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C/- Committee Secretary
Parliamentary Joint Committee on Corporations and Financial Services
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Canberra ACT 2600

By email: *corporations.joint@aph.gov.au*

18 November 2016

Dear Mr Irons,

AFA Submission – Inquiry into the Life Insurance Industry

The Association of Financial Advisers Limited (**AFA**) has served the financial advice industry for 70 years. Our objective is to achieve *Great Advice for More Australians* and we do this through:

- advocating for appropriate policy settings for financial advice
- enforcing a Code of Ethical Conduct
- investing in consumer-based research
- developing professional development pathways for financial advisers
- connecting key stakeholders within the financial advice community
- educating consumers around the importance of financial advice

The Board of the AFA is elected by the Membership and all Directors are required to be practising financial advisers. This ensures that the policy positions taken by the AFA are framed with practical, workable outcomes in mind, but are also aligned to achieving our vision of having the quality of relationships shared between advisers and their clients understood and valued throughout society. This will play a vital role in helping Australians reach their potential through building, managing and protecting wealth.

Summary of the AFA's position

The AFA supports scrutiny into the life insurance industry. As evidenced by ASIC report 498, there is significant scope to improve the claims practices and policies of Australian life insurers to better serve Australian families. The AFA is consistent in its position that life insurance reform needs to be approached holistically in order to avoid the unintended consequences of limiting the scope of reforms to only adviser-related issues. Holistic reforms will ensure that outcomes are truly in the consumer and the community's interests. This has begun through the package of reforms announced by Minister O'Dwyer in November 2015 to:

- introduce a Life Insurance Code of Practice
- review life insurance advice Statements of Advice
- widen approved product lists
- reform remuneration for life insurance advice
- and collect data on policy cancellations for ASIC to complete a review by 2021.

It is the AFA's view that the Committee's inquiry would be best served by not duplicating the recent previous inquiries into life insurance financial advice – such as that covered by the Financial System Inquiry (**FSI**) chaired by David Murray and the Life Insurance Advice Working Group chaired by John Trowbridge. The AFA believes that as the measures that resulted from these inquiries have had bi-partisan support and were the result of extensive consultation with all stakeholders – including with consumer representative associations – those measures need time to show their value before they are reviewed again by this or another Parliamentary Committee. However, as identified by Senator Williams in his call for this inquiry, there are other areas that need further scrutiny.

One in particular is the recently released Life Insurance Code of Practice. As far back as November 2014, as party to the Life Insurance and Advice Working Group (**LIAWG**), the AFA recommended a comprehensive Code be developed to, amongst other things, **ban the sales tactics of insurers that are likely to interfere with the quality of advice**. To this point, we again call for the Financial Services Council (**FSC**) to update their Code of Practice to enable this outcome for the common good and benefit of consumers. In the AFA's view the FSC's Code falls short of what is needed to adequately reform the culture within life insurers, deliver better practices and protect the interests of Australian families relying on their life insurance to protect them.

The most glaring deficiency with the Code (which to be fair the FSC has acknowledged) is the insufficient coverage. As superannuation trustees are not covered by the Code, not all life insurance policies will be protected by the Code. Likewise, there are carve outs for legacy products that are still in use, claims subject to legal proceedings, improvements to medical definitions and the requirement to underwrite policies. These selective omissions and carve outs are not in the interest of consumers and requires scrutiny from Parliament to find out why they are necessary.

We recommend the Committee review the FSC's Code to consider whether the voluntary measures set out in the Code are a sufficient commitment from insurers to reform their practices and culture. Further, the

Code needs to include commitments to consumers *and* the financial advice profession as 50% of Australia's $15 billion in life insurance is arranged through the expert advice and support of financial advisers. We are concerned that a CEO of one large insurer was recently quoted as saying that the FSC's Code is not the place for outlining obligations between life insurers and advisers.[1] The AFA is concerned that the industry will not adequately self-regulate their distribution practices towards advisers. If the FSC does not address the deficiencies we have identified in the Code by its first review (July 2019) of the Code – including standards of conduct for insurer-adviser interactions – and insurers do not improve consumer confidence in their services, the AFA recommends that this committee consider whether the Code become a statutory Code with Parliamentary oversight. It may be appropriate to have ASIC consider this in their review in 2021.

Other aspects of the reforms that appear to have not been implemented – or are at risk of not being implemented – as intended by the Minister are the improvements to approved product lists, policy cancellation scrutiny and improved Statements of Advice. The latter two measures appear to be affected by insufficient funding allocated to ASIC, while little has been announced from the industry about following through with widening approved product lists. It seems that all three areas would benefit from some direction from Parliament to move them closer toward their intended result, such as:

- for guaranteed funding to be provided to ASIC to enable granular data on policy cancellations to be captured instead of bulk data that will not allow for meaningful analysis to be conducted as to whether the cancellations are generally in the consumer's best interests,
- for guaranteed funding to be provided to ASIC to secure the fulsome services of the consultant ASIC has engaged to conduct the review of life insurance Statements of Advice, and
- for clear direction be given to ASIC, AFS licensees and insurers to begin the process of guiding the industry on how approved product lists should be widened, taking into account existing conflict of interest and conflicted remuneration rules.

Effective and fair life insurance is such an important service that can distinguish Australia as a leader in financial services. Leading on life insurance also has a significant impact on the public purse by reducing reliance on public health care and social security for income support during times of need. It is therefore imperative that we get this right; that we improve the welfare of Australian families and put them in a position to hold insurance policies that prepare them and cover them for life's unexpected events. Ultimately, as insurance is peace of mind for the individual, so too is a properly functioning insurance industry peace of mind for the Australian community.

[1] CEO of a large insurer quoted in *RiskInfo* article, "Insurer obligations to advisers will not be set by FSC" (1 November 2016) http://riskinfo.com.au/news/2016/11/01/insurer-obligations-to-advisers-will-not-be-set-by-fsc/

Summary of the AFA's recommendations

The AFA's recommendations are directly relatable to the Committee's terms of reference:

Part A – the need for further reform and improved oversight of the life insurance industry

i. The statutory unfair contract regime to be extended to life insurance contracts

ii. Insurers be required to auto-upgrade existing policies when revising policy features

iii. Consistent future upgrading of medical definitions

iv. Simplified products and product innovation to be encouraged

v. Insurers need to commit to consumer education, especially in relation to life insurance concepts

vi. The Life Insurance Code of Practice to become a statutory Code if the 2021 ASIC review determines that the Code does not address remaining shortcomings

Part B – the differences between direct insurance, group insurance and retail advised insurance

i. Insurers be required to underwrite all insurance products at the time of application banning the practice often seen in direct and group insurance of underwriting at the time of claim

ii. Insurers be required to not increase premiums during the first two years of policy commencement (thus matching the clawback period), except for CPI increases in the sum insured

iii. Insurers to comply with the duty of utmost good faith with disclosure comparisons to enable informed decisions before consumers choose to replace existing policies that they hold into direct channels

iv. To facilitate better transparency and decision making, superannuation funds to disclose their arrangements with life insurers in relation to their group life insurance agreements

v. Review remuneration rules to ensure that people insured through group insurance are able to access quality financial advice

