Life Insurance Code of Practice

2025 Review

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afca
Australian Financial Complaints Authority

Contents

Introduction

The Australian Financial Complaints Authority (AFCA) is the independent external dispute resolution (EDR) scheme for the financial services sector.

AFCA welcomes the opportunity to provide input to the 2025 Review of the Life Insurance Code of Practice (the Code). Financial sector codes play a critical role in lifting standards and improving consumer outcomes in the financial system. AFCA and predecessor schemes have strongly contributed to the development and evolution of financial services industry codes for more than 30 years.

AFCA has a dual role in relation to financial sector codes of practice:

- in our primary dispute resolution role, we must have regard to applicable industry codes or guidance in accordance with AFCA's Rules[1]
- a separately operated and funded team in AFCA, the Code Group, acts as the administrator for several industry codes.

AFCA's Code Group supports independent code compliance committees, including the Life Code Compliance Committee (Life CCC), to monitor compliance with codes to achieve service standards people can trust.

This submission is made on behalf of the AFCA, not the Life CCC.

Executive summary

Strong and effective industry codes are integral to the financial sector consumer protection framework. They give practical guidance to subscribing firms and drive improvements to industry standards, extending beyond those set in the law. Robust codes also support timely, fair and efficient dispute resolution.

Life insurance plays a vital role in providing financial security for Australians at some of the most vulnerable times in their lives. This review is an important opportunity to strengthen the Code to ensure it addresses longstanding issues, new and emerging challenges in the sector and changing community expectations.

Last financial year AFCA received over 100,000 complaints. Around 1,500, or 1.5%, were life insurance complaints (LI Complaints).[2] A similar volume, approximately

[1] Under Rule A 14.2, in assessing and determining life insurance complaints, an AFCA decision maker must do what they consider is fair in all the circumstances, having regard to: a) legal principles b) applicable industry codes or guidance c) good industry practice and d) previous relevant determinations of AFCA or predecessor schemes.
[2] LI Complaints data captures complaints where the product line is identified as life insurance.

1,600 or 1.6%, were received about life insurance in superannuation (Super Complaints).[3]

Income protection (IP), funeral insurance products, and total and permanent disability (TPD) products have generated the majority of complaints over the last five financial years, with delays in claims handling, claim amounts, claim denials and incorrect premiums being persistent issues in complaints bought to AFCA.

While these volumes have been relatively steady over the past three years, AFCA data for the first four months of this financial year (July to October 2025) shows a 15% increase in LI Complaints compared to the same period last year, with 540 LI Complaints received. The are no readily apparent drivers behind this increase. **Appendix A** provides a more detailed breakdown of AFCA's complaint data.

AFCA welcomes this Code Review which presents a powerful opportunity to centre the human experience in life insurance products.

We recommend the updated Code commit insurers to:

- prioritise the economic participation and independence of First Nations peoples
- design products and processes that respond to known consumer harms.

A robust and effective Code means enhancements need to be 'designed in' to products and processes at inception.

AFCA centres the experience of many Australian consumers, particularly First Nations consumers, whose experience of life insurance products powerfully illustrates where, when and how they fail to meet the needs of customers. Too commonly, consumers are failed because:

- products are mis-sold
- product offerings (design) do not respond effectively to customer needs
- product features and limitations are poorly explained and understood
- products are complex, yet customers bear the cost of complexity
- pricing changes on long tail products are poorly understood resulting in poor outcomes
- processes are opaque or unfair
- communications are confusing or culturally inappropriate
- where problems inevitably arise, processes are poorly tailored to respond.

[3] Super Complaints data captures complaints where the product line is identified as superannuation and the product complained about is TPD, IP, term life and terminal illness. AFCA also receives complaints about death insurance cover in superannuation; however, these are very rare and therefore they have not been included in the data.

These are not new issues. There is a long history of effort, including regulatory intervention, to try and respond to these persistent problems. It is imperative that this Code Review extends protections and responds meaningfully to these issues.

AFCA encourages this Review to enhance the standards in the Code to deliver meaningful improvements to consumer outcomes from the purchase and retention of life insurance products, to:

- improve product design, systems and processes along the entire product life cycle
- enhance communications, disclosures and transparency
- respond effectively to the needs of consumers, particularly First Nations consumers
- acknowledge and better support consumers experiencing vulnerability
- respond to the increasing demand for improvement to service standards, noting also reforms to introduce mandatory service standards in superannuation
- signal the strength of the Code commitments to customers by making the standards in the Code contractually enforceable and subject to ASIC approval.

AFCA's submission and recommendations

This submission focuses on seven key areas for enhancement and details specific issues we recommend be prioritised as part of the Code Review.

1. Enforceability and ASIC approval
2. Product and process design
3. Communications and disclosure
4. Applications, definitions, data and underwriting issues
5. Claims, complaints handling and record keeping
6. Consumer centred design and processes
7. Code governance, compliance and review

1. Enforceability and ASIC approval

1.1 Incorporating the Code into contracts

AFCA considers that the Code must be enforceable if it is to effectively deliver on its promises to consumers. AFCA recommends that, at a minimum, Code commitments are contractually enforceable by consumers (as is the case with the Banking Code of Practice (Banking Code)). This would provide consumers a clear mechanism to hold insurers directly accountable for Code breaches.

This would also help to position the Code as a best practice Australian industry code of practice. The Insurance Council of Australia (ICA) has signalled in public comments that the General Insurance Code of Practice (GI Code) 'should be contractually enforceable, with clear rights and obligations of insurers set out in easy-to-understand language'. [4] This aligns with ASIC *Regulatory Guide 183: Codes of conduct for the financial services and credit sectors* (RG 183), which states that effective codes are enforceable when contractually binding on subscribers.

AFCA acknowledges that consideration will need to be given to how this is achieved where the contract of insurance is held by a party that is not the life insured (a common example is where the superannuation trustee holds the insurance for the benefit of its members under a group life arrangement). In these cases, we consider that specific clauses will need to be built into the contract between, for example, the superannuation trustee (the policy owner) and the insurer, so the trustee could enforce Code breaches for the benefit of its members (the life insured).

1.1.1 Comprehensive enforceability

In AFCA's submission to ASIC's recent review of RG 183 relating to arrangements to make industry codes enforceable under the Enforceable Code Provisions Framework, AFCA:

- supported code enforcement via contractual terms and conditions
- noted that to build stakeholder confidence and promote certainty, enforcement ought to be applied to the entire code rather than targeting particular provisions.[5]

1.2 ASIC approval of the updated Code

AFCA recommends that the Code, once reviewed, is submitted to ASIC for approval. ASIC approval is a powerful signal to all stakeholders that the Code is one they can have confidence in.

2. Product and process design

Funeral insurance represents a study in product design where products and processes persistently fail to meet consumers' genuine need to try and manage foreseeable future funeral costs.

2.1 Funeral insurance products: systemically poor consumer outcomes

Of the 8,863 LI Complaints that AFCA received in the five years to June 2025, 20% (1,767) related to funeral plans (see **Appendix A**). This cohort of complaints included:

- 477 complaints about funeral insurance products sold by life insurers

[4] Insurance Council of Australia *New insurance Code of Practice to deliver for consumers*, 30 May 2025 Media Release.
[5] AFCA's submission to ASIC Regulatory Guide 183: Codes of conduct for the financial services and credit sectors, September 2025.

- 1,290 complaints relating to entities in the Aboriginal Community Benefit Fund (ACBF) / Youpla Group, in liquidation.[6]

While the ACBF / Youpla category of funeral plan products were not regulated life insurance products, the issues in this category of complaints and resulting poor outcomes also commonly arise in complaints involving regulated funeral insurance products. Common issues include:

- aggressive and misleading sales practices
- steep premium increases for over-50-year-olds, while income and capacity to pay declines with age[7]
- poor value for many consumers with high cancellation rates and loss of benefit.

Poor product understanding

In complaints to AFCA, we see:

- consumers frequently misunderstanding that a policy is not a savings plan and that a benefit will only be paid on the death of the life insured
- policy holders failing to understand the likely costs of policies over time
- poorly disclosed or communicated limitations on cover, with some funeral policies only covering deaths caused by accidents in the first year
- consumers unaware of available alternatives, such as the life insurance held in superannuation or the availability of non-insurance options such as funeral bonds or pre-paid funeral arrangements
- poor consumer understanding that premiums may exceed the maximum possible payout.

Common AFCA complaints for funeral products involve consumers in their 70s and 80s lodging complaints about steep premium increases. This shows too many consumers fundamentally misunderstand how the product operates and how costs will change over time.

By the time a consumer makes an AFCA complaint, the product has typically become unaffordable, particularly to consumers on low or fixed incomes at a time in their lives when worry about managing future funeral costs is most pressing.

These consumers can feel upset and as though they have wasted their money. They may blame themselves for failing to understand that there were other options available such as savings or self-insuring. They often feel trapped into retaining a

[6] These entities aggressively sold funeral plans to First Nations people. AFCA received over 1,200 complaints about these companies and issued 178 decisions finding that they misled consumers and used deceptive sales tactics. These practices had a devastating impact on many First Nations peoples and communities. The companies collapsed in 2022 leaving many without the cover they thought could help with Sorry Business (important cultural mourning practices that follow a death of a loved one).
[7] This was also noted in ASIC Report 454 Funeral Insurance: A snapshot, October 2015.

product despite the unaffordable premiums, and resulting financial hardship involved.

Current Code settings do not respond to the problem

The Code currently imposes obligations on insurers when *selling* funeral insurance. This includes requirements for insurers to clearly explain the product in plain language, including its nature as insurance (not savings), benefits, exclusions, premium types and increases, cancellation terms, and affordability risks, particularly for stepped premiums (clauses 2.28 to 2.31).

However, AFCA's experience shows that problems with funeral insurance may only become apparent years (and sometimes decades) after purchase. Many complaints to AFCA relate to policies issued before the Code came into effect. The Code's current obligations are largely forward-looking and focus on the point of sale.

Determination 12-24-173968 speaks to poor consumer understanding of product features, where premiums exceeded the benefit sum insured. AFCA ultimately found in favour of the insurer in this case noting that the protections afforded by the Code did not apply when the policy was sold.

AFCA recommendations

Continuing poor outcomes mean that it is essential to strengthen settings and extend them to products sold before the Code came into force. The onus should lie with insurers to ensure their products deliver genuine benefits to consumers, not on consumers to manage the risk of poor outcomes that may arise many years post purchase. We suggest that consumers be made aware and reminded of key product features, limitations and risks across the product life cycle.

