an explanation of the relevance of the information requested. If you disagree with the relevance of any requested information, the request will be reviewed. If you are not satisfied with the outcome of the review, we will tell you how to make a complaint.

7.27 If we obtain new information or assessments, or you make further representations and submissions or provide further information, we will have another 15 **business days** from the receipt of the new information to review that information.

7.28 If our review results in us querying the insurer's decision, we will tell the insurer within 5 **business days** of completing our review. If we believe the claim has a reasonable prospect of success, we will advocate on your behalf. We will keep you informed as the claim proceeds.

7.29 In **exceptional cases**, the timeframes for our review in this section may not be appropriate. In these cases, we will tell you that we need more time, and will clearly communicate our revised expected timeframes until our review is complete. We will tell you how to make a complaint if you are not satisfied.

Claim decision

7.30 If the claim is approved and paid to us by the insurer, we will confirm this with you as soon as we have carried out our assessment of whether you have met the requirements for the money to be released from your superannuation account. Within 5 **business days** of confirmation being given, we will release the claim money to you,[10] provided that:

a) valid identification, and payment instructions and other necessary documents have been received from you
b) we have confirmed that the legal requirements for release of funds from your superannuation account have been satisfied
c) for death benefit claims, we have contacted all potential beneficiaries where relevant and given them the opportunity to provide submissions in support of their claim to be paid a benefit.[11]

7.31 If your claim is declined, we will tell you within 5 **business days** of completion of our review:

a) the reasons for the decision in writing in plain language
b) that you can request copies of the documents and information relied on in line with the standards in section 13
c) how you can make a complaint if you are not satisfied with the decision.

Income protection claims

7.32 For income protection claims, we will support the insurer to:

a) seek to identify ways to support your recovery as quickly as possible

[10] For income protection claims, the insurer may make the payments to you directly.
[11] The distribution of death benefits under a regulated superannuation fund is generally at our discretion, applied in line with the terms of our trust deed and subject to the *Superannuation Industry (Supervision) Act 1993*.

b) collaborate with your doctor, other healthcare providers and employer to maximise the health outcomes
c) promote best-practice rehabilitation and injury management where these are consistent with the terms of the policy.

7.33 Where you are receiving ongoing income protection payments, we will have oversight processes in place to determine whether the information you are required to provide is reasonable, and ensure you and your doctor are providing the required information, to assist you to receive timely payments. We will also have processes in place to oversee our insurer's decisions about continuing or stopping income protection payments, and we will raise any concerns that we have with the insurer regarding a decision to stop payments.

7.34 If we become aware that you have made claims against more than one income protection policy, we will explain how the off-setting arrangements operate, and provide you with information about the factors you may want to consider to determine the best financial outcome from your multiple policies. You may be entitled to a premium refund in line with section 11.1 below.

7.35 If we identify that any of your claim payments are going to be offset or reduced by income you are receiving from other sources including Centrelink and workers' compensation, we will let you know.

8. Premium adjustments

8.1 If we receive money or other material benefits (other than claims payments for members and any related costs) directly or indirectly from an insurer or reinsurer, we will publish details of the arrangement on our website. These arrangements are sometimes referred to as premium adjustment mechanisms.[12]

8.2 Any premium adjustment payments we receive from an insurer will be passed onto our insured members through adjustments to future premiums charged to members, including for insurance administration.

8.3 Any premium adjustment payment made to us by an insurer or any deficit incurred will be allocated to our insurance reserve, governed by a board-approved insurance reserving policy.

8.4 Our annual report, product disclosure statement and relevant insurance documentation will include information about our premium adjustment arrangements and policy and the members to which it applies.

8.5 We will report details of any premium adjustment payments made to and from our insurance reserve, and what the payments from the reserve have been used for.

9. Promoting our insurance cover

[12] For the avoidance of doubt, where premiums cover both insurance risk and an investment component (known as participating policies), these are not considered to be premium adjustment mechanisms.

