FSC Standard No. 28

Claims Handling for Superannuation Funds

30 November 2022

FSC FINANCIAL SERVICES COUNCIL

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FSC Membership this Standard is most relevant to:	This Standard is relevant to FSC superannuation Members that provide claims handling services for life insurance products covered by the FSC Life Code of Practice.
Date of this version (and commencement):	This Standard will commence on 1 January 2023 on a voluntary compliance basis. Full compliance with this Standard from 1 July 2023 is mandatory.
Main Purposes of this Standard:	The purpose of this Standard is to implement mandatory standards for claims handling by superannuation trustees.

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1. Introduction

1.1 This Standard may be cited as FSC Standard No 28: Claims Handling for Superannuation Funds.

1.2 This Standard was issued on 1 January 2023.

1.3 Effective Date: this Standard commences operation on 1 January 2023 on a voluntary compliance basis. Full compliance with this Standard from 1 July 2023 is mandatory. Earlier compliance with this Standard is nonetheless permitted and encouraged. The provisions contained in the "Implementation Guidance" highlighted sections are not intended to constitute mandatory requirements but seek to assist with interpretation in implementing this Standard.

1.4 Application General Principle: this Standard applies to FSC superannuation members who are trustees (relevant licensees) holding a public offer or extended public offer licence (relevant licence) to operate a Registrable Superannuation Entity under the provisions of the Superannuation Industry (Supervision) Act 1993.

1.5 Complying with a relevant FSC standard is mandatory as a minimum standard. Trustees may choose to implement processes and standards that further improve customer outcomes.

1.6 This Standard seeks to avoid duplicating or repeating any relevant legislation. However, it should be remembered that there may be additional standards set by regulatory instruments relevant to claims handling, such as those for RSE licensees in the provision of 'superannuation as a trustee service'[1]. Where they may overlap, or be inconsistent with, this Standard the legislation or regulatory instrument will of course prevail.

1.7 This Standard also does not attempt to prescribe how obligations imposed by legislation or regulatory instrument work in practice. For example, the 'superannuation as a trustee service' licensing obligations require the service to be provided honestly, fairly and efficiently, however, while this Standard requires certain practices which may support these obligations it does not attempt to align or link practices to specific obligations.

1.8 Significant parts of the Insurance in Superannuation Voluntary Code of Practice (the **Code**) were largely implemented as legislative reform and regulatory changes. For this reason, the Code owners (Australian Institute of Superannuation Trustees (**AIST**), Association of Superannuation Funds of Australia (**ASFA**) and the FSC) agreed in 2021 to maintain and strengthen only those sections of the Code relating to vulnerable customers and claims handling as these were not affected by legislative reform and regulatory changes. This was done through FSC Guidance Note 42 (Claims Handling Standards for Superannuation Funds) and FSC Guidance Note 41 (Developing a Vulnerable Member Policy). This Standard has been implemented to replace FSC Guidance Note 42.

[1] See also ASIC Information Sheet INFO 253 *Claims handling and settling: how to comply with your AFS licence obligations.*

2. Claims handling

2.1 Principles for claims handling

2.1.1 Claim time can be difficult for **members**[2] and each situation is unique. Trustees will treat every claimant with empathy, compassion and respect.

2.1.2 Trustees will ensure that the claims process is timely, made as straightforward as possible and all communications are written in plain language to the extent practicable.

2.1.3 Trustees will ensure requests for information or assessments it needs are made as early as possible and multiple information requests or assessments are minimised where possible.

2.1.4 Trustees will ensure that members are helped to identify any cover held within the fund under which a member may be entitled to claim. Trustees will not discourage members from making a claim.

2.1.5 Trustees will oversee the claims process, and help members navigate through it[3].

2.1.6 Trustees are responsible for overseeing the conduct of the life insurer and any **Service Provider** engaged in the claims process. The trustee will proactively engage with other parties in the claims process to minimise delays and remove unnecessary duplication from the process.

2.1.7 Trustees will ensure that there are appropriate governance arrangements put in place for claims handling by the trustee and its delegates.

2.1.8 Trustees will publish their insurers' claims philosophy on the fund website, and assess the claims philosophies of their life insurers to ensure they align with the trustees' expectations[4].

2.1.9 The trustee may delegate any claims assessment function to its life insurer in agreement with the life insurer. However, the trustee must remain independent from the life insurer's claim assessment and decision.