We recommend updating Code settings to:

- require that the distinct needs and cultural protocols of First Nations peoples be considered in the design, sale, and administration of funeral insurance products (see related recommendations in section 6.1 below)
- require accessible point in time and ongoing information as a key to mitigating risks
- include average mortality rates to help customers understand that:
  - on *average* they will pay premiums for 20 years given *average* mortality rates[8]
  - the product is a risk product which provides immediate cover, but premiums will increase steeply as they get older.
- require lifetime premium projections at pre-policy stage alongside the sum insured

[8] Men aged 65 in 2021–2023 could expect to live another 20.1 years (an expected age at death of 85.1 years), and women aged 65 in 2021–2023 could expect to live another 22.7 years (an expected age at death of 87.7 years) (Table 9.1). This also includes average life expectancy data for First Nations people. *Australian Institute of Health and Welfare*, *Deaths in Australia: Life expectancy*, updated 9 April 2025 www.aihw.gov.au/reports/life-expectancy-deaths/deaths-in-australia/contents/life-expectancy.

- mandate that annual statements include lifetime premium projections compared to benefit sum insured, the amount of premiums paid to date, and mortality rates
- include percentages, as well as dollar premium amounts, in re-rate increase notices
- extend disclosure obligations to all products (including legacy products).

3. Communications and disclosure

3.1 Premium disclosure

AFCA encourages a thorough review of the Code's premium disclosure provisions. We recommend enhancements apply to all life insurance products, responding in tailored ways to specific harms for certain product types, such as funeral insurance (discussed in section 2.1 above). Consideration could be given to requiring:

- lifetime projections of the applicable premium type (including any changes over time) before sale, as part of any quote for cover
- lifetime premium projections to be included in the product disclosure statement (PDS) and policy document, and during the life of the policy (in annual statements and on request)
- annual statements to include lifetime premium projections and a summary of premiums paid to date
- specific disclosures in the re-rate notice and the next annual statement when a premium re-rate is applied, stating, for each impacted cover:
  - the re-rate percentage applied, and
  - the dollar amount by which the premium will increase because of the re-rate
- embedding of new industry premium labels into the Code.

3.1.1 Inadequate disclosure resulting in 'bill shock'

AFCA has regularly called out concerns that premium disclosure for life insurance products is inadequate, resulting in 'bill shock' for consumers.[9]

This generates complaints to insurers at internal dispute resolution (IDR) and to AFCA. For example, in the five years to 30 June 2025, incorrect premiums were the:

- fourth most complained about issue in LI Complaints
- fifth most complained about issue in Super Complaints
- subject of five AFCA systemic issue reports to regulators (see **Appendix A and B**).

Improving salient disclosures to consumers, to show cost impacts both at point in time and over time:

[9] See, for example: AFCA's submission to the last independent review of the Code, February 2019.

- contributes to better consumer understanding of the policies they purchase
- helps ensure that people buy a product that is suitable, affordable and sustainable for them over the long term
- reduces bill shock
- reduces the likelihood of complaints, and their costs, to insurers at IDR and AFCA.

Complaints to AFCA show the severe adverse impact that bill shock can have on consumers, resulting in poor consumer outcomes. For example:

- when insurance premiums become unexpectedly unaffordable, people with health issues may find that they are unable to obtain suitable alternative cover
- unaffordable premiums may lead to consumers letting their policies lapse.

Recent action by regulators and the industry highlights the need to improve consumer outcomes in this area. The Review's Consultation Paper refers to some of this action, including:

- ASIC and APRA's joint letter to life companies on 5 June 2025
- the Council of Australian Life Insurers (CALI) publishing a fact sheet - *Life insurance premiums: Key facts* dated May 2024, which includes the new industry labels to describe premium types that are designed to improve understanding for consumers by more accurately reflecting how premiums may change over time.

3.1.2 Disclosure standards need to be enhanced across all policy types

AFCA recommends strengthening disclosure for all products. Disclosures should be accessible and explicitly address known areas of consumer misunderstanding.

AFCA's experience shows that inadequate information creates difficulties for consumers in understanding:

- the extent of premium increases
- the ability of insurers to increase premiums
- the resultant impact in terms of premiums paid and benefits provided.

This is the case across all life insurance products, and particularly IP and death benefit policies.

AFCA sees ongoing problems with consumers failing to understand how products and their pricing mechanisms work. For example:

- consumers routinely interpret 'level' premiums to mean the price is fixed for the life of the policy, when in fact the insurer is able to vary the price over time
- consumers have not received sufficient warning through disclosure material that a 'stepped premium' model can often result in extremely large premium increases

(particularly after re-pricing), leading to significant consumer confusion and distress.

Determination 12-00-1019257 relates to a complaint involving very significant premium increases in a life insurance policy where the monthly premiums increased from $173 in 2005 to $2,339 by September 2023. AFCA found in favour of the insurer but a key issue in the complaint was consumer misunderstanding of how the product worked and how the premium would increase over time, despite this product being purchased with help from a financial advisor.

Given the well understood limitations of disclosure as a consumer protection mechanism[10], behavioural research and consumer testing may be necessary to ensure any enhancements are effective and work as intended. We also suggest that updated requirements be subject to periodic post implementation review to identify potential improvements for future iterations of the Code.

4. Applications, definitions, data and underwriting issues

This section identifies opportunities for the Code to:

- deliver meaningful improvements in the application process so that consumers can better understand decisions
- clarify the prohibition on blanket mental health exclusions and deliver greater transparency in relation to mental health matters, including through detailed data collection
- provide more effectively for medical definitions to be brought and kept up to date
- build in consumer protections in relation to the use of Artificial Intelligence (AI) and other new technologies.

4.1 Applications for insurance

AFCA recommends that the Code be updated to require that insurers:

- communicate important information regarding applications for insurance in writing
- give consumers a plain language summary of the material relied upon to make decisions about applications for insurance and provide this information upon request (including making statistical and actuarial data available)
- review underwriting and explain to consumers, in writing and in plain language, why alternatives (such as higher premiums and caps on the benefit sum insured) are not a suitable alternative to an exclusion.

The Code frequently uses phrases such as ‘will tell you’ or ‘will let you know’ when requiring insurers to communicate important information to a consumer about their

[10] ASIC Report 632, Disclosure: Why it shouldn’t be the default, October 2019.

application for insurance. The Code does not clearly state whether insurers must provide the information in writing or whether consumers can be given the material the insurer relied on to reach decisions. For example:

- clauses 4.14 and 4.22 of the Code sets out the information an insurer needs to provide when offering insurance on alternative terms, which includes:
  - the alternative terms
  - how long alternative terms apply
  - that a consumer can request a review
  - risks of replacing the policy.
- clause 4.25 of the Code requires insurers to give information to a consumer about the denial of an application for insurance, which includes:
  - the reasons for denial
  - option for a review of the decision
  - opportunity to provide new information
  - details of the complaints process (such as AFCA's contact details).

As noted above, these clauses do not explicitly require this information to be given in writing. If the information in these clauses is only communicated verbally, it will be difficult for the consumer to absorb and remember.

Consumers need information that helps them to understand how decisions were reached and raise concerns effectively. AFCA recommends that the Code include requirements for insurers to provide:

- the material relied on by the insurer when making decisions upon request, including actuarial and statistical data used in underwriting guidelines
- plain language explanations for complex and technical information, such as actuarial and statistical inputs, to improve consumer understanding
- clear written records of what was communicated to a consumer throughout the application process.

AFCA also recommends that the Code explicitly require insurers to provide information in writing and/or provide supporting evidence upon request for the following clauses:

- clause 4.3 (reasons for underwriting decision)
- clause 4.8 (updates on independent service provider reports)
- clause 4.10 (consent to access health information)
- clause 4.11 (access to health information)
- clause 4.20 (accept application)
- clause 4.21 (issue of temporary insurance)

- clause 4.23 (advise not to cancel existing cover until new application accepted)
- clause 4.24 (risks of replacing a new policy)
- clause 4.27 (giving information relied upon to decline application)
- clause 4.31 (option to reinstate a cancelled policy).

4.2 Mental health

As noted in the Review's Consultation Paper, rates of mental ill-health are climbing in Australia, and life insurance claims related to a mental health condition are similarly rising.

Mental ill health is not only a common claim driver, but a heightened risk at claim time given that consumers may be unwell, work-impaired, financially stressed or grieving the loss of a loved one.

Many of AFCA's complaints about life insurance touch on mental health, from disputes about insurers excluding cover for mental health conditions, to complaints about insurer conduct causing or exacerbating a mental health condition.

4.2.1 Clarify scope of prohibition on blanket mental health exclusions

AFCA suggests the Code be updated to:

- expressly require insurers to remove blanket mental health exclusions:
  - when a new policy is issued
  - for all existing policies.
- clarify that a 'blanket' mental health exclusion is not confined to a total exclusion of all mental health conditions.

Clause 2.1b) of the Code prohibits insurers from designing new products that include blanket exclusions for mental health conditions in standard form contracts, consistent with provisions in the *Disability Discrimination Act 1992* (Cth) and equivalent State or Territory legislation.

AFCA understands that there may be differing views on:

- what constitutes a 'blanket' exclusion; for example, AFCA has seen complaints where the mental health exclusion in standard form contracts is so broad, that it effectively amounts to a blanket exclusion (such as permitting claims for schizophrenia but excluding claims for anxiety and depression)
- which products clause 2.1 b) applies to; for example, the case study below illustrates that some insurers may be reluctant to revise the terms and conditions of legacy products to reflect current Code obligations prohibiting blanket mental health exclusions.

Case study 1: blanket mental health exclusions in legacy products

In a systemic issues investigation, AFCA raised concerns with an insurer about a possible blanket mental health exclusion in a life insurance policy. AFCA was concerned that the exclusion may be in contravention of the *Disability Discrimination Act 1992* (Cth). The insurer said that the product in question was a legacy product that had not been on sale for several years. The insurer justified the exclusion on the basis of actuarial and statistical data, and that all applicants were subject to the same terms. The insurer also advised that existing policies would retain the exclusion. While AFCA did not determine there was a systemic issue, it referred the matter to the relevant regulator for consideration.

