asfa
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Claims Handling in Superannuation

Insurance and health related claims

Service Standard

July 2025

ASFA has been operating since 1962 as the peak policy, research and advocacy body for Australia's superannuation industry. ASFA represents the APRA regulated superannuation industry with over 100 organisations as members from corporate, industry, retail and public sector funds, and service providers.

We develop policy positions, service standards and practice guidance through collaboration with our diverse membership base and use our deep technical expertise and research capabilities to assist in advancing superannuation and retirement outcomes for Australians.

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1 About ASFA Service Standards

ASFA Service Standards are intended to provide superannuation trustees (trustees) and funds with information and guidance about ways of doing things that work and benefit members and the superannuation industry.

This paper is intended as a guide only and is not intended to be used as a substitute for professional advice.

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Regulatory requirements

This Service Standard does not repeat or duplicate any relevant legislation. There may be additional standards set by regulatory instruments relevant to insurance benefit payments. Where they overlap or are inconsistent with this Service Standard, the legislation or regulatory instrument will prevail.

The Service Standard also does not attempt to clarify how obligations imposed by legislation or regulatory instrument work in practice. While this Service Standard recommends practices which may support these obligations it does not attempt to align or link practices to those obligations.

3 Introduction

The purpose of this Service Standard is to set out good practice in relation to handling of insurance and health related claims by superannuation trustees.

3.1 Background

An important feature of Australia's system of superannuation is the provision of default insurance cover to eligible superannuation fund members on a group insurance basis. More than 9 million superannuation accounts have insurance such as death insurance, total and permanent disability insurance (TPD) and/or income protection (IP) provided through their superannuation. With some exceptions[1], it is mandatory for funds to offer death and TPD insurance on an opt-out basis to members holding MySuper products.

Insurance in superannuation is consistent with the objectives of the superannuation system because it provides access to cover if members are unable to continue working until the end of their working lives. The provision of default insurance augments the provision of retirement benefits in these circumstances[2].

For the year ended 31 December 2024, 30,660 members made TPD claims with an average sum insured of $154,000 each. There were also 26,641 claims for IP benefits with an average sum insured of $4,000 per month[3].

3.2 Purpose and scope of this Service Standard

This Service Standard has been developed by ASFA and its members to set out good practice and undertakings by superannuation trustees (trustees) in relation to the handling of insurance claims and other health related claims by members for benefits to ensure that claims are processed in a timely manner and superannuation fund members (members) are provided with helpful and timely service during the claims process.

It establishes guidance for trustees with respect to these claims. Trustees undertake to consider reflecting/incorporating these service standards into arrangements that they have with relevant service providers.

ASFA is grateful for the participation of the Super Members Council (SMC), Council of Australian Life Insurers (CALI) and Financial Services Council (FSC) in the development of this Standard.

[1] Members under 25 years of age or with a balance below $6,000

[2] Superannuation (Objective) Act 2024, Explanatory Memorandum paras 1.20-1.26

[3] APRA data

SCOPE OF THIS SERVICE STANDARD

The types of insurance covers in superannuation and conditions of release for superannuation relating to ill health to which this standard applies are:

Insurance in superannuation

- Total and Permanent Disability Cover (TPD)
- Income Protection Cover (IP)
- Terminal illness benefit (TIB)

Conditions of release

- Permanent incapacity
- Temporary incapacity
- Terminal medical condition

3.3 Interaction with the Life Insurance Code of Practice

The Life Insurance Code of Practice (Life Code) issued by the Council of Australian Life Insurers (CALI) establishes obligations that life insurers agree to uphold including with respect to insurance claims. Life Code places responsibilities on life insurers to determine claims within specific timeframes.

Trustees should be aware of the standards in the Life Code when considering their regulatory obligations and the guidance provided under this Service Standard, especially where they have engaged a life insurer to provide claims handling services.

Some of these services may be performed by a third-party service provider on behalf of the trustee.

Trustees should have in place effective governance and oversight of these arrangements. Trustees, insurers and superannuation fund administrators (where relevant) should work together to ensure a consistent and efficient process for members.

