

Life Code independent review

Final Report

30 June 2026



Final Report

About this paper

This is the Final Report setting out the Independent Reviewer's recommendations for the Life Insurance Code of Practice

30 June 2026



Table of contents

1. Background, process and overall observations	4
2. Final recommendations.....	8
2.1. Mental health	9
2.2. Supporting customers experiencing vulnerability	19
2.3. Family and domestic violence	20
2.4. Supporting customers experiencing financial hardship	20
2.5. First Nations customers	22
2.6. Claims handling	22
2.7. Medical definitions	26
2.8. Training	26
2.9. Advertising and sales practices	26
2.10. Communication	28
2.11. Complaints	29
2.12. Genetic testing	30
2.13. Code structure	31
2.14. LGBTIQ+ customers	31
2.15. Blood-borne diseases	31
2.16. Code governance and compliance.....	33
2.17. Enforceability of the Code	33
2.18. Future Code reviews	34
2.19. ASIC Approval	34
3. List of recommendations	36
4. Appendix.....	48
4.1. Objectives and scope	49

1. Background, process and overall observations



This Report sets out the Independent Reviewer's final recommendations from the 2025-26 review of the Life Insurance Code of Practice (the Code). It should be read alongside the Interim Report released in April 2026. Where there are no significant changes from the Interim Report the discussion is not repeated in this Report.

The Reviewer has:

- Included additional discussion and recommendations on mental health, taking into account the feedback in response to the questions in the Interim Report; and
- Addressed several specific areas of feedback on the Interim Report and explained where recommendations have changed.

In response to submissions on the Interim Report, some recommendations have been removed, some have been amended and several new recommendations have been added. This means the numbering of recommendations in the Final Report has changed from the Interim Report.

The majority of the 85 recommendations require a change to the Code. There are also some recommendations for actions by insurers, the Council of Australian Life Insurers (CALI) and/or the Life Code Compliance Committee (LCCC) to support the effective operation of the Code and improve consumer outcomes, but that do not require changes to the Code (these are noted in the list of recommendations in section 2 of the Report).

Process and submissions

The 2025-26 independent review of the Code commenced on 1 October 2025. Background on the Code and the terms of reference are included in the Appendix to this Report.

The Reviewer has undertaken comprehensive stakeholder engagement throughout the review.

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. Most of these submissions incorporated the views of multiple stakeholders (e.g. the Joint Consumer Groups' submission has input from 10 different organisations). In addition, CALI made a supplementary submission on mental health on 24 March 2026.

An Interim Report was published on 10 April 2026, which included proposed recommendations, with submissions requested by 8 May 2026. The Reviewer received nine public and two confidential submissions. These included four from organisations that did not submit in the first round.

All public submissions have been published on the Code review website (www.lifecodereview.org.au).

In addition, the Reviewer held over 50 meetings with interested stakeholders to discuss the Code and issues in the review, including the life insurance industry, industry bodies, consumer representatives, mental health advocates, medical experts, legal practitioners, the Australian Prudential Regulation Authority (APRA), the Australian Securities and Investments Commission (ASIC), Commonwealth Treasury, the Australian Financial Complaints Authority (AFCA), the Australian Human Rights Commission (AHRC) and the LCCC.

The Reviewer thanks all stakeholders for the constructive and thoughtful engagement on the many issues covered in the review.

Overall Observations

The Code plays an important role in setting out the commitments that life insurers make when dealing with their customers. These commitments include high level statements of principle that guide the actions of insurers, as well as specific promises across the insurance journey from product design and sales to claims handling and complaints management.

The extent of interest and detailed feedback from a wide range of stakeholders indicates the significance that stakeholders place on the Code. It is seen as a key initiative from the life insurance industry that should contribute to consumer and community trust and confidence. Given that life insurance supports people when they are at their most vulnerable, it is not surprising that there is a strong emphasis from stakeholders on fairness and transparency in the Code.

The review found that there are opportunities to improve the Code as well as to clarify the commitments it contains. This includes the opportunity for the insurance industry to refresh the overall principles and the objectives of the Code. There are clear expectations that the Code should continue to develop to meet evolving customer and community standards. This needs to occur while ensuring that the Code continues to be practical and clear for insurers and other stakeholders.

The recommendations are intended to address the key objectives underpinning the review, being:

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.

While a wide range of topics were covered in the review, the most challenging issues arose in relation to the life insurance industry's approach to dealing with mental health conditions and the increase in claims in this area. There has been extensive material provided to the review and there are diverse stakeholder perspectives on this issue. Going forward, it will be critical for the Code to contain strong standards that ensure consumers experiencing mental health conditions are treated fairly and transparently, while also enabling insurers to respond to sustainability challenges. While there is a set of recommendations designed to help achieve these objectives, this will require further work by the industry in consultation with stakeholders to develop the approach to mental health in the Code. This is covered in the next section of the Report.

There are also law reforms underway that will potentially impact the way in which the life insurance industry interacts with its customers, such as the proposed mandatory standards for superannuation. This means that there will be some parts of the Code that will require further review once there is greater clarity on these matters.

2. Final recommendations



This section sets out the Reviewer’s final recommendations. In some areas, a response to feedback received on the Interim Report is included, especially where changes have been made to recommendations and/or recommendations have been added or removed.

2.1. Mental health

Mental health has been the most significant area of focus in the review. In the Interim Report, the Reviewer posed additional questions on the issue of permitting product design features that contain exclusions or limitations for mental health cover in standard form policies (without individual underwriting) in response to the industry’s supplementary submission on this issue¹.

At the outset, the Reviewer makes two broad observations:

1. Most stakeholders indicated that they understood the life insurance industry is facing significant sustainability challenges in light of the increase in claims relating to mental health. For example, the Actuaries Institute stated:

Mental health and the funding of mental health care, including from insurance safety nets, remains a pressing issue for Australian society, including the life insurance industry and its consumers. ... The Code should support the industry to respond and adapt to evolving expectations in a way that balances accessibility of insurance with equity for the insured population as a whole – considering fairness at both a macro and individual level.²

2. The range of views expressed by stakeholders relating to the coverage of mental health conditions in the Code is wide-ranging. In response to this issue, the Reviewer has recommended a series of changes to the Code as well as new commitments. However, there are aspects of this issue that cannot simply be resolved at this point through a change to the Code, but rather will require industry to engage with stakeholders to consider in more detail an appropriate path forward that supports both sustainability and the fair treatment of customers. As APRA noted in a recent speech on this issue:

A solution will not come from waiting for perfect conditions or pulling one lever. It will require disciplined risk management and coordinated action across claims, product design and stakeholder alignment.³

Overall Commitment to Mental Health

As discussed in the Interim Report, the Code should include a clear and prominent upfront statement of commitment to appropriate support for people experiencing mental health conditions (a statement currently sits in Appendix B of the Code). The statement could build on the existing commitments to take

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

² Actuaries Institute (12 May 2026) *Life Insurance Code of Practice Review – Interim Report Response*, Life Code review website, p 1.

³ Jane Magill, ‘TPD Sustainability: a product made for one world tested in another’ (Speech, All Actuaries Summit, 27 May 2026), APRA website.

extra care and treat people with empathy, compassion and respect, which are in turn supported by specific commitments in the Code.

Standard form contracts and blanket mental health exclusions

Clause 2.1(b) of the Code currently states that insurers, when designing new products, will not incorporate a blanket exclusion specific to mental health in the general terms and conditions of the standard form contract, consistent with their obligations under the Disability Discrimination Act 1992 (DDA). This does not apply to Group policies or products designed to cover specific conditions such as trauma and critical illness policies.

As noted in the Interim Report, there are different views as to what clause 2.1(b) currently requires of Code subscribers. Most stakeholders view it as representing a commitment to go beyond the minimum requirements of the DDA and to not include blanket mental health exclusions in policies before individual underwriting even if these were permissible under the DDA. The Reviewer accepts this position. In its supplementary submission to the Consultation Paper, CALI also acknowledged that this clause “is widely understood to prohibit terms and conditions in standard form contracts that exclude or limit coverage for mental health conditions above and beyond the requirements of the DDA.”⁴

In its supplementary submission CALI argued that this prohibition is not sustainable as it does not enable insurers to adequately respond to the growing challenges associated with the rise of mental health conditions in the community and the increase in claims. CALI recommended that the Code should allow product design features that limit cover for mental health conditions, which would potentially constitute discrimination – to the extent allowable under the exemption for life insurers in the DDA. The CALI submission sets out the industry’s preferred approach – to be able to incorporate such design features into new products as long as this is consistent with the exemptions allowed under the DDA.