We note that a recent Life CCC review of six insurers' practices in relation to underwriting indicates that broad mental health exclusions are still commonly embedded in standard policy terms. This practice effectively removes the opportunity for consideration of a consumer's individual circumstances, which is required under clause 4.12 b) of the Code.[11]

Consistent with a consumer-focused and industry-improvement approach, AFCA recommends that the Code require insurers to remove blanket mental health exclusions when a new policy is issued and for all existing products.

We also consider that any general exclusion for a specific mental health condition in standard terms and conditions not involving individual underwriting of the life insured is a blanket mental health exclusion.

4.2.2 More detail on when a mental health condition must be disclosed

AFCA suggests introducing new Code obligations that provide:

- greater specificity and clarity on what must be disclosed as a mental health condition (for example, a formal diagnosis with regular treatment) and what does not (for example, short-term low mood or stress without a diagnosis)
- refined, specific and staged questions about pre-existing mental health conditions, avoiding broad or ambiguous prompts.

AFCA also recommends that the Code definition of 'mental health condition'[12] be reviewed and re-developed with appropriate clinical and consumer experts, so it aligns with recognised diagnostic standards and provides practical guidance to support accurate consumer disclosure.

[11] FINAL-LCCC-Inquiry-Report-Keeping-the-Promise-Mental-Health-and-Life-Insurance-Commitments-September-2025.pdf, 16 September 2025.
[12] The Code definition of a mental health condition is "A broad range of disorders, illnesses, and syndromes including mood or anxiety disorders, bipolar disorder, schizophrenia, and personality disorders" (section 9).

The current Code definition of 'mental health condition' is broad and open-ended and does not assist consumers in understanding their disclosure obligations.

AFCA sees many complaints where consumers are uncertain about when disclosure is required, leading to significant consequences such as claim denial or policy avoidance. Life insurers often rely on section 29 of the *Insurance Contracts Act 1984* (Cth) (ICA) to avoid a policy, alter its terms, or reject a claim, alleging misrepresentation or failure to disclose aspects of their mental health history during the application process. An example of how this commonly plays out is below.

Example 1: Retrospective mental health exclusion

A consumer makes a claim on the basis they have a mental health condition that temporarily or permanently leaves them unable to work. The insurer may assert that the consumer made a misrepresentation about their previous mental health history, apply a retrospective mental health exclusion on the insurance cover and then decline the claim.

AFCA has identified ongoing uncertainty among consumers about disclosure triggers, such as whether disclosure is required:

- after a GP consultation about low mood or stress
- for transient psychological distress
- for low mood that had no impact on capacity to work
- upon formal diagnosis of a mental health condition
- when there is regular treatment from a mental health professional.

Notably, consumer perceptions of what constitutes a 'condition' often differ from the definitions applied by insurers.

Case study 2: Duty to disclose pre-existing condition

In Determination 928852 and 963560, AFCA found an insurer's mental health exclusion invalid. The consumer held IP cover through their superannuation and claimed benefits for an adjustment disorder with mixed anxiety and depressed mood. The insurer alleged non-disclosure of prior stress and applied a mental health exclusion from policy inception. AFCA was not satisfied the consumer knew, or could reasonably have known, he had a psychological or mental health condition at application. Stress alone was not considered a disorder, and the complainant's only response, removing themselves from work, did not constitute treatment.

4.2.3 Greater transparency about mental health in applications and underwriting

Insurer to explain why alternatives are not appropriate

AFCA suggests that the Code require insurers and reinsurers to review underwriting and explain to consumers, in writing and in plain language, why alternatives (such as higher premiums and caps on the benefit sum insured) are not a suitable alternative to an exclusion because of a mental health condition.

Clause 4.13 of the Code provides that if a consumer discloses a past or current mental health condition, the insurer will determine whether it can provide cover by managing any additional risk through higher premiums, exclusions, limits and caps rather than not providing cover at all.

This clause does not require insurers to explain why they have applied a mental health exclusion instead of managing the additional risk through other options, such as premium loading or by capping or limiting the amount of cover provided.

Requiring insurers to provide reasons for ruling out alternatives would lift transparency, help improve consumer understanding and make better-informed decisions, as well as empower consumers to challenge unfair outcomes.

A recent Life CCC report found that when individuals disclose their circumstances to insurers during the application and underwriting process, it rarely leads to tailored outcomes. The report found insurers typically default to exclusions, with limited use of alternative terms and in many instances even mild or well-managed conditions lead to exclusions[13].

Insurer to provide written reasons and supporting material

We reiterate the suggestions in section 4.1 Applications for insurance:

- important information regarding applications for insurance be communicated or confirmed in writing (for example, decision to decline an application or offer alternative terms because of a mental health condition)
- insurers give consumers a plain language summary of the material relied upon to make decisions about applications for insurance and provide this information upon request (including making statistical and actuarial data available).

Written reasons, an accessible summary of the evidence, and provision of supporting documents on request would improve consumers' understanding of mental health underwriting and place them in a stronger position to question or challenge decisions.

[13] FINAL-LCCC-Inquiry-Report-Keeping-the-Promise-Mental-Health-and-Life-Insurance-Commitments-September-2025.pdf,16 September 2025.

4.2.4 Improving insight through data, reporting and expert partnerships

AFCA suggests that the Code require insurers to:

- collect data and report annually to the Life CCC on:
  - the number of applications for insurance disclosing a mental health condition
  - the number of declined and accepted applications where a mental health condition is disclosed
  - the number of applications offered on alternate terms that are subject to mental health exclusions
  - number of instances where cover is avoided or varied due to a mental health condition
  - the number of claims that are declined because of a mental health condition
  - decision timeframes for claims that relate to a mental health condition
  - withdrawal rates for claims that relate to a mental health condition
  - proportion of declined claims overturned that relate to a mental health condition
- commit to using insights from mental health related complaints in product and process design cycles
- establish partnerships with mental health experts to inform policy, product design, and case handling.

CALI has announced that Australia's life insurers will develop a new industry action plan for mental health, stating that 'Australia is in the middle of a national mental health crisis, and we need to set clear, evidence-based guidance about the support life insurers provide'.[14]

Robust data collection is an essential step in developing a clear understanding of current issues and challenges. A recent Life CCC report on how insurers make underwriting decisions when a mental health condition is disclosed found insurer data significantly lacking.[15]

Against this backdrop, AFCA suggests a more evidence-led approach to the experience of consumers with a mental health condition such as:

- stronger data capture and reporting
- more rigorous analysis of complaints
- meaningful partnerships with mental health experts.

These steps would improve diagnosis of issues, inform effective policy and product responses, and sharpen accountability. In turn, this ought to support better consumer outcomes, product sustainability, and fewer disputes and instances of unmet expectations.

[14] Life insurers commit to mental health action plan - CALI, 13 October 2025.
[15] FINAL-LCCC-Inquiry-Report-Keeping-the-Promise-Mental-Health-and-Life-Insurance-Commitments-September-2025.pdf,16 September 2025.

4.2.5 Move unique requirements in Appendix B to the body of the Code

To support clarity and ease of understanding, AFCA suggests that:

- Appendix B of the Code be removed
- any unique requirements in Appendix B move to the body of the Code.

Appendix B sets out sections of the Code that may be of particular interest to consumers experiencing mental health conditions. It does not offer notable additional interpretive content. Having largely similar content in two locations, with minor additions, risks creating confusion.

While Appendix B does not provide additional interpretive guidance, it does include some unique requirements. Of note, having an assigned claims assessor throughout the claims process for mental health income-related claims. This differs from the Code itself, which only requires the appointment of 'a primary contact person'. This distinction is significant, and it is preferable to have the requirement in the main body of the Code.

Consideration could also be given to developing a standalone document that offers guidance on the Code's mental health obligations, including practical examples, as this could serve as a valuable resource.

4.3 Medical definitions

AFCA continues to see complaints where insurers use outdated or overly restrictive medical definitions in their policies, leading to significant consumer harm. There is an opportunity for the Code to ensure that all insurers adopt current medical standards and meet community expectations of fairness and transparency.

To address the issues, we suggest Code changes to:

- update medical definitions in section 9 and expand their application
- enhance requirements to update medical definitions in policies.

4.3.1 Update and expand medical definitions in section 9 of the Code

Revising definitions in section 9

AFCA suggests the medical definitions in the Code should define minimum, rather than severe, conditions. For example, we suggest replacing the severe heart muscle damage definition in section 9 with the Fourth Universal Definition of Myocardial Infarction (2018) (Universal Definition).

Clause 5.67 of the Code requires a heart attack claim to be assessed against two definitions so that the definition most favourable to the consumer can be applied. The definitions are:

- the applicable definition in the PDS or policy document

- if different, the current definition in section 9 of the Code.

Section 9 includes a definition of 'heart attack with evidence of severe heart muscle damage'. This is not the 'Universal Definition' of heart attack used widely by doctors.

From around 2016, denial of claims based on outdated medical definitions has generated public controversy. Reviews[16] focused on this issue and the Hayne Royal Commission[17] found that an insurer's failure to update its heart attack definition fell below community standards and expectations. While some insurers have responded by aligning their definitions with the Universal Definition, there are still insurers who are using outdated definitions.

AFCA has made determinations requiring application of the Universal Definition rather than a definition in the relevant policy or section 9 of the Code. These determinations set out detailed reasons, including an outline of key developments in recent years.[18]

Case Study 3: Claim denied based on outdated heart attack definition

In 1993, the complainant took out an insurance policy that covered conditions including heart attacks within a stated definition.

The complainant suffered a heart attack in 2021 that did not satisfy the definition in the policy or the heart attack definition set out in the Code. Her heart attack did satisfy the Universal Definition, however.

The insurer denied the complainant's claim based on the definition in the policy.

AFCA decided it was good industry practice to apply the Universal Definition, taking into account the conduct of other insurers and the findings of the Hayne Royal Commission. The insurer was required to pay the sum claimed with interest.

Medical definitions need to be updated effectively now and regularly in future. An important step toward this goal would be updating the medical definitions specified in section 9 of the Code – to update requirements for all subscribing insurers.

Expanding application of definitions in section 9

AFCA suggests removing the limitation in clause 5.66 that refers to the date 1 July 2017. This change would allow the medical definitions in section 9 to apply more broadly, covering claims on older policies.

[16] For details of the reviews, see *ASIC Report 498 Life insurance claims: An industry review,* October 2016 and *Report on Inquiry into the Life Insurance Industry by Parliamentary Joint Committee on Corporations and Financial Services*, 27 March 2018.
[17] *Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry*. See Final Report, Volume 2, p. 327.
[18] See determinations published by AFCA, for example 607118 and 989722. Published determinations are available on AFCA's website: Search published AFCA decisions | Australian Financial Complaints Authority.

