Consultation Paper:

Insurance in Superannuation Code of Practice

September 2017

The Insurance in Superannuation Working Group

CONTENTS

FOREWORD

Group insurance in superannuation and particularly its automatic issuance on an opt-out basis has been a successful policy for Australia which has resulted in better risk protection for Australians from all walks of life. It provides a safety net to millions of Australians who would have otherwise not chosen or been able to take out life and disability insurance individually. These benefits contribute significantly to addressing Australia's underinsurance gap and relieving fiscal pressures on our social security system.

The Insurance in Superannuation Working Group (ISWG) was formed in November 2016 to collaboratively enhance future iterations of policy development. While the current policy settings are fundamentally right, there is industry acknowledgment that changes need to be made to improve the experiences of superannuation fund members.

The ISWG is comprised of Australia's superannuation bodies: the Association of Superannuation Funds of Australia (ASFA), the Australian Institute of Superannuation Trustees (AIST), the Financial Services Council (FSC), Industry Funds Forum (IFF) and Industry Super Australia (ISA), who share the common belief that group insurance in superannuation is fundamentally the right policy setting for millions of Australians.

Members need to be placed at the top of a complex stakeholder hierarchy with clarity that superannuation funds are advocating on their behalf. Superannuation funds and insurers must work together in order to achieve the most sustainable benefits for members. Accordingly, the ISWG contains superannuation fund, insurer, industry and consumer representatives.

The ISWG believes that: ***The objective of insurance in superannuation is to support the purpose of superannuation by 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.

A key deliverable for the ISWG is a Code of Practice that will apply to superannuation funds. This code will extend on the current FSC Life Insurance Code of Practice (FSC Insurer Code) by setting standards that ensure a common end to end experience for all classes of life insurance consumers.

This consultation paper outlines the content of the draft Insurance in Superannuation Code of Practice (Code), the full text of which is included as Appendix 1. Feedback received during stakeholder consultation on this paper will be incorporated into the development of the Code, prior to a final version being approved and published by the end of 2017.

Unless stated otherwise, the statements in this paper reflect the views of the ISWG as a collective.

EXECUTIVE SUMMARY

The overarching objective of the ISWG in developing the Code was to improve the insurance in superannuation offered to fund members, as well as trustees' processes in providing insurance.

Insurance in superannuation is usually provided automatically when a member joins a fund. The ISWG is aware that many Australians do not realise that they hold insurance cover automatically through their superannuation account, and thus there is a risk that members have not engaged adequately to ensure the cover they hold is appropriate for them. Much of the Code is targeted at automatic cover, provided to Automatic Insurance Members.

One of the key objectives called out in Section 4 of the Code is that insurance offered on an automatic basis must be appropriate and affordable, and must not inappropriately erode members' retirement income.

There are a number of Code measures that are intended to operate together to achieve this objective. When a trustee is designing benefits, they must be assessed against different segments of the membership for appropriateness and affordability. When a new member joins a fund, the trustee must ask for permission to carry out a search for any other insurance cover that the member holds in superannuation; the purpose being to prevent someone paying premiums for benefits that are not needed or for which they may not be able to claim.

Trustees will identify where they are no longer receiving contributions for a member; this could be due to them ceasing employment, or contributing to another fund. In these situations, and also where a trustee receives very low or infrequent contributions, the trustee will communicate with the member to ensure they understand the impact of their insurance premiums on their account balance. For Automatic Insurance Members, to ensure their balance is not inappropriately eroded, cover will automatically cease where no contributions are received for 13 months if no response is provided to any of the three communications provided by the trustee.

While these measures will reduce the risk that a member pays premiums for cover on which they are ultimately unable to claim, the Code also provides for refunds of premiums to be provided to members who are unable to claim a benefit in various circumstances.

A further objective of the Code is to assist member understanding of the role of insurance in superannuation and the details of their cover in particular, through the provision of clear, timely and plain-language communications. As trustees improve the data they hold about their members, they will be able to better tailor their communications. The communication requirements in the Code are designed to prompt members to evaluate the appropriateness of their cover, with options provided to easily change or cancel cover.

The third key focus of the Code is to improve the member experience at claim time. The trustee is required to play a visible role in the claims process, and ensure that the person claiming receives regular updates on progress and a decision in a reasonable timeframe.

In developing the Code, there have been areas where the ISWG has been limited in its ability to respond to industry issues, due to legislative or regulatory constraints, or because trustees do not have

access to sufficient information about their members. This consultation paper notes those areas that require a legislative or regulatory response, or where further consideration should be given to broadening the standards in future iterations of the Code.

We want your feedback

We invite you to comment on the draft Code and the key questions that have been raised. All submissions on this discussion paper are due by **Friday 20 October 2017** and should be sent to the Project Management Office at:

ISWG-PMO@kpmg.com.au

All submissions will be treated as public documents unless you specifically request that we treat the whole or part of your submission as confidential.

SECTION A: DEVELOPMENT OF THE CODE

A.1 The process to date

The ISWG has previously released five discussion papers for consultation, which have formed the basis for the Code's development:

- ***Account balance erosion due to insurance premiums.*** This paper examined how to address the issue of members paying for cover they don't need through having multiple super accounts.
- ***Claims handling.*** This paper examined existing practices and issues associated with insurance claims handling and outlines some ambitious changes in timeframes developed by superannuation and life industry representatives to improve the member experience.
- ***Member communication and engagement.*** This paper outlined options to improve member engagement and understanding of their insurance arrangements within superannuation.
- ***Data management.*** This paper outlined proposals that seek to enhance member insurance outcomes by improving access to timely and relevant information.
- ***Premium Adjustment Mechanisms.*** This paper outlined how practices sometimes described as 'profit share arrangements' apply across the industry and operate in practice.

The above discussion papers and the public submissions received by the ISWG can be found at the following industry association websites:

AIST: *http://www.aist.asn.au/policy/insurance-in-superannuation-working-group-(iswg)/overview*

ASFA: *https://www.superannuation.asn.au/policy/insurance-in-superannuation-working-group*

FSC: *https://fsc.org.au/policy/life-insurance/insurance-in-superannuation-working-group-iswg/*

ISA: *http://www.industrysuperaustralia.com/campaigns/insurance-in-super/*

The ISWG has developed the draft Code with the input of a Technical Committee and a Code Development Committee, with decisions ultimately made by a Governance Board.

The ISWG also formed a small external consultation group that has carried out weekly meetings to provide ongoing feedback on early drafts of the Code. This group is made up of Alexandra Kelly, Senior Solicitor at Financial Rights Legal Centre, and John Berrill, principal at Berrill Watson Lawyers and former Maurice Blackburn partner.

A.2 Current consultation

We want your feedback

We invite you to comment on the draft Code and the key questions that have been raised.

All submissions on this discussion paper are due by **Friday 20 October 2017** and should be sent to the Project Management Office at:

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All submissions will be treated as public documents unless you specifically request that we treat the whole or part of your submission as confidential.

A.3 Next steps

As part of the consultation on the draft Code, the ISWG will engage a plain language expert to conduct a review of the Code. Key concepts will also be consumer tested for comprehension, ahead of the Code being finalised.

Once the consultation period is complete, the ISWG will continue to develop the Code in consultation with superannuation funds, insurers, regulators, consumer advocates and key external stakeholders.

It is intended that the final Code is approved by the ISWG and published by the end of 2017.

SECTION B: SUMMARY OF KEY CODE STANDARDS

B.1 Scope of the Code

The Code is intended to bind superannuation fund trustees that offer insurance within an APRA-regulated superannuation fund. The ISWG is currently contemplating options for ensuring the Code is mandatory for all superannuation trustees, in order to achieve broad industry change. This may include seeking a regulatory solution.

The suggested transition period for the Code is one year from the date of commencement until the date on which trustees must adopt the Code's standards. All of the standards of the Code would apply from the date of adoption, with the exception of the requirements relating to benefit and premium design. The design principles will apply when a trustee enters into a new policy or resets an existing policy. All existing policies must be reset within two years of the trustee's date of adoption, to reflect the Code's standards.

The trustee's relationship with its insurers is very important to ensure the member's experience is seamless. The Code explains that there is a requirement on both parties to comply with their own standards, as life insurers are bound by the FSC Insurer Code. It is acknowledged that it would be more straight-forward for a consumer to be able to understand the requirements that are relevant to them without having to read two codes, particularly as the distinction between the trustee's and the insurer's responsibilities may not be clear to those unfamiliar with the industry. There may be benefit in considering the amalgamation of the requirements on trustees and insurers in the future, into one all-encompassing life insurance code.

FOR CONSIDERATION IN FURTHER ITERATIONS OF THE CODE

- One life insurance code that covers both insurers and trustees, encompassing the standards in the FSC Insurer Code and the ISWG's Code.

