

The AFCA Approach to delayed insurance claims in superannuation

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We have created a series of AFCA Approach documents, such as this one, to help consumers and financial firms better understand how we reach decisions about key issues.

These documents explain the way we approach some common issues and complaint types that we see at AFCA. However, it is important to understand that each complaint that comes to us is unique, so this information is a guide only. No determination (decision) can be seen as a precedent for future cases, and no AFCA Approach document can cover everything you might want to know about key issues.

1 At a glance

1.1 Scope

This document sets out how AFCA approaches superannuation complaints about delays in handling insurance claims held through superannuation. It forms part of a broader suite of guidance on how AFCA resolves superannuation complaints.

This document does not relate to complaints about:

- Delays in insurance claims when the insurance policy is held outside of superannuation; or
- Delays in the administration of death benefit claims.

There are some important differences between AFCA's superannuation jurisdiction and its broader jurisdiction. The Appendix to this document sets out the approach AFCA takes in determining superannuation complaints.

1.2 Summary

It is common for people to hold insurance cover for death and total permanent disablement (TPD) through their superannuation. Although less common, people may also hold income protection (IP) insurance.

Unnecessary and unexplained delays in claims handling can add to stress and uncertainty, therefore it is important that claims are determined in a timely manner.

If a complainant has expressed dissatisfaction about a delay in the handling of a superannuation-related insurance claim, then AFCA will consider whether there has been a delay and whether it is unreasonable or unfair in the circumstances.

In complaints about delay, AFCA will generally raise a complaint against the trustee and the insurer. This is because the insurer decides whether to admit or deny an insurance claim, and the trustee holds the insurance policy, consequently making a decision on whether an insurance benefit is paid.

Reviewing the trustee's decision

In reviewing the trustee's decision and conduct, AFCA will consider whether the trustee has reasonably done everything necessary to ensure there were no unreasonable delays, including by the insurer.

Reviewing the insurer's decision

In reviewing the insurer's decision and conduct, AFCA will consider whether the insurer unreasonably delayed the handling of the claim.

What is considered an unreasonable delay

AFCA will consider the relevant circumstances including the:

- Terms of the policy
- Complexity of the claim; and
- Industry standards such as those set out in the *Life Insurance Code of Practice* and the *Insurance in Superannuation Voluntary Code of Practice*.

2 In detail

2.1 Jurisdiction

Under s1053(5)(a) of the *Corporations Act 2001* (Cth), an insurer or trustee's failure to make a decision is taken to be a decision, which can be considered by AFCA.

Under s1053(5)(b) of the *Corporations Act*, the conduct, or the failure to engage in conduct (in relation to making a decision) is also taken to be a decision, which can also be considered by AFCA.

These provisions are relevant to complaints about delay as AFCA can review both a failure to make a decision and the conduct, or failure to engage in conduct, in the making of a decision.

2.2 Assessing complaints about delay

When assessing complaints about delayed insurance claims handling (in superannuation), AFCA will consider whether the delay is unreasonable or unfair in the circumstances.

AFCA considers there are three different sources of delay in an insurance claim (in superannuation). These are delays caused by:

- A financial firm, such as the insurer or the trustee
- The complainant; or
- A third party (such as a medical practitioner).

AFCA approaches each of these sources of delay differently.

2.2.1 Delays caused by a financial firm

Delays in this category may be caused by the insurer, the trustee, or their agents.

AFCA considers the timeframes set out in the Financial Services Council Life Insurance Code of Practice set a minimum standard of accepted industry practice and expects the insurer to meet them.

Key timeframes in this Code include:

- Making a decision on IP claims within 2 months unless exceptional circumstances apply
- Making a decision on TPD claims within 6 months unless exceptional circumstances apply
- Making a decision on IP or TPD claims within 12 months if exceptional circumstances apply
- Making a decision within 10 business days of receiving all information necessary to assess the claim
- Providing updates on the claim process every 20 business days; and
- Replying to update requests within 10 business days.

If insurers don't comply with these timeframes AFCA will expect them to provide compelling reasons.

AFCA also expects trustees to hold insurers to these timeframes, noting the trustee's obligation under s52(7)(d) of the *Superannuation Industry (Supervision) Act 1993* (Cth) to 'do everything that is reasonable to pursue an insurance claim for the benefit of a beneficiary, if the claim has a reasonable prospect of success'.

For example, AFCA expects trustees to bring claims to the attention of their insurer quickly so that assessment can begin, even where a complete set of documents and evidence has yet to be provided.

AFCA also expects a trustee to prevent the insurer from delaying the denial of a claim that does not have a reasonable prospect of success (in the trustee's opinion).

