LIFE CODE review

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Life Code independent review

Interim Report

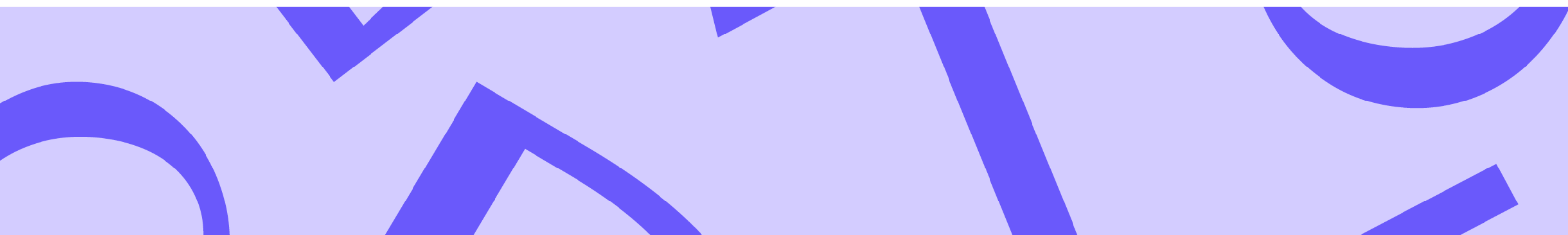
10 April 2026

Interim Report

About this paper

This is an Interim Report to guide stakeholder feedback on preliminary findings and potential areas for improvement in the Life Code

10 April 2026



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1. Background and process

The purpose of this Interim Report is to set out initial observations, findings and recommendations from the first phase of the independent review of the Life Insurance Code of Practice (the Code). This follows extensive consultation with stakeholders and consideration of written submissions. The Interim Report also contains additional questions on the issue of mental health. The Reviewer welcomes stakeholder feedback on these preliminary findings and potential areas for improvement to the Code.

Process and submissions

The 2025 independent review of the Code commenced on 1 October 2025. A Consultation Paper was published on 17 October 2025, with submissions requested by 15 December 2025. In total the Reviewer received 11 public submissions and three confidential submissions. Several submissions incorporate the views of multiple stakeholders (e.g. the Joint Consumer Groups' submission has input from 10 different organisations). The public submissions were published on the Life Code review website (www.lifecodereview.org.au) on 28 January 2026. The Council of Australian Life Insurers (CALI) provided a supplementary submission on 24 March 2026.

The Reviewer has held over 40 meetings with stakeholders to discuss the Code and issues in the review, including the life insurance industry, industry bodies, consumer representatives, regulators and government agencies, medical experts, legal practitioners, the Australian Financial Complaints Authority (AFCA) and the Life Code Compliance Committee (LCCC).

Overall stakeholder feedback is that the Code is structured appropriately and focuses on the right areas of consumer interaction with life insurers. There is recognition that it has contributed to improvements in the industry, for example in claims handling timeframes. The Code provides a foundation for the industry to build on its commitments to customers and increase consumer trust over time.

There is also a wide range of areas where stakeholders have identified opportunities to improve and strengthen the Code. Stakeholders have provided many recommendations for how the Code can be enhanced, both through improving existing obligations and through new requirements. In considering these, the independent Reviewer has been mindful of the objectives set out in the Terms of Reference:

- **Ensuring the Life Code is fit for the needs of today and the future.** Ensure the Life Code is meeting community expectations and needs of consumers, responds to changes in the regulatory environment and reflects good industry practice.
- **Enhancing the customer experience.** Ensure the Life Code provides certainty and makes it easier for customers to deal with life insurers, for example, when they buy insurance or make a claim.
- **Increasing consumer accessibility and usability of the Life Code.** Improve the understanding of or simplifying the Life Code without losing meaning or reducing consumer protection.
- **Ensuring the Life Code is effective, robust, and enforceable.** Ensure the Life Code delivers the promised consumer protections, while being operationally practicable for life insurers, the Life CCC, customers and other stakeholders.

Submissions that address the recommendations or proposals from the Reviewer are invited from any interested organisation or person by 8 May 2026. To help reduce effort, the Reviewer is not looking for a restatement of earlier submissions or feedback provided in response to the initial Consultation Paper.

Submissions are being accepted via the review's online submission page at lifecodereview.org.au/make-a-submission.

Submissions will be treated as public and published on the review website unless the submitter indicates clearly that they wish the submission to be treated as confidential. Further information about providing a confidential submission can be obtained from the review secretariat at secretariat@lifecodereview.org.au.

After considering responses to this Interim Report, and further engagement with stakeholders, the Reviewer will provide a final report to CALI by 30 June 2026.

Enquiries on this Interim Report or the review process can be directed to secretariat@lifecodereview.org.au.

2. Key areas for consideration

2.1. Mental health

The Reviewer has been asked to consider the effectiveness of the Code provisions relating to customers who are experiencing a mental health condition, including when buying a life insurance product or making a claim.

As outlined in the Consultation Paper, mental health is a key issue for the life insurance industry and its customers. Almost one in two Australians will have a mental health condition in their lifetime. Mental health insurance claims have risen significantly over the past decade, and on average the proportion of insured Australians who are permanently disabled due to a mental health condition has more than doubled.

Mental health featured prominently in submissions by all stakeholders. Issues were raised in relation to:

- clause 2.1(b) relating to blanket mental health exclusions in standard form contracts;
- individual underwriting for mental health conditions;
- communication to consumers about mental health and life insurance;
- claims handling for mental health conditions; and
- the utility of the current Appendix B in the Code as an appropriate way to summarise commitments to consumers experiencing mental health conditions.

CALI's initial submission of 15 December 2025 covered mental health, as well as range of other Code issues. On 24 March 2026, CALI provided a supplementary submission specifically on mental health, providing clarification and further detail on the industry's position on mental health commitments in the Code. Given the timing and significance of this submission, the Reviewer has set out some further consultation questions for stakeholders in this report.

In its submissions, CALI has highlighted the challenges with long-term affordability and financial sustainability arising from the increase in claims related to mental health. Data provided by CALI indicates:

- Mental health is now the number one reason why Australians are turning to life insurers to claim when they are permanently unable to work. Mental ill-health is now the driver for almost one in three TPD claims and one in four income protection claims;
- Life insurers are paying out $1.2bn more in mental health claims than they were five years ago; and
- the rate of mental health claims in 2024 was four times that rate of cancer claims and twice the rate of accident claims.[1]

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[1] CALI (24 March 2026) *Life Code independent review – CALI supplementary submission on mental health*, Life Code review website, p 4.

Running in parallel to the Code review, CALI is also undertaking a process to develop a sustainable disability insurance action plan.[2] The industry's stated aim is to ensure insurers can provide affordable, accessible disability insurance in a fair and transparent way.

Regulators and other stakeholders have highlighted this issue. For example, in relation to life insurance, the Australian Prudential Regulation Authority (APRA) has stated that "…growing levels of mental ill health require coverage solutions to address this previously neglected area."[3]

Consumer group submissions also emphasised the importance of the industry's approach to mental health cover and claims. For example, Super Consumers Australia said:

> *Mental health-related cover and claims are one of the most pressing consumer issues in life insurance. While insurers have raised concerns about rising mental health-related TPD claims, consumers face widely inconsistent and often harsh policy tests and conditions. The joint consumer recommendations in this area are among the most urgent and important for insurers.*[4]

In responding to the challenges of increasing rising mental health claims, the commitments in the Code should require insurers to treat customers with empathy and respect. Life insurers need to ensure that they have a fair and transparent approach when dealing with mental health in product design, when assessing applications for life insurance where the customer discloses a mental health condition or when assessing claims related to mental ill-health.

The Code can play an important role in setting out appropriate standards for the industry's approach to mental health. However, in considering the commitments in the Life Code, it is important to note that providing support for mental health in the community goes well beyond the provisions of the Code. There is wider consideration underway of how both the fair treatment of people with mental health conditions and sustainability challenges can be addressed. This includes access to treatment and support through the health system, in workers' compensation schemes and the National Disability Insurance Scheme.

The following discussion of mental health covers several areas:

- The industry's overall statement of commitment to appropriately deal with consumers experiencing mental health conditions;
- Mental health coverage in standard form insurance policies (i.e. how mental health is dealt with at a policy design level rather than individual underwriting). This includes a discussion of 'blanket exclusions' for mental health conditions;
- Individual insurance decisions relating to mental health coverage (individual underwriting); and
- Consumer information on mental health and insurance.

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[2] CALI (13 October 2025) *Life insurers commit to mental health action plan* [media release]. CALI website.

[3] Suzanne Smith, *'Think Bigger: The Power of a Thriving Insurance Industry'* (Speech, Actuaries Summit, 1 May 2024), APRA website.

[4] Super Consumers Australia (15 December 2025), *Supplementary consumer submission - Life Insurance Code of Practice review*, Life Code review website, p 2.

2.1.1. Statement of overall commitment on mental health

The current Code states that industry members “are committed to taking extra care to support customers with a Mental Health Condition” and are required to treat them and their family, carer or support person “with empathy, compassion and respect”. However, this statement currently sits in an appendix to the Code rather than as a key upfront commitment.

Given the significance of mental health issues in the community and for the life insurance industry, the Code should include a clear statement of commitment to appropriate treatment and support for people experiencing mental health conditions. This ‘statement of principle’ should be given a clearer and more prominent place in the Code rather than in Appendix B. This would provide the industry with an opportunity to set out its position on this issue more clearly. The statement could build on the existing commitments to take extra care and treat people with empathy, compassion and respect, which are in turn supported by specific commitments in the Code.

Recommendations

1. *The Code should contain a new overall industry commitment to dealing appropriately with customers experiencing mental health condition in Section 1 rather than in Appendix B.*

2.1.2. Standard form contracts and blanket mental health exclusions

Insurers have obligations under the *Disability Discrimination Act 1992* (Cth) (DDA) not to discriminate based on disability, including mental health. However, in recognition that insurance is a risk-based product, there is an exemption which allows an insurer to refuse insurance to a person with a disability or offer different price or terms for the policy, provide the discrimination is reasonably based on actuarial or statistical data, or, if data is not available, the discrimination is reasonable having regard to any other relevant factors.[5]

In this context, coverage of mental health conditions has come up in the review as both a general issue in insurance product design as well as in relation to the treatment of individual customers at the point of underwriting or claim. This section focuses on the former.

It has become evident during the consultation process that there are different views on the nature of the existing Code commitment in clause 2.1(b) relating to blanket mental health exclusions. This has implications for how the commitment on this issue should be framed going forward.

[5] Disability Discrimination Act 1992, section 46.

Blanket mental health exclusions – the current Code

Clause 2.1(b) requires insurers to design new products that:

> *do not incorporate a blanket exclusion specific to mental health in the general terms and conditions of the standard form contract, consistent with our obligations under the Disability Discrimination Act 1992 and equivalent State and/or Territory law.*

The primary difference in stakeholder positions on this clause related to whether the Code commitment: (1) allows blanket exclusions as long as these are consistent with the exemptions allowed under the DDA (and equivalent State and/or Territory law); or (2) prohibits blanket exclusions altogether. That is:

1. if clause 2.1(b) only represents a commitment to comply with the DDA, then insurers could include a blanket mental health exclusion in a policy provided it is supported by actuarial and statistical data, or other relevant data, in accordance with s 46 of the DDA; or
2. alternatively, if clause 2.1(b) represents a commitment that goes beyond the minimum requirements of the DDA, then blanket exclusions are not allowed.

It is apparent from submissions, stakeholder engagement, and past public statements by the industry association, that most stakeholders understand the current commitment in clause 2.1(b) as consistent with the second position. That is, clause 2.1(b) is seen as a statement that Code subscribers will go beyond minimum legal requirements and not include blanket exclusions in new standard form policies as a general practice (i.e. irrespective of actuarial or other relevant data). Instead, insurers would only apply exclusions or limitations on cover as a result of individual underwriting decisions. For example, the LCCC said their understanding is that "…the intent of the current Code is to move product design away from automatic exclusions in favour of individualised assessment and evidence-based underwriting."[6] In its supplementary submission, CALI acknowledges "…that clause 2.1(b) is widely understood to prohibit product terms and conditions in standard form contracts that exclude or limit coverage for mental health conditions above and beyond the requirements of the DDA."[7]

A second area where stakeholder views diverge concerns the definition of blanket exclusion. There is no statutory or agreed definition, and individual insurers and other stakeholders have interpreted this term differently. Several stakeholders support a broader definition that suggests any limitation on cover for mental health represents a 'blanket exclusion'.

The Reviewer accepts that the current Code is appropriately understood as representing a commitment by insurers to go beyond the minimum legal requirement of the DDA and not include blanket exclusions in new standard form policies. The issue then for the Code review is what should be the nature of the commitment in relation to standard form policies in a revised Code.

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[6] LCCC (December 2025) *Life CCC Submission to the Life Insurance Code of Practice Review*, Life Code review website, p 3.

[7] CALI (24 March 2026), p 8.

Going forward - limitations on mental health cover

CALI's supplementary submission clarifies and expands upon the industry's preferred position going forward. This would involve amending the Code to allow product design features that limit cover for mental health conditions in standard form contracts without individual underwriting, rather than prohibiting blanket exclusions altogether in standard form contracts. CALI recommends that the commitment for life insurers to comply with the DDA, which was in the 2017 Code, should be reinstated, which would mean that exclusions or limitations would be allowed if there is relevant supporting evidence. This is, in effect, a step back from the current commitment that goes beyond the requirements of the DDA.

In summary, CALI recommends that clause 2.1(b) should be removed, and that:

1. *The Life Code should be amended to reinstate an explicit commitment for life insurers to comply with the DDA, and any other State or Territory anti-discrimination legislation.*
2. *The Life Code should be amended, consistent with the DDA, to:*
    a. *permit sustainable product design features that limit cover for mental health conditions in standard form contracts without individual underwriting, and*
    b. *recognise that standard form contracts can offer different cover between mental health conditions and other causes of claim without individual underwriting.*
3. *The Life Code should be reviewed and strengthened to ensure transparency and support customer understanding about how sustainable product design features in the standard terms apply to them; and*
4. *Specific commitments within the Life Code should be reviewed and strengthened to ensure customer understanding and transparency about outcomes on their application for mental health cover.*[8]

The CALI submission sets out that the sustainable design features could include (but would not necessarily be limited to) higher premiums, financial limits or caps, benefit and/or assessment instalment designs, or waiting periods.