2.1.10 If the life insurer is assessing the claim then where possible, the life insurer and the member should be able to communicate with each other directly.

2.1.11 This Standard contains timeframes which the trustee will ensure are met, unless **Exceptional Circumstances** apply. If **Exceptional Circumstances** apply, see clause 2.5.9.

2.2 The claims process

2.2.1 The claims process incorporates a number of steps, and there are roles for trustees, and for the life insurer. The member may need to provide relevant documents and attend assessments.

2.2.2 The **Life Code** places responsibilities on life insurers to determine claims within specific timeframes. Trustees will work together with life insurers to ensure a consistent and efficient process for members.

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[2] Note the definition of "member" includes other persons e.g. a representative and Third Party Beneficiary (also defined)– see Definitions in Section 3. For ease of reading subsequent references to "member" do not appear in bold text.

[3] Trustees should also consult the FSC Guidance Note "DEVELOPING A VULNERABLE MEMBER POLICY" if the member is a vulnerable customer. This Guidance Note was jointly developed by AIST, ASFA and the FSC to provide guidance on dealing with vulnerable customers. It is relevant to all FSC superannuation members.

[4] APRA's SPG 250 *Insurance in Superannuation* requires an RSE licensee to give due consideration to claims philosophy when selecting an insurer. In APRA's view, an insurer's claims philosophy reflects the insurer's ability and willingness to assess and pay legitimate claims expeditiously. See SPG 250 page 17.

2.2.3 Trustees will ensure that members are provided with the contact details for the primary contact person(s) during the claim process and specify whether this person(s) is working for the life insurer, the trustee or the fund administrator.

2.2.4 Trustees may arrange independent medical reviews or an interview with the member, or ask for certain information from a member. If so, they will have regard to the relevant standards in the **Life Code**[5].

2.3 Making a claim

2.3.1 If a member tells the trustee that they wish to make a claim, the trustee will ensure that the member is helped to provide the information for the claim. To do this, the trustee may direct the member to the appropriate forms or information online, or email these to the member by the next business day. The trustee should also ask some high-level questions relating to eligibility to assess whether the member has (or had) insurance cover at the relevant time.

If hard copy forms are required, the trustee will ensure that these are sent within **5 business days**.

If the trustee offers a service to collect claim information over the telephone, and the member asks to use this service, the trustee will offer the member a telephone appointment to take place within **5 business days** for the member to provide details about their claim**.**

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At a minimum, it is intended that the trustee will give someone enquiring about a claim some generic information or forms by the next business day. However, trustees should also 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 filling out forms etc.

2.3.2 On receipt of a completed claim[6] from the member, or a completed telephone interview, within **10 business days** a trustee will ensure that:

a) receipt of the claim is acknowledged;

b) an assessment is made, either manually or digitally, of whether the member has provided all of the necessary information and/or documentation;

c) an initial eligibility assessment is carried out to assess whether the member has insurance cover, based on the information available if this did not occur before issuing forms;

d) the member is provided with a summary of the claim process (if this has not already been provided to the member when first enquiring about making a claim), which will include the information set out in clause 2.3.4 below;

e) either the claim is provided to the life insurer, or the member is told they are not eligible to make a claim based on the information available and they are given an explanation why not.

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[5] See Life Code Chapter 5 *Claims* and Clauses 5.18 to 5.44. Note that as a general matter the Life Code contains minimum standards for insurers. However, trustees and insurers may enter into service level agreements containing higher standards.

[6] A completed claim requires lodgement of claim forms with the trustee or insurer, or provision of requested claim information via telephone.

IMPLEMENTATION GUIDANCE

The commitment referred to above is that the "trustee will ensure that", which is to build in some flexibility as to whether it is the trustee itself, the life insurer or a third party delegate that in fact carries out a relevant step.

If a member makes a claim directly with the life insurer rather than to the trustee, the **Life Code** will apply with regards to how the life insurer acknowledges the claim and takes it forward, including any relevant timeframes that apply to the life insurer. The life insurer may re-direct the claim to the trustee if the trustee holds the member specific information concerning initial eligibility.

A trustee's arrangements with a life insurer should include details about how a trustee and life insurer will share responsibilities for claims.

2.3.3 If a claim is made via telephone, the trustee will ensure that a written record or call recording is kept and sent to the member on request.