B.1 Feedback questions

SCOPE OF THE CODE

1. How should the ISWG ensure that all trustees are bound by the Code?
2. What are the practical implications of the transition arrangements?
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)?

B.2 Appropriate and affordable cover

Benefit design

Section 4 of the Code addresses one of the key Code objectives; that is, to ensure that insurance offered on an automatic basis is appropriate and affordable for members, and does not inappropriately erode retirement income. Trustees must publish their insurance strategy, including outlining how their automatic cover has been designed.

The Code requires trustees to consider the particular characteristics of their membership in order to determine their insurance needs. Once benefits have been designed, they need to be assessed against segments of the membership to ensure they are broadly appropriate; the Code calls out the particular needs of younger members, members with low or infrequent contributions to their superannuation account, and members nearing retirement.

Trustees must also assess the affordability of their benefit design for these segments of their membership; as an example, they must take into account the fact that young people may have lower contributions and account balances than older members, while potentially having lesser requirements for risk protection.

Section 4.15 of the Code requires that trustees not automatically include members in higher-risk divisions of the fund (for example, divisions for smokers or "heavy blue" workers) without an evidence basis for this. It is noted that trustees would be better able to allocate members to the appropriate division of their fund if employers were required to provide more information about their employees when they join the fund.

MATTERS REQUIRING LEGISLATIVE/REGULATORY CHANGE

- Requirement for employers to provide more information about employees when they join the fund, to allow trustees to better align members to their risk characteristics.

Premium limits

The ISWG has been working on maximum premium limits for different segments of a fund's membership that will protect account balances from inappropriate erosion. Carrying out modelling of various proposals for maximum premium limits has revealed that this piece of work is highly complex. While the ISWG's recommended suite of proposals on premium limits is detailed below, it is acknowledged that there may be alternative options raised by submitters that will be considered by the ISWG prior to the Code being finalised. It is also important that the final position arrived at is evidence-based; as part of the consultation process, trustees are asked to apply the below proposals to their own benefit design, fund characteristics and relevant segments of their membership, and report to the ISWG (on a confidential basis) the extent to which their current premiums meet or exceed the maximum limits below. A methodology for carrying out this testing will be provided to trustees separately.

The Code includes a maximum premium limit that trustees must use when designing benefits for automatic cover, which is 1% of ordinary time earnings for relevant segments of the membership, and the membership generally. Trustees can determine the level of earnings they use to carry out this assessment, based on the particular characteristics of their membership, their period of membership, and relevant segments therein.

In addition, trustees must set their premiums for the segment of members that are under the age of 25 at a level that does not exceed 0.5% of earnings. As above, trustees can determine the level of earnings and the period of membership that they apply to their younger members, and they will need an evidence base to justify the assumptions made.

The ISWG notes that in order to achieve the premium limits noted above, there may need to be a reduction of cover for some segments of members in order to reduce their premiums. The ISWG welcomes feedback as to how this reduction of cover is communicated to members, and the impact if a member wishes to retain their original cover (which may not reduce their premiums, and in fact could increase their premiums). A further question remains to be worked through about whether a member who chose to retain their original cover would remain an Automatic Insurance Member.

Some funds may have a segment of their membership which is classified as higher risk due to the members' occupation. Where these members are unlikely to be able to purchase appropriate and affordable cover outside superannuation, a trustee may provide automatic cover to this segment with premiums that exceed the 1% earnings cap. In order to rely on this provision, the trustee will need to satisfy the independent code administrator that the cover provided is both appropriate and affordable, and that the segment of members would be unlikely to be able to purchase equivalent insurance outside of superannuation on acceptable terms.

While Section 4 of the Code affords trustees a necessary level of flexibility to determine the benefit design that suits their members, they will need to be able to provide an evidence base to the independent code administrator to show that their benefits are affordable and appropriate, and premiums are within the product design thresholds. This will need to occur not just for the membership generally, but at a segment level for younger members, and any other relevant segments of the membership.

The ISWG will develop Good Practice Guidance, to assist trustees to interpret and meet their Code obligations, and to promote continuous improvement in standards. It is anticipated that the Good Practice Guidance will detail different methods that trustees could use to determine their benefit design and premium limits, including the underlying average earnings they can apply if they do not have sufficient information about their membership to derive their own earnings profiles.

GOOD PRACTICE GUIDANCE CONTENT

- Different methods that trustees can use to determine benefit design and premium limits
- Case studies for the application of premium limits
- Guidance on determining the appropriate measure of average earnings for a fund's membership.

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?
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?
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?
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?

Cancellation and cessation of cover

The Code requires trustees to make the process of cancelling, or "opting out" of automatic cover straight-forward and transparent for members. Members must be able to cancel through a fund's website, over the phone or via email. Instructions on how to cancel must be provided clearly in member communications.

One of the Code's significant protections of member account balances is the requirement that trustees cease a member's cover where no eligible contributions have been received for 13 months, unless the member advises that they want to retain the cover. The ISWG has considered the appropriate timeframe before cover is automatically ceased, balancing the likelihood that someone who is not contributing to their account may be contributing to another account with automatic cover, against the possibility that someone who has left the workforce for a substantial length of time (for example, on parental leave) may value their continuing automatic cover.

The 13-month period is measured from the end of the period covered by the most recent eligible contribution where this is known by the trustee; otherwise the measure is the date of the most recent eligible contribution. The intention is for the period of no contributions to not exceed 13 months wherever possible.

Linked to the Section 4 process for ceasing a member's cover for lack of contributions is a process in Section 5 requiring multiple communications to a member before cessation can occur.

The Code also includes an ability for a member's cover to be reinstated within 60 days after it has ceased. The ability to have automatic cover re-established is necessarily limited, due to the anti-selection risk of allowing members to receive cover without underwriting.

MATTERS REQUIRING LEGISLATIVE/REGULATORY CHANGE

- Requirement for employers to communicate reasons for ceasing contributions, for example terminated employment, to assist superannuation funds with more targeted communication.

B.2 Feedback questions

CANCELLATION AND CESSATION OF COVER

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

Duplicate insurance cover

Members who have more than one superannuation account may also hold multiple automatic insurance covers. For members with multiple income protection policies, there is a risk that they will be unable to claim on more than one policy.

Trustees are currently limited in their ability to assist members to identify whether they hold duplicate insurance. While SuperMatch will reveal whether insurance cover is held by a member, it does not clarify what benefits are contained in this cover. In line with the existing limitations of SuperMatch, the Code requires trustees to ask new members for permission to help them identify any other insurance cover held within superannuation.

MATTERS REQUIRING LEGISLATIVE/REGULATORY CHANGE

- Extension of Single Touch Payroll to provide real-time view of existing accounts and insurance and allow members to consolidate their existing accounts.

B.2 Feedback questions

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?

B.3 Helping members to make informed decisions

The objective of Section 5 of the Code is to assist members to understand what insurance products they hold and the impact insurance premiums can have on their retirement savings. Members need to be able to easily review, change or cancel their level of cover, and trustees should provide guidance to assist members to make these decisions.

A key commitment of the Code is for trustees to communicate with members in plain language, and to consumer-test key insurance concepts for comprehension. To this end, as part of the development of the draft Code, the ISWG will have the Code reviewed by a plain language expert, and will identify key concepts for targeted consumer testing.

The ISWG has considered the extent to which insurance definitions can be standardised across the industry, to assist members to understand the cover they hold. It is recognised that this is a longer-term project, which would require extensive consultation with trustees and insurers, as well as input from regulators. Definition and benefit design standardisation could have an impact on premiums, so would need to be carefully considered.

In order to go some way towards assisting with understanding of definitions, the Code requires trustees to clearly explain how their definitions of total and permanent disability and income protection cover will be applied in practice. There are also standard plain-language headings that must be used for total and permanent disability cover to help members understand technical total and permanent disability definitions. Trustees must also regularly review their insurance offering to ensure the interpretation and

application of their insurance definitions are consistent with any changes in their policy terms, their insurer's approach and developments in the law.

The ISWG intends to develop Good Practice Guidance that contains plain-language statements that trustees can use to explain how their definitions will be applied.

The Code includes a template for an industry-standard Key Facts Sheet as an Annexure, which is aimed at providing fund-specific information about a fund's automatic cover in a consistent format. There is also a requirement for tailored, member-specific information to be provided to a new member as part of a welcome pack. The intention is that a member would be able to use the welcome pack information and the Key Facts Sheet to get a high-level view of the cover they hold.

Trustees are also required to communicate with members on an ongoing basis, to prompt members to evaluate whether their cover is appropriate for their current circumstances. In addition to the annual statement which will now contain further insurance-related information, there is a requirement to communicate with a member when no eligible contributions have been received for six months, when cover ceases, and when contributions in a 12-month period are low or infrequent. These communications are intended to engage with members whose premiums may be inappropriately eroding their account balance.

