GENERAL INSURANCE

CODE OF PRACTICE

INSURANCE COUNCIL OF AUSTRALIA

FOREWORD

The current Code of Practice was last revised in February 2012. These latest changes are intended to take effect no later than July 1, 2012.

The Board of the Insurance Council of Australia is pleased to support this update of the General Insurance Code of Practice.

The Code sets out the way in which consumers can expect their insurer to behave, and the recourse that policyholders have in disputes. The Code is binding on ICA member companies, and breaches are treated seriously. This is natural and desirable, and complements legislated and regulated measures.

The Code is a living document. The most recent improvements build on changes that have been made in previous years. They demonstrate the desire of the ICA's member companies to continually review their performance and conduct, and to raise standards of service for customers across the general insurance industry.

Insurers provide risk protection to Australians and their communities, and thereby play a vital role in supporting the nation's financial security and stability. Several recent revisions stem from the experiences of the 2011 storm season, while others have been developed over the past few years following extensive consultation with consumer groups and the industry.

Please feel free to download the Code at http://www.codeofpractice.com.au.

Mr Rob Scott
President
Insurance Council of Australia
February 14, 2012

CONTENTS

INTRODUCTION

1.1 We are committed to raising standards of service to our customers. This voluntary Code sets out the minimum standards we will uphold in the services we provide to you.

1.2 The 2006 General Insurance Code of Practice remains in effect for all insurance contracts which were covered by that Code and which were entered into before adopting this Code[1]. This Code is an amendment to the 2006 General Insurance Code of Practice.

1.3 But all policies taken out and new claims received by us[2] after we have adopted this Code will be covered by this Code[3].

1.4 This Code covers all general insurance products except workers compensation, marine insurance[4], medical indemnity insurance[5], and compulsory third party insurance including where there is linked driver protection cover[6]. It does not cover reinsurance.

1.5 This Code does not apply to life and health insurance products issued by:
a) life insurers; or
b) registered health insurers.

1.6 Under a co-insurance arrangement, if one or more of the insurers has not adopted this Code, then that policy is not covered by this Code.

1.7 Members of the Insurance Council of Australia, other industry participants and service providers may adopt this Code[7].

1.8 This Code operates together with the many laws governing the financial integrity and conduct of the general insurance industry.

1.9 Where there is any conflict or inconsistency between this Code and any Commonwealth, State or Territory law, that law prevails.

1.10 Where this Code imposes an obligation on us in addition to obligations applying under a law, we will also comply with this Code except where doing so would lead to a breach of a law.

1.11 FOS is responsible for monitoring our compliance with this Code.

1.12 This Code does not provide to you or anyone else any legal entitlement or right of action against us, other than that you may:
a) ask us to address a matter;
b) report your concerns to FOS; and/or
c) access our complaints handling procedures (see section 6).

1.13 If we fail to meet our obligations under this Code the Code Compliance Committee may impose sanctions on us (see section 7).

1.14 An independent party will be appointed by the Insurance Council of Australia to review this Code every three years[8].

1.15 The review will consider whether this Code operates in accordance with its objectives. It will be conducted in consultation with FOS, the Insurance Council of Australia, insurers, consumer and business representatives, and ASIC.

1.16 In addition to the formal review of this Code, the Insurance Council of Australia will consult with FOS, consumer and business representatives, and other stakeholders to develop this Code on an ongoing basis.

1.17 The objectives of this Code are:
a) to promote better, more informed relations between insurers and their customers;
b) to improve consumer confidence in the general insurance industry;
c) to provide better mechanisms for the resolution of complaints and disputes between insurers and their customers; and
d) to commit insurers and the professionals they rely upon to higher standards of customer service.

1.18 The objectives of this Code will be pursued and its provisions applied, having regard to:
a) the requirement of insurers to meet the prudential standards established under the Insurance Act 1973;
b) the fact that insurance contracts and arrangements between customers and insurers are governed by the Insurance Contracts Act 1984, the Corporations Act 2001 and the Australian Securities and Investments Commission Act 2001;
c) the fact that the insurance contract is the governing document of the relationship of the customer and insurer; and
d) the need for effective competition and cost efficiency in the general insurance industry, and flexibility in the development and enhancement of products and services for customers.