2.3.4 The summary of the claim process referred to at clause 2.3.2 above will include:

a) an explanation of the terms of cover, including any waiting periods, relevant benefits and the policy's standard exclusions and limitations;

IMPLEMENTATION GUIDANCE

Regarding the explanation of the terms of cover, this may be limited based on the fact that the life insurer will develop the full impact of the terms on the member's claim. Trustees will need to take care to avoid inadvertently providing an explanation that confuses the member and should coordinate with the life insurer as appropriate. The trustee and the life insurer should take care to avoid providing a member with conflicting or inconsistent information. For example, some group policies may have different definitions and terms that apply at different times and it is important that either the trustee or the life insurer determine which terms and definitions apply to the particular claim and communicate that information to the member in a consistent manner.

If the trustee is not aware of the event date, it should use its best efforts to provide the relevant policy terms based on an assumed event date. If it later transpires that the event date is different from the date assumed and accordingly different policy terms apply, or a different life insurer is to be used or there's no cover at all, this should be communicated to the member.

Simply providing the member with the policy schedule obtained from the life insurer is unlikely to give the member an explanation that they can easily understand.

As mentioned above, the Life Code contains separate provisions which regulate how a life insurer must respond to a claim.

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 **Life Code** or other agreed service standards with the life insurer and the trustee's review of the life insurer's decision;

c) the trustee's role and duties and the life insurer's role and duties;

d) who will be the member's primary contact and the contact details the member can use to get information about the progress of their claim. If the primary contact is not yet known, then the contact details of the claims team;

e) whether the member 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 the member 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 the trustee will review the life insurer's decision.

2.3.5 If the trustee determines during the claim lodgement process that the member is not eligible to make a claim, the trustee will ensure that:

a) the reason why the member is ineligible to make a claim is explained in writing to the member;

b) the member is given the opportunity to provide more information so that the trustee can review the member's eligibility;

c) the member is told that if the member is not satisfied with its decision, the member can make a complaint[7];

d) the member is provided with details of the complaints process.

2.4 While a claim is being assessed

2.4.1 If a member has a query about their claim while it is being assessed, the trustee will ensure that:

a) an acknowledgment is provided by the **next business day**;

b) a response to a member's requests for information is provided within **10 business days**.

2.4.2 The trustee will ensure that a member receives progress updates at least every **20 business days** until a claim decision is made (unless a different timetable is agreed with the member) or earlier if something of significance to the claim occurs. The trustee will communicate proactively with members if circumstances change. The trustee will note the member's preference regarding the method of communication and try to tailor their approach where practicable, however in some circumstances alternative methods may be required. If there are any matters delaying assessment of the claim, the trustee will ensure that the member is informed of these.

IMPLEMENTATION GUIDANCE

The principle here is that the updates ought to be 'pushed not pulled' – they should be proactive, rather than member-initiated. It would not be sufficient if the trustee simply allowed the member to log into a website or app for an update, nor if the trustee contacted the member every 20 business days to let them know they could log in for information.

However, if a member tells the trustee that they want their updates to be delivered differently – for example, they only want to be notified when there is an update online – then the trustee should contact them in accordance with their communication preference.

For death claims where there is a sum insured, it is expected that all potential beneficiaries of whom the trustee is aware will receive regular updates.

[7] See also Life Code Chapter 7 *Complaints* Clauses 7.16 to 7.19 *Superannuation fund trustees will respond to other Complaints.*

2.4.3 The trustee will ensure that the progress of the claim is overseen to minimise delays and intervene if it becomes aware that the life insurer fails to comply with the timeframes provided in the **Life Code.**

2.4.4 If the life insurer tells the trustee that it cannot make a decision on a member's claim in the timeframes provided in the **Life Code**, the trustee will update the member regarding the information that the life insurer has told the trustee including the life insurer's rationale, unless the life insurer has already done this or agreed to do so. Where a timeframe cannot be met, the **Life Code** contains provisions that require the member to be informed and kept updated and these will apply in various circumstances. For example, if the member's medical condition (where relevant) has not yet stabilised to allow a decision to be made, the member would be informed that the claim will be considered further when more information is available and whether the member is required to provide any further information to allow a decision to be made.

2.4.5 If the trustee becomes aware of any errors or mistakes in the claim or in the information requested, the trustee will ensure that these are addressed promptly. The trustee may request more information to correct errors or mistakes.

