

July 2009

Insurance
Law
Service



Submission to the
Review of the General Insurance Code of Practice
by the
Insurance Law Service
(a project of the Consumer Credit Legal Centre
(NSW) Inc)

The Consumer Credit Legal Centre is a community legal centre that also maintains a project called the Insurance Law Service (“ILS”). The ILS is a pilot project funded by the Legal Aid Commission of NSW, the Law and Justice Foundation of NSW and the Victoria Law Foundation. It has recently been granted funding for the 2009/2010 financial year from the Commonwealth Attorney-General’s Department.

The service has so far given advice or information to over 2,000 consumers in relation to insurance issues, and provided casework assistance to nearly 130 consumers. While over 70% of our work has been for NSW residents, we are available nationally and over 20% of our assistance has been given to consumers from other states, giving us a broader perspective than a state based service.

Further, 68.5% of our work relates to General Insurance.

Thank you for the opportunity to prepare a submission to the review of the General Insurance Code of Practice.

This submission is endorsed by the following organisations:

1. Legal Aid NSW
2. Consumer Law Centre (ACT)/CARE Financial Counselling

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Executive Summary

We would be remiss if we did not start this submission by raising the issue that due to the limitations placed on the consumer movement in this Review of the Code, we have unfortunately not been able to coordinate a joint submission representing interested consumer advocates' united opinions and recommendations.

We also wish to raise our concern that unlike the Banking Code of Practice, provisions in the General Insurance Code of Practice are not made a part of the insurance contract. Equally concerning is the fact that the Code does not bind all general insurers. The Code must be compulsory.

Having stated the above, in these submissions, the ILS has focused on the issue of the code's inadequate treatment of consumers in financial hardship. By consumers we mean both customers and non customers as often both are interrelated in situations where customers are responsible for damage to non customers' property. These financial hardship concerns range from the code's inadequate treatment of customers who cannot pay their excess, the inflexible monthly direct debit payment of premiums resulting in the very serious consequence of customers being unaware of the cancellation of their covers as well as inadequacies in the financial hardship (third party debt recovery) clauses.

The ILS is concerned also about the considerable barriers and delays experienced by consumers throughout the claims and complaints handling stages of the insurance process. We argue that these problems are not only causing detriment to consumers who eventually obtain assistance from external dispute resolution (EDR) schemes, but they are also causing customers to withdraw from the pursuit of valid disputes, engendering poor outcomes for those customers and poor customer/insurer relationships. In some cases, consumers have become disillusioned with insurance *per se* as a result of their negative experience of attempting to claim.

We submit that insurers are relying on ambiguous timeframes in the Insurance Code of Practice to extend times for claims/complaints assessment and or/investigation processes indefinitely. It is also disconcerting that some of those who reach the IDR stage of the insurance dispute process, are trapped within convoluted IDR processes and procedures. Insurers are also reluctant to issue formal written claims rejections, leaving customers in limbo and without any knowledge of their rights in relation to dispute resolution. In some cases, customers are persuaded against claiming and it is also not uncommon to hear that insurers do not provide claim forms when requested.

Other persistent concerns also revolve around post claims approval issues not being recognised as complaints, insurers sending unsolicited/unexplained cheques, deeds of releases and direct bank deposits, unusual/unique covers such as uninsured motorist extensions in third party property insurances and some insurers' refusal to mitigate legal costs where the insurers' actions in delaying the claim has resulted in legal action against the insured.

This submission also deals with problems experienced by Non English speaking consumers in the general insurance industry for which the Code's terms of reference is able to provide redress under all four objectives as stated in clause I.17.

The remainder of this submission is employed to disclose our support for the submissions to this Review by Victoria Legal Aid and various other additional submissions as well as addressing the erroneous nature in which section 15 of the *Insurance Contracts Act 1984* (Cth) prevents the application of beneficial amendments created in Acts such as those proposed to be introduced through the Unfair Terms/Consumer Law Act.

It is noted that many of the issues raised in this submission call for an expansion of the Code's current provisions in line with requiring insurers to commit to higher stands of customer service and improving "consumer" confidence in the general insurance industry.

Further, a significant step towards the resolution of continuing Code breaches may be achieved by adding among the code's current objectives, a requirement that the industry aim for "best practice."

The problems experienced by consumers are demonstrated primarily by case studies drawn from the work of the Insurance Law Service (ILS) or NSW Legal Aid. In some instances the case studies have been copied or adapted from the Joint Submission to the FOS Terms of Reference review, to which this service was a contributor, or the ILS/West Heidelberg Legal Centre submission to the Insurance Ombudsman Service Process Review.

Due to the interrelated nature of the Review's terms of reference, the ILS has decided to provide a summary of the relevant sections in this submission that target particular areas of the terms of reference. To do otherwise would be to unnecessarily repeat entire sections of this submission. We anticipate that this will be invaluable in the perusal of this submission as it relates to the Review of the Code.

Whether the Code of Practice:

- promotes better, more informed relations between insurers and their customers
 - Part 1: Financial Hardship
 - A. Cannot Pay Excess and
 - B. Direct Debit Instalment Concerns
 - Part 2: Claims handling and Complaints handling
 - Part 3: Problems experienced by Non English Speaking Consumers
 - Part 4: Application of Unfair Terms Contracts to General Insurance Contracts
- Improves **consumer** confidence in the general insurance industry
 - Part 1: Financial Hardship
 - Part 2: Claims handling and Complaints handling
 - Part 3: Problems experienced by Non English Speaking Consumers
 - Part 4: Application of Unfair Terms Contracts to General Insurance Contracts
 - Part 5: Our Support of Victoria Legal Aid's submissions
 - Part 6: Additional Submissions
- Provides better mechanisms for the resolution of complaints and disputes between insurers and their customers

- Part 1: Financial Hardship
 - A. Cannot Pay Excess and
 - C. Third Party Recoveries
 - Part 2: Claims handling and Complaints handling
 - A. Delays and Indefinite Time Frames
 - B. The Internal Dispute Resolution Trap
 - C(i) Refusal/Reluctance in issuing formal claims rejection letters
 - C(ii) Persuading customers not to claim and Not issuing claim forms when requested
 - C(iii) Post claims approval issues not being recognised as complaints
 - Part 3: Problems experienced by Non English Speaking Consumers
- Commits insurers and the professionals they rely upon to higher standards of customer service.
 - Part 1: Financial Hardship
 - A. Cannot Pay Excess and
 - B. Direct Debit Instalment Concerns
 - Part 2: Claims handling and Complaints handling
 - Part 3: Problems experienced by Non English Speaking Consumers
 - Part 4: Application of Unfair Terms Contracts to General Insurance Contracts

The following is a list of recommendations made throughout this submission:

1. Include among the code's current objectives, a requirement that the industry aim for "best practice."
2. **Cannot Pay Excess.** The ILS submits that there are alternatives to the payment of excess upfront which the code should specifically make provision for.

An example of wording that should be added to the Code would be:

If you are experiencing difficulty paying your excess due to financial hardship, we will consider a request from any affected persons, any one of the following options:

- (a) *allowing the payment of excess to be made in instalment arrangements suitable to insured's circumstances; or*
- (b) *allowing the excess fee to be deducted from the final payout, where the approval of the claim is not expected to be at issue.*

If you have no capacity to pay the excess by instalments, and it is impractical to deduct the excess payment from your claim, or there are compelling compassionate grounds for doing so, we will consider waiving the requirement to pay an excess.

If we are unable to reach an agreement with the person about the payment of excess, we will provide information to them about:

- (a) *our complaints handling procedures;*
- (b) *the existence of the Australian Financial Counsellors and Credit Reform Association (www.afccra.org) for a referral to a not for profit, free financial counselling service;*

- (c) the existence of Legal Aid Commissions and Community Legal Centres for free legal advice; and
- (d) the existence of the Financial Ombudsman Service.

Where a complaint remains unresolved and is made by a person other than the insured, we will agree to submit to the jurisdiction of the FOS.

3. **Direct Debit Instalment Concerns.** The ILS submits that a clause such as the following be added into the Code in the Insurance Claims section after the section on “Repair workmanship and Materials”:

Direct Debit Premiums Payments

3.* *Where you have requested either verbally or in writing, we will agree to the debiting of your direct debit premium payments to be made in line with your pay cycle. This may include the direct debit of your insurance premiums in ways other than by monthly or yearly deductions, such as through fortnightly direct debits.*

3.** *We will inform you of your rights under 3.* when you obtain insurance with us and upon every renewal period.*

3.*** *Where we have cancelled your policy due to your failure to make payments of your premiums or the dishonour of your direct debit premium payments,*

- a) *we will immediately inform you verbally of:*
 - a. *the date your policy was cancelled;*
 - b. *the reason for the cancellation;*
 - c. *the date from when you are no longer insured;*
 - d. *what you need to do to correct this matter if you do not wish for your policy to remain cancelled; **and***
- b) *upon 7 calendar days of the date of cancellation, we will provide you with written notice indicating:*
 - a. *the date your policy was cancelled;*
 - b. *the reason for the cancellation;*
 - c. *the date from when you are no longer insured;*
 - d. *what you need to do to correct this matter if you do not wish for your policy to remain cancelled.*

4. **Clause 3.10.** Clause 2.4.6 should be amended to

Training of our Employees and Authorised Representative will include:

- a) *principles of general insurance and any relevant consumer protection law including the ACCC/ASIC Debt Collection Guideline for Collectors and Creditors;*
- b) *product knowledge; and*
- c) *the requirements of this Code.*

In addition, a new provision should be inserted after 3.12

Training of any agent authorised to collect debts on our behalf will include:

- a) *Any relevant consumer protection law including the ACCC/ASIC Debt Collection Guideline for Collectors and Creditors; and*

d) the requirements of this Code.

Compulsory education of insurance employees and their representatives about the ACCC and ASIC Debt Collection Guidelines.

5. **Clause 3.11.** The ILS proposes that the wording for clause 3.11 be amended as follows:

*Where a person is experiencing financial difficulty repaying a debt due to illness, unemployment or other reasonable cause and they reasonably expect to be able to discharge the debt if repayment terms are arranged, **we will agree** to one of the following options:*

- (a) Extending the period of repayment and reducing the amount of each payment due accordingly;*
- (b) Postponing payments for an agreed period; or extending the period of repayment and postponing payments for an agreed period; or*
- (c) Extending the period of repayment and postponing payments for an agreed period;*

If, due to illness, unemployment or other reasonable cause, a person cannot make any payments towards repaying a debt, or can only make such low repayments as to make the administration of the agreement uneconomical, we will consider waiving the debt. In deciding whether to waive a debt under this clause we will consider:

- (a) the likely duration of the person's financial hardship;*
- (b) their overall financial position;*
- (c) whether any enforcement options are realistically available to collect the debt, and*
- (d) other compassionate grounds.*

6. **Clause 3.12.**

- Insurers' letters of demand to alleged debtors relating to third party recovery debts should explain the insurance debt recovery process and advise consumers of their rights and the insurers' obligations under the Code (for example, through the provision of an unabridged citation of the applicable third party recoveries clauses under the Code).
- Wording similar to the following should also be added to the Code:

We will not refer your debt with us to any debt collectors for at least 60 days from the date of our letter of demand to you.

Within 14 days of being aware or being made aware that an agreement about the repayment of the debt cannot be reached, we will provide the person with a standard letter containing information that complies with clause 3.12 of the Code.

- Clause 3.12 of the Code should be amended as follows:

If we are unable to reach an agreement with you about the repayment of the debt, we will provide information to you about:

- (e) *our complaints handling procedures;*
 - (f) *the existence of the Australian Financial Counsellors and Credit Reform Association (www.afccra.org) for a referral to a not for profit, free financial counselling service;*
 - (g) *the existence of Legal Aid Commissions and Community Legal Centres for free legal advice; and*
 - (h) *the existence of the Financial Ombudsman Service Code Compliance Committee.*
- Compliance with the above clauses should be the subject of a specific campaign by Code Compliance including an education campaign for insurers about their responsibilities and a follow-up audit.

7. Delays and Indefinite Time Frames.

- The ILS proposes that the Code provide for a consistent time frame for all claims and complaints handling. Noting that the FOS's proposed new terms of reference is currently awaiting approval from ASIC and that this proposal includes a time frame for lodgement into the FOS scheme of 2 years from an insurer's IDR decision, the proposal below does not conflict with and is not inconsistent with this.
- We appreciate that some claims involve more detailed investigation than others. The current timeframes, however, can be extended indefinitely and are therefore rendered meaningless. The ILS submits that there must be a trigger point at which the consumer is armed with the information they need to enlist the assistance of an independent "referee" (whether that be the insurer's IDR or FOS) to determine whether any further delay is justifiable by the circumstances.
- After lodgement of a claim/complaint, the insurer should provide the customer with a copy of the relevant time frames and provide the option for contacting the FOS should these time frames not be adhered to.
- A consistent 14 days (2 weeks) time frame from receiving a claim or complaint should be applied for:
 - notifying insureds about the progress of their claim;
 - notifying insureds of the information the insurer requires to make a decision on their claim;
 - appointing (if necessary) a loss assessor/loss adjuster; and
 - providing an initial estimate of the time required to make a decision on a claim;
 - notifying the insured of the appointment of a loss adjuster/assessor/investigator (if applicable)
 - responding to routine requests for information made by the insureds
- The code should emphasise that the duty of notifying customers about the progress of their claim is that of the insurers
- If the insurer is waiting on information from either a third party or the insured, this should be relayed to the consumer immediately or as soon as is practicable.

- Where no decision has been made in relation to a claim for 60 days from the date of lodgement, then the insurer should be obliged to inform consumers in writing of the reason for the delay and their complaints process, including the right to apply to EDR.

8. IDR Trap.

The ILS submits that insurers should not be able to use the IDR process as a means to delay and frustrate claims, or to deny access to EDR. To ensure that this does not occur we submit that:

- Insurers must publish their IDR contact details including the name of the contact person, name of department, direct postal address, direct fax number, direct phone number and direct email for correspondence both on their websites and on the FOS website.
- Insurers should be obliged to inform consumers of their complaints process, including the right to apply to EDR, at the time the consumer is informed about any adverse decision or action, including an indication that the insurer is “going to investigate or reject the claim”.
- As to the general format of a standard IDR letter, we are aware that the FOS are currently in the process of developing this standard form IDR letter. The Code should confirm that the format and content of the standard IDR rejection letter should follow those of the FOS guidelines or sample IDR letter when it is released.
- At a minimum, the IDR letter must include:
 - Details about the FOS;
 - That FOS is a free process;
 - The binding nature of FOS determinations to insurers and the non binding nature of FOS determinations to insureds
 - The date to make a complaint to FOS
- One person to undertake the IDR process
- All unresolved claims which remain outstanding for more than 6 months must be:
 - Reported to IDR Team leader with sufficient details as to when a decision will be made on the claim; and
 - Independently audited by the IDR Team Leader to determine whether it complies with clauses 3.1 to 3.4
- All unresolved claims which remain outstanding for more than 12 months must be:
 - Reported to the Code Compliance Manager, FOS; and

- Independently audited by Code Compliance Manager to determine whether it complies with 3.1 to 3.4

9. Refusal/Reluctance in issuing formal claims rejection letters.

- No rejection of claims or decisions on complaints should ever only be made verbally. Rejections/decisions should always be in writing and if it follows a verbal rejection/decision, rejections/decisions should be given within 14 days of the verbal rejection/decision.
- Even if a rejection is on the basis that a claim is not covered under the policy (as will be the case with many verbal rejections over the telephone), it should be provided in writing to enable insureds to access their rights to dispute resolution processes.

10. Persuading Customers not to claim and Not issuing claim forms when requested.

- The opening provisions in clauses 3 (Insurance Claims) and 6 (Complaints Handling) should have an additional clause requiring the insurer to acknowledge in writing that a claim/complaint has been made regardless of whether that claim/complaint was made by telephone or in writing. It may state something similar to the following:

3.0 Within 7 days of receipt of your claim or receipt of information from you of facts/circumstances giving rise to a claim (whether received verbally or in writing and whether the word “claim” is used), we will provide you with written:

- (a) acknowledgement of your claim;
- (b) advice about your rights and our obligations under the Code relevant to the resolution of your claim; and
- (c) advice about the claims process and what will happen next.

3.* If we decide to accept your complaint we will confirm this in writing and confirm what this means.

6.0 Within 7 days of receipt of your complaint or receipt of information from you or a third party of facts/circumstances giving rise to a complaint (whether received verbally or in writing and whether the word “complaint is used), we will provide you with written:

- (a) acknowledgement of your complaint;
- (b) advice about your rights and our obligations under the Code relevant to the resolution of your complaint; and
- (c) advice about the complaints process and what will happen next.

6.* If we decide to accept your complaint we will confirm this in writing and confirm what this means.

“You” and “your” above include those who are third party beneficiaries of any general insurance cover.

11. **Post Claims approval issues not being recognised as complaints**

In the “Definitions” section of the Code, the following should be included:

- Adoption of the ASIC approved definition of complaint in AS ISO 10002-2006 – “An expression of dissatisfaction made to an organisation, related to its products or services, or the complaints handling process itself, where a response or resolution is explicitly or implicitly expected.” More specifically, as it relates to general insurance,
 - A complaint includes an expression of concern or dissatisfaction that a decision has not been made
 - A complaint includes a disagreement or expression of dissatisfaction about the amount of a claim, or the nature and scope of repairs to be done pursuant to a claim
 - A complaint also includes an expression of dissatisfaction about an aspect of the claims assessment/investigation process/post claims approval disputes
- In relation to dodgy repair work insurers should have procedures in place where complaints require the repairer’s work to be reviewed and if necessary replace the builder/repairer.
- Within 14 days insurers must provide progress reports in relation to post claims approval issues such as repair work, selection builders/repairers etc.... This can be done through the inclusion of such issues as complaints (as stated above) and by requiring insurers to provide progress reports on “complaints.”
- Insurers undertake to ensure that they only pay out to repairers (including builders) who are licenced and solvent.