The issue for the review is what the position in the Code should be going forward. The Reviewer set out a range of questions in the Interim Report to test stakeholder views on the industry’s preferred approach to coverage of mental health conditions in the Code. Submissions to the Interim Report indicate that there are different understandings and, in some cases, conflicting views on the key elements of this issue. There are several related aspects where key differences are apparent:

- What exclusions or limitations insurers *can* include in the design of standard form contracts (i.e. the legal basis for discrimination);
- What exclusions or limitations insurers *should* include in the design of standard form contracts; and
- What a ‘blanket exclusion’ and/or ‘limitation’ means for the purposes of insurance policy design.

The Interim Report also sought feedback on what principles, provisions or ‘guardrails’ might be included in the Code if it permitted insurers to incorporate limitations for mental health conditions in standard form contracts (before individual underwriting). There was less feedback on this issue i.e. there was less

⁴ CALI (24 March 2026), p 8.

feedback provided in submissions on matters such as any restrictions on the types of exclusions or limitations that may be appropriate, or the information that could be specified to help ensure consumers were well informed when making a choice in such circumstances.

The legal position on limitations on coverage for mental health conditions

The majority of submissions accepted that insurers could incorporate exclusions or limitations into standard form contracts under the DDA provided they have relevant actuarial or statistical data and appropriately consider other relevant factors. However, the submission from the Financial Rights Legal Centre (FRLC) and Justice and Equity Centre (JEC, formerly Public Interest Advocacy Centre) argued that it is “highly unlikely that life insurers are able to use standard forms to discriminate on the basis of mental health issues”.⁵ This FRLC/JEC submission argues that an ‘individual’s particular circumstances’, as one of the relevant factors to be considered under the DDA exemption, ought to have particular prominence.

It is not the role of the Reviewer to provide a definitive legal view on when insurers can incorporate exclusions or limitations on mental health cover. However, to help inform the Final Report the Reviewer obtained advice from Counsel (Stephen Walsh) on this issue (available on the Code review website: www.lifecodereview.org.au). Some stakeholders (e.g. the LCCC) suggested that legal advice would assist with the consideration of this issue. The purpose of obtaining this advice is to help guide recommendations in this area, rather than seeking to comprehensively resolve all possible legal issues in relation to mental health coverage in life insurance policies.

Counsel’s responses to the following questions are relevant for this issue:

1. Are insurers permitted to incorporate a total exclusion for mental health conditions, or particular categories or types of mental health conditions?

*Yes, provided they can meet the actuarial or statistical data or unjustifiable hardship exemptions in the DDA. In practice, a total exclusion of all mental health conditions will be more difficult to justify than an exclusion which is targeted to a particular category or type of mental health condition.*⁶

2. Can insurers limit cover for mental health conditions (for example, lower payouts, instalment payments, higher premiums for cover that includes mental health conditions, or lower premiums for consumers that opt out of mental health cover) that are not imposed with respect to physical conditions?

Again, yes, provided they can meet the actuarial or statistical data or unjustifiable hardship exemptions in the DDA. In practice, it would be necessary for the insurer to be able to justify the limitation by reference to actuarial or statistical data relevant to the mental health conditions in

⁵ Financial Rights Legal Centre (13 May 2026) *Supplementary Submission to the Life Code Review*, Life Code review website, p 12.

⁶ Stephen Walsh, ‘Advice on Application of the Disability Discrimination Act to Limitations on Coverage for Mental Health Conditions in Standard Form Insurance Contracts’ (Legal Opinion, 8 June 2025), pp 14-15.

*question and/or other relevant factors. The insurer would also need to be able to justify the differential treatment of mental health conditions and physical conditions by reference to actuarial or statistical data and/or other relevant factors.*⁷

Counsel goes on to state that, “[t]he ultimate question is whether the discrimination is reasonable having regard to all of the circumstances...The factors that will apply will vary from case to case, depending on the circumstances.”⁸ Counsel also noted that “[t]he relevant factors to be considered will not necessarily all point one way (that is, for or against the reasonableness of the discrimination).”⁹ That is, the factors that determine the legal position will be specific to the design of the particular insurance product and will depend on the evidence and other relevant factors.

Code Commitments on Mental Health Cover in Standard Form Contracts

As noted by Counsel and in various submissions, design features that limit cover for mental health conditions in standard form contracts may be permissible under the DDA, if the requirements in the insurance exemption in section 46 of the DDA are met. However, there are different views on what insurers *should* commit to doing in relation to any limitations on cover for mental health conditions (i.e. when or how discrimination should be allowed even if the exemption under the DDA is satisfied).

This goes to the heart of the industry’s approach to mental health and is a key issue for the Code. The Code should provide a framework for what the industry should do in dealing with mental health cover that ensures fair treatment of customers.

Developing an appropriate approach will necessarily involve a range of commitments. In summary, the Reviewer recommends the following:

- A commitment in the Code to comply with the DDA (and other relevant anti-discrimination laws);
- A prohibition in the Code on the complete exclusion of mental health cover in standard form contracts, even if consistent with the DDA (i.e. a prohibition on an exclusion of cover for all mental health conditions).
- Except for a complete exclusion, no prohibition in the Code on the ability of insurers to include design features that limit cover for mental health conditions in standard form contracts, if this is consistent with the DDA, other relevant Code provisions and industry guidance that is developed on this issue.
- The Code should require that any standard form limitation on mental health cover must be supported by documented actuarial or statistical data and consideration of other relevant factors.
- A commitment in the Code that insurers should be required to undertake regular review of these product designs at least every three years to ensure they remain necessary, proportionate and are supported by relevant data.

⁷ Stephen Walsh, p 15.

⁸ Stephen Walsh, p 15.

⁹ Stephen Walsh, p 12

- The development of a consumer information guide (which includes information to assist understanding of design features that limit cover).
- A process led by industry for further work on this issue in consultation with key stakeholders to develop guidance, some of which may become part of the Code.
- The LCCC should consider a review of this area prior to the next Code review.

These recommendations are discussed below.

Commitment to comply with anti-discrimination law

A range of submissions supported the reinstatement of a clear and explicit commitment in the Code to comply with the DDA (and other relevant anti-discrimination legislation).

The Reviewer supports this approach (noting that this commitment should not be restricted to disability discrimination but also laws relating to sex and age discrimination). This should replace the current clause 2.1(b) in the Code.

However, simply stating insurers will comply with the DDA is insufficient. There is a clear expectation that the Code will contain specific commitments that support fair and transparent treatment of customers and that provide meaningful standards and guidance for compliance. Further, there are areas where the Code should set standards that exceed minimum legal requirements if fair consumer outcomes are to be achieved.

Prohibition against complete mental health exclusions

As noted above, the Reviewer found that there was a wide range of views on what constitutes a ‘blanket exclusion’ under the Code, including how broadly this is defined. In its current form it is not a term that provides clear guidance on product design or compliance. The term would no longer be a feature of the Code if the current clause 2.1(b) was removed.

Having said this, while opinions on the breadth of ‘blanket exclusion’ varied, there were clearer views on the undesirability of a complete exclusion of cover for all mental health conditions. That is, multiple stakeholders raised concerns about the potential for a *complete* exclusion of mental health cover in a standard form contract, even if this satisfied the DDA exemption. These concerns also applied to potential product designs whereby consumers could opt out of cover for all mental health conditions.

It would be an inappropriate response by the insurance industry to the mental health sustainability challenge to ‘walk away’ from mental health cover altogether in disability products. This is likely to cause significant detriment to consumers and would undermine the industry’s social licence. Concerns raised in relation to this issue included the ability of consumers to understand the implications of choosing such policies given uncertainty about their potential future needs. For example, the Actuaries Institute noted that “when policy limitations effectively exclude meaningful cover, some consumers may need to seek support from other parts of the safety net or may find themselves without adequate financial support at

all”.¹⁰ It is also the case that, as Counsel and other stakeholders noted, it is likely to be more difficult to justify a complete exclusion under the DDA.

The Reviewer recommends that this position is clearly stated in the Code. It should be made clear that a complete exclusion refers to policies that do not offer any cover for mental health conditions, including where consumers can opt out of mental health cover entirely.

