SUBMISSION

Parliamentary Joint Committee on Corporations and Financial Services: Inquiry into the life insurance industry

CommonwealthBank

Contents

1. Introduction

Commonwealth Bank welcomes the opportunity to provide a submission to the *Parliamentary Joint Committee inquiry into the Life Insurance industry*.

The inquiry's terms of reference are an opportunity to consider practices in the life insurance industry and where improvements can be made.

Commonwealth Bank submitted a response to the *Senate Economics References Committee inquiry into the Scrutiny of Financial Advice* in April 2016 (the SOFA Inquiry). Aspects of the SOFA Terms of Reference and our submission remain relevant for this inquiry, so Commonwealth Bank's submission to the SOFA Inquiry is attached to this response for your reference. The SOFA Inquiry submission focused on Life Insurance and included the topics:

- Life Insurance industry context
- CommInsure business claims practises including governance, processes and outcomes
- CommInsure's response to allegations that had been raised in the media
- Policy recommendations

This submission provides an update on CommInsure's response to allegations that were raised in the media earlier this year, and outlines CommInsure's ongoing commitment to broader industry reform.

Life insurance supports customers and their families at some of the most difficult times in their lives. Commonwealth Bank and CommInsure take that responsibility very seriously.

Commonwealth Bank is committed to constantly improving our products and services to deliver better customer outcomes. We also believe it is important that the life insurance industry, superannuation funds and advisers work together to progress the industry's product, sales and service offerings. To achieve this, we work with regulators, government and consumer bodies to ensure that we continue to evolve to meet the changing needs of customers.

Background

Commonwealth Bank's life insurance subsidiary, CommInsure, was the subject of ABC and Fairfax reporting in March and April 2016 which made a number of allegations concerning CommInsure's business practices.

CommInsure has responded by conducting a broad and extensive range of reviews into its life insurance claims handling, products, culture and practices. These reviews, together with other previous work already commissioned, involve well-regarded independent specialists and encompass policy definitions, claims review processes, and other factors such as remuneration. CommInsure has been engaging with the regulators on the reviews, which are nearly complete.

The allegations raised do not reflect the values of Commonwealth Bank's or CommInsure's people or business. Commonwealth Bank and CommInsure aspire to be ethical in all our dealings. Being an ethical business does not mean being perfect, but where we could have done better we acknowledge it and seek to put things right. CommInsure remains

committed to Commonwealth Bank's vision to excel at securing and enhancing the financial wellbeing of people, businesses and communities.

To date, CommInsure has not found evidence to substantiate any of the allegations of wilful misconduct, nor has CommInsure identified any systemic issues regarding inappropriate decline of claims. The reviews commissioned by CommInsure have also been conducted in order to identify improvements that CommInsure can make to its processes to deliver a more consistent experience for customers and members.

2. Update on CommInsure's reviews and actions taken

This is a summary of the progress on the reviews and actions taken by CommInsure in relation to the allegations made against it earlier in 2016.

Findings to date

Medical files:

CommInsure has found no evidence to substantiate the allegation of unauthorised tampering or malicious deletion of medical opinions from its database.

CommInsure takes customer and employee privacy and confidentiality very seriously and has policies, standards and guidelines for information security. It investigated concerns about medical files when they were initially raised in late 2014. The investigation, completed in March 2015, found no evidence of files being maliciously deleted or tampered with, as was alleged.

A CommInsure Board committee commissioned an additional, independent review into the allegations of file tampering in the Medical Officer Referrals Database in April 2016. The Board committee concluded that there was no evidence to substantiate the allegation of tampering or maliciously deleting medical opinions from the database.

Furthermore, the Board committee was satisfied that the original investigation in 2015 was appropriate.

As part of its ongoing investment in claims technology, CommInsure has introduced a new claims management technology platform. Medical referrals are now stored in this system.

Incentives to decline claims:

KPIs and associated payments for CommInsure claims staff do not raise issues that would drive undesirable outcomes for customers.

An independent review of claims staff key performance indicators (KPIs) for 2015 and 2016 led to Commonwealth Bank and CommInsure being satisfied that, overall, the KPIs did not raise issues that would lead to adverse customer outcomes.

CommInsure claims staff are trained and experienced, have a strong focus on fair customer outcomes and values, and their KPIs are generally balanced between good quality decisions and customer experience. Any incentives generally represent a small proportion of a CommInsure claims staff member's overall pay.

Past surveillance practices:

Assertions in the media that CommInsure "massively" increased surveillance in 2013[1] are incorrect.

[1] On 12 March 2016, the *Sydney Morning Herald* reported that "…in the second half of 2013 CommInsure went on an all-out assault on the privacy of its policy holders by increasing the number of claims under surveillance by a massive 48 per cent to 366 investigations in a six-month period…".

A CommInsure Board committee commissioned a review of past surveillance practices in response to allegations in the media that CommInsure "massively" increased surveillance in the second half of 2013.

The Board Committee is satisfied that the assertions regarding increased surveillance are incorrect. In the second half of 2013, CommInsure's investigative activities included factual investigations, intelligence gathering and surveillance. While there was a small increase in overall investigative activity, there was no material change in the number of cases under surveillance.

The review also explored CommInsure's adherence to industry practices for investigations at that time. In 2013 there was no formal industry-wide code of conduct for life insurance claims investigations. The Board Committee is satisfied that the surveillance practices adopted by CommInsure were consistent with broader industry practice, relevant legal requirements and the requirements of corresponding Codes applying to general insurance and private investigations.

CommInsure is committed to the Life Insurance Code of Practice, which includes standards for life insurance claims surveillance.

Whistleblower practices:

No employee is disadvantaged as a result of reporting a concern in good faith.

Commonwealth Bank encourages employees to speak up if they see activities or behaviours that concern them or are inconsistent with our values. CommInsure rejects assertions that it was not responsive to employees' concerns.

Commonwealth Bank and CommInsure strive to provide a safe environment for employees to raise issues or concerns. Where concerns are raised these are taken seriously and where appropriate investigated. We recognise that vital information that employees and customers can deliver to management in certain instances is essential for improving our business, and we are open to suggestions around improvements to how they provide this information.

In relation to the specific allegations regarding Dr Benjamin Koh, the Commonwealth Bank Group took Dr Koh's concerns seriously, including through the CommInsure Board conducting a review. Dr Koh's employment was not terminated for raising concerns; it was terminated for serious and repeated breaches of Commonwealth Bank policies, including by sending significant amounts of customers' highly sensitive personal, medical and financial information to his personal email account. This conduct occurred over a long period of time. Dr Koh is taking legal action against Commonwealth Bank in relation to the termination of his employment. Commonwealth Bank is defending the matter.

Other actions taken in response to the concerns

Outdated medical definitions:

CommInsure has upgraded and backdated certain definitions to 2014.

In March 2016, CommInsure accelerated a planned update of definitions related to heart attack and severe rheumatoid arthritis in its retail advice products. The updated definitions were backdated to May 2014. This was the last time CommInsure introduced new features

to the product. CommInsure wrote to around 630,000 current and former customers to inform them of this change.

In May 2014, CommInsure's heart attack definition was similar to some competitors. In 2015, CommInsure had commenced work on a planned update of its retail products, which included the new definitions. It planned to launch the definitions later in 2016, but brought forward to March the definitions for heart attack and severe rheumatoid arthritis.

In addition, CommInsure proactively identified declined cases since May 2014 to reassess against the updated definitions. CommInsure has paid 17 people who became eligible under the updated definitions. We have a similarly small number of claims to review where customers have provided more information to us, and we are following up with other customers.

In November, CommInsure announced a range of further enhancements to its CommInsure Protection offering, including changes to trauma definitions and enhancements to its income protection product.