Part C – whether entities are engaging in unethical practices to avoid meeting claims

i. Policy holder investigations to be standardised according to community expectations of privacy and responsible use of intrusive means

ii. Review and standardise insurer practices in relation to daily activity diaries

iii. Insurers be required to always consider whether policyholders may be entitled to a benefit under other policies

iv. Encourage best practice claims management amongst insurers

Part D – the sales practices of life insurers and brokers, including the use of Approved Product Lists

i. Ban insurers' sales practices that interfere with the quality of financial advice

ii. Train business distribution staff to better understand financial advisers' best interest duty

iii. Insurers and all associated companies to cease offering specific listed incentives that may conflict with an adviser's obligations

Part E – the effectiveness of internal dispute resolution in life insurance

i. Establish an independent industry-wide tribunal to review complex claims decisions

Part F – the roles of ASIC and APRA in reform and oversight of the industry

i. Appropriately resourced regulator

ii. Introduce an ASIC-legislative instrument to ensure insurers provide granular data on policy cancellations to ASIC

iii. ASIC's 2021 Review to include a review of the Life Insurance Code of Practice

iv. Life insurers to share lapse and policy cancellation data with licensees and professional associations on a per adviser basis

Part G – any related matters

i. Government to commission studies to better understand the effects of life insurance regulation and reform, as well as to determine the social and economic benefits of people holding personal, appropriate levels of life insurance cover

ii. Introduce tax deductibility of life insurance advice fees

iii. Review the practices of lawyers who assist policy holders to submit claims on their super-held insurance to ensure those practices are in line with the community interest and in the best interests of the client

Further detail on the AFA's recommendations

Part A – the need for further reform and improved oversight of the life insurance industry

i. Unfair contract regime to be statutorily extended to insurance contracts

Unfair contract terms should statutorily be extended to insurance contracts. This is a long overdue gap in the consumer protection framework, which was begun, but not resumed either side of the 2013 Federal Election. The Productivity Commission recommended it in 2008 and in 2009 the Senate Economics and Legislation Committee recommended the same, noting that consumers are not provided with adequate protection in insurance contracts under existing law.[2]

The differential cost of policy premiums for individual policies is not a justification anymore for not subjecting standard form policy series contracts – especially group insurance and default superannuation held insurance – to this important consumer protection measure. Surely insurers should be subject to the same consumer protection laws that apply to all other consumer goods and services.

The AFA accordingly recommends Parliament re-open the previous attempts to extend unfair contracts terms to life insurance policies. This is a glaring gap in the Australian Consumer Law and should be rectified without delay to ensure that consumers have greater negotiating ability about how their lives are protected.

ii. Insurers be required to auto-upgrade existing policies when revising features

Insurers be required to commit in their Code of Practice to **auto-upgrade existing policies when revising features** rather than incorporate those revised features within a new product and subsequently closing an existing life insurance product to new applications. It is an unfair practice for insurers to end a product series due to a minor change in the features of a particular insurance policy. When a policy ends, whether by an insured's initiative or an insurer's, the insured loses any protection[3] they may have had against insurers voiding a policy for innocent non-disclosures or misrepresentations. The statutory protection applies to policies that have been in force for three years or more, so if a policy held for more than three years ends, the insured loses that protection.

If a policy is largely unaffected by an amendment to the terms and conditions of the policy, then the insurance contract should not end or be cancelled by the insurer. Instead, the AFA considers that the statutory protection provided by section 29 should obligate insurers to only end an insurance contract for significant changes and that the Code should establish guidance on what is significant. This would then require insurers to take the alternative path of upgrading a policy series for feature changes or a definition change to a policy. It would therefore preserve the statutory rights of all consumers holding existing non-cancellable life insurance contracts.

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[2] Senate Economics Legislation Committee Report on *Trade Practices Amendment (Australian Consumer Law) Bill 2009*, paragraphs 10.8-10.14.

[3] Under section 29 of the *Insurance Contracts Act 1984.*

Over time, those policy holders with good health often upgrade to the new product. Whilst the new insurance product series often has better definitions and can often be less expensive, those policy holders that have experienced a health event or a decline in their insurability remain in the existing product without the prospect of getting covered elsewhere. Insurers frequently then are left with a legacy product with increased risk through the relative decrease in the health of the lives insured, and as such they substantially increase the premium rates to a degree that appear unfair and potentially opportunistic in the eyes of policy holders and advisers.

Accordingly, principles and guidance should be developed by the industry around providing a legitimate upgrade path for clients covered under current policy series to ensure that insurers act consistently and consumers are not at detriment. Further, upgrading policy series facilitates product choices for advisers to act in the client's best interests by reducing the level of unnecessary policy cancellations.

iii. Consistent future upgrading of medical definitions

Upgrading of **medical definitions should be independently reviewed every three years** to ensure that life insurers comply with their undertaking to improve their maintenance of definitions with current medical practices. Recent media reports have highlighted practices that question whether policy holders have been afforded policy terms that reflect current medical practices and therefore raises concerns that definition upgrades may not be implemented fairly through internal inertia in future.

The AFA recommends that an independent medical advisory board empanelled with appropriately experienced professionals to facilitate and oversee the upgrading of medical definitions in life insurance policies. This advisory board – which would be subject to public scrutiny – could also extend itself to other advisory roles, such as the appointment or nomination of Chief Medical Officers and underwriting staff within Life Insurers. In the AFA's view, collaboration will bring additional expertise and commitment to the table which can only benefit policy holders and the wider community with a greater level of oversight in this important area.

iv. Simplified products and product innovation is needed

Insurers need to **develop simplified products that better balance affordability issues against insurance needs** and fairly balance the commercial imperatives of the insurer with the desire for more Australians to hold appropriate levels of life insurance. Many current policies start with a plainly stated rule or expectation which is then watered down with layers of exclusions, exceptions and conditions. This is an unfortunate practice that has become more prevalent in life insurance policy documents over time.

Policy documents also commonly have several pages of disclaimers and qualifications that at worst obfuscate the true nature of the policy and at best create misunderstanding. **If what the insurer offers or agrees to cannot be stated simply due to the design of the product, then design a simpler product.** This is another area that could be effected through insurers' commitments within their Code of Practice and competitive effects could propel innovation in the consumers' interests. A clear example of this is group

income protection (salary continuance) insurance provided through a super fund where all claims related to mental health issues are automatically excluded under the policy. This precludes around 20-30% of all income protection claims based on industry data. Without an absolutely clear statement to this effect, coupled with fair information on the prevalence of mental health claims, this represents an example of not effectively simplifying a product. The imbalance is too far in favour of the insurer and does not give fair regard to the knowledge and experience deficit of the consumer.

v. Insurers need to commit to consumer education, especially in relation to Life Insurance concepts

Insurers must genuinely commit to consumer education, especially in relation to life insurance concepts. This is critically important and whilst financial advisers play an important role in improving consumers' financial literacy, insurers have a duty to also reduce misunderstanding or incorrect perceptions amongst policy holders. This initiative goes hand in glove with simplifying products because as insurance terms and conditions are simplified, so too will be the policy documents that explain them.

Consumer education could extend to initiatives outside of policy wordings. For example, an industry standard two-page policy summary could accompany every policy clarifying key concepts of the cover provided, key risks and benefits. Whilst not a replacement for the contractual terms of the insurance policy, establishing such a supplementary document through regulation as industry standard could go a long way toward improving the understanding of how individual policies work, how insurance generally works and to have an additional effect of improving financial literacy amongst the wider community.

vi. The Life Insurance Code of Practice has not yet gone far enough to address remaining shortcomings, or become a statutory code

The Life Insurance Code of Practice was established because it was a commitment required from the FSC as one element of the package of reforms contained in the Life Insurance Framework (LIF) negotiated between the Minister, the FSC, AFA and Financial Planning Association (FPA) in November 2015.