Further information on the Life Insurance Code of Practice can be found at https://cali.org.au/ife-code/

3.4 How insurance claims in superannuation work

Where an insurer accepts and approves the payment of a total and permanent disability (TPD) or terminal illness benefit insurance claim in respect of a superannuation fund member[4], the insurer generally pays the proceeds of the insurance cover to the superannuation fund. The superannuation fund must then assess if the member meets any relevant SIS conditions of release that enables payment of a benefit (the account balance and the insured amount where applicable) to the member.

[4] As the trustee owns the policy, although the member submits a claim, it is the trustee that makes the claim on the insurer.

Accordingly, this Service Standard incorporates the trustee's role in the payment of an insured benefit to a member.

Claims for early release of the superannuation account balance due to temporary or permanent incapacity, or terminal medical condition, may also arise where the member is making a claim in circumstances where the member does not hold insurance in superannuation. These claims are also covered by this Standard[5].

Death benefit claims, including death claims that involve a death insurance claim, are not covered by this Standard. They are covered separately in ASFA's Death Benefit Payments Service Standard, issued September 2024.

3.5 Commencement

The Service Standard is effective upon issue in July 2025. ASFA encourages trustees to adopt (where not already in place) the Standard as soon as possible and in any event no later than 1 July 2026.

3.6 Review

This Service Standard will be reviewed every three years.

[5] The requirements for claiming early release are contained in the Superannuation Industry (Supervision) Act and Regulations.

4 The Claims Handling Process

The claims process incorporates a number of steps, and there are roles for trustees, for the insurer, for the superannuation fund administrator, and for the member.

Claims generally comprise two key decisions prior to the payment of a benefit to the member:

- Where the member holds insurance, the insurer assesses the claim to determine whether a benefit is payable to the trustee under the insurance policy – see 4.1 below for a summary of the typical process

- The trustee then assesses whether the member meets a condition of release under superannuation law and the requirements of the Trust Deed / governing rules of the Fund that enables payment of a benefit (the account balance and the insured amount where applicable) to the member

- There may also be claims for early release of superannuation on the grounds of ill-health that are made by members who do not hold insurance or are not otherwise eligible to make an insurance claim

4.1 Summary of the typical insurance claims process

The typical insurance claims process is set out below. In some cases some of these steps might be undertaken directly with the insurer or administrator. Some trustees may have processes that enable members to lodge claims directly with an insurer.

This Service Standard has been based on this process.

4.1.1 A member or their authorised third-party representative contacts the trustee to initiate or lodge a claim or discuss the member's eligibility to apply for payment of a health related benefit.

4.1.2 The trustee will determine whether the member holds valid insurance cover on their account for the relevant period. If so, the trustee or the insurer (as appropriate) provides the member with the required documentation for completion including forms for the member's treating doctor / s to complete.

4.1.3 If insurance cover is not held, the trustee may proceed to assess the claim as a claim for early release of superannuation in accordance with Fund Rules and Legislation or provide information to the member or their representative about early release of superannuation.

4.1.4 Upon receipt of all the required documentation from the trustee or member

the insurer begins assessing the insured component of the claim[6].

4.1.5 Once the insurer makes a decision on the insured component of the claim, they will advise the trustee. The trustee reviews the decision and if it agrees with the insurer the trustee (or insurer if delegated) will advise the member of the outcome of the decision in writing and confirm any amount payable to the member's account in the Fund, and any requirements to make or commence payments.

4.1.5.1 In general, where a TPD or terminal illness claim is approved in relation to the insured component of the claim, the insurer will pay the insured component to the trustee who holds the insurance policy on behalf of member. The trustee will then allocate it to the member's superannuation account and contact the member to discuss options with accessing their insured component and account balance[7].

4.1.5.2 For TPD and terminal illness claims, the member will be able to withdraw their benefit payment from their superannuation account subject to satisfying a condition of release.

