INSURANCE IN SUPERANNUATION VOLUNTARY CODE OF PRACTICE

DISCUSSIONS ON COMPLIANCE AND INTERPRETATION

This document contains a table of the standards of the Code beginning at section 3, along with a record of any discussions that the Transition Committee has had to date on complying with the standards. This table will be developed over time as the Transition Committee meets, and the updated table will be made available to all trustees who have adopted or are intending to adopt the Code.

Trustees are encouraged to input their own questions and comments into the spreadsheet, and provide these to the Code Owners, or to Sarah Phillips at sarah@phillipsadvisory.com.au, for discussion by the Transition Committee.

CODE STANDARDS	DISCUSSIONS ON COMPLIANCE AND INTERPRETATION
3. Scope of the Code	
Who is bound by the Code?	
3.1 The parties bound by the Code are superannuation fund trustees who have adopted the Code.	
3.2 We will ensure our staff and our Service Providers comply with the Code when they are acting on our behalf.	
What products are covered by the Code?	
3.3 The Code covers insurance products held by superannuation funds. These are commonly referred to as:	The Code covers individual retail cover taken out on a voluntary basis in addition to group cover; however, the standards that relate only to Automatic Insurance Members or automatic cover do not apply to individual retail cover (for example, the standards relating to benefit design and premiums).
a) death cover, which pays on the death of an insured member, or if they are diagnosed as terminally ill with a life expectancy less than a specified period (generally 12 or 24 months)	
b) total and permanent disability (TPD) cover, which pays if an insured member becomes disabled and is unable or unlikely to ever work again, or unable or unlikely to look after themselves ever again	
c) income protection cover, which is designed to provide a replacement income of a specified amount for members who are unable to work due to illness or injury. Depending on the policy,	

	payments may continue up to a specified age if the disability is ongoing or permanent, or may be payable for a specified maximum period.	
3.4	The Code does not cover insurance products held outside superannuation funds, including health insurance products issued by health insurers.	
When does the Code apply from?		
3.5	The Code starts on 1 July 2018, and we will state on our website by 31 March 2018 our intention to adopt the Code. By 31 December 2018, we will publish on our website our transition plan for how our funds will become compliant with the standards of the Code.	The minimum approach is for a trustee to publish its intention on the trustee's website only. A trustee can also choose to publish its intention on each fund's website as well, in order to assist with member understanding, but this is not required. When the Code commences on 1 July, trustees are not required to do anything additional if they have already published an intention to adopt. Trustees may also choose to provide further information to members at this time, such as a link to the Code or FAQs.
3.6	Our transition plan will include when and how we will comply with the following sections (which can have different dates of compliance):	The minimum approach is for a trustee to publish the dates on which it will comply with the three groups of standards listed below. Any anticipated challenges with transition or compliance should be noted in the transition plan. Specifically, if a trustee is aware when publishing its transition plan that it intends to set premiums that exceed 1% of salary in accordance with section 4.9(c) of the Code, or it intends to alter any of its Code commitments in accordance with section 3.11 of the Code, it should note these in the transition plan. If a trustee's transition plans or timeframes change materially after the date of publication, trustees are expected to update the plan, to assist with transparency.
	a) benefit design and premiums (sections 4.1 to 4.17)	
	b) automatic cessation of cover and reinstatement (sections 4.25(e) and (f), 4.27, 4.28 and 4.29)	
	c) the rest of the Code.	
	We will comply with the Code as early as we can, and no later than 30 June 2021, to allow for our existing contractual arrangements to be adjusted.	

3.7	For applications for insurance, claims or complaints that already exist on the date we transition to the Code, if the Code commits us to do something within a specified timeframe, that timeframe begins on our date of transition.	
Our relationship with insurers		
3.8	We will work closely with our insurers who issue the cover that applies to you, to ensure you have a consistent end-to-end experience.	
3.9	Life insurers who are members of the Financial Services Council are bound by service standards, set out in the Financial Services Council's Life Insurance Code of Practice (Financial Services Council Insurer Code). Any contract that we enter into with an insurer will require both parties to comply with the code to which they subscribe.	
Legal status of the Code		
3.10	The Code operates alongside and is subject to existing laws and regulations. Where there is any conflict or inconsistency between the Code and any law or regulation, that law or regulation prevails.	
3.11	We have a legal requirement to perform our duties and exercise our powers in the best interests of our beneficiaries. We will comply with our commitments in the Code to the extent that they are in the best interests of beneficiaries and consistent with our other legal duties. However, we cannot comply with anything in the Code that limits our ability to comply with our statutory and general law duties, and our trust deed. This may require us to alter our Code commitments, which we will publish in our annual Code compliance report. We will use our discretion when making decisions about the insurance benefits that we provide.	
3.12	The Code does not limit your rights under any law or regulation.	
3.13	The Code does not apply if you start proceedings in any court, tribunal or external alternative dispute resolution process (with the exception of the External Dispute Resolution organisation that is relevant to your complaint).	

4.	**Appropriate and affordable cover**	
4.1	For the purposes of sections 4.2 to 4.17, "you" refers to **Automatic Insurance Members** only.	
Benefit design		
4.2	Insurance in superannuation is often provided automatically. We will design insurance benefits for our **Automatic Insurance Members** with the objectives that they are appropriate and affordable for our membership.	
4.3	We will publish our insurance strategy on our website. This will include an explanation of how we have designed our automatic insurance cover, to help **Automatic Insurance Members** decide whether the automatic insurance cover is appropriate for them.	
4.4	If a benefit design is determined by a party other than us, for example a sponsoring employer that is paying the premiums, we will review the design to ensure it is appropriate and affordable.	The trustee has an overarching obligation to review the affordability of insurance; this can be important if an employer stops paying for the cover. There is also an impact on a member's concessional contribution cap.
4.5	When we design insurance benefits for our **Automatic Insurance Members**, we will assess our members' likely insurance needs, including considering the following characteristics of our membership where we know them and believe them to be relevant:	
	a) age distribution	
	b) gender	
	c) industry and occupation	
	d) work status (for example, full-time, part-time, contract, casual)	
	e) salary	
	f) employer contribution levels	
	g) claims history	
	h) insurability outside automatic arrangements	
	i) member feedback based on member research and attitudes to insurance.	
4.6	We will assess the appropriateness of our benefit design, including types and levels of automatic insurance cover, for our membership	

	generally, and for the particular categories of members described below at 4.10 to 4.12.	
4.7	As well as determining the insurance needs of our **Automatic Insurance Members**, we will design cover that is affordable and does not **inappropriately erode** the retirement income of our **Automatic Insurance Members**. We will specifically consider the impact on the categories of members described below at 4.10 to 4.12.	
4.8	We will adjust cover levels or other factors impacting cost such as terms and conditions or definitions (subject to legislative, regulatory and Code constraints) so that we are satisfied that our automatic insurance cover is affordable.	
4.9	As part of determining affordability when we design insurance benefits for our **Automatic Insurance Members**, premiums for this benefit design will be set at a level that does not exceed 1% of an estimated level of salary for our membership generally, and/or for segments within the membership, subject to 4.9(c) below.	
We will document and publish:		
	a) our basis for determining an affordable level of cover within the 1% of salary limit(s) for our membership generally and/or for segments within the membership	
	b) the measures of salary and timeframes we have used to apply the 1% of salary limit for our membership, including the specific measures we have used for insurance provided to our **younger** members	
	c) the rationale for instances in which cover has been provided to **Automatic Insurance Members** with premiums that exceed 1% due to the identification of particular circumstances relating to the membership generally and/or segments within the membership.	
Categories of our membership		
4.10	For **younger** members, when designing benefits we will consider:	
	a) appropriate types and levels of cover, given that **younger** people are less likely to have children and other dependants or significant	