Post Claim Approval Issues for Non Customers

To address this inadequacy, we suggest that in addition to clause 3.13, further clauses in the section entitled “Repair workmanship and materials” is required. We suggest the following additional clauses:

3.14 We will accept a complaint in relation to clause 3.13 from a person other than the insured where we have directly authorised a repairer to repair their property arising from a claim by our insured.

3.15 Where a complaint in relation to repair workmanship and materials remains unresolved and is made by a person other than the insured, we will agree to submit to the jurisdiction of the FOS.

12. **Unsolicited Cheques.** Insurers must not send cheques, deeds of releases and must not deposit money into insureds’ accounts without first reaching an agreement with the insureds about settlement amounts, without first notifying the insureds that

they intend to do so and without providing written explanation/itemised list of what exactly the amount relates to.

- 13. Unusual/Unique Covers such as Uninsured Motorist Extensions in third party property insurances.** The Code should make provision for General insurers to undertake to advise insureds of unusual/unique covers and their right to claim under those unusual/unique covers during all relevant stages of the insurance process and not simply through the one off provision of product disclosure statements or other policy documents when insurance is initially purchased.
- 14. Liability of insurer to mitigate legal costs where the insurer's actions in delaying the claim resulted in legal action against the insured.**

The Code should contain the following provision:

Where we have delayed in processing your claim and this has resulted in legal or other enforcements costs against you, in addition to the damages amount we will also agree to pay the legal and enforcements costs incurred.

15. Request for documents.

Amend clause 3.4(3) should be amended to include the following:

- The insurance company will provide copies of all requested documents within 30 days of the request
- If access is being refused reasons will be provided in writing within 30 days of the request
- Copies of insurance policies will be provided free of charge to consumers
- Copies of all current insurance policies will be available on the website of the insurance company
- Copies of statements made by the consumer or transcripts of interviews with the consumer will be provided on request at no cost.

16. Problems experienced by Non English Speaking consumers

- Recordings
 - The Code should include provisions for
 - the mandatory sound recording of
 - all investigator interviews;
 - all verbal disclosures relating to applications for insurance
 - access to these recordings as part of a request under clause 3.4(3) and 6.1(4).
 - Although we are not suggesting that all verbal conversations be recorded as this would result in sizable compliance costs, all verbal disclosures should be confirmed within 14 days to the insured in writing providing them with an opportunity to correct any mistakes in the insurer's version of that disclosure.

- Consumers should be able to have access to telephone recordings (where possible) before a claim or dispute. This would be relevant not only to disputes with NESB customers but also with disputes concerning whether a customer has made certain relevant disclosures, whether a customer has advised about their change of address for renewal notices to be sent etc. It also affords insurers the opportunity to support their claim that certain disclosures weren't made or that their representatives did ask certain questions or make certain representations such as those concerning policy conditions and exclusions.
- Interpreters
 - Insurers should ensure that NESB customers have a real opportunity to tell their story. Therefore, the Code should include provisions for the mandatory "offer" of the services of a qualified interpreter where the insurer is aware (or a reasonable person would suspect) that the consumer has limited English comprehension skills.
 - We do not suggest that all NESB clients should be forced to accept interpreting services, but what is mandatory is the "offer" to these consumers of the services of qualified interpreters. It will then be up to the consumer to decide whether to accept this offer.
 - Asking NESB customers to rely on their family members or friends for interpreting services is fraught with conflict of interest issues. Family members are also not trained and qualified interpreters.
- The Code should require section 22 (Insurance Contracts Act 1984) notices on an insured's duty to disclose, to be in a language that NESB customers can understand.
- Commitment to ongoing cultural awareness training, especially for agents of insurers, including investigators.

17. Application of Unfair Terms Contracts to General Insurance Contracts.

The ILS proposes that the Code adopt the unfair terms legislation.

In the alternative, the ILS proposes that the Code, under three objectives as outlined in clauses 1.17(a), (b) and (d) of the Code, should adopt a provision similar to Part D, clause 4 of the Mutual Banking Code of Practice - Credit Unions and Mutual Building Societies July 2009. This clause provides for the following:

4. Fair terms and conditions

(4.1) The standard Terms and Conditions applying to our products and facilities will be:

- *clear, unambiguous, and not misleading*
- *distinct from our advertising and promotional material*
- *written in a plain language style, and legibly presented.*

(4.2) Our standard Terms and Conditions will be consistent with this Code and will strike

a fair balance between:

- *your legitimate needs and interests as our member or customer, and*
- *our interests and obligations, including our prudential obligations.*

(4.3) *We will not adopt standard Terms and Conditions that you are unlikely to be able to*

comply with.

(4.4) *This section:*

- *is not intended to limit our right to determine the pricing of our products and facilities on a commercial basis*
- *only applies to standard Terms and Conditions entered into after the Commencement Date of this Code (see Part A - Introduction).*

18. Our Support of Victoria Legal Aid's submissions.

- Clause 4.5 should be amended to allow for a 6 months (instead of 1 month) reopening of insurance settlements by insureds in catastrophe and disaster cases. This is a reflection of the Insurance Council of Australia and the general insurance industry's practice during the recent Victorian Black Saturday bushfires.
- The right to reopen settlements is exclusive to insureds only. Insurers should not be able to reopen settlements once agreed to by insureds.
- The Code should distinguish whether emergency accommodation or advance payments reduce sum insured or whether it is additional as a form of grant or emergency relief.

19. Additional Submissions

- Amend Clause 7.18 to include other factors for the Code compliance Committee to consider when determining sanctions to be imposed;
 - a. what is fair and reasonable in all the circumstances;
 - b. good insurance practice;
 - c. established legal principles.
- The definition of "significant breach" to be changed to include the following considerations:
 - a. a presumption that breaches involving dishonesty or breach of duty of good faith is a "significant breach."

Detailed Submissions

Part I Financial Hardship

Unlike the banking industry, the general insurance industry has either been quite reluctant to enter into negotiations about the payment of excess and payment of debts to them, or do not currently have procedures in place to assist both customers and non customers where there is a genuine case of financial hardship,

Given the impact of the current global economic crisis, this situation is only going to increase the dissatisfaction consumers have with the general insurance industry.

The Code has several sections dedicated to dealing with financial hardship. In our view those clauses are inadequate. While some of the issues raised below relate to compliance concerns, we submit that there is also a case for extending the commitments expressed in the Code relating to financial hardship based on the Code objective of improving “consumer” confidence in the industry.

What follows is a list of some of the major financial hardship issues the ILS and other consumer advocates have experienced on a disturbingly regular basis.

A. Cannot Pay Excess

An issue of notable concern to the ILS is the requirement that insureds pay their excess upfront before a claim can be lodged, processed or approved.

The ILS submits that this requirement fails to take into account an insured’s financial hardship, which could potentially render them unable to pay their excess. It is unreasonable in such circumstances to require the payment of excess before a claim is lodged, processed or approved.

In this regard we note that section 54(3) of the Insurance Contracts Act relevantly states that:

“Where the insured proves that no part of the loss that gave rise to the claim was caused by the act, the insurer may not refuse to pay the claim by reason only of the act.”

Taking the “act” as the insured’s inability to pay excess, the insurer may not refuse to pay a legitimate claim by reason only of the insured’s inability to pay excess because no part of the loss that gave rise to the claim was caused by the insured’s inability to pay the excess.

It is also arguable that to refuse to pay a claim on the basis of non payment of excess is a breach of the *Insurance Contracts Act 1984* duty of utmost good faith (Sections 13 and 14(1) of the *Insurance Contracts Act*.)

Section 13 of the states that,

*“A contract of insurance is a contract based on the utmost good faith and there is implied in such a contract a provision requiring each party to it to act towards the other party, **in respect of any matter** arising under or in relation to it, with the utmost good faith.”*

(Emphasis Added)

More specifically, section 14(1) of the *Insurance Contracts Act* states,

“If reliance by a party to a contract of insurance on a provision of the contract would be to fail to act with the utmost good faith, the party may not rely on the provision.”

In addition to the above discussion, we note the practice of some insurers in offering lower premiums in return for higher excesses. While not wishing to limit the capacity of insurers to offer such flexibility, or to suggest that this is a cynical exercise on their part, if the net effect of this is that in some cases customers are excluded from lodging any claim in practice by their inability to meet the excess, then this is an extremely poor outcome for those consumers and reflects very badly on the industry.

“Non-customers” are also adversely affected by this practice. For example, those trying to claim against an insurance company for the damage their insured did to the non-customer’s vehicle. In such cases, the insured person’s inability to pay their excess has resulted in the insurer refusing to pay the non-customer. This is not only detrimental to the non-customer but also to the insured driver (as despite having insurance, the insured will then have to face a demand or legal action being made against the insured from the non customer). This single event has the potential to generate substantial consumer loss, generate hostility towards the particular insurer, and undermine confidence in insurance as a reliable method of managing risk.

As will be seen in all of the case studies below, insureds are never given information regarding their rights to review any decision about the requirement to pay excess or information about how they can dispute a general insurer’s rejection of their offer to pay the excess in instalments. In fact, all of these decisions are made verbally when insureds contact their insurers to make a claim and any written reasons are never provided about these decisions. A customer who cannot pay their excess is invariably left in limbo, their claim neither paid, nor denied. Such customers are significantly less likely to spend their money on insurance cover in the future.

Case Studies

The case study below is also referred to as “**Knock, Knock, Knockin’ on EDR’s door**” (Case Study 31) for a different reason in the section entitled “Claims Handling and Complaints Handling”

Case Study I

Source: Insurance Law Service, Casework

FOS-GI Reference: 34817

Issue – Can’t pay excess

Mr & Mrs B's house was destroyed by a fire in early December 2007. A claim was made on their home and contents policy. Although there were numerous difficulties in accessing IDR/EDR, the ILS was eventually able to successfully lodge in the FOS.

In mid June 2009, the FOS made a determination that required the insurer to pay out the claim in accordance with the policy and also pay interest on the claim from June 2008 to the date of payment.

From the period the fire started (December 2007) to the favourable FOS determination one and a half years later (June 2009), no request had been made for the payment of excess. In attempting to determine the amount payable by the insurer, the ILS has requested that the insurer deduct the excess of \$500 from the amount of the final payout due to the insureds' severe financial hardship.

Financially both Mr and Mrs B receive Centrelink income, a Carer and a Disability Support Pension. They live in rental accommodation and have had to move a few times due to insufficient funds to maintain rental payments as well as being evicted on one occasion. Mr B has numerous serious medical conditions, which have also been exacerbated by the prolonged insurance dispute process. He is now regularly in and out of hospital. Mrs B has similarly suffered medically and psychologically throughout this process. In addition to basic living expenses, both have incurred significant expenses in recovering all requested documents, crippling medical and travel expenses to various hospitals and medical expenses from prescription medication needed to treat and alleviate Mr B's medical conditions.

Mr and Mrs B have also had to endure the consequences of the fire for over a year and a half now including not least the financial stress of not having a home and money to afford new clothes. The first insured could not even afford to have trauma counselling, a fact which his treating doctor found most concerning as his case has worsened after the fire.

Although we are currently awaiting a response to our request for the excess to be deducted from the final payout, this case study serves to highlight that those in severe financial hardship and also those who are the victims of a severely protracted insurance dispute process should not be precluded from receiving a payout simply because their unfortunate financial position means that they won't be able to afford to pay the excess.

Therefore, options such as those recommended below must include the reduction of excess from the final payout.

Case Study 2

Source: Insurance Law Service, telephone advice

Issues – Can't pay excess

Ms X's property was damaged during the May 2009 floods in VIC. Her area was subsequently declared a natural disaster zone. She made a claim on her home building insurance policy with her general insurer.

Her insurer and their authorised repairer insisted that although she is covered for flood damage, she has to pay the \$300 excess on the claim before they are able to process the claim and begin repair work.

Ms X is a pensioner and cannot afford to pay the excess in one lump sum payment. Ms X's property urgently needs repairs. Delays in flood damage cases will only make the house more uninhabitable as mould and mildew become increasingly more of a problem.

Case Study 3

Source: Insurance Law Service, telephone advice

Issues – Can't pay excess

Mr I was involved in a motor vehicle accident in which he bumped into another driver's car. He immediately made a claim on his car insurance with his general insurer. His insurer requested that he pay the \$500 excess required to commence the claim.

Mr I had to sell his trailer in order to pay for the \$500 excess. He paid the insurer this amount but the insurer stated that because the other driver had not yet made a claim for damage to their property, the insurer returned the \$500 to Mr I.

At the time of calling the ILS service, Mr I indicated that the other driver had now made a claim against Mr I's insurer for damages. Mr I was again requested to pay the excess, which the insurer had originally returned. The problem now however, was that Mr I has already spent that money and is no longer in any position to pay the excess. He also no longer has any other assets of much value to sell just as he did previously with his trailer, to come up with money for the excess.

Mr I is on a Disability Support Pension and his wife receives an Age Pension from Centrelink.

If Mr I cannot come up with the excess, which the insurer has requested upfront, he will have to face the prospect of a claim against himself from the other driver which may result in legal action against him.

Case Study 4

Source: Insurance Law Service, telephone advice

Issues – Unscrupulous insurer conduct in asking insured to borrow money from a friend to pay excess, Can't pay excess, failure to give information about rights to review decision to reject offer to pay excess in instalments

Mr V was involved in an accident in which the other party's insurance company alleged that he was at fault. Mr V himself was comprehensively insured with a general insurer. He

claimed but his insurer required the payment of \$500 excess upfront before they would agree to process his claim.

Mr R informed the insurance representative that both he and his wife were on Centrelink. His wife recently had to take money from her superannuation account to help the family to survive as Mr V was put on dialysis. Mr V informed the representative that he was therefore in no position to pay the excess in one upfront payment. He specifically requested that he be given the opportunity to pay this amount off in instalments, but the general insurance representative responded with words to the effect “borrow it off a friend.”

The insurance representative did not provide a means by which Mr V could dispute the insurer’s decision to reject this offer to pay excess in instalments. He was not informed about any rights he had to a review of this decision communicated by telephone. It was given as if it was the insurer’s final say on the matter.

In the midst of all of this, Mr V will be faced with a demand for \$2,000 to pay the other party’s insurance company for damage the other party sustained in the accident. This stress is likely to be highly detrimental to his health.

Mr V stated that he was covered for this accident and therefore should not be so severely penalised simply because he is currently not in a position to make the excess payment upfront. It is also arguably improper for the insurance representative to advise Mr V that he should borrow the excess money from his friends.

Case Study 5

Source: Insurance Law Service, telephone advice

Issues – Can’t pay excess

Ms N’s car was damaged when a chemist sign fell off and scratched her car during a particularly windy day. Ms N claimed under her comprehensive car insurance with her general insurer. Her insurer has informed her that she is covered under her policy for this type of event but refused to accept the claim as they require the payment of excess upfront.

Ms N informed the insurer that she cannot afford to pay the excess, however the insurer insisted that this was a necessary condition of her policy. The failure to pay the excess will mean that she will not be compensated for an event for which she was covered for under her policy.

Case Study 6

Source: Insurance Law Service, telephone advice

Issues – Can’t pay excess

Ms K was involved in a motor vehicle accident in which she scratched her car against a brick fence. Her car sustained about \$1,000 worth of damages. She claimed under her

comprehensive car insurance with her general insurer. The insurer insisted that Ms K pay the excess of \$550 first before the claim could be lodged. Ms K asked the insurer to either waive or reduce the excess amount, but the insurer refused to enter into any arrangements about the payment of excess. Ms K is a single mother in her late 50s whose sole source of income is from a Single Parent Pension from Centrelink. Her son has a mental illness and receives disability support pension.

After receiving advice from the ILS, Ms K called back to say that her general insurer has agreed to reduce the excess to \$250 and has allowed her to pay this off in instalments of \$50 per fortnight. However, this offer did not take into account what Ms K, in her current financial position would be able to afford.

The insurer should have given Ms S the option of deducting the excess from the final payout. Even if the result is that she would only be indemnified for half of the damage she sustained, it would be better than not receiving any form of compensation whatsoever due to a strict requirement that excess must be paid before the claim can be lodged, processed or approved.

Case Study 7

Source: Insurance Law Service, telephone advice

Issues – Can't pay excess

Ms U's house was destroyed by a vehicle that crashed into her property. Ms U claimed under her home building policy for repairs to the damages her building sustained in that accident.

Ms U's general insurer requested that she pay the excess before the claim can be lodged. Ms U is a pensioner, she was diagnosed with cancer and even on the pension and she could not afford the medication required for her treatment. She therefore cannot afford to pay an excess of \$450 to repair her damaged property, damage that was caused by a reckless driver.

Recommendations for improvement of the Code

The requirement to pay excess upfront in these cases emphasises how unreasonable and onerous it is for those who are in financial hardship. They have insurance and have been paying premiums for insurance, but ultimately cannot access the benefit of that insurance.

While we appreciate the usefulness of the requirement to pay an excess in terms of both risk distribution, and allowing for greater flexibility in the setting of premiums, the ILS submits that there are alternatives to the payment of excess upfront which the code should specifically make provision for.

An example of wording that should be added to the Code would be:

If you are experiencing difficulty paying your excess due to financial hardship, we will consider a request from any affected persons, any one of the following options:

- (c) allowing the payment of excess to be made in instalment arrangements suitable to insured's circumstances; or
- (d) allowing the excess fee to be deducted from the final payout, where the approval of the claim is not expected to be at issue.

If you have no capacity to pay the excess by instalments, and it is impractical to deduct the excess payment from your claim, or there are compelling compassionate grounds for doing so, we will consider waiving the requirement to pay an excess.

