Insurance in superannuation claims handling

Claims handling standards for Superannuation Funds

Guidance Note

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About Guidance Notes

Guidance Notes are intended to provide superannuation trustees and funds with information about ways of doing things that work.

The use of a guidance approach does not mean one size fits all. It means seeking out ideas and experience from those who have undertaken similar activities in related fields, deciding which of those practices are relevant to your situation, testing them out to see if they work, before incorporating the proven practices in your own documented processes.

Association member organisations cover a diverse range of goals, member needs and resources according to which they can adapt this Guidance Note's recommendations to their own particular needs.

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

Each association expressly disclaims all liability and responsibility to any person who relies, or partially relies, upon anything done, or omitted to be done, by this publication.

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Claims Handling Reference Materials

The Financial Services Council's Life Insurance Code of Practice, section 8.

ASIC information sheet *Claims Handling and settling: How to comply with your AFS licence obligations* (INFO 253).

3 Introduction

This Claims Handling Guidance Note derives from the Insurance in Superannuation Voluntary Code of Practice (the Code).

The Code was launched in 2018, however, significant parts became redundant due to legislative reform and regulatory changes. In particular, the *Protecting Your Super and Putting Members' Interests' First* legislative packages made substantial sections of the Code redundant. For this reason the Code owners (AIST, ASFA and the FSC) agreed in 2021 to maintain only those sections of the Code upholding consumer protections that were not supported by regulation and to do so through the use of guidance.

The use of guidance or best practice papers allows the establishment of industry practices but also has the flexibility to adapt quickly to changing circumstances. Given the recent attention directed to insurance in superannuation and the pace of change it is likely that such flexibility will be required in the medium term.

One example of recent and ongoing change is the release of ASIC's information sheet for insurance claims handling (INFO 253). For RSE Licensees the information sheet outlines Australian Financial Services Licence (AFSL) obligations that apply to the provision of 'superannuation as a trustee service' and this includes claims handling obligations. These claims handling obligations align with the amendments to the Corporations Act that remove the exemption of claims handling as a financial service.

This Guidance Note will avoid duplicating or repeating any relevant legislation. However, it should be remembered that there may be additional standards set by regulatory instruments relevant to claims handling, such as those for RSE licensees in the provision of 'superannuation as a trustee service'. Where they may overlap, or be inconsistent with, the Guidance Note the legislation or regulatory instrument will of course prevail.

The Guidance Note also does not attempt to clarify how obligations imposed by legislation or regulatory instrument work in practice. For example, the 'superannuation as a trustee service' licensing obligations require the service to be provided honestly, fairly and efficiently, however, while this Guidance Note recommends practices which may support these obligations it does not attempt to align or link practices to those obligations.

IMPLEMENTATION GUIDANCE

During the Code's transition phase a Code Implementation Committee was established to develop practical guidance and clarification for the implementation of the Code obligations. Where relevant, this additional guidance is provided to assist members in interpreting the recommendations for best practice claims handling.

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Claims handling

4.1. Principles for claims handling

4.1.1. Claim time can be difficult for members and trustees should treat every claimant with compassion and respect. The claims process should be timely, made as straightforward as possible and all communications should be written in plain language.

4.1.2. Trustees should help members identify any cover held within the fund under which a member may be entitled to claim. Members should not be discouraged from making a claim.

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

4.1.4. Trustees are responsible for overseeing the conduct of the insurer and any **Service Provider** engaged in the claims process. There should be proactive engagement with other parties in the claims process, such as any representative that the member engages, to minimise delays and remove unnecessary duplication from the process.

4.1.5. There should be appropriate governance arrangements put in place for claims handling by the trustee and its delegates.

4.1.6. Trustees should publish their claims philosophy on the fund website, and assess the claims philosophies of their insurers to ensure they align with the trustees' philosophy.

4.2. The claims process

4.2.1. The claims process incorporates a number of steps, and there are roles for trustees, for the insurer and for the member. The member may be required to provide relevant documents and attend assessments.

4.2.2. **The Financial Services Council Insurer Code** places responsibilities on insurers to determine claims within specific timeframes. Trustees and insurers should work together to ensure a consistent and efficient process for members.

4.2.3. Trustees should provide members with the contact details for the primary contact during the claim process.

4.2.4. Trustees may arrange independent medical reviews or an interview with the member. If so, they should have regard to the relevant standards in the Financial Services Council Insurer Code.

4.3. Making a claim

4.3.1. If a member tells the trustee that he or she wishes to make a claim, the trustee should help the member provide the information for the claim, or direct the member to the appropriate forms or information online, or email these to the member by the **next business day**. If hard copy forms are required, the trustee should send these within **5 business days**.

IMPLEMENTATION GUIDANCE

At a minimum, it is intended that the trustee will give someone enquiring about a claim some generic information or forms within one business day. However, trustees may wish to ask some high-level questions relating to eligibility over the phone or in a covering letter; for example, ensuring the member has considered the prerequisite of having ceased work 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 fillng out forms etc.

