Law Council
OF AUSTRALIA

Legal Practice Section

19 December 2025

Peter Kell
Independent Reviewer of the Life Insurance Code of Practice

Submitted online via: lifecodereview.org.au/make-a-submission

Dear Mr Kell,

2025 Independent Review of the Life Insurance Code of Practice

1. This submission has been prepared by the National Insurance Law Committee (the **Insurance Committee**), the Australian Consumer Law Committee (the **Consumer Committee**) and the Superannuation Law Committee (the **Super Committee**) of the Law Council of Australia's Legal Practice Section. The Committees welcome the opportunity to make a submission to you as the independent Reviewer of the Life Insurance Code of Practice (the **Code**).

2. The Life Code Independent Review consultation paper dated 17 October 2025 (the **Consultation Paper**) addresses a broad range of issues in respect to the Code. The committees have not sought to comprehensively respond to each of the questions posed in the Consultation Paper but have prepared this submission on the specific topics addressed below.

3. In some instances, throughout this submission there may be a divergence of opinions as to certain matters that are the subject of your review between the committees. Wherever such divergence of opinion occurs, we will ensure that it is clear which committee holds certain opinions. Where there is no divergence of opinion, you can assume that all the committees agree on that matter.

Mental health conditions—Questions 3.1 and 3.3

4. If and to the extent consideration is given to expanding the compliance obligations imposed on insurers in respect of the provision of cover (or exclusion of) mental health conditions, the Insurance Committee submits that it will be important to ensure that those obligations are fully aligned with the *Disability Discrimination Act 1992* (Cth) (the **DDA**).

5. Specifically, insurers do not unlawfully discriminate against a person on the ground of their disability where the discrimination is based upon actuarial or statistical data on which it is reasonable for the insurers to rely, and it is reasonable having regard to the matter of the data and other relevant factors (or, where no such actuarial or statistical data is available and cannot reasonably be obtained, the discrimination is reasonable having regard to any other relevant factors) in accordance with section 46 of the DDA.

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6. Any additional obligations sought to be imposed through the Code to improve underwriting practices ought to be clearly aligned to the DDA. That is, they should promote compliance with the DDA rather than augment the legal position that currently exists.

7. The Consumer Committee agrees that any amendments ought to align with the requirements of the DDA. In addition to ensuring compliance with the DDA, it is the Consumer Committee's view that to ensure that consumers can understand the basis for any exclusion being applied, an insurer should be required upon request to produce the actuarial or statistical data that is relied upon to justify the decision. At present, in the experience of the Consumer Committee insurers will generally refuse to provide any such actuarial or statistical data on the basis that it is commercial in confidence or similar. In the Consumer Committee's view, it is good industry practice (and procedurally fair) to ensure that when a decision is made that is adverse to the interests of a consumer, the consumer should be provided with a copy of any material relied upon to justify that decision.

8. The Insurance Committee does not agree that insurers should be compelled to disclose commercially sensitive actuarial or statistical data.

9. We note that the Attorney-General's Department is currently reviewing the DDA,[1] as part of the Australian Government's response to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. A review of the relevant permanent exemptions in DDA, including section 46, is occurring as part of this process.

Claims handling timeframes—Questions 3.14 and 3.16

10. The Insurance Committee is aware of the stress that making a claim can involve and concurs with the Reviewer's sentiments that insurers must deal with claims as efficiently as possible and with a high level of empathy and compassion. The timeframes in section 5 of the Code are intended to ensure that claims are handled in a timely manner and that claimants are kept apprised of the progress of their claim.

11. The Insurance Committee considers the Code obligations in section 5, including claims handling timeframes, adequately protect consumers, as currently drafted, and, when considered in conjunction with other rights and legal obligations, including the duty of utmost good faith under the *Insurance Contracts Act 1984* (Cth) and the general obligations of Australian Financial Services Licensees under the Corporations Act 2001 (Cth), particularly the requirement to do all things necessary to ensure that the financial services covered by the licence are provided efficiently, honestly and fairly. These obligations reflect a principle-based approach that necessarily balances consumer protection requirements with standards of reasonable business conduct, providing necessary flexibility to deal with all relevant circumstances. The Code's approach and timeframes provide a level of prescription and certainty for consumers but enables sufficient flexibility for insurers where the circumstances require which are aligned to complimentary legal obligations.