GOOD PRACTICE GUIDANCE CONTENT

- Plain-language statements that trustees can use to explain their total and permanent disability and income protection definitions.

FOR CONSIDERATION IN FURTHER ITERATIONS OF THE CODE

- Standardised insurance definitions.

B.3 Feedback questions

HELPING MEMBERS TO MAKE INFORMED DECISIONS

12. Which parts of the Code require particular attention for consumer testing?
13. How could the Key Facts Sheet template better assist members to understand and compare their cover?
14. Do the communication requirements in the Code achieve the right balance between prescription and trustee flexibility?
15. What further steps could be taken to engage members who are making no contributions or low or infrequent contributions?

B.4 Claims handling

The objectives of Section 6 of the Code are to provide persons claiming with timely communications during the claims process, with clear timeframes for decision-making.

The standards in the Code operate alongside the life insurers' responsibilities under their own code of practice, and trustees must make it clear to persons claiming which party will be their primary contact during the claim process.

The Code prescribes timeframes for:

- assessing initial eligibility and providing a person claiming with information about the claim process (within five business days);
- providing responses to enquiries (within ten business days);
- reviewing an insurer's decision (within 15 business days for a decline);
- querying an insurer's decision (within five business days of completing a review); and
- paying a claim (within five business days, providing all other requirements are met).

The trustee is required to provide the person claiming with detailed information about the claim process when a claim is made, including an explanation of their cover, the roles and duties of the various parties, and a reasonable expectation of the end-to-end timeframe for assessment of the claim.

The trustee must oversee the progress of the claim, even where the insurer is taking the primary role in assessing the claim, in order to minimise delays and ensure compliance with the relevant timeframes. The trustee will advocate for the person claiming in dealings with the insurer where they believe a claim has a reasonable prospect of success.

The Code also requires that persons claiming are given an opportunity to provide further information where a trustee determines that they are not eligible to make a claim, or before a claim is declined. As part of the trustee's review of an insurer's decision to decline a claim, the trustee must determine whether the person claiming has been provided with reasons for the decision, the evidence relied on in forming a view and all documents obtained during the assessment, as well as an opportunity to provide further information. Where these have not been provided by the insurer, the trustee must provide these to the person claiming.

Where a member is receiving ongoing income protection payments, the trustee must have in place oversight processes to ensure information required to be provided by the member or their doctor is reasonable, and is being provided in a timely fashion to ensure payments are made. Where an insurer determines that a member is no longer entitled to income protection payments (for reasons other than their benefit period ending, their having returned to work or information not having been provided), the trustee has five business days to raise any concerns with the insurer about this decision.

It has been suggested that the superannuation industry work with legal representative bodies to develop protocols for the engagement of legal practitioners in insurance claims, and communication protocols between the various parties. While the ISWG has not yet had an opportunity to progress this work, it is an appropriate consideration for the second iteration of the Code, in order to make the Code more encompassing of the parties involved in claims handling.

FOR CONSIDERATION IN FURTHER ITERATIONS OF THE CODE

- Protocols for the engagement of legal practitioners in insurance claims.

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

B.5 Vulnerable consumers

Section 7 of the Code acknowledges that there are groups of members that will have unique needs that trustees must address, such as disabilities, language difficulties, and identification issues. Trustees are required to put in place their own internal policies to assist their staff to identify vulnerable people, and to take practical steps to support them, such as escalating their needs to those equipped to engage with them appropriately.

Where a member tells a trustee that that they require support or assistance, this should be recorded, which will allow trustees to start building better data about their membership, and ultimately be able to tailor their processes and communications.

Where a member has difficulty providing legal identification, for example those living in remote Indigenous communities, trustees will take a flexible approach to their identification requirements, in accordance with guidance provided by the Australian Transaction Reports and Analysis Centre (AUSTRAC).

The Code also includes standards for the use of interpreting services, which may include internal or external interpreters.

Where a member is granted release of their superannuation account balance due to terminal illness, the Code requires trustees to advise the member that they should retain sufficient funds in their account to meet their premiums so that they do not lose their insurance cover. The ISWG strongly believes that members should be protected from unknowingly losing valuable insurance cover; there is currently a risk of this occurring as insurance policies can have a stricter definition of "terminal illness" than the legislated superannuation definition. The ISWG intends to consider the alignment of definitions in its further work on the Code and in consultation with the insurance industry.

FOR CONSIDERATION IN FURTHER ITERATIONS OF THE CODE

- Aligning the requirements for release of a member's account balance and their eligibility for payment of an insurance benefit.

B.5 Feedback questions

VULNERABLE MEMBERS

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

B.6 Premium adjustments

Some trustees have in place a premium adjustment arrangement with their insurers, to either return surplus premium to the trustee's insurance reserve when the cost of members' claims turns out to be less than the insurer expected when determining the pricing of our insurance cover, or to adjust future premiums to reflect a premium deficit.

Section 8 of the Code requires any premium adjustment payments to be passed onto insured members through adjustments to future premiums.

Trustees must make any premium adjustment policy publicly available, and must publicly report details of any payments made to and from the insurance reserve.

B.6 Feedback questions

PREMIUM ADJUSTMENTS

21. Are the premium adjustment arrangements sufficiently transparent?
22. What further detail could the Code include?

B.7 Promoting our insurance cover and changes to cover

Section 9 of the Code requires trustees and any financial advisers or dealer groups that they engage to ensure that any promotion of insurance within superannuation is clear and not misleading, and is targeted at an appropriate audience. This includes identifying segments of a trustee's membership for whom promoted additional cover is appropriate, affordable and of value.

Section 10 of the Code provides a process for members to change their cover, including applying for additional cover over and above their automatic cover. For changes that do not require the approval of the insurer (such as reducing cover), the trustee must confirm the changes within five business days.

Where an insurer is required to assess and approve the changes (such as where a member applies to increase their cover), the trustee must explain the process to the member within five business days, and give them a primary contact. The trustee must also provide the member with information about the additional premiums payable and the impact on their account balance.

The Code also provides that where a member is transferred between different divisions in a fund (for example, if they leave an employer and are automatically transferred from the employer's plan to a different division), the trustee will make it clear if the terms of their cover changes.

B.7 Feedback questions

PROMOTING OUR INSURANCE COVER AND CHANGES TO COVER

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

B.8 Refunds

Section 11 details several circumstances in which a member's premiums will be refunded into their superannuation account.

As part of the Code objective to prevent the inappropriate erosion of members' retirement income, a number of measures have been put in place that will operate together to achieve this. These include the standards around identifying duplicate cover, communicating with members who are not contributing to their account, and automatically ceasing Automatic Insurance Members where no contributions are received for 13 months. While these measures will reduce the risk that a member pays premiums for multiple insurance covers on which they are ultimately unable to claim, the Code also provides for refunds of premiums to be provided to members who are unable to claim on their cover.

Where a trustee become aware at claim time that a member has multiple automatic insurance covers and has made multiple claims, with the result that all of the member's benefit is completely offset against another policy and no claim payment is to be made, the trustee will refund premiums for the duration of the overlap of the multiple covers, for a maximum of six years.

As part of the consultation on the draft Code, the ISWG wishes to assess the potential cost impact of the above refund proposal, to determine the appropriate maximum duration of refunds payable. Trustees and insurers are encouraged to review this proposal against their own claims experience and provide feedback to the ISWG on a confidential basis, so that the final position in the Code can be evidence-based.

If a trustee identifies that a member was never eligible to claim against their cover for any event from the start of the cover, premiums will also be refunded.

B.8 Feedback questions

REFUNDS

24. What are the practical and administrative implications of the refund requirements provided?
25. Are there any issues with the maximum time limits for the duration of refunds?
26. For superannuation funds – what are your current practices for refunding premiums, and the duration of any refunds?

B.9 Staff and Independent Service Providers

Section 12 of the Code contains expectations for the training and expertise of staff and third-party service providers that a trustee formally engages, including the provision of training on their responsibilities under the Code.

Existing agreements with Independent Service Providers must be updated to make reference to the requirements of the Code no later than two years after the trustee's date of adoption.

Both internal staff and external Independent Service Providers must be monitored by the trustee. For anyone external, this monitoring would incorporate regular reporting, quality assurance measures, and analysis of data.

B.9 Feedback questions

STAFF AND INDEPENDENT SERVICE PROVIDERS

27. Do the standards for training and monitoring staff require further detail?
28. What are the practical implications of requiring trustees to ensure Independent Service Providers comply with the Code?

B.10 Enquiries and complaints

Section 13 provides a process for members to receive information or documents from a trustee, and includes a timeframe of ten business days for the trustee to provide a full response.