4.1.5.3 Tax concessions may apply if the trustee has been provided with information confirming that the member satisfies the criteria for permanent incapacity[8] or a terminal medical condition under superannuation law[9].

4.1.5.4 Where an IP claim is approved, the insurer will generally (where a delegation is in place) pay the benefit directly to a bank account nominated by the member (less any applicable tax).

4.1.6 If the claim is not approved by the insurer, the insurer will notify the trustee who will complete an independent review of the insurer's decision[10].

4.1.6.1 The trustee will assess whether the trustee agrees with the insurer's decision based on the evidence obtained and the terms of the Policy.

4.1.6.2 Upon its review, if the trustee disagrees with the insurer's decision, it will refer the claim back to the insurer for further assessment that may require the insurer to obtain additional medical or other information.

4.1.6.3 The trustee and insurer will work together regarding re-assessment of the claim to find common ground and finalise the decision on the claim.

4.1.6.4 If the trustee agrees that the claim should be declined, the trustee will advise the member of the outcome of the review, providing reasons as to why the claim was declined and provide the member with information on the process for objecting to the decision.

[6] Depending on the administrative arrangements in place the trustee may receive the documents and send these to the insurer, or they may be provided directly to the insurer.
[7] Payment by the insurer of an IP benefit directly to the member is only one option the trustee could take. The trustee could outsource the administration of the IP benefit payment to the insurer. Alternatively, the trustee could authorise any service provider to pay the benefit, or pay it themselves.
[8] To access the benefit with a concessional tax-free component, Section 307-145 of the Income Tax Assessment Act 1997 requires two legally qualified medical practitioners to have certified that, because of the ill-health, it is unlikely that the individual can ever be gainfully employed in a capacity for which he or she is reasonably qualified because of education, experience, or training.
[9] A member may qualify to access their superannuation account balance under the terminal medical condition SIS condition of release but may not yet meet the insurance definition for a terminal illness benefit. This means their superannuation account balance could be released, but their insured component payout may be delayed until they meet the insurer's stricter criteria for terminal illness (e.g., a 12-month life expectancy).
[10] SIS s.52(7)(d) requires Trustees to review claims declined by insurers and pursue claims on behalf of beneficiaries where the claim has a reasonable prospect of success.

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Service Standards for Claims Handling

5.1 General Principles

5.1.1 Claim time can be difficult for members and trustees should treat every member with compassion and respect. The claims process should be timely, made as straightforward as possible and all written communications (regardless of channel) should be written in plain language.

5.1.2 It is important to acknowledge that at the time of a claim, members can be experiencing vulnerability, even temporarily, depending on the nature of the illness or injury that has given rise to the claim. Trustees should be responsive to the person's circumstances as they undertake the process of assessing the claim. A positive claims experience can support members' emotional and financial wellbeing. In addition, ASFA's June 2021 Guidance Note 'Developing a Vulnerable Member Policy' may assist superannuation funds in meeting the needs of members experiencing vulnerability.

5.1.3 Trustees should help members identify any benefit held within the fund under which a member may be entitled to claim. Trustees should not put any impediments in the way of facilitating a claim where the member is eligible.

5.1.4 Trustees should oversee the claims process, and help members navigate through it.

5.1.5 Trustees are responsible for having frameworks in place to oversee the conduct of the insurer and any service provider engaged in the claims process. There should be frameworks in place that require proactive engagement with other parties in the claims process, such as any authorised third party to minimise delays and remove unnecessary duplication from the process.