debt, and are more likely to require total and permanent disability or income protection, rather than death cover	
b) the impact of premiums on members who typically have low account balances	
c) the likelihood that **younger** members will be earning significantly lower salaries than older members	
d) working patterns, which may be casual or part-time	
e) fair treatment of **younger** members, taking into account whether there is any cross-subsidisation by premium with older members of the fund,	
and as a consequence of the above considerations, it is expected that levels of cover or premiums will be lower for **younger** members than for the membership generally.	
4.11 For members with low or infrequent contributions, when designing benefits we will consider:	
a) the characteristics of these members, which may include people who have taken leave for substantial lengths of time and members who are casual or part-time workers	
b) the impact of premiums on members who have low or infrequent contributions	
c) fair treatment, taking into account whether there is any cross-subsidisation between different groups of members, for example members at different ages.	
4.12 For members nearing retirement, when designing benefits we will consider:	
a) appropriate types of cover given they will generally have higher superannuation balances, which may reduce the amount of cover needed	
b) the impact of high premiums associated with their higher likelihood of claiming	
c) the greater emphasis members at these ages typically place on building savings for retirement as opposed to life insurance protection.	

4.13	We will not automatically include you in a division of our fund that is higher risk than the membership generally due to smoker status or occupation (where such a designation exists) without relevant evidence.	If a membership is predominantly blue collar, members can be defaulted into a blue-collar division, with lower risk workers given the ability to select white-collar status. The appropriateness of the default settings should be measured across the membership of the division generally.
Reviews and changes to benefit design		
4.14	We will review and update as necessary the benefits we offer and the policy details at each insurance contract renewal (and our review will occur no later than every 3 years), to ensure they remain appropriate and affordable for the categories of members described in sections 4.10 to 4.12 above.	
4.15	We will assess the premiums for our **Automatic Insurance Members** at each policy renewal (and no later than every 3 years) to ensure premiums remain consistent with section 4.9 above.	
4.16	If we decide to change any of the benefits offered (including the definition of the benefits) as part of your cover, we will provide you with details of the changes and any options available to you to change or cancel the new cover.	
4.17	If the impact on your cover or premiums is material,[1] we will let you know **in writing** at least 30 days before the changes take effect.	
Cancelling your insurance cover		
4.18	You can cancel or reduce the insurance cover which we arrange for you at any time, and the associated premiums will no longer be deducted from your superannuation account. You can cancel part of your cover and keep some of it, provided this is permitted under our fund rules and the insurance policy. We will make the process straight-forward. You can cancel or reduce your cover in the following ways, subject to appropriate member identification: [2]	
	a) via our website, the insurer's website or our digital application	

[1] In line with the requirements of section 1017B of the *Corporations Act 2001*.

[2] The cancellation standards in the Code do not apply to members of a defined benefit fund, in which the value of the retirement benefit is defined by the fund rules, or where the insurance arrangement with an employer does not allow for member cancellation.

	b) over the phone	
	c) **in writing** by email or post.	
4.19	We will include clear instructions on how to cancel or reduce your insurance cover in your insurance welcome pack, our disclosure information, your annual statement, and on our website. If you request a cancellation form, we will send it to you within 5 **business days**.	The objective is to make cancelling as easy as possible for a member. If a member calls to request a cancellation form, and the business does not have a standard form, the member should not be seen to be discouraged by being asked to write to the insurer/trustee; the cancellation could instead be carried out during the phone call.
4.20	As part of the cancellation process, we will tell you that:	
	a) you will not be able to make a claim for insurance benefits for events or conditions that arise after your cover has cancelled	
	b) we will no longer deduct insurance premiums from your account	
	c) your ability to restart your cover may be subject to health assessment and acceptance by the insurer, and you may not be able to get cover	
	d) if you are replacing your cover with alternative cover, you should not cancel until the replacement cover is in place	
	e) you can get independent financial advice to help you to make a decision on cancellation.	
4.21	We will confirm that you have cancelled your insurance cover and the date on which your cover will stop **in writing**.	
4.22	If you cancel within 14 calendar days of us telling you that we have provided you with automatic insurance cover or that we have increased your level of automatic insurance cover, any premium we have deducted from your account for that insurance cover will be waived or refunded back to the cover start date or the start of the increased cover (as applicable). No cover will then apply for that period.	It is intended that this applies when there is a benefit redesign applied across the fund, e.g. where the default level of cover is increased; it is not intended that this applies when the sum insured changes each year in line with a member's age. The 14 days starts when a member is notified that they have insurance; e.g. when the welcome pack is provided, even if this is some time after the cover has commenced. The premium must be refunded back to the cover commencement date, even if this is longer than 14 days.
Communicating to you about your lack of contributions		
4.23	It is important that you do not pay for insurance that you do not need, for too much insurance or insurance that you cannot claim on, as this will erode your superannuation account balance.	

4.24	If we stop receiving contributions to your account, we will contact you no later than 6 months after receipt of your last **eligible contribution**.[3]	The footnote is designed to capture contributions where contributions are paid after the event. Where a trustee is aware that contributions are paid late, it should measure the inactivity from the end of the period rather than the date of payment – the objective is to not stretch the period of inactivity out longer than 13 months where at all possible. While the terms of the Code provide that the 6 months starts on the date that a trustee transitions to this standard, some trustees may wish to go further and issue the communications on the date of transition, for all accounts who have not contributed for 6 months or more.
4.25	The communication will be **in writing** and will include:	The requirements of 4.25 apply to all members (not just AIMs), but (e) and (f) apply only to AIMs.
	a) general information about the impact of insurance premiums on retirement savings when there are no longer contributions	
	b) an explanation that if you have started contributing to another fund, you may be over-insured, and that if you hold multiple income protection covers, you may be unable to claim on more than one benefit	
	c) information about the impact of losing cover	
	d) a request for your consent to cancel your cover in order to avoid eroding your account balance	This may read as something like "if you want to cancel based on the information provided in this letter, here are your options… We won't do anything unless you tell us" Trustees may wish to send this communication on a regular basis (for example, annually), if it views that it is in the best interests of members to continue to communicate about a lack of contributions.
	e) for **Automatic Insurance Members** who hold income protection cover, our intention to automatically cease your income protection cover 13 months from the date of your last **eligible contribution**, unless you advise us you wish to keep this cover	

[3] Contribution inactivity is measured from the later of the date we transition to the relevant standards of the Code, or the date of the most recent **eligible contribution** we receive for you. Where we are aware that the contribution we receive covers an earlier period, we will measure contribution inactivity from the end of that period.

