Carter Newell LAWYERS

CN|FACT SHEET 1

GENERAL INSURANCE AND CODE OF PRACTICE SUMMARY AND TIME LINES

The 2020 General Insurance Code of Practice, widely referred to as GICOP (**the Code**) will be fully implemented by 1 July 2021. On 7 May 2020, the Insurance Council of Australia (**ICA**) announced that due to the impact of COVID-19 insurers will fast-track their support for customers who are experiencing vulnerability, including financial hardship to 1 July 2020 (or earlier where possible). The key consumer provisions are in parts 9 (supporting customers experiencing vulnerability) and 10 (financial hardship) of the new Code. Insurers will take extra care in dealings with vulnerable customers to arrange additional support, including flexible options for customers experiencing financial hardship. Once members subscribe to the Code they commit to uphold a set of minimum service standards. The ICA encourages all general insurers to adopt and maintain the standards set out in the Code the Code. Lloyd's Australia Ltd has adopted the Code for coverholder-issued policies. A key element of the Code is claim time management – the obligations are summarised in the following chart.

Topic / Action	Details	Timing
Commencement	Participating insurers (including ICA members, any other general insurers, and other ICA approved entities).	▪ The family violence, supporting customers experiencing vulnerability, and financial hardship provisions of the Code took effect on 1 July 2020; and ▪ The balance took effect on 1 July 2021.
Code monitoring	The Australian Financial Complaints Authority (**AFCA**) and the Code Governance Committee (**CGC**).	
Objectives of the Code	▪ High standards of service; ▪ Better, more informed communications between insurers and the insured; ▪ Maintain and promote trust and confidence in the general insurance industry; ▪ Provide fair and effective resolution of complaints; ▪ Continuous improvement of the general insurance industry.	

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Application	The Code applies to all general insurance products except those specifically excluded (below). Notably applies Retail Insurance and Wholesale Insurance. Lloyd's has exemptions for open market placements and policies applying outside of Australia but has otherwise adopted the Code for coverholder-issued policies. The Code applies differently to Retail Insurance and Wholesale Insurance. The entire Code applies to Retail Insurance. However, the following parts do not apply to Wholesale Insurance: ▪ Part 5 – standards for service suppliers; ▪ Part 6 – buying insurance; ▪ Part 7 – cancelling an insurance policy; ▪ Part 8 – making a claim; ▪ Part 9 – supporting customers experiencing vulnerability; and Part 11 – complaints (except in certain limited circumstances where it is available to an uninsured and in relation to Wholesale Insurance products).	
Excluded policies	▪ Reinsurance; ▪ Workers' compensation Insurance; ▪ Motor Vehicle Injury Insurance; ▪ Marine Insurance; ▪ Medical Indemnity; ▪ Domestic Builders Insurance or Domestic Builders Warranty/Indemnity Insurance; ▪ Life insurance products issued by a life insurer; and ▪ Health insurance products issued by a registered health insurer.	

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Topic / Action	Details	Timing
Part 8: Making a claim	▪ If a claim is made but further information or assessment is required or loss adjuster is to be appointed, the insurer will provide to the insured an estimate of the likely timeframe and an overview of the process the insurer will use to make a decision about the claim;	▪ Within 10 business days of receiving a claim (Para 68(a), (b) and (c) and 71);
	▪ Insurers will provide update as to the progress of a claim;	▪ At least every 20 business days (Para 70);
	▪ Advice of acceptance or denial of claims to an insured (Retail Insurance only): ◦ If no further information is required or once all relevant information is gathered and all enquiries have been completed; and ◦ Urgent claims e.g. claims arising out of natural disasters will in certain circumstances be fast tracked,	▪ Within 10 business days of having access to all relevant information and having completed all enquiries (Para 76);
	▪ Where no exceptional circumstances apply decision will be made;	▪ within four months of receiving the insured's claim (Para 77);
	▪ Where there are exceptional circumstances e.g. catastrophe or fraud;	▪ Within 12 months of receiving the insured's claim (Para 78);
	▪ Information to be provided in writing when a claim is denied or do not pay in full (Para 81): ◦ the aspects of the claim that the insurer does not accept; ◦ the reasons for the decision to deny the claim or not pay in full; ◦ that the insured has the right to ask for information relied upon when the insurer assessed the claim; ◦ that the insured has the right to ask for copies of any Service Suppliers' or External Experts' reports relied upon by the insurer;	▪ Information provided at the time the decision is made except where asked in relation to Service Suppliers' or External Experts' reports relied upon, within 10 business days (Para 82).