4.3.2 Enhance requirements to update medical definitions in policies

AFCA suggests the provisions in clauses 2.7 to 2.9 for updates of medical definitions are enhanced so that they:

- require regular reviews of the definitions and resulting updates to meet current and objective medical standards
- extend the process for regular reviews and updates to legacy products.

Standards for reviews and updates

Clause 2.7 requires certain definitions to be reviewed at three-year intervals 'with help from relevant medical specialists' but does not set any further requirements to satisfy in reviews of definitions. There is a commitment in clause 2.8 to make updates 'if needed'. The provisions do not deal with issues such as:

- the process for selecting medical specialists; we believe these specialists need to be appointed or nominated by an appropriately qualified and objective person such as the Federal President of the Australian Medical Association or their nominee
- the types of evidence that reviews must consider
- ensuring there are adequate safeguards so that a review gives due weight to a recommendation by a medical specialist
- the process for updating medical definitions
- ensuring insurers commit to adopting updates of medical definitions when they develop new products.

In our view, the Code needs to specify standards that reviews of medical definitions and resulting updates must meet. At a minimum, we recommend the Code require that reviews are thorough, and updates are implemented effectively. We suggest the Code commitments require reviews and updates to meet objective medical standards, such as standards set by the World Health Organisation.

Application of review and update requirements

Clauses 2.7 and 2.8 are drafted in limited terms and only apply to 'policies available to new customers'. To ensure medical definitions remain aligned with community expectations and current diagnostic practices, these requirements also need to apply to legacy products.

4.4 Consumer protections around use of AI and other new technologies

We suggest adding a new Code provision to reinforce that insurers are responsible for maintaining consumer protection standards where new technologies such as AI are used. This could be an overarching commitment to put in place processes, systems and any other safeguards needed to meet Code obligations covering all conduct – regardless of the technology used in those activities. A commitment expressed in broad terms could potentially build on clause 1.1b), which refers to the Code's goal to ensure continuous improvement of services.

In some circumstances, relying solely on AI is not appropriate because it may compromise customer care and service. We recommend that the Code require human involvement in key roles, including:

- making decisions on underwriting, claims and complaints
  - human oversight helps strengthen quality assurance and mitigate risks of potential bias or discrimination - for example, in cases involving mental health conditions.
- handling consumers' enquiries about their premiums or how their policies work
- being designated as an insurer's contact for applications for insurance or claims assessments
- leading an insurer's work to ensure a consumer experiencing vulnerability receives sufficient support[19]
- overseeing systems that rely on AI to identify patterns and process data.

We also suggest that the Code require all use of AI in claims handling to be disclosed and explained to consumers, to improve consumer understanding and transparency.

5. Claims, complaints handling and record keeping

5.1 Strengthen record keeping obligations

AFCA recommends the record keeping obligations in the Code are updated to ensure insurers retain key documents including PDSs, applications, underwriting files, original applications, policy documents and any upgrades for policies remaining on foot and for at least seven years after a policy is cancelled.

Complaints where parties disagree over life insurance policy terms continue to reach EDR. AFCA sees cases in which the insurer has not retained critical documents such as disclosure documents and policies. It is crucial that insurers maintain robust record keeping practices so they can properly assess any claim and reduce the risk of a complaint arising. If there is a complaint, ready access to these documents is essential for early and efficient resolution.

5.2 Claims handling

5.2.1 Reducing delays in linked 'Any Occupation' - 'Own Occupation' claims

To facilitate a reduction in delays in claims handling processes, consideration should be given to amending the Code to require an insurer to:

- concurrently consider linked TPD 'Own Occupation' and 'Any Occupation' claims (after requesting information about whether the life insured meets both definitions)

[19] Clause 6.2 states a commitment to treat customers experiencing vulnerability with empathy, compassion and respect.

- make a decision as soon as the information shows the life insured meets either definition
- notify the claimant of a first completed decision (generally when the life-insured meets the 'Own Occupation' definition) and allow them to decide whether the insurer pay the benefit based on that policy cover or continue to assess whether the 'Any Occupation' definition is met.

As background, linked policies exist where there is 'Any Occupation' TPD cover via a group life insurance policy arranged through the superannuation trustee for the superannuation member (individual) as well as 'Own Occupation' TPD cover held directly by the same individual via a retail policy through the same insurer. Any TPD payment via the superannuation policy is paid directly to the superannuation fund and is subsequently subject to a superannuation trustee decision under the *Superannuation Industry (Supervision) Act 1993* (Cth) (SIS Act) before it can be released and paid to the superannuation member. A TPD payment via a retail policy is paid directly to the individual policy owner. Any TPD payment on one linked policy automatically reduces the TPD cover on the other linked policy.

Currently some insurers' policies require the insurer to make a decision in relation to the 'Any Occupation' cover (higher evidentiary standard to meet) prior to making a decision on the 'Own Occupation' cover (lower evidentiary standard to meet).

AFCA has received varying complaints in relation to linked cover. Of note, there have been complaints regarding the delay of the payment of 'Own Occupation' cover where the definition has been met, as the insurer had not concluded its investigation of 'Any Occupation' cover.

AFCA has also received a complaint about the insurer accepting the claim and paying the TPD benefit based on 'Any Occupation' definition to the trustee of the superannuation fund. The superannuation fund trustee did not release the benefit because the complainant did not meet the release requirements under the SIS Act. The complainant had otherwise met the 'Own Occupation' TPD definition.

To promote flexibility and to improve the claimant's experience, there needs to be an option for payment of an earlier decision (provided there is agreement from the claimant) rather than waiting for a decision on both covers. In practice, earlier decisions would generally relate to 'Own Occupation' cover rather than waiting for a decision in relation to 'Any Occupation' cover. This would be beneficial to claimants who have ceased working due to an injury or illness and are faced with cost-of-living pressures such as mortgage repayments requiring imminent access to benefits payable.

5.2.2 More robust obligations around medical opinions

Requiring input from treating doctor before rejecting claim

AFCA suggests a new Code provision to improve the quality of evidence relied upon by insurers when assessing claims.

AFCA is concerned that, in some cases, insurers do not consult with treating doctors when confirming whether the life insured satisfies the relevant policy medical definitions. Instead, insurers rely on their own staff to make these assessments which can result in decisions to deny claims.

A new provision to address this issue could be drafted along these lines:

> 'We will not reject a claim based on a medical question unless we have previously requested an opinion on that question from your treating doctor who is best qualified to answer the question.'

Ensuring practitioners hold Australian medical qualifications

AFCA suggests the Code include a provision to ensure insurers only request medical opinions from practitioners with Australian qualifications.

Through complaint resolution work, we have seen that some insurers obtain and rely on medical opinions from practitioners who have no medical qualifications in Australia. These opinions can be internal – for example, from an insurer's Chief Medical Officer, or external opinions.

We note insurers do not permit claimants to rely on medical opinions from practitioners without Australian qualifications.

5.2.3 Stronger service standards

Increasing accountability of Code subscribers

To increase accountability and compliance in regard to claim handling, AFCA suggests the Code:

- expressly state that insurers outsourcing functions covered by the Code to entities that are not Code subscribers are liable for any Code breaches to which those entities contribute
- hold an insurer responsible for any claim delays caused by its reinsurer or specifically provide timeframe obligations for reinsurers.

Clauses 1.5, 2.13 and 2.21 of the Code limit an insurer's liability for its distributors for sales of policies. However, distributors that do not subscribe to the Code may undertake other functions such as claims handling. We also note that the obligations of reinsurers to comply with the Code are unclear due to clause 1.16.

Currently, reinsurers that subscribe to the Code are only required to meet the principles of the Code and help life insurers meet their obligations. The Code does not impose obligations for reinsurers to meet specific timeframes. For example, an insurer

may refer a matter to a reinsurer as part of claims assessment but there is no timeframe by which the reinsurer needs to provide a response. The timeframes for insurers to request information or make a decision begin when they receive the response from the reinsurer.

Primary contact person for claim

AFCA suggests changes to clause 5.4 to:

- require a 'primary contact person' assigned to a claim to be the claims assessor for that claim
- extend clause 5.4 to apply to all claims (and not to be limited to income related claims).

These changes would ensure that a claimant has a central and consistent contact point at all times and that a primary contact point will meet the training requirements for claims assessors in clause 5.45.

Communicating in writing

To help claimants understand progress of their claims, AFCA suggests changes to strengthen communication obligations in the Code consistent with our recommendations in Section 4.1 Applications for insurance.

Where the Code requires an insurer to give a claimant information relating to their claim, we consider the information needs to be provided in writing. Having this information in writing, available to re-read and consider carefully, may help claimants to understand and respond to the information and seek further assistance if necessary.

Examples of provisions in section 5 that require communications without specifying whether insurers must provide all the information in writing include:

- clauses 5.5 to 5.11 (on regular contact about claims)
- clauses 5.12 to 5.15 (on requests for information or agreement to its collection)
- clause 5.18 and 5.20 (on arrangements for medical examinations)
- clause 5.29 (on locations of interviews).

5.2.4 Enhance timeframe requirements

For years, delay in claims handling has featured as a prevalent issue in life insurance complaints received by AFCA. Table 2 in **Appendix A** shows that, in the five years from July 2020 to June 2025, delay in claims handling was:

- clearly the most prevalent issue in Super Complaints received
- the second most prevalent issue in LI Complaints received.

Improving timeframes for making and communicating decisions

AFCA suggests changes to require claims decisions to be made and communicated more quickly by:

- requiring all claims to be decided within a strictly limited period after an insurer completes reasonable enquiries and information gathering
- reducing the application of the exception for 'Circumstances Beyond Our Control' (CBOC)[20]
- reducing the timeframe currently allowed for communicating decisions.

To make these improvements, we suggest section 5 of the Code is amended as outlined below.

Decisions under clause 5.48 or 5.49

Clauses 5.48 and 5.49 could require the insurer to obtain all the information it reasonably needs and complete all reasonable enquiries as soon as possible and no later than 5 business days after it should reasonably have been aware that it needed to obtain information or conduct enquiries.

The current obligations to make decisions within a two or six month timeframe could be rewritten as obligations to communicate decisions in writing within that timeframe.[21]

The revised versions of clauses 5.48 and 5.49 could state that they apply 'unless there are Circumstances Beyond Our Control'.