9.1 When we promote the insurance cover that we offer, we will:

a) be clear and upfront and not misleading
b) consider the target audience for the communication and whether it provides adequate information for that audience
c) ensure that statements in communications are consistent with the features of the relevant policy and the disclosures in any corresponding product disclosure statement
d) ensure that any images used do not contradict, detract from or reduce the prominence of any statements used
e) if prices or premiums are referred to, ensure that these are consistent with the prices or premiums likely to be offered to the target audience for the communication
f) make clear if a benefit depends on a certain set of circumstances
g) ensure that any use of phrases such as "free" or "guaranteed" are not likely to mislead
h) comply with the Australian Securities and Investments Commission (ASIC)'s guidance for advertising financial products and services and guidance regarding unsolicited sales.

9.2 If we enter into an agreement or renew an agreement (no later than two years after we adopt the Code) with a financial adviser or dealer group to distribute the products we offer, including any insurance cover available via those products, the agreement will require the adviser to comply with the requirements of this section of the Code.

9.3 When we promote insurance cover additional to our automatic insurance cover, we will only target any promotion to the segments of our membership for whom we have identified the cover is likely to be appropriate, affordable and of value.

9.4 We will investigate any concerns raised or identified with the practices of our staff and the financial advisers that we engage. If as a result we identify that cover has been promoted or recommended inappropriately:

a) we will contact you to discuss an appropriate remedy, in consultation with the insurer. Appropriate remedies will vary depending on the circumstances, and may include:
    i. cancelling the cover
    ii. arranging a refund of premiums paid
    iii. payment of interest on the refunded premium
    iv. adjusting the cover or arranging for more suitable cover
    v. correcting incorrect information
b) if you are not satisfied with our proposed remedy, we will review this and tell you how to make a complaint
c) we will correct any identified conduct issues, including through further education and training.

10. Changes to cover

10.1 If we provide a calculator or other tool to help you to determine the level of insurance you need, we will make it clear that any insurance cover you request may be subject to assessment and approval by us and the insurer.

10.2 We will include clear instructions on how you can change your cover in our insurance welcome pack, our disclosure information, your annual statement, and on our website.

10.3 We will let you know the consequences of any changes you request.

10.4 If you tell us that you want to reduce your cover or make any other changes that do not require the approval of the insurer, we will confirm your changes and the date on which your cover has changed **in writing** within 5 **business days** of receiving your instructions.

10.5 If you tell us that you want to increase your cover, replace cover you have in another fund, or make any other changes that we determine will require assessment and approval by the insurer, we will explain the process to you within 5 **business days**. You will be given contact details for the primary contact during the application process.

10.6 We will have oversight processes in place to monitor the decisions of our insurers, as part of our duty to act in our members' best interests.

10.7 We may take responsibility for a step in the application process, such as arranging an independent medical examination. In these cases, we will comply with the relevant standards in the **Financial Services Council Insurer Code**.

10.8 We will have complied with the requirements to communicate with you in this section even if the communications are provided to you by the insurer or a **Service Provider**.

10.9 At the start of the application process, before asking you any health-related questions, we will explain the duty of disclosure (information you need to tell us) and the consequences of not disclosing all relevant information and answering all questions honestly and completely.

10.10 If you tell us that you are replacing existing insurance cover that you hold elsewhere, we will tell you:

a) that you should not cancel any existing cover until your new application is accepted
b) the general risks of replacing existing cover, including the loss of any accrued benefits, the possibility of waiting periods to start again (if applicable), and the implications of any nondisclosure on an application for cover (even where unintentional)
c) that once your new cover is accepted, if you do not cancel your previous cover, you may be unable to claim on multiple insurance covers (depending on the terms of your policies).

10.11 We will provide you with information about any change in your premiums and general information about the impact of insurance premiums on retirement savings.

10.12 If cover is offered on alternative terms based on your personal circumstances, such as:

a) a higher premium
b) the exclusion of specific events, activities or medical conditions that are not covered
c) alterations to any waiting periods that apply before benefits can be accessed
d) alterations to the benefit period that applies, including the term of the insurance cover
e) any other specific terms or conditions that may be applicable to the policy,

we will make it clear to you what alternative terms are being offered.