If we are unable to reach an agreement with the person about the payment of excess, we will provide information to them about:

- (e) our complaints handling procedures;
- (f) the existence of the Australian Financial Counsellors and Credit Reform Association (www.afccra.org) for a referral to a not for profit, free financial counselling service;
- (g) the existence of Legal Aid Commissions and Community Legal Centres for free legal advice; and
- (h) the existence of the Financial Ombudsman Service.

Where a complaint remains unresolved and is made by a person other than the insured, we will agree to submit to the jurisdiction of the FOS.

B. Direct Debit Instalment Concerns

The clients of our service are, as a result of their financial circumstances, more likely to opt to pay their insurance premiums in monthly instalments than to be able to pay an annual lump sum. Unfortunately, for the same reason, they are also more likely to have a direct debit dishonoured as a result of having insufficient funds in their accounts.

Case Studies

Case Study 8

Source: Insurance Law Service, casework

Issues: Claim rejected due to direct debit dishonour leading to failure to pay premiums

Our client opted to pay his insurance monthly via direct debit. He was contacted by another driver's insurer and asked for \$8,100 as a result of an alleged accident. Our client tried to claim on his insurance and found that his policy had been cancelled due to a failure of his direct debit payments.

Case Study 9

Source: Legal Aid NSW

Issues: Claim rejected due to direct debit dishonour leading to failure to pay premiums

A client contacted Legal Aid NSW when her claim was rejected due to non-payment of the premium. She had received a letter from her insurer threatening to cancel the policy if she didn't rectify the non-payment of premiums by a particular date but she had never been told the policy had been cancelled. She thought the letter would have been necessary.

Case Study 10

Source: Consumer Credit Legal Centre - relative of a staff member

Issues: Claim rejected due to direct debit dishonour leading to failure to pay premiums

Mr G received a letter from his insurance company regarding a direct debit dishonour. The letter said that the insurer would try to debit the account again on a particular date. Having checked that the account had sufficient funds on that date, Mr G did not think about the issue again until he had an accident two months later. At that point he discovered that his account had not been debited on the designated date and the policy had subsequently been cancelled.

Case Study 11

Source: Insurance Law Service, advice

Issues: inconvenience of monthly direct debit option when income received fortnightly

Ms S pays her premiums monthly by direct debit. She receives her salary payment fortnightly. She originally selected a date that would ensure the direct debit occurred one or two days after she was due to be paid to make certain that there would be sufficient funds in her account. Over time however, her pay day and her monthly payment fell out of alignment and her direct debit was regularly rejected. She has a large family and rarely has more than a few dollars in her account at the end of her pay cycle. She is forced to contact the insurance company every few months to arrange an alternative date for the direct debit to occur.

Case Study 12

Source: Insurance Law Service, advice

Issues: Claim rejected due to direct debit dishonour leading to failure to pay premiums

Our client works in a remote outback location. His mail is collected weekly when he visits his parents in the nearest regional centre. He paid his insurance premiums via regular direct debit. After having an accident he discovered that his payments had been dishonoured. He was very upset and couldn't believe that his policy could be cancelled without notice. He later discovered that, due to an error in the initial on the envelope, the letter threatening to cancel this policy had been given to his brother by his parents by mistake. The insurer refused to allow him to rectify the payments and claim for the accident despite their contribution to the confusion.

Case Study 13

Source: Insurance Law Service, advice

Issues: Claim rejected due to direct debit dishonour leading to failure to pay premiums – credit card account changed

Mr H called the ILS when his wife had crashed his car in February. He had believed he was comprehensively insured but found when he tried to claim that his policy had been cancelled. He had changed credit cards the previous December and forgotten to inform the insurance company about the change. He claimed to have received no warnings or other correspondence about the cancellation, despite not having changed address.

Case Study 14

Source: Insurance Law Service, advice

Issues: Claim rejected due to direct debit dishonour leading to failure to pay premiums

A caller to the ILS had an accident and tried to claim on her insurance. She was informed that her policy had been cancelled. She had moved address and said she had notified the insurance company of her change of address details by phone shortly thereafter. The insurer claimed no record of this call. They had tried to contact her by phone and mail at her old address, and receiving no contact after her direct debits had failed, they cancelled the policy.

Case Study 15

Source: Insurance Law Service, advice

Issues: Policy lapsed because renewal received while client on holidays

Ms F had a third party property policy for her motor vehicle. Her renewal arrived while she was on an extended holiday and she had not therefore renewed the policy in time. The policy lapsed in June and she had an accident in August. She contacted the insurer about the accident immediately and they allowed her to pay the premium on the phone. The insurer later rejected the claim on the basis that she had not been covered at the relevant time. They argued that the payment they accepted on the phone was not retrospective and only covered the period from the phone call until 12 months later.

While the opportunity to pay insurance premiums by instalments is vitally important in ensuring greater access to insurance cover, the current situation where this is only available monthly, contributes unnecessarily to customer/insurer disputes and to the frequency of uninsured incidents.

We recognise that some insurers have greatly improved their processes for contacting customers when direct debit payments have failed, but these practices are not universal. Further, offering instalment arrangements that align more closely with the cash flow of the insured has the potential to not only reduce the necessity to cancel such cover, but to greatly reduce the resources put into notifying customers of failed payments. Fortnightly instalments of premium should therefore be available in addition to monthly instalments to match consumer pay cycles, including Centrelink payments.

The ILS also submits that customers should be notified when their insurance policy has been cancelled and the date from which cover has ceased. The current practice of notifying that the policy will be cancelled if certain conditions are not met (such as money being available in the insured's bank account on a particular date), while often complying with the Insurance Contracts Act, can lead to considerable confusion, contribute to the incidence of uninsured events, and undermine confidence in the industry.

Recommendations for improvements in the Code

The ILS submits that a clause such as the following be added into the Code in the Insurance Claims section after the section on "Repair workmanship and Materials":

Direct Debit Premiums Payments

3. Where you have requested either verbally or in writing, we will agree to the debiting of your direct debit premium payments to be made in line with your pay cycle. This may include the direct debit of your insurance premiums in ways other than by monthly or yearly deductions, such as through fortnightly direct debits.*

*3.** We will inform you of your rights under 3.* when you obtain insurance with us and upon every renewal period.*

*3.*** Where we have cancelled your policy due to your failure to make payments of your premiums or the dishonour of your direct debit premium payments,*

- a) we will immediately inform you verbally of:
 - a. the date your policy was cancelled;*
 - b. the reason for the cancellation;*
 - c. the date from when you are no longer insured;*
 - d. what you need to do to correct this matter if you do not wish for your policy to remain cancelled; **and****
- b) upon 7 calendar days of the date of cancellation, we will provide you with written notice indicating:
 - a. the date your policy was cancelled;*
 - b. the reason for the cancellation;*
 - c. the date from when you are no longer insured;*
 - d. what you need to do to correct this matter if you do not wish for your policy to remain cancelled.**

C. Third Party Recoveries

We applaud the intention behind the insertion of the financial hardship (third party recoveries) clauses in the Code (3.10, 3.11 and 3.12). However, we regret to advise that in practice, these clauses have not been strictly complied with by the general insurance industry to the detriment of consumers.

In our experience, third party recovery debt matters are eventually transferred (if not automatically transferred) to debt collection agencies whose main interest is to collect the

debt and who either do not seem to be aware of the existence of the hardship clauses in the Code or ignore its application to general insurance matters. This transfer incorrectly and misleadingly implies that the insurer is longer bound by the Code in relation to the collection of third party debts.

i. Clause 3.10

This clause requires industry compliance with the ACCC and ASIC Debt Collection Guideline: for Collectors and Creditors. The ILS are concerned about the increasing number of calls to our service complaining about unscrupulous practices of debt collectors relating to third party insurance debt recoveries.

Complaints centre mainly around the following areas:

- Debtor harassment – bullying tactics over the phone;
- Encouraging debtors to borrow from family and friends;
- Persuading family and friends to make payments for the debtor;
- Persuading debtors to enter into unsuitable arrangements; and
- Inaccurate and misleading threats of imminent legal and enforcement proceedings commencing.

It would seem that general insurance representatives whose job it is to recover third party debts are either not familiar with the debt collection guidelines or ignore their application to general insurance matters altogether. The following case study provides a useful illustration.

Case Studies

Case Study 16

Source: West Heidelberg Legal Service

Issues – Debtor Harassment, breach of clause 3.10 of the Code

Mrs X has a son with a disability. Her son receives a Centrelink Disability Support Pension. Her son has a driver's licence and an inexpensive uninsured car. After an accident in which the son admitted fault but was unable to pay for the damages, Mrs X was repeatedly contacted by staff of the insurer of the other party, seeking payment on behalf of her son. Eventually after numerous calls, and tired of the harassment, Mrs X agreed to pay \$1,000.

On being told this behaviour was a breach of the ACCC/ASIC debt collection guidelines and therefore breach of clause 3.10 of the Code, Mrs X has asked whether she can seek to recover the money paid under duress.

For additional case studies on this issue, please refer to Case Studies 25 and 26 below.

Recommendations for improvements in the Code

Clause 2.4.6 should be amended to

Training of our Employees and Authorised Representative will include:

- a) principles of general insurance and any relevant consumer protection law including the ACCC/ASIC Debt Collection Guideline for Collectors and Creditors;
- b) product knowledge; and
- c) the requirements of this Code.

In addition, a new provision should be inserted after 3.12

Training of any agent authorised to collect debts on our behalf will include:

- a) Any relevant consumer protection law including the ACCC/ASIC Debt Collection Guideline for Collectors and Creditors; and
- d) the requirements of this Code.

Compulsory education of insurance employees and their representatives about the ACCC and ASIC Debt Collection Guidelines.

ii. Clause 3.11

This clause is worded in such a way that in cases of consumers experiencing difficulties repaying a debt, insurers are only required to “consider” alternative repayment arrangements.

Further, we submit that in practice, consumers seeking to rely on this clause are inevitably forced into repayment arrangements demanded of them from insurers without regard to their personal circumstances. For example, an insurer might say “pay \$x within y days”.

With some general insurers and their representatives, when a consumer requests alternative arrangements more suitable to their circumstances, they are either told that no alternative arrangements can be made or that they must accept the arrangements offered by the insurance representatives if they do not want the sheriff at their door.

From the benefit of ILS casework undertaken in relation to third party debt cases, other concerning conduct practiced by some general insurers includes:

- refusing to communicate via letters and maintaining only verbal communication; and
- ignoring hardship variation requests.

Additionally, we note that this clause lacks the provision for a consideration of the waiver of the debt based on the stated hardship grounds.

In some cases of financial hardship, insurers are proverbially, trying to “get blood out of a stone” and a further analysis of the case will reveal that it is simply uneconomical to continue to pursue those who do not have any money to offer anything at all.

Additionally, in practice, we note that the majority of insurers in the industry have been willing to consider and do in fact offer a write off in circumstances of financial hardship based on the third party recoveries hardship provisions in the Code.

In the Insurance Ombudsman Service 2006-2007 Annual Review, at page 28, the Code Compliance Committee, in their Code of Practice Compliance Report stated the following:

“Participating companies have implemented various measures to facilitate and ensure compliance with the requirements of Sections 3.10, 3.11 and 3.12 of the Code. These measures include the following...Waiving the debt in appropriate circumstances”

Consistent with the above findings, the ILS has also been able to successfully negotiate for a write off of these debts based on the same provisions. We are aware that many other consumer advocates have been similarly successful in their attempts.

However, all insurers are not equally amenable to considering debt waivers. Further, in some cases, the amount of information and documentation required to convince the insurer to write off the debt, or agree to a repayment arrangement is such that the negotiations are disproportionately resource intensive for the insurer and the consumer and/or their representative. Some insurers insist upon interminable, very low amount, repayment arrangements which are costly to maintain (for the insurer) and impose a financial burden on disadvantaged consumers, for no other purpose it would appear, than to make a “moral” statement.

In many cases the insurer would have few enforcement options against such consumers. In NSW however, the effect of pressuring or harassing an impecunious debtor, or continuing to enforce a debt through the court system where the debtor has no capacity to pay, is likely to be voluntary bankruptcy, as the household goods protected in bankruptcy are more extensive than those protected from seizure and sale by the sheriff. Forcing such debtors into bankruptcy does not benefit the insurer, does not inspire consumer confidence in the industry, and has the potential to disadvantage other smaller creditors who may otherwise have been paid.

Therefore, for the reasons outlined above, and as the industry is already writing off debts in practice based on the hardship provisions in the code, debt waiver should be something that is added to the code as an option in addition to the various repayment arrangements already in the Code.

Case Studies

For Case Studies on clause 3.11 please refer to Case Studies 24, 25 and 26 below.

Case studies on the need for waiver of third party recovery debts

Case Study 17

Source: Victoria Legal Aid

Issues – the need for a waiver

Mrs A was involved in a motor vehicle accident in May 2007. The other party’s insurer demanded \$2,009.01 in damages from her.

Mrs A is a married mother of three children, the most recent born about a few months ago. One of her daughters is very ill and has had to undergo ten operations in the Children’s Hospital. The hospital has arranged for payment of medication for the daughter because of the poverty of the family which simply cannot afford it.

The client is receiving a fortnightly Carer's Allowance and Parenting Payments from Centrelink. Her husband receives a long-term Disability Pension. Her income is protected by the Judgment Debt Recovery Act 1984 (JDRA). All of her assets are valued at less than \$5,000 so the sheriff will not be able to seize them.

It is extremely unlikely that Mrs A's financial position will improve. Her income is \$275.50 and their weekly expenses are roughly \$400. Mrs A will be entitled to remain on Centrelink payments for at least fifteen years and longer if she has more children. Insurer's staff requested information about the husband's income despite the fact that he has no liability for the accident. The insurer was advised that the husband was in receipt of Centrelink benefits, which is also protected by the JDRA.

The insurer was advised that the Hospital was paying for medication and suggested that insurer take urgent action to finalise the debt on compassionate grounds. Although the insurer's solicitor stopped all court action, the insurer continued to seek further financial information.

Case Study 18

Source: Darebin Legal Service ('DLS')

Issues – the need for a waiver

Mr H was involved in a motor vehicle accident in 2006. The amount demanded of him by the other party's insurer was \$1,365.

At the time of the accident, Mr H was employed as a taxi driver. He is no longer employed and his income comes from a carer's pension for a member of his family. He lives with his wife and his 19 year old daughter. He owes money to Centrelink and this is being deducted from his benefit payments. He has no assets or savings. As such, he is judgment proof under the Judgment Debt Recovery Act 1984.

He was contacted by debt collectors in relation to this debt. A financial statement was submitted to the debt collector who agreed that he was not in a position to pay back the debt. They sent the debt back to the insurer because of Mr H's financial hardship. DLS contacted the insurer who said it was their policy not to write off debts. They have not asked for a financial statement but DLS assumed that this is because the debt collector passed on the financial statement they had. They have notified the insurer that Mr H is judgment proof but they again said that it was their policy not to write off debts. DLS have alleged that the insurer's actions are a breach of the Insurance Code of Practice because they are failing to deal with financial hardship.

Almost two years later the matter is still unresolved and the most Mr H would be able to pay is \$10 a month—a 10 year repayment plan. This makes it very clear that he is not in a position to pay off the debt and is struggling financially. The length over which this has been going on indicates that his financial position is unlikely to improve in the foreseeable future. It is likely that he will be on a carer's pension until he is old enough to qualify for the age pension. It should be noted that the insurer's response when the debt was returned to them, after a debt collector recognised that the client would not be able to pay, was to say that they would send it to another debt collector.

Case Studies demonstrating industry practice of waiving third party debts

Case Study 19

Source: Insurance Law Service, casework

Issues – write off of alleged debt

Mr H's son was involved in a car accident in early 2008. Mr H was the registered owner of the car at the time of the incident. Five months later, Mr H received correspondence from an insurer regarding a claim for almost \$2,000 in damages.

Mr H is 87 years old, living in a retirement village and relies on his Veterans Affairs Pension as his sole source of income. He cannot afford to pay the \$2,000 requested.

The ILS negotiated with the insurer to write-off the claim for damages on the basis that Mr H's circumstances fell within the meaning of clause 3.10 and 3.11 of the Code of Practice.

The insurer agreed that in view of Mr H's financial circumstances, they will not pursue any claim arising from the car accident.

Case Study 20

Source: Insurance Law Service, casework

Issues – write off of alleged debt, communication through debt collector

Mr D was involved in a car accident in June 2008. He received a letter of demand for nearly \$600 from a debt collection agent acting on behalf of an insurance company. Mr D is elderly and very ill. His sole source of income is from Centrelink Age Pension and he cannot afford to pay the \$600 requested.

The ILS successfully negotiated for the waiver of the alleged debt based on Mr D's financial hardship. The agent acting for the insurance company agreed that they will not pursue Mr H for the alleged debt on the basis that to pursue the debt further would be "uneconomical."

Case Study 21

Source: Insurance Law Service, casework

Issues – write off of alleged debt, communication through debt collector

Ms S was involved in a motor vehicle collision in which she was at fault. Ms S only had CTP insurance so was effectively uninsured for the damage to the other driver's car. About a month later she received a letter of demand from a debt collection agency saying they represent an insurance company and wanted \$3,000 from Ms S.

Ms S is an unemployed 34 year old single mother providing for her two young children aged 5 and 14. She lives in rental accommodation. Most of her white goods are rented from radio rentals. Ms S receives Centrelink payments and gets child maintenance payments from her ex partner.

The ILS successfully negotiated for the wavier of the alleged debt based on Ms S's financial hardship. Negotiations were conducted through the insurer's internal dispute resolution department. The insurer agreed that they will discontinue recovery action for the amount of the alleged debt based on Ms S's financial circumstances.