The industry position is based on a strong view that it will be financially unsustainable to deal with the growth and prevalence of mental health claims solely through individual underwriting decisions. CALI's supplementary submission contains a range of industry-level claims data as well as population health data to illustrate the growing impact of mental health conditions on insurance claims and the broad challenges this raises for the sustainability, affordability and accessibility of life insurance.

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[8] CALI Supplementary Submission on Mental Health, 24 March 2026, p3

Other stakeholders, for example the Joint Consumer Groups, support retaining and strengthening the prohibition on blanket mental health exclusions in standard form contracts. These submissions include proposals to expand the prohibition, for example through clarifying that the prohibition should apply to new sales of any underwritten product or reviewing all current policies to remove blanket exclusions. Some stakeholders also argue for a broad definition of 'blanket mental health exclusion'.

There are also several proposals to improve insurer compliance with the commitment, based in part on the findings of the recent LCCC report. This found that some insurers are "embedding broad exclusions for mental health conditions directly into their standard policy terms"[9].

Given the recent supplementary submission from CALI, and the divergence of views on blanket mental health exclusions, the Reviewer is seeking further feedback from stakeholders. This includes feedback on CALI's recommendations.

Questions and feedback

The Reviewer invites views on the issue of exclusions or limitations for mental health cover in standard form policies, in particular the industry position set out in CALI's supplementary submission.

1. *Would it be appropriate to change the current position set out in clause 2.1(b) to allow limitations on cover for mental health in standard form policies (consistent with the DDA) in light of the trends for mental health claims.*

2. *The impact the industry's proposed approach may have on consumers and insurers.*

3. *If the prohibition on blanket mental health exclusions was removed and design features in insurance policies that limit cover for mental health were permitted:*
    a. *How could the Code help ensure that such an approach was consistent with the requirements of the DDA*
    b. *Are there some general principles or 'guardrails' that should apply in the Code to ensure fair and transparent treatment of consumers experiencing mental health conditions as these design features are developed and implemented?*
    c. *Is there information that could be specified in the Code that would help ensure consumers understand why these policy features have been introduced and how they work?*
    d. *Is there information that could be specified in the Code that would help ensure consumers understand how policy features apply to their situation? (On this point, see the discussion below on individual underwriting)*

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[9] LCCC (September 2025) *Keeping the Promise: Mental Health and Life Insurance Commitments*, LCCC website, p 8.

2.1.3. Individually underwritten policies

In relation to individually underwritten policies, stakeholders have previously raised concerns about discrimination against people with mental health conditions in life insurance underwriting.[10] As noted above, insurers have obligations under the DDA not to discriminate based on disability, including mental health, but there is an exemption which allows an insurer to refuse insurance to a person with a disability or offer different price or terms for the policy, provided the discrimination is reasonably based on relevant data.

To address stakeholder concerns about discrimination, the 2023 Code introduced commitments for insurers to:

- provide consumers with an opportunity to provide information about their mental health condition before making a decision;
- consider a consumer's individual circumstances when deciding whether they can offer cover; and
- consider whether they can manage any additional risk through higher premiums, exclusions, limits, and caps rather than not provide cover at all.

The LCCC's 2025 review of how insurers are meeting these obligations[11] found that:

- insurers' underwriting guidelines for mental health too often default to exclusions or denials in response to a mental health disclosure for IP and TPD products, and they appear to be making underwriting decisions without giving sufficient consideration to other options for managing risk; and
- while the Code requires insurers to take into account the circumstances of individual customers, this rarely results in tailored outcomes.

Stakeholders have recommended that, where an insurer decides to decline cover or apply exclusions, consumers should be provided with, or be able to request, additional information on the reasons for the underwriting decision. In CALI's supplementary submission, recommendation 4 proposes that commitments to ensure customer understanding of outcomes on their applications for mental health cover be strengthened.

Most submissions on this issue have also suggested that the actuarial or other data relied on to make the decision should, in some form, be explained to the customer. For example, the Consumer Committee of the Law Council observed that "it is good industry practice (and procedurally fair) to ensure that when a decision is made that is adverse to the interests of a consumer, the consumer should be provided with a copy of any material relied upon to justify that decision."

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[10] For example: Public Interest Advocacy Centre (2021) *Mental Health Discrimination in Insurance*, Justice and Equity Centre website.

[11] LCCC (September 2025).

The Reviewer agrees that the Code should require insurers to provide consumers with more information when their application is declined or offered on non-standard terms. This requirement is covered in Section 4 of the Code (see clauses 4.22 regarding offers on alternative terms, and 4.25 regarding decisions to decline cover). Such information is to be provided within five days. There is scope to make this more accessible and transparent, and to ensure consistency across these two situations. The information should also be consistent as far as possible with the requirements in clauses 3.16-3.18 that explain insurers' obligations when they make a decision to vary or avoid cover for existing customers because of new information they have obtained.

This requirement should include:

- Clarifying that this information should be in writing.
- Aligning the information to be provided in an offer of alternative terms (4.22) with the information provided in a decision to decline cover (4.25), as far as possible. For example, in both situations the consumer should be given the reasons for the decision based on what the applicant disclosed and the risk of providing insurance, as well as the opportunity to correct information (4.25(c)).
- Instead of relying on the applicant to ask for information the insurer relied on to make the decision (4.25(b)), a plain English summary of the actuarial and statistical data or other relevant data the insurer has relied on for the decision should be provided. This would need to have sufficient detail to enable the consumer to understand the decision as it applies to their circumstances, not just a pro-forma or generic response.

Consumers would also benefit from clearer guidance on what they need to disclose in relation to existing or prior mental health issues at the time of application. Insurers generally ask broad questions which may prompt people to disclose more than they need to or to misunderstand what they should be disclosing. 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; and
- when there is regular treatment from a mental health professional.[12]

A consumer guide would potentially provide useful information to applicants in these situations. Consumers would benefit from 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). This is dealt with in more detail in section 2.1.4.

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[12] AFCA (December 2025) *Life Insurance Code of Practice: 2025 Review*, Life Code review website.

Recommendations

2. *When an insurer declines to provide cover or offers cover on non-standard terms for mental health, the Code's current provisions in Section 4 setting out required information for applicants should be revised to:*
    - *Clarify that this information should be in writing*
    - *Align the information to be provided in a decision to offer of alternative terms (4.22) with the information provided in a decision to decline cover (4.25), as relevant. For example, in both situations the consumer should be given the reasons for the decision based on what the applicant disclosed, as well as the opportunity to correct information;*
    - *Require a plain English summary of the actuarial and statistical data or other relevant data the insurer has relied on to justify the decision, with sufficient detail to enable the consumer to understand how this information relates to the decision on their application.*
3. *Insurers should be required to explain to consumers as part of underwriting questions what information on mental health needs to be disclosed and what does not. (This issue should be covered at a general level in the proposed 'Consumer Guide to Life Insurance and Mental Health' – see next section).*

2.1.4. Communication to consumers and Appendix B

Stakeholders consider it important that clear and accessible information is available to consumers about the consumer protections relating to mental health in the Code.

Appendix B of the Code sets out sections which may apply to customers experiencing mental health conditions and refers to relevant clauses of the Code.

It is important that consumers can readily access this information, but most stakeholders agree that Appendix B is not the best way to achieve that aim. As noted above, an overall statement of commitment on mental health would be better placed up front in the Code. Further, there are several places where particular commitments relating to mental health could be enhanced (e.g. information provision in section 4).

In addition, there would be benefit in CALI developing a standalone consumer guide to life insurance and mental health. The growth in mental health coverage and claims warrants such an approach.

A 'Consumer Guide to Life Insurance and Mental Health' would be a plain-English consumer document that provides information on life insurance and mental health, the Code and the law. For example, this guide should explain to consumers at a general level what they are expected to disclose in relation to mental health conditions, as stakeholder feedback indicates that this is a source of ongoing uncertainty. Readily accessible consumer information would also be important if the Code were to allow product design features that limit cover, as consumers would benefit from clear information about such limitations at a general level as well as in relation to specific products. It could also summarise a consumer's rights at the time of application. Any such guide should be developed with input from stakeholders, including consumer advocates and mental health experts.

With a clearer statement of the industry's commitment to appropriately dealing with mental health issues in the body of the Code, and the development of a consumer guide, Appendix B would be redundant and should be removed from the Code. With one exception, this would have no impact on the level of consumer protection the Code offers people with mental health conditions because Appendix B replicates Code clauses. The exception is clause 14 of Appendix B which refers to insurers providing an assigned claims assessor throughout the claims process for mental health income-related claims. This differs from clause 5.4 of the Code, which only requires the appointment of 'a primary contact person'. This distinction is significant, and the commitment should be maintained in the Code within the section on claims handling.

Recommendations

4. *Remove Appendix B of the Code (as recommended above, include a clear statement in the main body of the Code on mental health).*
5. *Develop a standalone plain-English consumer document* - 'Consumer Guide to Life Insurance and Mental Health'.
6. *Incorporate the commitment to provide an assigned claims assessor in clause 14 of Appendix B into the Code provisions relating to Claims Handling.*

2.2. Supporting customers experiencing vulnerability

Section 6 of the Code commits insurers to support customers experiencing vulnerability. The Reviewer has been asked to consider the effectiveness of the Code's overall commitments to dealing with customers experiencing vulnerability as well as specific commitments in relation to, for example, First Nations[13] customers or customers experiencing family violence. There are opportunities for enhancements in the Code to ensure it appropriately supports customers experiencing vulnerability and that the life insurance industry keeps pace with evolving community expectations and peer sectors.

Support for customers experiencing vulnerability is a common theme across the financial services sector, including other industries that have similar codes such as banking and general insurance. While some different issues arise in these sectors, many of the challenges in relation to customer vulnerability are similar.

[13] We use the term First Nations to respectfully refer to the Aboriginal and Torres Strait Islander peoples of Australia, recognising the diversity of Aboriginal and Torres Strait Islander cultures and identities.

In relation to other peer industries the Joint Consumer Groups argued that the life insurance industry should be a leader on dealing with customer vulnerability. They observed that:

> *Life insurance is by its very nature a trauma-based financial product and service. Life insurers should by rights be leading the financial services sector on the issue. They are not. Both the banking sector and the general insurance sector are well ahead of the life insurance sector in this regard.*[14]

Customer vulnerability was looked at in some detail in the recent review of the General Insurance Code of Practice (GICOP). The Initial Report issued by the Review Panel includes a useful discussion on customer vulnerability in sections 2.21-2.24[15] which is relevant for the life insurance industry. The Reviewer encourages stakeholders to read the section on customer vulnerability in that report in addition to the comments below.

2.2.1. Use of the term vulnerability

Some submissions raised concern about the use of the term ‘vulnerability’ or describing customers as ‘vulnerable’. CALI’s submission notes that , “our members tell us often customers may feel uncomfortable or stigmatised by being labelled as ‘vulnerable’.”[16]

The Reviewer agrees that consumers do not generally use the term ‘vulnerable’ and do not necessarily understand and think of themselves as ‘vulnerable’. It is important that insurers adopt appropriate language and avoid such a label when communicating directly with customers. However, for the purposes of the Code and regulation, ‘consumer vulnerability’ is an appropriate term. It is well understood by industry, regulators and oversight bodies and is the term used by the International Standards Organisation (ISO) in ISO 22458:2022 *Consumer vulnerability — Requirements and guidelines for the design and delivery of inclusive service*. Standards Australia has now reproduced ISO 22458, with national modifications, as AS 22458:2025 *Consumer vulnerability – Requirements and guidelines for the design and delivery of inclusive service*.

Recommendations

7. *Clauses 6.9 and 6.10 paragraphs in the Code that refer to customer disclosure of vulnerability should be redrafted to emphasise the disclosure of the consumer’s situation so as to identify their potential need for support e.g. clause 6.10 should read “We encourage you to tell us about your circumstances so that we can arrange additional support to help you should you need this.”*

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[14] Financial Rights Legal Centre (December 2025) *Joint Consumer Submission: Life Code Independent Review – Consultation Paper, October 2025*, Life Code review website, p 15.

[15] General Insurance Code Review (September 2024) *Initial Report*, Code of Practice review website.

[16] CALI (December 2025) *Life Insurance Code of Practice independent review: CALI submission to the initial consultation paper*, Life Code review website, p 16.

2.2.2. Principles-based approach to vulnerability

There is significant support for a principles-based approach to vulnerability in the Code. The Joint Consumer Groups recognised that the Code already takes a principles-based approach to "taking extra care" to support vulnerable customers, which is supplemented by some broad commitments and several specific commitments.

The overarching principle in the Code should be for insurers to treat every customer interaction with the potential for vulnerability in mind, particularly during claims when customers are most likely to experience stress. This does not require a formal 'checklist', nor does it require customers to self-identify or disclose sensitive circumstances when they do not wish to. Rather, insurers can proactively consider potential risk factors for vulnerability that may indicate the need for support. This can be based on information they already hold, additional information that is disclosed by customers, or in some cases information that can be the subject of reasonable inquiries.

Several stakeholders have suggested ISO 22458 should be adopted by insurers through the Code. As noted above, Standards Australia has now reproduced ISO 22458, with national modifications, as AS22458:2025. This greatly enhances its application in the Australian context.

AS 22458 defines consumer vulnerability as a "state in which an individual can be placed at risk of harm during their interactions with a service provider due to the presence of personal, situational and market environment factors".[17] This is a broad view of vulnerability recognising that people's circumstances are different, that vulnerability can affect anyone at any time, and that the impacts may vary from short to long term. The impact of that vulnerability can be exacerbated by the actions or inactions of organisations and can potentially lead to harm. The Code should adopt a similarly broad definition of vulnerability.

Requiring life insurers to meet AS 22458 through the Code would demonstrate the industry's commitment to best practice in supporting these customers. Alternatively, key features of AS 22458 could be adopted in the Code, including:

- The organisational commitment to a proactive and outcomes-focused approach;
- The principles of inclusive service design, in particular in customer service and claims, to ensure they are accessible and usable by the greatest number of consumers possible; and
- Requiring insurers to offer a range of free, easy to access contact channels so that consumers can choose their preferred method of communication for enquiries and complaints.

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[17] Standards Australia (November 2025 AS 22458:2025 *Consumer vulnerability – Requirements and guidelines for the design and delivery of inclusive service, Standards Australia website.*

Recommendations

8. *Section 6 of the Code should start with a broad definition of vulnerability consistent with AS 22458.*
9. *The Code should require insurers to comply with AS 22458.*
10. *Alternatively, the Code should require insurers to improve outcomes for consumers experiencing vulnerability by following the key principles in AS 22458, including:*
    - *A commitment to a proactive, outcomes focused approach.*
    - *Inclusive design, especially in customer service and claims processes.*
    - *Requiring insurers to have a range of free, easy to access contact channels so that consumers can choose their preferred method of communication.*

2.2.3. Proactive identification of vulnerability

The Code currently says that consumers are encouraged to tell their insurer about their vulnerability. It also suggests that insurers "may be unable to identify" vulnerability unless customers disclose it.