10.13 If insurance cover is not offered, or is offered on alternative terms, we will let you know (or your doctor, where appropriate):

a) the reasons for the decision

b) that you can request copies of the documents and information relied on in line with the standards in section 13
c) if you disagree with the decision, or if you think that the information relied on to make the decision is incorrect or out of date, you can discuss this with us and we will review the decision, and if you are not satisfied with the review we will tell you how to make a complaint.

10.14 Should we become aware after the cover is issued that information relied on for your application for insurance was incorrect or incomplete at the time the cover was issued, we will notify the insurer, and:

a) if we consider the information to be important for your cover, we will ask you to provide an explanation, including giving you an opportunity to review any relevant documents about you, before any decision is made such as changing the terms or cancelling your cover
b) once a decision has been made, we will advise you of the decision and any actions to be taken, and the process to have this reviewed or make a complaint if you disagree with the decision.

Transfer between divisions in our fund

10.15 There are circumstances in which we will transfer you between different divisions of our fund. For example, if you leave an employer, you may be automatically transferred from the employer's plan to a different division. This may change the type and/or the terms of the insurance cover you receive from us or could result in cancellation of your cover, for example due to legislation or fund rules.

10.16 If you have been transferred to another division which changes the type or terms of the cover you receive from us, we will contact you in writing within 30 days of the transfer to explain the changes and any options for changing or cancelling this cover.

10.17 We may also transfer a group of members to a different division, for example if your employer restructures its insurance. If this occurs, we will let you know **in writing** 30 calendar days before the transfer if circumstances permit. We will confirm to you any changes to your insurance cover and your options for changing or cancelling this cover.

11. Refunds

11.1 If at claim time we identify that you have multiple automatic insurance covers in superannuation and your benefit is offset or not able to be claimed on because you have claimed on another benefit under another similar policy, which means that no payment is made to you under the cover you hold with us, we will give you the option of a refund of your premiums into your account for the duration of the overlap of covers, to a maximum of 6 years, and we will then cancel your cover.

11.2 If we identify that you were not eligible to claim against your automatic insurance cover for any event from the start of the cover, we will refund your premiums to your account for the period you were ineligible.[13]

11.3 If you make a claim that is accepted, and your cover ceases under the terms of the policy on the date you became eligible to claim, we will refund your premiums to your superannuation account back to the date you became eligible to claim.

12. Staff and Service Providers

12.1 We will ensure our staff have the appropriate education and training to provide their services competently and to deal with you professionally, initially and on an ongoing basis. This will include training on their responsibilities under the Code. We will only allow our staff to provide services that match their expertise.

12.2 We will have processes in place to train our staff to help identify and engage appropriately with vulnerable consumers, to carry out any internal protocols we put in place, and to refer these consumers for appropriate support where required. Specific training regarding engaging appropriately with members who have mental health conditions will be provided.

12.3 Our claims handling staff who make initial eligibility assessments and review claim decisions made by insurers will be appropriately skilled and trained to make objective decisions. They will not make decisions on our behalf until they have demonstrated technical competency and an understanding of all relevant law and the requirements of the Code. Performance measures, remuneration and entitlements to bonuses will not be based on declined claims or deferrals of decisions.

12.4 We will monitor the performance of our staff and provide appropriate education and training to correct any identified performance shortcomings.

12.5 In addition to an insurer, we may engage another party to provide a service to you on our behalf; for example, a claims management service or a fund administrator. When we enter into an agreement, or renew an agreement (no later than two years after we adopt the Code) with a **Service Provider**, the agreement will require them to comply with the relevant standards of the Code.

12.6 We will review our agreements with **Service Providers** no later than every 3 years.

12.7 We will require **Service Providers** to act with honesty, fairness, respect, transparency and timeliness towards you and us.

12.8 We will only enter into agreements with **Service Providers** who reasonably satisfy us of their expertise, experience, qualifications and integrity, and who hold any required licensing.