1.19 The objectives of this Code will also be pursued and its provisions applied having regard to the

[1] Details of transitional arrangements (including technical matters relating to compliance monitoring, investigation and sanctions applying under the former Code) are available, on request, from Financial Ombudsman Service (FOS).
[2] New claims received by us after we have adopted this Code will be covered by sections 3, 4 and 6 of this Code.
[3] The 1994 General Insurance Code of Practice will continue to apply to all policies of companies in run-off prior to 18 July 2006.
[4] This Code does not cover marine insurance under the Marine Insurance Act 1906. It does cover pleasure craft covered by the Insurance Contracts Act 1984.
[5] This Code does not apply to medical indemnity cover for health care professionals under a contract of insurance within the meaning of the Medical Indemnity (Prudential Supervision and Product Standards) Act 2003.

fact that a contract of insurance is a contract involving the utmost good faith which requires each party to the contract to act towards the other party with the utmost good faith in respect of any matter arising under the contract.

1.20 This Code requires us to be open, fair, and honest in our dealings with customers and commits us to high standards of service when selling insurance, dealing with claims, responding to catastrophes and disasters and handling complaints.

1.21 You should carefully consider whether the insurance product you are buying suits your individual circumstances and needs and ensure that you meet your obligations under your insurance policy.

1.22 Definitions are included at the end of this Code.

[6] Ask us if your policy is covered under this Code.
[7] A register of all those who have agreed to adopt this Code is available from FOS.
[8] Subsequent reviews will be arranged three years after the implementation of the initial review. In October 2009 a review was conducted by an independent reviewer, Mr. Robert Cornall AO

2. BUYING INSURANCE

2.1 The following standards apply to the initial enquiry and buying of insurance and renewal of cover.

1. We will only ask for and take into account relevant information when assessing your application for insurance cover.
2. You will have access to information about you that we have relied on in assessing your application and an opportunity to correct any mistakes or inaccuracies. In special circumstances[9], we may decline to release information but we will not do so unreasonably. In these circumstances, we will give you reasons and you will have the right to request us to review our decision through our complaints handling procedures. We will provide our reasons in writing upon request.
3. Where an error or mistake in assessing your application for cover is identified, we will immediately initiate action to correct it.
4. Our sales process will be conducted in a fair, honest and transparent manner.
5. If we cannot provide you with insurance cover, we will:
   a) give you reasons;
   b) refer you to another insurer, Insurance Council of Australia or NIBA for information about alternative insurance options (unless you already have someone acting on your behalf); and
   c) if you are unhappy with our decision, make available information about our complaints handling procedures.

2.2 You may (if your policy permits) cancel your policy. If you cancel your policy, any money we owe you will be sent to you within 15 business days[10].

2.3 Information about our products and this Code will be available when you buy insurance as well as on request.

STANDARDS FOR OUR EMPLOYEES AND OUR AUTHORISED REPRESENTATIVES WHEN SELLING OUR PRODUCTS

2.4 The following standards apply to the selling of our products by our employees and Authorised Representatives.

1. Our employees and our Authorised Representatives will conduct their services in an honest, efficient, fair and transparent manner.
2. Our Authorised Representatives will notify us of any complaint they receive against them while they are acting on our behalf.
3. Our Authorised Representatives will inform you of the service they have been asked to provide and the identity of the insurer for whom they are acting.
4. Our employees and our Authorised Representatives will not perform functions which do not match their expertise.
5. Our employees and our Authorised Representatives will receive adequate training to carry out their sales tasks and functions competently.
6. Training of our employees and Authorised Representative will include:
   a) principles of general insurance and any relevant consumer protection law;
   b) product knowledge; and
   c) the requirements of this Code.
7. We or our Authorised Representatives will keep records relating to such training for at least five years and on request shall make those records available for examination by FOS.
8. We will:
   a) measure the effectiveness of training by monitoring the performance of our Authorised Representatives and our employees; and
   b) require additional or remedial training to address any identified deficiencies.
9. We will handle complaints relating to our Authorised Representatives under our complaints handling procedures, when they are acting on our behalf.