As we outlined to the FSC in our submission on the penultimate draft of the Code, **this Code could represent a catalyst to form a new culture within insurers**; one that positions the consumer's health and wellbeing alongside sustainable financial performance and therefore restore the social licence granted to life insurers to protect Australian's families when they are at their most vulnerable. To address the under-insurance problem in Australia, people need to trust insurers to be fair and reasonable. **A Code could be the vehicle to restore this trust and social license – provided the Code is constructed to hold insurers to account for their commitments to consumers' best interests.** The Code must be updated to capture these commitments.

Whilst some of the AFA's recommendations were captured in the Code, the Code does not require enough of life insurers to clearly provide a commitment to winning back their social license and community trust. Further, it ignores the interaction between insurers, financial advisers and the end client. As 50% or more

of Australia's life insurance is arranged through the expert advice and support of financial advisers, the Code needs to include commitments to consumers **and** the financial advice profession. The commitments to consumers are as yet insufficient in substance to drive cultural change; and the role of the life insurance advice profession has been ignored.

This Code needs substantial improvements before it can achieve the intent with which it was promised. A review of the Code has been scheduled to take place by July 2019 and the AFA has been invited to be involved. If the Code is not improved shortly after the review to ensure a comprehensive application and to restore insurer's social licence by delivering improvements in insurer practices, the AFA considers that the Government should consider intervening and develop a statutory Code to replace the industry initiated code. A statutory Code is going to be part of the standards that financial advisers are required to comply with in future under professional standards reforms and should the insurer cohort not improve protections voluntarily, they too should be subject to a statutory Code like advisers will be.

Part B – assessment of relative benefits and risks to consumers of the different elements of the life insurance market, being direct insurance, group insurance and retail advised insurance

About 50% or more of Australia's life insurance is currently arranged through the expert advice and support of financial advisers. The AFA supports measures that will see this proportion increase because advised policies:

- provide more appropriate cover for policy holders and beneficiaries,
- provide more appropriate benefit levels because they are subject to expert input on the consumer's insurance needs,
- are subject to less declined claims – see ASIC Report 498,
- advised retail insurance is often less expensive to consumers than group or direct – (find research), and
- are subject to less disputes about the policies – see 2015 FOS Annual Report which indicated that disputes are four to five times more likely for policies sold directly by insurers (or through non-advice channels) than for the same policies advised upon.

Despite these benefits, advised policies often experience premium increases within the first two years (with some even up to 40% increase). The different channels provide consumer choice and flexibility in the access to life insurance, however not all points of differentiation would be regarded as best practice or fair to the consumer. Accordingly, we outline some recommendations below to bring greater fairness, and ultimately consumer confidence, across the three distribution channels.

i. Insurers be required to underwrite all policies at time of application, not claim

Insurers should be required to underwrite all insurance products at the time of application instead of at the time of claim. Except where policies are auto-accepted, direct and group policies are often not subject to underwriting until a claim is made, which means that policy holders pay premiums for years

without actually being covered under the terms of the policy. This is critical to ensuring the integrity of the system that consumers rely upon in their time of need and has downstream implications for government social support and health systems, and importantly, trust of the industry. The desire of insurers to "maintain the flexibility" of continuing to provide cover without underwriting is unacceptable given the consequences to consumers who may not be aware that they are not actually covered until they claim.

ii. Insurers be required to not increase premiums for a policy's first two years (excl. CPI on sums insured)

Through the LIF legislation,[4] the government has imposed a requirement upon financial advisers to repay commissions received if a policy cancels in the first two years. As only a small set of situations will not trigger such a clawback of commission, **all life insurers should commit to <u>not</u> increase premiums during the clawback period except for CPI increases in the sum insured**.

Without this commitment, insurers can continue the current practice of raising premiums soon after implementation of a policy without regard to the consequences for the policy holder. This is a missing piece in the framework which will ensure that consumers' interests are put first. Advised policies have been shown in the recent ASIC Report 498 to be subject to lower claim denials indicating what the AFA have always said – advised policies are more appropriate for consumers and of greater quality and benefit to them. Ensuring that premium pricing offered to consumers through advised channels cannot be raised during the first two years of the policy would protect consumers from misleading sales practices designed increase sales in the short term whilst hiding the true cost of the policy which appear later through sudden and significant premium increases shortly after the policy is put in place.

The two-year clawback shifts an unfair proportion of the responsibility for lapsed policies onto the financial adviser in its current form. Restricting premium increases during the clawback period will bring greater fairness to this blunt instrument. The result will be greater trust from advisers and their clients towards life insurers.

iii. Consumers to be enabled to make informed decisions before replacing into a direct policy

Life insurers should be required to **comply with the duty of utmost good faith by assisting a customer to make informed decisions about replacing existing insurance policies** with group and direct-sold policies. Currently, the only consumers who receive the benefit of a comparison of the benefits, risks, disadvantages and other consequences of replacing existing insurance policies are the clients of financial advisers. This is a statutorily imposed requirement of section 947D of the *Corporations Act 2001* and has existed for over a decade. People who acquire their policies via group or direct channels do not receive the same comparison information and therefore are prevented from making informed decisions when they already hold life insurance.

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[4] The commonly referred to name for the *Corporations Amendment (Life Insurance Remuneration Arrangements) Bill 2016.*

Our proposal is to ensure that regardless of the channel, all consumers should receive a fact sheet that outlines the differences between existing and proposed policies. This would not require life insurance staff or representatives to necessarily provide personal advice to a customer because mere possession of personal information does mean that personal advice is provided.[5] Instead, factual information about a customer's existing policies should be required to be obtained by sales staff before proceeding with a sale and that information should be presented in a factual comparison for the customer to consider before deciding to proceed with the offered policies. We would see it being a necessary step to ask the consumer that "if they proceed with the new life insurance policy being discussed, do they intend to cancel any existing life insurance that they hold?" If the answer is "Yes" then the comparison needs to be prepared.

This measure can substantially improve the welfare and decision making of policy holders by arming them with information that they may not have been aware of. It will also ensure that enquiries are made into a policy holder's existing insurance policies, slowing down the process a little to allow consideration of the effect of replacing existing policies and taking some of the pressure out of the sales process. Most importantly, it will improve consumer decision making.

A clear example of where this protection is vital for a consumer would be where they already hold a comprehensive income protection insurance policy, and replace it with a contract bought for example over the phone through a direct sales channel, but where the new policy automatically excludes all claims for mental health issues. Under current rules, the direct sales channel is not required to outline this key weakness in their policy, and should the consumer proceed they would unwittingly be moving to a substantially weaker policy without any understanding that this is what they are doing in practice. Our proposal would resolve this.

iv. Superannuation funds to disclose their arrangements with life insurers in relation to their group life insurance agreements

Superannuation funds should be required to disclose their arrangements with life insurers. Improving transparency about the arrangements between superannuation trustees and their chosen group insurance providers will have the benefit of improving consumer decision-making – just as disclosure of remuneration arrangements between insurers and financial advisers does. Requiring disclosure is a matter of managing conflicts of interest that presently go undetected. Ultimately though, disclosure of these arrangements will facilitate better transparency and decision making.

