The following is the script from a presentation by Col Fullagar, Principal of Integrity Resolutions Pty Ltd, at the Financial Newswire Life Insurance Outlook function, 7 March 2023

LIFE INSURANCE CLAIMS (MIS)HANDLING

I have been asked to provide an overview of life insurance claims handling and to question whether the necessary lessons have been learnt in the wake of recent ASIC reviews.

To ensure I am on topic, I will quickly revisit the most recent ASIC review which gave rise to the report issued 2 September, last year.

In that report:

- ASIC expressed concern about the overuse of intrusive claims handling practices including non-disclosure investigations, physical surveillance and poor treatment of mental health claims leading to consumer harm. From my experience I would add the requesting of onerous and unnecessary claim proofs, unreasonable delays, bullying and insensitive behaviour towards claimants.

- ASIC expressed concern that some insurers still appear to be "fishing" for non-disclosures to avoid paying legitimate claims.

- Insurers were put on notice that ASIC would take action where it sees consumer harm arising out of poor claims handling practices and it reminded insurers they are now legally obliged to act efficiently, honestly and fairly when handling claims.

- Finally, ASIC sought to identify areas for improvement.

BY ANY MEASURE, THAT IS A HEADY LIST

In preparation for today, I had a look at the websites of several insurers to see what they were saying about their claims handling practices. The following statements were made:

"We're here to make sure your claims experience is supportive, flexible and runs as smoothly and quickly as possible"

"We strive to make a real difference to the lives of our customers during challenging circumstances"

"You want to know that your insurer is going to be there to pay your claim quickly and with empathy and sensitivity"

"When you choose us, you choose an insurer who cares"

So, if we are to accept the word of these and, no doubt other insurers, the lessons have been learnt; all is good and we can break early for drinks !!!!

Sadly, however, I am a cynic, albeit on an informed basis and from my experience, these statements are little more than Jibber Jabber.

So, in the small amount of time available today, rather than provide an "overview" of claims handling, I would like to provide an "underview" …… I will look at a few recent situations which arguably identify

arears still in breach of ASIC standards and needing improvement. In an attempt to assist insurers and advisers alike, I will toss in a couple of ideas and suggestions.

For the record, these examples represent a very, very small percentage of the problems and challenges I encounter daily and/or that are reported to me by advisers and claimants.

1. **Know your role**

Last week, I asked a senior claims manager "*What do you see as the fundamental role of a claims assessor?"*

"*To pay valid claims as quickly as possible*" was the answer given.

In fact, that is the role of the accounts department.

To my mind, the role of a claims assessor is to request the information **necessary** to identify whether or not a claim meets the relevant policy terms.

If the answer is "No" – either Decline the claim or request more information

If the answer is Yes:

- For a lump sum claim – Pay

- For a revenue claim – Pay and assess for how long the claim is validated by the information currently held at the end of which time, restart the cycle.

The key word is "**necessary**" ie the minimum amount required – anything beyond that by definition, is unnecessary and irrelevant. As per Section 8.5 of the Life Insurance Code of Practice - an insurer can only ask for information that is relevant to the claim and policy.

Assessors should be continually reminded of this. Yes, they need training, but they also need focus.

2. **Reason for information**

Not only do assessors need focus, they must understand and be able to clearly enunciate why information requested is necessary.

A claims assessor recently emailed an adviser to request that the claimant attend for an independent medical examination. The reason given was:

"The aim of the independent medical examination is to gain a more complete picture of your condition and circumstances and an independent opinion in regard to treatment and prognosis, which will assist us in determining if you satisfy the relevant definition"

Sounds impressive but it also is Jibber Jabber in so far that, if the insurer wanted to gain a more complete picture, the treating practitioner would be in a better position to assist. If it wanted an opinion in regard to treatment and prognosis, a physical examination will add little value.

The point being missed is that, if additional information is deemed necessary, in this case an IME, there must be a "gap" in the information currently held. That "gap" is the reason for the IME or whatever other claim proof is needed. It is the gap that needs to be identified and espoused, and please, can we stop playing Secret Squirrels ie do not be afraid to tell the truth, for example ……

"The medical information provided to us has been referred to one of our Medical Officers and she believes the reported symptoms do not align with the severity of the condition. We would like to obtain a second opinion …….. etc"

Could I suggest, never allow an assessor to communicate a claim requirement or decision unless the assessor knows and can espouse the reason for each. If you want training, I guarantee this will give it to you !!