CommInsure has committed to more regularly review its life products to ensure definitions reflect evolving medical standards and practices. CommInsure supports the use of standard definitions, which are being developed in the industry's Code of Practice and is a signatory to that Code.

Claims assessment safeguards:

Extra layers of review to ensure claims outcomes are fair, consistent and balanced.

In March, CommInsure established a Claims Review Panel to provide an objective and independent assessment of the merits of a claim as an extra layer of assurance in ensuring that claims outcomes are fair, consistent and balanced. By April, CommInsure had appointed four independent and well-respected industry identities to the panel. The four independent Claims Review panellists are:

- **Professor Justin Malbon**, professor of law at Monash University, former consumer representative on the Financial Ombudsman Service, and a former member of the Superannuation Complaints Tribunal
- **Dr Stan Goldstein**, with more than 30 years' experience in health services management, including as Head of Clinical Advisory at Bupa Australia and as an Associate Professor (Conjoint) in Public Health and Community Medicine at UNSW
- **Mr Chris McRae**, a former board member at the Financial Ombudsman Service, and financial services lawyer with more than 30 years' experience, including as a past Chief Legal Officer at AMP
- **Dr Robyn Napier**, a general practitioner, Chair of MDA National's Cases (Eastern) Committee and Corporate Social Responsibility Committee, AMA (NSW) Medical Secretary and Medical Director, and past AMA Federal Councillor

Matters are referred to the Claims Review Panel by CommInsure's complex claims committee. The Claims Review Panel comprises at least two of the independent panel members and the Managing Director of CommInsure.

Progress update on reviews still underway

CommInsure has taken the allegations in the media directed towards it seriously. It is determined to reassure customers, members, clients, advisers and employees that CommInsure is committed to securing and enhancing their financial wellbeing.

CommInsure's Board commissioned a series of independent reviews to investigate allegations raised in the media earlier this year, including ethical concerns. The reviews are making good progress, though given the size of the business, and our determination to investigate thoroughly, work remains ongoing.

Past declined claims:

An independent review of past declined claims over the five years to 30 April 2016.

In April 2016, CommInsure engaged Deloitte Touche Tohmatsu (Deloitte) to conduct an independent review of a substantial number of past declined group life and retail advice[2] terminal illness, death, trauma and total and permanent disablement claims over the five years to 30 April 2016. Deloitte has completed over 90 per cent of these reviews.

Among these completed reviews is a sample of death, trauma and total and permanent disablement claims over the past five years to 30 April 2016, every terminal illness benefit claim declined in the past three years to 30 April 2016, and a sample of terminal illness benefit declines in the two years preceding.

While retail and group life income protection and direct life policies were not addressed specifically in any allegations, CommInsure has also asked Deloitte to review a sample of income protection and direct life declined claims over the past five years to 30 April 2016. This review will commence in early 2017.

In addition, CommInsure has engaged Deloitte to conduct an independent, end-to-end review of CommInsure's claims handling processes and procedures. This review will be informed by Deloitte's observations from its review of declined claims. The review is underway.

While there is more work to be done, CommInsure has not seen any systemic issues regarding inappropriate decline of claims. CommInsure requested that the claims review identify improvements that CommInsure could make to its processes to ensure a more consistent experience for retail customers and superannuation fund members.

CommInsure has invested more than $50 million in its claims systems and processes over the last three years and will continue to invest.

Resources dedicated to the review

In the course of the reviews undertaken so far, CommInsure and its independent experts have electronically reviewed more than five million emails and documents, and manually

[2] Group policies are provided by CommInsure to entities like industry superannuation funds, corporate superannuation funds and master trusts. Retail advice policies are provided to individual customers who are the clients of financial advisers.

reviewed around 200,000 email documents and conducted around 80 independent interviews.

CommInsure has provided around 60,000 email records and documents to the regulators at their request. More than 150 people have been involved in these reviews, with many more contributing indirectly.

CommInsure recognises the importance of the role played by the regulators and aims to assist the regulators to help them in their work. CommInsure has been working with APRA and ASIC regarding the reviews and both regulators have had direct access to the appointed independent experts.

3. Broader Policy Commitments

Commonwealth Bank is committed to improving our products and services to deliver better customer outcomes. CommInsure believes it is important that the life insurance industry, superannuation funds and advisers work together to improve the industry's product, sales and service offerings. To achieve this, CommInsure engages with customers, trustees, consumer bodies, the government and regulators.

Commonwealth Bank has also worked closely with the Australian Bankers' Association (ABA) and other banks to develop an industry plan. We view the plan as an important step in ensuring that customers and the broader community can trust our industry to deliver the financial services so fundamental to the Australian economy.

Implementing the industry plan is a priority for Commonwealth Bank, building on measures we have put in place within the organisation in recent years.

Industry Regulation

Regulators have an important role in monitoring and supervising the industry. It is vital to customers' security and peace of mind that insurance companies operate sustainably, at an individual product as well as company level, to ensure they are able to pay claims into the future. This means that life insurers must remain well capitalised and incorporate a suitable level of profit into the design and pricing of insurance policies.

The Australian Prudential Regulation Authority (APRA), as the financial services sector prudential regulator, supervises life insurers, like CommInsure, according to the Life Insurance Act 1995 and a suite of prudential standards. This legislation is designed to ensure that the life insurance business is prudently managed with regard to the impact of its decisions on policyholders.

The Australian Securities and Investments Commission (ASIC) regulates life insurers, including CommInsure, through the *Corporations Act 2001,* the *Australian Securities and Investments Commission Act 2001* and the *Insurance Contracts Act 1984*. These acts provide a framework of consumer protections.

The Commonwealth Bank welcomes the *Life insurance claims: An industry review* report by ASIC and further discussion on expectations for improvements to the industry announced by APRA.

We support the intent of ASIC's report to ensure proper and fair claims processes throughout the life insurance industry that will help to ensure better outcomes for customers. We are committed to lifting the trust and confidence that consumers have in the life insurance sector.

We also support ASIC and APRA's proposal to establish a consistent public reporting regime for life insurance industry claims data and claims outcomes once the common frameworks are agreed.

The broader reforms across the industry are significant and represent a step forward in strengthening the industry's standards and practices.

Recent developments in life insurance and advice policy

Life insurance reform package

Commonwealth Bank supports the life insurance reform package. The reforms include a reduction in upfront commissions, new commission clawback rules and a new Life Insurance Code of Practice designed to further protect consumers. The reforms also include the development of a Financial Services Council standard for Approved Product Lists for insurance products and initiatives to improve Statements of Advice for life insurance.

Financial Adviser professional standards

Commonwealth Bank has been taking the industry lead on adviser education standards, applying them across the Commonwealth Bank Wealth Management Advice businesses, to all advisers and staff in supervision and monitoring roles. In addition to this Commonwealth Bank supports recent policy initiatives for the creation of a new professional standards framework that sets minimum qualifications for new and existing advisers, supervision requirements for new advisers, an industry exam and a model code of ethics.

Areas for further consideration

Standardisation of definitions

There is opportunity to improve insurance product offerings so that they are easy for customers to understand and assess. Better understanding of products and terms can also help customers during a claims process.

This could include setting minimum standards for life insurance products. There may also be some benefits to exploring opportunities to standardise policy terms and conditions where this helps consumers.

Further work to improve disclosure could also be beneficial for consumers.

Mental health

Forty five per cent of Australians will experience a mental health illness at some point, with one in five in any given year[3]. Aside from the direct impact on individuals and those around them, this is a challenging policy area for government and businesses, including the insurance sector.

CommInsure is working with the Financial Services Council to consider areas for improvement and have commenced discussion with experts in patient care and mental health matters to begin developing reforms in this area.