An approach that can help to more proactively identify consumers experiencing vulnerability is a 'risk factor' approach. A risk factor approach does not automatically require customers to be formally screened for vulnerability but helps staff dealing with customers to recognise those at risk. It should assist insurers to identify support or assistance options that may be important.

There is benefit in identifying relevant risk factors and clause 6.1 currently includes a list of factors that may contribute to consumers experiencing vulnerability. There was general support for maintaining such a list in the Code, but there were submissions that suggested it could better reflect the broader definition of vulnerability.

To reflect a risk factor approach and the broad definition of vulnerability, Clause 6.1 should be redrafted to:

- Recognise that anyone can become vulnerable at any time based on their circumstances; and
- Provide a non-exhaustive list of potential risk factors that are examples of characteristics that may increase the risk of vulnerability and may suggest a need for additional support. This list will include information that insurers may already hold and, in some circumstances, can ask for as part of establishing whether customers need support or assistance.

To give the list of risk factors a structure, the Reviewer recommends adoption of the categories from AS 22468. This would help the staff of insurers to identify vulnerabilities and to consider the type of support customers they might need. Based on AS 22458, Clause 6.1 could be drafted to specify that potential risk factors include, but are not limited to:

- *Personal characteristics*, e.g. age; cultural background; Aboriginal and Torres Strait Islander status; sexual orientation, gender identity and sex characteristics; remote location
- *Health and abilities*, e.g. disability; injury; mental health conditions; physical health conditions; cognitive impairment; suicidality or suicidal behaviours
- *Access and skills*, e.g. language barriers, literacy barriers
- *Life events*, e.g. bereavement; financial distress; family violence including financial abuse; trauma
- *External conditions*, e.g. economic pressures, natural disasters and extreme weather events

In addition to the current risk factors in clause 6.1, there are several additions that would assist in the identification of vulnerability. The factors of “sexual orientation, gender identity and sex characteristics” should be included, consistent with the ‘Worth the Risk’ report which found that LGBTIQA+ inclusion was not being consistently achivieved by insurers’ practices.[18]

Other additional factors should include “bereavement”, “cognitive impairment” and “trauma” as potential risk factors that should be specifically mentioned in the Code. It should also expand “family violence” to “family violence including financial abuse”.

The ‘risk factor’ approach can help to ensure a more proactive stance on identifying consumers that may be experiencing vulnerability. As noted in the GICOP review, insurers can actively engage with customers to assess their needs and determine if any additional support is required. This can be done in a way that supports customer engagement and does not require a customer to identify as ‘vulnerable’.

Importantly, this is not just a matter of identifying particular risk characteristics that may indicate vulnerability at the start of the customer relationship. Rather, insurers should be alert to risk factors or signs in ongoing interactions with customers that may prompt them to ask the customer whether they are experiencing difficulty or need additional support. This could be more explicitly reflected in those sections of the Code that deal with consumer communications and claims handling.

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[18] InsurePride (2023), ‘*Worth the Risk,* InsurePride website.

Recommendations

11. Clause 6.1 should be amended to:
- *Recognise that anyone can become vulnerable at any time based on their circumstances;*
- *Include a list of potential risk factors, incorporating the categories identified in AS 22458, that provide examples of characteristics which may increase the risk of vulnerability; and*
- *Add "bereavement", "cognitive impairment", "trauma" and "sexual orientation, gender identify and sex characteristics" as potential risk factors and expand "Family violence" to "family violence including financial abuse".*

12. Where risk factors are present, insurers should specifically ask consumers about their circumstances and whether any assistance or extra care is required to help them engage with their insurer.

13. Clause 6.15 should be expanded to include trauma-informed policies and training.

14. Insurers should take appropriate steps to record, with consent, personal information to help support people experiencing vulnerability.

15. Insurers should set out clearly on their website and in relevant customer communications the types of additional supports they make available to customers experiencing vulnerability.

2.2.4. Family and domestic violence

The 2023 Code requires insurers to publish a family violence policy on their website. To support this commitment, in 2025, CALI published the Best Practice Guidance (BPG) on Family and Domestic Violence (FDV) Policies.[19] Feedback from stakeholders is that the contents of the BPG represent best practice across the financial services sector. However, several stakeholders emphasised that the Code does not adequately connect to the BPG and it does not require insurers to comply with specific elements of the BPG.

Submissions suggested various ways this could be addressed, including by requiring insurers to comply with the key requirements of the BPG or incorporating some or all the commitments into the Code. The Reviewer agrees that integrating the BPG more effectively with the Code is desirable. If the industry is promoting the standard as evidence of the support it provides for people experiencing FDV, then customers and other stakeholders should be confident that insurers meet a minimum standard.

The Code commitments in relation to FDV would be improved by including a statement that there is a clear priority that whenever family violence is identified or suspected, the safety of the customer affected by the family violence and their family is prioritised. In addition, there are, at a minimum, several components of the BPG that should be mandatory for Code members, notably:

- Key content of the life insurer's FDV policy (pages 4-5)
- Safeguarding privacy and confidentiality (pages 12-13); and
- Incorporating Safety by Design principles into the design of new products.

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[19] CALI (2025) *Best Practice Guidance: Family and Domestic Violence Policies*, CALI website.

Recommendations

16. *Where family violence is identified or suspected, the Code should commit insurers to do everything possible to protect the safety of the person affected by family violence and their family*
17. *The Code should require insurers to comply with key requirements of CALI's Best Practice Guidance on Family and Domestic Violence Policies*
18. *In particular the Code should require insurers to:*
    - *Have publicly available FDV policies that address all the matters in the "Key content" section of the BPG;*
    - *Protect the privacy and confidentiality of customers experiencing family and domestic violence*; and
    - *Incorporate Safety by Design principles into the design of new products.*

2.3. Supporting customers experiencing financial hardship

The Reviewer has been asked to consider the clauses in Section 6 of the Code relating to support for customers experiencing financial hardship. This includes actions that insurers may take to support customers to maintain their cover or when dealing with their claim. For example, support could include offering flexible options to reduce premium payments, fast-tracking urgent claim assessments, or providing advanced benefit payments.

Overall, there is recognition that the existing financial hardship provisions in the Code are a good foundation. The Joint Consumer Groups note that "the current financial hardship section provides a solid platform upon which to build a more comprehensive approach to supporting those experiencing long- and short-term financial difficulties."[20]

To promote better customer outcomes, the Code commitments should require insurers to take all reasonable steps to ensure that customers receive timely, clear and appropriate assistance that helps them retain their cover wherever possible (although this may not be possible in all cases) and supports customers experiencing financial hardship through the claims process. Strengthening this expectation would help reduce avoidable loss of cover and support customers to navigate periods of financial difficulty with greater confidence and certainty.

This section covers:

- Identifying customers who are experiencing financial hardship;
- Expanding or clarifying hardship support options; and
- Improving communication before and during hardship arrangements.

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[20] FRLC (December 2025), p 36

2.3.1. Identifying financial hardship and promoting options

The Code includes a section on assisting customers experiencing financial hardship, which includes the offer of flexible support options.

As with customer vulnerability more generally, there is scope for including a risk factor approach that is specific to financial hardship, with the Code listing a broader range of the factors that may indicate financial hardship at any point, including during claims assessment. These could include hardship requests, arrears, reduction in the amount or type of cover, unsuccessful payment attempts, existing or previous hardship arrangements, and conversations with consumers that indicate difficulty in paying premiums or managing general living expenses. Representation by a financial counsellor or community lawyer or similar may also be an indication of hardship.

Consideration of financial hardship factors will be important for so-called legacy insurance products (see section 3.2.2), which a consumer may have entered into many years ago and which may be proving more difficult to afford for a variety of reasons (especially as premiums increase). Insurers should be alert to signs of hardship with customers in legacy products, especially as there is a greater probability that these will be older customers who may not have significant income,. Importantly, if such cases suggest systemic issues may be apparent then insurers should take a proactive approach to look at a wider customer cohort.

These hardship risk factors may be particularly relevant if associated with other risk factors that may indicate vulnerability e.g. poor health, loss of employment, advanced age.

Insurers will not always have full visibility of a customer's financial situation unless it is disclosed. However, most of the factors listed above that an insurer could use to help identify financial hardship will generally be available as part of its relationship with the customer. While insurers may not be able to identify all contributing factors for financial hardship, these more accessible indicators can help promote a more proactive consideration of flexible support options.

As currently drafted, clause 6.18 combines multiple concepts. There would be benefit in separating this clause into three separate clauses to provide clarity:

1. A statement of intent to work with customers in financial hardship to help them retain their cover if possible or expedite their claim if necessary, and to make hardship requests as straightforward as possible;
2. Identification of hardship through providing a guide to risk factors that can prompt further inquiry and/or discussion of customer needs; and
3. Potential flexible hardship support options.

Recommendations

19. *Redraft 6.18 to separate the concepts of overall intent on financial hardship; identification and risk factors; and possible flexible support options.*

20. *As part of the identification of hardship risk factors, introduce a Code clause that lists key risk factors for hardship as a guide that can initiate further investigation and/or conversation about hardship support options. This could include:*
    a. *hardship requests,*
    b. *payment arrears,*
    c. *requests for reduction in the amount or type of cover,*
    d. *unsuccessful payment attempts,*
    e. *existing or previous hardship arrangements, and*
    f. *customers that indicate difficulty in affording premiums or managing general living expenses, especially for customers with legacy products.*
21. *Where risk factors are present, insurers should ask consumers about their circumstances and whether any hardship support is required.*

2.3.2. Hardship support options

Clause 6.18 lists some possible flexible support options. Consistent with the objective of reducing avoidable loss of cover or expediting claims, it is important insurers think broadly about what can be done to support consumers experiencing hardship. There would be benefit in adding two additional options to provide guidance as part of a standalone clause on hardship support options:

- considering payment plans to cover a period of hardship; and
- facilitating access to and/or representation by financial counsellors or similar consumer representatives.

In relation to claims, the link to clauses 6.24 to 6.27 relating to fast tracking claims should remain in this section.

The Code should also contain an acknowledgement that financial hardship presents differently for different people and a commitment by insurers to tailor support appropriately. While some instances of hardship are temporary, such as a short period of illness or reduced work hours, others may be the result of more sustained difficulties like job loss or reduced capacity to earn income.

Recommendations

22. *The Code should require that insurers have readily accessible information (e.g. on websites) about financial hardship support.*
23. *Include a clause in the Code committing insurers to tailor support to the customer's circumstances and setting out additional examples of flexible support options.*

2.3.3. Communication before and during hardship arrangements

There are several clauses in Chapter 6 on communication in relation to hardship arrangements.

Clause 6.18 requires insurers to contact a consumer to tell them about support options when hardship is identified by the insurer or raised by the customer. This clause should specify that this communication should occur within five days.

Clause 6.20 requires insurers to contact a customer before a flexible support option comes to an end to explain the implications on their life insurance policy. It is important that consumers receive this information and have sufficient time to consider their options before the support ends. It would be appropriate that this includes a timeframe of 20 days.

Recommendations

24. *Amend clauses 6.18 to specify that the communication should occur within five days.*
25. *Include a timeframe of 20 business days before the support ends for clause 6.20.*

2.4. First Nations customers

The terms of reference ask the Reviewer to consider whether any changes are required to ensure the Code is meeting the needs of First Nations customers.

Since the Consultation Paper was issued, the LCCC has published the findings of its review of Indigenous supports. This review found that "insurers are taking steps to improve support but need to do more to ensure First Nations customers receive fair, culturally safe and accessible services."[21] CALI has publicly stated they are considering the LCCC's findings and recommendations.

Feedback from consumer organisations, as well as regulators and oversight bodies, is that support for First Nations customers is an area where they would like to see uplift by the life insurance industry, including in the Code, consistent with clear expectations for improved practice more generally across the financial services sector. There are significant opportunities for the life insurance industry to enhance its approach, which will require efforts on behalf of CALI and its members to meaningfully engage with groups representing First Nations consumers and develop culturally appropriate measures.

This section discusses:

- Insurers' policies and communication;
- Identification of Aboriginal or Torres Strait Islander customers;
- Engaging with First Nations customers; and
- Cultural competency training.

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[21] LCCC (8 December 2025) More needed to support First Nations customer [media release], LCCC website.

2.4.1. Industry policies and communication

Clause 6.8(e) of the Code requires insurers to make sure information about any support available for First Nations customers is easy to find and understand, so these customers can readily access the help they may need. The LCCC found that none of the insurers they reviewed maintained a dedicated webpage focussed specifically on supporting Aboriginal and Torres Strait Islander customers. This is now available, for example, on major bank websites. The Reviewer considers it would be beneficial for insurers to provide accessible information on support for First Nations customers, which should be tested or developed with input from First Nations representatives.

Recommendations

26. *Amend clause 6.8 to include an additional sub-clause requiring insurers to provide an easy-to-find link to "support targeted towards Aboriginal and Torres Strait Islander peoples."*

2.4.2. Identification of Indigenous customers

Several stakeholders, including groups representing First Nations consumers, have proposed that the Code should include a commitment by insurers to adopt a proactive and culturally safe approach to identifying Aboriginal and Torres Strait Islander customers. The LCCC said "[t]his information is essential for insurers to tailor their service, and to offer appropriate support as required."[22] The Reviewer supports introduction of such a requirement in the Code.

The Australian Transaction Reports and Analysis Centre (AUSTRAC) proposes that financial institutions provide customers with the option to advise whether they identify as Aboriginal and/or Torres Strait Islander. The Code currently references AUSTRAC guidance (clause 6.14), but this focuses on support for meeting verification and ID requirements. While this is positive, it would be beneficial to also have a Code requirement for insurers to provide the option for customers to identify as Aboriginal and/or Torres Strait Islander and seek consent to retain this information. It will be important for insurers to concisely explain why this information is collected and that it can assist in the provision of tailored support.

The Reviewer also notes that the LCCC found that some insurers have not fully integrated AUSTRAC guidance into their frameworks in relation to Aboriginal and Torres Strait customers. Insurers should review their approaches in line with their Code commitment.

Recommendations

27. *Insurers should provide the option for customers to identify as Aboriginal and/or Torres Strait Islander, and seek consent to retain this information, to enable flexible and tailored services.*

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[22] LCCC (December 2025), p 10.