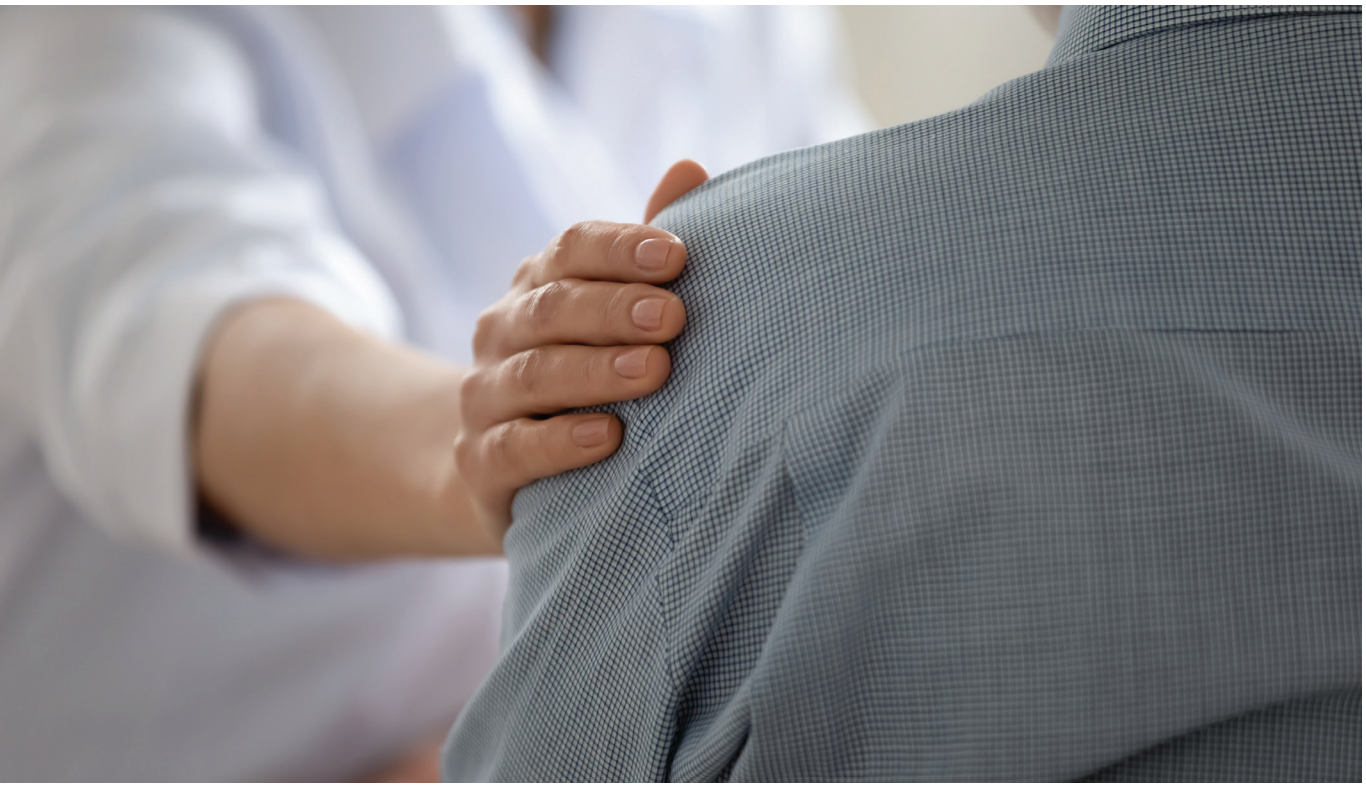
5.1.6 The types of relevant conduct of the insurer and any other service provider which should be overseen by the Trustee include the following:

- How the insurer and any other service provider manages and processes claims
- The level of customer service provided
- Adherence to regulatory requirements and industry standards
- Transparency and communication with members
- Fairness in assessing and deciding claims
- Timeliness in responding to queries, claims and making payments

- Business Rules determined by the trustee and agreed to by the insurer and any service provider/s
- The Group Policy entered into by the insurer and trustee
- Any service arrangements, contracts and undertakings between the trustee and the insurer or other service provider regarding service levels

5.1.7 Trustees should publish their claims philosophy and make it easy for members to access (for example, by publishing on their website and in guidance material). They should also publish updated examples and practical guides that help members understand how best to approach the claims process. For example, they should publish:

- Descriptions of the claims process
- Information on how the claim will be managed
- The types of communication a member can expect and at what time in the process they should expect this
- Prospective timeframes for various types of claims (noting potential issues that may extend such timeframes)



5.2 Methods of communication

5.2.1 Trustees should ensure that all communications regarding claims are delivered through methods that are accessible and convenient for the member or via the channel in which the member has requested communication be received.