There is also a process by which a member or beneficiary can make a complaint to a trustee. Trustees must respond to complaints about their own decisions or conduct, those of their insurer, and those of their Independent Service Providers. Where a complaint is about an insurer, the trustee must ask the insurer for a response, which will be considered as part of the complaints process.

Progress reports must be provided to the complainant at least every 20 business days, with a final response given within 45 days, unless there is an exceptional circumstance that requires additional time (which cannot exceed 90 days).

The Code notes that complainants have the right to take their complaint to an external determination. At the time of releasing the Code for consultation, the ISWG does not have detailed information about the transition from the Superannuation Complaints Tribunal (SCT) to the new Australian Financial Complaints Authority (AFCA), slated to commence in July 2018. At this stage, the Code mentions both authorities, and the draft will be updated as more information comes to hand.

B.10 Feedback questions

ENQUIRIES AND COMPLAINTS

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

B.11 Governance, enforcement and sanctions

Sections 14 and 15 provide a framework for the independent monitoring of Code compliance. In developing this framework, the ISWG has closely followed ASIC's Regulatory Guide 183, which contains ASIC's requirements for the approval of financial services sector codes of conduct. It is noted that the

governance framework detailed in the Code is also equivalent to that required by existing financial services codes, including the FSC Insurer Code.

The Code contemplates the creation of an independent committee to carry out the function of code administrator. The committee would be a creature of the Code and would not be a separate legal entity. Details of the code administrator's role would be contained in a separate Charter (for example, how the members of the committee are appointed), although its responsibilities are set out at a high level in the Code itself. The key role of the code administrator is to investigate alleged breaches of the Code at its discretion and where a breach occurs, agree with the trustee any necessary remedies.

If a trustee does not correct a Code breach after it has agreed to do so with the code administrator, or it does not agree on a remedy to the breach, the code administrator has powers of sanction, which are detailed in Section 15.

Section 14 also includes the roles of the Insurance in Super Code Owners, which are the industry associations that make up the ISWG. The Insurance in Super Code Owners will be responsible for the ongoing development of the Code including commissioning formal independent reviews of the Code as appropriate.

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?

LIST OF CONSULTATION QUESTIONS

Your feedback is invited

We invite you to comment on the key questions that have been raised in this consultation paper. All submissions will be treated as public documents unless you specifically request that we treat the whole or part of your submission as confidential.

B.1 Feedback questions

SCOPE OF THE CODE

1. How should the ISWG ensure that all trustees are bound by the Code?
2. What are the practical implications of the transition arrangements?
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)?

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?
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?
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?
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?

CANCELLATION AND CESSATION OF COVER

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

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?

B.3 Feedback questions

HELPING MEMBERS TO MAKE INFORMED DECISIONS

12. Which parts of the Code require particular attention for consumer testing?
13. How could the Key Facts Sheet template better assist members to understand and compare their cover?
14. Do the communication requirements in the Code achieve the right balance between prescription and trustee flexibility?
15. What further steps could be taken to engage members who are making no contributions or low or infrequent contributions?

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

B.5 Feedback questions

VULNERABLE CONSUMERS

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

B.6 Feedback questions

PREMIUM ADJUSTMENTS

21. Are the premium adjustment arrangements sufficiently transparent?
22. What further detail could the Code include?

B.7 Feedback questions

PROMOTING OUR INSURANCE COVER, CHANGES TO COVER

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

B.8 Feedback questions

REFUNDS

24. What are the practical and administrative implications of the refund requirements provided?
25. Are there any issues with the maximum time limits for the duration of refunds?
26. For superannuation funds – what are your current practices for refunding premiums, and the duration of any refunds?

B.9 Feedback questions

STAFF AND INDEPENDENT SERVICE PROVIDERS

27. Do the standards for training and monitoring staff require further detail?
28. What are the practical implications of requiring trustees to ensure Independent Service Providers comply with the Code?

B.10 Feedback questions

ENQUIRIES AND COMPLAINTS

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

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?

We invite you to comment on the draft Code and the key questions that have been raised. All submissions on this discussion paper are due by **Friday 20 October 2017** and should be sent to the Project Management Office at:

ISWG-PMO@kpmg.com.au

All submissions will be treated as public documents unless you specifically request that we treat the whole or part of your submission as confidential.

APPENDIX 1:

INSURANCE IN SUPERANNUATION CODE OF PRACTICE

INSURANCE IN SUPERANNUATION CODE OF PRACTICE

DRAFT FOR CONSULTATION

What is the Insurance in Superannuation 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 cover 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

1.1 The Insurance in Superannuation **Code** of Practice (**Code**) contains mandatory service standards that **we** must uphold when providing insurance services to **you**.

1.2 In the **Code**, "**we**" are trustees of superannuation fund. "**You**" are members of **our** fund who hold insurance, and beneficiaries of **our** members.

1.3 **Our** main responsibility in providing insurance is to act in the best interests of **our** members and their beneficiaries.

1.4 If **we** do not meet the standards of the **Code**, **we** can be sanctioned in accordance with section 15 of the **Code**.

1.5 **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** obligations in **our** communication and marketing materials.

1.6 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** deliver insurance to **you**.

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

a) transparent;
b) fair and respectful;
c) honest; and
d) 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 and a decision in a reasonable timeframe.

3. Scope of the Code

Who is bound by the Code?

3.1 The parties bound by the **Code** are:

a) superannuation fund trustees that offer insurance within an APRA-regulated superannuation fund; and
b) any other industry participant that adopts the **Code** by entering into a formal agreement with the **Insurance in Super Code Owners** to be bound by the **Code**.

You can find a list of the entities that are bound by the **Code** on the **Code** website.

3.2 References to "**we**", "**us**" and "**our**" mean the entity that is bound by the **Code**, acting individually and independently, and not collectively.

3.3 The **Code** does not apply to:

a) self-managed super funds;
b) life insurance companies; or
c) any other industry participants,

unless they have adopted the **Code** in accordance with clause 3.1(b).

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

Who receives the benefit of the Code obligations?

3.5 References to "**you**" and "**your**" mean an individual who holds insurance as a member of a superannuation fund covered by the **Code** and their beneficiaries. This includes members whose cover has been provided automatically and those members who have chosen specific cover.

3.6 In some sections of the **Code** "**you**" will only refer to **Automatic Insurance Members** and the standards will only apply to automatic cover; the sections will make this clear.

What products are covered by the Code?

3.7 The **Code** covers insurance held within superannuation funds. These are commonly referred to as:

a) death cover, which pays a lump sum on the death of an insured member, or if they are diagnosed with an illness with a life expectancy less than a specified period (generally 12 or 24 months);[1]
b) total and permanent disability (TPD) cover, which pays one or more lump sums or instalments 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; and
c) income protection cover, which is designed to assist an insured member who is unable to work due to illness or injury, during their recovery. It provides replacement income of a specified amount, and 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.

3.8 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?

3.9 The **Code** commences on 1 July 2018 and **we** have a transition period until 30 June 2019 to adopt the **Code**.

[1] This is referred to as a "terminal illness".

3.10 The benefit design and premium limit standards in Section 4 apply to any new or updated policies after the date **we** adopt this **Code**. Any existing policies must be updated to take into account the requirements of the **Code** within two years of **our** date of adoption.

3.11 The rest of the **Code** standards apply from the date **we** adopt the **Code**.[2]

Our relationship with insurers

3.12 **We** will work closely with the insurers who issue **your** cover, to ensure **you** have a consistent end-to-end experience.

3.13 Life insurers are also bound by service standards, set out in the Financial Services Council's **Life Insurance Code of Practice** (**FSC Insurer Code**). Any contract that **we** enter into with an insurer will require both parties to comply with the code to which they subscribe. Any concerns about code compliance can be raised with the relevant code's administrator.

Legal status of the Code

3.14 The **Code** operates alongside and is subject to existing laws and regulations and does not limit **your** rights under any law or regulation. Where there is any conflict or inconsistency between the **Code** and any law or regulation, that law or regulation prevails.

3.15 Where the **Code** imposes standards on **us** that are higher than the law, **we** will comply with both the law and the **Code**.

3.16 The **Code** is enforceable through:

a) the independent code administrator, to whom **you** can report any concerns about possible **Code** breaches; and
b) **our** complaints process and the external complaints process provided by the Superannuation Complaints Tribunal (**SCT**) and the Australian Financial Complaints Authority (**AFCA**), as set out in section 13 of the **Code**.

3.17 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**).

4. Appropriate and affordable cover

Benefit design

4.1 Insurance in superannuation is often provided automatically. **We** will design insurance benefits for **our Automatic Insurance Members** with the objectives that they are appropriate and affordable for **our** membership.

4.2 **We** will publish **our** insurance strategy on **our** website. This will include an explanation of how **we** have designed **our** automatic cover, to help **Automatic Insurance Members** decide whether the automatic cover is appropriate for them.