Rehabilitation

Supporting customers involves providing more than just financial support. CommInsure has its own internal rehabilitation team and medical team, consisting of dedicated staff that have experience and qualifications across varied disciplines, including psychology and psychiatry. CommInsure also support fund-employer engagement objectives.

However, life insurers are limited by legislative provisions in their ability to pay for rehabilitative treatments that would assist claimants to return to work. For a range of

[3] https://www.blackdoginstitute.org.au/docs/Factsandfiguresaboutmentalhealthandmooddisorders.pdf

reasons, rehabilitation is generally preferable and delivers quality of life outcomes. Limiting rehabilitation options may lead to poorer customer health outcomes and higher ongoing claims costs, which then flow through to higher premiums.

Government should consider reviewing legislation to explore opportunities to allow life insurers to fund rehabilitative treatments and assist workers in their return to the workplace, as work has been proven to contribute to good mental health and overall health and wellbeing.

Stronger engagement with the medical profession

In the UK, the British Medical Association and the Association of British Insurers work together on a range of medical matters including publishing a joint guidance on best practice and practical advice on the use of medical information in insurance.

There exists opportunities in Australia to build a collaborative working relationship between the life insurance industry and medical professional bodies to harmonise the efforts of both parties and to optimise both the insurance process and claims outcomes for patients.

Financial literacy

Commonwealth Bank has a particular commitment to improving the financial literacy of Australians. Indeed, in January 2015 Commonwealth Bank announced a $50 million dollar investment in our financial literacy programs over the next three years.

Low levels of financial literacy affect the ability to ensure financial wellbeing for Australians. Insurance is no exception to these issues.

Along with other educational, regulatory and government bodies, the life insurance industry should increase efforts to help improve the Australian community's understanding of life insurance.

Attachment A – CommInsure update

UPDATE: COMMINSURE REPORTS GOOD PROGRESS ON INDEPENDENT REVIEWS

In early 2016 CommInsure was the subject of media reports that raised concerns about its operations. Some of the issues raised were already being addressed by CommInsure. Since the reports were published, CommInsure has taken further steps to provide assurances including upgrading our product offering, reviewing past declined claims and further investigating the allegations made in the media reports.

In FY16 CommInsure paid $929 million in life and income protection payments to around 22,600 customers – that's more than $2.5 million paid every day.

Were medical files maliciously deleted or tampered with?	There has been no evidence found of medical files being maliciously deleted or tampered with. ■ We investigated allegations about medical files when they were first raised and found no evidence to substantiate these allegations. ■ CommInsure's Board commissioned an independent review into these allegations and it has concluded there was no evidence to substantiate the allegations of tampering or maliciously deleting medical opinions. ■ Furthermore, the CommInsure Board is also satisfied that the original investigation was appropriate.
Were concerns raised by employees ignored?	Assertions that CommInsure was not responsive to employees' concerns are incorrect. ■ All Commonwealth Bank employees are encouraged to speak up if they see activities or behaviours that concern them or are inconsistent with our values. ■ Employees can openly express concerns and we provide a safe environment for them to do this confidentially. ■ Any concerns raised are taken seriously and, where appropriate, investigated fully. No employee is disadvantaged as a result of reporting a concern in good faith.
Is there a culture of poor behaviour and practices?	Concerns raised earlier this year do not reflect the values of our people or our business. CommInsure is committed to doing the right thing by our customers, acting with integrity and transparency in all our dealings. We stand behind the quality of our people, products and services. ■ CommInsure's Board commissioned a series of independent reviews to investigate allegations raised in the media earlier this year. Some of these are still ongoing and a number are complete. ■ A review of past surveillance practices is complete. The CommInsure Board is satisfied that surveillance practices adopted in 2013 were consistent with industry practice, and that assertions in the media that CommInsure massively increased surveillance in the second half of 2013 are incorrect - there was no material change in the number of cases under surveillance.
Did claims staff receive incentives to decline claims?	No. Our claims staff are well trained and experienced, and have a strong focus on fair customer outcomes and values. ■ An independent review of claims staff key performance indicators (KPIs) for 2015 and 2016 led to the Commonwealth Bank and CommInsure being satisfied that, overall, the KPIs did not raise issues that would lead to adverse customer outcomes. ■ KPIs were found to be balanced between good quality decisions and customer experience, along with people and productivity, and incentives generally represent only a small portion of their overall pay.
Were life insurance heart attack and severe rheumatoid arthritis definitions out of date?	Our update of heart attack and severe rheumatoid arthritis definitions began in late 2015 for launch later in 2016, but we brought it forward. ■ In March 2016, we accelerated a planned upgrade to some definitions, backdated to May 2014, which was the last time we introduced new features to the product. We have written to around 630,000 current and former customers to inform them. ■ We actively searched for previously declined cases to reassess against our updated definitions and have now paid 17 customers who became eligible. We have a similarly small number of claims to review where customers have provided more information to us, and we are following up with other customers. ■ We have committed to more regularly review our life products to ensure definitions reflect evolving medical standards and practices.
Were claims inappropriately declined?	There is good progress being made on the independent reviews of a substantial number of retail advice and group* past declined life insurance claims and the processes used by our claims handling operation. ■ While there is more work to be done, from the work we have done to date there is nothing that supports the assertion of systemic inappropriate decline of claims. ■ What we have found are improvements that we need to make to our processes to ensure we consistently get the right outcome for our customers. CommInsure welcomes these opportunities to improve. ■ Over 70% of the past declined terminal illness, death, trauma and total permanent disablement claims selected by Deloitte have now been reviewed. ■ The independent review of CommInsure's claims handling processes is also underway and scheduled for completion by the end of 2016.

* Group policies are provided by CommInsure to entities like industry superannuation funds, corporate superannuation funds and master trusts.

Updated as at 8 November 2016.

Attachment B – Commonwealth Bank's SOFA submission

Contents

1. Introduction

Commonwealth Bank welcomes the opportunity to provide a further submission to the *Senate Economics References Committee inquiry into the Scrutiny of Financial Advice*.

The inquiry's expanded terms of reference to include matters specifically relating to life insurance are an opportunity to consider practices in the industry and where improvements can be made.

This submission includes:

- background information about life insurance and the Australian life insurance industry;
- a profile of CommInsure[1];
- Commonwealth Bank's response to recent public questions; and
- policy initiatives that could be undertaken by government and industry that would further strengthen confidence in the sector.

[1] The Colonial Mutual Life Assurance Society Limited (CMLA) is a wholly-owned subsidiary of the Commonwealth Bank Group. CMLA includes the life insurance business commonly known as CommInsure. For simplicity this submission refers to 'CommInsure' and generally excludes the superannuation and investments business.

2. Life Insurance

The life insurance industry provides a vital financial safety net for Australians. Millions of Australians hold policies which help to manage the financial impacts of accident, illness or death. In 2015 the life insurance industry paid $7.7 billion in customer claims[2].

Life insurance supports customers and their families at some of the most difficult and emotional times in their lives. CommInsure takes that responsibility very seriously.

Background to life insurance

Life insurance provides financial support in the event of death, accident, illness or inability to work. While policies vary, the major types of cover are:

Product types	Life	Total Permanent Disability (TPD)	Trauma	Income protection	Credit based
What's covered	A lump sum payment in the event of death or terminal illness	A lump sum payment in the event of total and permanent disablement, resulting in being unable to work again	A lump sum payment in the event of specified major illness or injury	A salary or wage replacement if unable to work due to illness or injury	Coverage of debt in the event of being unable to work due to illness or injury, death, and in some circumstances, unemployment

These types of cover are provided as either individual or group policies

Individual policies are purchased by the customer themselves. In group policies, the customer is provided cover through a policy purchased on their behalf. The most common, but not only, form of group insurance is where the policy owner is a superannuation fund providing life insurance cover to its members.