Limitations on cover for mental health conditions

Except for a complete exclusion of cover for mental health conditions, the Code should not contain a prohibition on product design features that limit cover for mental health in standard form contracts, as long as any design features comply with the DDA, other relevant Code provisions and industry guidance developed on this issue. The industry has clearly stated that the ability to include ‘sustainable design features’ is a necessary response to the financial sustainability challenges raised by growing mental health claims. While there are strong and legitimate concerns about how these design features may operate, the need to include product design as part of the response to the mental health sustainability was supported by several submissions and has also been highlighted by regulators.¹¹

If such design features are allowed, there will need to be careful consideration of the protections and standards in the Code (and other related industry policies or guidance) to minimise the risk of harm for consumers and support transparency and fair treatment.

Stakeholders raised concerns about how any product design features that limit cover for mental health conditions in standard form contracts (consistent with the DDA) will work in practice. For example, the LCCC argued that, should limitations be allowed, “the Code should set clear industry commitments that support fair and transparent outcomes for customers, including protections that clarify how mental health limitations will be designed, explained, reviewed and applied in practice...[and] that any such additional Code safeguards be developed in consultation with key stakeholders.”¹²

In this light, the Reviewer makes several recommendations designed to support good practice and fair treatment of consumers that should be incorporated into the Code.

- The Code should state that any standard form limitation on mental health cover must be supported by documented actuarial or statistical data and/or consideration of other relevant factors; and
- Given that this is likely to be an area of ongoing evolution in both the community experience of mental health and design of products, the Code should require insurers to undertake regular review of these product designs (at least every three years, consistent with existing Clause 2.2) to ensure they remain necessary, proportionate and are supported by relevant data.

¹⁰ Actuaries Institute (12 May 2026), p 6.

¹¹ For example, a speech by APRA Executive Director Jane Magill to the 2026 All Actuaries Summit underlines (see footnote 3 above) the importance of rethinking policy design as part of the overall response to rising mental health claims.

¹² LCCC (May 2026) *Life Code Review Interim Report – Submission by the Life Code Compliance Committee*, Life Code review website, p 4.

In addition, there should be enhancements to the information provided to consumers on mental health cover and claims. The Reviewer recommended in the Interim Report that the industry should produce a 'Consumer Guide to Life Insurance and Mental Health' (with stakeholder input). This Guide is intended to be a plain-English consumer document that provides information on life insurance and mental health, the Code and the law. It should therefore also include information that improves understanding of the issues relating to any limitations on mental health cover in standard form contracts. Any such guide should be developed with input from stakeholders, including consumer advocates and mental health experts.

A process to identify principles and guidelines for mental health cover

The above recommendations will help to ensure the Code supports a fair and transparent approach to mental health by the life insurance industry. However, there will be a need for further work to develop key principles and guidelines on mental health and appropriate policy design. The industry's recent clarification of its preferred position means there has not been sufficient opportunity for stakeholders to develop an understanding of, and provide feedback on, all aspects of the approach to design limitations and mental health cover.

The Reviewer therefore recommends that CALI institutes a process to work with stakeholders to develop key principles and guidance for ensuring fair and transparent cover and fair dealings with customers with mental health conditions. This could include (but need not be limited to):

- Guidance on high level principles that might inform approaches to sustainable product design features. For example, while limitations are permitted, policies should still include meaningful cover for mental health and any limitations or exclusions should be defined as narrowly as practicable to support sustainability. These principles could also include any relevant output from the industry process to develop a sustainable disability insurance action plan which CALI has been running in parallel to this review;
- The identification of any aspects of policy design that may pose higher risk of consumer detriment and consideration of how these could be addressed. (It would not be feasible nor desirable for the industry to develop a list of permissible policy design features);
- Guidance around the data that might support and/or assist policy design in relation to limitations on mental health cover, including qualitative data and other relevant factors that would comply with the DDA. Consideration could also be given to whether some industry level data on mental health claims could be made publicly available on a more regular basis; and
- Relevant content for the proposed 'Consumer Guide to Life Insurance and Mental Health', designed to help ensure consumers understand the implications of different product designs, levels of cover and individual underwriting options.

The Reviewer acknowledges that this is an area where different approaches to risk appetite by individual insurers and the requirements of competition law may prevent detailed prescription of policy design. Nonetheless, it would be desirable for the Code to require insurers to comply with the key aspects of the industry principles or guidance that are developed.

The Reviewer is not prescribing the details of this process or its outcomes. It will need to be owned and led by the industry, although there may be benefit in having third party expertise to build trust in the

process and help ensure it is efficient and effective. As well as industry, other stakeholders that should be considered include the AHRC, groups representing consumers, mental health advocacy organisations, financial adviser organisations, legal representatives, the LCCC, AFCA and regulators. A timely process should aim to identify any additional changes to the Code within a reasonable timeframe. There would also need to be recognition that this is an evolving area, so that 'once and for all' guidance on all issues is unlikely to be possible.

Once such arrangements have been in place for an appropriate period it would be desirable for this issue to be reviewed by the LCCC, preferably prior to the next Code review. (This recommendation is made with the understanding that the LCCC will make its own independent decisions about the reviews it undertakes).

Recommendations

1. *The Code should contain a new overall industry commitment to dealing appropriately with customers experiencing a mental health condition in Section 1 rather than in Appendix B.*
2. *Develop a standalone plain-English consumer document - 'Consumer Guide to Life Insurance and Mental Health' that is readily available to consumers and is prominently positioned on insurer websites. This should have relevant stakeholder input.*
3. *The Life Code should explicitly state that insurers will comply with relevant anti-discrimination law including the Disability Discrimination Act 1992, Sex Discrimination Act 1984, Age Discrimination Act 2004 and any other Federal, State or Territory anti-discrimination legislation.*
4. *The Life Code should prohibit total exclusions of coverage for mental health conditions in standard form contracts i.e. insurance policies that automatically exclude cover for all mental health conditions, even if these might be consistent with the DDA. This would include where the customer can opt out of mental health cover entirely. (This would not apply to products designed to cover specific conditions such as critical illness insurance or accidental injury cover).*
5. *The Code should require that any standard form limitation on mental health cover must be supported by documented actuarial or statistical data and consideration of other relevant factors.*
6. *Insurers should be required to undertake regular review of these product designs at least every three years (consistent with clause 2.2) to ensure they remain necessary, proportionate and are supported by relevant data.*
7. *CALI should institute a process to work with stakeholders to develop principles and/or guidance for ensuring fair and transparent cover and fair dealings with customers with mental health conditions. This could include (but need not be limited to):*
 - *Guidance on high level principles that might inform approaches to sustainable product design features. For example, while limitations are permitted, policies should still include meaningful cover for mental health and any limitations or exclusions should be defined as narrowly as practicable to support sustainability. This could also include any relevant output from the industry process to develop a sustainable disability insurance action plan which CALI has been running in parallel to this review;*
 - *The identification of any policy design features that may pose higher risk of consumer detriment. (It would not be feasible nor desirable for the industry to develop a list of permissible policy design features);*

- *Guidance around the data that might support and/or assist the design of limitations on mental health cover, including qualitative data and other relevant factors that would comply with the DDA. There also may be scope to make some industry level data more publicly available; and*
 - *Relevant content for the proposed 'Consumer Guide to Life Insurance and Mental Health', designed to help ensure consumers understand the implications of different product designs, levels of cover and individual underwriting options.*
8. *The LCCC should review insurer experience and compliance with these Code requirements prior to the next Code review.*

Individually underwritten policies

For individually underwritten policies, when an insurer declines to provide cover or offers cover on non-standard terms, it should provide a clear explanation to customers.

In the Interim Report, the recommendation was that a plain English summary of the actuarial and statistical data or other relevant data it has relied on to justify the decision. However, feedback was that not all customers require a summary of the actuarial and statistical data.

To ensure consumers receive clear information on underwriting decisions, while providing access to the relevant data on which a decision is based, the Reviewer has separated the proposal into two recommendations.

Firstly, 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.

The intent of this recommendation is that customers receive a meaningful explanation which would enable them to understand why the insurer has declined their application or is only willing to offer alternative terms. If relevant, in some cases this information may assist the customer to provide additional information that could alter the decision on cover.

In addition, a new clause should be included in the Code that would require insurers, on request, to provide a plain English summary of the actuarial and statistical data or other relevant data on which the decision is based, with sufficient detail to enable the consumer to understand how this information relates to the decision on their application. This is consistent with existing legislative obligations in various discrimination acts which require insurers to provide information to consumers (on request) when they rely on the insurance exemptions provided in those acts, including:

- the Australian Capital Territory’s Discrimination Act 1991 requires insurers to, on request, “give the consumer a copy of the data or other documents, or a meaningful explanation of the data or other documents in writing” or make them available for the consumer to inspect;¹³
- the South Australian Equal Opportunity Act 1984 requires insurers to provide on request “a summary of the actuarial or statistical data on which it [a decision to discriminate in insurance] is based”,¹⁴ and
- the Federal Sex Discrimination Act 1984 requires insurers to make available on request “a document containing the data” that has been used to justify reliance on the insurance exemption.¹⁵

While this issue is being raised in the context of mental health, the recommendations are intended to apply to all underwriting decisions.