Case Study 22

Source: Insurance Law Service, casework
Issues – write off of alleged debt

Mr B was involved in a motor vehicle accident in which he hit another car. He later received a letter of demand from an insurance company requesting payment of \$5,500.

Mr B was 69 years old, his only source of income was from an aged pension, and he lives in government housing with his pensioner wife.

The ILS service was able to successfully negotiate with the insurer for the waiver of this alleged debt.

Case Study 23

Source: Insurance Law Service, casework
Issues – write off of alleged debt

Mr J was involved in a car accident in September 2008. He received a final letter of demand for almost \$4,500 from an insurance company for damage to their insured's car.

Mr J's sole source of income was from Centrelink. The ILS was able to successfully negotiate an arrangement where the insurer agreed to close their file and not pursue MR J for the alleged debt on the basis of "commercial considerations".

For additional case studies on the industry practice of waiving third party debts, please refer to Case Studies 24 and 25 below.

While it could be argued that the above results mean that the current Code provisions are sufficient, we reiterate that the previous case studies, and those in the subsequent section below, demonstrate that this practice is not universal. Further, all of these results were achieved with the assistance of an advocate. We submit that these cases demonstrate that inserting a provision providing for a waiver of debts in appropriate cases will not require a change of practice for many insurers, and will provide a means of addressing those

circumstances in which one company or debt collector is bringing the industry into disrepute by their harsh treatment of disadvantaged consumers.

Recommendations for improvements in the Code

The ILS proposes that the wording for clause 3.11 be amended as follows:

*Where a person is experiencing financial difficulty repaying a debt due to illness, unemployment or other reasonable cause and they reasonably expect to be able to discharge the debt if repayment terms are arranged, **we will agree** to one of the following options:*

- (a) Extending the period of repayment and reducing the amount of each payment due accordingly;*
- (b) Postponing payments for an agreed period; or extending the period of repayment and postponing payments for an agreed period; or*
- (c) Extending the period of repayment and postponing payments for an agreed period;*

If, due to illness, unemployment or other reasonable cause, a person cannot make any payments towards repaying a debt, or can only make such low repayments as to make the administration of the agreement uneconomical, we will consider waiving the debt. In deciding whether to waive a debt under this clause we will consider:

- a) the likely duration of the person's financial hardship;*
- b) their overall financial position;*
- c) whether any enforcement options are realistically available to collect the debt, and*
- d) other compassionate grounds.*

iii. Clause 3.12

This clause requires general insurers to provide information to consumers about their complaints handling procedures and the existence of financial counsellors, should a repayment arrangement not be reached.

Based on the ILS's experience, we can confirm that this is the least complied with clause in the code. Most, if not all of the calls we have received and certainly all of our casework in this area has only served to alarm us at the blatant lack of compliance with this clause.

In practice, insurers and their representatives have either ignored this clause, are not aware of its existence, or if they are aware of its existence do not know how to comply with it.

As it stands, we are not even able to recollect one example of compliance with this clause or provide the Reviewer with an example where an insurer has delivered the required information.

This clause is also noticeably silent on the existence of available free legal advice through community legal centres and Legal Aid.

Case Studies

Case Study 24

Source: Insurance Law Service, casework

Issues – write off of alleged debt, refusing to provide written confirmation of a decision to reject a hardship arrangement, failing to advise of complaints handling procedures and the existence of financial counsellors, communication through debt collectors

Mr Q was involved in a car accident in which he hit another car. He was uninsured. The insurer's debt collection agent sent a letter of demand for almost \$7,000. Q has never received any letters from the insurer, just from their debt collectors.

Q's personal life is in disarray. His wife left him. He looks after and provides for 4 children who stay with him on the weekends. His phone line had been disconnected numerous times. He was unable to afford the orthopaedic shoes required to manage his disability. He was also in immediate danger of being made homeless as his rental payments were in arrears. His only source of income is from a Disability Support Pension and a Pension Supplement.

The ILS assisted Mr Q to request a waiver of the \$7,000 based on Mr Q's severe financial hardship. Communications were sent to the insurer along with all available supporting documentation. During the negotiations process, a suitable arrangement was not agreed to by the insurer's representative. They insisted on payment when it was clear that Mr Q did not have any money from which to make payments.

When negotiations broke down, the insurer's representative refused to change their decision and simply stated that they will forward the matter to their debt collection agents. When the ILS solicitor requested that the matter be reviewed by someone more senior, the insurance representative responded with words to the effect of "no one can." The ILS solicitor then questioned, "does this mean I would have to go to the Chief Executive Officer in order to raise a dispute?"

When the ILS solicitor requested that written confirmation of the insurer's refusal to change their decision, the insurance representative responded with words to the effect of "why do you need it in writing?" When the ILS solicitor responded with "because it is a matter of professionalism", the insurance representative agreed to send a response in writing. However, the ILS did not ever receive this written confirmation of their decision.

A complaint was made to the Insurer's internal dispute resolution department with a copy sent to the Financial Ombudsman Service Code Compliance. The complaint referred to the above conversation and argued that a breach of clause 3.12 had occurred. This breach related to a failure to provide details about the insurer's complaints handling procedures and failure to advise of the existence of financial counselling services.

Approximately 1 month later, the internal dispute resolution department wrote back to the ILS advising that they have agreed to waive the alleged debt.

The FOS also wrote back a few weeks later to formally state that:

“On the basis of all the information available to FOS, and having regard to the terms of the [General Insurance] Code, FOS has recorded a breach of section 3.12(a) and section 3.12(b) of the Code.”

The ILS was assured that the insurer now has “processes and systems in place which will facilitate its compliance with the financial hardship provisions of the Code.” With the benefit of a few more months of experience with this insurer, we beg to differ. See case study 25 and 26 below, all occurring after this case study and all with this same general insurer.

Case Study 25

Source: Insurance Law Service, casework

Issues – write off of alleged debt, unscrupulous debt collection practices, forcing consumers to accept unsuitable hardship arrangements, failing to advise of complaints handling procedures and the existence of financial counsellors

Mr C was involved in a motor vehicle accident in which he hit another vehicle. The insurer representing their insured sent a letter of demand to Mr C for about “\$2,000.”

In terms of income, Mr C was living on a Centrelink Disability Support Pension. A money plan completed with the ILS’s assistance revealed that Mr C had been living at a net loss. Every day for him was a difficult fight for financial and personal survival. Various household bills were in fact overdue. In addition to his financial woes, Mr C was also suffering from numerous debilitating diseases requiring frequent and ongoing treatment. He suffered from diabetes type 1 and 2, chronic pancreatitis, avascular necrosis (a type of bone disease) and Sherman’s disease (a spinal disorder affecting the lower back). Mr C had few assets and none of much value. His car was valued at \$200 and he had some old kitchen appliances.

Initial correspondence including supporting evidence sent to the insurer was not responded to. A follow up letter resulted in numerous telephone calls from an insurance representative sceptical of our client’s situation. During the negotiation process, the ILS solicitor requested confirmation in writing as to all additional information the insurer required. It was impractical to constantly call the ILS solicitor for further information whenever the insurance representative came up with a new piece of information he wanted. The insurance representative responded with words to the effect of “no, it is our policy to telephone only.” The insurance law service had to initiate all written correspondence to confirm telephone conversations and to provide the requested information.

No complaints to FOS were raised in relation to this insurer’ conduct, as the insurer’s representative had later agreed to waive the alleged debt. Funnily enough, this was received in writing although it was via email. Apparently written confirmation was possible, but obviously not preferred or at least only through electronic correspondence.

Case Study 26

Source: Insurance Law Service, casework

Issues – failing to advise of complaints handling procedures and the existence of financial counsellors, unscrupulous debt collection practices, forcing consumers to accept unsuitable hardship arrangements,

Ms G was involved in a motor vehicle accident with an insurer's insured. Ms G was not herself insured for the damage to the other party's car. The insurer sent a letter of demand for almost \$5,000.

Ms G is a 39 year old single mother with the sole responsibility of providing for her two young children; a 6 months old baby and a 16 year old daughter. She is living in rental accommodation and owns minimal assets. Her ex fiancé who normally contributes to household expenses, has now left her. Currently, her only sources of income are from the Centrelink benefits, a maintenance payment and a small fortnightly income from her local church.

Prior to contacting us for assistance, Ms G had been harassed over the telephone by the insurer's representatives. In one conversation, a male representative requested she make an immediate payment of \$3,000 within 28-35 working days, or otherwise the insurer will take procedures to commence enforcement action for the full amount. In our client's words, what followed were words to the effect of "why can't I pay off the \$3,000 over 6 months. He replied they do not have a pay off account system." Presumably this implied that the insurer did not have any hardship arrangement procedures in place.

In a later telephone call, a female insurance representative contacted Ms G requesting payment of the alleged debt. During that conversation, the representative used words to the effect of "we don't offer a pay-off system." Ms G was informed that if payment was not received by a stated deadline, then the matter would be referred to a debt collection agency and enforcement action will commence.

A letter was written to the insurer noting Ms G's financial hardship and requesting a waiver of the alleged debt. This letter was not responded to. A follow up letter a few weeks later was similarly not responded to.

A complaint has been made to the FOS Code Compliance Committee on behalf of Ms G on the basis of a breach of clause 3.11 and 3.12 of the Code.

The ILS contends that not taking Ms G's circumstances into account, in consistently informing Ms G using words to the effect of "we don't offer a pay off system" and threatening enforcement action if the insurer's proposed arrangement (as opposed to an arrangement suitable to Ms G in her circumstances) was not entered into, amounts to a breach of clause 3.11 of the Code.

In not responding to our letters requesting a hardship variation, the insurer has also very likely breached clause 3.12 for failing to advise of their complaints handling procedures and the existence of financial counselling services. In relation to the second telephone conversation, our client wrote to us stating that the representative "didn't even find out if I could find any way to pay off or seek help. It was rather upsetting."

This matter is currently being investigated by the FOS Code Compliance.

Recommendations for improvement of the Code

- Insurers' letters of demand to alleged debtors relating to third party recovery debts should explain the insurance debt recovery process and advise consumers of their rights and the insurers' obligations under the Code (for example, through the provision of an unabridged citation of the applicable third party recoveries clauses under the Code).
- Wording similar to the following should also be added to the Code:

We will not refer your debt with us to any debt collectors for at least 60 days from the date of our letter of demand to you.

Within 14 days of being aware or being made aware that an agreement about the repayment of the debt cannot be reached, we will provide the person with a standard letter containing information that complies with clause 3.12 of the Code.

- Clause 3.12 of the Code should be amended as follows:

If we are unable to reach an agreement with you about the repayment of the debt, we will provide information to you about:

- (a) our complaints handling procedures;*
- (b) the existence of the Australian Financial Counsellors and Credit Reform Association (www.afccra.org) for a referral to a not for profit, free financial counselling service;*
- (c) the existence of Legal Aid Commissions and Community Legal Centres for free legal advice; and*
- (d) the existence of the Financial Ombudsman Service Code Compliance Committee.*

- Compliance with the above clauses should be the subject of a specific campaign by Code Compliance including an education campaign for insurers about their responsibilities and a follow-up audit.

Part 2 Claims Handling and Complaints Handling

Although the ILS acknowledges that various mechanisms for the resolution of complaints and disputes between insurers and their customers exist under the Code, it is our submission that these time frames and procedures are ineffective in practice. In this regard, we note numerous problems experienced by customers in relation to either claims or complaints handling.

We have grouped these problems into the following categories:

- Delays and indefinite time frames;
- The IDR Trap; and
- Other persistently complained about “customer” concerns

It is also our submission that these ineffective mechanisms consequently reflect poorly on the other Code objectives (and the Review’s terms of reference) serving to aggravate relations between insurers and their customers, to reduce consumer confidence in the general insurance industry as well as to severely undermine general insurers’ commitment to providing supposedly high standards of customer service.

The problems experienced by customers are demonstrated primarily by case studies from the work of the Insurance Law Service, Legal Aid Commission of NSW and other community legal centres.

A. Delays and Indefinite Time Frames

Under clauses 3.1 to 3.3 and clauses 6.2 to 6.9 of the Code, various time frames are set out. One such a time frame promises that insurers will process claims within 10 business days unless subject to further investigation. However, the Code puts no limit on the time allowed for such investigations and does not provide an obvious trigger to force a decision on a claim, allowing an unlimited number of 20 business days for investigation subject to notification to the insured.

The ILS submits that in practice, customers with a dispute can often be in claims, investigation and IDR for many “months” and not just “days” as referred to under the Code.

For many customers, this waiting period can be personally and financially detrimental, sometimes seriously so.

The ILS submits that these time frames are inconsistent, confusing and misleading. The days for response can range from 5, 10, 20 and even extend ad infinitum depending on the availability of supposedly “necessary information” and the actions of adjusters, claims investigators, assessors or other insurance representatives.

Customers have also raised strong concerns that insurers are not complying with their duty to keep them informed about the progress of their claims as required under the Code (clause 3.2(3)). Customers’ complaints in this regard have revolved around the fact that they are the ones that seem to constantly initiate contact with insurance representatives and not

the other way around. These representatives also promise to respond by certain time frames, but inevitably most fail to do so.

The ultimate result is that customers become frustrated, disillusioned about the claims and complaints handling processes and may even withdraw from the process altogether. Customer/insurer relationships are also strained as some telephone calls to insurers inevitably result in arguments between the two about progress issues.

Case Studies

Case Study 27

Source: Insurance Law Service, telephone advice

Issues - Extended investigations process forces insured to withdraw claim, effectively denying the insured access to IDR/EDR

Mr T's car was stolen. He lodged a claim with his insurer, who proceeded to investigate the claim. The insurer requested extensive and seemingly irrelevant financial information from Mr T, implying they suspected fraud. Throughout this time the car, which had been recovered in slightly damaged condition, was in the insurer's possession. Mr T supplied one lot of financial information, only to be told they required another lot, going back further in time.

Eventually Mr T, who was paying a fortune in taxis to transport his disabled children around and didn't know what else to do, withdrew his claim in order to procure the return of his vehicle. He paid a mere \$500 for the damage to be fixed. Mr T felt he had no choice but to drop his claim because the cost of doing without his car was greater than the damage caused by the theft. He is completely disillusioned with the usefulness of insurance.

Case Study 28

Source: Insurance Law Service, telephone advice

Delay in claims processing and poor communication

Ms B's roof was damaged in a storm. She put in a claim with her insurer who sent out an assessor. Ms B was unhappy with the assessor's report so the insurer agreed to send out another assessor. Ms B has been waiting for over 5 weeks for the new assessor. She has received no contact about her claim for over 7 weeks and has been hung up on when trying to make calls of inquiry.

Case Study 29 Detriment caused by delay and failure to respond to legal proceedings issued against consumer

Source: Insurance Law Service, telephone advice

Issues - Delay in claims processing and poor communication, unwarranted delay/processing error resulting in legal proceedings being issued against insured; failure to provide effective access to IDR

Mr R had a third party property insurance policy. He had a motor vehicle accident in March. The money to pay the excess on the claim cleared from his bank account in April. He heard nothing more about the claim and assumed that it had been settled. In late September he received a letter from the other driver's insurance company informing him that as he had not paid his excess, his insurer had not paid the claim, and they were therefore claiming for the damage to the other vehicle directly from him.

Mr R contacted his insurer on the same day to dispute the alleged non-payment of the excess. The insurer agreed it was a mistake and would be fixed within one week. He received an e-mail confirming this. In early November he received a statement of claim from the other driver's insurer. He tried to contact IDR at his insurance company without success. He sent several e-mails to an IDR contact he found on the internet, but received no response. Finally he contacted a claims officer who told him not to worry, but still nothing happened to settle the claim.

In frustration, the client who was from a non-English speaking background and spoke in heavily accented English, contacted the ILS. The ILS solicitor dictated a letter citing clauses 3.1, 3.2 and 3.3 of the Insurance Code of Practice and asking for a decision to be made on the claim by a given date a few days hence, while also preparing the client to file a defence in the event that it should be necessary. The client faxed this letter to the insurance company and they immediately agreed to pay the claim and the legal costs incurred in issuing the statement of claim. The other driver's insurance company agreed to discontinue the proceedings. The client wrote to the ILS to say thank you and to say:

"I would like to thank you and appreciate your help regarding insurance claim. I logged [sic] an Insurance Claim in March 2008 & my insurance company was not settling down the claim. I have received settlement of claim from court & I did not know what to do because outside solicitor charge a lot for their consultation.

You have helped me over the phone to draft legal letter which I faxed to my insurance company, which made them to settle my claim within week."

It is likely that without the ILS's assistance Mr R would also have had a judgment debt for an event for which he had paid for insurance cover and lodged a valid claim.

Case Study 30

Source: Insurance Law Service, telephone advice

Issues - Failure to process a claim in a timely manner; unreasonable use of referral back to IDR to prolong an already protracted dispute

Caller first contacted ILS in early July 2007 about a storm damage dispute. He called again in late August because it had now been 3 months since the damage occurred and there had been no refusal or acceptance of claim. There was not even a written assessor's report. He called again in late September to say that he had referred the matter to IDR on our advice six weeks previously and had still heard nothing. A solicitor made representations to IOS on his behalf. In mid-October he called again to say the insurer was considering the claim after

they were contacted by IOS. The Insurer responded and offered Mr B \$3000, when his claim was for \$5000. Mr B made a further complaint to IOS. He was told he would have to go back to IDR again before IOS could consider it as it was now a “new” dispute, as before the dispute was about whether a type of damage was covered and now it was about quantum. Mr B contacted the insurer again, but IDR ignored him all over again. By this time it had been 5 months since the damage was incurred.