[13] It is intended that this applies to blanket exclusions where a member can never claim for any event, such as "*if you have ever been paid a TPD benefit, you will not be eligible to claim for TPD*." It is not intended that this applies to pre-existing exclusion limitations where the claimant could be eligible for a benefit in some circumstances.

12.9 We will require **Service Providers** to comply with the *Privacy Act 1988* and maintain confidentiality of your information, and only use that information for the purpose of the service they are providing.

12.10 We will monitor the activities of any **Service Providers** that we engage to ensure that they are complying with the relevant standards of the Code. This can include requiring regular reporting, putting in place quality assurance measures, and analysing data such as claim decisions and complaints.

12.11 We will require any **Service Providers** that we engage to notify us if you make a complaint to them about their services, and we will handle the complaint in line with our complaints process.

13. Making enquiries and complaints

How to make an enquiry

13.1 If you have a question about your cover, your premiums, any communication we have sent you or a decision that has been made regarding your cover, you can make an enquiry to us. We will provide you with information without requiring you to make an insurance claim.

13.2 You can also access the following information (in an electronic format if preferred) upon request:

a) details of your cover
b) our insurance contract with our insurer (sometimes called the policy document)
c) the product disclosure statement relevant to your cover
d) our trust deed
e) any personal information we hold about you
f) information relied on to decide your claim or complaint.

13.3 We will respond to your enquiry:

a) with an acknowledgment by the next **business day**
b) with a full response within 10 **business days**.

13.4 If we cannot comply with a timeframe for providing information required by the Code, for example because we are waiting for permission from a third party to release the information, we will tell you why before the end of the timeframe, and this will not constitute a Code breach.

13.5 In some circumstances, information may not be able to be provided, for one of the following reasons:

a) where information is protected from disclosure by law, including the *Privacy Act 1988*
b) where we reasonably determine that the information should be provided directly to your doctor
c) where the release of the information may be prejudicial in relation to a dispute about insurance cover, a claim, or a complaint
d) where we reasonably believe that the information is commercial-in-confidence.

13.6 If information is not provided:

a) we will act reasonably
b) we will give you a schedule of the documents not provided and the reasons for doing so
c) we will tell you how you can make a complaint if you are not satisfied.

13.7 If you are not satisfied with our response to your enquiry, you can make a complaint.

How to make a complaint

13.8 You can make a complaint to us about any of our decisions or conduct, or the decisions or conduct of a **Service Provider**. If you make a complaint to us about a decision or conduct of our insurer, we will ask the insurer for a response and we will review this as part of our complaints process.

13.9 We will make information about your right to make a complaint and our process for handling complaints available on our website and in our relevant communications to you.

13.10 Your complaint will be handled by someone different from the person or persons whose decision or conduct is the subject of the complaint.

13.11 We will notify you of the name and contact details of the person assigned to liaise with you about your complaint, and an overview of the process and timeframe.

13.12 We will only ask for and rely on information relevant to the investigation of your complaint and our response to your complaint.

13.13 If we become aware of errors and mistakes in the handling of your complaint, we will address these promptly.

13.14 You will receive progress updates at least every 20 **business days** (unless a different timetable is agreed with you). If there are any issues delaying assessment of your complaint, we will let you know.

13.15 We will provide a final response to your complaint **in writing** within 45 calendar days of receiving your complaint. In **exceptional cases**, we will need more time to investigate and respond to your complaint. In these cases, we will tell you that we need more time, and will clearly communicate our revised expected timeframe, which will not exceed 90 calendar days.

13.16 If we do not respond to your complaint within 90 calendar days, we will give you written reasons for the delay before the end of the 90-day period, and we will let you know that you can take your complaint to **External Dispute Resolution**.

13.17 In our response to your complaint, we will explain:

a) our decision on your complaint and the reasons for that decision
b) that you can request copies of the documents and information relied on in line with the standards of this section
c) that you have the right to take your complaint to **External Dispute Resolution** if you are not satisfied with our decision and the timeframe within which you must take your complaint to **External Dispute Resolution**
d) contact details for the relevant **External Dispute Resolution** organisation.