We consider that the CBOC exception set out in clause 5.47 at present ought not apply to provisions in section 5 other than clauses 5.48 and 5.49. The CBOC exception can be built into clauses 5.48 and 5.49 as suggested above, and clause 5.47 can be deleted.

Claims where clauses 5.59 and 5.60 apply

If there are CBOC, clauses 5.59 and 5.60 merely require the insurer to give the claimant information and – in cases of long delay – to also conduct and report on a review. The Code does not set any revised timeframe for making a decision in this scenario.

To reduce delay in claims affected by CBOC, we suggest the Code includes new provisions for these claims, requiring the insurer to:

- take reasonable steps to complete information gathering and enquiries promptly (within timeframes aligning with clause 5.48 and 5.49)

[20] 'Circumstances Beyond Our Control' is defined in section 9 of the Code.
[21] This would be consistent with the previous version of the Code, which required decisions to be communicated in writing within the two or six month timeframe.

- make and communicate in writing a decision on the claim within a specified number of days after completing information gathering and enquiries.

Reducing timeframe in clause 5.50

AFCA suggests reducing the timeframe in clause 5.50 from 15 to 10 business days. In the previous version of the Code, the equivalent timeframe was 10 business days.

Clause 5.50 operates to ensure the insurer communicates a decision in writing promptly from the date it has received all the information required to make a decision. It applies at any stage of the claims assessment process.

Requiring timeframes for claim payments

AFCA suggests the Code set a timeframe for prompt payment of claims that are not for ongoing income-related benefits.

Clause 5.63 states a timeframe for payment of ongoing income-related benefits. An equivalent provision for other claims is needed. We believe it is appropriate to require an insurer to pay benefits within five business days of receiving bank account details.

Clear timeframe for insurers to request information

AFCA suggests clause 5.13 is modified to set a more specific timeframe for information requests made by insurers.

Clause 5.13 requires requests to be made 'as soon as possible'. We consider it would be appropriate to also specify an upper limit of five business days. The provision could be reworded as a commitment along these lines:

> 'We will ask for information we reasonably need from you and third parties as soon as possible and no later than five business days from the date we reasonably should have been aware the information was needed. We will minimise multiple information requests.'

Reducing timeframe for reports from independent medical examiners

AFCA also suggests reducing the timeframe in clause 5.23 from 20 to 10 business days – again, to reduce delay. This would be consistent with the 10 business day timeframe in clause 4.6 at present.

5.2.5 Greater clarity around group policies

AFCA suggests that the Code require:

- insurers to communicate to consumers, in clear terms and plain language, the respective roles that the insurer and the group policy owner play in decisions and communications
- a single, clearly nominated contact for consumers during the claims process

- the insurer be the contact during the claims process in respect to group employer policies.

Group life insurance in superannuation is the main way that Australians hold life insurance.[22] There are other types of group policies that are also covered by the Code, such as:

- group employer policies (where the employer takes out a group policy providing salary continuance cover to employees)
- self- managed superannuation fund group policies.

The application of the Code obligations in relation to group policies can be complex. The Code often notes that certain clauses do not apply to these policies, which can leave consumers unclear about who is responsible for what. The split in responsibility can lead to fragmented communication and contribute to service delays.

Consumers need clarity about the roles and responsibilities of the group policy owner and insurer. This is particularly important during the claims process, which can be a time of heightened consumer stress and complex evidence gathering, and where delays should be avoided.

In the case of group employer policies, the employee claimant would benefit from having the insurer as their direct contact when the claimed condition is allegedly caused by the employer. Insurers have greater experience and knowledge of the claims process, progress and policy terms, enabling them to inform and assist claimants more effectively.

The Code will also need to be updated to work alongside new superannuation service standards to ensure alignment, appropriate cross referencing and plain language explanations for unavoidable differences.

5.3 Complaints handling

To upgrade complaint resolution arrangements, AFCA suggests these measures:

- state a commitment to comply with RG 271 prominently in the Code
- ensure the Code reflects key standards in RG 271 and supports the use of complaint information to drive systemic improvements
- respond to delays in complaints handling (a recurrent issue in AFCA complaints).

[22] For example, in its Life insurance in focus report of September 2023, CALI stated that the majority of lives insured are insured through superannuation.

5.3.1 Internal dispute resolution: Alignment to ASIC's Regulatory Guide 271

RG 271 sets the standards for IDR in the financial services sector and includes standards to ensure complainants can pursue complaints through to EDR at AFCA where necessary.

Clause 1.13 of the Code permits a broad range of organisations to become subscribers and some potential subscriber categories would not be subject to RG 271.

AFCA recommends the revised Code include:

- a commitment that insurers comply with RG 271, noting that other industry codes, including the Banking Code and the GI Code, state commitments to comply with RG 271[23]
- changes to align Code commitments with RG 271 and ensure that:
  - anyone who may have a complaint can easily access complaint processes
  - keeping complaint processes as simple as possible.

The following two examples illustrate some discrepancies between RG271 and the Code.

Example 2: Facilitating complaints

RG 271.131 says 'firms should encourage complaints and make it easy for people to voice their concerns'. The complaint provisions in section 7 of the Code open with this statement, in negative terms: 'We will not discourage you from making a complaint' (in clause 7.1).

We note that the 2016 version of the Code described complaint rights in positive, broad terms (in clause 9.1): 'You are entitled to make a complaint to us about any aspect of your life insurance policy, claim or customer experience with us, or with one of our authorised representatives or independent service providers'

We also note that the current version of the GI Code's complaint provisions open with this positive statement: 'You may complain to us about any aspect of your relationship with us' (in paragraph 139).

Example 3: Keeping complaint processes simple

RG 271.134 states that an IDR process must be easy to understand and use. Clause 1.21 of the Code states:

[23] See Banking Code paragraph 195 and paragraph 141.

‘If you make a Complaint about an Independent Service Provider, we will follow our internal Complaints process unless we are satisfied the Independent Service Provider has a comparable process of an equivalent standard. We will tell you whether we or the Independent Service Provider are dealing with your Complaint.’

The IDR process in this scenario hinges on an insurer’s assessment comparing the standards of two complaint processes. The complainant needs to wait to be told how their complaint will be handled.

While the Code does not need to repeat provisions of RG 271, we recommend it reflect its key standards. For example, we suggest the Code commits insurers to giving consumers ready access to complaint procedures and policies in accordance with RG 271.172. The new commitment could be modelled on paragraph 140 of the GI Code.

5.3.2 Using complaint information to drive improvement

AFCA suggests adding a Code commitment for insurers to use complaint information to enable systemic improvements.

This commitment could help to address issues identified in ASIC’s recent review of the direct sale of life insurance[24]. ASIC observed from the review that some life companies had:

- limited information sharing about complaints between internal teams
- insufficient standards for analysing complaint trends and root causes to identify systemic issues
- performed only limited evaluation of the effectiveness of changes that had been introduced to address previously identified issues.

We acknowledge RG 271 already imposes comprehensive obligations to identify, analyse and address systemic issues. A new overlapping commitment is suggested to give clear support to the goal stated in clause 1b) of the Code – for insurers to continuously improve their services. This could apply to all complaint information that could drive improvement, without being confined to systemic issues.

6. Consumer centred design and processes

This section identifies a range of opportunities to update the Code to more effectively respond to known barriers and frictions, improve consumer outcomes and adopt a more nuanced and contemporary approach to situational vulnerability.

At the time of a claim on a life insurance policy, every claimant is likely to be experiencing some form of vulnerability as they deal with complex and life changing

[24] For more detail, see ASIC’s Letter to the CEOs of regulated life insurers, friendly societies and distributors , 18 August 2025.

events, unemployment, illness, disability or grief after the loss of a loved one. Bringing that lens to consumer engagement at all stages of the product and service life-cycle will guide insurers on how best to meet the diverse needs of their customers.

6.1 First Nations consumers

First Nations consumers purchase life insurance products to benefit from the economic protections they offer. In practice, these protections too often fail to deliver. AFCA's complaints experience shows that First Nations consumers have:

- endured systemic failures and harmful practices in their dealings with life insurers
- continued to face significant barriers when engaging with life insurance
- experienced poor outcomes, likely significantly underrepresented in AFCA data.

In the five years to June 2025, and excluding the ACBF/Youpla complaints which comprised 489 or 78% of the 626 LI Complaints to AFCA, First Nations people lodged:

- 137 LI Complaints, most of which were about IP and term life products, with delays in claims handling and claim denials as the top two issues
- 201 Super Complaints, with the top two issues also being delay in claim handling and denial of claim; and TPD topped the most complained about product, followed by IP.

See **Appendix A** for data on complaints from First Nations consumers.

The insights that follow are drawn from AFCA complaints and direct engagement with First Nations peoples, communities and representatives, including financial counsellors and community lawyers. Case experience and feedback shows:

- consumers and their families who, at a time of grief, claim on an insurance policy, only to find that the policy that was sold was not fit for purpose (examples include family members finding cover is not available because the policy was an accidental death and serious injury policy, not, as they had believed, a life insurance or funeral insurance policy)
- insurers miss opportunities to explain policy coverage in accessible and culturally safe terms
- poor interactions with life insurers and gaps in cultural understanding and customised support that amplifies harms
- limited awareness or understanding of life insurance entitlements resulting in eligible people not making claims where they have an entitlement under a policy
- poor or absent communication and engagement strategies
- people failing to receive support to help with phone, digital or other accessibility barriers, including access to financial counsellors or health professionals.

We note a recent report from Super Consumers Australia, MobStrong Debt Help, and Impact Economics & Policy which highlights similar issues in superannuation customer service. The report found that inadequate and culturally insensitive practices, such as unclear communication and offensive or inappropriate interactions, create significant barriers for members, particularly those in remote Aboriginal communities.[25]

We consider it imperative that this Code Review respond to the needs and aspirations of First Nations people and sets clear, strong and actionable standards.

We recommend the Code developers work closely with First Nations representatives and/or organisations with relevant expertise, to design and deliver on commitments to improve outcomes for First Nations consumers. This includes:

- documenting specific Code commitments in a Reconciliation Action Plan
- introducing measures inviting consumers to identify as First Nations consumers
- strengthening standards to support a clear, consistent approach to documentation and identification
- enhancements to training, communication and engagement.