Recommendations for improvement of the Code

- The ILS proposes that the Code provide for a consistent time frame for all claims and complaints handling. Noting that the FOS’s proposed new terms of reference is currently awaiting approval from ASIC and that this proposal includes a time frame for lodgement into the FOS scheme of 2 years from an insurer’s IDR decision, the proposal below does not conflict with and is not inconsistent with this.
- We appreciate that some claims involve more detailed investigation than others. The current timeframes, however, can be extended indefinitely and are therefore rendered meaningless. The ILS submits that there must be a trigger point at which the consumer is armed with the information they need to enlist the assistance of an independent “referee” (whether that be the insurer’s IDR or FOS) to determine whether any further delay is justifiable by the circumstances.
- After lodgement of a claim/complaint, the insurer should provide the customer with a copy of the relevant time frames and provide the option for contacting the FOS should these time frames not be adhered to.
- A consistent 14 days (2 weeks) time frame from receiving a claim or complaint should be applied for:
 - notifying insureds about the progress of their claim;
 - notifying insureds of the information the insurer requires to make a decision on their claim;
 - appointing (if necessary) a loss assessor/loss adjuster; and
 - providing an initial estimate of the time required to make a decision on a claim;
 - notifying the insured of the appointment of a loss adjuster/assessor/investigator (if applicable)
 - responding to routine requests for information made by the insureds
- The code should emphasise that the duty of notifying customers about the progress of their claim is that of the insurers
- If the insurer is waiting on information from either a third party or the insured, this should be relayed to the consumer immediately or as soon as is practicable.
- Where no decision has been made in relation to a claim for 60 days from the date of lodgement, then the insurer should be obliged to inform consumers in

writing of the reason for the delay and their complaints process, including the right to apply to EDR.

B. The Internal Dispute Resolution (IDR) Trap

Under clause 6.2 of the Code, general insurers promise to respond to IDR complaints within 15 business days provided they have all necessary information and have completed all their investigations.

We submit that this time frame is often misleading as it is rarely applicable in practice. The reality based on our experience is that many complainants have not been able to obtain a decision on their claim or have been advised that the insurer has a two or more tiered IDR process.

An IDR decision is important as the current FOS terms of reference requires it as an entry requirement into their EDR scheme. Some common problems experienced by consumers in relation to this include:

- While insurers appear to have a clear idea of what constitutes IDR in their particular organisation, this is not clear to customers, who invariably don't understand what is or how to get there. It is also not clear that customers are in IDR when they do get there.
- Disputes arise as to what constitutes an IDR decision.
- IDR can involve several levels with the IDR decision occurring at the end of the process

A great risk, as demonstrated by the case studies below, is that consumers get fatigued during investigation or IDR even when they have a meritorious dispute.

The above system fails to drive improvements in the efficiency of IDR because:

1. IDR has no incentive to be efficient because the consumer is “trapped” until a decision is made; and
2. The insurer has an incentive to keep consumers in investigation or IDR to avoid the costs of EDR or to avoid paying the claim if they succeed in causing the consumer to give up.

Case Studies

Case Study 31 – Knock, Knock, Knockin’ on EDR’s door

Source: Insurance Law Service, Casework

FOS-GI Reference: 34817

Issues – multitiered IDR processes, protracted claims and dispute resolution process causing severe personal, financial and medical detriment to insureds

Mr & Mrs B’s house was destroyed by a fire in early December 2007. A claim was made on their home and contents policy.

After seven months of investigation the claim was finally formally rejected in late June 2008 as a result of “factual inconsistencies” in the claimants’ story. Throughout this period, Mr & Mrs B had been in contact with IOS (now FOS) on numerous occasions and were referred back to the insurer each time.

In early July 2008 ILS wrote to FOS – General Insurance seeking access to EDR on the basis that our clients were in severe financial hardship, that the claim had already been examined by a variety of internal sections of the insurer, that the dispute was entrenched and unlikely to be resolved, and that in the circumstances a referral back to IDR would only exacerbate the delay and resultant hardship. FOS responded by referring the matter back to IDR in mid July.

In August the ILS wrote again to the FOS, and this time to ASIC also, pointing out that the matter had already been to the National Customer Dispute Resolution Manager and the Customer Advocacy Case Manager, the likelihood of an alternative resolution to the matter was very unlikely. FOS agreed to accept the dispute in mid-August 2008.

The insureds are living in financial hardship because they are now required to pay rent from their Centrelink payments when formerly they owned their home. Mr B was seriously injured in the fire, requiring resuscitation and intubation from severe smoke inhalation. He has since been diagnosed with Post-traumatic Stress Disorder.

Mr and Mrs B have approached the insurer for permission to sell the property but the insurer responded as follows:

“Regarding the sale of the property we have no objection to your clients selling the property provided the risk passes to the potential buyers when the contract is signed. We will then remove the safety fencing and have nothing more to do with the property. No-one (either Real Estate Agent or potential buyer or inspectors of any kind) may breach the safety fencing on the property until our liability is removed.”

The ongoing delays, the months of requests for further and differing information and statements about their personal affairs, have all taken their toll on the insureds.

In mid June 2009, the FOS made a determination that required the insurer to pay out the claim in accordance with the policy and also pay interest on the claim from June 2008 to the date of payment.

Although the issue of liability has been resolved, the issue of the amount payable is currently being determined.

From the period the fire started (December 2007) to the favourable FOS determination one and a half years later (June 2009) and now that the amount of the claim may be at issue as well, to Mr and Mrs B, there appears to be no end to this severely protracted insurance claims and dispute resolution process.

Mr B is now regularly in and out of hospital, he suffers from unexplained and regular paralysis to his hips and hands. He also can no longer eat food. He is currently on heavy doses of various medications as doctors continue to be baffled by his deteriorating condition. He fears he may not survive to see his claim paid out.

Mr and Mrs B argue that all this has occurred as a result of the consequences of their claim not being paid out when it should have been approved and the financial sacrifices that they have had to make to continue to survive. This included sacrifices that meant that they had to choose food and rent over medication for their conditions.

Mrs B has also been heavily affected, she regularly collapses on the streets for unknown reasons and is currently attending hospital to check on the possibility of her bowel cancer returning. Both Mrs B and her husband are currently seeing doctors at private hospitals because they have not been able to get into the public hospital system. The expenses associated with private hospital treatments have meant that they have often gone days without food.

Had their claim been paid out when it was made, they would not have had to suffer through the deterioration in health that has meant that even if a certain sum of money is paid, it will not bring them back to the position they were in prior to the fires that damaged their property and destroyed their lives.

Even if the claim is eventually paid out, the grim legacy of this insurance claim will forever be imprinted in their minds as they struggle to piece together their lives and struggle to survive amidst the chaos and consequences of the claims and insurance dispute resolution processes.

Case Study 32 – How do you tell if an IDR rejection letter is an IDR rejection letter?

Source: Insurance Law Service, Casework

Issue – what is an IDR rejection letter?

Mrs V is the executor and beneficiary of her late husband's will. Her husband had a home insurance policy which Mrs V is trying to claim, under the name of the estate. Her husband died as a result of a fire which also destroyed the insured property.

The insurer rejected Mrs V's claim. A subsequent letter from Mrs V disputing the rejection resulted in a letter from the insurer's solicitors confirming the insurer's decision to reject.

At this stage, Mrs V contacted the ILS for assistance.

Upon examining the insurer's solicitor's rejection letter, the ILS did not consider it to be an IDR rejection letter as we felt that it did not comply with clause 3.4(5) of the General Insurance Code of Practice (by failing to provide information about the insurer's complaints handling procedures) and clause 7.3 of the then FOS- GI Terms of Reference (by failing to advise on the availability of the Financial Ombudsman Service). This argument was put to the insurer's solicitors and a formal IDR letter was requested. The solicitors for the insurer responded by stating that they did not agree with the contents of the ILS's letter and that they did consider their letter to be an IDR rejection letter.

As to the provision of the required information? The insurer's solicitors responded with this. A "copy of [the insurer's] Product Disclosure Statement [was provided and] specifically referred to the dispute resolution process" with the denial of Mrs V's claim. It appears that they did not consider that such "required" information as complaints handling procedures and the availability of FOS as an EDR scheme should have been included in the rejection letter itself; rather Mrs V was required to browse through a thick booklet of terms and conditions to find such information.

Whilst this dispute was continuing, it remained uncertain whether Mrs V's 3 month time limit from an IDR letter to lodge with the FOS was applicable from the date of the solicitor's letter or not.

The consequence of this confusion was that the ILS had to request a Referral Notice from the FOS, noting that we disputed the insurer's IDR rejection was in fact an IDR rejection under the Code and the FOS Terms of Reference. By the last day of the 3 month deadline for a FOS lodgement, FOS had not provided Mrs V with a Referral Notice. The ILS decided to lodge our complaint without a Referral Notice on the date of the deadline and requested that FOS accept the complaint.

Later that day, FOS emailed the ILS to indicate that it was in the process of seeking to request a confirmation from the insurer whether their solicitor's letter was an IDR rejection letter. It therefore could not provide Mrs V with a Referral Notice but stated that they were willing to accept the dispute.

The ILS had not intended to represent Mrs V on the substantive issue of the insurer's rejection but ultimately were forced to intervene by having to lodge a complaint to FOS without a referral notice. To do otherwise would have resulted in the FOS time limit expiring through no fault of Mrs V.

Almost a month later, the ILS received a letter from the insurer advising that they have not had an opportunity to forward this dispute through to their internal dispute resolution department and requested 15 business days to do so.

It appears then that the insurer's solicitor's letter which they argued was an IDR rejection letter was not in fact an IDR rejection letter.

In the above case study, if we had not assisted Mrs V, all the confusion about what is an IDR rejection letter would have resulted in her not being able to access free EDR services.

Case Study 33 - Wearing consumers down by delay and extended assessment or investigations processes

Source: Victoria Legal Aid, casework

IOS No 34166

Issues - Failure to advise claim outcome; failure to provide IDR

Mr A had comprehensive insurance. He had an accident and made a claim in Jan/Feb 08. He spoke limited English and relied upon telephone contact to pursue the claim. A dispute

arose as to whether the car should be written off or repaired and whether the insurer would be prepared to cash settle.

Although the insurer had assured Mr A that the claim would be paid there was no formal written notification of the claim or the amount to be paid. After months of frustration Mr A approached Victoria Legal Aid for assistance. He believed that the claim was being settled on the basis that the repairs would cost \$5,039.84 according to his quote or that the insurer would cash settle and he would receive that amount by way of a cheque.

Mr A, despite being in dispute, had not been advised that he could access IDR or EDR. However, in the absence of an actual decision he would not have been able to access dispute resolution. VLA insisted on a written decision on the claim and the insurer advised that the payment would be limited to \$1,852 after deduction of a \$450 excess and not the \$5,039.84 Mr A believed had been agreed. Despite the time taken to obtain a decision on the claim Mr A was required to proceed to IDR before he could access EDR.

An initial request for IDR was refused on the basis that the insured was asked to put his request for IDR in writing for consideration by claims management. After a Code complaint the insurer provided an IDR decision. An application was made to EDR in June. The Code Manager found that the insurer had breached the Code. The insurer noted by way of explanation that the Code “was breached inadvertently, due to language barriers that existed, and discussions between the parties that were at cross purposes”. No interpreter was used and no reference made to IDR or EDR.

Mr A then advised that the process had taken too long, that he had lost confidence in VLA to solve his problem and he wanted to go to a private solicitor. Procrastination on the part of the insurer had won the day.

Recommendations for improvement of the Code

The ILS submits that insurers should not be able to use the IDR process as a means to delay and frustrate claims, or to deny access to EDR. To ensure that this does not occur we submit that:

- Insurers must publish their IDR contact details including the name of the contact person, name of department, direct postal address, direct fax number, direct phone number and direct email for correspondence both on their websites and on the FOS website.
- Insurers should be obliged to inform consumers of their complaints process, including the right to apply to EDR, at the time the consumer is informed about any adverse decision or action, including an indication that the insurer is “going to investigate or reject the claim”.
- As to the general format of a standard IDR letter, we are aware that the FOS are currently in the process of developing this standard form IDR letter. The Code should confirm that the format and content of the standard IDR rejection

letter should follow those of the FOS guidelines or sample IDR letter when it is released.

- At a minimum, the IDR letter must include:
 - Details about the FOS;
 - That FOS is a free process;
 - The binding nature of FOS determinations to insurers and the non binding nature of FOS determinations to insureds
 - The date to make a complaint to FOS
- One person to undertake the IDR process
- All unresolved claims which remain outstanding for more than 6 months must be:
 - Reported to IDR Team leader with sufficient details as to when a decision will be made on the claim; and
 - Independently audited by the IDR Team Leader to determine whether it complies with clauses 3.1 to 3.4
- All unresolved claims which remain outstanding for more than 12 months must be:
 - Reported to the Code Compliance Manager, FOS; and
 - Independently audited by Code Compliance Manager to determine whether it complies with 3.1 to 3.4

Rationale: Simply notifying consumers about EDR requires them to take the next step, it is important that Code Compliance should be aware of such delays so that it can investigate the cause.

C. Other persistently complained about “customer” concerns

In addition to the above, the ILS is also deeply concerned about the conduct of some general insurers in relation to the following:

I think the next two sections should be merged – the division is a little artificial and the solutions probably the same –for instance in the UME case

i. Refusal/ Reluctance in issuing formal claims rejection letters

From the work of the ILS, we are concerned about some insurers being reluctant to issue formal claims rejections, despite being required to do so under the Code, clause 3.4(5). The result is that customers are left in limbo and without any knowledge of their rights in relation to dispute resolution.

Case Studies

Case Study 34

Source: Insurance Law Service, casework

Issues - Failure to give formal written rejection; failure to provide and/or expedite IDR in urgent circumstances

Mr U obtained travel insurance with medical cover from an Australian insurer for his trip from Greece to Australia. After several months in Australia, Mr U suddenly became ill one night and went into convulsions. An ambulance was called and after extensive tests, it was determined that Mr U had a cancerous growth on one of his vital organs requiring immediate surgery.

A claim was made immediately on Mr U's travel insurance. The insurer responded via email and indicated that it intended to reject the claim because its medical officer deemed the surgery not urgent.

There was no mention of IDR in the email. Without knowing what other options he had, Mr U went back to the insurer's claims department only to be told that he should return to Greece for treatment.

Mr U's doctor strongly advised against travel in his current condition and insisted that he should book in for surgery in Australia. Immediate surgery was predicted to give Mr U a significantly greater chance of recovery.

Mr U's son-in-law, despite being on a low income, was able to obtain a personal loan to cover the cost of surgery. Surgery was arranged to occur within 14 days. Mr U's son-in-law then approached the Insurance Law Service ("ILS") for assistance.

The ILS solicitor contacted IOS (now FOS) and obtained the insurer's IDR contact. In fact the contact number was only to the Insurer's customer service operator. The operator said that the matter was not an issue for IDR.

The ILS solicitor insisted that this was a dispute that should not only be considered by IDR, but also that IDR should be fast tracked given the urgency of the treatment required and the family's financial hardship.

The operator repeated that the insurer intended to reject the claim but would not be willing to offer any immediate formal rejection in writing. The operator then spoke to a supervisor at the ILS solicitor's insistence, and subsequently indicated that a written complaint would have to be sent to a Queensland post office box address, but warned that the response time was likely to be slow.

The ILS solicitor was advised that the insurer's IDR did not accept faxes. The operator repeated that if Mr U was concerned, he should leave the country as instructed. The ILS solicitor explained that Mr U was in medical care and was unfit to travel.

It was eventually conceded that the insurer would reject the claim in writing so that IDR could be triggered.

The ILS solicitor contacted IOS the following day and obtained the details of a senior officer in the insurance company. The insurer then granted access to IDR and agreed to settle the claim shortly thereafter.

Case Study 35

Source: Insurance Law Service, telephone advice

Issues - Failure to provide formal written rejection; failure to provide access to IDR

Mr S's car was damaged when another car tried to overtake him on a single lane road. Mr S put in a claim with his insurer and the other car also put a claim with his insurer. The other car alleges that Mr S hit him from behind and thus he is not at fault. Mr S has submitted numerous independent witness statements from persons at the scene to his insurer. His insurer rejected the claim but has refused to put the rejection in writing.

Without a formal rejection, Mr S does not understand the basis for his rejection and has not been told how to escalate a complaint. After obtaining advice, Mr S sent a letter requesting an IDR review. He received a phone call from the insurer telling him to give up the matter as it would not be reviewed.

It has been over 10 months since Mr S put in a claim, and he has still not received a formal rejection letter. Despite numerous conversations with the insurer in relation to his claim, he had no knowledge of the availability of IDR or EDR. Meanwhile, his car had not been repaired and debt collectors for the other driver's insurer were harassing him for payment of damages to their insured's car.

Case Study 36

Source: Insurance Law Service, telephone advice

Issues – Failure to provide formal written rejection; no access to IDR/EDR

Mr M's house was affected by floods. Mr M was storing shirts for a new business in his garage. The garage was flooded and the shirts were damaged. Mr M took photographs of the shirts before throwing them out.

After two and half months of argument, the insurer conceded that the event was a storm event, but said that the shirts had not existed. Mr M provided the insurer with photographs of the damaged boxes and shirts, invoices for the goods and witness statements from neighbours who had helped clean up.

Mr M told the insurer that he wanted to launch his business and needed to settle quickly. The insurer offered \$2,000 which was refused by Mr M. The insurer then rejected the claim on the grounds that the shirts did not exist. Mr M asked for the rejection in writing, but the insurer refused. Mr M also has difficulty with English and believes he is being taken advantage of.

Case Study 37

Source: Insurance Law Service, casework, IOS Determination Case no: 32511

Issues - Delay in claims processing; failure to properly assess claim; failure to provide formal written rejection; failure to provide access to IDR/EDR

Ms W's house was damaged by storms in June 2007. Ms W lives on a pension and is a carer for her disabled daughter who had a room on the 2nd storey. Ms W suffered from a stroke and as a result suffers memory loss. However, she keeps detailed written records of what has occurred between her and the insurer. She had been in dispute with her insurer for the over 3 months when she contacted the ILS.