AFCA expects trustees to comply with the timeframes set out in the Insurance in *Superannuation Voluntary Code of Practice* (ISVCP). While AFCA notes this Code is voluntary, AFCA considers the timeframes set out in the ISVCP represent industry practice and many trustees have agreed to the terms of the ISVCP in whole or part.

Key timeframes in the ISVCP:

- Reviewing the decision of an insurer to accept a claim within 5 business days
- Reviewing the decision of an insurer to decline a claim within 15 business days
- Communicating with the complainant within 5 business days of the review if they confirm the insurer's decision
- Communicating with the insurer within 5 business days of the review if they disagree with the insurer's decision
- Ensuring a progress update is provided to the complainant every 20 business days.

2.2.2 Delays caused by the complainant

Delays in this category may be caused by the complainant or someone acting on their behalf. Examples of this type of delay include delays caused by a complainant refusing to provide an authority to an insurer to obtain their medical records, or by refusing to attend a medico-legal examination.

However, just because a complainant may *appear* to be the source of the delay does not mean they are.

In determining the actual source of the delay AFCA will consider if any requests made by an insurer were reasonable. For example, AFCA may consider it reasonable for a complainant to refuse to attend a medico-legal examination if there is already sufficient evidence on the file for the insurer to make a decision.

In this instance AFCA would consider the insurer, not the complainant, is the source of the delay and apply the approach set out in 2.2.1 above. Other examples include where it is not possible for the complainant to attend appointments due to injury, illness or distance / mobility.

Where AFCA determines the source of the delay relates to the actions of the complainant (or their agent), then we may consider whether it is appropriate to exclude the complaint under the AFCA Rules.

It is worth noting AFCA may be able to review a subsequent decision of an insurer and trustee relating to the same set of facts, even if it has excluded the decision about the delay. For example, if an insurer subsequently decides to decline the claim, and the trustee agrees with the decision of the insurer, AFCA will be able to review the decision to decline.

2.2.3 Delays caused by a third party

Delays in this category may be caused by a third party, such as a medical practitioner or the complainant's former employer.

AFCA acknowledges third party delays occur, however considers this does not necessarily mean the insurer and trustee have acted reasonably by not being the source of the delay.

In the case of third party delays, AFCA expects the insurer and trustee to be able to explain:

- Why this third-party evidence is necessary to decide the claim
- Why this third-party evidence cannot be obtained from another source, such as an alternative medical practitioner
- What communications and attempts the trustee and insurer have made to follow up the third party; and

- What other parts of the investigation the insurer and trustee are progressing in the meantime (while waiting on the third-party information).

When choosing a medical practitioner to conduct a medico-legal examination, AFCA expects insurers will take into account their previous experiences with that medical practitioner, the practitioner's availability, timeliness and responsiveness.

2.3 What information does AFCA need?

In a complaint about insurance claims handling delays (in superannuation), AFCA expects the insurer to provide:

- A detailed timeline of the claim, setting out:
 - > all contact and correspondence with the complainant and third parties
 - > all information requested and an explanation about why information was needed to progress the claim
 - > all follow up requests when timeframes have not been met
 - > any timeframes that do not comply with the relevant codes and an explanation for the non-compliance
- Any correspondence to the complainant explaining why a timeframe would not be met and why delay had occurred
- A copy of the claim file in chronological order including any records of decision and supporting material (such as chief medical officer reports)
- A detailed submission as to why the insurer is not currently able to make a decision on the claim; and
- The strategy the insurer is pursuing to decide the claim and to address third-party delays (if any).

AFCA expects the trustee to provide:

- A submission setting out whether the trustee agrees with the dates set out in the insurer's timeline
- An outline of the steps the trustee has taken to ensure it has met the timeframes set out in the ISVCP; and
- A detailed submission, including an outline of the steps the trustee has taken to avoid unreasonable delays by the insurer in their investigation and decision.

2.4 Consequences for unreasonable delay

AFCA cannot award non-financial loss to complainants in the superannuation jurisdiction. This means AFCA cannot award compensation for a complainant's stress or inconvenience caused by unreasonable delay.

However, AFCA has other tools it can use if it finds there has been an unreasonable delay.

If AFCA considers there is enough information to accept a claim, AFCA can determine an insurer has delayed unreasonably, directing the insurer to accept the claim together with interest paid, in line with section 57 of the *Insurance Contracts Act 1984* (Cth).

If AFCA considers an insurer has delayed unreasonably, but there is not enough evidence to admit the claim, AFCA can remit the matter to the insurer to consider with specific directions.

In the event AFCA considers an insurer has delayed unreasonably, and there is enough evidence to decline the claim, AFCA may remit the matter to the insurer and direct it to decline the claim.