Recommendations

9. *When an insurer declines to provide cover or offers cover on non-standard terms, 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; and*
 - *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.*
10. *Insurers should be required to provide, on request, a plain English summary of the actuarial and statistical data or other relevant data the insurer has relied on for the decision, with sufficient detail to enable the consumer to understand how this information relates to the decision on their application.*
11. *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’).*
12. *Remove Appendix B of the Code (as recommended above, include a clear statement in the main body of the Code on mental health).*
13. *Incorporate the commitment to provide an assigned claims assessor in clause 14 of Appendix B into the Code provisions relating to Claims Handling.*

¹³ s 28(3), Discrimination Act 1991 (ACT).

¹⁴ s 89, Equal Opportunity Act 1984 (SA).

¹⁵ s 41(e), Sex Discrimination Act 1984 (Cth).

2.2. Supporting customers experiencing vulnerability

As discussed in the Interim Report, 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 the commitments made by peer sectors.

Recommendations

14. *Clauses 6.9 and 6.10 in the Code that refer to customer disclosure of ‘vulnerability’ should be redrafted to emphasise the disclosure of the consumer’s situation. This should be done so to assist to the identification of 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.”*
15. *Section 6 of the Code should start with a broad definition of vulnerability consistent with AS 22458.*
16. *The Code should require insurers to follow the key principles in AS 22458 so as to improve outcomes for consumers experiencing vulnerability. These include:*
 - *A commitment to a proactive, outcomes focused approach;*
 - *Inclusive design, especially in customer service and claims processes; and*
 - *Requiring insurers to have a range of free, easy to access contact channels so that consumers can choose their preferred method of communication.*
17. *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 identity and sex characteristics” as potential risk factors and expand “Family violence” to “family violence including financial abuse”.*
18. *Where risk factors are identified, insurers should specifically ask consumers about their circumstances and whether any assistance or extra care is required to help them engage with their insurer.*
19. *Clause 6.15 should be expanded to include trauma-informed policies and training.*
20. *Insurers should take appropriate steps to record, with consent, personal information to help support people experiencing vulnerability.*
21. *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.*

2.3. Family and domestic violence

The Reviewer notes feedback that requiring insurers to do “everything possible” to protect the safety of the person affected by family violence may be difficult to apply in all cases. There will be instances, due to the operation of relevant laws, when the actions available to insurers may be constrained. To reflect this the recommendation has been amended to require insurers to do “everything reasonably possible”.

This requirement sits alongside the other recommendations that the Code should require insurers to comply with the key requirements of CALI’s Best Practice Guidance on Family and Domestic Violence Policies. It is important that customers and other stakeholders can be confident that insurers meet a minimum standard and can be held to account for that through the Code.

Recommendations

22. *Where family violence is identified or suspected, the Code should commit insurers to do everything reasonably possible to protect the safety of the person affected by family violence and their family.*
23. *The Code should require insurers to comply with key requirements of CALI’s Best Practice Guidance (BPG) on Family and Domestic Violence Policies.*
24. *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.*

2.4. Supporting customers experiencing financial hardship

The Reviewer recommended new Code clauses that:

- set out a non-exhaustive list of risk factors that may prompt an insurer to initiate further investigation and/or a conversation about hardship support options; and
- where risk factors are present, require insurers to ask consumers about their circumstances and whether hardship support is required.

The Reviewer notes feedback that prescriptive lists should be avoided in this area. However, as noted in the Interim Report, this recommendation is not setting out a prescribed list but rather guidance on relevant risk factors. These recommendations build on the existing commitment in clause 6.18 of the Code, which requires insurers to contact customers to tell them about hardship support options where financial hardship is identified by the insurer or disclosed by the customer. The examples of risk factors are intended to be a guide that may indicate to an insurer that a consumer is experiencing financial hardship. Providing a non-exhaustive list of this nature should not reduce an insurer’s ability to identify potential financial hardship risk factors (including ones not on the list) in a flexible and principles-based way.

The Reviewer is also recommending an additional risk factor be added to the list of examples. In circumstances where a person is overpaid benefits from an insurance policy, the impact of a sudden and unanticipated decision by the insurer to recover the amount by reducing payments, ceasing payments or requiring repayment can cause significant hardship. In these cases, insurers should consider whether support is required. It would be appropriate to add this to the list of examples.

The Interim Report included two comments which were not reflected in the recommendations:

1. Two additional hardship support options which should be included in clause 6.18:
 - Considering payment plans to cover a period of hardship; and
 - Facilitating access to and/or representation by financial counsellors or similar consumer representatives; and
2. Including an acknowledgement that financial hardship presents differently for different people and a commitment by insurers to tailor support appropriately

The recommendations have been updated to incorporate these points.

Recommendations

25. *Redraft 6.18 to separate the concepts of overall intent on financial hardship; identification and risk factors; and possible flexible support options.*
26. *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,*
 - f. *customers that indicate difficulty in affording premiums or managing general living expenses, especially for customers with legacy products, and*
 - g. *customers who are asked to repay an overpayment of benefits*
27. *Where risk factors are present, insurers should ask consumers about their circumstances and whether any hardship support is required.*
28. *The Code should require that insurers have readily accessible information (e.g. on websites) about financial hardship support.*
29. *Include a clause in the Code acknowledging that financial hardship presents differently for different people and committing insurers to tailor support to the customer's circumstances and setting out additional examples of flexible support options, including:*
 - *considering payment plans to cover a period of hardship; and*
 - *facilitating access to and/or representation by financial counsellors or similar consumer representatives.*
30. *Amend clauses 6.18 to specify that the communication should occur within five days.*
31. *Include a timeframe of 20 business days before the support ends for clause 6.20.*

2.5. First Nations customers

The LCCC's review of Indigenous support identified 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.”¹⁶ The Reviewer has made recommendations to address key areas of improvement identified by the LCCC.

In the Interim Report, the Reviewer said, “insurers should examine ways to improve access to interpreters in line with the Code commitment, and as part of the response to the LCCC review”. This has now been included as a recommendation.

Feedback on the Interim Report has also reinforced the importance of developing communication materials for First Nations customers in consultation with First Nations representatives. Where possible, insurers should consult with First Nations representatives on communications that are targeted to First Nations customers and certainly look to do so for key communication materials. This was reflected in the discussion in the Interim Report and has now been included in the recommendations.

Recommendations

32. *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.”*
33. *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.*
34. *Insurers should examine ways to improve access to interpreters in line with the Code commitment, and as part of the response to the LCCC review.*
35. *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.*
36. *Insurers should consult with First Nations representatives on key communication materials specifically targeted to First Nations customers.*

2.6. Claims handling

Industry feedback has raised some concerns relating to timeframes included in the recommendations on claims handling. Overall, the Reviewer considers that timeframes for key processes are important to set a minimum standard and ensure they do not lead to uncertainty and potentially lengthy delays in claims handling.

¹⁶ LCCC (8 December 2025) *More needed to support First Nations customers* [media release], LCCC website.

When a claim is received

The Reviewer accepts that the reduced timeframe of five business days in clause 5.5 is challenging and unlikely to improve consumer outcomes given that insurers still need to meet the overall claims handling timeframes. This recommendation has been removed, and the industry should continue to comply with the existing timeframe in clause 5.5 to deliver key information within 10 business days.

Reopened claims

The Reviewer proposed that timeframes should be applied for reopened claims and that these should be shorter than the timeframe for an initial claim.

CALI proposed that fixed timeframes should not be imposed for reopened claims because this would constrain the ability to properly assess the claim, particularly where significant further investigation or assessment is required.

The Reviewer accepts there will be some reopened claims where the insurer is largely starting from scratch, for example, if the claim was closed because limited information was received from the claimant. However, there will be many cases where a thorough process has taken place, but a query is being raised about the decision to close or a dispute has arisen. 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) and a shorter timeframe should apply to reopened claims. The Reviewer notes that 'Circumstances Beyond our Control' (CBOC) would continue to apply to reopened cases.

To clarify the recommendation it has been amended to include timeframes of one month for income-related claims and three months for lump sum claims (these represent half of the standard timeframes allowed for initial claims), and to explicitly note that CBOC will also apply to reopened claims.