5.2.2 Recognising the evolving nature of communication technologies and the decline in traditional postage use, the trustee should provide a range of delivery options that cater to the preferences and needs of members.

5.2.3 These options may include, but are not limited to, electronic mail (email), secure online portals, mobile messaging services, or other digital communication platforms. The trustee will also accommodate members who prefer or require non-digital communication methods.

5.2.4 All communications must be secure, timely, and preserve the confidentiality of the member's information. The trustee will obtain the member's consent for their preferred method of communication at the outset of the claims process and will review and update these preferences periodically to ensure continued convenience and accessibility.

5.2.5 If a claim is made via telephone, a written record or call recording should be kept with the member's permission and be sent to the member on request.

5.3 Commencing a claim

This section applies to the trustee's conduct in relation to a claim.

5.3.1 If a member (or their authorised third party) tells the trustee that they wish to make a claim, the trustee should help the member by:

a) providing the member with a summary of the claim process

b) advising the member of any benefit held within the fund which a member may be entitled to claim under a condition of release[11]

c) directing the member to the appropriate forms or information online, supporting the member to complete them over the phone, or emailing these to the member within two business days, or posting to the member within **five business days**

5.3.2 On receipt of a completed claim from the member the trustee should immediately take steps to acknowledge receipt and within **10 business days**[12] at the latest:

[11] In accordance with general principle 5.1.3 of this Standard

[12] Life Code section 5.5 contains obligations for Life Insurers to provide clients with certain information within 10 Business Days of the Claim Received Date.

a) assess whether the member has provided all of the necessary information and documentation

b) carry out an initial review to assess whether the member has insurance cover based on the information available to determine the appropriate next steps

c) either provide the claim to the insurer to undertake their assessment of the insurance component of the claim, or

d) tell the member that he or she is not eligible to make an insurance claim based on their insurance status and any preliminary enquiries made by the trustee[13]

5.3.3 If a trustee is providing claims processing information to a member, that information should include:

a) the role and duties of the trustee, insurer and any other service providers involved in the process

b) the steps involved in the claim process and a reasonable expectation of the end-to-end timeframe for the assessment of the claim, taking into account the timeframes relevant to the insurer's assessment of any insurance component of the claim[14]

c) the trustee's process for review of the insurer's decision and the trustee's consideration of conditions of release

d) the primary contact for the member and the contact details the member can use to get information about the progress of his or her claim

e) applicable definitions based on the claim type (and/or condition of release), an explanation of the terms of cover, including the policy's standard exclusions and limitations and other relevant conditions of the policy (set out in the PDS or Insurance Guide) or Trust Deed impacting the claim

f) whether the member may be required to attend ongoing assessments

g) how payments will be made if the claim is accepted

h) that there may be financial or tax implications and the member may wish to get independent advice; and

[13] Eligibility under the insurance policy will generally be assessed by the insurer. Trustees should make preliminary enquiries relating to eligibility over the phone or in a covering letter; for example, ensuring the member has considered the prerequisite of having ceased work for the required waiting period before applying for a TPD benefit.

[14] Regarding timeframes for the insurer's assessment, consideration may be given to clauses 5.48 to 5.49 of the CALI Code, which provide for timeframes of two months for income protection claims and 6 months for other lump some claims such as death, terminal illness and total and permanent disablement.

i) the impact on the amount of the claim of receiving income from other sources, including Centrelink and workers' compensation, if offsets are applied[15]

5.4 Eligibility to make an insurance claim

5.4.1 When determining if a member is eligible to make a claim the trustee will make preliminary enquiries as to whether the insurance cover was applicable to the member at the time of the event.