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Part 8: Making a claim […/cont]	▪ If any of the timeframes in Part 8 of the Code (which relates to the making of a claim) is are not practical e.g. due to the complex nature of a claim, the insurer will agree to a reasonable alternative timetable with the insured; ▪ If the insured and insurer cannot reach an agreement on an alternative timetable, the insurer will provide details of their Complaints process; and ▪ Catastrophes are dealt with efficiently, professionally, practically and compassionately.	▪ Alternative time frames may be mutually agreed (Para 83); ▪ The insurer will respond to Catastrophes efficiently, professionally, practically, and compassionately (Para 88); ▪ The insurer will co-operate and work with the Insurance Council of Australia under the latter's Industry Catastrophe Coordination Agreements (Para 89); ▪ For property claims resulting from a Catastrophe that are resolved within 1 month, a review can be requested if the insured believes the assessment was not complete or accurate, even if a release had already been signed. Reviews must be requested within 12 months of finalization of claim. (Para 90).
Part 9: Supporting customers experiencing vulnerability (Applicable only to Retail Insurance products**)**	▪ Vulnerability may be due to a range of factors, including age, disability, mental/physical health, family violence, language barriers, literacy barriers, cultural background, Aboriginal/Torres Strait Islander status, remote location or financial distress;	Once an insurer has been told that, due to a vulnerability, a person needs additional support/assistance, the insurer will seek to work with that person as soon as practicable and the insurer will also seek to protect that person's right to privacy.

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Topic / Action	Details	Timing
Part 9: Supporting customers experiencing vulnerability (Applicable only to Retail Insurance products**)** […/cont]	▪ An insurer will work with the vulnerable person to make accommodations – this may include allowing the involvement of a support person (e.g. lawyer, friend, consumer representative); ▪ An insurer will take reasonable measures in supporting a person meet identification requirements; ▪ Where practicable, an interpreter will be provided; ▪ Those who had/have a mental health condition will be accounted for: ◦ Products designed and sold by the insurer will be in compliance with the Disability Discrimination Act 1992 and any other relevant state/territory anti-discrimination requirements; ◦ The person will be treated fairly; ◦ Relevant questions will only be asked when deciding whether to provide cover for a pre-existing mental health condition; and ▪ If the cover for a condition cannot be provided, the insurer will tell the person about their right to ask the insurer for the information the latter relied on when assessing the application.	
Part 10: Financial hardship	▪ A person/entity suffering from financial hardship has a right to ask the insurer to fast track a claim; ▪ An insurer will put on hold recovery actions/proceedings if a person is found to be experiencing financial hardship;	▪ An insurer will let the insured know of the outcome of their financial hardship application within 21 days (unless the insurer has requested more information) (Para 121); and

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Topic / Action	Details	Timing
Part 10: Financial hardship […/cont]	▪ A person/entity suffering from financial hardship may ask the insurer to release, discharge, or waive a debt or obligation (although no automatic entitlement); ▪ Other forms of support that could be offered to persons/entities suffering from financial hardship include: ◦ Delaying the date of a payment; ◦ Paying in installments; ◦ Paying a reduced lump sum amount; ◦ Delaying one or more instalment payments for an agreed period; and ◦ Deducting the excess from the claim amount the insurer pays. ▪ Regarding money collection, the insurer will abide by the Debt collection guideline: for collectors and creditors and clearly state the reasons behind any money they wish to collect; and ▪ If a party intends to declare bankruptcy, the insurer will work with them to agree to an amount owed. If there is no agreement, the insurer will inform the person/entity as to the relevant complaints process.	▪ If, after receiving an application the insurer requires more information from the insured, the insured must supply this information within 21 Calendar Days unless agreed otherwise (Para 117). After additional information has been supplied, the insurer will make its decision within 21 calendar days (Para 122(a)). If the insured does not give any additional information, an outcome will be delivered within 7 days (Para 122(b)).
Part 11: Complaints	▪ The internal complaints process requires insured to be kept informed about progress of Complaint; ▪ Information relied upon in assessing the complaint to be provided;	▪ An update of the complaint will be given at least once every 10 business days (Para 146); ▪ Information relied upon in assessing the complaint will be given within 10 business days of the insured requesting it (Para 151);

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Part 11: Complaints […/cont]	▪ Confirmation of complaint;.	▪ Once complaint had been received (Para 142);
	▪ Contact details of person assigned to complaint;	▪ Once complaint had been received (Para 143);
	▪ Written response regarding complaint including reasons for decision and informing the insured of their right to take complaints to the Australian Financial Complaints Authority (AFCA);	▪ Within 45 Calendar Days or, if the insurer cannot make a decision within those 45 days, the insured will be informed of reasons for the delay and their right to take their complaint to the AFCA (Para 147);
	▪ Information relied on in making a decision about a complaint must be provided; and	▪ Within 10 Business Days of the request for information (Para 151); and
	▪ If complaint referred to AFCA	▪ Complaint can be referred to AFCA at any time and if the complaint is not resolved within 45 Calendar Days after it was first received by the insurer (Para 154).

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