2.4.3. Engaging with First Nations customers

Some First Nations customers experience difficultly engaging with life insurers due to language difficulties and/or cultural communication practices such as gratuitous concurrence.

The Code recognises the issue of gratuitous concurrence and requires insurers to take additional care to ensure an Aboriginal or Torres Strait Islander customer's consent is genuine. First Nations consumer representatives have said that this is an important commitment to have in the Code but that the depth of understanding and application of measures to ensure gratuitous concurrence is not exploited varies widely.

The issue of gratuitous concurrence can arise in the sale of life insurance products by both insurers and third-party distributors. There are concerns that some insurers and/or distributors are ignorant of the practice or, in egregious cases, exploit the practice when selling products. Insurers should take further steps to increase their employees' and distributors' awareness of this and other similar cultural practices and how to obtain genuine consent (see report section 2.4.4 regarding cultural competency training).

The Code currently includes a commitment about interpreters for customers experiencing vulnerability, including that insurers will arrange for and pay for an interpreter if they or the customer identify that one is required. The LCCC found that, while all insurers offer interpreting services, none provided services in Aboriginal and Torres Strait Islander languages. Insurers should examine ways to improve this access to interpreters in line with their Code commitment, and as part of the response to the LCCC review.

2.4.4. Cultural competency training

Several stakeholders highlighted the importance of appropriate training to underpin insurers' policies to support First Nations customers. Clause 6.16 currently requires insurers to provide cultural awareness training to staff who regularly help customers in remote Indigenous communities. There would be benefit in expanding this requirement to require insurers to provide training to any staff whose work directly interacts with First Nations customers, irrespective of whether these customers are in remote communities or other locations.

The training should also be made available for other staff, an approach which is consistent with the Banking Code of Practice.

Regardless of the breadth of the training, stakeholders reinforced that it needs to be developed through significant consultation with First Nations people and organisations and should cover topics that are relevant to life insurance such as sorry business and First Nations kinship systems.

Recommendations

28. *Expand clause 6.16 to require insurers to provide training to any staff whose work directly interacts with First Nations customers. This should include cultural competency training that covers (but is not limited to) gratuitous concurrence, sorry business and First Nations kinship systems.*

2.5. Claims handling

Making a claim is a key point of interaction between a customer and insurer, and it is often when a customer is most likely to experience vulnerability. The Code includes important commitments on claims handling. It sets out what consumers can expect when they make a claim including specific timeframes for communication and decisions, and prescribes practices in relation to areas such interviews, surveillance and medical evidence. This can be a particularly stressful time, and it is critical that insurers deal with claims as efficiently as possible and with a high level of empathy and compassion. The Code commitments enhance legal requirements and support insurers to meet their Australian Financial Services Licensee obligations in providing claims handling as a financial service.

Claims handling is also a major driver of trust and confidence in the industry. Poor communication during a claim can be a significant driver of complaints. The LCCC has noted:

> *If claimants are provided with a clearly identified, capable contact and receive timely, specific written information at key stages, it will reduce confusing, repeat contacts for updates and unnecessary complaints.*[23]

Financial Rights Legal Centre reported that poor claims handling was the number one issue for their clients and was raised in 29.7% of cases.[24]

There are opportunities for improvements in claims handling commitments, including:

- Clarifying or strengthening certain claims handling timeframes;
- Communication during claims;
- Giving greater clarity and focus to ‘Circumstances Beyond our Control’; and
- Enhancing other specific parts of the claims process, including interviews, surveillance and medical evidence.

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[23] LCCC (December 2025), p 14.

[24] FRLC (December 2025), p 46

2.5.1. Claims handling timeframes

The Code requires insurers to make decisions on claims for income-related benefits (i.e. IP and salary continuance insurance) within two months and decisions on claims for lump sum benefits (e.g. Death and TPD) within six months.

There is recognition that the timeframes for claims handling have been beneficial in improving insurers' claims handling practices. APRA data[25] shows that, across all product types, average claim processing durations are within the Code timeframes and there have been improvements in processing times since the Code was introduced. Overall, stakeholders did not raise significant issues with the headline timeframes for claims decisions (i.e. the two-month and six-month periods).

Nonetheless, a minority of overall claims still exceed timeframes, in some cases significantly. Insurers highlighted that some claims involving complex medical issues or treatment will not be able to be resolved in a short timeframe. In a smaller number of cases, it may be important to provide for extra time to reach an appropriate decision that ensures the best outcome for the customer. There are also cases where factors outside of the control of the insurer result in longer timeframes (see 'Circumstances Beyond Our Control' below). However, consumer stakeholders also highlighted cases where prolonged claims timeframes caused significant stress and hardship.

For some policy types, a greater number of claims take longer to resolve than the overall average for Code timeframes. For example, in 2025, around 18% of individually advised TPD claims took longer than six months and around 14% of income protection claims took longer than two months. Not surprisingly, these tend to relate to policy types that have more complex claims.

While a minority of total claims may exceed timeframes, where these are particularly long and/or they arise for reasons that should be avoidable they can have significant impacts on both individual claimants and, more broadly, on trust in the industry. Further, in some cases where claims are re-opened or where additional steps are undertaken (e.g. an investigation) it is unclear in the Code as to what timeframes then apply and/or what actions insurers will take to resolve a claim (for example, in their dealings with third parties).

When a claim is received

When a claim is first received, the Code requires insurers to provide specific information to claimants within 10 business days (Clause 5.5). This information should be made available in a shorter timeframe of 5 business days. (The content of this information is discussed further below).

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[25] APRA (2025) *Life insurance claims and disputes statistics* [data set], APRA website.

Provision of written decisions

Several stakeholders have recommended that insurers should be required to provide written decisions within the existing two-month and six-month timeframes. Currently clause 5.50, in effect, allows up to an extra 15 business days beyond these timeframes to send a written decision. The Reviewer agrees that this step should be completed within the overall two- and six-month claims handling timeframes.

Reopened claims

Clause 5.57 allows an insurer to restart the clock on the claims timeframes if they reopen a claim, whether in response to a customer complaint or other reason. The clause also states insurers will not ask for information they already have or repeat steps that have already been taken, unless they have reasonable grounds to do so.

This issue interacts with the timeframes for complaints. An insurer has up to 30 calendar days to make the IDR decision to reopen the claim in response to a customer complaint, which adds to the timeframe for resolution. If a claim is reopened, the claim is referred back to the claims team, which restarts the clock on the claims timeframe on top of the IDR time.

For reopened claims, the Reviewer considers it is unreasonable for insurers to be able to restart the clock in its entirety (i.e. to restart a two-month or six-month timeframe). A shorter timeframe of one month for income-related claims or two months for lump sum claims is appropriate, noting that “Circumstances Beyond our Control” will continue to apply to these claims.

Recommendations

29. *Reduce the timeframe in clause 5.5 to five business days.*
30. *Redraft clause 5.50 to require the insurer to tell the claimant about their decision within 15 business days and within the relevant claims handling timeframe.*
31. *Where an insurer reopens a claim under clause 5.57, the claims reassessment should be completed within one month for income-related claims or two months for lump sum claims.*

2.5.2. Customer communication during claims

There is a wide range of commitments in the Code that prescribe the timing and content of communication at particular points in the claims process.

When a claim is received

Clause 5.5 sets out a range of information the insurer will provide to the claimant at the initial Claim Received Date. The definition of the ‘Claim Received Date’ explicitly recognises that the claimant may not have provided all relevant information at this point. Given this, it would be beneficial to elevate sub-clause 5.5(d), which outlines the requirement to provide information on the claims process and contact information, to be sub-clause 5.5(a). There should also be a new sub clause that requires insurers to tell claimants, as far as practicable, what additional information needs to be provided to have their claim progressed (ensuring that it is specific to the claim being made).

Regular updates during a claim

The Code requires insurers to provide updates to claimants every 20 business days for the duration of a claim.

The LCCC observes that "without minimum content standards, these can be generic 'in progress' messages that do little to reduce uncertainty or provide guidance to the claimant."[26] These updates are important to ensure claimants understand how their claim is progressing and any obstacles to finalising the claim. To ensure these updates are useful, the Code should specify that the updates under clause 5.6 should, at a minimum, include:

- key steps that have occurred since the last update;
- anything that the insurer is waiting on from the claimant or a third party and:
  - where the consumer has not provided required information, reiterate the offer to assist the consumer where possible (clause 5.3); and
  - where there is a delay with a third party, what the insurer is doing to expedite the process and when it is expected to be completed; and
- what next steps will be taking place.

In addition, clauses 5.59 and 5.60 should both reference clause 5.6 in relation to the regular updates required under those clauses. This will ensure it is clear that updates provided under those clauses should contain the same content.

Requesting of information

Clause 5.13 of the Code says that insurers will ask for any information they reasonably need for a claim "as soon as possible and will minimise multiple information requests."

One of the frustrations that stakeholders have raised is multiple requests for the same or similar information from the claimant when this information has already been provided.

The Reviewer considers it is reasonable to expect that multiple requests for the same information are avoided. When asking for information from claimants, reasons should be provided for why the information is needed and insurers should offer to provide assistance to claimants who may need help obtaining the information required in accordance with clause 5.3.

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[26] LCCC (December 2025), p 13.

Method of communication

Some stakeholders have provided views on the method of communication during claims. In general, the Code should set expectations on what is communicated and when. While there should be flexibility for both consumers and insurers in the method of communication, there are some key communication points when some prescription is appropriate. Notably, where the Code requires an insurer to give a claimant information relating to their claim, this should be provided in writing (although this does not require hardcopy communication). Being able to re-read and consider the information will help claimants respond and seek further assistance if necessary. It may also help insurers by reducing disputes over what was communicated during the claim.

Primary contact

Making a claim can be the most complicated and stressful stage in any consumer's relationship with their life insurer. It is also the point where the life insurer demonstrates the practical support that they can provide for the customer. In this context, it is not unreasonable for consumers to expect they can speak to someone who can respond to their claim and deal with it appropriately.

Currently the Code requires income-related claimants to be provided with a "primary contact" for their claim. This should be broadened to cover all claims.

What constitutes a "primary contact" is not defined in the Code. It should be clear that it should be a human who can assist the claimant with their claim.

This requirement should not prevent the adoption and use of digital claims management approaches. These may improve customer service and provide an initial point of contact, a streamlined way of dealing with less complicated inquiries and/or a more convenient way of communicating for some customers. However, it is important that, if required, there is a primary contact that is accessible to help consumers navigate the process during what will usually be a difficult period in their life.

Long delayed claims

Clause 5.60 applies where a claim has not been resolved within 12 months. In these circumstances, insurers are required to escalate the claim to a senior team member or review committee to review the circumstances. As part of the requirement to communicate the outcome of the review in writing, insurers should be required to explain why the claim has been delayed and provide a clear plan indicating the path to a resolution and how long it will take, including any actions involving third parties. If there are any actions that the claimant needs to take these should be clearly set out.

Recommendations

32. *Regular updates under clause 5.6 should, at a minimum, include:*
    - *steps that have occurred since the last update;*
    - *anything that the insurer is waiting on from the claimant or a third party and:*
        - *where the consumer has not provided required information, reiterate the offer to assist the consumer where possible; and*
        - *where there is a delay with a third party, what the insurer has done to expedite the process and when it is expected to be completed; and*
    - *what next steps will be taking place.*
33. *Amend clauses 5.59 and 5.60 to reference clause 5.6 in relation to the regular updates required under those clauses.*
34. *When asking for information from claimants, insurers should be required to provide reasons for why the information is needed as part of the offer to provide assistance to claimants who may need help obtaining the information under clause 5.3.*
35. *Amend clause 5.4 to require insurers to provide a primary contact for all claims and specify that a primary contact must be a real person who is able to assist the claimant with their claim.*
36. *Amend clause 5.60 to add a requirement that insurers explain why the claim has been delayed, provide a plan that indicates the path to resolution of the claim and how long it will take.*

2.5.3. Circumstances Beyond our Control

Clause 5.59 specifies that an insurer will not have breached the Code if they do not meet claims handling timeframes due to 'Circumstances Beyond our Control' (CBOC). What constitutes CBOC is set out in the definition section of the Code, and the list includes eight circumstances (parts (a)-(h)).

There is broad recognition across stakeholders that the concept of CBOC is reasonable in the claims context. That is, there will be cases where, due to circumstances that are outside of its control, an insurer will not be able to resolve a claim within the prescribed timeframes. However, there was concern expressed by multiple stakeholders about: (1) the clarity and breadth of the framing of the CBOC; and (2) the operation of CBOC in practice. Concerns were raised about the extent to which some circumstances represent genuinely uncontrollable delays. For example, the LCCC observed that:

> *Several parts of CBOC definitions, particularly those that relate to waiting for information from customers, procedural fairness cycles and further investigation of non-disclosure or fraud are reasonable in principle but fail to clearly distinguish between genuine external roadblocks and delays arising from internal processes. Our observations indicate that some insurers have applied CBOC because of operational delays rather than uncontrollable events.*[27]

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[27] LCCC (December 2025), p 12.

Data from the LCCC's Annual Data and Compliance Program shows that 79% of CBOC applications arise because of part (a) *insurers have not received or have not had a reasonable time to assess reports, records, evidence, or other information reasonably requested from relevant parties such as the customer, the Group Policy Owner, independent service providers, medical practitioners, government agencies, or other entities.* However, as noted below, this sub clause is overly broad and unhelpful in identifying the key causes of CBOC.

There are opportunities to clarify the CBOC definition in the Code, to remove overlaps, to give more certainty for timeframes, and to provide greater guidance as to what actions insurers or customers may take when CBOC arises. This would also help insurers and other stakeholders by ensuring that the reporting of CBOC was more useful and specific. These improvements do not change the underlying basis for CBOC but rather make the concept clearer and more actionable for insurers, customers and other stakeholders.

Greater specificity in CBOC

Several CBOC provisions are overly broad, notably (a). The breadth of this part of the definition means that it is difficult to identify the specific drivers of CBOC applications. This does not assist insurers, customers or other stakeholders to focus on areas where actions or improvements may be needed. Part (a) not only covers a wide range of entities, it mixes two different causes of delay, being:

- the insurer *has not* received information from the customer or a range of other entities; or
- the insurer *has* received information from the customer or a range of other entities but has not had a 'reasonable time' to assess the information.

Furthermore, part (a) then overlaps with parts (b) and (d) of the definition, which also relate to circumstances where information has not been received.

Who is responsible?

There would be benefit for the claimant to understand if the reason for a CBOC is due to an action (or lack of action) that they are responsible for, as distinct from a third party such as a medical expert. This would help ensure that the communication to claimants about CBOC was clearer and, where possible, more actionable (as per clauses 5.59 and 5.60).