Within each policy there are variations in benefits which include the events that are covered and the amount that would be paid. Policies can be funded in different ways, such as directly by the customer or by using their superannuation.

As in other markets for financial products, insurance companies compete on product features, 'premiums' (or the cost of the policy) and service. More comprehensive features are typically reflected in higher expected claims and therefore higher premiums.

For some customers 'higher end' products which incorporate broader coverage might not be affordable or suitable to their circumstances. Insurers regularly review the experience[3] of each product line and this is taken into account along with competition and other factors, in changes to their products.

[2] Source: APRA quarterly Life Insurance Performance, December 2015: Table 1a, Gross Policy Expenses: Death and Disability Claims

[3] Actual performance compared to the actuarial assumptions used in product design – including, for example, lapse rates and claims.

Sometimes, an insurer might identify product improvements, such as broader coverage of a particular event, which it decides to provide to customers. At other times, the insurer might decide not to expand its product with that feature because of the price impact to its customers.

Life insurance differs from other forms of insurance because the insurer has long term obligations to the customer. Most life insurers offer either guaranteed renewable policies or non-cancellable policies and life insurers cannot make existing policies more restrictive.

Access to life insurance

Customers can purchase life insurance in many different ways, including through financial advisers, through their superannuation fund, or directly.

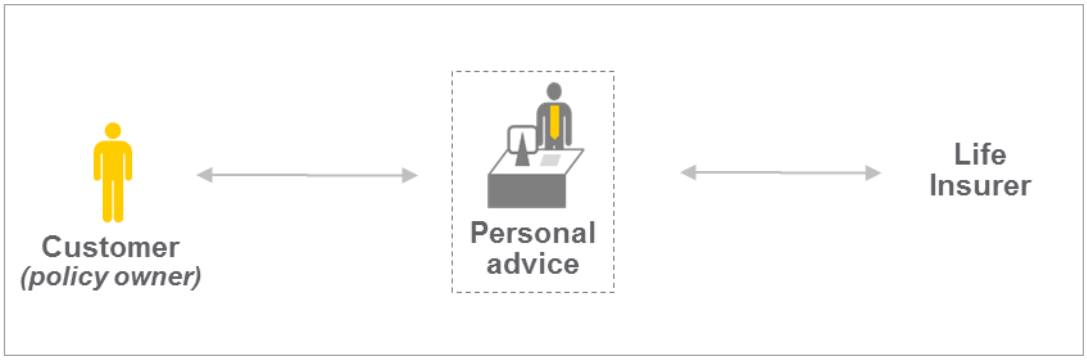
Life insurance through a financial adviser

Financial advisers typically provide advice on a customers' personal financial needs, including the risks that should be covered by life insurance. Usually such advice is personal advice as defined by the *Corporations Act 2001*. In meeting the customer's best interest, there may be some circumstances, when a financial adviser provides advice on life insurance only.

Financial advisers provide advice to their client on which life insurance providers and products would best suit their particular needs, with respect to the type of insurance, amount of coverage, affordability and whether the policy should be held within or outside superannuation. This type of policy is generally underwritten, with customers answering questions to help the insurer understand the individual's risk profile (for example, their medical history).

The financial advisers assists the customer through the application process, which generally involves engagement with the product provider, to establish the policy. Many advisers also assist their customers in the event of a claim.

A high-level view of the way in which customers buy life insurance through advisers is shown below.



Life insurance through a superannuation fund

Customers also access group life insurance via a superannuation fund. The insurance provided through group schemes following the introduction of compulsory superannuation was initially relatively simple life insurance and TPD, commonly at low levels of cover. In the last decade the level and diversity of life insurance provided through superannuation funds has increased.

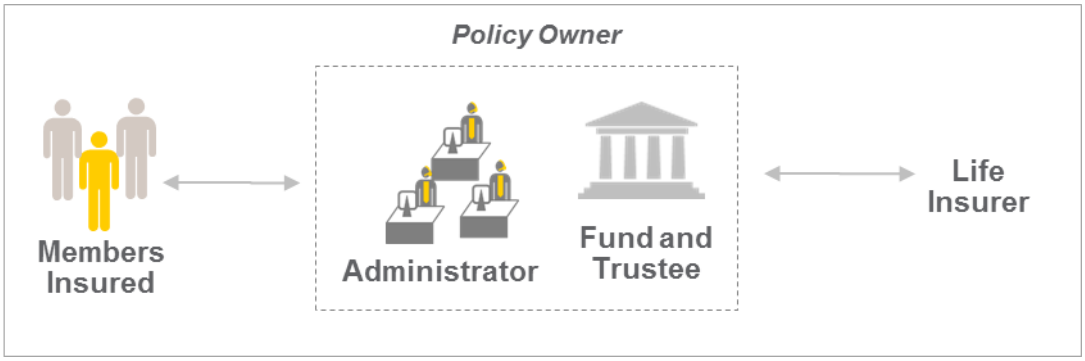
Superannuation trustees balance what is included in insurance cover with the costs of providing that cover to their members and the impact on their retirement savings. In the case of superannuation,

premiums are generally deducted from members' accounts and typically are provided as part of default arrangements, which means that all members are generally covered providing they meet the eligibility requirements established by the trustees.

Trustees make decisions regarding the type, specific policy terms and level of cover provided to their members. They are also involved in the claims process and are required to review claims decisions before they are communicated to members.

An administrator acts on behalf of Funds and Trustees and are the intermediary for member enquiries and interactions. The administrator runs day to day operations.

A high-level view of the way in which customers buy life insurance through superannuation funds is shown below. A similar process typically applies for group schemes outside superannuation.

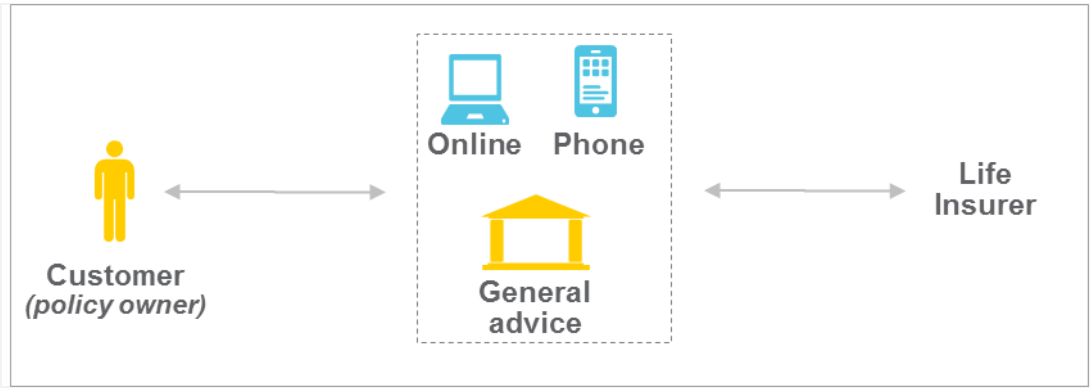


Life insurance direct from an insurer

Customers may also buy life insurance cover directly from insurers. This has been particularly enabled by the proliferation of digital technology and the growth of credit insurance which is often provided along with the provision of credit. Some customers also access insurance as a result of media advertising, telemarketing and through other third parties.

Direct products are commonly provided to customers with general advice.

A high-level view of the way in which customers buy life insurance directly is shown below.



Industry regulation

Life insurers are subject to close monitoring and supervision by two key regulators and must comply with a comprehensive legislative framework.