[1] Attorney-General's Department, *Disability Discrimination Act 1992 Review*, Discussion Paper, 1 August 2025. See also Law Council of Australia, *Disability Discrimination Act 1992 Review,* Submission to the Attorney-General's Department, 14 November 2025.

12. The Insurance Committee does not consider there to be a compelling case for amending the timeframes and has not identified a need for any timeframes to be incorporated that would improve claimant outcomes. This includes the definition of Circumstances Beyond Our Control (**CBOC**) which necessarily adopts a degree of flexibility to cater for all relevant circumstances through the use of "reasonable" qualifying language. Given the nuanced and peculiar circumstances of each claim, it remains appropriate for the Code to enable flexibility when it comes to consideration of CBOC for an insurer.

13. The Consumer Committee agrees that the current timeframes set out in the existing Code are appropriate. However, the Consumer Committee is concerned with the broad definition of CBOC. The Consumer Committee has seen some instances in which insurers have failed to make a decision based upon circumstances which it does not believe are reasonable. For example, under the existing definition (see part a) of the definition) an insurer would be entitled to refuse to make a decision on a claim because they had not received records from Medicare, Centrelink or the ATO. That would be so, even if those documents were only requested 5 months into the claim process, where the same documents could reasonably have been requested at the commencement of the claim. Likewise, an insurer is entitled under the Code to conduct an endless investigation into non-disclosure/misrepresentation or fraud. We do not consider that is reasonable: any such investigations should be conducted promptly.

14. The Consumer Committee recommends that the definition of CBOC be tightened and defined as follows:

Circumstances Beyond Our Control means:

Any of the following:

a. *We have not received or had a reasonable time **<u>of not more than 2 weeks</u>** to assess reports, records, evidence or other information we reasonably requested from you, the Group Policy Owner, an Independent Service Provider, your doctor, a government agency, or another person or entity (but not a Reinsurer).*

b. *You or the Group Policy Owner have not responded to our reasonable enquiries or requests for documents in a reasonable timeframe.*

c. *We have not had a reasonable opportunity **<u>of not more than 4 weeks</u>** to complete our assessment of your claim and make a decision after we issue a Show Cause or Procedural Fairness letter.*

d. *We have been unable to contact you about your claim.*

e. *You are, or will be, undergoing rehabilitation, retraining or further treatment, which means we are unable to make a final decision about your claim.*

f. *You or the Group Policy Owner have asked for a delay or extension to part of the claims process.*

> ~~*g. We reasonably suspect there was non-disclosure, misrepresentation or a failure to take reasonable care before the cover or policy started that we believe may impact your claim, and we need further investigation, evidence and/or information.*~~
>
> ~~*h. We reasonably suspect that your claim is fraudulent and need further investigation, evidence and/or information.*~~

15. In response, the Insurance Committee considers that limbs (g) and (h) of the definition should be retained to ensure insurers are able to properly investigate the circumstance of non-disclosure, misrepresentation or fraud, though the provisions could be subject to 'reasonable' qualifiers if appropriate as follows:

> *g. We reasonably suspect there was non-disclosure, misrepresentation or a failure to take reasonable care before the cover or policy started that we believe may impact your claim, and we have a* ***reasonable basis for*** *further investigation, evidence and/or information.*
>
> *h. We reasonably suspect that your claim is fraudulent and* ***have a reasonable basis for*** *further investigation, evidence and/or information.*

16. The Insurance Committee also considers that, if amendment is made to para (a) as proposed by the Consumer Committee, it should include reference to the date information is received:

> *a. We have not received or had a reasonable time* ***<u>of not more than 2 weeks</u>*** *to assess reports, records, evidence or other information we reasonably requested* ***<u>and received</u>*** *from you, the Group Policy Owner, an Independent Service Provider, your doctor, a government agency, or another person or entity (but not a Reinsurer).*

17. In relation to claims handling timeframes for superannuation complaints, if mandatory standards are to be imposed on superannuation trustees, see our comments on Question 6.9 Enforceability (paragraphs 41, 42 and 43).

Medical definitions—Questions 3.18 and 3.19

18. There are a number of significant legal impediments to insurers being able to effectively update the medical definitions in their policy wordings, particularly for legacy products. This is not an issue that is capable of being resolved by the Code but does provide important context for the need for the Code to address changing medical definitions in the way that it does.