Regular updates during a claim

In the Interim Report, the Reviewer recommended the Code should require that regular updates provided to claimants under clause 5.6 include:

1. key steps that have occurred since the last update;
2. anything that the insurer is waiting on from the claimant or a third party and:
 - a. where the consumer has not provided required information, reiterate the offer to assist the consumer where possible (clause 5.3); and
 - b. 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
3. what next steps will be taking place.

Industry feedback suggested that insurers have no reliable means of determining when a third party will respond in all cases and therefore that detail should not be included in the updates. The Reviewer accepts that insurers do not have control over third parties and may not always be able to provide an exact time for when a third-party process will be completed. However, this is an obvious question that claimants will have, and it is important that insurers communicate a reasonable estimate of when it is

expected to be completed, even if this estimate is appropriately qualified. Therefore, the recommendation has not been changed.

Circumstances Beyond our Control

As discussed in the Interim Report, it is reasonable for the Code to make allowances for CBOC which may prevent insurers from resolving a claim within the prescribed timeframes. However, the Reviewer has recommended that the components of CBOC should be expressed more clearly to ensure it is more informative and actionable for insurers, customers and other stakeholders. This includes adding timeframes for insurers to complete an investigation relating to suspected non-disclosure (part (g)) or fraudulent claims (part (h)) where they rely on those limbs of the CBOC definition.

Industry feedback has suggested this should be amended so that there are no fixed timeframes and instead the Code should require strong governance and timely progression for investigations into suspected non-disclosure, misrepresentation or fraud.

While there may be uncertainty in some cases, the Reviewer considers it important that timeframes for these investigations are included in the Code. This is to ensure they do not become a mechanism for potentially lengthy ongoing delay when a claim has not been resolved within the expected timeframes. Further, it should already be the case that there is strong governance for investigations. The appropriate length of the timeframes could be reviewed after they have been in operation for 12-14 months or before the next Code review.

The Reviewer also recommended that the LCCC should publish data on how insurers use CBOC based on a clearer structure, including the frequency and grounds for CBOC. While it is standard practice for the LCCC to consult with the industry on data collection, the recommendation has been amended to clarify that the reporting framework for CBOC should be developed by the LCCC in consultation with CALI and Code subscribers.

Surveillance

The Reviewer has recommended that the Code permit one defined period of surveillance of no more than four months for each claim (which is consistent with the current provision). CALI has recommended that this be clarified to permit multiple instances of surveillance not exceeding four months. However, this would effectively provide insurers with open-ended surveillance because there would be no limit on the number of four-month periods of surveillance an insurer could undertake. The Reviewer believes it is important that there is a reasonable limit on insurers' ability to undertake surveillance and one period of no more than four months should generally be sufficient. A limited allowance for additional surveillance in exceptional circumstances where material new information comes to light could be included. The reasons for any recourse to such an exception should be documented by the insurer.

Medical evidence

The Reviewer recommended that insurers should be required to consult with a claimant's treating doctor before making a decision on whether a claimant satisfies the relevant policy medical definitions. In response to the Interim Report, CALI provided evidence of existing industry processes that involve

obtaining information from treating medical practitioners, including examples of insurers' standard claims forms that seek this information. It is important that insurers have good practices to do this and ask appropriate questions of relevantly qualified treating medical practitioners to enable them to consider all relevant evidence in determining whether a claimant meets a policy definition. However, it would not appear to require an additional obligation in the Code at this point and the recommendation has been removed.

Recommendations

37. *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.*
38. *Where an insurer reopens a claim under clause 5.57, the claims reassessment should be completed within one month for income-related claims or three months for lump sum claims. Circumstances Beyond our Control should apply to reopened claims.*
39. *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;*
 - *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 a reasonable estimate of when it is expected to be completed; and*
 - *what next steps will be taking place.*
40. *Amend clauses 5.59 and 5.60 to reference clause 5.6 in relation to the regular updates required under those clauses.*
41. *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.*
42. *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.*
43. *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.*
44. *Amend the definition of CBOC to provide a clearer structure, links to other Code commitments and timeframes as listed in section 2.5.3 of the Interim Report.*
45. *The LCCC should publish data on how insurers use CBOC (under the revised structure), including the frequency and grounds for CBOC. The reporting framework should be developed by the LCCC in consultation with CALI and Code subscribers*
46. *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 allowance for additional surveillance in exceptional circumstances where material new information comes to light could be included. The reasons for any recourse to this exception should be documented by the insurer.*
47. *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. This should not delay the development of a new Code that responds to other recommendations in the Final Report.*

2.7. Medical definitions

The Reviewer found that there would be benefit in establishing a separate medical definitions guide (MDG) and improving the process for updating medical definitions, including through the establishment of an MDG expert panel.

Recommendations

48. *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.*
49. *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.*
50. *The expert panel should review the three existing Code medical definitions as soon as possible.*
51. *The Code should include a definition of "obsolete method of diagnosis or treatment".*
52. *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.*
53. *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.*

2.8. Training

To supplement existing role-specific training obligations in the Code, 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

54. *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, which should include:*
 - *the requirements outlined in the Code;*
 - *the relevant products and services provided by the Code Subscriber; and*
 - *dealing appropriately with customers experiencing vulnerability.*

2.9. Advertising and sales practices

The Reviewer identified the need for the industry to strengthen commitments on unacceptable sales practices including (but not limited to) pressure selling. The Reviewer has considered feedback on the specific recommendations relating to funeral insurance as discussed below.

Funeral insurance

Stakeholder feedback on the Interim Report confirmed that funeral insurance remains an area of concern. The feedback also helped identify potential opportunities to simplify the recommendations. This will provide more effective consumer protection against poor value products and reduce the reliance on disclosure for both customers and insurers.

As a new recommendation, the Reviewer considers that the Code should require issuers of funeral insurance to incorporate a 'premium guarantee' in the design of products, whereby the benefit paid under a funeral insurance policy would be the higher of:

- The insured sum or cover amount; or
- The total amount of premiums paid.

This would provide protection to consumers, especially those who may have lower levels of financial literacy or do not fully understand the long-term cost and value of such policies. If this measure is adopted, several recommendations in the Interim Report could be removed or amended, notably communicating total premiums paid to date on annual statements.

As part of this commitment, consideration would also need to be given to policyholders who cease payments on their policy and the policy is cancelled. This is a concern that was highlighted by consumer stakeholders, especially when longer term customers face affordability challenges e.g. if premiums increase and/or they leave the workforce. This should not result in an unfair outcome for customers in such circumstances. The commitment should therefore include a requirement that the premium guarantee operates to ensure the repayment of premiums to customers when policies are cancelled. It may be appropriate to set a minimum timeframe for this requirement e.g. policies that have been held for two years.

The Reviewer believes there is merit in retaining an age limit on selling funeral insurance. However, if the above commitment was introduced, the age limit could be reduced from under 50 years of age (as proposed in the Interim Report) to under 40 years of age.

Insurers should still be prohibited from selling funeral insurance to consumers who already have a funeral policy. The Reviewer accepts that, in many cases, insurers will need to rely on information from the customer to determine whether they already have a funeral insurance policy. However, the onus should be on insurers to ask the customer as part of the sales process rather than relying on voluntary disclosure.

Recommendations

55. 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."*

56. *The Code should require issuers of funeral insurance to incorporate a “premium guarantee” in the design of products, whereby the benefit paid under a funeral insurance policy would be the higher of:*

- a. The insured sum or cover amount; or*
- b. The total amount of premiums paid.*

The premium guarantee should also operate to ensure the repayment of premiums to customers whose policies are cancelled after having been held for two years or more.

57. *Insurers should be prohibited from selling funeral insurance to consumers who are under 40 years of age.*

58. *As part of the sales process, insurers should be required to ask potential customers whether they have an existing funeral insurance policy and be prohibited from selling funeral insurance to consumers who are identified as already having a funeral policy.*

59. *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”.*

2.10. Communication

The discussion below includes responses to feedback on two areas of communication that were not addressed in the Interim Report.