	f) for **Automatic Insurance Members**, if we determine that you are likely to have an account balance of less than $6,000 13 months from the date of your last **eligible contribution**, our intention to automatically cease your death and total and permanent disability cover at this time, unless you advise us you wish to keep this cover	
	g) your options to cancel your cover immediately, reduce your cover, or keep your cover.	
4.26	If you tell us that you want to keep your cover even though you are not making any contributions, we will record this and stop sending you communications about your lack of contributions. If you are an **Automatic Insurance Member** and you tell us you want to keep your insurance cover, we will tell you that you will no longer be an **Automatic Insurance Member**, but that you will still receive any updates we make to our automatic insurance cover.	
4.27	For **Automatic Insurance Members**, we will write to you again within nine months of your last **eligible contribution** with the information required above at 4.25. If we receive no response from you, and have not received any **eligible contributions**, we will write again after 13 months:	
	a) if you hold income protection cover, to confirm that we have automatically ceased it	
	b) if your account balance is $6,000 or under, to confirm that we have automatically ceased your death and total and permanent disability cover	
	c) if your account balance is more than $6,000, a request for your consent to cancel your death and total and permanent disability cover in order to avoid eroding your account balance.	This may read as something like “if you want to cancel based on the information provided in this letter, here are your options… We won’t do anything unless you tell us” Trustees may wish to send this communication on an annual basis, if it views that it is in the best interests of members to continue to communicate about a lack of contributions.

Reinstatement of cover	
4.28 If your cover has automatically ceased due to a lack of contributions,[4] it can be reinstated if you tell us within 60 calendar days, if both of the following apply:	
a) you meet our requirements for new **Automatic Insurance Members** choosing to join our fund	Trustees need to take a common-sense approach to applying eligibility requirements for new members to a reinstatement. If an eligibility requirement for new members is that a contribution is received from the employer within X months of the member commencing employment, this may not be relevant to a reinstatement where cover ceased due to a lack of contributions. However, an at-work test would remain relevant at the time of reinstatement.
b) your account has enough funds to pay the premium owed for the intervening period.	
4.29 If you tell us that you wish to reinstate your cover within 60 calendar days of the cessation date but your account balance cannot cover your premium, we will allow you to make contributions to your account within the 60-day period to top up the balance if you wish.	
4.30 In addition, we will explain our process and the circumstances for members to apply to restart cover after if it has automatically ceased or you have cancelled it, when we confirm that the cover has ended.[5]	
Duplicate insurance cover	
4.31 When you become a member of our fund, we will ask your permission to help you to determine whether you have any other insurance cover in a superannuation fund. The purpose of this is to ensure you do not unintentionally pay premiums for multiple insurance covers, or for any cover on which you may be unable to claim. If we identify that you have other insurance cover, we will let you know.	
5. Helping members to make informed decisions	
How we will provide you with information	

[4] For members of employer funds, **we** may offer a continuation option when employment ceases.

[5] This process may differ between trustees and may involve a health assessment.

5.1	We will help you to make better informed decisions by giving you appropriate and easy-to-understand information when we provide you with cover and on an ongoing basis.	
5.2	We will seek to understand the characteristics of our members, so that we can tailor our communications.	
5.3	We will use plain language in our insurance communications, and will limit the use of jargon and acronyms. If acronyms or jargon are used, plain language definitions will be provided. We will ensure that the wording of key insurance concepts has been consumer tested for comprehension.	Jargon refers to any industry-specific terms that someone unfamiliar with insurance would not be likely to understand without a definition. Trustees' consumer testing may reveal terms that could be categorised as jargon. The Transition Committee will collate a list of jargon terms and may consider standard definitions for these as part of strengthening the Code.
5.4	We will regularly review the insurance communications that we provide to ensure they are appropriate and consistent.	Trustees are free to determine the regularity of these reviews. It would be appropriate to review the appropriateness of comms at such times that any other updates to content are made. When the Insurance Management Framework is reviewed or the policy terms are changed, it would be appropriate to subsequently review the insurance communications.
5.5	We will publish a Key Facts Sheet for our automatic insurance cover in a standard industry format on our website.	The Code Owners will publish a standard form for the KFS, which has been legally reviewed and consumer-tested as early as possible.
5.6	The purpose of the Key Facts Sheet is to provide high-level, fund-specific insurance information in a format that is consistent across the industry, to help you to better understand your cover and to compare cover across different superannuation funds.	
5.7	We will also provide you with clearly identifiable insurance-specific information in a welcome pack when we provide you with automatic insurance cover. This may be provided as part of a broader welcome pack about our superannuation fund.	
5.8	The purpose of the insurance welcome pack is to give you greater awareness and better information about the insurance cover that you receive automatically from us.	
5.9	The insurance information in our welcome pack will contain the following:	The insurance information does not have to be sent in one hit along with the rest of the welcome pack (see 5.7 above); in fact, it may assist with consumer

		engagement to have the insurance information sent separately from the super information. Trustees should take a member-centric approach to determining whether the requirements of 5.9 have been sent in a timely and engaging fashion.
	a) a copy of the Key Facts Sheet	
	b) how much you are insured for	
	c) the premiums you will pay	
	d) any other information specific to you that is not included in the general information on the Key Facts Sheet	
	e) that you should consider whether you hold cover elsewhere, either within another fund or outside superannuation, and the impacts of holding multiple insurance covers	
	f) a link to the Code	
	g) a link to the product disclosure statement and other relevant insurance information on our website.	
5.10	We will make the following information easily accessible on our website, and provide you with hard copies upon request:	
	a) the Key Facts Sheet	
	b) the product disclosure statement for our automatic insurance cover	
	c) information about the benefits and costs of insurance in superannuation	
	d) information on how to cancel your insurance and the consequences of cancelling	
	e) how to make a claim	
	f) how to make a complaint.	
Explaining our definitions		
5.11	We will clearly explain on our website and in our product disclosure statement our intention in providing total and permanent disability and income protection cover, and how the definitions that we use will be applied in practice.	The Transition Committee will work on further guidance for plain language explanations in accordance with this section, including the possibility of industry-standard explanations as part of strengthening the Code.

5.12	We will agree on the interpretation and application of our definitions with our insurers to ensure a consistent approach.	These agreements would likely be recorded throughout the policy document, the claims philosophy, the Insurance Management Framework, the insurance guide and any Significant Event Notices.
5.13	We will undertake a regular review to ensure the interpretation and application of our definitions are consistent with any changes in our policy terms, and our insurers' approach.	These reviews would be expected to occur when any of the documents listed above are updated.
5.14	We will use the following standard headings that are relevant to our total and permanent disability cover:	These headings are intended to be plain English descriptions for member use in understanding their TPD cover. They are not intended to replace the policy document definition of TPD, nor the SIS conditions of release.
	a) Total and permanent disability – [unable/unlikely] to do a suited occupation ever again	
	b) Total and permanent disability – [unable/unlikely] to do your own occupation ever again	
	c) Total and permanent disability – [unable/unlikely] to look after yourself ever again	
	d) Total and permanent disability – [unable/unlikely] to do basic activities associated with work ever again	
	e) Total and permanent disability –permanent loss of intellectual capacity	
	f) Total and permanent disability – loss of limbs and/or sight	
	g) Total and permanent disability – suffering a specifically defined medical condition and permanently unable to work because of it	
	h) Total and permanent disability – significant impairment to your whole body.	
5.15	If the total and permanent disability definition that we use has more requirements than those listed above, we will ensure they are described in similar plain language terms to the descriptions above.	
5.16	If the total and permanent disability definition that we use is different from the standard definition which allows superannuation benefits to be released under legislation,[6] we will explain the differences in plain language.	