Interaction with other Code provisions

Several parts of the CBOC definition interact with other commitments in the Code. This should be made clearer. This includes where the Code commits insurers to provide additional information to claimants or to take other actions to reduce the likelihood of delays e.g. if claimants require help from the insurer to provide information (5.3) or the insurer needs to take steps to follow up where it has not received information (5.53).

Guidance on timeframes

There are several parts of the CBOC definition where timeframes would be desirable. For example, at present there is no guidance on what a reasonable timeframe is to complete an investigation relating to suspected non-disclosure (part (g)) or fraudulent claims (part (h)).

Clearer overall structure

While the underlying rationale for CBOC remains unchanged, the Reviewer proposes that the definition of CBOC would benefit from restructuring and clarification that makes it clearer as to the cause and, where possible, what actions could be taken to help resolve the circumstance:

1. **The insurer has not received information from the claimant:**
   - This would include where the insurer has not received information reasonably requested from the claimant or has been unable to contact the claimant about the claim.
   - Before an insurer can rely on this, they should have offered to provide assistance (5.3) or, where they have not been able to make contact, they should have ensured multiple attempts are made to communicate with the claimant in accordance with clause 5.56.
2. **The insurer has not received information from a Third Party:**
   - This would include where the insurer has not received information requested from parties other than the claimant e.g. a Group Policy owner, an independent service provider, the claimant's doctor, a government agency or another person or entity (but not a reinsurer).
   - Depending on the type of third party and contractual relationship, insurers will have varied levels of influence to expedite information provision. However, insurers should have proactively pursued the information with the third party before relying on this part of the CBOC definition.
   - The third party should be identified. Any delay in information from a third party should also be included in the regular updates under clause 5.6 and, where it is overdue, include steps being taken to expedite the process and an expected completion date where possible.
3. **Information has been received but the insurer has not had a reasonable time to assess this information:**
   - This would cover situations where an insurer has received the requested information but not in a timely manner that allows it to be assessed in a reasonable timeframe that will allow the insurer to comply with the Code timeframes. This may include responses to Show Cause or Procedural Fairness letters.
   - The insurer should be clear as to whether this is information from the claimant or a third party.
   - The Reviewer notes that clause 5.50 requires an insurer, once it has received all the information it reasonably needs, and completed all reasonable inquiries to tell the claimant about their decision in writing within 15 business days. Based on this, it would seem to follow that, for the purposes of this part of the CBOC definition, a reasonable time to consider information that is received is no more than 15 days.

4. **The claimant is undergoing rehabilitation, retraining or further treatment:**
    - The outcomes of rehabilitation, retraining, and further treatment may affect an insurer's claims decision and may be reasonable grounds for a delay in some circumstances.

5. **The claimant has requested a delay:**
    - The claimant has asked the insurer to delay or extend part of the claims process.

6. **The group policy owner has requested a delay:**
    - The group policy owner has requested a delay. Reasons for this request should be identified. This is likely to interact with the forthcoming mandatory standards on claims handling for superannuation trustees and should be reviewed once those standards are finalised.

7. **Potential non-disclosure, misrepresentation or failure to take reasonable care before the policy commenced:**
    - The insurer reasonably suspects there was non-disclosure, misrepresentation or a failure to take reasonable care before the cover or policy started that may impact their claim, and requires further investigation, evidence and/or information.
    - When this occurs, it is reasonable to expect that the insurer conducts an investigation or obtains relevant evidence as quickly as possible. A timeframe of two months could apply, except where a surveillance is undertaken with a maximum timeframe of four months.

8. **Potential fraudulent claim**
    - The insurer reasonably suspects that the claim is fraudulent and requires further investigation, evidence and/or information.
    - Any investigation or evidence gathering should be completed within two months except where a surveillance is undertaken with a maximum timeframe of four months.

To improve transparency of the use of CBOC, there would be benefit for both industry and consumers in having greater clarity in reporting, and the suggested structure should allow for a better understanding of the reasons for CBOC. This would not add significantly to current reporting requirements (for some parts not at all). It should focus on the direct cause of the CBOC, and in this way it would enable a greater understanding of which reasons and/or entities are generating the most CBOC delays, the extent of use across the industry, whether CBOC is being consistently, and whether there are areas that suggest that better communication could help reduce CBOC. It will be particularly important to understand where delays are arising from the actions (or inactions) of Group Policy owners in the context of proposed superannuation mandatory standards.

The LCCC should collect and report on this data as it does at present. To supplement this data and identify whether CBOC is being used appropriately, it should also undertake occasional reviews of insurers' compliance with CBOC.

Recommendations

37. *Amend the definition of CBOC to provide a clearer structure, links to other Code commitments and timeframes listed above.*
38. *The LCCC should publish data on how insurers use CBOC based on a clearer structure, including the frequency and grounds for CBOC.*

2.5.4. Other claims issues

Surveillance and investigations

Some submissions suggested there may be ambiguity in clause 5.42(h) in relation to timeframes for investigations. This says that insurers must ensure that investigators do not continue surveillance for longer than four months. Stakeholders have suggested it is unclear whether this limits surveillance to no more than four months in any claim or whether multiple periods of surveillance not exceeding four months would be permitted. This clause should be amended to clarify that the commitment is one defined period of no more than four months of surveillance in any claim. A limited exception for very long-duration claims could be included.

Medical evidence

Medical evidence is an important element of life insurance claims, with insurers requiring documentation to verify diagnoses, treatment, and pre-existing conditions. This information can come from a claimant's treating doctor, medical officers employed by insurers or an independent medical examination requested by an insurer.

AFCA has noted 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. It is good practice for an insurer to consult with a claimant's treating doctor before making a decision on whether a claimant satisfies the medical definitions.

Recommendations

39. *Clarify clause 5.42(h) to permit insurers to undertake one defined period of surveillance of no more than four months for each claim A limited exception for long-duration claims should be included.*
40. *Insurers should be required to consult with a claimant's treating doctor as part of making a decision on whether a claimant satisfies the relevant policy medical definitions.*

2.5.5. Mandatory standards for life insurance claims in superannuation

In January 2025, the Government announced it will introduce mandatory and enforceable service standards for all large APRA-regulated superannuation funds, including for insurance claims.[28]

Most stakeholders highlighted the need for the Code to align with the forthcoming mandatory service standards for superannuation trustees, particularly as these relate to insurance claims handling. These standards are still in development and, as yet, no detail has been publicly released to enable an assessment of how they will impact on life insurers and the Code. In principle, it is desirable for the Code to align with and support the standards. For this reason, it will be important to review the relevant provisions of the Code relating to Group insurance as soon as practicable after the final form of the mandatory standards are clear.

Recommendations

41. *A review of the provisions of the Code relevant to mandatory service standards for super should be undertaken as soon as practicable after the finalisation of these reforms.*

2.6. Medical definitions

Medical definitions play an important role in life insurance by specifying what conditions or medical events qualify for a claim and what conditions must be met, for example the level of severity of a particular medical condition.

The Code currently sets requirements for insurers to review and update medical definitions in on-sale products at least every three years and includes a section on specific medical definitions that apply for trauma and critical illness cover for:

- cancer, excluding certain early-stage cancers;
- heart attack, with evidence of severe heart muscle damage; and
- stroke in the brain resulting in permanent impairment.

These definitions apply to the first $2 million of trauma or critical illness cover for life insurance policies issued or group schemes that started on or after 1 July 2017.

[28] Assistant Treasurer (28 January 2025) *Mandatory service standards for the superannuation industry* [media release], Australian Government.

The Consultation Paper asked whether there may be benefit in having a 'Medical Definitions Guide' (MDG) that sits outside the Code to allow for quicker and more focused reviews and updates. Stakeholders generally supported this approach, and the Reviewer agrees a separate Code-related standard, underpinned by a structured process of development and review, would be of benefit. The guide should include any industry agreed medical definitions and plain-English information on their purpose and how they relate to definitions in individual insurer's policies. The Code should refer to the MDG and maintain the existing Code requirements regarding medical definitions, subject to the comments below.

For the review and development of such a guide, it would be appropriate for CALI to establish an MDG expert panel to develop the definitions. This should include underwriters and medical officers from insurers as well as relevant independent medical experts. There should also be a requirement for consultation with consumer stakeholders, AFCA, the LCCC and relevant medical organisations on this guide as it is developed or reviewed.

The Code already requires insurers to regularly review medical definitions in their own policies at least every three years. The Reviewer considers that the same requirement should apply for the MDG, although there would be benefit in having the MDG expert panel meet more regularly. In both cases, the Code should include commitments about the timing of these reviews.

Clause 5.67 requires insurers to assess claims based on the better of the Code definition or the definition in their own policy. On this basis, the Code definitions operate as minimum standard definitions. These definitions should always be based on the most contemporary accepted clinical definition. However, it may be appropriate that they incorporate a severity element that enables insurers to sustainably manage their risk exposure – this would be an issue for the expert panel to consider. Regardless of the Code definition, insurers are always able to offer a definition that is better for consumers if they wish.

In relation to definitions in insurers' policies, the Code should provide a definition of "obsolete method of diagnosis or treatment". The exact wording of this definition could be agreed by the expert panel as part of their first review. Where an insurer replaces an obsolete method with a current method of diagnosis or treatment in a claims assessment (in accordance with clause 2.9), this should be clearly explained to the customer as part of the claims handling process and decision.

It would also be preferable for the industry to align terminology to ensure a clear relationship between definitions in insurers' policies and the Code definitions. For example, insurers' policies may specify cover applies to "Heart attack (of specified severity)" or similar whereas the Code definition is "Heart attack, with evidence of severe heart muscle damage". Aligning terminology to "Heart attack (of specified severity)" or a similar label across the MDG, the Code and insurers' policies would clarify that they are referring to the same definition or standard.

Some stakeholders have suggested that the industry should develop additional medical definitions (i.e. for other conditions) and/or apply definitions to other types of insurance. This a matter that the industry and the MDG expert panel should consider in consultation with stakeholders.

Recommendations

42. *Move the three existing Code medical definitions into a separate medical definitions guide (MDG), to be developed through the establishment of an MDG expert panel, while maintaining the existing Code requirements regarding medical definitions.*
43. *The Code should require the industry standard definitions to be reviewed by the MDG expert panel at least every three years, with the Panel meeting more often as required. Consultation processes with consumer organisations, AFCA and the LCCC should be built into the Panel's operation.*
44. *The expert panel should review the three existing Code medical definitions as soon as possible.*
45. *The Code should include a definition of "obsolete method of diagnosis or treatment".*
46. *Where clause 2.9 applies to a claims assessment, the Code should require the insurer to clearly explain which definition was applied and the comparative results.*
47. *The industry should also consider whether it would be beneficial to include definitions for other medical conditions in the guide and/or definitions that apply to other types of insurance products. Such a review should be undertaken with advice from the Expert Panel and other stakeholders.*

3. Other issues

In addition to the areas of focus set out in the terms of reference, the Reviewer has considered other issues and opportunities for improvement raised by stakeholders.

3.1. Training

The Code currently includes several commitments relating to training and in some cases specifies what that training should cover.

All these commitments relate to training for staff in particular roles in insurers (e.g. underwriters, claims handling). There is no overarching obligation for insurers to provide training on the Code itself to all employees and/or third parties. There would be benefit in having a general obligation that all Code subscriber employees, distributors and service providers should receive general training on the Code.

Recommendations

48. *The Code should include an overarching obligation for education and training requirements on the key elements of the Code for all employees, distributors and service suppliers.*
49. *The requirements should stipulate that education and training must include:*
    - *the requirements outlined in the Code;*
    - *the relevant products and services provided by the Code Subscriber; and*
    - *dealing appropriately with customers experiencing vulnerability.*

3.2. Application of the Code

3.2.1. Group insurance policies

The Code does not apply to superannuation trustees or other owners of group policies, but relevant sections of the Code apply to life insurers in relation to group policies. In several places, the Code specifies clauses that do not apply to group policies. For example, clauses relating to product design (clauses 2.1-2.5), medical definitions (clauses 2.7-2.9) and hardship (clauses 6.18-6.22) do not apply to group policies. In relation to claims, some clauses specify that particular steps will be undertaken either by the insurer or the group policy owner (e.g. 5.11, 5.59 and 5.60).

Stakeholders have raised concerns about the interaction between insurers and group policy owners, particularly in relation to group polices held through superannuation. This includes concerns about delays, as well as lack of clarity for customers as to who is responsible for claims handling, communications and complaint handling. As noted above, the Government has announced an intention to introduce mandatory services standards for superannuation, which includes insurance claims handling, in part to address such concerns. Given this, it will be important to review the relevant provisions of the Code relating to Group insurance as soon as practicable after the final form of the mandatory standards are clear.

Irrespective of the requirements of the mandatory standards, there are some areas where the Code could contribute to improvements in the interaction between insurers and group policy owners. The Reviewer has made several recommendations about timeframes and information provision that are relevant - an example is the reasons for delay in claims handling relating to 'Circumstances beyond our Control'. The Reviewer has recommended in section 2.5.3 that where CBOC is a result of actions (or lack of action) by the Group policy owner that this is reported separately.

3.2.2. Legacy products

During the review, the Reviewer has been presented with multiple case studies and examples of poor consumer outcomes that relate to legacy products. These are problematic examples of consumer harm. First Nations customers are disproportionately represented in the cases that have been raised with the Reviewer, including but not limited to funeral insurance.

'Legacy products' generally refers to 'closed' insurance policies that are no longer offered for sale and, relevantly for the Code, were sold before the Code was developed, in some cases many years or even decades ago. The Code is not retrospective in all respects. As the sale of these policies pre-dates the existence of the Code there is no direct obligation for an insurer to apply certain protections offered in the Code, particularly as they relate to product design and sales practices. However, there are some provisions of the Code that apply to policies such as hardship provisions, claims handling timeframes and complaints handling processes, irrespective of when they were sold.

If issues relating to legacy products are not addressed, they will continue to be a source of consumer harm and negative stakeholder concern for the industry. There is significant frustration about some of the industry's past practices, especially in relation to products where there had been a history of mis-selling.