Premiums

The Financial Advice Association Australia (FAAA) has raised concerns about upfront discounting (or duration-based pricing) by insurers and has recommended that it should be prohibited. The FAAA and financial advisers are concerned that while upfront discounting is used to attract new business, it leads to large increases in premiums once the discounting ends that may have a detrimental impact on affordability. This was also an area of focus in APRA and ASIC’s joint review of life insurance premiums. In their final report, APRA and ASIC said they expect life companies to:

- *only use duration-based pricing where this reflects a reduction in the risk they face, and*
- *do more at the outset to make consumers aware of duration-based pricing and other temporary discounts and how they unwind over the life of a policy.*¹⁷

This is a significant issue and may impact sustainability. However, industry codes are typically not used for detailed prescription of product pricing, which in this case would be the pricing discount structures used by life insurers. The Reviewer has highlighted the importance of clear communication of premiums in the sales process, including through recommendation 61 of this Report.

¹⁷ APRA & ASIC (5 June 2025) *Premium increases in life insurance: Are life companies addressing issue identified by regulators?*, APRA website.

Policy cancellations

Consumer groups have identified consumer harm that arises due to communication with customers regarding cancellations of insurance policies. The Code already requires insurers to let policy owners know if there is an option to reinstate the policy where it has been cancelled due to unpaid premiums. To clarify the Code commitments on cancelled life insurance policies, the current section of the Code titled 'Customers can cancel policies they do not want' should be separated under two separate headings: one using the existing title and one titled 'Insurers may cancel policies in some circumstances'. Existing clauses should be moved under the relevant heading. This should be supplemented by commitments that cancellation processes will be transparent, straightforward, and do not require the provision of unnecessary information, and, where the insurer cancels a policy, to provide a clear explanation. These have been added as recommendations.

Recommendations

60. Update the Code to reflect the new premium labels for retail life insurance policies.
61. 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.
62. Amend Section 3 in relation to information provided to customers with existing policies where there is a decision to vary or avoid as above.
63. The current section of the Code titled 'Customers can cancel policies they do not want' should be separated under two separate headings: one using the existing title and one titled 'Insurers may cancel policies in some circumstances'. Existing clauses should be moved under the relevant headings. This should include a commitment that cancellation processes will be transparent, straightforward, and do not require the provision of unnecessary information.
64. Where insurers cancel a policy, they should be required to provide a clear explanation of the reason to the customer.

2.11. Complaints

In addition to the recommendations in the Interim Report, the Reviewer has identified some minor additional recommendations to clarify the clauses dealing with complaints, including that:

- Clause 4.25 should be amended to require insurers to inform applicants about both the insurer's complaints process and external dispute mechanisms; and
- It would be beneficial to align the language in clause 7.13 with clause 7.17. A consumer should receive the same information whether a final written response is provided by a superannuation trustee or an insurer. Subclause (d) should specify that information will be provided on how to contact AFCA and any time limit for doing so.

Recommendations

65. Include a clause that explicitly states that Code Subscribers will have internal dispute resolution processes that comply with ASIC Regulatory Guide 271.
66. Amend clauses 7.13, 7.15 and 7.17 to refer to 'the Australian Financial Complaints Authority' rather than 'an External Dispute Resolution body'.
67. The Code should require insurers to have processes in place to ensure complaints are a feedback mechanism for continuous improvement.
68. Clause 4.25 should be amended to require insurers to inform applicants about both the insurer's complaints process and external dispute mechanisms.
69. Amend clause 7.13 to be consistent with clause 7.17. Subclause (d) of both clauses should specify that information will be provided on how to contact AFCA and any time limit for doing so.

2.12. Genetic testing

The Reviewer has recommended removing *Appendix A: Moratorium on Genetic Tests in Life Insurance* now that the Insurance Contracts Act 1984 has been amended to include the ban on the use of genetic testing in life insurance.

This legislation operates prospectively. It does not require insurers to identify customers who have previously received underwriting outcomes based on adverse genetic test results and remove the loadings or exclusions. Consumer groups have recommended that this should be a requirement in the Code.

The Reviewer notes that this was considered by the Senate Economics Committee when it reviewed the legislation. The Committee said:

*While recognising the challenges involved in having the ban apply retrospectively to existing life insurance contracts, the committee considers this a vital area for the Australian Government to address in conjunction with industry. As such, the committee encourages the Assistant Treasurer to provide an update on efforts to extend the ban to existing life insurance contracts.*¹⁸

Given this and ongoing stakeholder concern, CALI and its members should consider what they can do to address this issue. However, the Code is not the appropriate vehicle for imposing specific retrospective remediation processes of this sort. Such processes, if implemented, would require regulatory oversight and, as identified in the Senate Economics Committee report, this is appropriately a role for the Government working with industry.

¹⁸ Senate Economics Legislation Committee (February 2026) *Treasury Laws Amendment (Genetic Testing in Life Insurance and Other Measures) Bill 2025*, Australian Parliament House website, p 40.

Recommendations

70. Remove 'Appendix A: Moratorium on Genetic Tests in Life Insurance' and clause 4.17 from the Code.

2.13. Code structure

Overall, the Reviewer observes that the Code is appropriately structured and covers the right issues, with some adjustments and additions as recommended in this Report. Nonetheless, as discussed in the Interim Report there are opportunities to improve the clarity in the Code by:

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

Recommendations

71. 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.

72. The Code should contain a link to all relevant CALI industry guidelines and protocols.

2.14. LGBTIQ+ customers

Consumer groups have recommended that, in line with the recommendations of the Worth the Risk report,¹⁹ the Code should include a provision in clause 2.1 that insurers will design new products that do not discriminate against consumers based on their sexual orientation, gender identity, or intersex status, consistent with obligations under the Sex Discrimination Act 1984 and equivalent state and/or territory law. Recommendation 3 of this Report has been drafted to include all discrimination legislation, including the Sex Discrimination Act 1984 and Age Discrimination Act 2004.

2.15. Blood-borne diseases

Consumer groups raised several issues with the industry's approach to HIV and AIDS and other blood-borne diseases that were not addressed in the Interim Report.

This includes some changes to the Code and related documents, which have been added as recommendations, including:

- For ease of reading, the Code should separate out the provisions on mental health (clauses 4.12-4.14), family medical history (clauses 4.15-4.16) and HIV (clauses 4.17A-4.17C);

¹⁹ InsurePride (2023), 'Worth the Risk', InsurePride website.

- update the phrase “Human Immunodeficiency Syndrome” to “Human Immunodeficiency Virus”; and
- CALI should work with the Financial Services Council (FSC) to remove its HIV/AIDS underwriting guidelines as they are no longer relevant and have been superseded by the Code. CALI has advised the Reviewer that they have commenced discussions with the FSC.

Given the relatively new commitments in the Code relating to HIV, the LCCC should consider conducting an inquiry on how insurers approach decisions for customers who disclose HIV or other blood-borne viruses that includes:

- a. insurers' procedures and policies implemented to ensure compliance with requirements of the Code and anti-discrimination legislation relating to HIV and other blood-borne viruses; and
- b. statistics on coverage denials or less favourable terms offered to people with HIV and other blood-borne viruses.

The LCCC should consider incorporating this inquiry into their next annual workplan.

Consumer groups also proposed that CALI should establish a working group to enable insurance providers to collaborate with HIV and hepatitis organisations to implement the requirements of the Code relating to HIV and other blood-borne viruses, including ensuring that assessment processes and risk evaluation questions are as appropriate, relevant, and non-stigmatising as possible. This, and any other changes to the Code in relation to blood-borne viruses, should be considered by CALI following the completion of the LCCC inquiry and proposals that may come out of that inquiry.

Recommendations

73. *Separate out the provisions on mental health (clauses 4.12-4.14), family medical history (clauses 4.15-4.16) and HIV (clauses 4.17A-4.17C).*
74. *Update the phrase “Human Immunodeficiency Syndrome” in section 4 of the Code to “Human Immunodeficiency Virus”.*
75. *CALI should work with the Financial Services Council (FSC) to remove its HIV/AIDS underwriting guidelines.*
76. *The LCCC should consider conducting an inquiry on how insurers approach decisions for customers who disclose HIV or other blood-borne viruses that includes:*
 - a. insurers' procedures and policies implemented to ensure compliance with requirements of the Code and anti-discrimination legislation relating to HIV and other blood-borne viruses; and*
 - b. statistics on coverage denials or less favourable terms offered to people with HIV and other blood-borne viruses.*
77. *Following the completion of the LCCC inquiry, CALI should consider the need for any changes to the Code or other actions, in consultation with relevant stakeholders.*

2.16. Code governance and compliance

The Reviewer found there are opportunities to strengthen and clarify the powers of the LCCC to enhance its ability to monitor compliance with the Code and impose sanctions.

Recommendations

78. 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.

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

80. 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.

81. Amend clause 8.13 to clarify that all significant breaches of the Code should be reported to the LCCC while minimising duplicative reporting.