The Australian Prudential Regulation Authority (APRA), as the financial services sector prudential regulator, supervises life insurers, like CommInsure, according to the Life Insurance Act 1995 and a suite of prudential standards. This legislation is designed to ensure that the life insurance business is prudently managed with regard to the impact of its decisions on policyholders.

It is vital to customers' security and peace of mind that insurance companies operate sustainably, at an individual product as well as company level, to ensure they are able to pay claims into the future. This means that life insurers must remain well capitalised and incorporate a suitable level of profit into the design and pricing of insurance policies.

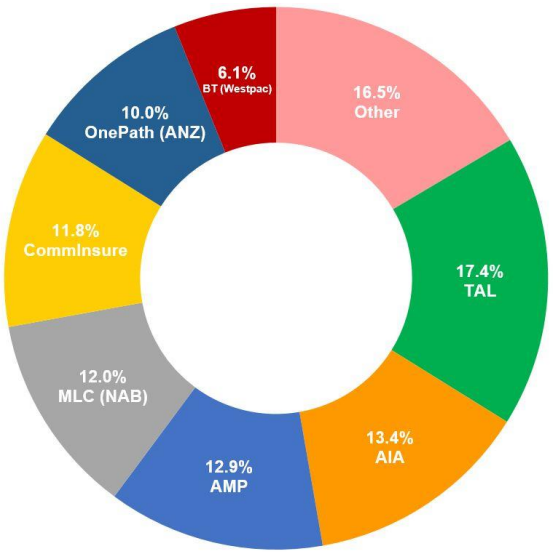
The Australian Securities and Investments Commission (ASIC) regulates life insurers, including CommInsure, through the *Corporations Act 2001,* the *Australian Securities and Investments Commission Act 2001* and the *Insurance Contracts Act 1984*. These acts provide a framework of consumer protections. For example, the *Insurance Contracts Act 1984* imposes a duty of utmost good faith on parties to an insurance contract, including in the management of claims.

Both regulators have extensive investigative and enforcement powers to regulate insurer behaviour, including the power to call for documents and ask questions of management. Between them they have the power to deregister the business, ban individuals, sue, and impose conditions, fines and sanctions.

Competition in the sector

Customers have a wide choice of life insurance providers. There are over 25 licensed life insurance companies operating in Australia.

Figure 1: Australian Life Insurance Market Shares[4]



[4] Plan for Life - Detailed Risk Statistics December 2015 (tab premium inforce group)

3. CommInsure business

The original predecessor to the business which is now CommInsure was first established in 1873. CommInsure is the fifth largest life insurance provider in the Australian market, providing insurance cover or investment services to around 4.4 million customers. CommInsure paid more than $850 million in claims in 2015 to over 22,000 customers[5].

CommInsure is the third largest group insurance provider, serving 1.7 million members through more than 10 industry funds, more than 100 corporate clients and more than 400,000 mastertrust members. It is the fifth largest life insurer through financial advisers with more than 250,000 policyholders. CommInsure is also a significant provider of consumer credit insurance, including loan protection insurance and credit card insurance products.

Finally, CommInsure also manages a range of legacy insurance, superannuation and investment products, many of which are no longer sold directly to customers.

Governance

The board which governs CommInsure comprises four independent non-executive directors, three non-executive directors and the managing director[6]. The legislation governing life insurance imposes unique duties which are distinct and separate from those of the Commonwealth Bank.

One of the independent non-executive directors serves as chair. The independent non-executive directors also comprise the Board Audit Committee and the Board Risk Committee. Each committee is chaired by an independent non-executive director who is not the chair of the board.

The directors are a diverse group of qualified individuals with extensive knowledge, experience and business expertise across financial services, both domestically and internationally. Their specialised fields of knowledge include life insurance, general insurance, actuarial, economics, audit, finance, accounting, corporate strategy, governance, investment, funds and asset management, and risk management.

Claims process

Customers make claims at some of the most difficult times in their lives. It is important to treat claimants with compassion and respect and make decisions about claims in a timely fashion.

Life insurance requires the insurer to reach a conclusion about whether or not an event has occurred which should lead to a payment. In making these decisions, CommInsure has obligations under the *Insurance Contracts Act 1984* to act with utmost good faith towards the insured person. Claims management must have due regard for customer expectations, the reality of difficult medical and employment determinations, and the implications of paying invalid claims on the affordability of cover for both current and future customers.

If claims are denied, insurers must give reasons for this and inform the customer that they can ask for the information relied upon for the decision to be reviewed.

[5] Includes death claims within superannuation and investment products.
[6] APRA's Prudential Standard CPS510 Governance sets out the requirements for independence and the definition of a non-executive director.

While some claims are straightforward to determine, many take longer to assess. The circumstances of each customer are unique. This requires careful assessment of every claim, both for the personal circumstances of the event as well as the specific terms of the policy. Even as claims are being reviewed, personal and health circumstances may change.

Attachment A provides some illustrative examples of different types of claims. It illustrates that some cases are very straightforward to determine, while others require considerable expertise.

CommInsure's claims management processes vary to account for the claim type and nature of the policy. Once CommInsure receives a claim from a customer, it assigns an individual case manager to the claim. The time taken to complete the assessment will differ depending on waiting periods, specific requirements within the policies, the amount of information provided at commencement of the claim and whether CommInsure has authority for direct customer contact. Some assessments may also involve requesting an opinion or support from a specialist**.**

CommInsure makes contact with each claimant personally or via their representatives, to ensure that it understands the circumstances of each claimant. In some situations contact is made via a third party such as a superannuation fund or an adviser.

Ultimately the case manager will make a determination on the claim which may, subject to various delegations and approval requirements, require an additional internal review.

In the case of group policies, before the outcome of the claim is communicated to the individual end customer, the decision is first reviewed and approved by the relevant trustee. Trustees have a responsibility at this point to ensure that valid claims are paid because they have an obligation to their members. In addition, it is in the trustee's interests that the insurer does not pay out invalid claims as that is ultimately reflected in higher ongoing premiums to the total member pool.

In July 2015 CommInsure changed its life insurance structure from being arranged according to product type, into a structure in which there is a single customer facing distribution and product function, and a single customer service function that includes the claims management team. In part, the purpose of these changes was to improve efficiency and consistency in operations, particularly claims processing.

Since 2013, CommInsure has invested over $45 million in a program to transform its claims management capabilities. Improvements for the benefits of customers in recent years include:

- new technology and processes that improve efficiency which has facilitated the fast-track processing of straightforward claims and direct other claims to more experienced staff;
- better processes to gather the right information first time to help provide consistent claims decisions and pay customers faster;
- increased investment in staff training including mental health awareness and empathy training to assist claims staff to help customers in difficult circumstances; and
- a new customer telephone system to improve customer service.

Review of decisions

CommInsure's aim is to get things right the first time. However, not all customers will agree with the outcome of their claim. After a decision has been provided, they have the opportunity to request a review or to present additional information to support their claim.

Commonwealth Bank's Group Customer Relations team, which is separate from CommInsure, conducts reviews of life insurance determinations if a customer expresses dissatisfaction. A representative of this team will discuss the complaint with the customer and investigate whether the decision was appropriate. Each matter is considered on its own merits and this team will often request additional information to aid their investigations. If there is evidence that a mistake has been made, then the decision will be corrected.

Customers can also ask to have their decision reviewed by an independent external body. These include the Financial Ombudsman Service (FOS), or for customers whose coverage is through superannuation, the Superannuation Complaints Tribunal (SCT). Customers are advised of the availability of these services in the event that their claim is declined. These are established bodies with considerable experience and are free for customers within the ASIC approved terms of reference, and statutory provisions.