19. The Code requires insurers to apply the more favourable of the medical definition in the claimant's policy wording or the medical definition set out in the version of the Code current at the date of the insured event. This is a pragmatic and consumer-friendly approach which the Insurance Committee supports retaining.

20. The Insurance Committee acknowledges the potential for confusion by claimants who may be unaware of the Code. It is possible that a potential claimant could be deterred from making a claim if they review the relevant medical definition in their policy wording and conclude that they are ineligible to claim on the basis of that definition. This is certainly an undesirable outcome, which could be unfair.

21. On balance, the Insurance Committee considers that it is preferable for the Code to continue to operate as it currently does in respect of medical definitions. This will likely provide a better result for a much wider cohort of claimants, now and in the future. The risk of a potential claimant being deterred from making a claim can be mitigated through public education produced by the industry and supported by insurer communications that provide clear guidance in this respect—for example, insurers can include content in anniversary notices that directs potential claimants' attention to the medical definitions in the Code.

Third party service providers—Question 4.3

22. In considering whether the Code is currently sufficient for the management of the conduct of third parties, the review should be mindful of new and significant regulatory requirements now in place. Life companies regulated by APRA are subject to *Prudential Standard CPS 230: Operational Risk Management* (**CPS 230**) which imposes onerous obligations in respect of the management of operational risk, including the appropriate oversight and control of material third party service providers.

23. To the extent that consideration is given to expanding the Code in respect of third parties, the Insurance Committee reiterates the importance of the Code being consistent with and aligned to the law and regulation that life insurers must otherwise comply with.

24. The Consumer Committee believes that the existing obligations under clauses 1.18–1.24 of the Code are appropriate.

Complaints—Questions 4.12 and 4.13

25. The Insurance Committee submits that the complaints handling provisions in section 7 of the Code should be reviewed and any overlap and duplication of matters addressed in *ASIC Regulatory Guide 271: Internal dispute resolution* (in particular, the enforceable provisions of that Guide) be removed from the Code. This reflects the approach to the Code generally that it is not a restatement of the law.

26. Otherwise, the Insurance Committee considers the content of section 7 of the Code to be appropriate, functions well as drafted, and does not require amendment at this stage.

27. The Consumer Committee notes that under clause 7.7 of the Code there are three possible outcomes in relation to a complaint, being:

    (a) Re-open or reassess a claim;

    (b) Maintain the original decision; or

    (c) Overturn the original decision.

28. The Consumer Committee has observed instances in which insurers have responded to a complaint in relation to a declined claim, where a consumer has sought a review of a rejection of a claim, and the complaint response is a commitment to "reopen or reassess" a claim. However, in the Consumer Committee's view that is not

adequate. That is, if a claim has been declined and a consumer has sought a different outcome to their claim, the insurer should be required to substantively deal with the issue and make a review decision rather than merely have the claim referred back to the claims team for continued reassessment (sometimes by the same person who assessed the claim initially).

29. It is the Consumer Committee's view that the above approach is consistent with clause 7.5 and good IDR practice. That is, a consumer should be able to ensure that their complaint is substantively dealt with within the prescribed timeframes for complaints.

30. It is the Consumer Committee's view that clause 7.7 of the Code should be reworded as follows:

> *7.7 When we give you our final decision in respect of your Complaint about a declined claim, or about the value of a claim, we will tell you what we will do regarding your claim which will be one of the following:*
>
> *a) reopen or reassess your claim*
>
> *b) maintain our original decision, or*
>
> *c) overturn our original decision*
>
> ***However, where you have complained in relation to a claim which has been declined or about the value of a claim, we will provide a substantive response to your complaint within the timeframes in this Code.***

Code accessibility—Questions 6.1, 6.2 and 6.4

31. The Insurance Committee considers that the Code could be improved and be made more accessible to consumers if it included flow charts for key processes, such as disclosure, claims and complaints.

32. The Code could also be re-drafted in simpler plain English to make it easier for consumers to navigate and understand. Any re-drafting must be carefully reviewed to ensure that the purpose and effect of the drafting remain consistent with the purpose of the Code and wholly aligned to relevant legal obligations.

Enforceability—Question 6.9

33. The Insurance Committee does not consider it necessary or appropriate at this stage to include any enforceable code provisions (**ECP**s) in the Code. The absence of ECPs is consistent with other industry codes of practice, such as the General Insurance Code of Practice and the Insurance Brokers Code of Practice, and the reasonable expectations of consumers.