82. Limit the LCCC's ability to investigate a breach reported matter if it is already under investigation by a regulator.

2.17. Enforceability of the Code

In the Interim Report, the Reviewer noted the importance for consumer trust of having effective compliance frameworks and enforcement for Codes.

As part of the discussion of Code compliance and enforcement in the Interim Report, the Reviewer recommended that the Code should be incorporated into new customer contracts so that commitments are contractually enforceable. As noted, this would enhance consumers' ability to ensure that the commitments in the Code apply in practice. It would also be in line with the current or proposed approach in other parts of the financial services sector including banking and general insurance. There was strong support for contractual enforceability from a range of stakeholders.

Insurers raised concerns about contractual enforceability. CALI set these out in its submission, including:

- The guaranteed renewable nature of life insurance products. While this would not prevent contractual enforceability, the Reviewer accepts it is an added complexity that is not faced in banking or general insurance;
- That it would result in a Code that is more prescriptive and legalistic in nature to achieve contractual certainty and manage legal risk; and

- The relative lack of maturity of the Code when compared with other financial services industry codes.

These concerns raise legitimate challenges. However, robust compliance and enforcement is critical to the effectiveness of codes. The Reviewer supports the introduction of contractual enforceability as part of the compliance and enforcement framework for this Code. This would ultimately require the removal or modification of existing clause 8.10 about the provisions of the Code.

However, the timing of this change is complicated by other recommendations and related policy initiatives. As discussed in earlier sections there are several areas of the Code where significant further work will be required. Most notably, the Reviewer has recommended further work with stakeholders on developing the approach to mental health coverage, which may result in additional Code commitments and related guidance. The Reviewer also notes the potential impact of the mandatory superannuation service standards on various aspects of the Code and insurers' legal obligations, especially but not only in relation to group insurance.

Given this, the Reviewer is recommending that priority should be given to incorporating the review recommendations as well as the outcomes of the further work on mental health and changes resulting from mandatory superannuation service standards. Once this has occurred, CALI should initiate a process to work through how the Code can support contractual enforceability in new customer contracts, leading to the removal of clause 8.10. Recognising that this will take time, this objective should be included as part of the terms of reference for the next Code review, although the process to identify steps for contractual enforceability could commence before that time.

Recommendations

83. CALI should not seek designation of any code provision as an ASIC enforceable code provisions.
84. The Code should be developed to enable contractual enforceability in new customer contracts, including the removal of clause 8.10. A process to consider how this can be implemented should be commenced by CALI following the proposed work on mental health. This should form part of the terms of reference for the next Code review.

2.18. Future Code reviews

In line with ASIC's expectations in *Regulatory Guide 183: Codes of conduct for the financial services and credit sectors*, the Code should be reviewed every five years.

Recommendations

85. The Code should be reviewed every five years.

2.19. ASIC Approval

As noted in the Consultation Paper and the Interim Report, the review has been conducted in a manner intended to support an application for approval of the Code by ASIC, should CALI seek to do so. This has included independent review, multiple opportunities for stakeholder input through the Consultation

Paper and Interim Report, as well as extensive stakeholder engagement. As is apparent from the discussion in these reports, as well as the recommendations, there are many areas where enhancements to the Code have been identified that, if accepted, will see improvements to consumer outcomes and industry practices.

ASIC approval would help lift trust in the Code. It would help to give substance to the commitments that will underpin the industry's approach to dealing with mental health. The initial steps in any application for approval should not have to wait until consideration of mental health issues is concluded.

3. List of recommendations



Recommendation	Requires Code change
Mental health	
1. The Code should contain a new overall industry commitment to dealing appropriately with customers experiencing a mental health condition in Section 1 rather than in Appendix B.	Yes
2. Develop a standalone plain-English consumer document - 'Consumer Guide to Life Insurance and Mental Health' that is readily available to consumers and is prominently positioned on insurer websites. This should have relevant stakeholder input.	No
3. The Life Code should explicitly state that insurers will comply with relevant anti-discrimination law including the Disability Discrimination Act 1992, Sex Discrimination Act 1984, Age Discrimination Act 2004 and any other Federal, State or Territory anti-discrimination legislation.	Yes
4. The Life Code should prohibit total exclusions of coverage for mental health conditions in standard form contracts i.e. insurance policies that automatically exclude cover for all mental health conditions, even if these might be consistent with the DDA. This would include where the customer can opt out of mental health cover entirely. (This would not apply to products designed to cover specific conditions such as critical illness insurance or accidental injury cover).	Yes
5. The Code should require that any standard form limitation on mental health cover must be supported by documented actuarial or statistical data and consideration of other relevant factors.	The outcome of this may require changes to the Code
6. Insurers should be required to undertake regular review of these product designs at least every three years (consistent with clause 2.2) to ensure they remain necessary, proportionate and are supported by relevant data.	No

<p>7. CALI should institute a process to work with stakeholders to develop principles and/or guidance for ensuring fair and transparent cover and fair dealings with customers with mental health conditions. This could include (but need not be limited to):</p> <ul style="list-style-type: none"> • Guidance on high level principles that might inform approaches to sustainable product design features. For example, while limitations are permitted, policies should still include meaningful cover for mental health and any limitations or exclusions should be defined as narrowly as practicable to support sustainability. This could also include any relevant output from the industry process to develop a sustainable disability insurance action plan which CALI has been running in parallel to this review; • The identification of any policy design features that may pose higher risk of consumer detriment. (It would not be feasible nor desirable for the industry to develop a list of permissible policy design features); • Guidance around the data that might support and/or assist the design of limitations on mental health cover, including qualitative data and other relevant factors that would comply with the DDA. There also may be scope to make some industry level data more publicly available; and • Relevant content for the proposed ‘Consumer Guide to Life Insurance and Mental Health’, designed to help ensure consumers understand the implications of different product designs, levels of cover and individual underwriting options. 	<p>Yes</p>
<p>8. The LCCC should review insurer experience and compliance with these Code requirements prior to the next Code review.</p>	<p>Yes</p>
<p>9. When an insurer declines to provide cover or offers cover on non-standard terms, the Code’s current provisions in Section 4 setting out required information for applicants should be revised to:</p> <ul style="list-style-type: none"> • Clarify that this information should be in writing; and • 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. 	<p>Yes</p>

10. Insurers should be required to provide, on request, a plain English summary of the actuarial and statistical data or other relevant data the insurer has relied on for the decision, with sufficient detail to enable the consumer to understand how this information relates to the decision on their application.	Yes
11. 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').	Yes
12. Remove Appendix B of the Code (as recommended above, include a clear statement in the main body of the Code on mental health).	No
13. Incorporate the commitment to provide an assigned claims assessor in clause 14 of Appendix B into the Code provisions relating to Claims Handling.	Yes
Supporting customers experiencing vulnerability	
14. Clauses 6.9 and 6.10 in the Code that refer to customer disclosure of 'vulnerability' should be redrafted to emphasise the disclosure of the consumer's situation. This should be done so to assist to the identification of 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."	Yes
15. Section 6 of the Code should start with a broad definition of vulnerability consistent with AS 22458.	Yes
16. The Code should require insurers to follow the key principles in AS 22458 so as to improve outcomes for consumers experiencing vulnerability. These include: <ul style="list-style-type: none"> • 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. 	Yes

<p>17. Clause 6.1 should be amended to:</p> <ul style="list-style-type: none"> • 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 identity and sex characteristics” as potential risk factors and expand “Family violence” to “family violence including financial abuse”. 	<p>Yes</p>
<p>18. Where risk factors are identified, insurers should specifically ask consumers about their circumstances and whether any assistance or extra care is required to help them engage with their insurer.</p>	<p>Yes</p>
<p>19. Clause 6.15 should be expanded to include trauma-informed policies and training.</p>	<p>Yes</p>
<p>20. Insurers should take appropriate steps to record, with consent, personal information to help support people experiencing vulnerability.</p>	<p>Yes</p>
<p>21. 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.</p>	<p>Yes</p>
<p>Family and domestic violence</p>	
<p>22. Where family violence is identified or suspected, the Code should commit insurers to do everything reasonably possible to protect the safety of the person affected by family violence and their family.</p>	<p>Yes</p>
<p>23. The Code should require insurers to comply with key requirements of CALI’s Best Practice Guidance (BPG) on Family and Domestic Violence Policies.</p>	<p>Yes</p>
<p>24. In particular the Code should require insurers to:</p> <ul style="list-style-type: none"> • 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. 	<p>Yes</p>
<p>Supporting customers experiencing financial hardship</p>	
<p>25. Redraft 6.18 to separate the concepts of overall intent on financial hardship; identification and risk factors; and possible flexible support options.</p>	<p>Yes</p>