[2] For applications, claims or complaints that already exist on the date **we** adopt the **Code**, if the **Code** requires **us** to do something within a specified timeframe, that timeframe begins on the date of adoption.

4.3 If benefit design is determined in conjunction with a party other than **us**, for example a sponsoring employer that is paying the premiums, **we** will test the benefit design for appropriateness and affordability.

4.4 When **we** design insurance benefits for **our Automatic Insurance Members**, **we** will assess **our** members' likely insurance needs, including considering the following characteristics of **our** membership where these are known and relevant:

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

4.5 **We** will assess the appropriateness of **our** benefit design, including types and levels of automatic cover, for **our** membership generally, and for the segments of members described below at 4.11 to 4.13.

4.6 As well as determining the insurance needs of **our Automatic Insurance Members**, **we** will design cover that is affordable and does not **inappropriately erode** the retirement income of **our Automatic Insurance Members**. **We** will specifically consider the impact on the segments of members described below at 4.11 to 4.13.

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

4.8 As part of determining **our** benefit design, premiums for **our** automatic cover will be set at a level that does not exceed 1% of earnings.[3] **We** will assess the premiums against a level of earnings that is appropriate for relevant segments of **our** membership and for **our** membership generally. In addition, premiums for the segment of **our Automatic Insurance Members** under the age of 25 will be set at a level that does not exceed 0.5% of earnings.

4.9 **Our** basis for determining premiums, the level of earnings **we** apply to segments of **our** membership and the assumed period of membership over which premiums will be assessed will be documented and reported to the code administrator.

4.10 Where a segment of **our** membership that is classified as higher risk due to the members' occupation would be unlikely to be able to purchase appropriate and affordable cover outside superannuation, **we** may provide automatic cover to this segment with premiums that exceed the 1% earnings cap. In order to rely on this provision, **we** must satisfy the code administrator that the cover provided is both appropriate and affordable, and that the segment of members would be unlikely to be able to purchase equivalent insurance outside of superannuation on

[3] Ordinary time earnings from personal exertion.

acceptable terms. If **we** include **you** in a segment of **our** membership where premiums exceed the 1% earnings cap, this will be clearly communicated to **you**.

Segments of our membership

4.11 For younger members, when designing benefits **we** will consider:

a) appropriate types and levels of cover, given that younger people are less likely to have children and other dependants or significant debt, and are more likely to require total and permanent disability or income protection, rather than death cover;
b) the impact of premiums on members who typically have low account balances;
c) working patterns, which may be casual or part-time; and
d) fair treatment of younger members, taking into account whether there is any cross-subsidisation with older members of the fund.

4.12 For members with low or infrequent contributions, when designing benefits **we** will consider:

a) the characteristics of these members, which may include people who have taken leave for substantial lengths of time and members who are casual or part-time workers;
b) the impact of premiums on members who have low or infrequent contributions; and
c) fair treatment, taking into account whether there is any cross-subsidisation.

4.13 For members nearing retirement, when designing benefits **we** will consider:

a) appropriate types of cover given they will generally have higher superannuation balances, which may reduce the amount of cover needed;
b) the impact of high premiums associated with their higher likelihood of claiming; and
c) the greater emphasis members at these ages typically place on building savings for retirement as opposed to life insurance protection.

4.14 **We** may limit the type or level of cover offered to **you** as an **Automatic Insurance Member** if **we** believe that cover cannot be provided at a reasonable cost; for example, if **you** are employed in a hazardous occupation.

4.15 **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 sufficient evidence.

Reviews and changes to benefit design

4.16 **We** will review and update as necessary the benefits **we** offer and the policy details at each policy renewal (and no later than every three years), to ensure they remain up-to-date and suitable for the segments of members described in sections 4.11 to 4.13 above.

4.17 **We** will assess the premiums for segments of **our Automatic Insurance Members** at each policy renewal (and no later than every three years) to ensure premiums remain less than 1% of earnings, and less than 0.5% of earnings for the segment of members under the age of 25.

4.18 If **we** determine that any of the benefits offered as part of **your** cover need to be updated or redesigned, **we** will provide **you** with details of the changes and any options available to **you** to amend or cancel the new cover.

4.19 If the impact on **your** cover or premiums is material,[4] **we** will let **you** know **in writing** at least 30 days before the changes take effect.

Cancelling your insurance cover

4.20 **You** can cancel the insurance cover with which **we** provide **you** at any time, and premiums will no longer be deducted from **your** superannuation account. **You** can cancel part of **your** cover and retain some of it, provided this is permitted under **our** fund rules. **We** will make the process straight-forward. **You** can cancel in the following ways, subject to appropriate member identification: [5]

a) via **our** website or digital application;
b) over the phone; and
c) **in writing** by email or post.

4.21 **We** will include clear instructions on how to cancel **your** insurance cover in **our** 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 five **business days**.

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

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

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

4.24 If **you** cancel within 20 **business days** of **us** telling **you** that **we** have provided **you** with automatic cover or that **we** have increased **your** level of automatic 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 commencement of the increased cover (as applicable). No cover will then apply for that period.

[4] In accordance with the requirements of section 1017B of the Corporations Act 2001.

[5] 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 agreement with an employer does not allow for member cancellation.

Cessation of cover due to lack of contributions

4.25 If **you** are an **Automatic Insurance Member**, in order to avoid eroding **your** account balance, **your** cover will cease if no **eligible contributions** have been received by **us** for 13 months,[6] unless **you** tell **us** at any time that **you** want to retain **your** cover.

4.26 Before ceasing **your** cover, **we** will contact **you** in accordance with sections 5.23 to 5.26.

4.27 If **your** cover ceases due to lack of contributions, **we** will confirm this in writing, including the date of cessation and the options for reinstatement of cover.

Reinstatement and recommencement of cover

4.28 If **your** cover has ceased due to a lack of contributions in accordance with section 4.25,[7] it can be reinstated in the following circumstances without any health assessment being required or break in cover, provided **you** are capable of active employment and **your** account has adequate funds to pay the premium owed for the intervening period:

a) if **you** tell **us you** want to reinstate **your** cover within 60 calendar days of the cessation date; or
b) if sufficient **eligible contributions** are made within 60 calendar days of the cessation date.

4.29 If **you** tell **us** that **you** wish to reinstate **your** cover within 60 calendar days of the cessation date but **your** account balance is insufficient to cover **your** premium, **we** will allow **you** to make contributions to **your** account within the 60-day period to top up the balance if **you** wish.

4.30 In addition, **we** will explain **our** process and the circumstances for members to apply to recommence cover after if it has ceased automatically or is cancelled when **we** confirm that the cover has ended.[8]

Duplicate insurance cover

4.31 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.

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[6] Contribution inactivity is measured from the later of the start date of the **Code** or the end of the period covered by the most recent **eligible contribution we** receive for **you** (where this is known). Where this is not known, contribution inactivity will be measured from the later of the start date of the **Code** or the date of the most recent **eligible contribution we** receive for **you**.

[7] For members of employer funds, **we** may offer a continuation option when employment ceases.

[8] This process may differ between trustees and may involve a health assessment.

5.2 **We** will seek to understand the characteristics of **our** members, in order to tailor **our** communications.

5.3 **We** will use plain language in **our** insurance communications, and will limit the use of jargon and acronyms. **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 use **our** best efforts to keep **our** members' contact details current, so that **we** can provide the communications required by the **Code**.

Explaining our definitions

5.6 **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.

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

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

5.9 **We** will use the following standard headings as relevant to **our** total and permanent disability cover:

a) Total and permanent disability – unable or unlikely to do a suited occupation ever again;
b) Total and permanent disability – unable or unlikely to do your own occupation ever again;
c) Total and permanent disability – unable or unlikely to look after yourself ever again;
d) Total and permanent disability – unable or 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; and
h) Total and permanent disability – significant impairment to your whole body.

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

5.11 If the total and permanent disability definition that **we** use is different from the standard definition used in legislation,[9] **we** will explain the differences in plain language.

Key Facts Sheets

5.12 **We** will publish a Key Facts Sheet for **our** automatic insurance cover on **our** website.

[9] Superannuation Industry (Supervision) Act 1993 (Cth).

5.13 The format of the Key Facts Sheet is included as an Annexure to the **Code**.

5.14 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.

5.15 Where **we** offer **you** insurance arrangements that are different to **our** automatic cover (for example, tailored cover for an employer), **we** will ensure that **you** are provided with information on **your** specific cover.

Insurance welcome pack

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

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

5.18 The insurance welcome pack will contain the following information:

a) the types of cover **you** hold automatically;
b) how much **you** are insured for;
c) the premiums **you** will pay;
d) the policy's standard inclusions and exclusions;
e) the benefits of insurance in superannuation;
f) how **you** can increase, decrease or cancel **your** cover based on **your** individual needs;
g) a link to the **Code**; and
h) a link to the product disclosure statement on **our** website.