The insurer's preferred builder inspected the damage and quoted \$7,100 to repair the damage that he attributed to the storm. The insurer sent a cheque for \$5,916, which Mrs W rejected.

A loss adjuster was appointed who put the claim at \$14,456. Again the insured rejected the estimate and requested a review. The insurer had stated verbally that Ms W's larger claim had been rejected because her roof did not comply with Australian building standards but did not put anything in writing.

The ILS assisted Mrs W to take her dispute to IOS. The Determination made the following observations:

"The member has referred to a number of policy conditions and exclusions and although there is some indication from file notes that the member may have discussed this with the applicant or her representative these discussions are not clearly documented." (p4)

"The member appears to have relied upon its trade assessors to communicate with the applicant rather than clearly communicating with the applicant itself. The Panel believes that if the member wished to rely on policy conditions or exclusions as part of its claims decision then it should be addressed appropriately in correspondence during the claims process.

"The Panel does not accept the member has acted appropriately or in a timely manner to address the issues during the claims process. Particularly as the member has now indicated 'that an inspection by a consultant as recommended would have assisted in resolving the matter'

"The member did not take any steps to appoint a building consultant until 4 January 2008 even though the applicant and member had been in dispute since July 2007 as to the scope of works." (p4)

The Panel determined a cash settlement of \$22,000 was appropriate and Mrs W accepted this amount. The Determination was signed on 21 July 2008, over 12 months after the claim was lodged.

Case Study 38

Source: Legal Aid NSW

Issues - failure to provide formal written rejection, claims limbo (claim neither paid nor denied), failure to provide insured with regular updates on progress of his claim, failure to respond to requests for progress reports on claim, unacceptable prolonged investigations period

Mr F financed the purchase of his car through a car loan with a financial service provider. He had also obtained a comprehensive insurance policy on the car with a general insurer.

In March 2007 his car was stolen and he lodged a claim immediately. The police subsequently found that the car was burnt down. Mr F attempted to follow up with the insurer on the claim but was always told that they were continuing to investigate. The insurer had not paid the claim, nor had it refused the claim.

In early 2008, the car loan went into serious default and the car finance provider commenced Court action against Mr F. At this point, Mr F desperately attempted to get the insurer to make a final decision on his insurance claim. Again, the insurer failed to respond. After some time, Mr F simply filed a cross-claim against the insurer on the basis of breach of the insurance contract.

Case Study 39

Source: West Heidelberg Community Legal Centre

IOS Decision No 32938 - Failure to advise claim outcome; failure to provide IDR

Mrs F is a Tongan resident in Australia with her husband and now adult children. In May 2007 her car was stolen from her home during the night. The car was badly damaged in a crash in the early hours of the morning. It subsequently became apparent that it was likely her 18-year-old son had taken that car. Her son moved out of home and avoided his parents and the police to avoid being questioned about the crash and theft.

The insurer embarked on an investigation seeking to prove that Mrs F had given her son permission to drive the car or knew for certain the son had taken the car and had failed to advise the insurer of this fact.

Nine months later the insurer refused to make a decision on the claim. The IOS demanded a decision from the insurer, which then refused the claim and confirmed the decision immediately through IDR. Mrs F could not access IDR or EDR without a decision. She was subjected to enormous pressure from the insurer to drop the claim in order to protect her son.

Case Study 40

Source: Insurance Law Service, casework

Issues – failure to provide formal written rejection, failure to provide access to IDR/EDR

Mr M was involved in car accident a few years ago where the other driver was at fault. He had 3rd party insurance with uninsured motorist extension cover and made a claim to his insurer over the phone.

His insurer verbally rejected his claim because there was conflicting witness testimony about the accident. However the insurer failed to tell Mr M about his appeal rights to their dispute resolution department, or about the availability of EDR schemes where he could continue to pursue his claim. This left Mr M in a position where he thought his only remedy was to pursue the other driver himself through the court system.

Recommendations for improvement of the Code

- No rejection of claims or decisions on complaints should ever only be made verbally. Rejections/decisions should always be in writing and if it follows a verbal rejection/decision, rejections/decisions should be given within 14 days of the verbal rejection/decision.
- Even if a rejection is on the basis that a claim is not covered under the policy (as will be the case with many verbal rejections over the telephone), it should be provided in writing to enable insureds to access their rights to dispute resolution processes.

ii. Persuading customers not to claim and Not issuing claim forms when requested

Also of major concern to the ILS is the issue that customers are persuaded out of lodging or pursuing a claim, in preference to the insurer recording and acting appropriately on a claims refusal by providing claim forms (if applicable) and formal rejection letters (a requirement under clause 3.4.5 of the Code).

Case Studies

Case Study 41

Source: Insurance Law Service, telephone advice

Issues - Refusing to allow insured to lodge a claim, Failure to provide access to IDR/EDR

Ms Q's house was damaged by what she considered to have been construction work on the adjoining property. When she contacted her insurer to make a claim, she was advised that her claim was not covered as a defined event. She twice requested a formal claim be lodged, however, the insurer declined to accept the lodgement of her claim. The insurer did not provide any reasons for rejecting the lodgement of her claim.

Regardless of whether insurer was entitled to ultimately deny the claim, the insured is entitled to lodge a claim and to be provided with written reasons if that claim is subsequently rejected.

In the above case study, refusing to accept the lodgement of a claim and denying it outright over the telephone is inconsistent with the insurer's duty of utmost good faith under the Insurance Contracts Act and is clearly a breach of the Code. However, in practice, we sadly note that this conduct happens all too often.

Case Study 42 - Verbal pressure to give up on a claim

Source: Insurance Law Service, advice

Issues - Insurer putting verbal pressure on insured to not proceed with claim; failure to provide access to IDR/EDR

Ms R's house was damaged by storms. The insurer has been slow to respond and has informally harassed Ms R into dropping her claim. Ms R has made many requests that the matter be forwarded to the Insurer's IDR department. Although she has been assured that this will happen, she has received no confirmation from the insurer in writing.

Case Study 43

Source: Insurance Law Service, telephone advice

Issues – preventing a customer from claiming by not issuing claim forms when requested, no formal written claims rejection, failure to provide access to IDR/EDR, problems with consumer credit insurance policies

Mr C had a \$9,000 personal loan with a financial service provider. He also had a consumer credit insurance policy from a branch of the provider who offers general insurance services.

When Mr C was made redundant, he tried to claim from the insurer under his consumer credit insurance policy. He contends that he tried to request claim forms (he termed it "paperwork") and in all contacted the insurer on six different occasions making this request. He never heard back from the insurer. He never received any claim forms. After waiting for some time, he became frustrated with the process of claiming under his consumer credit insurance policy **and gave up**. Instead, he obtained a home loan on his house to pay out the outstanding debt with the financial service provider.

There may well be some exclusion preventing Mr C from successfully claiming. Even if this was the case, claim forms should have been provided (or the numerous phone calls trying to claim should have been accepted as lodged) and if rejected, the claimant should have been entitled to a formal written rejection (as is required under clause 3.4.5 of the Code)

As it stands however, Mr C had to obtain a home loan to repay the debt which he may have been covered for under his consumer credit insurance policy. He also is left wondering what else he had to do to claim on a policy which he had legitimately paid premiums for. This example is additionally exacerbated by the fact that Mr C was not told how to dispute

the insurer's refusal to give him claim forms or how to dispute a refusal to allow him to claim altogether.

His frustrated attempts at trying to claim on his consumer credit insurance policy are arguably a recurrent feature of consumer credit insurance policies. Many who have such insurance covers often don't know how to go about claiming and have never received any insurance documents except the linked credit application details, meaning that they don't know much (if any) about the nature of consumer credit insurance policies.

Case Study 44

Source: Legal Aid NSW

Issues – encouragement not to make a claim, failure to advise insured to make a claim, failure to provide access to IDR/EDR

Ms C had credit card insurance which was triggered if she used her credit card to pay for the travel.

Ms C was diagnosed with terminal illness and was forced to cancel an overseas trip that was already booked.

She telephoned the insurer to make a claim on the policy and was told that under the policy she was not covered as there was an exclusion clause in the policy that would prevent her from being compensated if she had contracted a terminal illness.

As polite and sympathetic as they were, she was verbally advised that "there was nothing they could do" to help.

Legal Aid NSW assisted Ms C to make a claim under the policy and was able to demonstrate that the failure of the credit card company or insurer to provide her with a copy of the policy meant that the insurer was not able to rely upon an exclusion where the customer hadn't been clearly advised in writing of that unusual term: s 14 and s 37 *Insurance Contracts Act*.

Recommendations for improvement of the Code

The opening provisions in clauses 3 (Insurance Claims) and 6 (Complaints Handling) should have an additional clause requiring the insurer to acknowledge in writing that a claim/complaint has been made regardless of whether that claim/complaint was made by telephone or in writing. It may state something similar to the following:

- 3.0 Within 7 days of receipt of your claim or receipt of information from you of facts/circumstances giving rise to a claim (whether received verbally or in writing and whether the word "claim" is used), we will provide you with written:
- (a) acknowledgement of your claim;

- (b) advice about your rights and our obligations under the Code relevant to the resolution of your claim; and
- (c) advice about the claims process and what will happen next.

3.* If we decide to accept your complaint we will confirm this in writing and confirm what this means.

6.0 Within 7 days of receipt of your complaint or receipt of information from you or a third party of facts/circumstances giving rise to a complaint (whether received verbally or in writing and whether the word “complaint is used), we will provide you with written:

- (a) acknowledgement of your complaint;
- (b) advice about your rights and our obligations under the Code relevant to the resolution of your complaint; and
- (c) advice about the complaints process and what will happen next.

6.* If we decide to accept your complaint we will confirm this in writing and confirm what this means.

“You” and “your” above include those who are third party beneficiaries of any general insurance cover.

iii. Post claims approval issues not being recognised as complaints

It is our experience that post claim issues are often (if at all) not recognised by insurers as a formal complaint even though they cause severe distress to customers, exacerbate customers in financial and personal hardship (e.g. those who have their houses flooded or destroyed by fires) and damages insurer/customer relationships.

The nature of these concerns relate mostly but not exclusively to customers whose claims have been approved but who are waiting on authorised insurance representatives to begin, continue or correct poor quality repair and building works. Many customers often feel that any complaints during this process will somehow be to their detriment in that it may exacerbate what was essentially an approved claim.

Customers also complain that insurers fail to keep them updated on what is happening in relation to these matters. Failure to provide progress report on post claims approval issues such as these leaves consumers frustrated. Clause 3.2(3) is arguably only applicable to claims handling. The Code neglects the need for progress reports in relation to post claims issues such as repair work.

Further in these scenarios, customers do not ever receive formal rejection letters as clearly their dissatisfaction is not considered a complaint and consequently customers are denied access to IDR/EDR.

Amidst all these concerns, practically speaking, delays in repair works can often result in further damage to home and contents, mould and mildew growing in cases of water related events, accumulation of dust and if relevant asbestos, and in severe cases unnecessarily preventing customers from returning to their homes.

Although we note that under clause 3.13 of the Code, insurers promise to assume responsibility for the quality of workmanship and materials, and to handle any complaints about quality and timeliness of the work or conduct of repairers, it is our submission that in practice, breaches of this clause happen all too often.

Given that objectives of the code include a commitment to high standards of customer service, better dispute resolution mechanisms, improving consumer confidence in the industry and promoting better customer/insurer relations, persistent breaches of this clause implies that concerns of customers in relation to this area aren't being recognised as "complaints" or that insurers do not know how to practically comply with this clause given the involvement of third parties such as repairers and builders.

Case Studies

Case Study 45 – Refusal to provide access to IDR on post claims approval issue

Source: Insurance Law Service, telephone advice

Issues – failure to recognise post claim approval issues as "complaints", failure to provide access to IDR even on request

Ms Q's house was damaged by storms. A contents claim was paid out at full value. Ms Q is also covered with her insurer for \$176,000 for the house itself. The insurer sent out an assessor, who said that only a portion of the house required repair. Ms Q had an independent report done, which found that the whole house had been damaged and works were needed on the whole structure. The insurer sent out a builder to do a quote on both proposals. The quote for the assessor's work was \$32,000, and the quote for Ms Q's independent report work was \$38,000.

The insurer indicated it would only proceed to do the work contained in the smaller quote. Ms Q rejected this and has repeatedly requested that the matter be moved into IDR. The insurer has refused, saying that there is no dispute and that no work will be done until Ms Q signs for the scope of the work.

Case Study 46

Source: Fiona Guthrie, Independent consumer representative

Issues - failure to recognise post claim approval issues as "complaints", failure to provide access to IDR, failure to provide progress report on post claims approval issues

Ms G's Brisbane home was damaged by a severe storm in or around January 2009. Although her claim has been approved, she is having difficulties trying to get some damaged items repaired. The following is her account of this experience.

"[The insurance representative] turned up forgetting some of the stuff he needed and then asked me what needed to be done. I had already gone through it all with the assessor, again with the appointed builders, and again with the guy doing the quote. You would think that someone would have it on record to pass on to the contractor that actually does the work and the homeowner.

The feeling that you are left with is that what is happening to the home that is your pride and joy and the place that is the shelter for your family is really not that important.

We are not kept in the loop unless we constantly make phone calls (squeaky wheel gets the oil) and that makes you feel as if you are bothering people all the time...

I feel that even though we have paid insurance forever and have never made claims, we are beholden to the insurance company and should be happy to get what we can.”

(Emphasis Added)

Case Study 47

Source: Insurance Law Service, minor case assistance

Issues - failure to recognise post claim approval issues as “complaints”, failure to provide access to IDR, failure to provide progress report on post claims approval issues

Mr Z’s house was damaged by a hail storm in early December 2007. He is from a Non English speaking background. Even while hail was continuing to fall, Mr Z immediately contacted his insurer to make a claim. The insurer approved the claim and sent out an assessor to inspect his property.

One item that was damaged was Mr Z’s roof. The insurer authorised a repairer to come onto Mr Z’s roof to replace up to 40 tiles. However, in the process of doing the repair work, the repairer left many other tiles broken and chipped. A complaint to the insurer was not responded to. After a while, the roof repairers returned but this time managed to use the wrong size tiles, leaving Mr Z’s roof filled with tiles all of varying sizes.

Before the roof was repaired and while the dodgy repairs were taking place, more rain had entered the house from recent storms. The culmination of delays and dodgy repair work meant that Mr Z’s carpets were soaked, water marks and stains appeared throughout his house, and mould formed on his ceiling and walls in several rooms.

In his own words, Mr Z stated that he “experienced crises while my house is being repaired because **the insurance company did not intend to initiate action, I had to do it for them.**” He contends that whenever he called the insurers to make complaints, the insurance representatives would threaten him with stopping all repair works. Mr Z further states that,

“without my million calls to the insurance company nothing would have been done and my house would have been [even] more in ruin[s] after I signed the scope and while I had more...rain and strong winds. More damage occurred to my house’s interior. At one stage my insurance company stated that they would only stick to the repairs listed in my scope which only referred to 20 broken tiles to be replaced.

*About a hundred times I called the insurance company from work. I was asked to wait until they do something for me while I am waiting. **Their answer was never we will call you back. Once the call is over there was no follow up action or not much work done until further calls by me. If I left a message there were no reply calls by the insurer.***

I was given the run around by the insurer staff...

All talks over the phone with my insurer followed but no written assurances given to me except for a brief scope or statement of repairs and an email which was very brief to tell me to wait for the follow up [that never came].

...the [insurer's] claim department staff answering my calls [were] irresponsible and careless and less committed to their task...

I asked the [insurer] to change the builder but I was told that the same builder has to finish his job...I was asked by [my insurer] to bring my own roofer to check my roof...

...On my calls or [my letters] in writing, the insurer seems to dislike me for referring to several issues. Maybe the [insurer] would like me if [I] only...raised one or two issues and expected me to cop the rest and pay for them myself.

The [insurer] prolonged their repairs by creating excuses and broken promises by managers over the phones...

The builder blamed [the insurer] for being slack to respon[d] and the [insurer] blamed the builder for being slack...

After Mr Z called the ILS, the ILS assisted him in his negotiations with the insurer and in drafting letters to his insurer. The insurer did not seem to treat Mr Z's various complaints as a "complaint". He was not informed about the process of complaining once his claim has already been approved. The ILS encouraged Mr Z to request assistance from the FOS. The FOS allocated a case manager for Mr Z who immediately contacted the insurer. The insurer has since promised to immediately rectify all dodgy repair works and any outstanding repairs due to the hail damage.

Mr Z also added that,

"until now, I can't believe how much time, money spent on phone bills and...the thoughts, the energy, effort besides the anxiety I put in to bring my house close to its original condition again. I could not have made real progress without help and advice I received from [the ILS]..."

At times I ask myself, would it be worth it if you buy your dream house and beautify it internally and externally and meet your insurance premiums and when you are in environmental crises and need insurance to replace your damage[d] property you get treated as a second class citizen [by your insurer].

Do we insure our properties to face the above issues and uncertainties?

What would I have done in this case if I were a pensioner, disabled or with little knowledge of English language? I surely should have been a lawyer before I insure my house to be able to stand for my rights."

(Emphasis in original)

Case Study 48

Source: Legal Aid NSW

Issues – Failure to put rejection of complaint in writing, failure to recognise repair issues as a complaint, failure to provide interpreter when requested, failure to provide access to IDR/EDR

Ms Y is an NESB client, of Greek background, who has very limited English skills. She had been with her insurer for a number of years and made a claim on her home and contents insurance in April 09 following water damage to her home due to cracks in the roof tiles. The claim was processed with a repairer from the insurer.