AUSTRALIAN FINANCIAL SERVICES LICENSEES ACTING ON OUR BEHALF

2.5 We may contract with other persons who are not our Authorised Representatives but who are licensed by ASIC to sell insurance products. These may include insurance brokers, banks, or credit unions. If they do not comply with this Code when selling our products on our behalf you can:
   a) ask us to address the matter; and
   b) report your concerns to FOS.

[9] Such as where information is subject to privacy laws, where information is protected from disclosure by law, or where the release of the information may be prejudicial to us in relation to a dispute about your insurance cover.
[10] In cases where you buy insurance through an insurance broker, different arrangements will apply. Ask your broker what arrangements apply to you.

3. INSURANCE CLAIMS

3.1 Within 10 business days of receipt of your claim, we will decide to accept or deny your claim and notify you of our decision, if we have received all necessary information at the time your claim is lodged and no further assessment or investigation is required.

3.2 The following standards apply to all claims where further information, assessment or investigation is required.

1. Within 10 business days of receiving your claim, we will:
   a) notify you of the detailed information we require to make a decision on your claim;
   b) if necessary, appoint a loss assessor/loss adjuster; and
   c) provide an initial estimate of the time required to make a decision on your claim.

2. If we decide to appoint a loss assessor/loss adjuster and/or investigator, we will notify you within 5 business days of appointing them.

3. We will keep you informed of the progress of your claim, at least every 20 business days.

4. We will respond to your routine requests for information within 10 business days.

5. When we have all necessary information and have completed all investigation that was required to assess your claim, we will decide to accept or reject your claim and notify you of our decision within 10 business days.

3.3 If these time frames are not practical due, for example, to the complex nature of your claim we will agree reasonable alternative time frames with you. If we cannot reach an agreement you can access our complaints handling procedures.

3.4 The following standards apply to specified classes of policies.

1. Unless exceptional circumstances apply, where a claim is made under such a policy and further information, assessment or investigation is required:
   a) we will make a decision to accept or deny your claim within 4 months of receipt of your claim; and
   b) if we do not make a decision, we will inform you in writing of your right to:
      i. access to our internal dispute resolution process, and
      ii. take any complaint in relation to the handling of your claim to an external dispute resolution scheme, if you so choose.

2. Where exceptional circumstances apply under 3.4.1 we will make a decision to accept or deny your claim within 12 months.

3. If you ask us whether such a policy provides cover for a loss you have suffered, we will:
   a) ask you whether you would like to lodge a claim,
   b) explain that if you do, the question of coverage will be fully assessed, and
   c) not discourage you from lodging a claim even if we are of the view that it is unlikely to be accepted.

4. Where we engage an external expert to provide a report which is necessary to assess your claim, we will instruct them to provide their final report to us within 12 weeks. If the external expert fails to provide a final report within this period, we will inform you of this and keep you informed of progress in obtaining the report.

3.5 The following standards apply to all claims.

1. We will conduct claims handling in a fair, transparent and timely manner.

2. We will only ask for and take into account relevant information when deciding on your claim.

3. You will have access to information about you which we have relied on in assessing your claim and an opportunity to correct any mistakes or inaccuracies. In special circumstances[11] or where a claim is being or has been investigated, we may decline to release information and reports but we will not do so unreasonably. In these circumstances, we will give you reasons and you will have the right to request a review of our decision through our complaints handling procedures. We will provide our reasons in writing upon request.

[11] Such as where information is subject to privacy laws, where information is protected from disclosure by law, or where (except in the case of external expert reports) the release of the information may be prejudicial to us in relation to a dispute about your claim.

4. Where an error or mistake in dealing with your claim is identified, we will immediately initiate action to correct it.

5. If we deny your claim, we will:
   a) provide written reasons for our decision to deny your claim;
   b) inform you of your right to:
      i. ask for copies of information about you that we rely upon in assessing your claim and
      ii. request a review under 3.5.3 of any decision we take to decline to release such information;
   c) provide information about our complaints handling procedures; and
   d) on request, other than in the circumstances referred to in 3.5.3 above, provide copies of reports from our service providers and external experts which we have relied on in assessing your claim. The copies of external experts' reports will be sent to you within 10 business days of your request to us.