Such disclosure would also allow for greater scrutiny of the services that superannuation funds provide to their members in relation to the arrangements that the fund has with the life insurer, which could have the effect of improving competition amongst superannuation funds – for better insurance arrangements for their members – as well as improving competition for members' funds. For example, superannuation funds could begin competing on the standard of claims service and assistance they provide to their members – measured by member satisfaction surveys – which is a more productive form of competition than on pure

[5] See ASIC Regulatory Guide 175 at paragraph 175.46.

financial terms, such as premiums. Improving transparency should therefore result in members' interests being better served by their superannuation fund, whether by improved outcomes from a better managed claims service or by improving decision-making and community confidence.

v. Review remuneration rules to ensure that people insured through group insurance are able to access quality financial advice

The AFA considers that the Committee should review remuneration rules to ensure that people insured through group insurance are able to access quality financial advice. Currently section 963B(1)(b) restricts the types of remuneration that financial advisers can receive when they provide financial advice about group insurance or insurance held within default superannuation. The rule prevents policyholders from permitting an adviser to receive commissions or insurer-paid remuneration because of apparent conflict of interest rules. This is a different situation to life insurance that is not acquired through group policies or through default superannuation.

This prevents those members and beneficiaries from receiving expert advice on all of their life protection options. Those members and beneficiaries can only receive factual information or intra-fund advice about their insurance options – which would not allow them to weigh the quality of their policy compared to another. Nor does it allow them to receive an expert opinion from a financial adviser on the appropriateness of the insurance terms to their situation or goals. It is unclear why people insured through these options should not get the benefit of quality advice from experienced life insurance experts.

The AFA recommends that the Committee should review the discrepancy and consider whether section 963B(1)(b) as currently worded protects vested interests or acts toward the community interest. In our view, all people who benefit from a life insurance policy should have access to expert financial advice and they should be entitled to pay that financial adviser the same as they could if their policies were held outside super or a group arrangement. At the very least, members of default super funds should have access to workplace super specialists who can advise them individually or collectively on appropriate levels of insurance cover for them.

Part C – whether entities are engaging in unethical practices to avoid meeting claims

Surveillance and private investigators

i. **Policy holder investigations to be standardised according to community expectations of privacy and responsible use of intrusive means**. The surveillance and private investigator clauses of the FSC's Life Insurance Code of Practice start by saying insurers *may* use private investigators and then goes on to outline how surveillance and investors must conduct themselves. As we outlined to the FSC in our submission on the draft Code, there is nothing in these clauses that is not already reflected in the law.

The AFA considers that to restore consumers' trust in insurers, there needs to be a threshold standard about *when and in which situations* surveillance and private investigators will be used. Without a clear standard that puts the community's interest and right to privacy first, the FSC members' claims departments will continue to waste funds on surveillance and private investigators in every case of suspected fraud in vain attempts to catch or entrap insured parties. The reasons why we say 'vain' and 'a waste of funds' are because:

a) **Not a single FOS determination has relied upon surveillance evidence or private investigator evidence to find fraud** in a life insurance determination that was not evidenced by other less intrusive means.

b) The surveillance footage rarely – if ever – redacts the identities of other people captured in the footage, which is **a particularly repugnant practice when children are reflected in the footage**. On this point, the Code has made some progress with the introduction of section 8.12(e) but we do not think this far enough when an investigator can switch off a camera when a child is in the vicinity of a subject.

c) Further, there appears to be a practice of disregarding the effect of using surveillance and private investigators on the wellbeing and recovery of people suffering from mental illness. **We question how can video footage demonstrate or a private investigator's observations highlight what is happening inside someone's mind.**

To restore confidence and trust, **a threshold standard must be met *before* an insurer *can* use surveillance or private investigators,** especially where the claimant has children or has lodged a mental illness claim. This threshold must be a high threshold given the lack of benefit to date in using surveillance and private investigators and it must be more than a mere suspicion of fraud. This is because it appears to the AFA, our Members and many members of the public that insurance claims departments (including general insurers) are increasingly beginning from a position of suspicion in any claim.

The AFA acknowledges that fraudulent claims influence the cost of premiums for all existing and future policy holders. However, there is also a financial cost when surveillance and private investigators are used and there is both a financial and non-financial cost to the community and insurers' payout levels when inappropriate conduct by insurers and their agents exacerbates a person's mental health conditions.

The community expects insurers to act responsibly when discharging of their duties. The AFA considers that not only should the potential benefit of using surveillance and private investigators be weighed against these competing costs, **there must be a cultural shift in claims departments to use intrusive options *only* as a last resort** when less intrusive means will not provide the evidence being sought. The AFA recommends that the Committee require insurers to change their practices because we are not confident that the culture can change on this aspect without some external incentive.

ii. Review and standardise insurer practices in relation to Daily activity diaries

The AFA also considers that **there must be a threshold standard for the use of daily activity diaries**. We question how a daily activity diary completed by a person claiming to be mentally unwell can be beneficial to understanding their claim. There must be a consideration – and in fact, it must be a health professionals' consideration – of how such an intricate examination of the person's activities may affect their condition before that introspective task is required of a claimant. Insurers must remember that nobody wants the stigma of being mentally unwell.

The use of daily activity diaries is an increasingly common practice used by claims departments for anyone who is on an income stream benefit for any longer than three months. It appears that the purpose is to obtain information that can be used against claimants to justify bringing them off claim. **When people are asked to report everything they do in a given day, they naturally think that they are not trusted**. Even parolees who have actually been found guilty of criminal activity in an independent court of law do not have this level of scrutiny into their daily movements. Although fraud does unfortunately take place, it is and should be approached as the exception to the rule and the legitimate suspicion of fraud is not a reason to impose greater scrutiny on insurance claimants than the community expects of convicted offenders.

To mitigate against daily activity diaries being abused in future, **insurers should set a high threshold standard** where:

a) the purpose of requiring a daily activity diary must be set out,

b) the purpose must have a constructive effect, such as setting out how the information to be captured will help understand how a person's rehabilitation can be improved,

c) the net benefit of using a diary must outweigh the financial and non-financial cost – including potential psychological effects on the person,

d) alternative strategies that could be employed must be set out and explained why they are not preferred,

e) advice sought from the claimant's treating medical practitioner as to how the diary will assist in their recovery, and

f) all of this information should then be communicated to the claimant to help them understand why they are being requested to record their daily movements.

Without appropriate checks and balances to mitigate against their continued abuse, daily activity diaries will continue to be used for improper purposes and create perceptions of mistrust amongst policy holders and their communities. The practice needs to be urgently reviewed and regulated according to decent standards of community expectations.

The AFA accordingly recommends the Committee to seek evidence from insurers about their use of daily diaries and consider whether those practices should continue in their current form without oversight.

iii. **Insurers be required to always consider whether policy holders may be entitled to a benefit under all of their policies – not just the one the policy holder lodges a claim form for**

Where a policy holder makes a claim under a policy and they hold cover under other policies with the same insurer, the **insurer should always consider whether the person may be covered under all other policies they may be entitled to a benefit under**. Whilst this is the approach of the better insurers in the market, not all insurers will look at all of the insured's policies held with that insurer. This can be due to several reasons ranging from that the various arms of insurance companies do not communicate effectively with each other to a view that it is the insured's obligation to know what they are covered for, when and with whom.