The Reviewer considers it is important for the industry, collectively and individually, to carefully consider any complaints that arise in relation to legacy products, and not to simply treat these as 'historical'. It is also important to consider whether these are systemic rather than just individual cases. Where relevant, action should be taken to address the issues that have been raised. An example is the response to the joint review of premium increases by APRA and the Australian Securities and Investments Commission (ASIC), with Code members reviewing aspects of premium disclosure in legacy products and offering remediation.[29]

The Reviewer acknowledges there are some limitations to what the industry can do in respect of product design for closed polices in the absence of a framework for the rationalisation of legacy products. There would be benefit in policy reform to enable the implementation of such a framework to help facilitate the transfer of consumers who currently have 'outdated' policies into new products where this would benefit consumers. However, this should not prevent insurers from taking steps to applicable Code commitments to legacy products where they can. For example, a more proactive approach to dealing

[29] APRA & ASIC (5 June 2025) *Premium increases in life insurance: Are life companies addressing issue identified by regulators?* APRA website.

with hardship needs to be part of the response by insurers and considered through the lens of their broader Code obligations.

The Reviewer has made some specific recommendations on this issue in the sections on Financial Hardship (report section 2.3).

3.3. Advertising and sales practices

Section 2 of the Code deals with advertising and sales practices, including obligations relating to direct sales of life insurance and communication requirements for funeral insurance and consumer credit insurance.

3.3.1. Sales practices and pressure selling

The Reviewer considers that the Code should include stronger industry commitments on unacceptable sales practices including (but not limited to) pressure selling. This is an area that continues to evolve, particularly in the online environment, and can cause significant consumer harm. Recent examples of widespread harm following lead generation practices in superannuation are an example.

In August 2025, ASIC published a letter to life insurers outlining concerns and urging action following a review of direct sales practices.[30] While ASIC indicated it had seen improvements, it found ongoing deficiencies in some industry practices and included recommendations to improve sales and pay practices and apply consistent quality standards to retention calls and streamlining cancellation processes. While ASIC's letter primarily deals with direct selling, it has lessons more generally for insurers' sales practices.

Clauses 2.12 and 2.13 require insurers to have measures in place to ensure that their salespeople, Authorised Representatives and Distributors do not use "unacceptable sales practices including Pressure Selling." 'Pressure Selling' is then defined in the definitions section of the Code. To enhance the Code's commitments on unacceptable sales practices, there would be benefit in expanding the definition of 'pressure selling' - in effect to replace it with a definition of 'unacceptable sales practices including pressure selling'. This would align the definition with the language in clauses 2.12 and 2.13. It is also more relevant in an online environment where lead generation techniques are increasingly designed to artificially create customer consent rather than simply engage in pressure selling. This might occur, for example, through the inclusion of 'small print' or 'hidden' terms and conditions in online comparison sites, online competitions or surveys which state the consumer has agreed to receive marketing calls.

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[30] ASIC (19 August 2025) *ASIC urges life insurers to spearhead improvements to direct sales practices* [media release], ASIC website.

While the range of unacceptable selling practices is potentially broad, the definition would benefit from some additional examples as part of a non-exhaustive list, such as:

- Using techniques to artificially create consumer consent to sales calls, such as certain lead generation practices;
- Offers to compare products for consumers that are primarily mechanisms for switching the consumer into another product where this does not provide meaningful benefits and/or is more expensive; and
- 'Down-selling' customers who want life insurance into more restricted and 'lower quality' products without explaining the difference.

It is also important to recognise that unacceptable sales practices and pressure selling do not occur solely at the initial point of purchase but also can arise during retention and cancellation processes. Clause 4.30 includes a commitment that insurers will not pressure a consumer to keep a policy they no longer want. This should also be reflected in the definition of unacceptable sales practices by replacing the phrase "Using certain techniques to pressure, compel or otherwise encourage someone to buy a policy they do not want" with "Using techniques to pressure, compel or otherwise encourage someone to buy a policy *or retain a policy* they do not want."

Cancellation processes should be simple and accessible. In addition to the existing commitments on cancellations in clauses 4.28-4.32, the Code should include a commitment that insurers will ensure cancellation processes are transparent, straightforward and do not require customers to provide extensive paperwork to cancel their policies

Recommendations

50. Replace the definition of 'pressure selling' with a definition of 'unacceptable sales practices including pressure selling' and update the definition to:
- *provide additional examples; and*
- *replace the phrase "Using certain techniques to pressure, compel or otherwise encourage someone to buy a policy they do not want" with "Using techniques to pressure, compel or otherwise encourage someone to buy a policy or retain a policy they do not want."*

51. Insurers should be required to ensure cancellation processes are transparent, straightforward, and do not require the provision of unnecessary information.

3.3.2. Funeral insurance

Clauses 2.29-2.31 of the Code are intended to ensure that insurers clearly explain the features of funeral insurance to a potential purchaser. This has been an area of significant focus from regulators and consumer organisations arising from widespread poor sales practices and significant consumer complaints. This was highlighted in submissions with examples of ongoing consumer harm.

As noted elsewhere in this report, there are still concerns about legacy products including funeral insurance, resulting in ongoing complaints, particularly from First Nations customers. Notwithstanding some improvements in product design, funeral insurance remains a disproportionate driver of individual consumer harm and negative reputation for the industry. The Code should be amended to enhance consumer protection, including ceasing sales of such products to younger people (below 50 years old), avoiding the sale of policies to a consumer who already has funeral insurance and providing clearer ongoing information on premiums paid.

Recommendations

52. *Insurers should be prohibited from selling funeral insurance to consumers who are under 50 years of age.*
53. *Insurers should be prohibited from selling funeral insurance to consumers who already have a funeral policy.*
54. *Insurers should provide annual statements that disclose total premiums paid to date on funeral insurance.*
55. *The key facts sheet referred to in clause 2.30 should include the information listed in 2.30(a) and (b) and sub-clause (a) should be amended to refer to "variable premiums".*

3.4. Communication

The importance of clear and understandable communication is underlined by the range of commitments that currently exist in the Code. Communication has been discussed throughout this report, including in relation to vulnerability, financial hardship, claims handling and complaints. This section covers two additional communication issues:

- The disclosure and communication of premiums and premium changes; and
- Communication channels
- Communication on variations/avoidance of cover.

3.4.1. Premiums

According to AFCA data, concern about premiums is one of the most common causes of complaints about life insurance. This is an area that has received considerable attention from ASIC and APRA in recent years. Their joint regulatory review commenced in 2023 due to concerns that repeated premium increases in life insurance may not have been applied in accordance with policy terms and may not have met reasonable policyholder expectations created through relevant disclosure and marketing materials. The regulators' expectations are that life insurers will communicate clearly and unambiguously the potential volatility of premiums. Generally, this 'volatility' will represent an increase in premiums. When increases are necessary to ensure sustainability, they expect life insurers to be transparent and supportive when managing the impact of premium increases.[31]

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[31] APRA & ASIC (5 June 2025).

From 1 January 2025, life insurers adopted new labels to describe premium types for new retail life insurance policies. The terms 'level' and 'stepped' will no longer be used and have been replaced in new policies with 'fixed', 'fixed age-stepped', 'variable' and 'variable age-stepped' policies. The aim is to help make premium types and labels more understandable for consumers by ensuring they better reflect how premiums change over time. A consumer fact sheet is available on CALI's website that explains the differences between the premium types.[32] The Code itself continues to refer to the old labels of level and stepped premiums, so these references will need to be updated in the next version of the Code.

The Joint Consumer Groups recommended that the industry should review and test the comprehensibility of the new premium labels. While it is not a Code commitment, given that these labels will now be incorporated into the Code the Reviewer agrees such as review should occur to ensure the labels are working as intended, once there has been a reasonable time for the market to use these terms (e.g. two years).

In light of the level of complaints and the ongoing focus on premiums, it would be reasonable for the Code to include a more coherent commitment to communicate information about premiums. At present, requirements to explain premiums are scattered throughout sections 2 and 3 (e.g. 2.11(c), 2.14(a), 2.27 (d), 2.29 (g), 2.30 (a), 3.5-3.7 and 3.10). They are not well integrated, in some areas they are limited in their focus, and there is overlap and repetition (e.g. both 2.27 and 3.7 set out commitments relating to premium information through direct sales). In relation to information on premiums prior to or at the time of sale, the key summary points of the CALI Consumer Fact Sheet provide a better overall guide for what this premium information should contain and would sit well in the Code. This could require a commitment to explain premiums early in the sales process, and that premiums can change over time and are likely to be higher over the long term.

These changes should be included under a new heading such as '*Premiums will be clearly explained'* in section 2 of the Code. Those clauses that relate to premium information that is specific to particular products should remain, notably for Funeral Insurance in 2.29(h) and CCI in clauses 2.32 – 2.36, as well as premium information at policy anniversary (3.10).

Recommendations

56. *Update the Code to reflect the new premium labels for retail life insurance policies.*
57. *Introduce a new provision in Section 2 that require insurers to communicate key information about premiums early in the sales process in a clear and upfront manner. This should include:*
    a. *The key difference between variable and variable age stepped premiums;*
    b. *That premiums are likely to increase over time;*
    c. *The impact of the cessation of any discount; and*
    d. *That premium increases typically get larger as the customer ages.*
    e. *Provide an example of premium changes over time*

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[32] CALI (January 2025) *Life insurance premiums: key facts*, CALI website, accessed 13 October 2025.

3.4.2. Communication channels

The Code contains extensive commitments to communicate with consumers in section 3. Other sections of the Code also contain various requirements for insurers to communicate with customers.

Where possible the Code should permit flexibility in the method of communication, as set out in clause 3.1. Consumers should be able to indicate their preferred communication method and insurers should communicate with them in that way as far as possible.

However, there are key pieces of communication/information which should be provided in writing. Technology supports different ways to do this, and such communication does not need to be a hard copy but should be able to be stored and retrieved by the consumer. This issue is covered above in the discussion of claims handling.

While verbal updates can be part of insurers' engagement with customers at pivotal points, this should be confirmed in writing, using plain language that clearly sets out key facts, any reasons for a decision, next steps and the customers rights and options.

3.4.3. Communication on variations/avoidance of cover

In Section 3, the clauses relating to how insurers will communicate with consumers when they vary or avoid cover could be made clearer (3.16-3.18). It would be helpful to amend the heading above 3.16 to read 'Insurers will give you a chance to explain before they vary or avoid your existing cover' and to add a sentence at the beginning of 3.16 providing context that states, 'When you hold a policy, we may vary or avoid your cover if new or additional information comes to our attention'.

Recommendations

58. *Amend Section 3 in relation to information provided to customers with existing policies where there is a decision to vary or avoid as above.*

3.5. Complaints

Section 7 of the Code sets out how insurers will deal with complaints from customers. Standards for complaints handling by financial services providers are also set out in ASIC's *Regulatory Guide 271: Internal dispute resolution* (RG 271)[33], which was updated in September 2021 and makes some of the standards and requirements enforceable.

As currently drafted, Section 7 of the Code aligns with RG 271. On this basis, there is no need for substantive change to the complaints handling commitments. Clauses 7.10-7.19 include a summary of the key enforceable elements of RG 271. This provides consumers with an explanation of key elements of the process and what they are entitled to expect from insurers. There is benefit in having this information sit in the Code alongside the other key promises that insurers make.

Given this, there would be benefit in explicitly stating that Code subscribers' internal dispute resolution processes will comply with RG 271 (with a link). In addition, references to 'an External Dispute Resolution Body' in 7.13, 7.15 and 7.17 should be changed to 'the Australian Financial Complaints Authority'.

Concerns were raised by some stakeholders about insurers' compliance with Code commitments that relate to internal dispute resolution. Examples were provided of overly difficult and onerous requirements on vulnerable consumers using financial counselling or community legal centre representation, which is inconsistent with clause 6.13, or unreasonable identification requirements for remote First Nations customers.

CALI has proposed that the Code should position complaints as a valuable feedback mechanism for continuous improvement. The Code should include a statement that insurers will ensure they use complaints in this way. In implementing this recommendation, insurers should seek to address feedback from ASIC in its recent review of direct sales of life insurance that found that some insurers had:

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

The approach to handling complaints relating to insurance in superannuation, as set out in clauses 7.16 to 7.19, is likely to be impacted by the Government's foreshadowed mandatory service standards for superannuation trustees as they relate to insurance claims handling. It will be important to review this section as soon as practicable in the light of these reforms. A key aim should be to ensure that the claimant has a clear understanding of who is responsible for the key aspects of the complaints process upfront e.g. who is responsible for communicating with claimants on the final decision.

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[33] ASIC (September 2021) Regulatory Guide 271: Internal dispute resolution, ASIC website.

Recommendations

59. *Include a clause that explicitly states that Code Subscribers will have internal dispute resolution processes that comply with ASIC Regulatory Guide 271*
60. *Amend clauses 7.13, 7.15 and 7.17 to refer to 'the Australian Financial Complaints Authority' rather than 'an External Dispute Resolution body'.*
61. *The Code should require insurers to have processes in place to ensure complaints are a feedback mechanism for continuous improvement.*

4. Interaction with the law

The Consultation Paper sought views on how the Code interacts with the law and whether this could be improved. Overall, stakeholders did not raise significant issues in this area.

The Code is a voluntary standard that complements the laws applying to the life insurance industry. It is intended to ensure that insurers deliver a high standard of customer service and continuously improve the services offered to consumers. In some areas it helps subscribers better meet their legal obligations by elaborating on the steps that will support compliance. In other areas it goes beyond minimum legal requirements to address issues not covered by the law.

In some cases, the Code sets out directly the legal requirement for customer service. An example is the commitments on complaints which set out the key requirements of RG 271 (see section 3.5). However, stakeholders generally agree that, where duplication exists, it is beneficial. For example, CALI notes that this duplication helps clarify the practical application of the law for consumers without creating new obligations for insurers. The Reviewer did not find major areas where the Code unnecessarily restates legal obligations.

As noted in the Consultation Paper, the Government currently has several law reform processes underway that will affect the life insurance industry and aspects of the Code, depending on the final details of the reform. These include the ban on the use of genetic testing in life insurance underwriting, the proposal to develop mandatory standards on insurance claims handling for superannuation trustees and the review of the DDA.

The Government has introduced legislation to enact the ban on the use of adverse genetic testing results by life insurers. Once the ban comes into effect, the Genetic Testing Moratorium in Appendix A of the Code will be redundant and should be removed.

For the other reforms, sufficient detail is not yet publicly available to enable the Reviewer to fully consider impacts at the time of this report. However, as discussed elsewhere in this report, it is desirable for the Code to align with and support the mandatory standards for superannuation trustees. For this reason, it will be important to review the relevant provisions of the Code relating to Group insurance as soon as practicable after the final form of the mandatory standards are clear.