3.6 The standards of section 3 of this Code do not apply if you or another person who may be entitled to benefits under your policy have commenced any proceedings in any court, tribunal or under any other dispute handling process (other than FOS) in respect of your claim.

STANDARDS FOR OUR EMPLOYEES AND SERVICE PROVIDERS FOR CLAIMS HANDLING

3.7 The following standards apply to the handling of claims by our employees and service providers.

1. Our employees and our service providers will conduct their services in an honest, efficient, fair and transparent manner; and

2. Our service providers will notify us of any complaint they receive against them when acting on our behalf.

3. Our service providers will inform you of the services they have been asked to provide and the identity of the Insurer for whom they are acting.

4. Our employees or our service providers will not perform functions that do not match their expertise.

5. Our employees and our service providers will have and maintain:
   a) a current licence if required under legislation; and
   b) membership of a relevant professional body or sufficient expertise.

6. Our employees will receive adequate training to carry out their claims handling tasks and functions competently and to deal with customers professionally.

7. Training of our employees will include:
   a) principles of general insurance and any relevant consumer protection law;
   b) what to do in the event of a claim;
   c) product knowledge;
   d) understanding the consumer situation, particularly in the aftermath of a catastrophe or disaster; and
   e) the requirements of this Code.

8. We will keep our employees' training records for at least five years and on request shall make those records available for examination by FOS.

9. We will:
   a) measure the effectiveness of training by monitoring the performance of our employees; and
   b) require additional or remedial training to address any identified deficiencies.

10. Our service providers will obtain our approval before subcontracting their services.

11. We will handle complaints relating to or received by our service providers under our complaints handling procedures, when they are acting on our behalf.

FINANCIAL HARDSHIP (YOU)

3.8 Where you demonstrate to us that you are in urgent financial need of the benefits you are entitled to under your policy as a result of the event causing the claim, we will:
   a) fast-track the assessment and decision process of your claim; and/or
   b) make an advance payment to assist in alleviating your immediate hardship within 5 business days of you demonstrating your urgent financial need.

3.9 We will notify any financial institution that you have told us has an interest in your insurance policy.

3.10 If you are unhappy with our decision, we will inform you of our complaints handling procedures.

FINANCIAL HARDSHIP (THIRD PARTIES RECOVERIES)

3.11 We and our service providers will comply with the ACCC & ASIC Debt Collection Guideline: for Collectors and Creditors[12], which require us to act fairly and in a considerate manner.

3.12 If a person is experiencing difficulty repaying a debt due to illness, unemployment or other reasonable cause, we will work with that person, if he or she cooperates with us, and consider one of the following options:

a) extending the period of repayment and reducing the amount of each payment due accordingly;
b) postponing payments for an agreed period; or
c) extending the period of repayment and postponing payments for an agreed period.

3.13 If we are unable to reach agreement with a person referred to in clause 3.12 about the repayment of their debt, we will provide information to them about:

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

REPAIR WORKMANSHIP AND MATERIALS

3.14 Where we have selected and directly authorised a repairer, we will:

a) accept responsibility for the quality of workmanship and materials;
b) handle any complaint about the quality or timeliness of the work or conduct of the repairer as part of our complaints handling process.

[12] For further information contact ACCC at www.accc.gov.au or ASIC on 1300 300 630 or infoline@asic.gov.au

4. RESPONDING TO CATASTROPHES AND DISASTERS

4.1. This section applies to catastrophes and disasters resulting in a large number of claims.

4.2. We will respond to catastrophes and disasters in a fast, professional and practical way and in a compassionate manner.

4.3. If you have a property claim resulting from a catastrophe or disaster and we have finalised your claim within one month of the catastrophe or disaster, you can request a review of your claim if you think the assessment of your loss was not complete or accurate, even though you may have signed a release. We will give you six months from the finalisation of your claim to ask for a review of your claim. We will inform you of:

a) this entitlement when we finalise your claim; and
b) our complaints handling procedures.