6.1.1 Document commitments to First Nations consumers

We recommend including a specific Reconciliation obligation which documents Code commitments to First Nations consumers in a Reconciliation Action Plan.

6.1.2 Measures supporting identification of First Nations consumers

Knowing if a consumer identifies as First Nations is foundational to delivering a culturally appropriate service. We recommend Code commitments that encourage identification of First Nations consumers to improve service delivery. These include measures to encourage insurers to:

- ask consumers whether they identify as First Nations, making it clear that it is optional to respond
- explain that insurers ask for identifying information to help deliver flexible and tailored services
- obtain appropriate consumer consents (for example to retain the information)[26]

[25] Building Futures Not Barriers: Superannuation that works, July 2025.
[26] The 2023/4 review of the GI Code of Practice made a similar recommendation. See Recommendation 32: GI Code Independent Review: Final Report, December 2024.

- use postcode-level demographic data to identify opportunities to better serve First Nations consumers; an approach supported by ASIC.[27]

6.1.3 Enhancements to training, communication and engagement

Cultural competence is central to delivering safe, respectful and accessible services, reducing miscommunication, misunderstanding or harms.

While the Code contains an obligation to provide cultural awareness training for staff who regularly help customers in remote Indigenous communities (cl.6.16), we consider this is too narrow and recommend it be broadened.[28] Most First Nations people live in major cities and inner-regional areas, not remote communities[29]. Cultural competence training is also relevant to non-customer facing staff, including staff engaged in product design and distribution and in claims and complaints processes.

AFCA suggests the Code could better support First Nations consumers by:

- requiring cultural competence training for staff whose work is likely to impact First Nations people, with training developed in partnership with First Nations representatives and/or organisations and to include content on cultural practices relevant to life insurance (for example, Sorry Business and First Nations kinship systems)[30]
- encouraging the use of a dedicated phone line for First Nations consumers to speak directly to a staff member with appropriate cultural competence training
- clarifying that interpreting services includes interpreting for Aboriginal and Torres Strait Islander languages[31] and that if an interpreter is not reasonably available, insurers use best efforts to ensure consumers can understand and act on information (for example providing, where appropriate, simple English summaries, audio-visual guides, visual materials or referrals to sources of assistance)
- requiring information about services and supports for First Nations consumers to be on the insurer's website as well as available through other communication channels (for example, marketing collateral). We note the Code currently only requires insurers to have easy to find website links to information for Aboriginal and Torres Strait Islander consumers (cl.6.8)
- engaging with First Nations consumers from a position of strength rather than deficit

[27] See ASIC *REP 785 Better banking for Indigenous consumers | ASIC*, 15 July 2024 and *REP 806 Taking ownership of death benefits: How trustees can deliver outcomes Australians deserve | ASIC*, March 2025.
[28] The 2023/4 review of the GI Code made a similar recommendation. See Recommendation 33: GI Code Independent Review: Final Report, December 2024.
[29] 40.8% of Aboriginal and Torres Strait Islander people live in major cities, 24.8% in inner regional areas and 19% in outer regional Australia. Only 15.4% live in remote or very remote parts of Australia. Australian Bureau of Statistics) Estimates of Aboriginal and Torres Strait Islander Australians, 30 June 2021 accessed 16 October 2025.
[30] This recommendation is consistent with those made in the recent Life CCC publication Supporting Aboriginal and Torres Strait Islander Customers - LCCC, 8 December 2025.
[31] This was Recommendation 34 in the 2023/4 review of the GI Code. See GI Code Independent Review: Final Report, December 2024.

- monitoring, learning and reporting on outcomes for First Nations consumers.

6.1.4 Strengthening practical commitments for First Nations consumers

We also recommend amending clause 6.17 of the Code to create an affirmative obligation on insurers to provide practical supports for First Nations consumers who live in regional, remote or very remote areas, a cohort of consumers who experience more exclusion and accessibility barriers than the wider Australian population.[32]

The current provision requires that, during underwriting and claims process, insurers consider the difficulties that people in these communities face in meeting timeframes to provide documents or to take part in assessments. The obligation appears to only go as far as awareness, rather than requiring actions to mitigate barriers.

We recommend the Code include provisions requiring insurers to:

- offer additional flexibility for consumers in remote and regional areas,[33] such as:
  - extending timeframes to prepare documents
  - funding or arranging necessary travel and accommodation
  - offering equivalent offline and low-data pathways
  - adopting a 'resolve at first contact' approach to minimise repeat touchpoints, progress an inquiry and minimise resolution delays.
- make best efforts to address digital-exclusion barriers, including lack of phone, internet, data or devices, and provide equivalent offline pathways (for example, a commitment to undertaking programmed in-person visits)
- monitoring outcomes to iterate and make improvements over time.

6.1.5 Strengthening obligations to help with identification and documentation requirements

Complex paperwork requirements and inflexible procedures can create overwhelming barriers for First Nations consumers, particularly where people may lack formal identification documents.

The Code currently requires insurers to adopt flexible approaches to meeting verification and identification requirements, in line with AUSTRAC guidance (cl.6.14). We consider that this commitment needs to be strengthened, particularly following the recent Life CCC report which found that some insurers have not fully integrated AUSTRAC guidance into their frameworks.[34]

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[32] 15.4% of Aboriginal and Torres Strait Islander peoples live in remote or very remote parts of Australia, compared to 1.4% of non-Indigenous peoples. Similarly, 43.8% of Aboriginal and Torres Strait Islander peoples live in regional areas compared to 25.2% of non-Indigenous peoples. Australian Bureau of Statistics , Estimates of Aboriginal and Torres Strait Islander Australians, ABS Website, 30 June 2021 accessed 16 October 2025.

[33] This was Recommendation 35 in the 2023/4 review of the GI Code. See GI Code Independent Review: Final Report, December 2024.

[34] Supporting Aboriginal and Torres Strait Islander Customers - LCCC, 8 December 2025.

AFCA recommends that the Code require insurers to:

- update policies and procedures to explicitly and consistently address the barriers some First Nations people face with identification
- adopt consistent approaches to meeting verification requirements to satisfy a claim (including accepting alternative forms of identification where standard forms are not available)
- empower staff to deliver tailored solutions, including reasonable departures from standard procedures
- provide clear alternative pathways for staff to resolve issues quickly.

6.2 Consumers experiencing vulnerability

AFCA suggests refreshing and updating Code obligations to reflect community expectations and contemporary practice to support people experiencing vulnerability.[35]

6.2.1 Identifying and understanding consumer vulnerability

We recommend updating the Code to reflect contemporary approaches and developments centring the human experience and recognising situational vulnerability. We suggest amending the current Clause 6.1 which states customers may experience vulnerability due to circumstances specified in a list, which is, in effect, the Code's definition of vulnerability (which is not defined in section 9).

We recommend the Code adopts a broad and contemporary approach to vulnerability, noting other examples, such as:

- The broad definition of vulnerability recommended in the latest review of the GI Code: 'where someone who, due to their personal circumstances and market practices, is especially susceptible to harm'[36]
- The definition of 'consumer vulnerability' in the International Standard ISO 22458: 'state in which an individual can be placed at risk of harm during their interaction with a service provider due to the presence of personal, situational and market environment factors'[37].

The list of circumstances in clause 6.1 is stated as an exhaustive list. We recommend moving away from such an approach. If a list of factors is considered useful, we suggest reframing it as an inclusive list of factors that may result in, or amplify existing vulnerabilities, such as bereavement, housing insecurity, trauma, elder abuse or barriers arising from geographical location.

[35] Appendix A sets out data on complaints submitted to AFCA by consumers experiencing vulnerability.
[36] See Recommendation 20 GI Code Independent Review: Final Report, December 2024.
[37] International Standard ISO 22458, *Consumer vulnerability – Requirements and guidelines for the design and delivery of inclusive service.*

6.2.2 Keeping policies and training up to date

We suggest the Code commits insurers to regularly updating the policies and training referred to in clause 6.15 to accord with best practice. We consider that the vulnerability provisions of the Code need to ensure insurers can and do proactively identify and respond to vulnerability. This hinges on the effectiveness of the policies and training referred to in clause 6.15.

6.2.3 Communicating effectively and sensitively

We suggest redrafting clause 6.10 as a commitment to encourage consumers to discuss their circumstances and any need for additional support, or to require insurers to ask specifically in claim forms whether any additional support is required in the handling of the claim.

Clause 6.10 begins 'We encourage you to tell us about your vulnerability…'. We recommend amending this drafting. Service delivery should focus on accessibility and inviting a person to identify any support they may need and avoid the use of a label that may be a barrier to help-seeking.

6.2.4 Accepting valid authorities

We suggest clause 6.13 include a commitment to ensure processes are flexible enough to recognise any valid authority of a support person or representative.

A recurring issue in financial services complaints over the years has been financial firms creating unnecessary barriers in accepting authorities from consumer representatives. Given this issue and the importance of supporting people who may be experiencing vulnerability, we are concerned that current wording of clause 6.13 includes the qualification 'where possible'.

6.2.5 Responding effectively to family violence

Strengthening requirements for family violence policies

We suggest replacing clause 6.6 with a new provision to state an insurer will comply with, and publish on its website, a family violence policy that:

- reflects good industry practice
- covers key areas (specified in the new provision)
- is regularly reviewed and updated.

At present, clause 6.6 merely requires an insurer to publish a family violence policy without setting any standards for the policy to meet.

CALI's recently released *Best Practice Guidance – Family and Domestic Violence Policies* could provide a model. We note CALI's website says the guidance 'sets out

what should be covered in' an insurer's family and domestic violence policy.[38] This statement goes beyond the obligations currently imposed in the Code.

Designing-in protections to reduce known consumer risks

AFCA suggests that, for new policies, the Code require insurers to design-in features to reduce the risk of family violence by:

- requiring an insurer to obtain consent in writing from anyone who is included as an adult life insured under a policy but is not the policy holder
- enabling the consent to be withdrawn through a process that does not itself present risks for a person affected by family violence.

We support CALI's guidance which acknowledges the need for such design features and encourages insurers to build consent arrangements into non-group policies.

Case Study 4: Safety concerns that could not be dealt with at AFCA

A complainant obtained a family violence intervention order against her estranged partner. She later became aware that her former partner held a life insurance policy in which she was the life insured and he was the sole beneficiary. This heightened her concern about her safety and wellbeing. The complainant asked the insurer to remove her from the policy but was told it could not do so because she was not a policy holder. A complaint was submitted to AFCA but was excluded. The complainant's former partner did not consent to the submission of the complaint and AFCA decided it was not appropriate to consider the complaint without that consent.[39]

We consider that introduction of a consent requirement into the Code could address this issue. A person unwilling to continue to be a life insured could take action safely by withdrawing consent. Insurers would be better placed to protect consumers and this would support early resolution of complaints.