The 'we will not argue their case for them because it might be prejudicial to us' is particularly deplorable when dealing with people who are in vulnerable states. Life insurance is only called upon when people become injured, sick or die. In all those circumstances, the claimants are in vulnerable states and the standard of care owed to them rises in other legal relationships. It should be standard for life insurers to presume that a policy claimant is vulnerable until otherwise shown, regardless of whether the injury or sickness was an accident or not which appears to elicit greater empathy amongst claims assessors than non-accidental situations (such as gradual decline).

Insurers should be statutorily required to consider all aspects of an insured's policies when a claim is lodged and not expect an insured to have industry-level of understanding about insurance. Consumers should not be disadvantaged by not having the support of an expert, such as advised policy holders have when their financial advisers assist them with their claim.

iv. **Encourage best practice claims management amongst insurers**

Insurers should be encouraged to implement **best practice standards for claims management**. A real and practical example of how this can be done is where AIA recently embedded claims assessors within the Sunsuper offices to better facilitate claims lodged on Sunsuper member's policies. This simple yet practical measure appears to be improving the experiences of vulnerable policy holders by giving them direct access to the decision-makers and simplifying the process to access benefits. It breaks down the barriers between claimant, super trustee and insurer. More needs to be done to encourage insurers and superannuation trustees to address issues that affect consumer experiences, otherwise confidence and trust may not be restored.

Part D – the sales practices of life insurers and brokers, including the use of Approved Product Lists

Business distribution practices

i. **Ban Insurers' sales practices that are likely to interfere with the quality of financial advice.** It is essential that insurers respect the obligations of financial advisers to act only in the best interests of

their client. To do this, several current insurer practices need to stop while other practices need to be introduced, including reforming business distribution practices with particular commitments to:

ii. **train business distribution staff to better understand financial advisers' best interest duty**. This has recently improved somewhat with the introduction of section 4.2(a) in the Code. As with other Code initiatives, the AFA considers that this could be improved by requiring insurers to extend this training to the non-consumer facing staff. The section 4.2(a) obligation only extends to the staff who sell insurance policies direct to retail consumers. Business distribution staff do not appear to be captured.

    As the intention in our recommendation has always been to have this training go hand-in-glove to prevent insurers sales teams from undertaking activities and offers that have the potential to entice advisers from meeting the best interests duties to their client, we consider the inclusion of the words "the best interests duty of financial advisers when providing financial advice" to be insufficient, and

iii. **cease offering specific listed incentives that may conflict with an adviser's obligations**. Inappropriate incentives include:

- offering or otherwise agreeing to arrangements:
    - for use of in-house product,
    - to attract product loyalty over honouring their best interests duty,
    - to transfer multiple clients from one insurer to another, or
    - to reward or mandate threshold based volumes/quotas from either individual advisers or licensees,
- offering or otherwise agreeing to excessive payments related to education and training. Genuine education and training can and should be provided but excessive payments to licensees and advisers to undertake that education and training affect integrity, and
- influencing the restriction of Approved Product Lists (**APLs**) with reduced licensee pricing for advisers to incentivise selecting the reduced APL over a broader APL, which is likely to compromise an adviser meeting their best interests duty.

As stated in our submission to the FSC about the Code of Practice, **"pressure selling" should be clearly and unambiguously defined** to ensure that all insurer sales and business distribution staff clearly understand which practices will not be accepted. Ensuring that pressure selling applies to business distribution staff and wholesale channels will ensure that the policies that flow onto the end consumer have greater integrity.

Contingent to this, the AFA considers that part of the cultural shift required in the industry is a paradigm shift in the types and sources of incentives offered by insurers. The Consumers' Choice Awards[6] are recognition from policy holders when they receive outstanding service from life insurers. The loyalty and referral benefits that flow from being recognised and appreciated by policy holders should be a greater driver for insurers than the cost reductions that might be achieved through stringent claims management or other poor practices. The AFA considers that recognitions such as the Consumers' Choice Awards and promoting achievement of such awards should become the standard in future to gain support from advisers and can replace the financial incentives that currently dominate.

Part E – the effectiveness of internal dispute resolution in life insurance

i. Establish an independent industry-wide tribunal to review complex claims decisions

The AFA would **support an independent industry-wide tribunal to review complex claims decisions** (unhindered by FOS-like restrictions to jurisdiction) and help the insurers to achieve a more transparent and cost-effective solution to the challenge of complex insurance claims. Media reports this year about claims issues in the industry highlight the importance of ethical, consumer-oriented practices during the time that policyholders are at their most vulnerable.

The AFA considers that an independent review process is a step in the right direction to ensure that any disputes about complex claims can have the benefit of an independent tribunal, regardless of whether they fit within the FOS-jurisdiction. One of the challenges of the FOS model is maintaining accessibility to the scheme as external influences change the value of insurance benefits. It is more common these days for individuals to have life insurance policies that provide benefits valued at several million dollars or more. These values mean that some people are outside FOS's terms of reference if a dispute about a claim arises.

The AFA considers that all complex claims should have the benefit of independent oversight. What constitutes a 'complex claim' is not for this submission to suggest and should involve empirical and expert input to determine. Whatever the 'entrance rules' of the scheme, the principle remains simple – provide a measure of oversight for claims that are more complex than others to ensure that the complexities are appropriately weighed, to ensure that fairness is achieved and to extend fairness beyond FOS's jurisdictional limits.

Part F – the roles of the Australian Securities and Investments Commission and the Australian Prudential Regulation Authority in reform and oversight of the industry

i. An appropriately resourced regulator

The financial services industry needs an appropriately resourced regulator with the regulatory tools required to fulfil its mandate to promote confident and informed participation by consumers in the

[6] http://www.consumerschoice.org.au/

financial system and to enforce and give effect to the law. It makes a great deal of sense to provide ASIC with the funding to more effectively monitor and police an already comprehensive regulatory regime.

A recent example of where resourcing is an issue is with the Statement of Advice project that ASIC commissioned Communication Research Institute of Australia to conduct. After an initial round of consultations, the project has now stalled potentially due to resourcing issues.

ii. Introduce an ASIC-legislative instrument to ensure insurers provide granular data on policy cancellations

ASIC has been tasked by the Minister with conducting a review into the LIF measures by 2021. ASIC Consultation Paper 245 appears to indicate that the 2021 Review will be restricted to bulk data being provided by insurers to ASIC's consultants, Plan For Life (recently renamed Strategic Insight). We consider that bulk data will provide few meaningful links between the information sets to allow for analysis of alleged churning in the industry.[7] ASIC has recently expressed a similar concern that the quality of information about insurance claims should "assist consumers and others to make decisions".[8] We consider that the same principle should apply to policy cancellation data provided by life insurers.

The **information on policy cancellations should be reported by insurers to enable correlations to be identified**, as it is not currently clear from the proposal whether the data groups will be related to each other to give substance and meaning to the information. For example, collecting data on how many policies are in force from an insurer and the types of each policy is important. Equally important is the data collected on policies sold with advice (both general and personal advice) or no advice. However, the groupings of those data sets will be less meaningful than identifying how many of each policy type was sold with advice or no advice, and less meaningful still than knowing how many policies of each product type were sold with personal advice and subsequently lapsed in the first two years due to the policyholder being unable to afford the premium.