5.4.2 If the trustee determines that the member is not eligible to make an insurance claim, the trustee will:

a) explain this in writing by an appropriate method of communication[16] unless the issue is resolved in the initial communication

b) give the member the opportunity to provide more information so that the trustee can review the member's eligibility

c) tell the member that they may be able to apply for release of their superannuation on the basis of permanent incapacity or terminal medical condition, depending on the member's circumstances

d) If the member wishes to make a permanent incapacity or terminal medical condition claim, inform the member of any additional information that the member will need to provide in relation to that claim, including claim forms and medical certificates required to satisfy the conditions of release

[15] This is typically for income protection cover only

[16] In accordance with section 5.2 of this Standard

5.4.3 If the trustee determines that the member is unlikely to satisfy the conditions of release, the trustee will:

a) explain this in writing

b) give the member the opportunity to provide more information so that the trustee can review the member's eligibility

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Provision of information upon commencement of a claim

When a member tells the trustee they would like to make a claim the trustee will direct the member to the appropriate forms or information online, support the member to complete them over the phone, or email/send these to the member within two business days or posting to the member within five business days.

Advising members of any benefits that they may be entitled to claim

In the initial stages of the claim process the trustee should advise the member of any benefit held within the fund which the member may be entitled to claim. The trustee should also advise the member of any additional documentary requirements which need to be satisfied to entitle the member to tax concessions upon withdrawing their benefit. This will support more expedient claims by enabling the member to consider their options at the outset and lodge claims with appropriate documentation as early as possible.

Preliminary enquiries regarding eligibility to make a claim

Trustees should also make preliminary enquiries relating to eligibility over the phone or in a covering letter; for example, ensuring the member has considered the prerequisite of having ceased work for the required waiting period before applying for a TPD benefit.

This reduces poor consumer outcomes by managing the member's expectations about their ability to claim before they incur costs and spend time seeking medical reports and filling out forms etc.

5.5 While a claim is being assessed

5.5.1 If a member has a query about their claim while it is being assessed, the trustee is responsible for ensuring that the member is provided:

a) with an acknowledgment within **two business days**

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

In some circumstances it may be possible to provide a more timely or even immediate response, for example, where the member makes contact by phone and the trustee has the information readily available to resolve the query.

A member should receive progress updates regularly and, in all cases, where there is a material update in relation to the claim status or further information is required from the member.

5.5.2 If the trustee should become aware of any errors or mistakes in the claim or in the information requested, these ought to be addressed promptly. The trustee may request more information to correct errors or mistakes.

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Updates ought to be 'pushed not pulled' – they should be fund-initiated, rather than member-initiated. It would not be sufficient if the trustee only updated the member if the member contacts the trustee for an update.

However, if a member tells the trustee that they want their updates to be delivered differently – for example, they only want to be notified when there is an update online – then the trustee should contact them in accordance with their wishes.

5.6 Trustee assessment of condition of release where insurance claim approved

5.6.1 If the insurer informs the trustee that it has approved the claim, the trustee should carry out a review within **5 business days** of receipt of the insurer's decision to assess whether the member has met the permanent incapacity or terminal medical condition requirements for the funds to be paid to the member from their superannuation account.

5.6.2 If the trustee's review identifies that there are differences between the insurer's requirements for the claim to be paid and the superannuation law requirements for the release of funds from the member's superannuation account,

the trustee should clearly explain the differences to the member in plain language and advise the member that the insured amount will be credited to their account, but they will not be able to access it until they satisfy a condition of release. If the member meets the permanent incapacity condition of release under superannuation law however does not satisfy the tax law requirements, the trustee should provide information to the member about the possible tax implications to enable the member to make an informed decision regarding the withdrawal of the benefit from their superannuation account.

5.6.3 The trustee should also have oversight processes in place to confirm that the insurer is paying the correct amount.

5.7 Trustee review of insurer's decision where insurance claim declined

5.7.1 If the insurer informs the trustee that it has declined the claim, the trustee should review the insurer's decision including all the relevant information relied upon by the insurer in making their determination within **15 business days**, unless further information is required from the insurer or member to properly assess the insurer's decision.

5.7.2 The trustee may liaise with the insurer to understand their decision or seek clarification.

5.7.3 Where further information is required from the member, this will be communicated to the member within the same **15 business day** window.