Claims outcomes

CommInsure paid more than 22,000 claims[7] and over $850 million in 2015 to our customers. While we believe the vast majority of claims decisions are correct, errors can occur.

CommInsure uses a range of measures to monitor its claim processes; these include participation in various external benchmarking studies, as well as data from FOS. These measures have not given rise to systemic concerns about the accuracy or integrity of our claims processing as we illustrate below.

An annual market study is run by NMG Consulting and is based on in depth interviews with decision-makers across adviser networks, industry funds, public sector funds, corporate schemes and master trusts. The most recent Mid-Tier Adviser and Group reports from 2015 had two distinct survey groups:

- in the Mid-Tier Adviser Study[8], adviser ratings of CommInsure's claims capability was in line with market average; and
- in the group study[9], CommInsure's claims capability was rated above-average overall with top quartile results on certain key measures.

NMG has also reported that CommInsure's gross claims ratios[10] in both group and advised insurance have been consistently higher than the market average, meaning CommInsure pays more in claims as a percentage of its premiums, than the average across the industry.

CommInsure also participates in the Lewers Life Insurance Intermediaries Study Australia that is based on independent adviser feedback on life insurers. The 2015 annual benchmarking study indicated that CommInsure is highly regarded by financial advisers for fairness and sensitivity in claims assessment, with opportunity to improve the timeliness of claims processing. Improving processing times has been the focus of recent investment.

CommInsure has reinsurance arrangements in place and as such has recently been subject to external audits of its claims functions by reinsurers who cover the industry. Those reports have not found any material issues in relation to CommInsure's claims functions.

APRA also regularly performs its own prudential regulatory assessments.

[7] Includes death claims within superannuation and investment products
[8] NMG Mid-Tier Adviser Study (April 2016)
[9] Australia Group Risk Programme 2015, End Customer Perspective (November, 2015)
[10] Gross Claims Ratios across the Industry include claims paid, reserving and other assumption changes

Finally, FOS provide annual comparative dispute numbers across the life insurance industry. Based on this information, CommInsure has relatively low rates of complaints referred to FOS compared to its industry counterparts.

In financial year 2014/5 the likelihood of a dispute involving CommInsure was two per 100,000 policies[11]. For comparison, CommInsure had the second lowest likelihood of a dispute per 100,000 policies and the other insurance companies had rates of between 0.7 and 16.6 disputes per 100,000 policies with an industry median of 3 disputes per 100,000 policies.

[11] FOS data includes investment products

4. Addressing recent issues raised

Commonwealth Bank and CommInsure aspire to be ethical in all our dealings. Being an ethical business does not mean being perfect, but where we could have done better we acknowledge it and seek to put things right.

In relation to recent allegations, some of those reports led us to take action to address areas where we should have done better, some can be immediately refuted and the remainder are being independently investigated.

CommInsure response to customer issues

Individual customer outcomes

We were saddened to learn of the poor experiences of some of our life insurance customers. CommInsure has a responsibility to engage with customers in a sensitive and compassionate manner.

For the benefit of the Committee, we provide a brief summary of some matters which led to the outcomes which were reached for the five customers who were the subject of a report on Four Corners. To protect the privacy of these customers we share minimal personal information. However, if the Committee requests further information we would be pleased to provide it on a confidential basis.

Two cases related to claims of total permanent disablement. Total and permanent disability can be among the most complex cases to assess. An assessor will consider whether the customer will ever be likely to work again as a result of their disability, taking into consideration age, occupation, education and the impact of reasonable medical treatment from their doctor. As a result, the time to assess TPD cases can be longer than for other types of insurance cover.

The entire process involving TPD claims requires compassion from all involved. The rejection of a claim can be extremely distressing to the claimant. The acceptance of a claim confirms that the person will be unlikely to work again, which can also have an enormous psychological impact, especially for a young person.

In one case there were challenges with differing medical opinions and whether the insured was receiving and following appropriate treatment. For this case the claim was paid in December 2015 independent of any media involvement.

For the other, the customer had a degenerative disease and a decision about their ability to work again was not straightforward. A review of this case was already underway before the media raised it.

These two cases also illustrate the difference between ill health retirement, and total and permanent disability. While policy definitions may vary, ill health retirement is generally a lower threshold, so it does not follow that someone who is ill health retired will automatically be paid a TPD benefit.

Two of the other cases related to terminal illness. Commonly, life insurance policies accelerate the life insurance payout if the insured has a terminal illness. This generally means that their doctor has advised that they have less than 12 months to live. Discussions regarding the probability of terminal illness are deeply upsetting and must be conducted with great sensitivity.

One of these terminal illness cases was initially declined in 2013, because the treating specialist advised that the customer was likely to live for more than 12 months. When the customer's health deteriorated and upon further advice from the treating specialist in 2014, the claim was paid.

The potential for a transplant was considered as part of the initial claim assessment. CommInsure changed its guideline on considering transplants in February 2015 and these are no longer considered as part of the assessment.

For the other case, the customer was initially declined in 2015 because they were likely to live for more than 12 months. When new medical advice was provided in 2016, that claim was paid in full.

All of these four cases were challenging to assess and our claims staff worked with the respective superannuation trustees.

Finally, one trauma claim related to the definition of a heart attack and its severity. As background, trauma policy pays a lump sum if the customer suffers a specified trauma condition.

Until recently, the definition of a heart attack under CommInsure's trauma policy only covered severe heart attacks. Based on medical reports provided the customer did not meet the specified severity in the policy. When the heart attack definition was updated and backdated, the customer became eligible under their policy.

More details on changes to CommInsure's heart attack definition are provided below.

In summary, two of the five customers had been paid prior to this year. When senior management became aware of two other cases, for one we sought and obtained additional information which resulted in a review and payment to the customer. For the other, it was clear after a review that we should have done better and we moved to put that issue right.

For the final case, we believe the assessment at the time of the claim was consistent with the terms of the policy.

The cases spanned a number of years. We acknowledge that our customers were in difficult circumstances and that the experience and time frames did not meet their expectations. As we illustrate in the section 'claims outcomes', these cases are not representative of the vast majority of customers' experiences with CommInsure.

We believe we have addressed these specific situations and have implemented a number of improvements to our business some of which we describe below.

Claims review

We acknowledge other customers may question the outcome of their claims assessment.

The CommInsure board has announced it will appoint an independent expert to oversee a claim review program focused on declined claims, with particular emphasis on customer advocacy. The independent expert will also specifically form a view on whether the circumstances surrounding the review of any particular claim warrants further action from the CommInsure board.

CommInsure has introduced an additional layer of independence and assurance to its claim assessment and decision-making processes. Where CommInsure's Complex Claims Committee recommends a claim be declined, it will be referred to the Claims Review Panel. The panel consists of

the Managing Director of CommInsure and at least two independent members with relevant expertise. The Board Risk Committee will monitor the outcomes of the panel.

Product changes

CommInsure has acknowledged that its heart attack definition was out of date.

A new measure for heart attack severity was introduced across Australian hospitals from the start of 2012. This allowed diagnosis of heart attacks that were less severe. The fundamental shift to expand the life insurance industry's heart attack definitions commenced around this time through to 2014.

CommInsure has accelerated the planned upgrade of its heart attack and its severe rheumatoid arthritis definitions in its trauma product. The product disclosure statements relating to these definitions for new customers have now been updated and coverage has been backdated and applies for all claim events from May 2014 onwards. May 2014 was the date of the last relevant product disclosure statement for the trauma product. On the basis of actuarial estimates we expect up to 100 customers will benefit from the backdating of these upgrades.