2.5 Systemic issues and Code referrals

If AFCA identifies a trend in complaint records about delays in insurance claims handling (in superannuation) by a trustee or insurer, then AFCA's Systemic Issues Team may choose to investigate whether the trend represents a systemic issue.

More information about AFCA's role in systemic issues can be found here:

afca.org.au/about-afca/systemic-issues

In addition, if AFCA identifies a potential breach by an insurer of the *Life Insurance Code of Practice*, then AFCA may refer the matter to the Life Insurance Code Compliance Committee for review. This may result in sanctions being imposed against an insurer – see clause 13.14 of the Life Insurance Code.

More information about AFCA's Code function can be found here:

afca.org.au/about-afca/codes-of-practice

3 Context

3.1 Case studies

Case study 1 – Unreasonable delay in approving the claim

The complainant lodged a complaint with AFCA about delays in the handling of her TPD claim.

The complainant had lodged a TPD insurance claim with the trustee of her superannuation fund because of post-traumatic stress disorder (PTSD) relating to procedures she had for leukemia. The leukemia was now in remission.

The complainant was 62 years old at the time of the claim and had worked as a nurse at a hospital prior to stopping work due to her leukemia treatments. The complainant's PTSD was particularly triggered by being around medical professionals.

The complainant's treating doctor had been seeing her regularly and prescribed medication for her symptoms. The complainant had been regularly taking that medication.

The insurer asked the complainant to attend a medico-legal examination with a psychiatrist. The psychiatrist said he believed the complainant would benefit from seeing a psychologist regularly. He also thought that with regular therapy some of her symptoms would improve and she may regain work capacity within six months, but her symptoms were likely to flare up around medical professionals.

The insurer sought to delay the TPD assessment to see if the complainant responded to therapy and asked the complainant to attend another medico-legal examination with a different psychiatrist. The complainant lodged a complaint to AFCA about the delay and said the insurer had sufficient information to approve her TPD claim.

AFCA reviewed the complaint and determined the insurer did in fact have enough material to approve the claim. AFCA noted the relevant test under the TPD policy was whether the complainant was unlikely to ever work again in an occupation for which she was suited, based on her education, training or experience.

AFCA determined that even the medico-legal psychiatrist's report supported the complainant's claim. The complainant was unlikely to ever work again in an occupation for which she was suited (based on her education, training or experience), noting she had previously worked as a nurse and her PTSD symptoms would flare up in a hospital environment.

AFCA also noted the complainant was 62 years old and was unlikely to work in other roles, even if she received a short refresher course in administration skills.

AFCA deemed the insurer's failure to make a decision to be a decision under s1053(5)(a) of the Corporations Act. AFCA determined the decision was unreasonable and set it aside, remitting the claim to the insurer with a direction to approve the TPD claim and pay interest (calculated with reference to s57 of the Insurance Contracts Act). AFCA also determined the trustee's decision to agree with the insurer was unreasonable, setting aside that decision as well.

Case study 2 – Unreasonable delay in declining the claim

In December 2019 the complainant lodged a complaint with AFCA about delays in the handling of his TPD claim.

The complainant lodged his TPD claim in December 2018, based on a date of disablement in February 2017. The complainant's condition was an adjustment disorder with anxiety and depressed mood.

At the time of the AFCA complaint, the insurer and trustee had yet to make a decision, after asking the complainant to attend numerous medical appointments (with different medico-legal mental health specialists). The insurer said it was not yet able to make a decision as it had conflicting medical evidence about the complainant's prognosis.

AFCA noted the complainant did not meet the terms of the policy in February 2017 – even though he had ceased work in one job at the time, he shortly afterwards found a job he was able to perform with reasonable adjustments. As a result, AFCA determined the complainant did not satisfy the relevant waiting period in the policy until February 2018 (60 days after he ceased work with the second employer).

AFCA also noted the complainant had rolled over his superannuation to a different fund when he started the second job, losing his insurance cover at that time.

AFCA realised the insurer was not going to be liable for the complainant's insurance claim, and the insurer should have denied the claim as soon as it became aware of the timeline.

AFCA determined the delay was unreasonable as the insurer should have denied the claim, without subjecting the complainant to numerous medico-legal examinations. AFCA also found the trustee's decision was unreasonable as it should have independently satisfied itself and alerted the insurer to the fact the TPD claim had no merit.

AFCA could not award non-financial loss however, the AFCA decision-maker referred the insurer and the trustee to the Life Insurance Code Compliance Committee and the Systemic Issues Team to investigate whether this represented a breach of the Code, also considering the insurer's and trustee's claims handling practices.

