Re: Inquiry into the life insurance industry

This submission will address the specific terms of reference:

a) the need for further reform and improved oversight of the life insurance industry;

with regards to reference of:

c) whether entities are engaging in unethical practices to avoid meeting claims;

To keep this simple (and because I have had many years dealing with two life-insurers, which has a huge history of unethical behaviour), I will address the main issues to be looked into in bullet point form.

Brief History:

- I am still on a "Salary Continuance Insurance" with one insurer and have successfully claimed a "Total and Permanent Disablement" lump sum insurance with another. Although I successfully was able to make a claim with both, the processes I have had to go through in order to obtain the TPD and remain relatively stress free on the SCI were terrible to the point where it made me even more ill due to the huge amount of stress when I was already very unwell.

Main Issue which needs to be addressed:

- When Life Insurers are engaging in unethical behaviour, often purposefully causing claimants to be extremely stressed (I believe this is usual practice in order to cause claimants to "give up" and drop the claim altogether themselves so they don't have to pay at all), we literally have no avenue to turn to in order to reprimand this behaviour (and the insurers know this, hence can usually get away with unethical behaviour). With my first insurer, I initially tried to get it dealt with the FOS. The FOS can ONLY deal with unethical behaviour IF there is a financial aspect attached to it. As I was already getting paid, they were not able to look at the behaviour, even though the behaviour was causing me to become even sicker and eventually caused me to lose my career as a result and render me TPD. Fortunately, I was able to "find" some financial dispute, which then only enabled the FOS to look at the claim. After they looked at the claim, it was ruled in my favour and since then the insurer has treated me ethically! This took me many years going through loop holes to enable this and at great cost to my health, which I shouldn't have had to do if there was a body to go through in the first place (their internal dispute team is useless as they have vested interest, especially when they haven't done anything "technically" wrong, but just ethically wrong). My second insurer was through my superannuation so I had to go through the SCT. There is no "loop hole" for the SCT to look at their behaviour so even though they did comment that their behaviour should be changed, they couldn't be reprimanded for this. Their behaviour nearly cost me my TPD insurance (as they initially rejected my claim), but again, this was with great cost to my health due to a lot of added stress, but I was able to finally obtain this insurance as well.

Thus with specific reference to term a), there needs to be reform so it is not so easy for Life Insurance to engage in unethical behaviour as they know there is literally no punishment if they do, there is no avenue for people to go to complain about such behaviour and it is to their advantage if they stress claimants out so much so they just drop it altogether and purposefully reject legitimate claims in order to try to not pay at all.

Some unethical practices to avoid meeting claims that I personally experienced:

- Purposefully rejecting the claim, based on skewed information, hoping that the claimant would be too sick to fight it.
- Phrasing skewed questions to the independent medical examiners and then extracting "answers" out of context that would go in their favour to reject the claim and totally ignoring mountains of reports etc. that would go in my favour.
- Not even going by their own policy wordings in order to not pay the claim and trying to interpret it to their favour in order to reject it. E.g. they even tried to state that because I was able to write succinct emails to complain about them, that this was "transferable work skills" and they stated this as part of the rejection in that I may be able to still work in part-time unskilled clerical work, even though I could no longer do my highly-skilled job. This was not part of the Policy to reject my claim as my policy is based on the work level of one's "education, training and experience". From my research, this is common practice to do this by insurers, which is unethical.
- Looking into private / outside matters that have nothing to do with the claim and then assuming things from this to try to not pay. For example, I have done arts / crafts as part of a hobby and part of therapy (and have not been paid for it). The insurer then tried to state that this could be used as "work" in order not to pay.
- Creating stress by lengthy delays, not paying legitimate claims, not answering questions in a timely manner, asking for information not relevant to the claim, ceasing payments without notification (clerical error), phoning up to say that I have been over paid (which was not correct).

The following is something that needs to be specifically addressed, which caused me many problems with privacy issues and caused me a lot of stress, making me more unwell:

- The insurer should NOT be able to ask for general information that may not be totally relevant to the claim, especially if they could get the specific information they require to process the claim from other sources. This has caused me a huge amount of stress, especially due to the sensitivities of my illness. For example, I have got many reports from many specialists, over many years, all confirming my illness. If they require "updated" information, the insurer also has the right to ask for yet another independent medical examiner to see if my condition has changed plus my doctor and I have to fill out a form telling them of any changes every three months. They should NOT, for privacy reasons, causing a huge amount of needless stress, ask for example my doctor's hand-written therapy notes or full hospital files which also have information on therapy discussions and contain extremely private matters from my childhood and deepest vulnerabilities etc.. If someone outside my therapists / treating professionals had access to these "thoughts" of mine, I would be very upset, stressed and this would cause me to become very unwell. As I said, any information relevant to the claim (i.e. ascertaining whether I am well enough to work again),

I am happy for my insurer to ask for a report from my doctors about these specific things relevant to my claim in order for them to process it but things that especially contain sensitive material such as full hospital record files should NOT be accessed by them. In the general sense, anything that isn't needed or relevant to assess the claim should not be requested as well, especially as they have a history of taking skewed information / assuming information out of context in order to justify not paying the claim (see above). This is what I went to the FOS about and the FOS ruled in my favour that the insurer must show due cause as to why they need to full record of these files for each request and cannot just request it as part of their usual processing. The insurer has not asked for these files since, which has made it a lot less stressful for me.

I know each individual case is different but it doesn't mean that each individual case is not important to look at at all. For me, privacy matters are very important and just merely obtaining this information for no good reason without caring about the huge amount of stress it causes me and making me very unwell is unethical behaviour, which the FOS ruled in my favour. The problem is that right now the Life Insurance companies can basically get away with unethical behaviour (there is actually no specific ruling / law against Life Insurers, unlike other insurers – I was even informed that because my insurance went through my work's policy, the "insurance law" regarding ethics didn't apply to me either) as we don't have anywhere to go to at the moment when such behaviours occur and this is what needs to be changed! I had to do extensive research and used the law of negligence (via the eggshell skull /psych rule) in order to legally argue my case when the FOS could eventually look at it (after going through loop holes). The FOS shouldn't have to have the blanket rule of requiring financial matters before looking at behaviour matters and my TPD insurer totally got away with their behaviour as the SCT couldn't look at behaviour matters at all. There needs to also be some form of reprimand for unethical behaviour such as a huge fine for them or something, otherwise they will just continue to do whatever they liked, not matter how it affects people. People shouldn't have to go through what I went through in order for their insurance company to treat them OK and have their claim reviewed ethically in the first place too.