5.7.4 As part of its review, the trustee should confirm in the first instance that the insurer has provided a procedural fairness letter to the member.[17]

5.7.5 If the trustee agrees that the claim should be declined, the trustee will advise the member of the outcome of the review within **5 business days**, including the following:

a) an explanation in plain language to enable the member to understand the reasons for the insurer's decision to decline the claim

b) an outline of the evidence relied upon in forming that view

c) a list of all documents relevant to the decision obtained by the insurer and the trustee during the assessment, and an opportunity to receive copies of any documents on request

d) information on the process for objecting to the decision

[17] Life Code section 5 contains obligations for Life Insures with respect to the issue of Procedural Fairness letters.

5.7.6 The trustee should ask the insurer to review the decision where it considers that there is insufficient evidence to decline the claim. The trustee should request that the insurer undertakes a further assessment and specify the basis upon which it has determined this

5.7.7 Wherever possible, when the trustee reviews the insurer's decision, in the first instance, the trustee should use information already collected during the claim assessment process, rather than asking the member to provide information again, or to attend any further assessments. If the trustee believes there is not enough information to make a properly informed decision, the trustee should request any further information or assessments it needs as early as possible and avoid multiple information requests or assessments where possible.

5.7.8 The trustee should only ask for, and rely upon, information and assessments that are relevant to the claim and policy, and the member is entitled to ask the trustee to explain the relevance of the information or assessment requested. If the member disagrees with the relevance of any requested information or assessment, the request should be reviewed. If the member is not satisfied with the outcome of the review, the trustee should inform the member about how to make a complaint via internal dispute resolution and the availability of external dispute resolution if the member remains dissatisfied.

5.7.9 If the trustee obtains new information or assessments, or the member makes further representations and submissions or provides further information, the trustee has another **15 business days** from the time of receipt of this information to review it.

5.7.10 If the trustee's review results in the trustee querying the insurer's decision, the trustee will tell the insurer within **5 business days** of completing its review. If the trustee believes the claim has a reasonable prospect of success, it is required to do everything that is reasonable to pursue the claim for the benefit of a member. The trustee should keep the member informed as the claim proceeds.

5.7.11 Where a trustee has requested additional information from the member, the trustee will clearly communicate the expected timeframes to make the assessment once the additional information has been received by the trustee from the member. The trustee should inform the member about how to object to the decision if they are not satisfied with the revised timeframe.

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Where a claim is declined by the insurer, the trustee will complete its initial review of the insurer's decision within 15 business days, unless further information is required to properly assess the insurer's decision. Where further information is required, this will be communicated to the member by the trustee within the same **15 business day** window.

5.8 Trustee assessment of conditions of release

5.8.1 As noted above, in all claims, the trustee will conduct an assessment to determine if a member has met a condition of release as per superannuation law and the requirements of the Trust Deed / governing rules of the Fund. The trustee should also consider whether the member can potentially satisfy the tax law requirements where applicable.

5.8.2 Where the trustee has confirmed that all the requirements for the release of funds from the member's superannuation account have been satisfied ("approved the claim"):

a) if valid identification, and payment instructions and other necessary documents, have been received from the member the benefit should be paid to the member within **5 business days**

b) if valid identification, and payment instructions and other necessary documents, have not been received from the member, the trustee will provide confirmation of approval of the benefit and request identification and payment instructions within **5 business days** (if the member wishes to access their superannuation benefit)

5.8.3 If, following the trustee's assessment of conditions of release, the trustee decides that the member does not meet the required definition the trustee should tell the member within **5 business days** of completion of its review:

a) the reasons for the decision in writing in plain language

b) that the member can request copies of the documents and information relied upon

c) how the member can make a complaint if they are not satisfied with the decision

5.9 Interaction of insurance decision and release of benefits from superannuation

5.9.1 As noted earlier in this Standard there may be dual considerations prior to releasing benefits to members, namely, the insurer's decision in relation to the member's claim for payment of their insured benefit, and separately, the trustee's decision in relation to whether a condition of release is met to allow the benefit to be paid from the superannuation fund to the member with tax concessions where applicable.