An advice product review had been initiated in 2015, and a comprehensive product relaunch was planned for late 2016. This will still occur. CommInsure has also committed to a more regular review of the life insurance offering to ensure definitions reflect evolving medical standards and practices.

At a broader level, CommInsure has undertaken frequent reviews of products, taking into account customer, adviser and trustee feedback. Approximately 80 per cent of CommInsure's customers hold a product that has been reviewed within the past three years.

When it is determined that a product change is appropriate, a series of activities (which take at least 6 months and often longer) are required prior to introduction. These types of changes may require input and review by claims, product, distribution, medical, actuarial, risk and compliance, legal, and marketing staff as well as consultation with reinsurers, trustees and research houses. The changes generally include updating Product Disclosure Statements, customer communications and for more substantial changes require updates to IT systems.

Other matters raised publicly

Culture and ethics

Commonwealth Bank is committed to doing the right thing by our customers and we take recent allegations about CommInsure seriously.

We do not believe these reports present an accurate reflection of the culture and ethics within our business. We do not tolerate behaviour that could put the financial wellbeing of the customers, businesses and communities we serve at risk. To date, we have not identified any instances of malicious staff misconduct which has led to the decline of a claim.

We accept that culture can always be improved, so over the last three years we have been working to strengthen the Commonwealth Bank's values and integrate a long term program, including better definition of our values, how they apply to our people every day, and how we can align our values with our policies and our performance management systems.

Response to internal concerns raised

Assertions that CommInsure was not responsive to concerns of Dr Benjamin Koh raised in the media are incorrect. These concerns were taken very seriously.

In response to concerns raised, the CommInsure board commissioned an independent review of targeted claim areas. When complete, the findings of the review were presented to the Board Risk Committee. The review concluded that there were no systemic issues in the areas covered but made a number of recommendations that either have been or are in the process of being implemented.

CommInsure also undertook a range of actions including:

- benchmarking of certain products across a range of considerations and global markets;
- governance changes to enhance structural independence, including escalation protocols for issues and changing the reporting line of doctors;
- workshops to clarify the roles and responsibilities in the claims management process;
- clarifying the advisory role of medical staff;
- senior management reviews of customer complaints and litigation;
- various changes to assessment guidelines including changing the terminal illness protocol;
- continuation of the investment in claims processes and technology; and
- additional training for claims staff, including customer empathy, professional protocols for interacting with doctors and duties owed to customers.

Allegations regarding treatment of staff and whistleblowers

Allegations that Dr Koh was dismissed for raising concerns about business practices at CommInsure are incorrect.

Dr Koh was dismissed for serious and repeated breaches of customers' privacy, involving highly sensitive personal, medical and financial information over a lengthy period of time. His statements and associated conduct during the investigation of his breaches were also misleading.

The investigation found that Dr Koh sent around 230 emails, attaching a total of around 260 documents, to his personal Gmail account. The emails were unencrypted and included sensitive customer files, medical reports, financial information and CommInsure corporate information. Emails were sent over an extended period from November 2013 to early 2015.

In addition, some of the responses provided by Dr Koh in response to management enquiries strongly suggested he was not sending information to his personal account. Yet, he had been doing so for many months before, and continued to do so for many months after, those responses. We also had concerns about Dr Koh's conduct during the investigation and his reaction when performance concerns were raised with him.

Commonwealth Bank records indicated that Dr Koh undertook our employee training in relation to protection of confidential information and appropriate use of IT systems, and had previously confirmed that he understood his obligations under the Acceptable Use of Group Technology Policy.

Dr Koh sent the first of these emails within one week of joining the organisation, a long time before he says he raised concerns about CommInsure. During the investigation, Dr Koh said that he sent the emails for a variety of reasons. Some of the reasons which have been recently reported are different to those given during the investigation.

More broadly, there have been suggestions that Commonwealth Bank and CommInsure do not encourage a culture in which concerns about processes or behaviours can be safely raised. These claims are untrue.

Commonwealth Bank encourages a culture where people can speak up with ideas, views and concerns. Senior leaders in the Commonwealth Bank routinely stress the importance of speaking up in their internal staff communications. Practical initiatives, such as daily and weekly team meetings, also provide a forum for staff to raise any concerns or improvement ideas.

Staff have the option of speaking with their line manager, a more senior leader or the Human Resources team who are independent of their line management. We also recognise that some staff may prefer to raise issues with a completely independent party and/ or remain anonymous.

Accordingly, Commonwealth Bank maintains arrangements to allow staff to speak up in circumstances where they wish to be anonymous or invoke whistleblower protections. We have a SpeakUp hotline, operated by qualified independent consultants which enables employees to raise issues impacting their role, wellbeing at work, or issues affecting the organisation. Employees are encouraged to feel safe to speak up about and take ownership of issues that otherwise might go unreported.

In 2015 we reviewed our arrangements and since then have made a range of improvements. This included ensuring people can leave a message with the SpeakUp hotline or email service 24 hours per day, seven days per week; ensuring the SpeakUp details are listed on the Commonwealth Bank website to encourage community members, customers and other stakeholders to use the channel if they wish; and implementing a new process for the careful management of whistle-blowers, including confidentiality arrangements. We also established an Internal Fraud and Misconduct Governance Committee to provide oversight of internal fraud and misconduct complaints. This committee comprises the Chief Risk Officer, Chief Financial Officer, Group Executive of Human Resources and the Group Legal Counsel.

Medical document management

Accusations have been made about the integrity of CommInsure's medical document management system and that key documents were allegedly mismanaged or destroyed.

Commonwealth Bank takes information security very seriously and applies mandatory policies, standards and guidelines to maintain privacy and confidentiality of customer and employee information. All Commonwealth Bank staff are required to complete annual training in data privacy, IT security and the risk of sharing data with unauthorised parties. All training completions are monitored and reported independent of individual lines of business with completion rates reported to senior management on a regular basis. These completion statistics are also considered in the risk assessment component of an individual's performance review process.

Concerns were raised in late 2014 in relation to our medical document management database. Medical opinions were held in an internal referral database as well as in the customer's claims file. Investigations conducted at the time concluded that all expected data was in the database, with the exception of a single document. The document was manually re-entered into the system so that it duplicated the opinion held on the case file.

Based on investigations at the time, we did not find any evidence of medical files being intentionally deleted or tampered with resulting in missing information, as has been alleged.

This database has been progressively replaced as part of the broader claims management system upgrade which commenced in 2013. This upgraded system has been deployed to over 70 per cent of relevant employees and is on track for completion in the coming months.

Remuneration and incentives

Commonwealth Bank Group offers various types of performance awards, depending on role and seniority. Performance-based remuneration (including the measures used to assess outcomes) is systematically reviewed and adjusted for risk. Key performance indicators (KPIs) differ for each role. Customer satisfaction and customer experience are important measures in determining performance and incentive outcomes across the Group.

All employees eligible for performance based remuneration must meet risk and compliance standards to ensure that behaviour is consistent with our regulatory obligations and our risk appetite. A key component of the performance process includes risk assessment and where this assessment is not positive, incentive outcomes may be reduced or forfeited or employment terminated.

CommInsure employees involved in the claims-handling process are also generally eligible to participate in annual incentive arrangements, which represent a relatively small proportion (on average around 12 per cent) of their overall remuneration.

The CommInsure board is satisfied that the current remuneration principles and balanced framework of the incentive schemes is appropriate for the business. The board commissioned an independent review of KPIs used within CommInsure as at March 2016. The board concluded that the independent report had not identified issues with KPIs that would drive undesirable outcomes for customers. The board has requested further work be done that will consider historical arrangements.