2.5 Review of life insurer's decision

2.5.1 Once the life insurer has made its decision about the member's claim, if the life insurer informs the trustee that it intends to make a payment to the trustee, the trustee will carry out a review within **5 business days** to assess whether the member has met the requirements for the funds to be released from their superannuation account. The trustee will ensure that there are oversight processes in place to confirm that the life insurer is paying the correct amount, either to the trustee or directly to the member.

2.5.2 If the trustee identifies as part of its review that there are differences between the requirements for the member's insurance claim to be paid and the legal requirements for the release of funds from their superannuation account, as soon as the trustee becomes aware of this they will ensure that the differences are explained to the member in plain language and that, while the amount will be credited to the member's account, they will not be able to access it until they have satisfied a condition of release.

2.5.3 If the life insurer informs the trustee that it has decided not to pay the claim, or to cease payments, the trustee will carry out a review (using properly trained and qualified staff) within **15 business days** of receiving notification from the life insurer.

2.5.4 As part of its review, the trustee will determine whether the life insurer has provided the member with the below, and ensure that the member is provided with any of the below if they have not yet been provided to the member:

a) a **Procedural Fairness letter** has been provided to the member, where the insurer has formed a preliminary view to decline a claim, where a subjective definition applies;

b) a written explanation of the life insurer's reasons for not paying the claim (and the trustee should also provide its own reasons, if different) and summary of the information about the claim that was relied on;

c) where a pre-existing condition is the reason for declining the claim, a written explanation of the medical connection between the pre-existing condition and the claim;

d) written confirmation that the member can ask for copies of the documents about the claim that the life insurer relied on;

e) written confirmation that the member can ask the life insurer to review their decision, or give the life insurer additional information to consider;

f) written information about the life insurer's complaints process.

2.5.5 Wherever possible, when the trustee reviews the life insurer's decision the trustee will ensure that information already collected during the claim assessment process is used, rather than asking the member to provide information again, or to attend any further assessments. If the trustee believes there is not enough information to make a properly informed decision, the trustee will ensure that the member is informed of this.

2.5.6 Where the trustee has requested information, it will ensure that only information and assessments that are relevant to the claim and policy are asked for and relied upon. If the member asks the trustee to give an explanation of the relevance of the information or assessment requested, the trustee will provide this within **10 business days**. If the member disagrees with the relevance of any requested information or assessment, the trustee will inform the member about how to make a complaint[8].

2.5.7 If new information or assessments are obtained, or the member makes further representations and submissions or provides further information, the trustee will review the new information or assessment within **15 business days**.

IMPLEMENTATION GUIDANCE

The **15 business day** timeframe is intended to cover only the trustee's review of new information or assessment, not the life insurer's next steps. If, as a result of the trustee's review, the trustee decides to send the claim back to the life insurer, that is dealt with in the following paragraph.

2.5.8 If the review results in the trustee querying the life insurer's decision, the trustee will inform the life insurer within **5 business days** of completing the review. If the trustee believes the claim has a reasonable prospect of success, it will advocate on the member's behalf. The trustee will ensure that the member is kept informed as the claim proceeds.

2.5.9 In **Exceptional Circumstances**, the timeframes for the trustee's review in this Standard may not be appropriate. In these cases, the trustee will ensure that the member is told that the trustee needs more time and the relevant **Exceptional Circumstances** that have caused the delay. The trustee will ensure that the expected timeframes for the trustee review to be completed are clearly communicated. The trustee will provide updates to the member every **20 business days**. The trustee will inform the member about how to make a complaint if they are not satisfied with the revised timeframe.

2.6 Claim decision

2.6.1 If the claim is approved and paid to the trustee by the life insurer, the trustee will ensure that this is confirmed with the member as soon as it has carried out its assessment as to whether the member has met the requirements for the funds to be released from their superannuation account.

Provided that:

a) valid identification, and payment instructions and other necessary documents, have been received from the member;

b) the trustee has confirmed that the legal requirements for release of funds from the member's superannuation account have been satisfied;

c) for death benefit claims, all potential beneficiaries have been contacted where relevant, the claim staking process referred to in section 1056 of the Corporations Act 2001 having been completed and any complaint arising as a result having been resolved;

the trustee will ensure that the claim proceeds are released to the member within **5 business days** of the conditions referred to above being satisfied.