Communication during the term of your cover

5.19 **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) the premiums **you** will pay;
c) an explanation for any increase in **your** premiums;
d) the policy's standard exclusions and limitations that may change **your** entitlement to benefits;
e) information about how to contact **us** to discuss options if **you** want to change the terms of **your** cover;
f) how **you** can increase, decrease or cancel **your** cover based on **your** individual needs;
g) information about the **Code**;
h) **our** rules for cessation of cover; and
i) what to do in the event of a claim.

5.20 **We** will contact **you** about **your** insurance cover when **we** become aware that:

a) a change in **your** employment arrangements may impact **your** cover;
b) **you** have stopped contributing for six months (or a shorter period as determined by **us**); or
c) **you** have ceased to be covered due to the terms of the policy.

5.21 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.

5.22 **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.

Communication of lack of contributions

5.23 If **we** stop receiving contributions to **your** account, **we** will contact **you** no later than six months from receipt of **your** last **eligible contribution**.[10]

5.24 The communication will be **in writing** and will include:

a) general information about the impact of insurance premiums on retirement savings when there are no longer contributions;
b) an explanation that if **you** have started contributing to another fund, **you** may hold multiple insurance covers and the impact of this, including possible offsets to income when a claim is made;
c) for **Automatic Insurance Members** only, that **we** intend to cease cover if no contributions are made for 13 months (or a shorter period as determined by **us**); and
d) **your** options to retain cover, cancel immediately, or reduce cover.

5.25 For **Automatic Insurance Members**, prior to ceasing cover, **we** will contact **you** at least twice, through **your** preferred communication method if **you** have nominated one, or through two different communication methods if possible, in accordance with sections 4.25 to 4.27.

5.26 If **you** tell **us** that **you** want to retain **your** insurance cover even though **you** are not making any contributions, **we** will record this and stop sending **you** communications.

Communication of low or infrequent contributions

5.27 If at the end of **our** financial year **we** have received contributions for **you** that are less than $1,800 in **Superannuation Guarantee** in the previous 12 months, **we** will contact **you** to let **you** know:

a) the cost of **your** premiums and general information about the impact of insurance premiums on retirement savings when there are low contributions; and
b) **your** options to retain cover, cancel immediately, or reduce cover.

5.28 This communication will be provided to **you** at least once a year if we continue to receive contributions that are less than $1,800 in **Superannuation Guarantee** in each 12-month period.

Accessing information

5.29 **We** will include the following information easily accessible on **our** website:

a) the Key Facts Sheet for **our** automatic cover;
b) the product disclosure statement for **our** automatic cover;

[10] Contribution inactivity is measured from the later of the start date of the **Code** or the end of the period covered by the most recent **eligible contribution we** receive for **you** (where this is known). Where this is not known, contribution inactivity will be measured from the later of the start date of the **Code** or the date of the most recent **eligible contribution we** receive for **you**.

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; and
f) how to make a complaint.

6. Claims handling

Principles for claims handling

6.1 **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**.

6.2 **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.

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

6.4 **We** will be responsible for overseeing the conduct of the insurer and any **Independent Service Provider we** engage in the claims process, in accordance 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, in order to minimise delays and remove unnecessary duplication from the process.

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

6.6 **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

6.7 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.

6.8 The **FSC Insurer Code** places responsibilities on insurers to determine claims within specific timeframes. The table at the end of this section provides an indication of the entire claims process, including the obligations on both **us** and the insurer. **We** will work together to ensure a consistent and efficient process for **you**.

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

6.10 **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 an **Independent Service Provider**.

6.11 **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 **FSC Insurer Code**.

Making a claim

6.12 If **you** tell **us** that **you** wish to make a claim, **we** will direct **you** to the appropriate forms or information online or email these to **you** within one business day. If **you** require hard copy forms, **we** will send these within five **business days**.

6.13 If **we** receive a claim submission from **you**,[11] within five **business days we** will:

a) acknowledge receipt of the claim;
b) assess whether the claim submission has been completed, and 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; and
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 accordance with section 6.16 below).

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

6.15 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) whether **you** may be required to attend ongoing assessments;
c) how payments will be made if the claim is accepted;
d) that there may be financial or tax implications and **you** may wish to get independent advice; and
e) the impact on the amount of the claim of receiving income from other sources including Centrelink and workers' compensation if offsets are applied;
f) 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 **FSC Insurer Code** and **our** review of the insurer's decision;
g) **our** role and duties and the role and duties of the insurer;
h) how **we** will review the insurer's decision; and
i) who will be **your** primary contact and contact details **you** can use to get information about **your** claim.

6.16 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; and
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

6.17 **We** will respond to **your** queries:

a) with an acknowledgment within one business day; and
b) with a full response within ten **business days**.

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

6.18 **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.

6.19 **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 **FSC Insurer Code.**

6.20 If the insurer tells **us** that it cannot make a decision on **your** claim in the timeframes provided in the **FSC 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 in order to allow a decision to be made, **we** will tell **you** that **your** claim will be progressed further when more information is available.

6.21 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 additional information to correct errors or mistakes.

Review of insurer's decision

6.22 Once the insurer has made its decision on **your** claim, **we** will review the decision, as part of **our** duty to act in **our** members' best interests.

6.23 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.

6.24 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.

6.25 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 insufficient information to make a properly informed decision, **we** will let **you** know. **We** will request any additional information or assessments **we** need as early as possible and will avoid multiple information requests where possible.

6.26 **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.

6.27 If the insurer informs **us** that it intends to make a payment to **us**,[12] **we** will carry out **our** review within five **business days** to assess whether **you** have met the requirements to withdraw the money from **your** superannuation account. **We** will also have oversight processes in place to confirm that the insurer is paying the correct amount to which **you** are entitled, either to **us** or directly to **you**.

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

6.28 If the insurer informs **us** that it has decided not to pay the claim, **we** will carry out **our** review within 15 **business days**. 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) a sufficient 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) all documents obtained during the assessment;
d) the insurer's and **our** obligations when a claim is declined and what **you** can expect; and
e) an opportunity to make further representations and submissions or provide further information in relation to **your** claim.

6.29 If **you** tell **us** that **you** want to make further representations and submissions or provide further information in relation to **your** claim while **we** are reviewing the insurer's decision, the timeframe for **our** review will not start until **we** have received **your** further information.

6.30 If **our** review results in **us** querying the insurer's decision, **we** will tell the insurer within five **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.

Claim decision

6.31 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** independent review. Within five **business days** of confirmation being given, **we** will pay **your** claim,[13] 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; and
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.[14]

6.32 If **your** claim is declined, **we** will tell **you**:

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

Income protection claims

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

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

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

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

6.34 Where **you** are receiving ongoing income protection payments, **we** will have oversight processes in place to ensure the information **you** are required to provide is reasonable, and **you** and **your** doctor are providing the required information, so that **you** receive timely payments.

6.35 If the insurer tells **us** that it has determined that **you** are no longer entitled to income protection payments for any reason other than **your** benefit period ending, **your** having returned to work, or **you** or **your** doctor not providing the required information, **we** will have five **business days** to review the decision and raise any concerns with the insurer.

6.36 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 accordance with section 11.1 below.

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

Claims handling timetable

<table>
<tr><th></th><th>Step</th><th>Trustee</th><th>Insurer</th><th></th></tr>
<tr><td rowspan="4">Lodgement</td><td>Send claim forms (email)</td><td>Within one business day of the request</td><td></td><td rowspan="11">For claims other than income-related claims, it is expected that the majority of claims would have an end to end cycle time within 7 months unless unexpected circumstances apply. For income-related claims, it is expected that the majority of claims would have an end to end cycle time within 3 months unless unexpected circumstances apply.</td></tr>
<tr><td>Send claim forms (hard copy)</td><td>Within five business days of the request</td><td></td></tr>
<tr><td>Acknowledge receipt of the claim, assess whether the claim has been completed, provide a summary of the claim process and provide claim to the insurer for assessment (if claimant has cover)</td><td>Within five business days of receiving the claim</td><td></td></tr>
<tr><td>Provision of introductory claims information</td><td></td><td>Within ten business days of the insurer receiving the claim∗</td></tr>
<tr><td rowspan="3">Assessment</td><td>Initial eligibility assessment of whether claimant has insurance cover</td><td>Within five business days of receiving the claim</td><td></td></tr>
<tr><td>Response to queries</td><td colspan="2">Within ten business days of the request</td></tr>
<tr><td>Progress updates to claimant</td><td colspan="2">Within 20 business days of the last update</td></tr>
<tr><td rowspan="4">Decision</td><td>Claim decision by insurer</td><td></td><td>Within ten business days of all requirements being received (including any additional information provided by claimant)</td></tr>
<tr><td>Trustee review of insurer’s decision</td><td>Within five business days if the insurer informs that it will pay the claim to the fund
Within fifteen business days if the insurer informs that the claim will not be paid</td><td></td></tr>
<tr><td>Provision of documents and information relied on in making the decision, if requested</td><td colspan="2">Within ten business days</td></tr>
<tr><td>Payment of the claim</td><td>Within five business days of the trustee confirming that a claim can be paid</td><td></td></tr>
</table>

∗ The **FSC Insurer Code** contains this requirement, and it will depend upon the arrangement **we** have with the insurer as to who will provide this information.