Recommendations

62. *Remove Appendix A from the Code once the legislative ban on the use of genetic testing in life insurance underwriting comes into effect.*

5. Code structure, governance and enforceability

5.1. Structure and clarity of the Code

Overall, stakeholder feedback is that the Code is appropriately structured and covers the right issues, although there are opportunities to change some elements of the structure to improve the focus and coherence of the Code. These have been discussed in earlier sections of this report, and include, for example:

- Removal of the Appendix A on genetic testing (see section 4);
- Removal of Appendix B on mental health (see section 2.1.4); and
- The transfer of medical definitions to a separate, related standard (see section 2.6).

There are also some opportunities to improve the clarity in the Code by:

- Simplifying the key Code principles or objectives;
- Confirming the role and status of related industry standards (e.g. the Best Practice Guide on FDV or the proposed Medical Definitions Guide); and
- Minimising the use of conditional language in the Code.

5.1.1. The Code Objectives and Guiding Principles

The Code currently includes five 'guiding principles' and ten 'service promises' in a preamble, as well as four overall commitments that constitute the 'goal' of the Code in clause 1.1 and seven 'key principles' in clause 1.16.

It is important for any Code to set out overarching principles or objectives. The opening principles, promises and goals set out in current Code are worthwhile in that they signal the industry's commitment to deliver customer benefits. However, the multiplicity of principles/promises creates a lack of clarity and focus. There is unhelpful repetition and overlap, and in some cases the commitments are overly specific or limited. Stakeholders, including CALI, the LCCC and Joint Consumer Groups, believe that these should be consolidated and simplified into a clearer framework.

The Reviewer suggests that industry members develop and collectively agree to a refreshed and simplified objective and guiding principles. It is preferable for the industry to develop and 'own' these key elements of the Code. Given this, the following are suggestions rather than recommendations:

- The Code would be benefit from a clearer initial statement that sets out its overall objective, rather than multiple 'goals';
- There could be several concise 'Guiding Principles' (potentially limited to four to six). These could be supported by a small number of commitments that provide some brief guidance on what the principle means. The Banking Code adopts such an approach; and
- There may also be benefit in setting out a brief statement of 'Your Rights as a customer' following the Guiding Principles. Again, the Banking Code provides a model that may be useful to consider.

Consultation with stakeholders would be beneficial as part of this process.

Recommendations

63. The current set of overall principles, promises and objectives are replaced by a more concise and focused set of guiding principles that is developed by industry members, with appropriate stakeholder consultation.

5.1.2. Code-related documents

There are a number of documents that set out standards or guidance that relate to aspects of the Code but do not form part of the Code. The Best Practice Guide on Family and Domestic Violence is a significant example. These standards are not administered or enforced directly as part of the Code.

In principle, the Reviewer considers that there are sound reasons to have some related documents that sit outside the Code. They may be appropriate for more technical, specialised or frequently changing topics, in situations where including all detail in the Code would make it overly lengthy. Alternatively, there may be benefit for consumers to have certain information published separately covering a specific topic.

However, having a large number of related standards or guides sitting outside the Code raises some risks. It may lead to confusion about the status of these standards in terms of compliance or enforceability. It is important that these documents are coherently and clearly referenced in the Code and, especially where they set industry standards, that insurers are required to comply with the key elements of those standards. The Reviewer has recommended changes to ensure this is the case for the FDV Best Practice Guide. There would also be benefit in having a link or reference in the Code to the industry guidelines or standards on the CALI website.

Two additional code-related documents have been recommended in this report:

- A Consumer Guide to Life Insurance and Mental Health; and
- A standalone Medical Definitions Guide.

Recommendations

64. The Code should contain a link to a CALI industry guidelines and protocols

5.1.3. Conditional drafting language

The Code currently includes a range of conditional language in commitments including “we will try to...”, “where reasonable” or “where practicable”. The Reviewer considers that this language can remove specificity from otherwise clear commitments, and a range of recommendations have been made to provide greater certainty in relation to some provisions (e.g. maximum timeframes for some elements of CBOC). Where possible, such language should be removed from the Code or greater guidance given as to what is ‘reasonable’ or ‘appropriate’. In some cases, a concise example or examples may assist to indicate expected standards.

5.2. Code governance and compliance

Section 8 of the Code sets out the functions and powers of the LCCC as well as obligations on Code subscribers to report breaches to the LCCC. These powers include sanctions that are available to the LCCC in the event of a breach of the Code. This is supported by further detail in the LCCC Charter.

The LCCC and other stakeholders have highlighted some restrictions on the LCCC's ability to impose sanctions and receive certain types of information from Code members about breaches.

5.2.1. Sanctions

The Code enables the LCCC to impose sanctions on insurers for 'significant breaches' of the Code. Possible sanctions for Code breaches include formal warnings, remediation, compliance audits, corrective advertising, customer communication, Community Benefit Payments (CBP) and naming by the LCCC. The LCCC can impose a CBP sanction of up to $100,000 paid by the Code subscriber to a registered charity. The process for CBP sanctions is set out in the LCCC Charter.

Clause 8.4 of the LCCC Charter includes requirements that, in some cases, prevent a CBP sanction being imposed, including:

- That a CBP sanction should not be applied in cases where the Code breach has been reported, or is reportable, to ASIC; and
- Restrictions that set strict limits on the amount of the CBP based on the amount of affected people.

These restrictions reduce the effectiveness of the CBP framework and should be removed. There should not be a hard threshold on the number of affected people where a CBP is imposed, although the LCCC should take this factor into account in determining an appropriate amount for any CBP. In addition, when requiring an insurer to make a CBP, the Code should explicitly require the LCCC to take into account any compensation awarded by AFCA related to the Code breach, as well as a regulatory body, as per clause 8.5(a)(iii) of the Charter.

Recommendations

65. Amend clause 8.4 of the LCCC Charter to:

- *Remove the restrictions on applying a Community Benefit Payment sanction to Code breaches that have been reported, or are reportable, to ASIC (but retain the requirement to take into account any compensation awarded as a result of an ASIC regulatory action);*
- *Remove prescriptive thresholds for the application of CBPs based on the amount of affected people; and*
- *Take into account any compensation awarded by AFCA related to the Code breach.*

5.2.2. Transparency in LCCC inquiries and reports

An important role for the LCCC is to undertake reviews and inquiries into industry compliance with certain Code commitments. At present, the LCCC cannot identify insurers in inquiry reports (except where providing an example of good practice). Generally, there will be a range of insurers covered in such reviews. There would be benefits to allowing the LCCC to name insurers that have been included in such reviews without attributing specific data, in a similar manner to the practices of regulatory agencies such as ASIC.

Recommendations

66. Enable the LCCC to name insurers involved in inquiries and reports without attributing specific data or outcomes to individual insurers.

5.2.3. Breach reporting

The requirement for insurers to report 'Significant Breaches' to the LCCC plays an important role in enabling the LCCC to effectively perform its oversight role.

To avoid any confusion, the definition of a 'Significant Breach' should be amended to replace 'Determine' with a lower-case version in the Definitions section of the Code. There would also be benefit in including the duration of the breach and/or time it remained undetected as factors that the LCCC can refer to in considering whether a breach is a Significant Breach.

At present there is a significant limitation on the LCCC's ability to receive breach reports. Clause 8.13 has been interpreted to mean that, where a Code Subscriber has reported or will report a breach to ASIC under the reportable situations regime, and they know it is also a Code breach, they do not have to also report to the LCCC. This clause should be amended to clarify that all Significant Breaches of the Code must be reported to the LCCC regardless of whether they are also reported to the relevant regulator (most likely ASIC). The LCCC is not able to fully discharge its role of monitoring and/or enforcing the Code if it does not receive information about all breaches of the Code. It is therefore desirable to remove this restriction, which is not in place for other comparable code compliance committees.

In implementing this change, consideration should be given to how to minimise the administrative burden of reporting to two bodies. For example, it may be appropriate for the LCCC to accept reporting in the same format as reports to other regulators. Further, it would be reasonable for the Code to limit the LCCC's ability to investigate a matter if it is already under investigation by a regulator.

Recommendations

67. *Amend the definition of 'Significant Breach' to:*
    - *Replace 'Determine' with a lower-case version; and*
    - *Add the "duration of the breach and/or time it remained undetected" as a factor that the LCCC can refer to in considering whether a breach is a Significant Breach.*
68. *Amend clause 8.13 to clarify that all significant breaches of the Code should be reported to the LCCC while minimising duplicative reporting.*
69. *Limit the LCCC's ability to investigate a breach reported matter if it is already under investigation by a regulator.*

5.3. Enforceability of the Code

The Reviewer has been asked to consider the enforceability of Code commitments, including but not limited to consideration of the enforceable code provisions framework.

Enforceability is critical to the effectiveness of any code. At its heart, an industry code is a promise to consumers about what they can expect when they engage with a subscriber to that code. Consumers should be able to rely on those promises. They cannot be confident in a code if there is not an effective enforcement framework that underpins and incentivises compliance, and there are inadequate consequences for non-compliance.

If there is inadequate compliance with the Code and/or enforcement of breaches, pressure will increase for further detailed provisions to be included in the Code that prescribe increasingly specific obligations on industry and methods for compliance. The Reviewer observes that several stakeholders and submissions expressed frustration with aspects of Code compliance and the perception of insufficient consequences for subscribers who do not meet the standards in the Code. As a result, stakeholders recommended additional requirements for insurers that are, in some cases, aimed at improving compliance and enforcement rather than changing underlying Code obligations. A more effective compliance and enforcement framework can help address these pressures.

Enforceability will also be a focus if CALI seeks ASIC approval for the Code. When approving an industry code ASIC must have regard to whether the obligations in the Code are capable of being enforced.

In general, the enforceability of industry codes is typically achieved through a combination of mechanisms. This is made clear in ASIC's *Regulatory Guide 183: Approval of financial services sector codes of conduct* (RG 183). In assessing code enforceability, ASIC considers several elements that may be part of the enforceability framework including:

- contractual enforceability;
- the ability of the independent code administrator (e.g. code compliance committee) to enforce the code and apply sanctions for breaches;
- dispute resolution mechanisms (notably AFCA) to enable consumers to enforce the code and access redress for breaches; and
- ASIC enforceable code provisions.[34]

This underlines the utility of a framework for Code compliance and enforcement that has several components to ensure it is effective.

At present, both the LCCC and AFCA have key roles in the overall compliance framework for the Code. However, there are also limitations to what they can do. The LCCC is the independent Code administrator. It monitors Code compliance and can apply sanctions for breaches but cannot make determinations on individual complaints and its investigatory and naming powers are limited. AFCA, as an external dispute resolution body, plays a vital function in hearing complaints and providing redress to individuals based on a determination of what is fair in all the circumstances, having regard to applicable industry codes, but AFCA rules will limit access for some consumers. Further, AFCA's role is not focused on administering sanctions to Code members.

As noted above, stakeholders raised examples where they have found insurers' compliance with the Code should be improved. Multiple stakeholders argued that enforcement of the Code should be strengthened. In looking at this issue, three options were raised as potential areas for improvement. This included suggestions to:

- Introduce ASIC enforceable Code provisions;
- Improve the powers of the LCCC; and
- Make the Code contractually enforceable

ASIC enforceable code provisions

Stakeholders were asked to identify whether any provisions should be considered for designation as enforceable code provisions, a breach of which would constitute a breach of the law and would be enforced by ASIC. To be identifiable as an enforceable code provision, a clause should not be broad or aspirational in nature and a breach must be likely to result in significant and direct detriment to a consumer.[35]

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[34] ASIC (1 March 2013) *Regulatory Guide 183: Approval of financial services codes of* conduct, ASIC website, clauses 183.24-25.

[35] ASIC (1 March 2013), clause 183.61.

Several stakeholders, including CALI and the Joint Consumer Groups, expressed concerns about the practical impact of the enforceable code provisions regime. The Reviewer agrees with these concerns. Furthermore, the maximum penalty that ASIC can seek for the breach of an enforceable code provision ($99,000) is less than the CBP which can be applied by the LCCC.

The Reviewer notes that the Banking Code approved by ASIC did not include any enforceable code provisions. In addition, the recent review of General Insurance Code of Practice did not recommend any clauses for designation as enforceable code provisions.

Strengthening the powers of the LCCC

As the previous section indicates, there are several areas where the LCCC's powers or coverage can and should be improved. This will help ensure the LCCC is better placed to promote compliance with the Code. However, as noted above, while the LCCC plays a key function in Code compliance, there are limitations in the LCCC's role as an enforcement body, particularly as this relates to individual customer complaints.

Contractual Enforceability

Several stakeholders have recommended that some or all of the Code should be made contractually enforceable by incorporating it into life insurance contracts.

There is precedent for this approach. The Banking Code of Practice and the Customer Owned Banking Code of Practice are already incorporated into contracts for banking products. The Insurance Council of Australia has publicly committed to redrafting the General Insurance Code of Practice to be contractually enforceable.

The Reviewer considers that this can also be an effective mechanism for the life insurance industry and the Code should be incorporated into new consumer contracts. This would provide consumers with contractual enforcement as an option alongside AFCA.

Recommendations

70. *CALI should not seek designation of any code provision as an ASIC enforceable code provisions.*
71. *The Code should be incorporated into new customer contracts so that commitments are contractually enforceable.*

5.4. ASIC approval

Under the *Corporations Act 2001*, ASIC has the power to approve voluntary industry codes of conduct.[36] The criteria for approval are set out in RG 183.

While it is not mandatory for an industry to seek ASIC approval of a code, this review is being conducted in a manner intended to support an application for Code approval should CALI seek to do so once the review is concluded.

Several stakeholders, including the LCCC, AFCA and Joint Consumer Groups noted their support for a revised Code to be submitted to ASIC for approval.

5.5. Future Code reviews

The Code currently require an independent review every three years. In RG 183, ASIC has said its expectation is that code owners complete independent reviews of codes (whether ASIC-approved or not) every five years. The Reviewer considers five years is appropriate.

Recommendations

> *72. The Code should be reviewed every five years.*

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[36] Corporations Act 2001, section 1101A

6. Recommendations

Mental health

1. The Code should contain a new overall industry commitment to dealing appropriately with customers experiencing mental health condition in Section 1 rather than in Appendix B.
2. When an insurer declines to provide cover or offers cover on non-standard terms for mental health, the Code's current provisions in Section 4 setting out required information for applicants should be revised to:
   - Clarify that this information should be in writing
   - Align the information to be provided in a decision to offer of alternative terms (4.22) with the information provided in a decision to decline cover (4.25), as relevant. For example, in both situations the consumer should be given the reasons for the decision based on what the applicant disclosed, as well as the opportunity to correct information;
   - Require a plain English summary of the actuarial and statistical data or other relevant data the insurer has relied on to justify the decision, with sufficient detail to enable the consumer to understand how this information relates to the decision on their application.
3. Insurers should be required to explain to consumers as part of underwriting questions what information on mental health needs to be disclosed and what does not. (This issue should be covered at a general level in the proposed 'Consumer Guide to Life Insurance and Mental Health').
4. Remove Appendix B of the Code (as recommended above, include a clear statement in the main body of the Code on mental health).
5. Develop a standalone plain-English consumer document - 'Consumer Guide to Life Insurance and Mental Health'.
6. Incorporate the commitment to provide an assigned claims assessor in clause 14 of Appendix B into the Code provisions relating to Claims Handling.