4.3.2. On receipt of a completed claim from the member, within **5 business days** a trustee should:

a) acknowledge receipt of the claim
b) assess whether the member has provided all of the necessary information and documentation
c) carry out an initial eligibility assessment to assess whether the member has insurance cover, based on the information available
d) provide the member with a summary of the claim process (if this has not already been provided to the member when first enquiring about making a claim);
e) either provide the claim to the insurer, or tell the member that he or she is not eligible to make a claim based on the information available.

IMPLEMENTATION GUIDANCE

If a claimant goes straight to the insurer rather than to the trustee, it is expected that the **5-business-day** requirement to acknowledge the claim will be complied with by the insurer.

The requirement for a trustee to put in place governance arrangements for claims should include how a trustee and insurer will share responsibilities.

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

4.3.4. The summary of the claim process that the trustee provides to the member should include:

a) an explanation of the terms of cover, including the policy's standard exclusions and limitations

IMPLEMENTATION GUIDANCE

If the trustee is not aware of the date of event, it should use its best efforts to provide the relevant policy terms. If it later transpires that - due to the date of the event being earlier than assumed - that different terms apply, this should be communicated to the member.

Simply providing the member with the policy schedule obtained from the insurer is unlikely to give the member an explanation that they can easily understand.

b) the steps involved in the claim process and a reasonable expectation of the end-to-end timeframe for the assessment of the claim, taking into account the timeframes in the **Financial Services Council Insurer Code** and the trustee's review of the insurer's decision

c) the trustee's role and duties and the role and duties of the insurer

d) who will be the member's primary contact and the contact details the member can use to get information about the progress of his or her claim

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

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

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

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

i) how the trustee will review the insurer's decision.

4.3.5. If the trustee determines that the member is not eligible to make a claim, the trustee should:

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

c) tell the member that if the member is not satisfied with its decision, the member can make a complaint and the trustee will explain its complaints process.

4.4. While a claim is being assessed

4.4.1. If a member has a query about his or her claim while it is being assessed, the trustee should respond:

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

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

4.4.2. A member should receive progress updates at least every **20 business days** (unless a different timetable is agreed) or earlier if something of significance to the claim occurs. The trustee should communicate proactively with members if circumstances change and, if the member expresses a preference, tailor the method of the communications according to the member's wishes. If there are any issues delaying assessment of the claim, the trustee should let the member know what these are.

IMPLEMENTATION GUIDANCE

The principle here is that the updates ought to be 'pushed not pulled' – they should be fund-initiated, rather than member-initiated. It would not be sufficient if the trustee simply allowed the member to log into a website or app for an update, nor if the trustee contacted the member every 20 days to let them know they could log in for information.

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.

For death claims where there is a sum insured, it is expected that all potential beneficiaries of whom the trustee is aware will receive regular updates.

4.4.3. The trustee should oversee the progress of the claim to minimise delays and intervene if it becomes aware that the insurer is not complying with the timeframes provided in the **Financial Services Council Insurer Code**.

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

IMPLEMENTATION GUIDANCE

This is not intended to mean that an insurer cannot decline a claim if a medical condition has not yet stabilised; that is a matter for the Financial Services Council Insurer Code. A trustee should explain to the claimant what the situation is when their medical condition has not yet stabilised.

4.4.5. 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.

4.5. Review of insurer's decision

4.5.1. Once the insurer has made its decision about the member's claim, if the insurer informs the trustee that it intends to make a payment to the trustee, the trustee should carry out a review within **5 business days** to assess whether the member has met the requirements for the money to be released from his or her superannuation account. The trustee should also have oversight processes in place to confirm that the insurer is paying the correct amount, either to the trustee or directly to the member.

4.5.2. If the trustee identifies as part of its review that there are differences between the requirements for the member's insurance claim to be paid and the legal requirements for the release of funds from his or her superannuation account, the trustee will clearly explain the differences in plain language and that, while the amount will be credited to the member's account, they will not be able to access it until they have satisfied a condition of release.

IMPLEMENTATION GUIDANCE

It is expected that the trustee will inform the claimant of any differences in requirements as soon as they become aware of this, in order to manage expectations.

4.5.3. If the insurer informs the trustee that it has decided not to pay the claim, the trustee should carry out a review within **15 business days**. As part of its review, it should determine whether the insurer has provided the member with the below, and provide the member with any of the below should it be asked for:

a) an explanation in plain language to enable the member to understand the reasons for the insurer's view
b) an outline of the evidence relied upon in forming that view
c) a list of all documents obtained by the insurer and the trustee during the assessment, and an opportunity to receive copies of any documents on request

IMPLEMENTATION GUIDANCE

This only requires a list of available documents, rather than copies of the documents themselves.

d) an opportunity to make further representations and submissions or to provide further information about the member's claim.

4.5.4. Wherever possible, when the trustee reviews the insurer's decision 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 inform the member of this. The trustee should request any further information or assessments it needs as early as possible and avoid multiple information requests or assessments where possible.

4.5.5. 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 give an explanation of 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.