7. Vulnerable consumers

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

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

7.2 **We** will have internal policies in place to help **our** staff to identify vulnerable consumers and to take practical steps to better assist them, which may include referral to people or services with the training and experience to appropriately engage with them.

7.3 Where **you** tell **us** that **you** require support or assistance from **us**, **we** will keep a record of this and **we** will provide support or assistance to the best of **our** ability.

Providing information

7.4 **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 a flexible approach to verification and identification in accordance with AUSTRAC[15] guidance, while still meeting **our** obligations under the law.

7.5 **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.

7.6 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.

Interpreting services

7.7 **We** will provide access to an interpreter at **your** request, or where **our** staff determine that an interpreter is needed to communicate effectively with **you**. **We** may use an interpreter who is a member of **our** staff, or an external interpreter.

7.8 **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.

7.9 **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

7.10 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.

Release of funds

7.11 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.

[15] Australian Transaction Reports and Analysis Centre.

7.12 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 **your** insurance cover and that **you** should leave sufficient funds in **your** account to pay the premiums for **your** cover.

8. Premium adjustments

8.1 If **we** have a premium adjustment arrangement in place with an insurer to return surplus premium to **us**, or to adjust future premiums to reflect a premium deficit, **we** will make **our** premium adjustment policy available on **our** website.

8.2 Any premium adjustment payments **we** receive from an insurer will be passed onto **our** insured members through adjustments to future premiums.

8.3 Any premium adjustment payment made to **us** by an insurer 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.

9. Promoting our insurance cover

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

a) be clear 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; and
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 recommend or promote the insurance benefits **we** offer, including insurance cover additional to **our** automatic cover, 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 cover, **we** will target any promotion to the segments of **our** membership for whom **we** have identified the additional cover is appropriate, affordable and of value.

9.4 **We** will investigate 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; or
   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; and

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 additional 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 five **business days** of receiving **your** instructions.

10.5 If **you** tell **us** that **you** want to increase **your** cover, transfer **your** cover from 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 five **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 **FSC 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 an **Independent 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 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 cover, **we** will tell **you** that **you** should not cancel any existing cover until **your** new application is accepted, and explain the general risks of replacing existing cover, including the loss of any accrued benefits, the possibility of waiting periods to start again, and the implications of any nondisclosure on an application for cover (even where unintentional).

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) an additional 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; or
e) any other specific terms or conditions that may be applicable to the policy,

we will make it clear to **you** what the alternative terms are that are 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 accordance with the standards in section 13; and
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 **our** 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; and
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

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**.

10.16 **We** will contact **you** about **your** insurance cover if **you** have been transferred to another division. **We** will confirm to **you** any changes to **your** insurance cover and **your** options for amending 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. **We** will confirm to **you** any changes to **your** insurance cover and **your** options for amending 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, which means that no payment is made to **you** under the cover **you** hold with **us** because **you** have been paid a benefit under another similar policy, **we** will refund **your** premiums into **your** account for the duration of the overlap of covers, to a maximum of six years.

11.2 If **we** identify that **you** were not eligible to claim against **your** cover for any event from the start of the cover, **we** will refund **your** premiums to **your** account for the period **you** were ineligible.[16]

11.3 If **you** make a claim that is accepted, **we** will refund **your** premiums back to the date **you** became eligible to claim.

12. Staff and Independent 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. 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 additional 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 a third 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 an

[16] Refunds will not be provided if **you** have an illness or injury that precludes **you** from cover due to a limited cover exclusion, because **you** will still be eligible for cover for any new illnesses or injuries.

Independent Service Provider, the agreement will require them to comply with the relevant standards of the **Code**.

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

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

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

12.9 **We** will require **Independent 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 **Independent 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 **Independent 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 accordance with **our** complaints process.

13. 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** 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**; and
f) information relied on to decide **your** claim or complaint.

13.3 **We** will respond to **your** enquiry:

a) with an acknowledgment within one business day; and
b) with a full response within ten **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** 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; or
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; and
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** are entitled to make a complaint to **us** about any of **our** decisions or conduct, or the decisions or conduct of an **Independent 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** in relation to **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 into **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 additional 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 the Superannuation Complaints Tribunal (**SCT**) or the Australian Financial Complaints Authority (**AFCA**)

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

a) **our** decision in relation to **your** complaint and the reasons for that decision;
b) that **you** can request copies of the documents and information relied on in accordance with the standards of this section;
c) that **you** have the right to take **your** complaint to the **SCT** or **AFCA** if **you** are not satisfied with **our** decision and the timeframe within which **you** must take **your** complaint to the **SCT** or **AFCA**; and
d) contact details for the **SCT/AFCA**.

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 the **SCT** or **AFCA** as appropriate.

13.20 Determinations made by the **SCT** and **AFCA** are binding on **us** at law.

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

14. Governance

Role of the code administrator

14.1 The code administrator is the independent body responsible for formal independent monitoring and reporting on compliance with the code.

14.2 The code administrator is made up of:

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

14.3 The code administrator's functions and powers are set out in its Charter. Its responsibilities include:

a) establishing appropriate data reporting and collection procedures;
b) monitoring compliance with the **Code**;
c) investigating breaches of the **Code** and imposing sanctions and remedial measures as appropriate;
d) reporting systemic **Code** breaches and serious misconduct to the relevant regulators;
e) publishing an annual report containing consolidated, de-identified analysis on **Code** compliance;
f) recommending amendments to the **Code** in response to emerging industry or consumer issues, or other issues identified in the monitoring process;
g) ensuring that the **Code** is adequately promoted;
h) ensuring that **our** staff are appropriately trained in the **Code** and that **we** make provision for this training; and

i) ensuring that there is a regular, independent review of the content and effectiveness of the **Code** and its procedures.

14.4 The code administrator will provide regular reports to the **Insurance in Super Code Owners**, with recommendations on any **Code** improvements and industry issues, including where non-compliance with any standards of the **Code** indicates an industry issue or highlights weaknesses in the **Code**.

14.5 The code administrator may outsource its functions to an appropriate body, with the exception of its powers to sanction.

Our role

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

14.7 **We** will work with **our** members to improve education in relation to 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

14.8 The **Insurance in Super Code Owners** are responsible for the development of the **Code**, including the Charter of the code administrator.

14.9 The **Insurance in Super Code Owners** will commission formal independent reviews of the **Code** as appropriate, no later than every three years. The code administrator may recommend to the **Insurance in Super Code Owners** that the **Code** be reviewed, if the code administrator believes the application of the **Code** is not meeting its objectives.

14.10 In addition to formal independent reviews of the **Code**, the **Insurance in Super Code Owners** will consult with the code administrator, relevant regulators, the **SCT** and **AFCA**, consumer and industry representatives and other stakeholders to develop the **Code** on an ongoing basis.

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

14.12 The **Insurance in Super Code Owners** will develop guidance documents from time to time which are not enforceable but assist **us** in improving standards over time, and in interpreting and meeting **our** obligations under the **Code**.

15. Enforcement and sanctions

15.1 Anyone can report alleged breaches of the **Code** to the code administrator. If the code administrator determines that **your** report is better dealt with through **our** complaints process, it will refer **you** to **us** to make a complaint in accordance with section 13 of this **Code**.

Our responsibility

15.2 **We** will:

a) have appropriate systems and processes in place to enable compliance with the **Code** including monitoring and analysing data on policies, claim volumes, claim declines and withdrawals, and internal and external complaints; and
b) report annually to the code administrator, **our** Executive and **our** Board of Directors on **our** compliance with the **Code**.

15.3 If **we** identify a **Significant Breach** of the **Code** within **our** organisation, within ten **business days** of becoming aware of the breach **we** will report it to the code administrator.

15.4 **We** will be in breach of the **Code** if **our** staff or **our Independent Service Providers** fail to comply with the **Code**.

15.5 **We** will cooperate with the code administrator in its:

a) review of **our** compliance with the **Code**;
b) investigations of any alleged **Code** breach; and
c) reasonable requests of **us** when it carries out its functions.

15.6 **We** will apply fair and reasonable corrective measures within set timeframes, as agreed with the code administrator, in response to a **Code** breach. For the avoidance of doubt, any corrective measures related to the breach agreed with **us** or imposed on **us** by any regulatory body will take precedence.