13.18 A summary of the complaints we handle will be regularly reported to our Board.

External determination of complaints

13.19 If you make a complaint to us and our final decision does not resolve your complaint to your satisfaction, or if we do not resolve your complaint within 90 calendar days, you may refer your complaint to **External Dispute Resolution**.

13.20 You may seek independent legal advice and access any other dispute resolution options that may be available to you or of which we are a member.

14. Promoting, monitoring and reporting on the Code

Our role

14.1 We will promote the Code and make it accessible, which will include providing information about the Code on our website, in our insurance communications and in relevant marketing documents.

14.2 We will:

a) have appropriate systems and processes in place to enable compliance with the Code including monitoring and analysing data on policies, our communications to members, claim data, and internal and external complaints
b) publish on our website an annual Code compliance report, which includes:
   i. instances where we have failed to comply with the Code
   ii. where we have determined that complying with the Code is not in the best interests of our members
   iii. any steps we are taking to improve our Code compliance.

14.3 If we identify that our failure to comply with the Code has resulted in direct detriment to one or more of our members, we will seek to remedy this. This could involve compensation for any direct financial loss.

14.4 We will work with our members to improve education on insurance in superannuation. We will report to our members in our annual report on the steps we have taken to improve member education.

Role of the Insurance in Super Code Owners

14.5 The **Insurance in Super Code Owners** are responsible for the development of the Code.

14.6 The **Insurance in Super Code Owners** may develop guidance documents from time to time to assist us in improving standards over time, and in interpreting and meeting our commitments under the Code.

14.7 The **Insurance in Super Code Owners** will commission formal independent reviews of the Code as appropriate, no later than every 3 years. Reviews will focus on whether the Code is meeting its objectives, in particular whether the Code has improved the insurance offered in superannuation, and the processes by which we deliver insurance.

14.8 In addition to formal independent reviews of the Code, the **Insurance in Super Code Owners** will consult with relevant regulators, **External Dispute Resolution**, consumer and industry representatives and other stakeholders to develop the Code on an ongoing basis. The

Insurance in Super Code Owners will meet at least once every year to determine whether any changes need to be made to the Code.

14.9 The **Insurance in Super Code Owners** will promote the Code to consumers and to trustees and other industry participants.

15. Definitions

business days means Monday to Friday excluding public holidays.

exceptional cases mean any of the following:

a) the claim is lodged so late that there are significant difficulties obtaining information necessary for the claim assessment
b) we believe that a claim which has been declined by the insurer may have a reasonable prospect of success, but involves complex matters that require further consideration by us
c) despite reasonable follow up, reports from third parties have not been received
d) the insurer has not provided information to us that we require to make a decision about a claim or complaint, which we have requested in line with our Code commitments
e) you or your representative has not responded to our reasonable enquiries or requests for information in a reasonable period of time
f) there are difficulties communicating with you that are out of our control
g) you have requested a delay
h) we or the insurer reasonably suspect the claim is fraudulent.

External Dispute Resolution means the external organisation that is relevant to your complaint, which may include the Australian Financial Complaints Authority, the Superannuation Complaints Tribunal, the Financial Ombudsman Service, or a complaints handling process mandated by legislation.

Financial Services Council Insurer Code means the Financial Services Council's Life Insurance Code of Practice.

in writing means a communication conveyed by mail or via electronic means such as via email, facsimile or text message, or any other means permitted by legislation or regulation.

inappropriately erode means the erosion of retirement balances as a result of insurance premiums to the extent that the primary purpose of superannuation, to provide income in retirement to substitute or supplement the Age Pension, is not met.

Service Provider means another party that we engage to provide a service on our behalf; for example, a claims management service or a fund administrator. A life insurer in its capacity as an insurer is not a **Service Provider**.

Insurance in Super Code Owners means the Australian Institute of Superannuation Trustees (AIST), the Association of Superannuation Funds of Australia (ASFA) and the Financial Services Council (Financial Services Council).

Superannuation Guarantee means the compulsory superannuation contributions made by employers on behalf of their employees.