Case study 3 – Unreasonable delay caused by the complainant

The complainant lodged a complaint with AFCA about delays caused by the insurer and the trustee in handling his IP claim.

After contacting the insurer and the trustee about the delay (and reviewing information provided by both), AFCA found the delay was caused by the complainant refusing to authorise the insurer to obtain his medical file from his treating general practitioner.

The group IP policy required the complainant to show he had been under the regular care of, and taking the advice of, a medical practitioner. The complainant indicated in his IP claim that he had met this requirement because he had been under the regular care of, and had taken the advice of, his treating general practitioner.

AFCA excluded the complaint about the delay on the basis the complaint was without merit and the financial firm had made no error. This was because AFCA was unable to determine whether this policy requirements had been met by the complainant without the medical file from the complainant's treating general practitioner.

Case study 4 – Unreasonable delay by a third party

In September 2018 the complainant lodged an insurance claim with the trustee for an IP benefit relating to a musculoskeletal disorder in her lower back.

The complainant provided evidence from her general practitioner indicating she had problems with her condition. The insurer was satisfied the complainant was unable to work due to her condition but was unsure if the complainant had ceased work due to sickness or injury; a requirement under the IP policy. The insurer was concerned because the complainant had given four months' notice before ceasing work with the employer, which seemed inconsistent with ceasing work due to sickness or injury.

The insurer and the trustee had both written to the complainant's employer on several occasions for the complainant's records, however the employer had not written back. The complainant's former employer assured the trustee it would attend to the matter shortly.

This initial request for information from the former employer was made three months earlier and since that time the claim had stalled, pending the outcome of the employer's information.

In September 2019 the complainant lodged a complaint with AFCA about the delays. The insurer indicated to AFCA the delay was a result of the complainant's former employer. The insurer said it was necessary to talk to the employer to determine why there was a four-month period of notice before terminating employment.

The complainant provided documents showing that even though she had given four months' notice, she had been on long-service leave and annual leave for that period

of time. The complainant provided her letter of resignation which indicated she was having difficulties performing the role due to her back issues.

AFCA determined there had been an unreasonable delay on behalf of the insurer. The insurer should have considered whether there was any other way to resolve its concerns after it became clear the former employer was not going to provide the required information in a timely manner.

AFCA set aside the decision of the insurer and remitted the claim to it with a direction that it finds the complainant had ceased work due to sickness or injury. AFCA also set aside the decision of the trustee to agree with the insurer.

3.2 References

Definitions

Term	Definition
Complainant	A person who has lodged a complaint with AFCA
IP claim	A claim for income protection insurance benefits
TPD claim	A claim for total and permanent disability insurance benefits

Useful links

Document type	Title / Link
AFCA Rules	afca.org.au/rules
Act	<i>Superannuation Industry (Supervision) Act 1993 (Cth)</i> legislation.gov.au/Details/C2019C00307
Act	<i>Insurance Contracts Act 1984 (Cth)</i> www.legislation.gov.au/Details/C2019C00115
Code	<i>Life Insurance Code of Practice</i> www.fsc.org.au/policy/life-insurance/code-of-practice
Code	<i>Insurance in Superannuation Voluntary Code of Practice</i> www.superannuation.asn.au/policy/insurance-in-superannuation-voluntary-code-of-practice

Appendix – AFCA’s superannuation jurisdiction

What are AFCA’s remedial powers for superannuation complaints?

Division 3 of the Corporations Act sets out additional provisions which relate to AFCA’s superannuation jurisdiction. These provisions impact the way in which AFCA determines superannuation complaints and the remedial powers it exercises.

When an AFCA decision-maker determines a superannuation complaint, they have all the same powers, obligations and discretions of the trustee (or other decision maker) whose decision or conduct is being reviewed.

An AFCA decision-maker can only make a determination to place the complainant (as nearly as practicable) in a position where the unfairness and / or unreasonableness no longer exists.

In addition, an AFCA decision-maker must not do anything contrary to law or the governing rules of the fund.

When an AFCA decision-maker determines a superannuation complaint, they step into the shoes of the superannuation provider, with the benefit of all the information provided.

Reviewing decisions (and related conduct)

If the AFCA decision maker is satisfied that the superannuation provider’s decision (or related conduct) operated fairly and reasonably in relation to the complainant in the circumstances, the AFCA decision maker must affirm it.

However, if the AFCA decision-maker is not satisfied and considers there is some unfairness or unreasonableness in the operation of the superannuation provider’s decision, then the AFCA decision-maker can take one of the following remedial actions:

- Vary the decision
- Set aside the decision and substitute their own decision; or
- Set aside the decision and send the matter back to the superannuation provider and insurer to make a new decision in accordance with AFCA’s directions.