<p>26. 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:</p> <ol style="list-style-type: none"> 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, f. customers that indicate difficulty in affording premiums or managing general living expenses, especially for customers with legacy products, and g. Customers who are asked to repay an overpayment of benefits 	<p>Yes</p>
<p>27. Where risk factors are present, insurers should ask consumers about their circumstances and whether any hardship support is required.</p>	<p>Yes</p>
<p>28. The Code should require that insurers have readily accessible information (e.g. on websites) about financial hardship support.</p>	<p>Yes</p>
<p>29. Include a clause in the Code acknowledging that financial hardship presents differently for different people and committing insurers to tailor support to the customer’s circumstances and setting out additional examples of flexible support options, including:</p> <ul style="list-style-type: none"> • considering payment plans to cover a period of hardship; and • facilitating access to and/or representation by financial counsellors or similar consumer representatives. 	<p>Yes</p>
<p>30. Amend clauses 6.18 to specify that the communication should occur within five days.</p>	<p>Yes</p>
<p>31. Include a timeframe of 20 business days before the support ends for clause 6.20.</p>	<p>Yes</p>
<p>First Nations customers</p>	
<p>32. 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.”</p>	<p>Yes</p>
<p>33. 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.</p>	<p>Yes</p>
<p>34. Insurers should examine ways to improve access to interpreters in line with the Code commitment, and as part of the response to the LCCC review.</p>	<p>Yes</p>

35. 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.	Yes
36. Insurers should consult with First Nations representatives on key communication materials specifically targeted to First Nations customers.	No
Claims handling	
37. 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.	Yes
38. Where an insurer reopens a claim under clause 5.57, the claims reassessment should be completed within one month for income-related claims or three months for lump sum claims. Circumstances Beyond our Control should apply to reopened claims.	Yes
39. Regular updates under clause 5.6 should, at a minimum, include: <ul style="list-style-type: none"> • steps that have occurred since the last update; • anything that the insurer is waiting on from the claimant or a third party; • 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 a reasonable estimate of when it is expected to be completed; and • what next steps will be taking place. 	Yes
40. Amend clauses 5.59 and 5.60 to reference clause 5.6 in relation to the regular updates required under those clauses.	Yes
41. 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.	Yes
42. 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.	Yes
43. 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.	Yes

44. 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.	Yes
45. The LCCC should publish data on how insurers use CBOC based on a clearer structure, including the frequency and grounds for CBOC. The reporting framework should be developed by the LCCC in consultation with CALI and Code subscribers	No
46. 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 allowance for additional surveillance in exceptional circumstances where material new information comes to light could be included. The reasons for any recourse to this exception should be clearly documented by the insurer.	Yes
47. 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. This should not delay the development of a new Code that responds to other recommendations in the Final Report.	No
Medical definitions	
48. 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.	Yes
49. 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.	Yes
50. The expert panel should review the three existing Code medical definitions as soon as possible.	No
51. The Code should include a definition of "obsolete method of diagnosis or treatment".	Yes
52. 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.	Yes
53. 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.	No

Training	
54. 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, which should include: <ul style="list-style-type: none"> • the requirements outlined in the Code; • the relevant products and services provided by the Code Subscriber; and • dealing appropriately with customers experiencing vulnerability. 	Yes
Advertising and sales practices	
55. Replace the definition of ‘pressure selling’ with a definition of ‘unacceptable sales practices including pressure selling’ and update the definition to: <ul style="list-style-type: none"> • 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.” 	Yes
56. The Code should require issuers of funeral insurance to incorporate a “premium guarantee” in the design of products, whereby the benefit paid under a funeral insurance policy would be the higher of: <ol style="list-style-type: none"> a. The insured sum or cover amount; or b. The total amount of premiums paid. The premium guarantee should also operate to ensure the repayment of premiums to customers whose policies are cancelled after having been held for two years or more.	Yes
57. Insurers should be prohibited from selling funeral insurance to consumers who are under 40 years of age.	Yes
58. As part of the sales process, insurers should be required to ask potential customers whether they have an existing funeral insurance policy and be prohibited from selling funeral insurance to consumers who are identified as already having a funeral policy.	Yes
59. 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”.	No
Communication	
60. Update the Code to reflect the new premium labels for retail life insurance policies.	Yes

<p>61. 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:</p> <ul style="list-style-type: none"> 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. 	<p>Yes</p>
<p>62. Amend Section 3 in relation to information provided to customers with existing policies where there is a decision to vary or avoid as above.</p>	<p>Yes</p>
<p>63. The current section of the Code titled ‘Customers can cancel policies they do not want’ should be separated under two separate headings: one using the existing title and one titled ‘Insurers may cancel policies in some circumstances’. Existing clauses should be moved under the relevant headings. This should include a commitment that cancellation processes will be transparent, straightforward, and do not require the provision of unnecessary information.</p>	<p>Yes</p>
<p>64. Where insurers cancel a policy, they should be required to provide a clear explanation of the reason to the customer.</p>	<p>Yes</p>
<p>Complaints</p>	
<p>65. Include a clause that explicitly states that Code Subscribers will have internal dispute resolution processes that comply with ASIC Regulatory Guide 271.</p>	<p>Yes</p>
<p>66. Amend clauses 7.13, 7.15 and 7.17 to refer to ‘the Australian Financial Complaints Authority’ rather than ‘an External Dispute Resolution body’.</p>	<p>Yes</p>
<p>67. The Code should require insurers to have processes in place to ensure complaints are a feedback mechanism for continuous improvement.</p>	<p>Yes</p>
<p>68. Clause 4.25 should be amended to require insurers to inform applicants about both the insurer’s complaints process and external dispute mechanisms.</p>	<p>Yes</p>
<p>69. Amend clause 7.13 to be consistent with clause 7.17. Subclause (d) of both clauses should specify that information will be provided on how to contact AFCA and any time limit for doing so.</p>	<p>Yes</p>
<p>Genetic testing</p>	
<p>70. Remove ‘Appendix A: Moratorium on Genetic Tests in Life Insurance’ and clause 4.17 from the Code.</p>	<p>Yes</p>

Code structure	
71. 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.	Yes
72. The Code should contain a link to all CALI industry guidelines and protocols.	Yes
Blood-borne viruses	
73. Separate out the provisions on mental health (clauses 4.12-4.14), family medical history (clauses 4.15-4.16) and HIV (clauses 4.17A-4.17C).	Yes
74. Update the phrase “Human Immunodeficiency Syndrome” in section 4 of the Code to “Human Immunodeficiency Virus”.	Yes
75. CALI should work with the Financial Services Council (FSC) to remove its HIV/AIDS underwriting guidelines.	No
76. The LCCC should conduct an inquiry on how insurers approach decisions for customers who disclose HIV or other blood-borne viruses that includes: <ul style="list-style-type: none"> a. insurers' procedures and policies implemented to ensure compliance with requirements of the Code and anti-discrimination legislation relating to HIV and other blood-borne viruses; and b. statistics on coverage denials or less favourable terms offered to people with HIV and other blood-borne viruses. 	No
77. Following the completion of the LCCC inquiry, CALI should consider further industry collaboration with HIV and hepatitis associations, and the need for any changes to the Code.	No
Code governance and compliance	
78. Amend clause 8.4 of the LCCC Charter to: <ul style="list-style-type: none"> • 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. 	Yes
79. Enable the LCCC to name insurers involved in inquiries and reports without attributing specific data or outcomes to individual insurers.	Yes

<p>80. Amend the definition of ‘Significant Breach’ to:</p> <ul style="list-style-type: none"> • 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. 	Yes
<p>81. Amend clause 8.13 to clarify that all significant breaches of the Code should be reported to the LCCC while minimising duplicative reporting.</p>	Yes
<p>82. Limit the LCCC’s ability to investigate a breach reported matter if it is already under investigation by a regulator.</p>	Yes
Enforceability	
<p>83. CALI should not seek designation of any code provision as an ASIC enforceable code provisions.</p>	No
<p>84. The Code should be developed to enable contractual enforceability in new customer contracts, including the removal of clause 8.10. A process to consider how this can be implemented should be commenced by CALI following the proposed work on mental health. This should form part of the terms of reference for the next Code review.</p>	Yes
Future reviews	
<p>85. The Code should be reviewed every five years.</p>	No

4. 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.

4.1. 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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