Supporting customers experiencing vulnerability

7. Clauses 6.9 and 6.10 paragraphs in the Code that refer to customer disclosure of vulnerability should be redrafted to emphasise the disclosure of the consumer's situation so as to identify their potential need for support e.g. clause 6.10 should read "We encourage you to tell us about your circumstances so that we can arrange additional support to help you should you need this."
8. Section 6 of the Code should start with a broad definition of vulnerability consistent with AS 22458.
9. The Code should require insurers to comply with AS 22458.
10. Alternatively, the Code should require insurers to improve outcomes for consumers experiencing vulnerability by following the key principles in AS 22458, including:
    - A commitment to a proactive, outcomes focused approach.
    - Inclusive design, especially in customer service and claims processes.
    - Requiring insurers to have a range of free, easy to access contact channels so that consumers can choose their preferred method of communication.
11. Clause 6.1 should be amended to:
    - Recognise that anyone can become vulnerable at any time based on their circumstances;

- Include a list of potential risk factors, incorporating the categories identified in AS 22458, that provide examples of characteristics which may increase the risk of vulnerability; and
- Add “bereavement”, “cognitive impairment”, “trauma” and “sexual orientation, gender identify and sex characteristics” as potential risk factors and expand “Family violence” to “family violence including financial abuse”.

12. Where risk factors are present, insurers should specifically ask consumers about their circumstances and whether any assistance or extra care is required to help them engage with their insurer.
13. Clause 6.15 should be expanded to include trauma-informed policies and training.
14. Insurers should take appropriate steps to record, with consent, personal information to help support people experiencing vulnerability.
15. Insurers should set out clearly on their website and in relevant customer communications the types of additional supports they make available to customers experiencing vulnerability.

Family and domestic violence

16. Where family violence is identified or suspected, the Code should commit insurers to do everything possible to protect the safety of the person affected by family violence and their family.
17. The Code should require insurers to comply with key requirements of CALI’s Best Practice Guidance on Family and Domestic Violence Policies.
18. In particular the Code should require insurers to:
    - Have publicly available FDV policies that address all the matters in the “Key content” section of the BPG;
    - Protect the privacy and confidentiality of customers experiencing family and domestic violence; and
    - Incorporate Safety by Design principles into the design of new products.

Supporting customers experiencing financial hardship

19. Redraft 6.18 to separate the concepts of overall intent on financial hardship; identification and risk factors; and possible flexible support options.
20. As part of the identification of hardship risk factors, introduce a Code clause that lists key risk factors for hardship as a guide that can initiate further investigation and/or conversation about hardship support options. This could include:
    a. hardship requests,
    b. payment arrears,
    c. requests for reduction in the amount or type of cover,
    d. unsuccessful payment attempts,
    e. existing or previous hardship arrangements, and
    f. customers that indicate difficulty in affording premiums or managing general living expenses, especially for customers with legacy products.
21. Where risk factors are present, insurers should ask consumers about their circumstances and whether any hardship support is required.
22. The Code should require that insurers have readily accessible information (e.g. on websites) about financial hardship support.

23. Include a clause in the Code committing insurers to tailor support to the customer's circumstances and setting out additional examples of flexible support options.
24. Amend clauses 6.18 to specify that the communication should occur within five days.
25. Include a timeframe of 20 business days before the support ends for clause 6.20.

First Nations customers

26. Amend clause 6.8 to include an additional sub-clause requiring insurers to provide an easy-to-find link to "support targeted towards Aboriginal and Torres Strait Islander peoples."
27. Insurers should provide the option for customers to identify as Aboriginal and/or Torres Strait Islander, and seek consent to retain this information, to enable flexible and tailored services.
28. Expand clause 6.16 to require insurers to provide training to any staff whose work directly interacts with First Nations customers. This should include cultural competency training that covers (but is not limited to) gratuitous concurrence, sorry business and First Nations kinship systems.

Claims handling

29. Reduce the timeframe in clause 5.5 to five business days.
30. Redraft clause 5.50 to require the insurer to tell the claimant about their decision within 15 business days and within the relevant claims handling timeframe.
31. Where an insurer reopens a claim under clause 5.57, the claims reassessment should be completed within one month for income-related claims or two months for lump sum claims.
32. Regular updates under clause 5.6 should, at a minimum, include:
    - steps that have occurred since the last update;
    - anything that the insurer is waiting on from the claimant or a third party and, where the consumer has not provided required information, reiterate the offer to assist the consumer where possible; where there is a delay with a third party, what the insurer has done to expedite the process and when it is expected to be completed; and
    - what next steps will be taking place.
33. Amend clauses 5.59 and 5.60 to reference clause 5.6 in relation to the regular updates required under those clauses.
34. When asking for information from claimants, insurers should be required to provide reasons for why the information is needed as part of the offer to provide assistance to claimants who may need help obtaining the information under clause 5.3.
35. Amend clause 5.4 to require insurers to provide a primary contact for all claims and specify that a primary contact must be a real person who is able to assist the claimant with their claim.
36. Amend clause 5.60 to add a requirement that insurers explain why the claim has been delayed, provide a plan that indicates the path to resolution of the claim and how long it will take.
37. Amend the definition of CBOC to provide a clearer structure, links to other Code commitments and timeframes listed in section 2.5.3 of the Interim Report.
38. The LCCC should publish data on how insurers use CBOC based on a clearer structure, including the frequency and grounds for CBOC.

39. Clarify clause 5.42(h) to permit insurers to undertake one defined period of surveillance of no more than four months for each claim A limited exception for long-duration claims should be included.
40. Insurers should be required to consult with a claimant's treating doctor as part of making a decision on whether a claimant satisfies the relevant policy medical definitions.
41. A review of the provisions of the Code relevant to mandatory service standards for super should be undertaken as soon as practicable after the finalisation of these reforms.

Medical definitions

42. Move the three existing Code medical definitions into a separate medical definitions guide (MDG), to be developed through the establishment of an MDG expert panel, while maintaining the existing Code requirements regarding medical definitions.
43. The Code should require the industry standard definitions to be reviewed by the MDG expert panel at least every three years, with the Panel meeting more often as required. Consultation processes with consumer organisations, AFCA and the LCCC should be built into the Panel's operation.
44. The expert panel should review the three existing Code medical definitions as soon as possible.
45. The Code should include a definition of "obsolete method of diagnosis or treatment".
46. Where clause 2.9 applies to a claims assessment, the Code should require the insurer to clearly explain which definition was applied and the comparative results.
47. The industry should also consider whether it would be beneficial to include definitions for other medical conditions in the guide and/or definitions that apply to other types of insurance products. Such a review should be undertaken with advice from the Expert Panel and other stakeholders.

Training

48. The Code should include an overarching obligation for education and training requirements on the key elements of the Code for all employees, distributors and service suppliers.
49. The requirements should stipulate that education and training must include:
    - the requirements outlined in the Code;
    - the relevant products and services provided by the Code Subscriber; and
    - dealing appropriately with customers experiencing vulnerability.

Advertising and sales practices

50. Replace the definition of 'pressure selling' with a definition of 'unacceptable sales practices including pressure selling' and update the definition to:
    - provide additional examples; and
    - replace the phrase "Using certain techniques to pressure, compel or otherwise encourage someone to buy a policy they do not want" with "Using techniques to pressure, compel or otherwise encourage someone to buy a policy or retain a policy they do not want."
51. Insurers should be required to ensure cancellation processes are transparent, straightforward, and do not require the provision of unnecessary information.

52. Insurers should be prohibited from selling funeral insurance to consumers who are under 50 years of age.
53. Insurers should be prohibited from selling funeral insurance to consumers who already have a funeral policy.
54. Insurers should provide annual statements that disclose total premiums paid to date on funeral insurance.
55. The key facts sheet referred to in clause 2.30 should include the information listed in 2.30(a) and (b) and sub-clause (a) should be amended to refer to “variable premiums”.

Communication

56. Update the Code to reflect the new premium labels for retail life insurance policies.
57. Introduce a new provision in Section 2 that require insurers to communicate key information about premiums early in the sales process in a clear and upfront manner. This should include:
    a. The key difference between variable and variable age stepped premiums;
    b. That premiums are likely to increase over time;
    c. The impact of the cessation of any discount;
    d. That premium increases typically get larger as the customer ages.
    e. Provide an example of premium changes over time.
58. Amend Section 3 in relation to information provided to customers with existing policies where there is a decision to vary or avoid as above.

Complaints

59. Include a clause that explicitly states that Code Subscribers will have internal dispute resolution processes that comply with ASIC Regulatory Guide 271.
60. Amend clauses 7.13, 7.15 and 7.17 to refer to ‘the Australian Financial Complaints Authority’ rather than ‘an External Dispute Resolution body’.
61. The Code should require insurers to have processes in place to ensure complaints are a feedback mechanism for continuous improvement.

Genetic testing

62. Remove Appendix A from the Code once the legislative ban on the use of genetic testing in life insurance underwriting comes into effect.

Code structure

63. The current set of overall principles, promises and objectives are replaced by a more concise and focused set of guiding principles that is developed by industry members, with appropriate stakeholder consultation.
64. The Code should contain a link to a CALI industry guidelines and protocols.

Code governance and compliance

65. Amend clause 8.4 of the LCCC Charter to:

- Remove the restrictions on applying a Community Benefit Payment sanction to Code breaches that have been reported, or are reportable, to ASIC (but retain the requirement to take into account any compensation awarded as a result of an ASIC regulatory action);
- Remove prescriptive thresholds for the application of CBPs based on the amount of affected people; and
- Take into account any compensation awarded by AFCA related to the Code breach.

66. Enable the LCCC to name insurers involved in inquiries and reports without attributing specific data or outcomes to individual insurers.
67. Amend the definition of 'Significant Breach' to:
    - Replace 'Determine' with a lower-case version; and
    - Add the "duration of the breach and/or time it remained undetected" as a factor that the LCCC can refer to in considering whether a breach is a Significant Breach.
68. Amend clause 8.13 to clarify that all significant breaches of the Code should be reported to the LCCC while minimising duplicative reporting.
69. Limit the LCCC's ability to investigate a breach reported matter if it is already under investigation by a regulator.

Enforceability

70. CALI should not seek designation of any code provision as an ASIC enforceable code provisions.
71. The Code should be incorporated into new customer contracts so that commitments are contractually enforceable.

Future reviews

72. The Code should be reviewed every five years.

7. Appendix

The Code was introduced in 2017 by the Financial Services Council (FSC) as a voluntary industry code. A review commenced in 2018, and a revised Code was published on 22 June 2022, taking effect on 1 July 2023. In 2022, the CALI was established as the industry body for life insurers. Ownership of the Code transferred to CALI in September 2023.

The Code sets out standards that life insurers commit to when dealing with customers. It is underpinned by key principles including clarity, transparency, fairness, respect, honesty, timeliness and plain language. It applies across the entire insurance journey from product design and sales to claims handling and complaints management. The Code also includes additional protections for customers who are vulnerable, experiencing financial hardship, or living with a mental health condition.

The Code covers life insurance policies issued by registered life insurers in Australia. The most common types of products are term life or death insurance, total and permanent disability (TPD) insurance, income protection (IP) or salary continuance insurance and trauma or critical illness insurance. It does not cover whole-of-life or endowment insurance products, products issued by general insurers and health insurance products.

The LCCC monitors industry compliance with the Code, reports publicly on breaches, and has powers to impose sanctions and financial penalties.

The Code is due for formal independent review in 2025 (this review) and at least every three years after that. Regular independent reviews are important to ensure the Code continues to meet evolving community standards and expectations. One of the stated goals of the Code is ensure that insurers continually improve the services offered to customers.

7.1. Objectives and scope

The terms of reference set out the objectives for the Code review.

The overarching principle for the review is to maintain or enhance the consumer protections and industry commitments in the Code.

The terms of reference state that in undertaking the review, the Reviewer should also have regard to the following specific objectives:

1. **Ensuring the Code is fit for the needs of today and the future.** Ensure the Code is meeting community expectations and needs of consumers, responds to changes in the regulatory environment and reflects good industry practice.
2. **Enhancing the customer experience.** Ensure the Code provides certainty and makes it easier for customers to deal with life insurers, for example, when they buy insurance or make a claim.
3. **Increasing consumer accessibility and usability of the Code.** Improve the understanding of or simplifying the Code without losing meaning or reducing consumer protection.
4. **Ensuring the Code is effective, robust, and enforceable.** Ensure the Code delivers the promised consumer protections, while being operationally practicable for life insurers, the LCCC, customers and other stakeholders.

The Reviewer will consider feedback and submissions on the operation of all aspects of the Code. In addition, the terms of reference for the review highlight the following areas for particular focus:

1. Whether any changes are required to ensure the Code supports and does not conflict with reforms in the legal and regulatory framework for life insurers that have occurred since the last review. This includes previous (and expected) Government reforms and guidance on complaints and complaints handling, the use of genetic testing in life insurance underwriting, service standards for superannuation trustees on insurance claims handling, changes to financial advice laws and other relevant reviews that have occurred since the last Code review;
2. The effectiveness of the Code provisions relating to customers who are experiencing a mental health condition, including when buying a life insurance product or making a claim;
3. Support for customers experiencing vulnerability and financial hardship. This could consider best practice approaches to identifying customers experiencing vulnerability and providing them with appropriate service and extra care;
4. Whether any changes are required to ensure the Code is meeting the needs of First Nations customers;
5. Whether the provisions of the Code relating to claims handling remain appropriate to ensure timely resolution of claims and complaints and effective communication with claimants and superannuation trustees (where applicable) throughout the process;
6. Opportunities for enhancements and clarifications to the Code to improve consumer understanding, suitability, accessibility and affordability of life insurance products for all Australians;
7. The role of medical definitions in the Code and whether any changes are required to the current definitions to ensure they set an appropriate standard for the industry;
8. The role of the LCCC and its functions, powers and resourcing set out in the LCCC Charter and whether any changes are required to improve the LCCC's oversight and enforcement of the Code; and
9. The enforceability of the commitments made under the Code, including but not limited to consideration of the enforceable code provisions framework.

LIFE CODE review

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