Code administrator responsibilities

15.7 The code administrator will:

a) receive allegations about breaches of the **Code**;
b) notify **us** of any alleged **Code** breaches by **us** and provide an opportunity for **us** to respond;
c) use its discretion to investigate alleged breaches in accordance with the **Code**;
d) determine whether a breach has occurred;
e) report any **Significant Breach** to the relevant regulator;
f) agree with **us** any fair and reasonable remedies to be implemented by **us** and the relevant timeframes, which can include:
    i. compensation for any direct financial loss or damage caused to an individual by the breach of the **Code**; and
    ii. binding non-monetary orders obliging **us** to take (or not take) a particular course of action to resolve the breach,

    taking into account any remedies related to the breach imposed on **us** by any regulatory body; and
g) monitor the implementation of any remedies by **us** and determine if they have been implemented effectively and within the agreed timeframe.

Sanctions

15.8 If the code administrator considers **we** have failed to remedy a **Code** breach in accordance with section 15.7, or if **we** cannot agree on fair and reasonable remedies, it will:

a) notify **our** Chief Executive Officer in writing; and
b) provide an opportunity for **us** to respond within 15 **business days**.

15.9 The code administrator will consider any response by **us** before making a final determination and imposing any sanctions.

15.10 The code administrator will notify **our** Chief Executive Officer and the **Insurance in Super Code Owners in writing** of its decision regarding any failure to remedy a **Code** breach and any sanctions to be imposed.

15.11 When determining any sanctions to be imposed, the code administrator will consider:

a) the principles and objectives of the **Code**;
b) the appropriateness of the sanction;
c) any measures related to the breach imposed on **us** by any regulatory body; and
d) whether the breach is a **Significant Breach**.

15.12 The code administrator may at its discretion impose one or more of the following sanctions:

a) a requirement that particular rectification steps be taken by **us** within a specified timeframe, taking into account any rectification related to the breach imposed on **us** by any regulatory body;
b) a formal warning;
c) a requirement that a **Code** compliance audit be undertaken;
d) public naming of **us** and **our** non-compliance on **our** website and on the **Code** website;
e) corrective advertising orders;
f) reporting to a relevant regulator and/or
g) suspension or termination of subscription to the **Code**.

15.13 The code administrator's decisions are binding on **us**.

16. Definitions

AFCA means the Australian Financial Complaints Authority.

Automatic Insurance Member means **you** are a superannuation fund member who holds insurance under an automatic acceptance limit, issued when **you** joined the fund, or **your** employer has ceased funding all or part of **your** premiums, such as when **you** leave the employer. **You** are not regarded as an **Automatic Insurance Member** if:

a) **you** make an application for cover (including cover that is underwritten or the recommencement of previous cover);
b) **you** vary the cover in any way, such as cancelling, fixing cover or changing the benefit or waiting period;
c) **your** insurance premiums are wholly paid for by **your** employer or not paid by deduction from **your** account; or
d) **you** are a defined benefit member.

business days means Monday to Friday excluding public holidays.

Code means the Insurance in Superannuation Code of Practice.

eligible contributions for measuring contributions inactivity consist of:

a) **Superannuation Guarantee**;
b) salary sacrifice; and
c) personal contributions (including a rollover and contributions made by a spouse).

They do not include government contributions, including co-contribution, super guarantee credits, or Low Income Super Tax Offset.

exceptional cases means:

a) the claim is lodged so late that there are significant difficulties obtaining information necessary for the claim assessment;
b) despite reasonable follow up, reports from third parties have not been received;
c) the insurer has not provided information to **us** that **we** require to make a decision about a claim or complaint;
d) **you** or **your** representative has not responded to **our** reasonable enquiries or requests for information;
e) there are difficulties communicating with **you**;
f) **you** have requested a delay; or
g) **we** or the insurer suspect the claim is fraudulent.

FSC Insurer Code means the Financial Services Council's Life Insurance Code of Practice 2017.

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.

Independent Service Provider means a third party that **we** engage to provide a service to **you** on **our** behalf; for example, a claims management service or a fund administrator. A life insurer is not an **Independent 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 (FSC).

SCT means the Superannuation Complaints Tribunal.

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

Significant Breach means a breach that is reasonably determined by **us** to be significant by reference to:

a) the number and frequency of similar previous breaches;
b) the impact of the breach on **our** ability to provide **our** services;
c) the extent to which the breach indicates that **our** arrangements to ensure compliance with **Code** obligations are inadequate; or
d) the actual or potential financial loss caused by the breach.

we, **us** and **our** mean the entity that is bound by the **Code**.

you and **your** mean an individual who holds insurance as a member of **our** fund and their beneficiaries.

ANNEXURE A: KEY FACTS SHEET

When you first become a member of

XYZ Superannuation Fund

you automatically receive life insurance cover prior to joining the Fund provided you meet certain eligibility criteria.

Insurance in Superannuation Key Facts Sheet

Why is this important?

Insurance is about covering life-changing events. It can give you peace of mind and provide financial support, to help protect what's important to you.

- Protect your lifestyle
- Protect your income
- Cover your debts
- Protect your family

Did you know?

- Around **70%** of working Australians hold life insurance through superannuation funds.
- In 2015-16, more than **72,000** claims were paid, worth **$4.9 billion**, through superannuation funds.
- The cost of **insurance premiums may be deducted from your super balance,** reducing the money available for your retirement but helping protect you along the way.
- You can **cancel** your automatic insurance cover at any time.

What automatic insurance cover is included?

	Terminal Illness	Death	Total and Permanent Disablement (TPD)	Income Protection (IP)
	Pays a lump sum payment if terminally ill.	Pays a lump sum to dependents or beneficiaries upon death.	Pays a lump sum payment if not able to work again due to illness or injury.	Pays a replacement income if temporarily unable to work due to illness or injury.
Automatic cover	yes	yes	yes	yes (2-year benefit period)
Cover starts	ages 14 - 60	14 - 60	14 - 55	14 - 55
Cover ends	age 75	75	65	65
Are pre-existing medical conditions covered?	yes	yes	yes — must be in Active Employment*	yes
Is cover limited if employer superannuation contributions are not received?	yes	yes	yes	yes
	contributions must be received within 120 days of starting work or Limited cover** may apply			
Does work status affect cover at date of injury or illness?	No	No	yes — must be working at least 20 hours.	yes — must be in gainful employment
Is cover provided if a claim has previously been paid under another superannuation fund?	No	Yes	No	Yes

*Active Employment means an ability to perform or capable of performing all the duties of your normal job on a full time basis on the date that cover starts. Limited cover** applies until in active employment for 2 consecutive months.

**Limited cover means that cover is only provided for an illness or injury that occurs on or after the date cover starts. Any pre-existing medical conditions are not covered.

What are my options?

Do nothing
Keep my automatic insurance cover.

Cancel
Choose to cancel my insurance cover.

Tailor it
Change my cover to meet my personal needs.

What if I'm happy with my insurance cover?
Whether your retirement is years away or just around the corner, it's important to be in a good super fund that provides you and your family with protection when you need it most.

Can cover be cancelled or changed?
Cover can be cancelled in full or in part If you cancel your cover and you decide to apply for cover in the future, you must provide health information that will be assessed by the Insurer.

When should I review my insurance cover?
Your insurance needs can change over time as your circumstances change. For example, if you change jobs, you start a family, divorce or your financial commitments change.

Frequently asked questions

Can I make a claim myself?
In the event of illness, injury or death, you or your beneficiaries may be able to make a claim on your insurance.You may not need a lawyer to make a claim or to have your claim reviewed. If you are not satisfied with our decision on your claim, we will tell you how you can make a complaint.

Nominated Beneficiaries
You can nominate who will receive your insurance benefit if you pass away. Please contact us to receive a nomination form.

What if I change my Superannuation Fund?
Before switching or consolidating super funds, make sure you can get the death, TPD or income protection cover you need, in your chosen fund. Be particularly careful if you have a pre-existing medical condition or are aged 60 or over.

Circumstances that may change your insurance cover

The following may change your automatic insurance cover:

- Ceasing work with your employer
- No superannuation contributions received after x months
- Changing or combining your superannuation funds
- Not having worked for a period of time longer than x months
- You are on extended employer approved leave
- Your account balance falls below $ xxxx

For further information, please refer to the Product Disclosure Statement or call us for further information.

Taking action is easy

Have you used our online insurance calculator? Check to see if your automatic insurance cover meet your needs.
Visit **xyz.com/calculator**

Happy for you to call us if you want to learn more.
2222 2222

Chat with our great team to learn more.
xyz.com/chat

Send us an email to learn more.
email@xyz.com

For more information on choosing insurance and to better understand insurance visit the Australian Government website: **www.moneysmart.gov.au**