[6] *Superannuation Industry (Supervision) Act 1993*.

Communication during the term of your cover[7]	
5.17 We will provide you with an annual statement which includes the following information:	
a) the types of cover you hold and how much you are insured for	
b) your current premium	If covers are bundled, then these do not need to be decoupled in order to provide separate premiums for each. However, if there is an ability for a specific cover to be increased or decreased (with an associated premium adjustment), then this cover should be set out separately in the statement. In particular, IP should be separated from other covers. The premium that is provided in the statement should state that it is current as at a specific date. Members should be advised that they can find out their current premium at any time on the website (if this is offered), or by contacting the fund.
c) an explanation for any change in your premiums	If a member's premium is likely to go up in the following 12 months, for example on the occasion of the member's birthday, the statement should note this. If the cover is also due to change on the member's birthday, this should also be made clear.
d) the policy's standard exclusions and benefit limitation terms that may impact your entitlement to insurance benefits	This can mirror the "Circumstances that may impact your cover" from the KFS. The statement can also point out that the member can refer to the Insurance Guide for more information.
e) if we have not received any eligible contributions in the previous year, or if your eligible contributions are less than $1,800 for the previous year, a warning that your premiums may be inappropriately eroding your account balance	The $1,800 figure was chosen to line up with the tax-free threshold. It is not required that trustees explain to members that they come within this threshold, or why this threshold has been chosen; the Code requirement is simply that members whose contributions are less than $1,800 are provided with the warning about erosion.
f) information about how to contact us to discuss options if you want to change the terms of your cover	
g) how you can increase, decrease or cancel your cover based on your individual needs;	

[7] For defined benefits members, the requirements for communication during the term of the cover will be tailored as appropriate to the insurance arrangements in place.

	h) information about the Code	The statement should say something like “We are a signatory to the Insurance in Superannuation Voluntary Code of Practice. You can find the Code and additional information about your rights at [link].”
	i) our rules for automatic cessation of cover	
	j) what to do in the event of a claim.	This can mirror the information given about claims in the KFS, along with contact details to use, and/or a website link. It is suggested that trustees give members additional information, over and above a mere website link, in order to assist and support them to make their claim, and to acknowledge that there are many ways to connect with a trustee.
5.18	We will contact you about your insurance cover if we become aware that:	
	a) a change in your employment arrangements may impact your cover	This may apply (for example) when a member changes from casual to permanent work, fulltime to part-time, when a contract renews, when they move into a higher-risk occupation, or when their working hours change which impacts a definition in their policy.
	b) you have stopped contributing for 6 months (or a shorter period as determined by us) in line with section 4.25	This communication is covered by the requirements at 4.25.
	c) you are no longer covered due to the terms of the policy.	This may apply (for example) when a member turns 65 and their cover expires.
5.19	The purpose of the communications during the term of your cover is to prompt you to evaluate the appropriateness of your cover, and ensure that you are kept informed of your options to change, review or cancel your cover.	
5.20	We will promote any digital tools that we provide, to help you to monitor your account and your contributions, the cost of insurance and the impact on your balance.	
Lost members		
5.21	We will use our best efforts to keep our members’ contact details current, so that we can provide the communications required by the Code.	
5.22	If we cannot contact you as we do not have your current contact details, we may be required to report to the Australian Taxation Office that you are a lost member.	

5.23	We will not be in breach of the Code if we are unable to provide you with any of the communications required by the Code.	
6.	**Supporting vulnerable consumers**	
6.1	We recognise that some people may have unique needs, such as older persons, people with mental health conditions, people with a disability, people from non-English speaking backgrounds, people with low levels of literacy, people in financial distress, and Indigenous Australians, when accessing insurance, making an enquiry, claiming on their cover, making a complaint and communicating with us.	
6.2	We will have internal policies in place to help our staff to identify vulnerable consumers and to take practical steps to better assist members who may need further support. This may include referral to people or services with specialist training and experience to appropriately engage with and support them.	
6.3	Where you tell us that you require support or assistance from us, we will provide support or assistance to the best of our ability. We will ask for your permission to keep a record of the support or assistance you require.	
Providing information		
6.4	We recognise that some groups of consumers (for example, people from Indigenous communities or those from non-English speaking backgrounds) may require support in meeting identification requirements. We will take reasonable measures to assist and a flexible approach to verification and identification in line with AUSTRAC[8] guidance, while still meeting our obligations under the law.	
6.5	We recognise that people living in remote and regional communities may have trouble meeting their obligations to provide us with documents and to take part in assessments in the timeframes we set. We will take this into account when going through the underwriting and claims processes.	

[8] Australian Transaction Reports and Analysis Centre.

6.6	If you need help with the claim process, in understanding what is required of you, completing claim forms or providing requested claim information, we will work with you and the insurer to find a solution. This may include endeavours to collect the information on your behalf, with your permission.	
Interpreting services		
6.7	We will provide access to an interpreter at your request, or where we need an interpreter to communicate effectively with you. We may use an interpreter who is a member of our staff, or an external interpreter.	
6.8	We will record your interpreting needs and plan ahead to meet these needs. Where an interpreter is offered but declined, this will also be recorded.	System notes are sufficient for recording purposes, as long as they are easily retrievable and visible to front line staff when the member makes contact. The purpose of the recording is so that it is clear to all staff that the member requires an interpreter.
6.9	We will provide a direct link on our website to information on interpreting services and any other relevant information for non-English speakers, including any insurance information that we have translated into other languages.	There is no minimum requirement to translate information into other languages; however, if a trustee has done so, this information should be easily accessible to members. Some trustees are utilising the Government's translating and interpreting services, which are user pays and can be referenced as an option on a trustee's website: https://www.tisnational.gov.au/
Guardianship		
6.10	Where you are under the care of a State-appointed guardian or administrator or the holder of your enduring power of attorney, any communications we provide will be sent directly to your guardian, administrator or attorney, and we may only accept payment instructions from them.	
Release of funds		
6.11	If we allow our members to receive early release of some of the money in their account on the basis of severe financial hardship or compassionate grounds, we will clearly explain the process on our website. If we do not allow this, we will explain the reasons for this on our website.	

6.12	If we grant you release of your superannuation account balance (for example, due to a terminal illness), we will let you know the impact on any insurance cover you still have at the time and that you can choose to leave enough funds in your account to pay the premiums for your cover.	
7.	**Handling claims**	
Principles for claims handling		
7.1	We acknowledge that claim time can be difficult. We will treat you with compassion and respect. We will make the claims process as straight-forward as possible for you.	
7.2	We will help you identify any cover held within our fund under which you may be entitled to claim. We will not discourage you from making a claim.	
7.3	We will oversee the claims process, and help you to navigate the process.	
7.4	We will be responsible for overseeing the conduct of the insurer and any **Service Provider** we engage in the claims process, in line with the standards in Section 12 of the Code. We will proactively engage with other parties in the claims process, such as any representative that you engage, to minimise delays and remove unnecessary duplication from the process.	
7.5	We will put in place appropriate governance arrangements for our claims handling.	
7.6	We will publish our claims philosophy on our website, and we will assess the claims philosophies of our insurers to ensure they align with our own philosophy.	
The claims process		
7.7	The claims process incorporates a number of steps, and there are roles for us, for the insurer and for you. You may be required to provide relevant documents and attend assessments.	