To ensure the position is certain from the outset, we suggest the Code could require an application for insurance to include:

- the consent of any adult (other than the policy holder) named as a life insured under the policy
- a declaration from the policy holder acknowledging that the life insured has the right to withdraw consent to being a named insured at any time, as a pre-condition to issuing the policy.

To provide adequately for withdrawal of consent, the Code could require the insurer to incorporate terms in the PDS/policy to make clear:

[38] Under Our Policies – Family and domestic violence.
[39] AFCA excluded this complaint under AFCA Rule C.2.2(i). Similar complaints could also be excluded under other rules, for example B.2.1(a) or B.2.1(c).

- any withdrawal of consent is to be in writing and provided directly to the insurer
- an insurer that receives a withdrawal of consent is to keep that document and notify the policyholder of the withdrawal
- if there is no remaining life insured under a policy after a withdrawal of consent, the policy can automatically end.

Where the new process results in a policy cancellation, the Code could also require the insurer to give written notice of the cancellation to all lives insured under the policy.

Reducing risks associated with existing policies

For existing policies with one policy owner and a different life insured/s, we suggest the Code requires the insurer to:

- notify in writing the life insured/s of a policy cancellation
- offer the life insured/s the option of taking up a policy with continuous cover and without any requirement for underwriting.

For existing policies with more than one policy owner, we suggest the Code require the insurer to:

- notify in writing all policy owners of a request from another policy owner to cancel the policy
- offer new separately held policies so that each policy owner holds a policy on their own life with continuous cover and without any requirement for underwriting.

Preventing perpetrators from benefitting financially

AFCA supports work to explore measures to prevent perpetrators of family violence from using policies to obtain financial benefits unfairly. The Code could include a commitment to apply the forfeiture rule and the mechanism of payment of a benefit into court under section 215 of the *Life Insurance Act 1995* (Cth).

6.2.6 LGBTQIA+ consumers

AFCA suggests the Code Review and developers engage the LGBTQIA+ community, including advocates and representatives, to respond to consumer harms faced by LGBTQIA+ community members. This will ensure products and processes respond appropriately to community needs and that product design and innovation processes identify areas where existing commitments need amending or updating.

AFCA's case experience is limited in this area, but feedback we have suggests that community members have suffered harms from insensitive, intrusive or inappropriate underwriting and claims processes.

6.2.7 Financial hardship

Our complaint resolution experience indicates that offering a premium pause for up to six months would help insureds in circumstances of financial hardship.

Current Clause 6.18 lists options including – in c) – not collecting a premium 'for a short time'. AFCA suggests replacing 'a short time' in clause 6.18c) with wording such as 'up to six months'.

7. Code Governance, Compliance and Review

7.1 Incorporate non-financial harm into Significant Breach definition

AFCA suggests the definition of Significant Breach in the Code be expanded to cover non-financial loss.

Currently, four factors are to be considered when deciding whether a Code breach is significant and non-financial loss is not one of these.[40]

Consumer harm resulting from a breach of the Code is not limited to financial loss. Non-financial consequences can also be substantial, and we recommend that this be recognised in the Code. AFCA often awards compensation in life insurance complaints for non-financial loss. Examples include excessive delays in claims handling, unreasonable information requests, poor communication in sensitive contexts and breaches of privacy.

7.2 Bolster sanctions

AFCA recommends enhancing sanctions for Code non-compliance through the following measures:

- the Code make clear that sanctions can apply to a serious individual breach allegation, not just significant breaches
- remove restrictions around the award of a community benefit payment
- the suite of available sanctions to include fines, reporting to a regulator, as well as expulsion as a signatory to the Code and from CALI.

Serious individual breaches

AFCA suggests the Code is revised to empower the Life CCC to sanction individual breaches in cases of serious misconduct that result in material harm or pose systemic risk.

At present, the Life CCC lacks the power to sanction individual breaches, regardless of severity of misconduct. Sanctions are restricted to Significant Breaches, leaving

[40] The four factors are set out in the definition of Significant Breach in section 9 of the Code: (a) number and frequency of previous similar breaches, (b) actual or potential financial loss (c) impact on ability to provide services and (d) extent to which the breach suggests arrangements to ensure compliance with Code obligations are inadequate.

serious but isolated breaches unaddressed. This gap could undermine the Life CCC's ability to hold insurers accountable and weakens public trust in its enforcement framework.

Community benefit payments

Under clause 8.21e) of the Code, an insurer can be required to make a community benefit payment of up to $100,000 to a charity as a sanction for a significant breach of the Code.

Clause 8.4 of the Life CCC Charter places numerous restrictions on community benefit payment sanctions, including that it should not be made in cases where the Code breach has been reported or is reportable to ASIC.

The restrictions in the Life CCC Charter do not exist in the GI Code or the General Insurance Code Governance Committee (CGC) Charter, and they are unduly limiting. This is particularly so in connection with ASIC reportable Code breaches. A community benefit payment is likely to be imposed for more serious contraventions of the Code. More serious Code contraventions are also more likely to be reportable to ASIC. Given that ASIC reportable matters are excluded from receiving a community benefit payment, the effectiveness of this sanction is significantly diminished.

We suggest the Review consider if the restrictions in the Life CCC Charter are necessary, noting they reduce the effectiveness of the community benefit framework.

Additional sanctions

Clause 8.21 of the Code lists the sanctions that the Life CCC can impose on an insurer.

Fines, expulsion as a code signatory, and expulsion from the industry association are not sanctions that are currently available to the Life CCC, but they are included in the ACCC's Guidelines for developing effective voluntary industry codes of conduct.[41] AFCA recommends that these sanctions be added to the suite of Life CCC enforcement tools.

AFCA also believes reporting the relevant breach to ASIC or another regulator should be provided for in the Code to further support transparency and accountability.

7.3 Improve transparency through named reporting

AFCA suggests that the Life CCC publish insurer names in regular compliance and data reports and have the discretion to do so in determinations.

By publishing reports and findings, including breach data, the LCCC must be able to call out areas requiring careful review and action. For full transparency, we call for

[41] ACCC Guidelines for developing effective voluntary industry codes of conduct, July 2011.

named reporting, which can assist in highlighting outliers and encourage greater compliance in, and help lift standards across, the industry.

While the Life CCC has the power to sanction an insurer by publicly naming them for having made a significant breach, AFCA recommends that the Life CCC be able to name an insurer in determinations, data and enquiry reports. This could drive improvement, for example by:

- making insurers more accountable for their conduct, driving better compliance
- improving transparency, demonstrating the independence of the Life CCC and increasing trust in the model for regulation under the Code
- enhancing protection for consumers by giving them more information to guide decisions
- enabling the code to meet community expectations and reflect current developments in the financial sector
- helps to lift standards and build trust in the life insurance sector.

Named reporting by the Life CCC would align with contemporary practice, including reporting by bodies such as ASIC and AFCA. We note the report on the latest review of the GI Code recommended named reporting be permitted in the general insurance context.[42]

7.4 Flexibility to keep the Code relevant

The Code currently requires the industry to commission an independent review of the Code at least every three years (clause 8.1 b)). This obligation relates only to the commissioning of the review, not to its completion.

AFCA supports greater clarity in timeframes to prevent excessive delays in between updates to the Code.

AFCA suggests commitments in the Code for CALI to:

- conduct an independent review so it is completed within five years from when the previous independent review report was finalised[43]
- conduct a review of the Code or specific sections of the Code between independent review cycles where there is an urgent issue or need to update the Code.[44]

[42] See Recommendation 96: The CGC should publish insurer names in regular compliance and data reports. GI Code Independent Review: Final Report, December 2024.
[43] This is consistent with statutory requirements for ASIC-approved codes set out in section 1101AB of the *Corporations Act* 2001 (Cth). ASIC's RG 183, at 183.89, outlines that the review must be completed within five years of the day the code of conduct was approved by ASIC (for the first review) or within five years of the day that the report of the previous review was provided to ASIC (for subsequent reviews).
[44] This suggestion aligns with the Banking Code and RG 183.92.

This ensures timely reviews and enables a targeted and responsive approach to updating the Code to respond to high-impact or emerging consumer issues and regulatory developments.

7.5 Coordinate Code and Charter updates

AFCA recommends that a review of the Life CCC Charter coincide with the independent review of the Code and that the Life CCC has power to recommend changes to its Charter.

There are areas of overlap in the Code and the Life CCC Charter. For example, in respect of sanctions:

- clause 8.18 of the Code and 8.2 of the Charter set out the process for imposing a sanction
- clause 8.20 of the Code and clauses 8.1 and 8.5 of the Charter set out factors that the Life CCC is to consider when deciding any sanction
- clause 8.21 of the Code and clause 8.3 of the Charter list the sanctions that can be imposed on an insurer.

Duplicate obligations in two documents can create confusion and the risk of inconsistency, particularly if one is updated and the other is not.

The Life CCC is well placed to draw on practical experience to provide expert advice on how its Charter can be updated to support it to function as effectively as possible. We note that section 1.4(b) of the 2025 CGC Charter allows the CGC to provide advice on amendments to the Constitution or the Charter.

7.6 Promises and key principles

Overarching service promise made by subscribers

AFCA supports moving the ten promises on page 4 of the Code so that they are set out in a numbered Code provision. This would make clear that the promises are enforceable and subject to monitoring by the Life CCC.

The present approach of stating the service promises in an introduction to the Code creates doubt as to whether the promises are enforceable or merely aspirational.

Key principles

AFCA suggests rewriting the statement of key principles in clause 1.6 to make clear they enhance enforceable provisions of the Code as well as informing the service promise on page four. Clause 1.6 could explain that the principles form the basis of obligations in numbered Code provisions or are factors to be considered when interpreting those provisions.

Appendix A - AFCA complaint data

This Appendix contains data on life insurance complaints (LI Complaints) and relevant superannuation complaints (Super Complaints) received by AFCA in the five financial years from 1 July 2020 to 30 June 2025.[45]

LI Complaints data captures complaints where the product line is identified as life insurance. This includes data about life insurers who have not subscribed to the Code. In particular around 14.5% of LI Complaints concern entities in the Youpla Group,[46] who were not Code subscribers. Therefore, we have also isolated data about LI Complaints that do not involve Youpla (LI Exc Youpla).