3. **Onerous claim proofs**

"We have identified that you have an interest in the following seven business entities. For each, could you please send us financial statements and tax returns for the last 3 years ……."

I have lost count of the number of times I see this request or its equivalent, which invariably results in the claimant having to find and ferry ten's, if not scores, of documents to the insurer and then field a range of questions coming out of the review of those documents eg Could you please advise if any of these is a passive entity or whether they are aligned to your personal exertion earnings?

Why not ask questions first and only obtain information relevant to the policy and the claim ……. and reduce the burden on the claimant, for example:

"We have identified that you have an interest in the following seven business entities; however, only those that are aligned to your personal exertion income are relevant. Could you please identify the relevant entities and, for each ……."

For the record, I have NEVER seen this approach taken.

4. **Unnecessary claim proofs**

Medical practitioners are time poor. This must be respected so their time is not wasted.

Two thoughts ……

A crucial part of the claims assessment process is the claimant's initial claim form; however, whilst it may sound like sacrilege, having the doctor complete an initial claim form arguably is a waste of their time in so far that the content of the form apparently is not believed.

From my experience, notwithstanding the completion of the Initial Attending Doctor's Statement and the opinions expressed therein, insurers invariably write for a report anyway.

Therefore, why not simply obtain the initial claimant form together with medical reports held by the claimant and subsequent to a review of these, write for a report if necessary – in other words, ditch the initial Attending Doctor's Statement…..Will this cause a delay; likely not. Will it cost the insurer extra – No, to the extent they write for a report anyway.

The second suggestion is to do with the requesting of reports from treating specialists who are even more time-stretched than general practitioners. As such, the questions put to them should be limited to those that cannot be put to a GP.

Please can we stop asking specialists to detail the medical history, the severity of symptoms, etc. Keep the questions short and relevant, for example:

"*Bearing in mind your examination findings could you please opine in regard to Mr Brown's ability to work in his role as a chiropractor"* and "*Bearing in mind current and possible future treatment options, could you please opine in regard to his short and long-term prognosis"*

5. **Surveillance**

This is an extract from a recent psychologist report "*My patient reported symptoms indicative of paranoid ideation which commenced in the last 12 months. This appears to be directly related to him being watched by his insurance company ……. Despite him being advised it is no longer occurring, he remains hypervigilant about this ……."*

To put it bluntly, the conduct of the insurer harmed the claimant

I am assisting another gentleman who at one stage thought he was being followed. He had taken out an AVO on a citizen who was stalking him and was anxious to find out if the AVO was being breached or if his insurer had him under surveillance. The question was asked of the insurer "*Has this person been placed under surveillance*?"

The woeful response "*In relation to your query regarding surveillance, as a matter of policy, we neither confirm nor deny whether surveillance has occurred on a claim."*

Where is the legal obligation to be honest and fair – the Life Code Commitment to be Open and Transparent – the insurer's Duty of Care …… ALL are breached

If an insurer feels surveillance is warranted, that's fine - get the necessary internal signoffs and do it BUT own it; be accountable.

If asked, fess up and advise the reasons surveillance was undertaken. Provide a copy of the tape and report, confirm outcome – arguably do it WITHOUT being asked.

6. **Plan lacking**

I have often represented to advisers that, at your peril rush to complete and lodge a claim form "*in order to get the process started as quickly as possible"*

As with the initial advice process, claims advice requires:

- Gathering the facts including a review of the new business file and application form

- Undertaking appropriate research including a review of the relevant policy terms

- Analysing the findings and checking for red flags

- Preparing and making a recommendation to the client that sets out a claim strategy

- Only when the above has been done should the completed claim documents be lodged

The impression I am increasingly getting is that, sadly insurers do not undertake the equivalent.

There is little more frustrating for an adviser and/or their claimant client than being asked for information 4 months after a claim was submitted that could have been requested 4 days after.

In a recent example, 6 months after a large TPD claim was lodged, literally the only thing the insurer had achieved was to clarify that the claimant's current occupation of labourer was different to the pre-claim occupation of General Manager of a construction company that employed in excess of 100 contractors.