The AFA considers that data should be collected to adequately identify reasons for policy expiry/cancellation, and whether replacement advice or premium default existed prior to policy expiry. The AFA submits that the 'reasons for cancellation' to at least specify subset categories that can help to understand:

- whether it was a client-directed or other reason (e.g. age-based expiry),
- whether the cancellation was preceded by a change in any features to the policy by either the insured or insurer,
- whether any payment difficulties preceded the policy cancellation, and
- whether the policy cancellation is relation to a premium paid.

[7] Confirmed by a recent *RiskAdviser* article about claims data: http://www.riskadviser.com.au/news/13817-claims-data-transparency-comes-with-risks-minterellison?utm_source=Risk%20Adviser&utm_campaign=14_10_16&utm_medium=email&utm_content=1

[8] Hansard, Senate Estimates (19 October 2016), page 29.

The AFA supports further definition of other types of policy cancellations that ASIC outlined in Consultation Paper 245 and surrounding circumstances to better understand each 'reason for cancellation', and that this subset category be clearly prescribed to assist insurers report meaningfully. Further, where an adviser is identified as having exceptionally high lapse rates through the data reported to ASIC, professional associations and the adviser's licensee should be notified for further investigation. Likewise, with respect to advised insurance, the focus of the ASIC review ought to be on replacement product advice that fails the Best Interest Duty – not just on broad policy cancellation data.

Without additional or special funding to conduct the Review, ASIC would be likely be restricted to collecting bulk data on policies from insurers. We support better funding and resourcing for ASIC to collect and analyse policy data from insurers and that this not rely solely on the quality of information provided by FSC and insurers.

iii. ASIC 2021 Review of LIF to include a review of the Life Insurance Code of Practice

The future ASIC-commissioned Review of LIF must consider the effectiveness of the FSC's Life Insurance Code of Practice and the effectiveness of the Life CCC and FSC to monitor and enforce the Code, including the levelling of appropriate sanctions where breaches occur. Should it not be found to be effective, the Government should be invited to introduce a statutory Code scheme just as it has been supported by the profession to do so with the professional standards of financial advisers Code of Ethics.

Statutory Codes are in existence and operate effectively and with associations' support we consider that they can be effective at regulating conduct in an industry or profession. As the FSC's Code has been launched and we have received commitments that the Code will be improved in further iterations, the AFA considers the FSC should have an opportunity to improve its members' conduct – subject to external assessment. Should ASIC be of the view that improvements have not resulted since Report 498 and the FSC's Code being launched, we support a statutory Code being introduced.

Information management

iv. **Life insurers to share lapse and policy cancellation data with licensees and professional associations on a per adviser basis** to help licensees and associations better advise ASIC and government on replacement business, instead of relying upon the aggregate APRA data to determine the level of lapses, churning and replacement business. This measure will assist ASIC to regulate the industry, supporting professional associations and licensees to monitor and improve adviser conduct ultimately leading to greater transparency and trust.

Further, a commitment to **upgrade the management of information flow between insurers, licensees and advisers** to support remuneration reforms, client orientation, improved capabilities and improved economics of licensees and advisers. Insurers should also to **upgrade the management of information flow between insurers and industry software providers** to support efficiency in adviser support of client's insurance arrangements. Both measures will have consumer benefits

because the process will become more efficient regardless of the channel the consumer organises their insurance through, which will improve their experience.

Part G – any related matters

i. **Government to commission studies to better understand the effects of life insurance regulation and reform**

The Regulatory Impact Statement in the LIF Bill[9] were drawn from previous enquiries (ASIC Report 413, Trowbridge and FSI) where assessments were not made with regard to the consumer costs nor the benefits of the recommendations. Like most financial services systems, the life insurance system is complex, involving a diverse mix of participants and encompassing many horizontal and vertical relationships. Any legislative change to the system needs to be cognisant of the many unique features of the market on both the demand and the supply sides and the factors that materially affect the nature of competition and the drivers of efficiency within the system as well as the downstream effect on community well-being and government resources.

We understand that future legislation may be necessary to drive changes within the industry. To properly assess the effects of any such changes though, there needs to be analysis or other research that examines and understands:

- The impact to consumers on access to and the affordability of personal financial advice on life insurance products and claims following implementation of the LIF Bill;
- The impact of more Australians holding adequate and appropriate life insurance on on social security and public health costs to government;
- The overall benefit and well-being to the community of appropriate insurance coverage; and
- The likely impact of upfront financial advice fees being made tax deductible to improve the access to and affordability of personal life insurance advice given the positive economic implications of more Australians holding adequate cover.

Such research should be efficient and effective and draw upon any available research already conducted by other institutions, such as the Beddoes Institute, the Productivity Commission and other quantitative analysts.

Until this research is conducted, policy making into life insurance is incomplete. Reform should be approached in a holistic manner. Life insurance was carved out of the FoFA reforms and now the industry and government is playing catch up because inappropriate practices were permitted to continue largely unchecked over the last three years. Although the measures introduced and commenced recently are welcome, without qualitative data analysing the effects of existing levels of insurance and advice,

[9] *Corporations Amendment (Life Insurance Remuneration Arrangements) Bill 2016*

government policy making on life insurance will be piecemeal and may not be targeted where it is required most.

ii. Introduce tax deductibility of life insurance advice fees

Tax deductibility of upfront personal financial advice fees would **encourage more consumers to accept the payment of fees for life insurance advice** and reduce reliance on commissions. There are material tax impacts currently depending on the type of life insurance held and the method of payment (for example, inside and outside of a superannuation fund). Material gains to superannuation adequacy could perhaps be achieved through improvements to the tax treatment of advice fees for life insurance purchased outside of a superannuation fund.

The AFA considers that this measure on its own would have a profound effect on the under-insurance problem in Australia. To **create an incentive for Australians to seek quality financial advice on their life insurance** is to see more Australians having life insurance coverage that is more relevant to their life priorities, their goals and their situation. Together with the recommendation above to review the conflicted remuneration rules that restrict financial advisers from advising on group insurance and default superannuation, this could see more Australians better protected – regardless of whether they held insurance inside or outside of their superannuation.

iii. Review the practices of lawyers who promote services to assist policy holders submit claims on their super-held insurance

The Committee members should have seen the television advertisements by law forms offering to assist policyholders to check whether they are covered under insurance held within their superannuation accounts. The services are generally promoted on "no win, no fee" terms. The AFA understands that there is no pre-condition that the policyholder be in dispute with the insurance company or superannuation trustee. Accordingly, the law firm services are initially to assist the client to lodge their insurance claim.

Whilst policy holders are entitled to choose their advocates and to choose the manner that they engage with their insurance companies, AFA members have reported that some of these law firms are failing to advise their clients (at a time of vulnerability due to injuries, illness or grieving) to obtain financial and/or taxation advice on their benefit options prior to finalising their claims. As the Committee would be well aware from the last Federal Budget measures, there are differences in the taxation treatments for people depending on their respective ages, their situation, and where they are in the retirement trajectory.

The AFA accepts that lawyers are often not qualified to provide this advice and it may not be within the terms of engagement agreed with their client. However, professional people have ethical obligations that sit above any contractual terms. In the AFA's view, a responsible and ethical law firm would advise vulnerable clients who are expecting insurance benefits to seek expert financial and taxation advice on their insurance benefit options before finalising their claims.