4.4. We will co-operate and work with the Insurance Council of Australia in its role of industry coordination and communications under the Insurance Council of Australia's catastrophe coordination arrangements.

5. INFORMATION AND EDUCATION

5.1. We will support industry initiatives aimed at explaining general insurance to consumers and the community.

5.2. We will, either directly or through the Insurance Council of Australia, make readily available to our customers:

a) up-to-date information on general insurance;
b) information to assist home and motor insurance customers to determine the level of insurance cover they require;
c) information about the key factors that affect premiums; and
d) information about this Code and its operation.

5.3. The Insurance Council of Australia will promote this Code and make copies widely available.

5.4. We will provide clear and accessible information in our product information and on our website including information about our claims process, the Code and how we deal with complaints (including your right to take your dispute to our external dispute resolution scheme).

6. COMPLAINTS HANDLING PROCEDURES

6.1. The following standards apply to all complaints handling.

1. We will conduct complaints handling in a fair, transparent and timely manner.
2. We will make available information about our complaints handling procedures.
3. We will only ask for and take into account relevant information when deciding on your complaint.
4. You will have access to information about you that we have relied on in assessing your complaint and an opportunity to correct any mistakes or inaccuracies. In special circumstances[13] or where a claim is being or has been investigated, we may decline to release information but we will not do so unreasonably. In these circumstances, we will give you reasons. We will provide our reasons in writing upon request.
5. Where an error or mistake in handling your complaint is identified, we will immediately initiate action to correct it.

INTERNAL DISPUTE RESOLUTION - COMPLAINTS

6.2. We will respond to complaints within 15 business days provided we have all necessary information and have completed any investigation required.

6.3. In cases where further information, assessment or investigation is required we will agree reasonable alternative time frames. If we cannot agree, we will treat your complaint as a dispute and we will provide information on how you can have your complaint reviewed by a different employee who has appropriate experience, knowledge and authority.

6.4. We will keep you informed of the progress of our response to the complaint.

6.5. When we notify you of our response, we will provide information on how our response can be reviewed by a different employee who has appropriate experience, knowledge and authority.

INTERNAL DISPUTE RESOLUTION - DISPUTES

6.6. If you tell us you want our response reviewed, we will:

a. treat it as a dispute;
b. notify you of the name and contact details of the employee assigned to liaise with you in relation to the dispute; and
c. respond to the dispute within 15 business days provided we receive all necessary information and have completed any investigation required.

6.7. In cases where further information, assessment or investigation is required we will agree reasonable alternative time frames. If we cannot reach agreement you can report your concerns to FOS.

6.8. We will keep you informed of the progress of our review of your dispute at least every 10 business days.

6.9. We will respond to your dispute in writing giving:

a) reasons for our decision;
b) information about how to access available external dispute resolution schemes[14]; and
c) notify you of the time frame within which you must register your dispute with the external dispute resolution scheme.

EXTERNAL DISPUTE RESOLUTION

6.10. If we are not able to resolve your complaint to your satisfaction within 45 days (including both the complaint and internal dispute resolution process referred in this section of the Code), we will inform you of the reasons for the delay and that you may take the complaint or dispute to our external dispute resolution scheme even if we are still considering it (and provided the complaint or dispute is within the scheme's Terms of Reference). We will inform you that you have this right and details of our external dispute resolution scheme before the end of the 45-day period.

6.11. Insurers subscribe to the independent external dispute resolution scheme administered by FOS[15].

6.12. FOS is available to customers and third parties who fall within the Terms of Reference of FOS[16].

6.13. External dispute resolution determinations made by FOS are binding upon us in accordance with the Terms of Reference.

6.14. Where FOS Terms of Reference do not extend to you or your dispute, we will advise you to seek independent legal advice or give you information about other external dispute resolution options (if any)[17] that may be available to you.