7.8	The **Financial Services Council Insurer Code** places responsibilities on insurers to determine claims within specific timeframes. We will work together to ensure a consistent and efficient process for you.	
7.9	You will be given contact details for the primary contact during the claim process.	
7.10	We will have complied with the requirements to communicate with you in this section even if the communications are provided to you by the insurer or a **Service Provider**.	
7.11	We may take responsibility for a step in the claim process that is not covered below, such as arranging an independent medical examination or an interview with you. In these cases, we will comply with the relevant standards in the **Financial Services Council Insurer Code**.	
Making a claim		
7.12	If you tell us that you wish to make a claim, we will help you provide the information for your claim, or direct you to the appropriate forms or information online or email these to you by the next **business day**. If you require hard copy forms, we will send these within 5 **business days**.	At a minimum, it is intended that the trustee will give someone enquiring about a claim some generic information or forms within one business day. However, trustees may wish to ask some high-level questions relating to eligibility over the phone or in a covering letter; for example, ensuring the member has considered the prerequisite of having ceased work before applying for a TPD benefit. This reduces poor consumer outcomes by managing the member's expectations about their ability to claim before they incur costs and spend time seeking medical reports and fill out forms etc.
7.13	If we receive a completed claim from you,[9] within 5 **business days** we will:	If a claimant goes straight to the insurer rather than to the trustee, it is expected that the 5-business-day requirement to acknowledge the claim will be complied with by the insurer. The requirement for a trustee to put in place governance arrangements for claims (see 7.5 above) should include how a trustee and insurer will delegate and share code responsibilities.
	a) acknowledge receipt of the claim	
	b) assess whether you have provided all of the necessary information and documentation	

[9] A completed claim requires lodgement of claim forms with **us**, or provision of requested claim information via telephone.

	c) carry out an initial eligibility assessment to assess whether you have insurance cover based on the information available	
	d) provide you with a summary of the claim process (if this has not already been provided to you when you tell us you wish to make a claim);	
	e) either provide the claim to the insurer, or tell you that you are not eligible to make a claim based on the information available (in line with section 7.16 below).	
7.14	If a claim is made via telephone, a written record or call recording will be kept and can be sent to **you** on request.	
7.15	The summary of the claim process that we will give you will include:	
	a) an explanation of the terms of your cover, including the policy's standard exclusions and limitations	If the trustee is not aware of the date of event, it should use its best efforts to provide the relevant policy terms, and if it later transpires that due to the date of event that different terms apply, this should be transparently communicated to the member.
	b) the steps involved in the claim process and a reasonable expectation of the end-to-end timeframe for the assessment of the claim, taking into account the timeframes in the **Financial Services Council Insurer Code** and our review of the insurer's decision	
	c) our role and duties and the role and duties of the insurer	
	d) who will be your primary contact and contact details you can use to get information about your claim	
	e) whether you may be required to attend ongoing assessments	
	f) how payments will be made if the claim is accepted	
	g) that there may be financial or tax implications and you may wish to get independent advice	
	h) the impact on the amount of the claim of receiving income from other sources including Centrelink and workers' compensation if offsets are applied	
	i) how we will review the insurer's decision.	

7.16	If we assess that you are not eligible to make a claim, we will:	
	a) explain this in writing	
	b) give you the opportunity to provide more information so that we can review your eligibility	
	c) tell you that if you are not satisfied with our decision, you can make a complaint and we will explain our complaints process.	
While a claim is being assessed		
7.17	If you have a query about your claim while it is being assessed, we will respond:	
	a) with an acknowledgment by the next **business day**	
	b) with a full response within 10 **business days**.	
7.18	You will receive progress updates at least every 20 **business days** (unless a different timetable is agreed with you). If there are any issues delaying assessment of your claim, we will let you know what these are.	
7.19	We will oversee the progress of the claim to minimise delays and intervene if we become aware that the insurer is not complying with the timeframes provided in the **Financial Services Council Insurer Code**.	
7.20	If the insurer tells us that it cannot make a decision on your claim in the timeframes provided in the **Financial Services Council Insurer Code** because information which is necessary for assessment has not been provided, we will tell you the revised timeframes. If your medical condition has not yet stabilised to allow a decision to be made, we will tell you that your claim will be progressed further when more information is available.	This is not intended to mean that an insurer cannot decline a claim if a medical condition has not yet stabilised; that is a matter for the insurer's FSC Life Code. A trustee should explain to the claimant what the situation is when their medical condition has not yet stabilised.
7.21	If we become aware of any errors or mistakes in the claim or in the information requested, these will be addressed promptly. We may request more information to correct errors or mistakes.	

Review of insurer's decision		
7.22	Once the insurer has made its decision on your claim, if the insurer informs us that it intends to make a payment to us,[10] we will carry out a review within 5 **business days** to assess whether you have met the requirements for the money to be released from your superannuation account. We will also have oversight processes in place to confirm that the insurer is paying the correct amount, either to us or directly to you.	
7.23	If we identify as part of our review that there are differences between the requirements for your insurance claim to be paid and the legal requirements for the release of funds from your superannuation account, we will clearly explain the differences in plain language.	It is expected that the trustee will inform the claimant of any differences in requirements as soon as they become aware of this, in order to manage expectations.
7.24	If the insurer informs us that it has decided not to pay the claim, we will carry out a review within 15 **business days**. As part of our review, we will determine whether the insurer has provided you with the below, and we will provide you with any of the below that you have not yet received:	
	a) an explanation in plain language to enable you to understand the reasons for the insurer's view	
	b) an outline of the evidence relied upon in forming that view	
	c) a list of all documents obtained by the insurer and us during the assessment, and an opportunity to receive any documents on request	
	d) an opportunity to make further representations and submissions or provide further information about your claim.	
7.25	Wherever possible, when we review the insurer's decision we will use information already collected during the claim assessment process, rather than asking you to provide information again, or to attend any further assessments. If we believe there is not enough information to make a properly informed decision, we will let you know. We will	

[10] This does not refer to payments that the insurer makes to you directly (such as with some income protection payments).