Following the repairs, the roof continued to leak. Ms Y attempted on various occasions to explain to the insurer that repairs were inadequate. Customer service staff refused to recognise that the quality of repairs was a complaint covered under the Code.

Despite her request, they refused to provide a Greek interpreter and it reached the point where they wouldn't take her call. Ms Y has even gone so far as attending the insurer's customer service centre on more than one occasion to have them consider her position. Meanwhile, she had to endure several months of faulty repairs.

Despite the provisions in the Code (3.13(b)) providing a clear right to have the quality and workmanship of the repairs considered, the client has received nothing in writing confirming the insurer's rejection of her concerns, in fact her concerns were never considered a complaint to begin with.

Case Study 49

Source: Legal Aid NSW

Issues – Builder running away with repair money, Non English speaking customer

Mr E was of Maltese origin. He was on a Disability Support Pension and had difficulties in reading and understanding English.

He had a Home and Contents Insurance Policy. In September 2006, his property was damaged by a fallen tree from his neighbour's property. He lodged his claim and the Insurer agreed to pay for repairs. However, instead of paying the funds to our client's account (as requested by our client, so that he could pay the builder proportionately according to the progress of repair), the Insurer (without checking beforehand) paid the funds directly to the builder who had went into liquidation in November 2006 and was no longer a licensed builder.

The unlicensed builder did not repair the damaged property and also refused to return the funds. The Insurer refused to provide any further funds. After Legal Aid filed an application to the IOS, the insurer agreed to pay the same amount of funds as was originally given to the dodgy builder, to Mr E.

Recommendations for improvement of the Code

In the “Definitions” section of the Code, the following should be included:

- Adoption of the ASIC approved definition of complaint in AS ISO 10002-2006 – “An expression of dissatisfaction made to an organisation, related to its products or services, or the complaints handling process itself, where a response or resolution is explicitly or implicitly expected.” More specifically, as it relates to general insurance,
 - A complaint includes an expression of concern or dissatisfaction that a decision has not been made
 - A complaint includes a disagreement or expression of dissatisfaction about the amount of a claim, or the nature and scope of repairs to be done pursuant to a claim
 - A complaint also includes an expression of dissatisfaction about an aspect of the claims assessment/investigation process/post claims approval disputes
- In relation to dodgy repair work insurers should have procedures in place where complaints require the repairer’s work to be reviewed and if necessary replace the builder/repairer.
- Within 14 days insurers must provide progress reports in relation to post claims approval issues such as repair work, selection builders/repairers etc.... This can be done through the inclusion of such issues as complaints (as stated above) and by requiring insurers to provide progress reports on “complaints.”
- Insurers undertake to ensure that they only pay out to repairers (including builders) who are licenced and solvent.

Post claim approval issues for non customers

This situation arises where an insured party damages the property of third party and the insured party claims on their insurance. The insurer of the insured party approves the claim and authorises a repairer to repair damage to the third party’s property. This example frequently occurs in Car insurance.

In such cases, we note that the code does not currently address the issue of a non customer’s right to complain or request review of the quality and timeliness of the work of the insurer’s authorised repairer.

Recommendations for improvements in the Code

To address this inadequacy, we suggest that in addition to clause 3.13, further clauses in the section entitled “Repair workmanship and materials” is required. We suggest the following additional clauses:

3.14 We will accept a complaint in relation to clause 3.13 from a person other than the insured where we have directly authorised a repairer to repair their property arising from a claim by our insured.

3.15 Where a complaint in relation to repair workmanship and materials remains unresolved and is made by a person other than the insured, we will agree to submit to the jurisdiction of the FOS.

iv. Unsolicited/unexplained cheques, deeds of releases and direct bank deposits by insurers

The ILS continues to also remain deeply concerned that some insurers send cheques and deeds of releases to insureds, and deposit money directly into insureds' accounts without first coming to an agreement with the insureds about the settlement of the claim, without first informing the insureds that the insurer intends to do this, and without explaining what that money is in relation to.

The ILS submits that such practices unfairly tempts the insureds into accepting the offer or face the dilemma of a possible lengthy/troublesome process of disputing the insurer's unsolicited offer. Acceptance of the offer is simple; the insureds can simply cash in the cheque, sign the deed of release or to remain silent and not dispute the money deposited into their accounts.

These actions are also not usually accompanied by any form of explanation leaving recipients confused about what has happened, questioning whether this is normal insurance practice and of most concern, it leaves insureds at a loss as to how to proceed to dispute the amount of the payout.

Often general insurance policies include additional benefits (temporary accommodation, debris removal and demolition, rebuilding fees etc) that are in addition to the sum insured. Directly depositing just the sum insured, sending a deed of release and cheques in such circumstances deprives the insureds of the opportunity to claim for additional benefits. In fact, it discourages them from looking into whether they should be entitled to more than what was deposited into their accounts or what was written in the cheques or deed of releases.

Further, if insureds have replacement policies, it's clearly deceptive to simply deposit a certain amount of money into their bank accounts or just send them a cheque for a certain sum as it may not represent their full replacement entitlement.

The above practices are not exclusive to insurers' conduct in relation to "customers" but also apply equally to "non-customers." See the final two case studies below.

Case Studies

Case Study 50

Source: Insurance Law Service, casework

Issue: unsolicited and unexplained cheques

Ms E had home building insurance. Her brick walls had started to crack due to some leaking pipes. She made a claim with her general insurer. Soon after the claim, she received a cheque in the mail. In her own words, one of the concerns Ms E had was the fact that

“there [were] no details on the cheque, other than, partial payment, to let us know what this cheque relates to.”

Further enquiries to the assessor revealed that the cheque would only cover internal repair works. Ms S decided to return the cheque but the insurer soon came back with a complete rejection of her claim.

Case Study 51

Source: Insurance Law Service and Victoria Legal Aid, telephone advice

Issue: unexplained direct bank deposit and deeds of releases

Mr and Mrs U had home and contents insurance. Their house was damaged by the recent Victorian Black Saturday bushfires. They made a claim on their insurance.

After the claim was made, Mr and Mrs U found a deed of release with a scope of works in the mail. Also, after a chance check of their bank account statement, they found a direct deposit from their insurer for the amount of \$10,000.

They had not previously been contacted by the insurer about any agreements as to what works were required and certainly had never come to any agreements with the insurer about the settlement amount for their claim.

The scope of works itself didn't actually bring their property to the condition it was in prior to the bushfires. Further, had they not haphazardly come across that bank account entry, they would have been none the wiser that any payments were made as the insurer did not inform them that this direct transfer had been made or of their intentions to do so.

Mr and Mrs U suspect that the \$10,000 might have been in relation to temporary accommodation but they have never received any communications from the insurer about this. If the amount was in relation to temporary accommodation, the lack of communication crucially didn't confirm whether this amount would be deducted from their final payout or whether it was in addition to the payout which they have yet to receive.

Case Study 52

Source: Insurance Law Service and Victoria Legal Aid, telephone advice

Issue: unexplained direct bank deposit

Mr K 's house was completely destroyed by the recent Black Saturday Bushfires. He made a claim on his home building and home contents policy. He had a replacement policy on his buildings cover.

A while after the claim was made, his insurer deposited \$205,000 into his bank account without any explanation of what that money was for. One of his main concerns was

whether that amount would cover actual rebuilding costs as his policy was a replacement policy. He had also never agreed to any payout amount or settlement offer.

Another of Mr K's concerns related to temporary accommodation. He suspects that \$5,000 of the \$205,000 deposited into his account may have been in relation to temporary accommodation but without any correspondence from the insurer, he had no way of confirming his suspicions. If the \$5,000 had been for temporary accommodation, Mr K indicated that he would have disputed the direct deposit payout as he believes he was entitled to much more under his policy.

Having stated the above, Mr K was actually quite reluctant to dispute the direct deposit payout as he felt that doing so would mean his insurer would take back the money already in his bank account.

Case Study 53

Source: Insurance Law Service, telephone advice

Issue: unsolicited/unexplained cheque and deed of release

Mr Y was an uninsured driver claiming \$6,000 from the insurance company of a driver who had hit his vehicle.

Some time after requesting payment for damage to his car, and whilst negotiations were still continuing, the insurer for the other party sent him a deed of release and a cheque for \$4,000. He contends that he had never agreed to any settlement below what he had claimed for. He felt pressured into signing the deed of release and cashing in the cheque.

As a non customer, he is not protected under the Code against such conduct by the insurer. There was also the dilemma of a counteroffer potentially rendering the previous offer void.

An almost identical scenario can be seen in the following case study, but as the ILS can confirm, with an entirely different general insurance company.

Case Study 54

Source: Insurance Law Service, telephone advice

Issue: unsolicited/unexplained cheque and deed of release

Ms M was an uninsured driver claiming \$6,500 from the insurance company of a driver who had hit her car.

Like Mr Y above, Ms M had also been given an unsolicited and unexplained cheque for \$4,650. This caller however, did not receive any deed of releases.

Her concern was that she had not agreed to anything and didn't expect a cheque to arrive in her mail whilst she was still in the process of negotiating.

Recommendations for improvement in the Code

Insurers must not send cheques, deeds of releases and must not deposit money into insureds' accounts without first reaching an agreement with the insureds about settlement amounts, without first notifying the insureds that they intend to do so and without providing written explanation/itemised list of what exactly the amount relates to.

v. Unusual/Unique Covers such as Uninsured Motorist Extensions in third party property insurances

Third party property insurance, for example in motor vehicle cases, covers the insured for damage that they cause to another person's vehicle or property. It usually does not cover them for damage done to their vehicle.

However, among those who have third party property insurance, some may have what's known as an Uninsured Motorist Extension (UME) clause that will enable them to make a claim for the damage that an uninsured driver does to the insured person's car even although their cover is only otherwise worded to cover damage that the insured does to the property of a third party. This will also usually have other conditions attached, such as the uninsured driver may need to be a certain percentage at fault.

That is, this UME is an additional part of their third party property insurance.

Although it is expected that most insureds are able to read and understand the extent of the cover their policy provides, if an insured has unusual/unique cover such as UME clauses embedded in their contract of insurance, it is submitted that general insurers have a responsibility to alert insureds to that additional cover and the possibility of claiming under that additional cover.

For example, where an insured calls to discuss the circumstances of their motor vehicle accident, insurers and their claims/customer service representatives should advise third party property insurance holders of their right to make a claim under the UME section of their policy.

Due to the ever changing landscape of the general insurance industry, there may be a limitless number of different and unusual/unique covers that one may not expect from certain policies, for this reason our submission refers to all "unusual/unique covers" not just the UME clauses in third party property insurances.

Case Studies

This case study was also included above in the failure to provide written claims refusal section.

Case Study 55

Source: Legal Aid NSW

Issue: failure to provide written claims refusal (rejecting only through the telephone), Failure to advise about Uninsured Motorist Extension cover

Ms V was involved in a motor vehicle accident in which the other driver was uninsured. The other driver admitted liability and was charged with negligent driving by the NSW Police.

Ms V had third party property insurance on her motor vehicle. She was not aware that her policy had cover for UME. Despite this, she did still contact her insurer in respect of the accident but was told by the customer service/claims representative that as she only had third party property insurance, there was nothing the insurance company could do to help her.

Ms V was provided with nothing in writing in respect of her claim. Crucially, she was not advised of the UME clause in her policy.

Like almost every client Legal Aid has ever advised in relation to this issue, she was not aware that she could claim under her own policy for damage to her vehicle, which was approximately \$2,500. Ms V came to Legal Aid after commencing a claim in the Local Court which had been of considerable expense and inconvenience to her.

The uninsured driver had gone out of his way to avoid service, had threatened her in respect of commencing a claim (he lived around the corner from her) and had advised that even if she was successful, she would get nothing out of him as he had no assets.

Legal Aid advised her to make a claim under the UME clause in her contract. Ms V followed this advice and we were recently advised that the insurer paid out on the damage to her vehicle under the UME clause.

Recommendations for improvements in the Code

The Code should make provision for General insurers to undertake to advise insureds of unusual/unique covers and their right to claim under those unusual/unique covers during all relevant stages of the insurance process and not simply through the one off provision of product disclosure statements or other policy documents when insurance is initially purchased.

vi. Liability of insurer to mitigate legal costs where the insurer's actions in delaying the claim resulted in legal action against the insured

Also of concern to the ILS is the issue of the liability of an insured A's insurer to mitigate legal costs when the other party's (B's) insurer incurs legal or other enforcement costs from having to seek the assistance of solicitors to commence court action against the insured A.

Often these situations occur because the insured A's own insurer delayed in settling the insurance claim that A made.

Case Studies

Case Study 56

Source: Insurance Law Service, experience of staff member

Issues – insurer should be liable to mitigate legal costs

Ms D had a car accident where she was clearly at fault. She made a claim on her comprehensive insurance policy and asked the insurer about how to pay the excess. She was informed that she could either pay the insurer directly or pay the repairer.

Ms D had not paid for replacement vehicle cover and it was some weeks before she could make alternative transport arrangements to allow her to submit her vehicle for repair. In the meantime she received a demand from the other driver's insurer for several thousand dollars and a nastily worded letter from her insurer saying that despite "numerous demands" for payment of the excess [completely untrue] payment had not been made and the insurer therefore assumed that she would be settling the matter directly with the other driver.

Ms D immediately contacted the insurer and paid the excess over the phone with her credit card. Her vehicle was subsequently repaired. However, after another month or more passed and Ms D was served with a statement of claim for thousands of dollars from the other driver's insurer!

Case Study 57

Source: Insurance Law Service, casework

Issues - Failure to act on legal proceedings issued by another party

N was in a motor vehicle accident involving 3 cars while driving Car N. It was not ascertained whether Car B hit Car A first then Car N hit Car B, or Car N hit Car B which then hit Car A. Damage to Car A was \$5,000. Damage to Car B was \$15,000. There was little damage to Car N.

Insurer A on behalf of Car A served a Statement of Claim on N, which he passed on to his Insurer N. Insurer N did not appear in court and a default judgment was obtained against N with a costs order of \$2,100. Insurer N paid out the \$5,000 and the \$15,000 but refused to pay the legal costs of \$2,100. This is despite the fact that the claim was being paid and the insurer was aware of the proceedings. Unfortunately the ILS lost contact with the client before this matter could be resolved.

Case Study 58

Source: Insurance Law Service, advice

Issues – insurer should be liable to mitigate legal costs

Mr F was involved in a motor vehicle collision in which he was at fault. Mr F made a claim with his insurer on 3 September 2008.

On 5 December 2008, Mr F was served with a statement of claim from the other party's insurer's solicitors.

Mr F contacted those solicitors to advise them to contact his own insurer as he had already made an insurance claim with his insurer. He thought that his insurer should have already resolved the issue.

Mr F's insurer agreed to accept liability for the amount of the damage being \$1,633 but refused to pay for the legal fees and interests amounting to \$549.34.

Mr F was told that his insurer will not pay for the legal fees and interest because they argue that he was the one that took too long with the claim by not paying his excess until 1 December 2008.

Mr F argues that he was never contacted by his insurer to request payment of excess and he was not told that he would have to send in a cheque for excess at the same time as making his claim. He argues that he was never billed for the excess until the time he called his insurer to find out the status of his claim. Soon after this conversation, Mr F immediately paid his excess.

These legal fees and interests were incurred because of the delay in the insurer processing the claim and failure to advise the insured to pay his excess or otherwise risk the prospect of legal action against him from the other party.

See also case study 29 above

In the IOS determination no. 401 11 14263, an issue arose involving the incurring of legal costs due to delays in payment of the claim from the insured's alleged non payment of excess on time. The IOS found that the relevant issue was whether the claimant paid her excess at the earliest opportunity.

The IOS also relevantly stated that:

"It is the insurer's responsibility to explain the provision of the policy requiring the payment of excess and the consequences flowing from non-payment or delay in payment of excess."

In this particular case, the IOS determined that,

"...the insurer, as a matter of good insurance practice and utmost good faith, is required to reimburse the legal costs incurred by the claimant..."

Although each case will depend on their factual circumstances, it does seem that it is within the scope of the duty of utmost good faith and good insurance practice to require insurers to mitigate legal costs in circumstances where the insurer was responsible for the delay by either delaying in processing the claim or delaying in advising that the insured will need to pay their excess and the consequences of non payment of excess.

Recommendations for improvements in the Code

The Code should contain the following provision:

Where we have delayed in processing your claim and this has resulted in legal or other enforcements costs against you, in addition to the damages amount we will also agree to pay the legal and enforcements costs incurred.

vii. Requests for documents

Under clause 3.4(3) of the Code, insurers promise that insureds “will have access to information about [them]...which [they]...have relied on in assessing [the]...claim...”

We submit that in practice, this clause has not always led to an unproblematic means of access to information possessed by general insurers.

In many instances we have had to refer callers to the Insurance Council of Australia’s dispute resolution managers to assist them in requesting documents from their general insurers.

Case Study 59

Source: Legal Aid NSW

Issue – failure to provide documents

Ms C had made a claim on her car insurance policy. Ms C approached Legal Aid NSW for assistance who told her to request a copy of the policy. Ms C received no response from the large insurance company. Legal Aid NSW became involved partly because of the difficulty Ms C was experiencing in getting copies of relevant documents from the insurance company. Legal Aid NSW then made a series of requests for documents which were unsuccessful. Eventually after several months of negotiation Ms. C’s documents were finally provided.

Recommendations for improvements in the Code

Amend clause 3.4.3 should be amended to include the following:

- The insurance company will provide copies of all requested documents within 30 days of the request
- If access is being refused reasons will be provided in writing within 30 days of the request
- Copies of insurance policies will be provided free of charge to consumers
- Copies of all current insurance policies will be available on the website of the insurance company
- Copies of statements made by the consumer or transcripts of interviews with the consumer will be provided on request at no cost.