[13] Such as where information is subject to privacy laws, where information is protected from disclosure by law, or where the release of the information may be prejudicial to us in relation to your complaint.
[14] For example, certain State and Territory Governments provide for the resolution of builders home warranty disputes through their consumer tribunals.
[15] If we are not an insurer, we will subscribe to FOS or an alternative external dispute resolution scheme.
[16] For further information on the external dispute resolution scheme, contact FOS.
[17] For example, certain State and Territory Governments provide for the resolution of builders home warranty disputes through their consumer tribunals.

7. CODE MONITORING AND ENFORCEMENT

REPORTING AN ALLEGED CODE BREACH

7.1. Alleged breaches of this Code can be reported to:

Financial Ombudsman Service Limited
GPO Box 3
Melbourne VIC 3001
1300 78 08 08 (National Toll Free)
Tel: (03) 9613 6300
Fax: (03) 9613 6390

OUR RESPONSIBILITY

7.2. We will:
- a) have appropriate systems and processes in place to enable FOS and us to monitor compliance with this Code;
- b) prepare an annual report to FOS on our compliance with this Code; and
- c) have a governance process in place to report on our compliance with this Code to our Board of Directors or Executive Management.

7.3. If we identify a significant breach of this Code we will report it to FOS within 10 business days.

7.4. We will be in breach of this Code if our employees, our Authorised Representatives, or our service providers fail to comply with this Code when acting on our behalf.

7.5. We will cooperate with FOS in its:
- a) review of our compliance with this Code; and
- b) investigations of an alleged Code breach.

7.6. We will apply corrective measures within set time frames, as agreed with FOS, in response to a Code breach.

FOS RESPONSIBILITY

7.7. FOS will monitor and report on our Code compliance.

7.8. FOS will prepare annual public reports containing aggregate industry data and consolidated analysis on Code compliance.

7.9. FOS will regularly supply, subject to privacy law, the Code Compliance Committee aggregated breach data on a quarterly basis to enable the Code Compliance Committee to better monitor compliance with the Code and to identify serious or systemic issues with regard to the Code or its application.

7.10. FOS, at its own discretion, will determine how or if it proceeds with any action based on any report it receives from the Code Compliance Committee pursuant to clause 7.16.

7.11. FOS will:
- a) receive allegations about breaches of this Code;
- b) investigate all alleged breaches[18];
- c) provide the opportunity for us to respond to alleged breaches;
- d) determine whether a breach has occurred;
- e) agree with us our corrective action and time frames, and monitor completion;
- f) determine if corrective measures have been implemented by us within the agreed time frame; and
- g) report any failure to correct the breach to the Code Compliance Committee within 10 business days of the expiry of the agreed time frame.

7.12. FOS will report to the Code Compliance Committee on:
- a) significant breach of this Code including our agreed corrective action;
- b) on the outcomes of FOS Code compliance monitoring reviews; and
- c) any incidents where we are unable to reach agreement with FOS regarding corrective action.

CODE COMPLIANCE COMMITTEE RESPONSIBILITY

7.13. The Code Compliance Committee is an independent committee consisting of:
- a) a consumer representative to be appointed by FOS Board;
- b) an industry representative appointed by the Insurance Council of Australia; and
- c) an independent Chair jointly appointed by FOS Board and the Insurance Council of Australia.

7.14. The Code Compliance Committee:
- a) monitors Code compliance through reports received from FOS; and
- b) makes determinations and imposes sanctions where FOS has reported a failure by us to correct a Code breach.

[18] FOS may decide not to investigate alleged breaches which occurred more than 12 months ago.

7.15. The Code Compliance Committee can conduct its own enquiries or request FOS to conduct further enquiries on its behalf.

7.16. The Code Compliance Committee will report, subject to privacy law, to FOS any findings or determinations it makes with respect to any data provided to it by FOS pursuant to clause 7.9.

7.17. Where FOS has reported a failure by us to correct a Code breach, the Code Compliance Committee may dismiss FOS findings[19] or request FOS to reconsider following further consultation with us.

7.18. If the Code Compliance Committee accepts FOS findings, it will:

a) notify our Chief Executive Officer in writing of the detailed findings; and
b) provide an opportunity for us to respond within 15 business days.