	request any further information or assessments we need as early as possible and will avoid multiple information requests where possible.	
7.26	We will only ask for and rely on information and assessments that are relevant to the claim and policy, and you can ask us to give you an explanation of the relevance of the information requested. If you disagree with the relevance of any requested information, the request will be reviewed. If you are not satisfied with the outcome of the review, we will tell you how to make a complaint.	
7.27	If we obtain new information or assessments, or you make further representations and submissions or provide further information, we will have another 15 **business days** to review the new information.	The 15-business-day timeframe is intended to cover only the trustee's review of new information, not the insurer's next steps. If as a result of this review, the trustee decides to send the claim back to the insurer, that is dealt with in 7.28.
7.28	If our review results in us querying the insurer's decision, we will tell the insurer within 5 **business days** of completing our review. If we believe the claim has a reasonable prospect of success, we will advocate on your behalf. We will keep you informed as the claim proceeds.	
7.29	In **exceptional cases**, the timeframes for our review in this section may not be appropriate. In these cases, we will tell you that we need more time, and will clearly communicate our revised expected timeframes until our review is complete. We will tell you how to make a complaint if you are not satisfied.	
Claim decision		
7.30	If the claim is approved and paid to us by the insurer, we will confirm this with you as soon as we have carried out our assessment of whether you have met the requirements for the money to be released from your superannuation account. Within 5 **business days** of confirmation being given, we will release the claim money to you,[11] provided that:	
	a) valid identification, and payment instructions and other necessary documents have been received from you	

[11] For income protection claims, the insurer may make the payments to you directly.

	b) we have confirmed that the legal requirements for release of funds from your superannuation account have been satisfied	
	c) for death benefit claims, we have contacted all potential beneficiaries where relevant and given them the opportunity to provide submissions in support of their claim to be paid a benefit.[12]	
7.31	If your claim is declined, we will tell you within 5 **business days** of completion of our review:	
	a) the reasons for the decision in writing in plain language	
	b) that you can request copies of the documents and information relied on in line with the standards in section 13	
	c) how you can make a complaint if you are not satisfied with the decision.	
Income protection claims		
7.32	For income protection claims, we will support the insurer to:	
	a) seek to identify ways to support your recovery as quickly as possible	
	b) collaborate with your doctor, other healthcare providers and employer to maximise the health outcomes	
	c) promote best-practice rehabilitation and injury management where these are consistent with the terms of the policy.	
7.33	Where you are receiving ongoing income protection payments, we will have oversight processes in place to determine whether the information you are required to provide is reasonable, and ensure you and your doctor are providing the required information, to assist you to receive timely payments. We will also have processes in place to oversee our insurer's decisions about continuing or stopping income protection payments, and we will raise any concerns that we have with the insurer regarding a decision to stop payments.	

[12] The distribution of death benefits under a regulated superannuation fund is generally at our discretion, applied in line with the terms of our trust deed and subject to the *Superannuation Industry (Supervision) Act 1993*.

7.34	If we become aware that you have made claims against more than one income protection policy, we will explain how the off-setting arrangements operate, and provide you with information about the factors you may want to consider to determine the best financial outcome from your multiple policies. You may be entitled to a premium refund in line with section 11.1 below.	
7.35	If we identify that any of your claim payments are going to be offset or reduced by income you are receiving from other sources including Centrelink and workers' compensation, we will let you know.	
8.	**Premium adjustments**	
8.1	If we receive money or other material benefits (other than claims payments for members and any related costs) directly or indirectly from an insurer or reinsurer, we will publish details of the arrangement on our website. These arrangements are sometimes referred to as premium adjustment mechanisms.[13]	
8.2	Any premium adjustment payments we receive from an insurer will be passed onto our insured members through adjustments to future premiums charged to members, including for insurance administration.	
8.3	Any premium adjustment payment made to us by an insurer or any deficit incurred will be allocated to our insurance reserve, governed by a board-approved insurance reserving policy.	
8.4	Our annual report, product disclosure statement and relevant insurance documentation will include information about our premium adjustment arrangements and policy and the members to which it applies.	
8.5	We will report details of any premium adjustment payments made to and from our insurance reserve, and what the payments from the reserve have been used for.	

[13] For the avoidance of doubt, where premiums cover both insurance risk and an investment component (known as participating policies), these are not considered to be premium adjustment mechanisms.

9.	**Promoting our insurance cover**	
9.1	When we promote the insurance cover that we offer, we will:	This is intended to cover any promotion of cover, not just promotion by advisers. For example, onboarding communications, campaigns and offers.
	a) be clear and upfront and not misleading	
	b) consider the target audience for the communication and whether it provides adequate information for that audience	
	c) ensure that statements in communications are consistent with the features of the relevant policy and the disclosures in any corresponding product disclosure statement	
	d) ensure that any images used do not contradict, detract from or reduce the prominence of any statements used	
	e) if prices or premiums are referred to, ensure that these are consistent with the prices or premiums likely to be offered to the target audience for the communication	
	f) make clear if a benefit depends on a certain set of circumstances	
	g) ensure that any use of phrases such as "free" or "guaranteed" are not likely to mislead	
	h) comply with the Australian Securities and Investments Commission (ASIC)'s guidance for advertising financial products and services and guidance regarding unsolicited sales.	
9.2	If we enter into an agreement or renew an agreement (no later than two years after we adopt the Code) with a financial adviser or dealer group to distribute the products we offer, including any insurance cover available via those products, the agreement will require the adviser to comply with the requirements of this section of the Code.	
9.3	When we promote insurance cover additional to our automatic insurance cover, we will only target any promotion to the segments of our membership for whom we have identified the cover is likely to be appropriate, affordable and of value.	
9.4	We will investigate any concerns raised or identified with the practices of our staff and the financial advisers that we engage. If as a	

	result we identify that cover has been promoted or recommended inappropriately:	
	a) we will contact you to discuss an appropriate remedy, in consultation with the insurer. Appropriate remedies will vary depending on the circumstances, and may include:	
	i. cancelling the cover	
	ii. arranging a refund of premiums paid	
	iii. payment of interest on the refunded premium	
	iv. adjusting the cover or arranging for more suitable cover	
	v. correcting incorrect information	
	b) if you are not satisfied with our proposed remedy, we will review this and tell you how to make a complaint	
	c) we will correct any identified conduct issues, including through further education and training.	
10.	**Changes to cover**	
10.1	If we provide a calculator or other tool to help you to determine the level of insurance you need, we will make it clear that any insurance cover you request may be subject to assessment and approval by us and the insurer.	
10.2	We will include clear instructions on how you can change your cover in our insurance welcome pack, our disclosure information, your annual statement, and on our website.	
10.3	We will let you know the consequences of any changes you request.	
10.4	If you tell us that you want to reduce your cover or make any other changes that do not require the approval of the insurer, we will confirm your changes and the date on which your cover has changed **in writing** within 5 **business days** of receiving your instructions.	
10.5	If you tell us that you want to increase your cover, replace cover you have in another fund, or make any other changes that we determine will require assessment and approval by the insurer, we will explain	If a member makes this application on an insurer's website rather than to a trustee, it is assumed that the online application will explain the process. In this scenario, the trustee would need to ensure that the member is given contact details.