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Likewise, an ethical and responsible law firm would also advise their client that it does not cost anything to lodge an insurance claim. It is a service that all policy holders are entitled to do on their own. If the policy holder elects to engage a professional thereafter to assist them lodge their claim and the professional discloses the cost of their services up front, then the policy holder has been able to make an informed decision. It is unethical to not tell the policy holder that they are entitled to lodge a claim by directly contacting the insurance company first, just as it is unethical to represent to policy holders that they can dispute an insurers' claim at no cost – through the Financial Ombudsman Service (**FOS**).

The AFA considers that the practices of some of these law firms is below the community standards. We also consider that some beneficiaries of super-held insurance are no maximising their entitlements when they opt for the assistance of law firms. We consider it to be unethical to not disclose the free nature of claims and the free service of FOS to dispute an insurance claim. Accordingly, to ensure those law firm practices are in line with the community interest and in the best interests of the client, we recommend that the Committee should review the practices of those law forms promoting "no win, no fee" insurance claims services.

Concluding comments

Additional information and **member comments and examples are included in the attached appendix**, to help bring to life the impact that current shortcomings are having on advisers and their clients.

We believe that on the whole the life insurance industry in Australia is at the better end of the world spectrum, but that doesn't mean we shouldn't strive for excellence. There are significant weaknesses that exist in the direct and group life insurance channels and whilst we believe those channels have a vital role to play, they need improvement to bring greater community benefit. Collectively, all three channels of life insurance need to reclaim their social license through improved conduct and standards. It is only ever evidence of continued good behaviour that builds trust and a desire to participate with an industry, company or product.

The reforms already implemented to the retail advised life insurance channel are substantial and they will drive innovations and improvements to the benefit of consumers over time. They do not require further scrutiny from this Committee. The direct and group channels however need to embrace the same opportunities to improve and bringing greater attention to this is warranted

If you require clarification of anything in this submission, please contact us on 02 9267 4003.

Yours sincerely,

Brad Fox
Chief Executive Officer
Association of Financial Advisers Ltd

Appendix – Member examples and comments

Below is a sample of correspondence from AFA Members to help bring contextual understanding of key concerns – especially from highly experienced life insurance advisers.

"Life companies are offering cheaper premiums to attract new clients while existing policy holders (10 to 15 years in some cases) are paying 25% more for the same cover. NO loyalty to long term clients. Companies claim it is more expensive to administer older policies."

"I agree clients deserve certainty in the first two years of their contracts but I refer to the price difference between old and new products for long term policy holders. All Insurers have old contracts and legacy business and I understand they often can't be upgraded to the newest series because of reinsurers etc. I have seen two cases in the last fortnight where clients who have been with the same insurer for 12 to 15 years are paying 25% more for the same cover offered to new clients. The Insurers involved were [Insurer A] and [Insurer B].

Both clients preferred to stay (on our advice) with the same Insurer in a show of loyalty but were disgusted in the "obvious price gouging and lack of loyalty" shown by their respective companies. I would be happy to provide any detail you require to present at the PJC enquiry into the lack of loyalty to long term clients by Insurers. With "churning" being such an issue I wonder what percentage of replacement business is being rewritten for just this issue [i.e. insurers raising prices in early years].

Please find case study comparison below.

1 – Renewal notice – [Insurer A] product commenced – premium per annum with CPI. per annum same sum insured.

2 – [Insurer A] produced quote new "complete" product. Same sum insured no CPI per annum.

Premium difference – same sum insured $ - per annum.

Client elected to update policy to a new 'complete" product at reduced premium. No medical evidence required. Nil commission paid on replacement by [Insurer A]. Client paid one off fee for service of $500 as a new SOA needed to be produced."

"Raising prices - [Insurer C] raised their premiums over this last year by 10% in addition to the normal increases impacting a number of clients in the first year of holding their policies. A couple of clients had been moved to [Insurer C] because their policies were increased by their previous insurer and were now out of line with the market, and I now have clients who are asking to be moved to another insurer due to them feeling that [Insurer C] have been less than ethical in getting them on board and then increasing their premiums immediately. I am currently trying to convince 1 client that this is not the best move and the risks of changing policies again, and the client is possibly going to make a decision that is not in their best interest because of the insurers actions. How can an actuarial table be wrong by 10% in a 12-month period? I raised the issue with [Insurer C] and the answer I was given is "but every insurer has raised their prices over the last few years".

Group insurance - I have a client who has had an IP claim declined through group insurance due to a change in definition of pre-disability income after the policy commenced. She has lodged a claim against the insurer with the [Superannuation Complaints Tribunal]. The ability to change definitions AFTER the contract has been entered into is something that clients do not understand and impacts the confidence in ALL life

insurance because clients do not understand the difference. I have 25% of a full time employee dedicated purely to managing any claim that comes in and without this many of our clients would not get paid."

"The issue of the 2-year claw back period, as proposed in the LIF legislation, needs significant clarification.

In particular, what is deemed to be a policy cancellation needs to be very clearly detailed and the impact of insurers increasing premiums within the first two years needs to also be considered.

Firstly, what is deemed to be a policy cancellation within the first two years must reflect the reality of certain situations clients may find themselves in. Anything that leads to a policy cancellation that is outside the control of the adviser MUST be excluded from the claw-back provisions. For example, if a client is unable to afford their premiums due to financial hardship or a significant change in their financial circumstances should NOT result in a claw-back to advisers. Another example is where there is a successful claim on a policy within the 2-year claw-back period. Should that occur and a claw-back applied, the most likely outcome for advisers is they will have established the policy and processed a successful claim for their client - only to receive no remuneration for either action. That is patently unfair to advisers and only protects the insurance companies without any consideration for the impact on advisers.

Another issue that I do not believe has been properly considered is the potential for insurers - through premium increases in the first 2 years of the policy - to put advisers in conflict with their Best Interest Duty to their clients. I will use a real-life example of what happened to a client of mine recently. This client was seeking an income protection policy as a suburban truck-driver. At the time (2014), there were only two insurers that offered an age 65 benefit period - [Insurer B] & [Insurer D] ([Corporate group name]). I recommended [Insurer D] to the client for a number of reasons as the premium difference between the two policies was negligible. Due to the clients' age, I also recommended a 'level' premium policy as it was considerably cheaper over the longer-term - on paper. However, on the first policy anniversary, the client was hit with a 10% premium increase. The same thing happened this year on the second policy anniversary (another 10% premium increase). So that is a 20% increase on the initial premium within 2 years!! The end result of these unexpected premium increases meant the [Insurer D] policy was now significantly more expensive than the [Insurer B] policy. As an adviser, in the post-LIF world of a 2-year claw back period, I would be put in the unenviable position to either recommend a policy change (under my Best Interest Duty) or leave it as is otherwise I would end up writing and processing two insurance applications but only get paid for one lot of the work.

An adviser should never be placed in such a situation simply because insurance companies choose to increase their policy premiums. A simple solution to this scenario would be a requirement on insurers (preferably incorporated in the Life Insurance Code of Practice) whereby they guarantee the premiums payable in the first 2 years of a policy commencing. This is currently in place for the first 12 months of a policy commencing through their insurance quoting software. Again, it is patently unfair for advisers to be penalised for the profiteering/mis-management of insurance companies."

"I have a number of complaints about [Insurer B].

The most serious: I have proof of level premiums increasing by 10% per annum for 4 years in a row, which is more than my clients' [Insurer B] stepped premium policies increased by. I understand that "level" does not equate to "will never change" but the magnitude of these increases is fraudulent in my opinion.