34. As the Reviewer identifies in the Consultation Paper, consumers can already seek the resolution of complaints against insurers via AFCA. In handling those complaints, AFCA will have regard to the Code and industry practice, which represents a de facto enforcement avenue for consumers. The Committee does not consider it necessary for consumers to also be able to bring private civil action against insurers to enforce

the Code. This may result in duplication of process and cost which would ultimately have an effect on the industry and consumers more broadly.

35. The Insurance Committee also does not consider it necessary or appropriate at this stage for the Code to be incorporated into insurance contracts, as is the case under the Banking Code of Practice for the banking industry's products. The terms of insurance contracts are already subject to strict consumer-friendly regulation under the Insurance Contracts Act, and the unfair contract terms regime under the *Australian Securities and Investment Commissions Act 2001* (Cth), and it is important that the contractual terms reflect the actual legal rights and obligations of the parties.

36. The Consumer Committee does not agree with the view of the Insurance Committee on this issue. It is noted that in the Hayne Royal Commission Final Report, Commissioner Hayne stated:

> *If industry codes are to be more than public relations puffs, the promises made must be made seriously. If they are made seriously (and those bound by the codes say that they are), the promises that are set out in the code, and are intended to govern the particular relations between the provider and the acquirer of a financial product or financial service must be kept. This must entail that the promises can be enforced by those to whom the promises are made: the customer who acquires the product or service, and the guarantors of loans to individuals and small businesses.*

37. *A*t present, clause 8.10 of the Code operates so as to exclude any provision of the Code from being the subject of court proceedings. This is not consistent with the view expressed by Commissioner Hayne. It is the Consumer Committee's view that clause 8.10 should be removed from the Code.

38. For practical reasons, the Consumer Committee does not believe that all Code provisions should be enforceable code provisions. However, there are some provisions that the Consumer Committee believe should be enforceable by consumers either before the AFCA or a Court. The Consumer Committee believes that the following Code provisions should be enforceable by consumers:

    (a) Clauses 5.47 to 5.49 in relation to claims timeframes;

    (b) Clause 5.58 in relation to claim declinatures;

    (c) Clauses 5.59 and 5.60 in relation to Circumstances Beyond Our Control;

    (d) Clause 7.5 in relation to who will undertake review of a Complaint; and

    (e) Clause 7.13 to 7.17 in relation to the handling of Complaints.

39. It is the view of the Consumer Committee that the above Code provisions are key provisions that relate to claims and which should be able to be enforced by a consumer in Court or via the AFCA.

Service standards for superannuation trustees—Question 6.9

40. As noted in the Consultation Paper (section 2.3), the Government has announced its intention to impose new mandatory and enforceable service standards for superannuation trustees, which are expected to include standards aimed at achieving fair and efficient processing of insurance claims. Importantly at this stage it is unknown whether the standards will be imposed only on superannuation trustees, or if life companies will be subject to the same standards. Consultation on these reforms is expected during 2026.

41. It is critical to the effective operation of the Code that it be consistent with these new service standards, and that life companies have the same obligations as superannuation trustees in relation to life policies issued to those trustees.

42. The Insurance Committee submits that if the mandatory standards are imposed on superannuation trustees and life companies in the same terms, the Code should exclude superannuation policies from the operation of aspects of the Code that are covered in the mandatory standards. Alternatively, if the mandatory standards are imposed on superannuation trustees only, the Code should impose the same standards on life companies, and the Super Committee would support that these standards should be ECPs.

Code reviews and amendments between reviews—Questions 6.10 and 6.11

43. The Insurance Committee believes that continuation of the current 3-year review cycle is appropriate and does not support extending the review cycle to 5 years.

44. The Insurance Committee submits that the Code should be amended to provide that CALI can review the Code, or consider amendments to the Code, outside of the ordinary 3-year review cycle, to ensure the Code remains current and fit for purpose. The decision to do so should be made by the CALI Board, either at its own instigation or following a recommendation from the Life Code Compliance Committee.

45. The Section would welcome the opportunity to discuss this submission with you. In the first instance, please contact Matt Ellis, [redacted] [redacted].

Yours sincerely

Greg McIntyre SC
Chair, Legal Practice Section