5. Policy Recommendations

Commonwealth Bank is committed to constantly improving our products and services to deliver better customer outcomes. We also believe it is important that the life insurance industry, superannuation funds and advisers work together to progress the industry's product, sales and service offerings. To achieve this, we work closely with regulators, government and consumer bodies to ensure that as an industry we continue to evolve to meet the changing needs of Australians.

Recent developments in life insurance policy

To support initiatives that improve the life insurance industry, Commonwealth Bank has been closely involved in the consultation process for the *Corporations Amendment (Life Insurance Remuneration Arrangements) Bill 2016* and the recent inquiry into this legislation by the Senate Economics Legislation Committee. Commonwealth Bank supports this reform package which reduces upfront commissions across the life insurance industry and increases clawback provisions for policies that lapse/transfer within two years.

Whilst the new arrangements are expected to take effect from this year, we recognise that there is a transition process as customers, advisers and insurers adjust to the new remuneration regime.

Next steps

Life insurance code of practice

Commonwealth Bank strongly supports the initial step of creating a Code of Practice and the current review by an additional steering group. A code of practice can improve protections for consumers, beyond that covered in legislation, and increase the accountability of life insurers to explain their obligations in assessing and determining claim to their customers.

We would welcome a further review of the code once the code is in operation to consider any findings that the Committee might make as well as other feedback.

Standardisation of definitions

There may be some benefits to exploring opportunities to standardise policy terms and conditions, including medical definitions. Industry, due to competition law constraints, is unlikely to be able to drive such a process.

In recognition of calls for greater clarity and in order to simplify the product offering and comparisons for consumers, the Federal Government could begin discussions about the benefits and risks of such standardisation.

Mental health

It is clear that the financial services industry as a whole, including CommInsure, can do better in relation to mental health.

Forty five per cent of Australians will experience a mental health disorder at some point, with one in five in any given year[12]. This is a challenging area for government and businesses, including insurance.

[12] https://www.beyondblue.org.au/the-facts

While complex, the diagnosis and treatment of mental health issues is also an enormous opportunity for the life insurance industry to make a material difference to customers' lives. Research shows that with early intervention, tailored treatment and understanding from those around them, those with mental illnesses can minimise the severity of their conditions and potentially recover faster.

We would support the Financial Services Council and the various regulators convening workshops to enable industry, government and experts in mental health matters to come together and identify further opportunities to improve in this area.

Rehabilitation

Supporting customers involves providing more than just financial support. CommInsure has its own internal rehabilitation team and medical team, consisting of dedicated staff that have experience and qualifications across varied disciplines, including psychology and psychiatry. CommInsure also provide employer forums to support fund-employer engagement objectives.

However, life insurers are limited by legislative provisions in their ability to pay for rehabilitative treatments that would assist claimants to return to work. For a range of reasons, rehabilitation is generally preferable and delivers quality of life outcomes. Limiting rehabilitation options may lead to higher ongoing benefit payments and claims administration costs, which then flow through to higher premiums.

The Federal Government should consider reviewing legislation to explore opportunities to allow life insurers to fund rehabilitative treatments and assist workers in their return to the workplace.

Financial literacy

Commonwealth Bank has a particular commitment to improving the skills and knowledge of Australians in the area of financial literacy. Indeed, in January 2015 we announced a $50 million dollar investment in our financial literacy programs over the next three years.

Low levels of financial literacy affect the ability to ensure financial wellbeing for Australians. Insurance is no exception to these issues. We believe that it is critical that customers have sufficient understanding to make good decisions about coverage and making a claim.

Along with other educational, regulatory and industry bodies, the life insurance industry should increase efforts to improve financial literacy in life insurance. For example, CommInsure has sought to enhance our customers' understanding of products by proactively improving the readability of Product Disclosure Statements. Changes include reducing legal jargon, better use of examples and improved overviews of types of cover.

Attachment A: Illustrative claims experience

The following fictional cases intend to illustrate the variety of claims that might be lodged with a life insurance company and some of the circumstances that arise.

Case type: Trauma with 24 hour turnaround time

The case manager quickly processes a straightforward trauma claim once all relevant documentation is received.

Greg, a 49 year old shop assistant, took out a trauma policy in 2010.

In August 2015, Greg:

- went to his GP because he felt a lump in his neck;
- was referred to a specialist to investigate the lump; and
- attended an urgent appointment with the specialist who organised a biopsy which confirmed thyroid cancer.

Greg notified his financial planner and the insurer immediately by phone about his diagnosis and was sent claim forms, which were completed by his specialist at his follow up appointment. The completed claim forms were submitted to the insurer via email and were allocated to a trauma claims case manager for assessment on the same day.

The case manager was able to review the claim immediately, seek a medical opinion from the in-house medical team and make a determination to pay the claim within 24 hours of receipt of the completed forms.

Case type: Death

The life insurance company has decided to paid the claim, but the trustee is trying to determine who the correct parties are to receive the funds.

John was a 55 year old bus driver when he died of a heart attack. John had been living in a de facto relationship with Anne for 9 years and they had a 6 year old son. John had an ex-wife, Sandra, with whom he had three dependent children aged 17, 14 and 10.

The following occurred:

- When John passed away, Anne contacted her financial planner to notify him of John's death. The financial planner contacted the insurer to notify them of her intention to submit a death claim and request the relevant claim forms.
- When the insurer received the completed claim forms and death certificate from Anne they commenced the claim assessment.
- When John passed away he did not have a nominated beneficiary for his superannuation fund or a will, which meant that the trustee would need to determine to whom the money should be paid.
- The insurer accepted the death claim and forwarded the claim documentation to the trustee of the super fund for their consideration.
- It is the role of the trustee to review the claim and notify all parties of its determination. The notified parties then have 28 days to provide notice of objections, this is called the claim-staking process.

Case type: TPD

The customer has multiple conditions and the case manager is trying to determine if they will ever be able to return to work.

Zhang, 40, who is self-employed, suffered a minor stroke and as a result experienced memory loss, inability to concentrate and temporary muscle weakness. He submitted claims forms and supporting documentation with his insurer.

The following factors were part of the assessment of Zhang's claim:

- Six months after his stroke whilst Zhang's level of cognitive function was improving he developed a secondary condition of adjustment disorder and depression.
- Zhang became concerned about the viability of his business. This compounded his depression and caused anxiety.
- While trying to assess the claim, the case manager was receiving conflicting reports from Zhang's treating doctors about his capacity to work because of the combination of cognitive impairment from the stroke and mental health issues.
- With physiotherapy his physical strength and conditioning had returned.
- The case manager arranged for independent medical examinations from a neurologist for his cognitive impairments and from a psychiatrist for his mental health concerns to get a clear picture of Zhang's prognosis and future capacity for work.
- An added consideration for the case manager was that Zhang's treating doctor was reluctant to state that he would never return to work and that his conditions would not improve. By stating this the treating doctor was concerned that Zhang's depression and anxiety may deteriorate further.
- The case manager also worked with Zhang to understand his education and employment background and to identify any transferrable skills.

Case type: Trauma

The case manager is trying to determine whether any pre-existing condition should have been disclosed when the customer applied for her trauma cover and if they are related to her diagnosis of lung cancer.

Janet is a 50 year old engineer who has held an insurance policy for 13 months and has submitted a claim after being diagnosed with lung cancer.

When assessing this claim the case manager:

- asks Janet's GP to complete a treating doctor report;
- asks Janet's treating specialist to complete a report;
- compiles the relevant pathology to understand how advanced the cancer is; and
- obtains authorities to allow the case manager to gather additional information directly from Janet's doctors.

In the review of the claim, the case manager reviewed Janet's medical history which revealed that two years ago Janet attended her GP with shortness of breath and a bad cough. At this time, Janet's GP recommended that she quit smoking and go for more tests to understand the cause of her symptoms.