[Insurer B] advisers make clients sign a declaration linking super accounts with inflated fees to their insurance policies, so that if they try to move to a lower cost super option their insurance will cease.

[Insurer B] refused to move my clients out of their "legacy" super product to a newer cheaper one and claimed that the product was a legacy [related company] one even though my clients joined long after

[related company] ceased to exist. Only [Insurer B]'s newest on-sale products have the features that they advertise; most clients are in fact in legacy products.

There is nothing about this organisation that is in my clients' best interests and I now move new clients out. The main issue of course is vertical integration; salespeople should be barred from claiming to be advisers. However, systems, processing and training are clearly also very flawed at [Insurer B]."

"My ex-employee was diligent with his disclosure to the insurer about his head injury - which later gave rise to a mental health condition

The insurer paid their psychiatrist to label the claimant a malingerer and ceased his IP claims after 2x years.

The insurer contested the claim for another 2 years before the parties settled out of court for less then 50% of the expected lifetime benefit, about $1m (i.e. they finally accepted the claim but then negotiated it down in a war of attrition).

The outcome saw: $100,k in legals + 100% of the benefit being taxed in the year it was received, at the highest marginal rate!

I was 'hosed off' by the insurers national Mgr, he assured me they had an independent, external 3rd party that reviewed and validated their processes to ensure clients received value. Hah!

For the two years the insurers recalcitrance imposed enormous financial stress on the insured and his home life, this greatly exacerbated the mental health condition and undoubtedly was the most significant contributing factor to cost my client his marriage and all future contact with his 3x young children.

Callous, uncaring, two-faced stonewalling tactics that eventually crumbled. They have no shame."

"Had a client, resigned due to ill health from his company plan. Did not know he could claim on his TPD until he came to see me and we discussed his condition and whether he would ever be able to work again. His cover was own occupation, so prior to changes to tax rules which made this benefit illogical to include within super.

Worked through the claim with client, who during the process ended up as an inpatient in hospital for around 6 weeks (from memory) - and where I went to meet him beside his hospital bed - and subsequently through major periods of ups and downs (many times with him sending me abusive txt messages for no reason and then speaking to me on the phone as though nothing had happened). Many times he'd txt me that he no longer wanted me as his adviser only to recant shortly afterwards. He spoke to a TPD lawyer during the claim because of the time being taken by the insurer to come to a decision (nearly two years). The lawyer was going to charge him an extra-ordinary amount to write a letter to the Trustee basically. As an accredited Trustee I knew this letter would make no difference to his claim, and I remained in constant contact with the insurer regarding progress. Eventually, after many delays, mostly incurred due to the client's health, the insurer accepted the claim and paid the amount. I spoke to the client to relay the good news and suggested he contact the lawyer he had engaged and tell him his services were no longer required. He should also renegotiate the fee because he had done nothing to deserve such a large fee. The lawyer hadn't even read the case notes, he had only submitted a letter requesting them. I think he managed to negotiate a fee around 30% of the amount quoted, around $3,500. So apart from not knowing he had the insurance and could make a claim, I helped him complete the paperwork and subsequent [many] documentation requirements, despite many hurdles (I persevered). I also managed to save him money on a superfluous lawyer's fee. It is my view that this is why we are paid to do our job. Help clients understand their rights, their benefits, the process and liaising with the insurer, and helping wherever possible to settle a claim.

It is not enough to say that - "yes, but every client pays you but only a few utilise the claims service you offer". But isn't this precisely the way insurance works! I think this is a good example of how an adviser can add value with comprehensive insurance services."

"I have been working in financial services for around 5 years in various roles, currently as a financial adviser, and have found personal insurers in general to be extremely easy to deal with on their sales side, and extremely difficult to deal with on their claims side.

In particular, group insurance (the insurance companies behind the cover within people's corporate superannuation funds) is absolutely atrocious, particularly [Insurer E] and [Insurer F].

One current example: A claim was for income protection within superannuation for a client of ours, who was originally on claim with [Insurer E] (with insurance provided by his employer) and managing this claim himself. During his claim, his doctor stated that he expected that our client could return to work in a month's time. After 1 month, without further update on our client's condition, [Insurer E] closed the claim based on this statement. Our clients condition actually continued over this period and worsened, and was later diagnosed as a much more serious condition (auto immune disease). During this period, our client had to resign from work as he was too unwell, though as he had resigned, [Insurer E] cancelled his insurance policy. [Insurer F] acknowledged that his condition had worsened, though they said that this was a separate illness, and as his policy had already been cancelled by them, he was unable to make any further claim on his now cancelled policy.

12 months after all of this I saw the client about other insurance under the advice of our practice that he didn't know he had, which was also within superannuation, [Company G], where the insurer is [Insurer F]. We submitted to [Insurer F] full and complete claim details, including the details from the [Insurer E] claim, clearly stating that his period of disability was constant, and he was not able to go back to work at any time. [Insurer F] took 6 months to assess this, and based their entire claim assessment off the old [Insurer E] claim forms that we had sent them, not their own claim forms that we had filled out, and closed the claim stating that they admitted liability for the small window that [Insurer E] did, and that no amount was payable (as he had already received payment from [Insurer E]). After this point I was shocked and furious and questioned this, and have since had to fight to get the claim reopened by pulling some strings through our contacts in the industry. The claim is now ongoing again, though I do not expect a fair resolution soon.

If our client was trying to manage this himself, he would have absolutely no chance of navigating their claim process, and would with absolute certainty be denied a claim. It is only through our constant fighting that this is even ongoing. This goes to show that the average Australian is getting their superannuation destroyed by insurance premiums (this client was actually paying per annum in premiums, because the insurer defaulted his occupation category to Heavy Blue Collar, despite the fact that he is a qualified Engineer so should be a Professional category), and they may never actually be able to make a claim, despite the legitimacy of their disability.

To summarise:

- There is definitely need for further reform and oversight of the insurance industry;
- There are a huge number of risks to customers of these insurance products, particularly where the insurance is within superannuation and provided automatically; and
- Insurers are engaging in unethical practices to avoid paying claims (unless these cases go to court or are likely to result in bad press, the insurers will act unfairly).

I have spent a few months contacting members of the [Company G] within our corporate superannuation funds who have literally had their retirement savings almost completely depleted by insurance premiums that they didn't even know they were paying, for cover they didn't know they had (and arguably didn't want

or need). This is a result of exorbitant increases in premiums through these channels over the last 2 years, with no communication of this to the clients.

The average Australian has a low level of financial literacy, and is getting taken for an absolute ride. They deserve better."

"The recent Findex case by ASIC talks to the difficulty in differentiating Bank aligned businesses and the IFA space.

Currently, although we are a small licensee that receives no product rebates, we cannot be classed as independent as 'we receive life insurance commissions'.

Given the expected changes to Remuneration structures under LIF wouldn't there be a reasonable argument to take Insurance commissions out of the Independent exclusion?

We do not want to go down the UK track which has involved copious amounts of regulation and monitoring with no benefit to the consumer or the businesses that built truly independent businesses.

The Findex example was even more confusing as they were fined for using the word 'non-aligned' as well which begs the question – what is the definition of aligned?

Clients genuinely express the desire for independent businesses and to date the moratorium on 'independent' clouds the waters enough so that bank owned and subsidised licensees and practices can appear independent as much as a boutique to the consumer."