5.9.2 Because of the overlapping nature of requirements trustees must consider making the process as efficient as possible for the member. This can include avoiding duplicate requests for information and processing elements of the early release claim simultaneously with the insurance claim, where possible.

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Where a TPD claim is made:

The trustee will advise the member of the two-step process required to release benefits from superannuation, and the documentation requirements for both claims - TPD insurance and early release of superannuation due to permanent incapacity.

If the trustee identifies that the member is not eligible to claim a TPD insurance benefit or the insurer determines there is no cover / the policy doesn't respond, the trustee will advise the member that they may be able to apply for early release of superannuation due to permanent incapacity.

The trustee will ensure that it collects all documentation relating to the claim (including any documentation provided directly by the member to the insurer) and will progress the permanent incapacity claim expeditiously using the information gathered i.e. the claims will be considered simultaneously / the trustee will not await an insurer's decision on the TPD claim prior to commencing consideration of the permanent incapacity claim.

This will not apply if the member wishes to retain their insured benefit in their superannuation fund, and the member's wishes in this regard should be determined at the outset to facilitate appropriate claims management in accordance with the member's wishes.

5.10 Income protection claims - multiple policies

5.10.1 The total income that a member suffering from a temporary disability can receive under income protection policies cannot exceed the income the member would have received if they were not disabled.

5.10.2 This means that where a member has multiple income protection policies and claims against those policies, their benefit payments will generally be offset by any other payments received. Benefits can also be offset due to income received from other sources.

5.10.3 Trustees will inform members when joining the superannuation fund and via ongoing communications of the importance of reviewing insurance cover to ensure it remains appropriate for their needs.

5.10.4 Trustees of funds that offer income protection cover (particularly default cover) will inform members of the importance of ensuring that they do not have cover against which they may not be able to make a claim and that the cover they do hold is suitable for their needs.

5.11 Income protection claims - payments

5.11.1 Where the member is receiving ongoing income protection payments, the trustee should have oversight processes in place to:

a) determine whether the information the member is required to provide is reasonable

b) assist the member and their medical practitioners to provide the required information

c) assist the member to receive timely payments

d) receive reports about the insurer's decisions about stopping income protection payments and use these to identify and raise concerns that the trustee may have with the insurer regarding a decision to stop payments.

5.11.2 The trustee will inform members about the timing of payments according to the policy. For example, if a member has a 30-day waiting period, explain whether the payment will be made at the start, middle, or end of the first month after the waiting period is completed.

5.11.3 If the trustee becomes aware that the member has made claims against more than one income protection policy, it should explain how the offsetting arrangements operate, and provide the member with information about the factors he or she may want to consider to determine the best financial outcome from multiple policies.

5.11.4 If the trustee identifies that any of the member's claim payments are going to be offset or reduced by income he or she is receiving from other sources, including Centrelink and workers' compensation, the trustee should inform the member.

5.11.5 The trustee should inform members when a claim is made of the requirement to maintain an adequate superannuation account balance to ensure that insurance is not cancelled and enable ongoing premium payments to continue if the member wishes to maintain insurance.

6 Definitions

Automatic cover means cover that trustees provide to eligible members automatically without the provision of health information to protect them against illness or accidents causing injury or death. Automatic cover is not tailored to individual needs and circumstances

Members are considered to have automatic cover in circumstances where members elect to take out or maintain the default cover that trustees provide automatically even if the member:

- is under the age of 25 years;
- has a superannuation account balance that is less than $6,000; or
- has an account that has become inactive

Automatic cover does not apply if:

- the member has voluntarily selected the level of cover;
- the member has varied the level of automatic cover;
- the member is a defined benefit member; or
- the premiums are wholly paid for by an employer (whether through contributions to the superannuation account or otherwise) or not paid by deduction from the member's account

Business days means Monday to Friday excluding public holidays.

CALI Code means the Code of Practice of the Council of Australia Life Insurers.

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

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