4.5.6. 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** to review the new information or assessment.

IMPLEMENTATION GUIDANCE

The **15-business-day** timeframe is intended to cover only the trustee's review of new information or assessment, not the insurer's next steps. If, as a result of the trustee's review, the trustee decides to send the claim back to the insurer, that is dealt with in the following paragraph.

4.5.7. If the 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 will advocate on the member's behalf. The trustee should keep the member informed as the claim proceeds.

4.5.8. In exceptional cases, the timeframes for the trustee's review in this section may not be appropriate. In these cases, the trustee will tell the member that it needs more time, and will clearly communicate the expected timeframes for the trustee review to be completed. The trustee should inform the member about how to make a complaint if he or she is not satisfied with the revised timeframe.

4.6. Claim decision

4.6.1. If the claim is approved and paid to the trustee by the insurer, the trustee should confirm this with the member as soon as it has carried out its assessment as to whether the member has met the requirements for the money to be released from his or her superannuation account. Provided that:

a) valid identification, and payment instructions and other necessary documents, have been received from the member
b) the trustee has confirmed that the legal requirements for release of funds from the member's superannuation account have been satisfied
c) for death benefit claims, the trustee has contacted all potential beneficiaries where relevant and given them the opportunity to provide submissions in support of their claim to be paid a benefit
d) the trustee should release the claim money to the member within **5 business days** of confirmation being given.

4.6.2. If the member's claim is declined, 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 not satisfied with the decision.

4.7. Income protection claims

4.7.1. For income protection claims, the trustee should support the insurer to:

a) seek to identify ways to support the member's recovery as quickly as possible

IMPLEMENTATION GUIDANCE

The FSC and insurers may be able to provide guidance from the same obligation in the Life Code.

The intent is that trustees should not put impediments in the way of 'return to work' strategies, and should facilitate recovery, where possible, alongside the insurer – noting that the sole purpose test constrains trustees from getting involved directly in the member's recovery.

b) collaborate with the member's doctor, other healthcare providers and employer to maximise the health outcomes of the member

c) promote best-practice rehabilitation and injury management where these are consistent with the terms of the policy.

4.7.2. Where the member is receiving ongoing income protection payments, the trustee should have oversight processes in place to determine whether the information the member is required to provide is reasonable, and to ensure that the member and his or her doctor are providing the required information, to assist the member to receive timely payments. The trustee should also have processes in place to oversee the insurer's decisions about continuing or stopping income protection payments, and raise any concerns that the trustee may have with the insurer regarding a decision to stop, or continue, payments.

4.7.3. If the trustee becomes aware that the member has made claims against more than one income protection policy, it should explain how the off-setting 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.

4.7.4. 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.

4.8. Refunds

4.8.1. If at claim time the trustee identifies that the member has multiple automatic insurance covers in superannuation and the benefit is offset, or not able to be claimed upon and paid out, because the member has claimed on another benefit under another similar policy, the trustee should give the member the option of a refund of his or her premiums for the duration of the overlap of covers, to a maximum of 6 years, and the trustee should then cancel the cover.

IMPLEMENTATION GUIDANCE

This does not apply only to IP claims; there are some group life policies that also offset against other lump sum payments. Trustees should refer to the terms of each policy to determine whether this applies.

Where the premium is refunded, it is expected that the policy will be cancelled for the shorter of the period that the policy was in place or the period of the refund, with no claims payable for this period. Before processing the refund, the member should be advised of the consequences of this cancellation (so that they can elect to keep the cover and not take the refund if they wish).

In calculating the duration of the overlap, trustees only need to refund for the period where there is a complete offset of cover. Trustees might, however, choose to refund partial offsets as well.

Trustees may determine their own policies for incorporating any adjustments into the amount to be refunded (i.e. inflation, unit adjustments, interest).

It is important to note that a refund in these circumstances is not an error on the trustee's part, so it is not expected that a trustee will return the member to the position they would have been in – i.e. paying foregone investment returns.

4.8.2. If the trustee identifies that the member was not eligible to claim against his or her automatic insurance cover for any event from the start of the cover, the trustee should refund premiums to the member's account for the period he or she were ineligible.

IMPLEMENTATION GUIDANCE

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

4.8.3. If the member makes a claim that is accepted, and the cover ceases under the terms of the policy on the date the member became eligible to claim, the trustee should refund premiums to the member's superannuation account back to the date he or she became eligible to claim.

IMPLEMENTATION GUIDANCE

The 'date you became eligible' is intended to be the date of disablement. For late-notified claims, it is intended that refunds would be provided back to the date of disablement.

4.9. Review

4.9.1. This guidance note will be reviewed every three years.

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Definitions

Automatic insurance cover means cover that trustees provide to members to provide members with automatic protection against illness or accidents causing injury. Automatic insurance cover is not tailored to individual needs and circumstances.

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

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

Automatic insurance cover does not apply if:

- the member has voluntarily selected the level of cover;
- the member has varied the level of automatic insurance cover;
- the member is a defined benefit member; or

the insurance 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.

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

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**.