Part 3 Problems experienced by Non-English speaking consumers

The ILS submits that the current Code is severely lacking in treatment for non English speaking consumers. With an objective of trying to promote better, more informed relations between insurers and their customers, improving consumer confidence in the general insurance industry, providing better mechanisms for the resolution of complaints and disputes between insurers and their customers, and to commit insurers and professionals they rely upon to higher standards of customer service, a future version of the Code would be remiss if non English speaking consumers do not experience the benefit of these objectives.

Being a Non English speaking consumer should not be a bar to being the recipient of high standards of customer service nor should it prevent them from adequately accessing the full mechanisms available to other consumers in the insurance claims and complaints handling process. Non English speaking consumers, despite their particular needs, are consumers of insurance as well. The Code should therefore reflect an understanding of their existence as consumers of insurance and provide adequate measures to enable them to participate as much as English speaking consumers in the insurance arena.

However, due to an almost complete lack of focus on insurance consumers of Non English speaking background (NESB), many are disadvantaged by their inability to effectively participate in all stages of the insurance process; from obtaining, claiming to disputing insurance.

Although we acknowledge that a review of the Code involves reviewing the effectiveness of provisions already in the current Code, the ILS submits that many more concerns have been raised since the formation of the Code which has highlighted the significant inadequacies in the current Code. The Code's objectives of improving consumer confidence in the general insurance industry should be interpreted broadly to encompass the necessary expansions and additions to the Code; reflecting the dynamic nature of the general insurance industry.

The following comments have been extracted from the relevant section of our joint submission (with West Heidelberg Community Legal Service) to the Financial Ombudsman Service relating to consumer experience with the General Insurance internal and external dispute resolution processes.

Most insurance transactions, both underwriting and claims are now conducted over the telephone. This process is disadvantageous to non-English speaking customers. It is difficult to ask for an interpreter and difficult for such customers to know when to ask for an interpreter.

Our services have seen recent cases where NESB consumers have purchased insurance over the telephone, without the involvement of an interpreter, even when it was clear that a third party has conducted the transaction for the consumer due to the potential insured's lack of English language skills. These consumers have later been accused of fraud, non disclosure and a lack of utmost good faith.

Our services have also seen NESB customers that have conducted claims negotiations over the telephone without access to interpreters and have suffered similar types of allegations. Even worse, low income disadvantaged consumers have been interviewed by investigators without the assistance of interpreters or by investigators that lack the capacity and training to fairly interview an NESB consumer with an interpreter.

Some examples of this behaviour include:

Case study 2 (Cited earlier)

Source: Victoria Legal Aid, casework
IOS No 34166

Mr A lodged a complaint about a Code breach as a result of the failure by the insurer to settle the claim. The insurer acknowledged the breach and commented “This occurred inadvertently, due to the language barriers that existed, and discussions between the parties that were at cross purposes.” The Code compliance manager noted the breach and the corrective action by the insurer stating the “the Insurer has altered its claims handling practices to provide for written correspondence to claimants, to ensure that the claims settlement and repair processes are properly understood, where language barriers exist.”

This consumer ultimately lost faith in the Code/IOS processes due to the delays and took his case to a private lawyer.

...

Case study 3 (Cited earlier)

West Heidelberg Community Legal Centre IOS Decision No 32938

Mrs F won her case despite the allegations of fraud raised by her insurer. In the decision the fraud referee made significant comments about the need for appropriate use of interpreters. He said

“The member has commented that, in its view, ‘the English language is merely a medium for the exchange of ideas.’ According to the member, the applicant’s written statement, that is her statement taken without the assistance of an interpreter, contained details of, among other information, her personal state of affairs, and her version of the event. This information, some of which was very ‘complicated and abstract’ was successfully communicated to the investigator, who faithfully put them in writing. How the member can make such an allegation, given that no interpreter was used and that it does not have a recording of the interview, nor given its concession at the oral examination, has it spoken to the investigator about the circumstances of the interview, is unclear.”

The Referee went on to comment

“It is part of procedural fairness to ensure that a person is not disadvantaged when providing information in response to what can be complicated questions.”

We agree with this assessment but wonder how many NESB consumers are forced to participate in interviews with investigators without the assistance of an interpreter.

Case study 20

Source: West Heidelberg Community Legal Centre IOS reference 33940

Mrs B purchased a comprehensive car policy with the assistance of a friend. She spoke little English. She asked her friend to purchase the policy by telephone. The insurer asked her to confirm her name and date of birth and obtained all other details from her friend. A Section 22 notice on non-disclosure printed in English was sent to her.

When she claimed for theft of her car the insurer alleged serious non disclosure. An investigator interviewed her with the assistance of an interpreter. The investigator asked a series of questions that were inappropriate in terms of her understanding including the following:

“In your own words, can you tell me what “utmost good faith” means to you ?

(INTERPRETER) What does mean? You asking what good faith mean?
Does she know ?

You want to tell me what good faith – I want to tell you what good faith is.

You need the insured to tell us in her terms, what “utmost good faith” means to her.

(INTERPRETER) I have to tell you straight – not right, not left. I don’t have to lie – no lies.

So she understands “utmost good faith”?

(INTERPRETER) Yes, of course.

Not surprisingly the claim was refused. Mrs B managed to have her case reviewed by IDR and EDR without ever speaking to a lawyer or anyone at the insurer or the Ombudsman. No- one has heard her story. She says that IOS sent a Notice of Referral in the mail which was completed by her friend who helped buy the policy. Importantly, no argument was put on her behalf that the Insurer had not discharged its obligation to warn her of her duty of disclosure. It could have been argued that the insurer was on notice that she could not speak English at the time of purchasing the policy and that sending a Section 22 notice printed in English was not sufficient to discharge its statutory obligation to the insured. (See *Suncorp v Cheik* (1990) 10 ANZ Ins Cases 61-442) It is enough that this argument should have been raised for consideration regardless of whether it would have been successful.

...

Other cases where NESB consumers have complained include:

Case study 21

Source: Insurance Law Service, advice only

No written refusal of claim; no access to IDR/EDR

Mr M’s house was affected by floods. Mr M was storing shirts for a new business in his garage. The garage was flooded and the shirts were damaged. Mr M took photographs of the shirts before throwing them out. After two and half months of argument, the insurer

conceded the storm, but said that the shirts had not existed. Mr M provided the insurer with photographs of the damaged boxes and shirts, invoices for the goods and witness statements from neighbours who had helped clean up. Mr M told the insurer that he wanted to launch his business and needed to settle quickly. The insurer offered \$2000 which was refused by Mr M. The insurer then rejected the claim on the grounds that the shirts did not exist. Mr M asked for the rejection in writing, but the insurer refused. Mr M also has difficulty with English and believes he is being taken advantage of.

Case study 22

Source: Insurance Law Service, casework

No interpreter offered; non-English speaking client “admits” liability

Mr C is African refugee from Burundi. He was involved in a motor vehicle accident. He speaks almost no English at all. He called the police to the scene of the accident but they could not understand him and went to his house instead. He then called a friend to interpret but the other driver left before the friend arrived. His friend assisted him to move his car off the road and called NRMA road assistance who assisted him to unbuckle the bonnet sufficiently to close it and leave the scene. The damage to his own car was minor and he took no further action.

He later received a letter from the other driver’s insurer demanding several thousand dollars for damage to the other vehicle. Mr C took the letter to a migrant community agency and a worker contacted the insurer. The worker explained that Mr C was disputing liability for the accident. The insurer said not to worry, a subsequent letter would be sent which attached quotes and asked for Mr C’s version of events. A few weeks later a further demand arrived with quotes attached.

The community agency then contacted the ILS. The ILS solicitor contacted the insurer, only to be informed that Mr A had apparently admitted liability. The ILS solicitor pointed out that Mr C could barely speak a word of English and asked how he could admit anything in any meaningful way without an interpreter. The insurer then agreed to accept an affidavit from Mr C setting out his version of events. The insurer then conceded that there were two equally credible versions of the event and no other evidence or witnesses and that each party should pay their own costs. It is highly unlikely Mr C could have achieved this result without the intervention of the community centre and the ILS.

Additional Case Studies concerning NESB customers

Case Study 60

Source: Legal Aid NSW

Issues – Failure to provide an interpreter when requested, Failure to record the investigator’s interview

Mr C is Australian but originally came from Cameroon. He can speak English but has gaps in his understanding.

He made a claim on his return to Australia. He was interviewed by an investigator from the insurer. He asked for the interview to be delayed so he could have his friend there as an interpreter. The investigator refused. The interview was not recorded.

The interviewer questioned Mr C then typed a statement out on his word processor, printed it and asked our client to sign. Mr C's English literacy is limited and as he knew he had told the investigator the truth he signed. The statement contained a number of inaccuracies and misunderstandings that likely arose due to Mr C's lack of complete English comprehension and the failure to provide him an interpreter.

The claim was later refused because the insurer said that Mr C had left his bag and that is when it was stolen. Mr C denied that he had left his bag and said the investigator had misunderstood.

The claim was also refused because the insurer argued that there was a factual dispute that they could not resolve. Legal Aid submitted that the only reason there was a factual dispute in issue was because the insurer had failed to follow proper procedures in the investigations phase which ultimately led to a misunderstanding about the circumstances in which the goods were stolen.

Case Study 61

Source: Legal Aid NSW

Issues – Unacceptable conduct towards NESB clients

Mr D, originally from Iraq, had a comprehensive car insurance policy with a general insurer. He had an accident in which he was at fault involving a lady with Middle Eastern background.

One of the "reasons" why the insurer refused the claim was because these two drivers both spoke the same language Fardi, or so it was assumed.

In actual fact, Mr D does not speak Fardi, but speaks Arabic and English only. The insurer's refusal was therefore based on incorrect facts/assumptions.

The insurer's investigator asked many irrelevant questions during the interview of Mr D including his racial/ethnic background, immigration status and personal relationships. Some of the irrelevant questions were also quite offensive. For example:

How long Mr D had been in Australia

Details of how he arrived in Australia - "So, how did you get here, by boat?"

Details of his immigration status –

“Are you still illegal today?” and

“And so what grounds did you seek asylum?”

Details of his passport - “So, have you – what passport have you got today?”

Information about his family and their whereabouts -

“What about your family?”

“What type of work does your Dad do?”

“Nothing to do with the army or anything like that?”;

Information about Mr D’s girlfriend - “And how long you know her for?”

Repeated questions regarding Mr D’s criminal record

After Legal Aid lodged this matter in the IOS (now FOS), Legal Aid requested the interview documents from the insurer. However, the insurer refused to provide these documents and only offered them after Legal Aid had raised this issue with the IOS.

This matter was eventually settled after Legal Aid’s submission to the IOS.

A complaint was also lodged in the FOS Code Compliance Committee for breaches of the Code. As yet, Legal Aid are still awaiting a response from the FOS Code Compliance Committee.

Case Study 62

Source: Legal Aid NSW

Issues – NESB Customer’s experience

Mr E was of Maltese origin. He was on a Disability Support Pension and had difficulties in reading and understanding English.

He had a Home and Contents Insurance Policy. In September 2006, his property was damaged by a fallen tree from his neighbour’s property. He lodged his claim and the Insurer agreed to pay for repairs. However, instead of paying the funds to our client’s account (as requested by our client, so that he could pay the builder proportionately according to the progress of repair), the Insurer (without checking beforehand) paid the funds directly to the builder who had went into liquidation in November 2006 and was no longer a licensed builder.

The unlicensed builder did not repair the damaged property and also refused to return the funds. The Insurer refused to provide any further funds. After Legal Aid filed an application to the IOS, the insurer agreed to pay the same amount of funds as was originally given to the dodgy builder, to Mr E.

For additional case studies on the need for interpreters, please refer to Case Studies 48 and 49 above.

Case Studies concerning the need for verbal recordings

Case study 63

Source: Insurance Law Service, advice

Issues - Dispute concerning disclosure which could easily be resolved if insurers kept and provided access to phone recordings

Mr M was involved in a single motor vehicle accident. He had comprehensive car insurance. A claim on this insurance was subsequently rejected by Mr M's insurer on the basis that Mr M had failed to disclose his traffic history for the past 5 years. The insurer alleged that Mr M had only disclosed his traffic history for the past 2 years. Mr M clearly recalls that he had telephoned the insurer to inform them of his traffic history for the past 5 years and not just for the past 2 years.

In order to resolve the dispute, Mr M requested telephone recordings of his conversation on that particular day. The insurers only provided him with a transcript of the telephone conversation. Mr M is adamant that a telephone recording would prove that he did disclose. He also contends that the transcript provided was only based on what the insurer's telephone operator recorded and was not an accurate reflection of what he disclosed.

Mr M has since received an internal dispute resolution rejection of his claim. He is in the process of lodging his dispute with the FOS in the hopes that the FOS would be able to compel the insurer to provide the telephone recording. Mr M feels frustrated because without the telephone recording to back him up, it is only his word against the insurer's.

Case study 64

Source: Insurance Law Service and Victoria Legal Aid, advice

Issues - Dispute concerning disclosure which could easily be resolved if insurers kept and provided access to phone recordings

Mr K's house was destroyed by the recent Victorian Black Saturday bushfires. After making enquiries to his insurance company, he discovered that he was not insured. The insurer explained that his insurance was cancelled due to him not paying his renewal premiums. Mr K contends that he never received the renewal notice. He argues that he had called the insurer to inform them of his change of address. He believes that the renewal notice may have been sent to his old address and hence the reason why he never responded to the renewal notice.

In the above case studies, it must be noted that the ILS does not seek to imply the accuracy of Mr M or Mr K's version of events. We only submit that had the insurers in both cases practised sound recording telephone disclosures, the provision of such recordings would definitively resolve the issues in dispute.

Recommendations for the Code Review

- Recordings

statements are subsequently relied upon and the inconsistencies highlighted as part of an allegation of fraudulent conduct.”

Part 4 Application of Unfair Terms Contracts to General Insurance Contracts Act

The Commonwealth Parliament recently released the exposure draft for a bill, the *Trade Practices Amendments (Australian Consumer Law) Bill 2009* (ACL) which will amend both the *Trade Practices Act 1974* (Cth) and *Australian Securities Investment Commission Act 2001* (Cth) (ASIC). The purpose of this bill will be to introduce a regime for determining “unfair terms” in a contract. It proposes to have broad applications in rendering void all unfair terms in a standard form contract.

However, at page 31-32 of the Explanatory Memorandum it states that the unfair terms legislation will not apply to general insurance contracts. The following is an extract.

“...section 15 of the Insurance Contracts Act 1984 provides that a contract of insurance...is not capable of being made the subject of relief under any other Commonwealth Act, a State Act, or an Act or Ordinance of a Territory. In this context, “relief” means relief in the form of:

- *The judicial review of a contract on the grounds that it is harsh, oppressive, unconscionable, unjust, unfair or inequitable; or*
- *relief for insureds from the consequences in law of making a misrepresentation,*

but does not include relief in the form of compensatory damages. The effect of section 15 is to mean that the unfair contract terms provisions of either the ACL or the ASIC Act do not apply to contracts of insurance covered by the Insurance Contracts Act 1984, to the extent that that Act applies.”

The ILS contends that clearly, this is an undesirable outcome and will mean that all the amendments proposed under the bill will not benefit consumers of insurance. Further, the fact that insurers have escaped the jurisdiction of the new laws will undermine consumer confidence in insurance as a “fair deal”.

Recommendations for Improvements in the Code

In view of this outcome, the ILS proposes that the Code adopt the unfair terms legislation.

In the alternative, the ILS proposes that the Code, under three objectives as outlined in clauses 1.17(a), (b) and (d) of the Code, should adopt a provision similar to Part D, clause 4 of the Mutual Banking Code of Practice - Credit Unions and Mutual Building Societies July 2009. This clause provides for the following:

4. Fair terms and conditions

(4.1) *The standard Terms and Conditions applying to our products and facilities will be:*

- *clear, unambiguous, and not misleading*

- *distinct from our advertising and promotional material*
 - *written in a plain language style, and legibly presented.*
- (4.2)** *Our standard Terms and Conditions will be consistent with this Code and will strike a fair balance between:*
- *your legitimate needs and interests as our member or customer, and*
 - *our interests and obligations, including our prudential obligations.*
- (4.3)** *We will not adopt standard Terms and Conditions that you are unlikely to be able to comply with.*
- (4.4)** *This section:*
- *is not intended to limit our right to determine the pricing of our products and facilities on a commercial basis*
 - *only applies to standard Terms and Conditions entered into after the Commencement Date of this Code (see Part A - Introduction).*

Part 5 Our Support of Victoria Legal Aid's submissions

The ILS understands that Victoria Legal Aid will be making submissions to the General Insurance Code of Practice Review. We wish to disclose our support for their submission especially in relation to the following issues:

1. Clause 4.5 should be amended to allow for a 6 months (instead of 1 month) reopening of insurance settlements by insureds in catastrophe and disaster cases. This is a reflection of the Insurance Council of Australia and the general insurance industry's practice during the recent Victorian Black Saturday bushfires.
2. The right to reopen settlements is exclusive to insureds only. Insurers should not be able to reopen settlements once agreed to by insureds.
3. The Code should distinguish whether emergency accommodation or advance payments reduce sum insured or whether it is additional as a form of grant or emergency relief.

Part 6 Additional Submissions

The following is a list of additional recommendations for the improvements in the Code in relation to issues not already discussed in this submission:

1. Amend Clause 7.18 to include other factors for the Code compliance Committee to consider when determining sanctions to be imposed;
 - a. what is fair and reasonable in all the circumstances;
 - b. good insurance practice;
 - c. established legal principles.
2. The definition of “significant breach” to be changed to include the following considerations:
 - a. a presumption that breaches involving dishonesty or breach of duty of good faith is a “significant breach.”