7.19. The Code Compliance Committee will consider any response by us before making a final determination and imposing sanctions.

7.20. The Code Compliance Committee will notify in writing our Chief Executive Officer of its decision and any sanctions to be imposed.

7.21. When determining any sanctions to be imposed, the Code Compliance Committee will consider:

a) the objectives of this Code;
b) the appropriateness of the sanction;
c) the significance of the breach; and
d) our role in the general insurance industry.

SANCTIONS

7.22. The Code Compliance Committee may impose one or more of the following sanctions:

a) a requirement that particular rectification steps be taken by us within a specified time frame;
b) a requirement that a compliance audit be undertaken;
c) corrective advertising; and/or
d) publication of our non-compliance.

7.23. Code Compliance Committee decisions are binding on us.

[19] The Code Compliance Committee may make a determination that no breach has occurred or that appropriate corrective action has been implemented by us.

DEFINITIONS

“ACCC” is the Australian Competition and Consumer Commission.

“ASIC” is the Australian Securities and Investments Commission.

“Australian financial services licensee” is licensed by ASIC to provide financial services (refer to section (s761A) of the Corporations Act).

“Authorised Representative” is an individual or company who is not our employee but is authorised by us to provide financial services under our Australian Financial Services licence.

“business days” are Monday to Friday, except public holidays.

“catastrophe or disaster” means natural events like fires, flooding, earthquakes, cyclones, severe storms and hail resulting in a large number of claims.

“claims management service” is an individual or company who is not our employee but is contracted by us to manage your claim on our behalf.

“collection agent” is an individual or company who is not our employee but is contracted by us to recover monies owing to us.

"complaint" means an expression of dissatisfaction made to us related to our products or services or to our complaints handling process where a response or resolution is explicitly or implicitly expected.

"dispute" means an unresolved complaint.

“exceptional circumstance” means:
a) the claim arises from an extraordinary catastrophe or disaster as declared by the Board of the Insurance Council of Australia;
b) the claim is fraudulent or we suspect fraud;
c) there is a failure by you to respond to our reasonable inquiries or requests for documents or information concerning your claim;
d) there are difficulties in communicating with you in relation to the claim due to circumstances beyond our control; or
e) you request a delay in the claims process.

"external expert" is an individual or company who is not our employee but who is engaged by us solely to provide an expert opinion as to the likely cause of your loss or damage but does not include a service provider.

“FOS” is the Financial Ombudsman Service Limited and is responsible for monitoring compliance with this Code and operating the external disputes resolution scheme to assist consumers.

"in writing" means a communication to you conveyed in person; electronically, such as by email or facsimile; or by mail sent to your postal address.

“Insurance Council of Australia” is the national representative body for the general insurance industry in Australia.

“investigator” is an individual or company who is not our employee but is contracted by us to verify the circumstances relating to your claim.

“loss assessor” or ”loss adjuster” is an individual or company who is not our employee but is contracted by us to examine the circumstances of your claim, assess the damage or loss, determine whether your claim is covered under your policy, may assist in obtaining repair/replacement quotes and help settle the claim.

“service provider” is an investigator, loss assessor/loss adjuster, collection agent, claims management service (including a broker who manages claims for an insurer) or its approved sub-contractors.

“specified class of policies” means any of the following types of policies:
a) motor vehicle
b) home building
c) home contents
d) sickness and accident
e) consumer credit; or
f) travel.

“significant breach” is a breach that is determined to be significant by reference to:
a) similar previous breaches;
b) the adequacy of our arrangements to ensure compliance with this Code;
c) the extent of any consumer detriment; and
d) the duration of the breach.

“third party recoveries” means action taken by us to recover monies owing to us for damage or loss to our customer caused by another individual or company.

“we”, “us” and “our” is the organisation that has adopted this Code.

“you” and “your” is the customer, an individual or business (or someone appointed or authorised to act on your behalf) seeking or holding an insurance policy.

INSURANCE COUNCIL OF AUSTRALIA

Level 4, 56 Pitt Street, Sydney NSW 2000 t 02 9253 5100 f 02 9253 5111
www.insurancecouncil.com.au