Having reached that point, the insurer then turned its attention to gathering and assessing medical evidence including writing to the treating GP and Psychiatrist for reports citing that their opinions in the initial forms were now out of date !!!!

No doubt there are some representatives here from insurance companies who are saying to themselves "*Well that isn't us. We formulate a plan right from the go get"*

To these and others, I add one thing …….. Do you share the plan with the claimant and/or the adviser? Do you seek their input? Their buy-in.

Remember claimants – they are either sick, injured, grieving or dying? Their self-esteem is low. Being kept hanging and in the dark is the last thing they need.

Ask for their input about the best doctor to approach, seek their sign off on the questions to be asked. Give them meaningful updates, timeframes and real deadlines rather than "in due course" or "as soon as possible".

If referrals are necessary, make them to people or positions rather than "seniors" or "external stakeholders"

7. Bullying behaviour

I am assisting a gentleman who has been on claim for 12 years. The veracity of the claim condition is not in question; however, he is still required to provide monthly forms so he had taken to responding to certain questions such as home address, phone number and similar with "no change".

Then he copped this from his new assessor "*Whilst I can appreciate you have not changed your address in 12 years you must complete each question in its entirety and do not put "no change" in any of the requested fields unless the question specifically asks if there has been a change."*

The same dude, different claimant ….."*Please be advised that the current way in which the form is being completed is insufficient, such as Question 10 where you put "as per above. We note the claim form is a legal document so you need to be specific in terms of your answers"*

There are many words I could use to describe this type of person, none of which I could use here. For the record, neither this assessor, nor his name, is Robinson Crusoe

The two crucial skills required of a claim's assessor are Aptitude and Attitude – Please make sure they are present

8. Bad to Bullshit

Unfortunately, the previously mentioned large TPD claim went from bad to bullshit.

It is relevant to add that the claim condition was related to a serious mental health problem manifesting in part as suicidal ideation with plans.

After 3 months of going back and forth on the medical side ie 9 months after the claim was lodged, the insurer requested an IME and also wanted to obtain a copy of the psychiatrists clinical notes

I called and spoke to the claims manager to question why the IME was required. The answer "*Well it is an ANY Occupation definitio*n" To which I responded, "*Well, in fact it is Own Occupation*" "*Let me get back to you ……"* he said.

The insurer and reinsurer had been assessing the claim for 9 months under the incorrect definition.

I then spoke to the so-called senior claims assessor to query the need for the psychiatrist's clinical notes rather than obtaining a report. The response "*Why is he reticent about us obtaining the clinical notes – Has he got something to hide?"*

It was about then that I went into Hanibal Lecter mode and calmly pointed out the importance of being able to share your inner most personal thoughts and feelings with your medical support team, and the potential terror you might feel if their clinical notes were being read by unknown others.

What happened to the specialist training required under FSC Standard 21 or is this an example of it !!

Sady, I get emails like the following all the time ….

"To be honest, I'm disgusted and ashamed I had so much faith when I was in the industry. Makes me very sad to see and experience this" (Ex-adviser making TPD claim)

"It is so frustrating; we take out insurance to protect us from this situation. I have paid years of crazy high premiums and have provided all the evidence asked for, while having my life tipped upside down, all the while thinking this insurance is in place to protect me and my family ….." (Insured making IP claim)

I am often asked if things are different post- the Royal Commission. I never hesitate in responding in the affirmative and then immediately add "Yes, things are much worse".

Michael Douglas said it well in the movie The American President *"We have serious problems to solve, and we need serious people to solve them"* or in the alternative *"We need people to be serious about solving them"*

My last suggestion is in regard to engendering an environment in which those people who can make a difference will take seriously the issues associated with claim handling practices.

For some time, Mike Taylor and I have discussed the setting up of a Trip Advisor equivalent for the rating of insurance companies in various areas including claims handling. If insurers want to brag "*When you choose*

us, you choose an insurer who cares" great – let's test the success and let's get serious …….. Licensees do not allow an insurer's risk products on your Approved Product List unless the insurer scores more than 4 out of 5; and Executives, let's tie bonuses to your company scoring more than 4 out of 5.

If you want Serious, again I guarantee this will give it to you !!!

Thank you ……..

(2,700 WORDS)