	the process to you within 5 **business days**. You will be given contact details for the primary contact during the application process.	The contact details do not have to be for an individual, and could be for a specialist team for example; the intention is that a member does not have to go through the call centre for enquiries about their application. While the Code does not require the contact details to be given within 5 business days, they would be most usefully provided at the same time as other information is given about the application process.
10.6	We will have oversight processes in place to monitor the decisions of our insurers, as part of our duty to act in our members' best interests.	
10.7	We may take responsibility for a step in the application process, such as arranging an independent medical examination. In these cases, we will comply with the relevant standards in the **Financial Services Council Insurer Code**.	
10.8	We will have complied with the requirements to communicate with you in this section even if the communications are provided to you by the insurer or a **Service Provider**.	
10.9	At the start of the application process, before asking you any health-related questions, we will explain the duty of disclosure (information you need to tell us) and the consequences of not disclosing all relevant information and answering all questions honestly and completely.	
10.10	If you tell us that you are replacing existing insurance cover that you hold elsewhere, we will tell you:	This obligation remains even if a trustee is aware that a member has a financial adviser, as the trustee will not know whether the information below has been provided to the member. The intention is that a trustee prepares some general information about the risks of replacing cover, and provides this across the board. If a trustee is aware that there is an adviser relationship, they may also suggest that the member speaks to their adviser.
	a) that you should not cancel any existing cover until your new application is accepted	
	b) the general risks of replacing existing cover, including the loss of any accrued benefits, the possibility of waiting periods to start again (if applicable), and the implications of any nondisclosure on an application for cover (even where unintentional)	

	c) that once your new cover is accepted, if you do not cancel your previous cover, you may be unable to claim on multiple insurance covers (depending on the terms of your policies).	
10.11	We will provide you with information about any change in your premiums and general information about the impact of insurance premiums on retirement savings.	The intention is for a member to receive a communication whenever their premium changes, which may be on an individual/group basis, through the annual statement detailed in s 5.17, or via a Significant Event Notice (for example). Best-practice would be for a member to be advised of the dollar amount that the premium is changing, although this may not be practical in all cases. With each communication about a change of premiums, it is intended that the trustee provide a general statement about the impact of premiums on savings; each trustee can prepare its own general statement.
10.12	If cover is offered on alternative terms based on your personal circumstances, such as:	
	a) a higher premium	
	b) the exclusion of specific events, activities or medical conditions that are not covered	
	c) alterations to any waiting periods that apply before benefits can be accessed	
	d) alterations to the benefit period that applies, including the term of the insurance cover	
	e) any other specific terms or conditions that may be applicable to the policy,	
we will make it clear to you what alternative terms are being offered.		
10.13	If insurance cover is not offered, or is offered on alternative terms, we will let you know (or your doctor, where appropriate):	
	a) the reasons for the decision	
	b) that you can request copies of the documents and information relied on in line with the standards in section 13	
	c) if you disagree with the decision, or if you think that the information relied on to make the decision is incorrect or out of date, you can discuss this with us and we will review the decision, and if you are not satisfied with the review we will tell you how to make a complaint.	

10.14	Should we become aware after the cover is issued that information relied on for your application for insurance was incorrect or incomplete at the time the cover was issued, we will notify the insurer, and:	
	a) if we consider the information to be important for your cover, we will ask you to provide an explanation, including giving you an opportunity to review any relevant documents about you, before any decision is made such as changing the terms or cancelling your cover	
	b) once a decision has been made, we will advise you of the decision and any actions to be taken, and the process to have this reviewed or make a complaint if you disagree with the decision.	
Transfer between divisions in our fund		
10.15	There are circumstances in which we will transfer you between different divisions of our fund. For example, if you leave an employer, you may be automatically transferred from the employer's plan to a different division. This may change the type and/or the terms of the insurance cover you receive from us.	
10.16	If you have been transferred to another division which changes the type or terms of the cover you receive from us, we will contact you to explain the changes and your options for changing or cancelling this cover.	If a non-AIM (who has selected their cover) is transferred to a default division, if they are given matching cover, they would remain a non-AIM. If they are given different cover in the default division, they would become an AIM until they confirm or otherwise engage with the cover.
10.17	We may also transfer a group of members to a different division, for example if your employer restructures its insurance. If this occurs, we will let you know **in writing** 30 calendar days before the transfer. We will confirm to you any changes to your insurance cover and your options for changing or cancelling this cover.	
11.	**Refunds**	This section deals with refunds where the member has made a claim, and not to any other requests to cancel cover. Trustees may negotiate with their insurer to offer refunds in other circumstances.

11.1	If at claim time we identify that you have multiple automatic insurance covers in superannuation and your benefit is offset or not able to be claimed on because you have claimed on another benefit under another similar policy, which means that no payment is made to you under the cover you hold with us, we will give you the option of a refund of your premiums into your account for the duration of the overlap of covers, to a maximum of 6 years, and we will then cancel your cover.	This does not apply only to IP claims; there are some group life policies that also offset against other lump sum payments. Trustees should refer to the terms of each policy to determine whether this applies. Where the premium is refunded, it is expected that the policy will be cancelled for the shorter of the period that the policy was in place or the period of the refund, with no claims payable for this period. Before processing the refund, the member should be advised of the consequences of this cancellation (so that they can elect to keep the cover and not take the refund if they wish).
11.2	If we identify that you were not eligible to claim against your automatic insurance cover for any event from the start of the cover, we will refund your premiums to your account for the period you were ineligible.[14]	It is intended that this applies to blanket exclusions where a member can never claim for any event, such as "*if you have ever been paid a TPD benefit, you will not be eligible to claim for TPD*." It is not intended that this applies to pre-existing exclusion limitations (as per the footnote 14 below) where the claimant could be eligible for a benefit in some circumstances.
11.3	If you make a claim that is accepted, and your cover ceases under the terms of the policy on the date you became eligible to claim, we will refund your premiums to your superannuation account back to the date you became eligible to claim.	The "date you became eligible" is intended to be the date of disablement. For late-notified claims, it is intended that refunds would be provided back to the date of disablement.
12.	**Staff and Service Providers**	
12.1	We will ensure our staff have the appropriate education and training to provide their services competently and to deal with you professionally, initially and on an ongoing basis. This will include training on their responsibilities under the Code. We will only allow our staff to provide services that match their expertise.	
12.2	We will have processes in place to train our staff to help identify and engage appropriately with vulnerable consumers, to carry out any internal protocols we put in place, and to refer these consumers for appropriate support where required. Specific training regarding	

[14] Refunds will not be provided if you have an illness or injury that means you are not covered due to a limited cover or pre-existing condition exclusion or limitation, because you may still be eligible for cover for any new or other illnesses or injuries.

	engaging appropriately with members who have mental health conditions will be provided.	
12.3	Our claims handling staff who make initial eligibility assessments and review claim decisions made by insurers will be appropriately skilled and trained to make objective decisions. They will not make decisions on our behalf until they have demonstrated technical competency and an understanding of all relevant law and the requirements of the Code. Performance measures, remuneration and entitlements to bonuses will not be based on declined claims or deferrals of decisions.	
12.4	We will monitor the performance of our staff and provide appropriate education and training to correct any identified performance shortcomings.	
12.5	In addition to an insurer, we may engage another party to provide a service to you on our behalf; for example, a claims management service or a fund administrator. When we enter into an agreement, or renew an agreement (no later than two years after we adopt the Code) with a **Service Provider**, the agreement will require them to comply with the relevant standards of the Code.	
12.6	We will review our agreements with **Service Providers** no later than every 3 years.	
12.7	We will require **Service Providers** to act with honesty, fairness, respect, transparency and timeliness towards you and us.	
12.8	We will only enter into agreements with **Service Providers** who reasonably satisfy us of their expertise, experience, qualifications and integrity, and who hold any required licensing.	
12.9	We will require **Service Providers** to comply with the *Privacy Act 1988* and maintain confidentiality of your information, and only use that information for the purpose of the service they are providing.	
12.10	We will monitor the activities of any **Service Providers** that we engage to ensure that they are complying with the relevant standards of the Code. This can include requiring regular reporting, putting in place quality assurance measures, and analysing data such as claim decisions and complaints.	