Super Complaints data captures complaints where the product line is identified as superannuation and the product complained about is TPD, IP, term life and terminal illness. AFCA also receives complaints about death insurance cover in superannuation; however, these are very rare and therefore they have not been included in the data.

All LI and Super Complaints FY2020-21 to FY2024-25

Complaint volumes

Table 1: LI Complaints and Super Complaints volumes FY2020-21 to FY2024-25

Year	Complaints received[47]			Complaints accepted[48]		Complaints closed	
	LI	LI Exc Youpla	Super	LI	Super	LI	Super
2020-21	1,622	1,497	1,767	1,153	1,556	1,578	1,830
2021-22	2,485	1,669	1,774	1,361	1,477	1,878	1,761
2022-23	1,891	1,550	1,905	1,001	1,405	1,461	1,844
2023-24	1,424	1,416	2,132	909	1,668	1,408	2,078
2024-25	1,441	1,440	1,656	1,803	1,279	2,428	1,818
Total	**8,863**	**7,572**	**9,234**	**6,227**	**7,385**	**8,753**	**9,331**

[45] Complaint numbers in this submission are based on the latest data available at the time of compilation. As complaints progress and/or new information is received, complaints may be reclassified. For this reason, there may be small variances between data in the submission and data in AFCA's Annual Reviews.
[46] Entities in the Youpla Group are ACBF Funeral Plans Pty Ltd (In liquidation), Aboriginal Community Benefit Fund No 2 Pty Ltd (In Liquidation), The Aboriginal Community Benefit Fund Pty Ltd (In Liquidation), and Community Funeral Plans Pty Ltd (In Liquidation).
[47] Complaints 'received' refers to the total number of complaints received at AFCA's registration and referral stage.
[48] A complaint is 'accepted' by AFCA if it does not close in the first stage of complaint resolution – registration and referral – and progresses to case management.

Top five issues

Table 2: Top five issues in LI Complaints and Super Complaints received FY2020-21 to FY2024-25

LI Complaints		LI Exc Youpla		Super Complaints	
Issue	**Complaints received**	**Issue**	**Complaints received**	**Issue**	**Complaints received**
Misleading product/service information	1,270 (14.3%)	Delay in claim handling	1,025 (13.5%)	Delay in claim handling	2,855 (31%)
Delay in claim handling	1,028 (11.6%)	Denial of claim	942 (12.4%)	Denial of claim	1,713 (18.6%)
Denial of claim	945 (10.7%)	Incorrect premiums	884 (11.7%)	Claim amount	1,420 (15.4%)
Incorrect premiums	903 (10.2%)	Service quality	587 (7.8%)	Cancellation of policy	625 (6.8%)
Service quality	598 (6.8%)	Claim amount	530 (7%)	Incorrect premiums	335 (3.6%)

Top five products

Table 3: Top five products in LI Complaints and Super Complaints received FY2020-21 to FY2024-25

LI Complaints		LI Exc Youpla		Super Complaints	
Product	**Complaints received**	**Product**	**Complaints received**	**Product**	**Complaints received**
Income protection	2,737 (31%)	Income protection	2,736 (36%)	Total and permanent disability	5,136 (55%)
Funeral plans	1,767 (20%)	Term life	1,721 (23%)	Income protection	4,268 (46%)
Term life	1,721 (19.5%)	Total and permanent disability	1,139 (15%)	Terminal illness	173 (2%)
Total and permanent disability	1,139 (13%)	Whole of life	712 (9%)	-	-

LI Complaints		LI Exc Youpla		Super Complaints	
Whole of Life	712 (8%)	Trauma	495 (6.5%)	-	-

Complaints from First Nations consumers FY2020-21 to FY2024-25

The tables below contain data on LI Complaints and Super Complaints received by AFCA in the five financial years to 30 June 2025, where the complainant has self-identified as First Nations. Data on LI Complaints that do not relate to Youpla entities has also been isolated.

Complaint volumes - First Nations consumers

Table 4: Complaints received FY2020-21 to FY2024-25 – First Nations

Year	LI Complaints	LI Exc Youpla	Super Complaints
2020-21	124	24	33
2021-22	386	22	36
2022-23	53	30	36
2023-24	40	39	55
2024-25	23	22	41
Total	626	137	201

Top three issues - First Nations consumers

Table 5: Top three issues in complaints received FY2020-21 to FY2024-25 – First Nations

LI Complaints		LI Exc Youpla		Super Complaints	
Issue	Complaints received	Issue	Complaints received	Issue	Complaints received
Misleading product and service information	333 (53%)	Delay in claim handling	23 (17%)	Delay in claim handling	76 (38%)
Unconscionable conduct	60 (9.6%)	Denial of claim	20 (14.5%)	Denial of claim	38 (19%)

LI Complaints		LI Exc Youpla		Super Complaints	
Interpretation of product terms and conditions	32 (5%)	Cancellation of policy	16 (12%)	Claim amount	26 (13%)

Top five products – First Nations consumers

Table 6: Top five products in complaints received FY2020-21 to FY2024-25 – First Nations

LI Complaints		LI Exc Youpla		Super Complaints	
Product	**Complaints received**	**Product**	**Complaints received**	**Product**	**Complaints received**
Funeral plans	512 (82%)	Income protection	42 (30%)	Total and permanent disability	116 (58%)
Income protection	43 (7%)	Term life	34 (25%)	Income protection	88 (44%)
Term life	34 (5.5%)	Funeral plans	24 (17.5%)	Terminal illness	4 (2%)
Total and permanent disability	19 (3%)	Total and permanent disability	19 (14%)	-	
Trauma	7 (1.2%)	Trauma	7 (5%)	-	

Additional assistance complaints FY2020-21 to FY2024-25

AFCA's complaint form asks the complainant whether they need to use the free telephone interpreter service we provide. It then asks the complainant whether we can provide other assistance, prompting them to refer to any relevant factors or conditions such as family violence, mental health, literacy and hearing. In other cases, AFCA staff may identify that a complainant needs special assistance.[49]

We note that in certain scenarios – such as early resolution – there may be no opportunity for requests or identification of special needs.

[49] For more detail, see 'Accessibility and support' on our website.

Our records flag complaints in which the complainant requested, or AFCA identified a need for, additional assistance. Flagged LI and Super Complaints are referred to below as 'Additional Assistance Complaints'.

The tables below present data on Additional Assistance Complaints received by AFCA in the five financial years to 30 June 2025.

Complaint volumes - Additional Assistance Complaints

Table 7: Additional Assistance Complaints received FY2020-21 to FY2024-25

	Complaints received		
	LI Complaints	**LI Exc Youpla**	**Super Complaints**
Total	**732**	**682**	**1,232**

Top three issues - Additional Assistance Complaints

Table 8: Top three issues in Additional Assistance Complaints received FY 2020-21 to FY2024-25

Issue	**Complaints received**		
	LI Complaints	**LI Exc Youpla**	**Super Complaints**
Delay in claim handling	145 (20%)	145 (21%)	425 (34.5%)
Denial of claim	140 (19%)	140 (20.5%)	269 (22%)
Claim amount	72 (10%)	72 (10.5%)	203 (16.5%)

This table shows the top three issues raised in the Additional Assistance Complaints to provide a broad indication of issues causing consumers experiencing vulnerability to pursue LI and Super Complaints through to EDR. Across LI and Super Complaints, the three top issues are the same, ranked in the same order.

Top five products – Additional Assistance Complaints

Table 9: Top five products in Additional Assistance Complaints received FY2020-21 to FY2024-25

LI Complaints	**LI Exc Youpla**			**Super Complaints**	
Product	Complaints received	Product	Complaints received	Product	Complaints received
Income protection	309 (42%)	Income protection	309 (45%)	Total and permanent disability	704 (57%)

LI Complaints	LI Exc Youpla			Super Complaints	
Total and permanent disability	136 (18.5%)	Total and permanent disability	136 (20%)	Income protection	562 (45.5%)
Term life	114 (15.5%)	Term life	114 (17%)	Terminal illness	21 (17%)
Funeral plans	92 (12.5%)	Trauma	53 (8%)	-	-
Trauma	53 (7%)	Funeral plans	42 (6%)	-	-

Appendix B – AFCA Systemic Issues data

This Appendix contains data on systemic issues (SIs)[50] that AFCA has reported to regulators[51] in the five financial years to 30 June 2025 in connection with life insurance and superannuation.

Unlike AFCA complaints data, superannuation SI data is generally not broken down by product type. However, a review of the 66 superannuation SIs indicates that about half (32) were about life insurance (two concern Code subscribers, while the rest concern superannuation trustees).

Systemic issues – volume

Table 10: Systemic issues reported to regulators FY2020-21 to FY2024-25

	Life	Super
2020-21	15	6
2021-22	4	8
2022-23	12	12
2023-24	2	16
2024-25	12	24
Total	**45**	**66**

Systemic issues – top ten issues

Table 11: Top ten issues in systemic issues reported FY2020-21 to FY2024-25

Life Issue	Count	Super Issue	Count
Policy interpretation	6	SIS Act	9
Increase in premium	5	Corporations Act	7
Application of legislation	3	Misleading conduct	7
Calculation of premium/bonus	3	Delay/error in superannuation rollovers	6
Cancellation of policies	3	Application of legislation	5

[50] AFCA uses the term 'systemic issue' to refer to an issue likely to have an effect on consumers in addition to any person who has submitted a complaint to AFCA. A SI may be raised in several complaints, a single complaint or otherwise be identified by information that we obtain.
[51] ASIC's Regulatory Guide 267 *Oversight of the Australian Financial Complaints Authority* requires AFCA to identify, refer and report systemic issues arising from complaints to regulators including ASIC, APRA and the ATO AFCA must also report any serious contraventions of the law and other reportable matters listed in section 1052E of the *Corporations Act 2001* (Cth).

Life Issue	Count	Super Issue	Count
Delays claims handling	3	Processing error	5
Misleading conduct	3	Delays in claims handling	4
Non-automated	3	Terms and conditions delivery	4
Terms and conditions	3	Cancellation of policies	3
Avoidance of policies	2	Policy interpretation	3
Direct debits	2	Account operations and features	2
Privacy Act and related legislation	2	Calculation of premium/bonus	2
Processing error	2	-	-