12.11	We will require any **Service Providers** that we engage to notify us if you make a complaint to them about their services, and we will handle the complaint in line with our complaints process.	The trustee can outsource its complaint management to an administrator; however, it remains ultimately responsible for the complaint, and should retain an oversight role. It should also have an escalation process in place, where any issues with third-party complaints handling are identified.
13.	**Making enquiries and complaints**	
How to make an enquiry		
13.1	If you have a question about your cover, your premiums, any communication we have sent you or a decision that has been made regarding your cover, you can make an enquiry to us. We will provide you with information without requiring you to make an insurance claim.	
13.2	You can also access the following information (in an electronic format if preferred) upon request:	
	a) details of your cover	
	b) our insurance contract with our insurer (sometimes called the policy document)	
	c) the product disclosure statement relevant to your cover	
	d) our trust deed	
	e) any personal information we hold about you	
	f) information relied on to decide your claim or complaint.	
13.3	We will respond to your enquiry:	
	a) with an acknowledgment by the next **business day**	
	b) with a full response within 10 **business days**.	
13.4	If we cannot comply with a timeframe for providing information required by the Code, for example because we are waiting for permission from a third party to release the information, we will tell you why before the end of the timeframe, and this will not constitute a Code breach.	
13.5	In some circumstances, information may not be able to be provided, for one of the following reasons:	

	a) where information is protected from disclosure by law, including the *Privacy Act 1988*	
	b) where we reasonably determine that the information should be provided directly to your doctor	
	c) where the release of the information may be prejudicial in relation to a dispute about insurance cover, a claim, or a complaint	
	d) where we reasonably believe that the information is commercial-in-confidence.	
13.6	If information is not provided:	
	a) we will act reasonably	
	b) we will give you a schedule of the documents not provided and the reasons for doing so	
	c) we will tell you how you can make a complaint if you are not satisfied.	
13.7	If you are not satisfied with our response to your enquiry, you can make a complaint.	
How to make a complaint		
13.8	You can make a complaint to us about any of our decisions or conduct, or the decisions or conduct of a **Service Provider**. If you make a complaint to us about a decision or conduct of our insurer, we will ask the insurer for a response and we will review this as part of our complaints process.	
13.9	We will make information about your right to make a complaint and our process for handling complaints available on our website and in our relevant communications to you.	
13.10	Your complaint will be handled by someone different from the person or persons whose decision or conduct is the subject of the complaint.	
13.11	We will notify you of the name and contact details of the person assigned to liaise with you about your complaint, and an overview of the process and timeframe.	
13.12	We will only ask for and rely on information relevant to the investigation of your complaint and our response to your complaint.	

13.13	If we become aware of errors and mistakes in the handling of your complaint, we will address these promptly.	
13.14	You will receive progress updates at least every 20 **business days** (unless a different timetable is agreed with you). If there are any issues delaying assessment of your complaint, we will let you know.	
13.15	We will provide a final response to your complaint **in writing** within 45 calendar days of receiving your complaint. In **exceptional cases**, we will need more time to investigate and respond to your complaint. In these cases, we will tell you that we need more time, and will clearly communicate our revised expected timeframe, which will not exceed 90 calendar days.	
13.16	If we do not respond to your complaint within 90 calendar days, we will give you written reasons for the delay before the end of the 90-day period, and we will let you know that you can take your complaint to **External Dispute Resolution**.	
13.17	In our response to your complaint, we will explain:	
	a) our decision on your complaint and the reasons for that decision	
	b) that you can request copies of the documents and information relied on in line with the standards of this section	
	c) that you have the right to take your complaint to **External Dispute Resolution** if you are not satisfied with our decision and the timeframe within which you must take your complaint to **External Dispute Resolution**	
	d) contact details for the relevant **External Dispute Resolution** organisation.	
13.18	A summary of the complaints we handle will be regularly reported to our Board.	
External determination of complaints		
13.19	If you make a complaint to us and our final decision does not resolve your complaint to your satisfaction, or if we do not resolve your complaint within 90 calendar days, you may refer your complaint to **External Dispute Resolution**.	

13.20	You may seek independent legal advice and access any other dispute resolution options that may be available to you or of which we are a member.	
14.	**Promoting, monitoring and reporting on the Code**	
Our role		
14.1	We will promote the Code and make it accessible, which will include providing information about the Code on our website, in our insurance communications and in relevant marketing documents.	
14.2	We will:	
	a) have appropriate systems and processes in place to enable compliance with the Code including monitoring and analysing data on policies, our communications to members, claim data, and internal and external complaints	The Transition Committee will develop a standard format for Code compliance monitoring and reporting.
	b) publish on our website an annual Code compliance report, which includes:	A trustee's first compliance report is due 12 months after the trustee has transferred to any of the standards of the Code, and should make it clear which standards are still to be transitioned to in the future, and which standards are not being adopted due to the best interests duty (this is the first time that a trustee needs to publish this).
	i. instances where we have failed to comply with the Code	
	ii. where we have determined that complying with the Code is not in the best interests of our members	This needs to be restated in each year's report.
	iii. any steps we are taking to improve our Code compliance.	
14.3	If we identify that our failure to comply with the Code has resulted in direct detriment to one or more of our members, we will seek to remedy this. This could involve compensation for any direct financial loss.	
14.4	We will work with our members to improve education on insurance in superannuation. We will report to our members in our annual report on the steps we have taken to improve member education.	
Role of the Insurance in Super Code Owners		

14.5	The **Insurance in Super Code Owners** are responsible for the development of the Code.	
14.6	The **Insurance in Super Code Owners** may develop guidance documents from time to time to assist us in improving standards over time, and in interpreting and meeting our commitments under the Code.	
14.7	The **Insurance in Super Code Owners** will commission formal independent reviews of the Code as appropriate, no later than every 3 years. Reviews will focus on whether the Code is meeting its objectives, in particular whether the Code has improved the insurance offered in superannuation, and the processes by which we deliver insurance.	
14.8	In addition to formal independent reviews of the Code, the **Insurance in Super Code Owners** will consult with relevant regulators, **External Dispute Resolution**, consumer and industry representatives and other stakeholders to develop the Code on an ongoing basis. The **Insurance in Super Code Owners** will meet at least once every year to determine whether any changes need to be made to the Code.	
14.9	The **Insurance in Super Code Owners** will promote the Code to consumers and to trustees and other industry participants.	
Definition of **Automatic Insurance Member**.		When a trustee transitions to the Code, it should use its best endeavours to identify which of its existing members are Automatic Insurance Members for the purposes of the Code. It is up to the trustee to determine its methodology for identifying its AIMs. Where a current member is on a previous default and has made no attempts to adjust their cover, they would remain an AIM for the purposes of the Code, even if the trustee's default has changed.