[8] See footnote 7.

2.6.2 If the member's claim is declined, the trustee will ensure that the member is told within **5 business days** of completion of the review of the claim, and also provided with the items set out in clause 2.5.4 above if not already provided.

2.7 Income protection claims

2.7.1 For income protection claims, the trustee should where practicable support the life insurer to:

a) seek to identify ways to support the member's recovery as quickly as possible;

> **IMPLEMENTATION GUIDANCE**
>
> The intent is that trustees should not put impediments in the way of 'return to work' strategies, and should facilitate recovery, where possible, alongside the life insurer – noting that the sole purpose test constrains trustees from getting involved directly in the member's recovery. A trustee may be able to assist being supportive of life insurers in providing back to work, rehabilitation and retraining initiatives to support improved member retirement outcomes.
>
> This section would also be relevant in dealing with adverse decisions including ceasing income protection benefits where the member has not returned to work. For example, if the life insurer has determined the member has a capacity to work but the claimant has not returned to work this would be adverse to the member and should be reviewed by the trustee and the member should be provided the opportunity to challenge the decision as a matter of procedural fairness.

b) collaborate with the member's doctor, other healthcare providers and employer to maximise the health outcomes of the member;

c) promote best-practice rehabilitation and injury management where these are consistent with the terms of the policy.

2.7.2 Where the member is receiving ongoing income protection payments, the trustee should continue to be satisfied that the life insurer is operating in line with its claim philosophy, agreed practices and the **Life Code**. If the member is receiving ongoing Income Protection payments, the trustee should have oversight processes in place to determine whether the information required for ongoing assessment is reasonable. The trustee should also have processes in place to oversee the life insurer's decisions about continuing or stopping income protection payments, and raise any concerns that the trustee may have with the life insurer regarding a decision to stop, or continue, payments.

2.7.3 If the trustee becomes aware during the claims process that the member has cover pursuant to more than one income protection policy, it will ensure that an explanation is provided of how the offsetting arrangements operate. The trustee may advise the member to obtain independent financial advice and provide information to the member on how to obtain it.

2.7.4 If the trustee identifies that any of the member's claim payments are going to be offset or reduced by income he or she is receiving from other sources, including Centrelink and workers' compensation, the trustee will inform the member.

2.8 Refunds

2.8.1 If at claim time the trustee identifies that the member has multiple **automatic insurance covers** in superannuation and the benefit is offset, or not able to be claimed upon and paid out, because the member has claimed on another benefit under another similar policy, the trustee will ensure that the member is given the option of a refund of their premiums for the duration of the overlap of covers, to a maximum of 6 years, and the cover will then be cancelled.

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This does not apply only to income protection 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 member agrees to a refund of premiums, the trustee will cancel the member's cover and no claims will be payable with effect from the cancellation date. This will typically be the date that the overlap of covers commenced. The premium will be refunded for the period from the cancellation date to the date of the last premium payment by the member. 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).

In calculating the duration of the overlap, trustees only need to refund for the period where there is a complete offset of cover. Where a premium refund offer is made, it will be made by the trustee, who will also explain the effect on the claim and the policy (that the claim will cease and the policy will be cancelled). The trustee will also refund the premiums where a refund is accepted and notify the life insurer that the trustee as the policyholder is withdrawing the claim and in agreement with the life insurer, refunding the premiums due to duplicate cover in superannuation.

The trustee must point out to the member that it will not be possible to reverse the decision for any reason at a later date. Such reasons could include the other insurance stopping or reducing its payment rate at a later date. The member should be advised to consider obtaining financial and legal advice.

Regarding clauses 3.8.1 to 3.8.3, trustees may determine their own policies for incorporating any adjustments into the amount to be refunded (i.e. inflation, unit adjustments, interest). It is important to note that a refund in these circumstances is not an error on the trustee's part, so it is not expected that a trustee will return the member to the position they would have been in – i.e. paying foregone investment returns.

2.8.2 If the trustee identifies that the member was not eligible to claim against their **automatic insurance cover** for any event from the start of the cover, the trustee will ensure that premiums are refunded to the member's account for the period they were ineligible.

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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 where the claimant could be eligible for a benefit in some circumstances.

2.8.3 If the member makes a claim that is accepted, and the cover ceases under the terms of the policy on the date the member became eligible to claim, the trustee will ensure that premiums are refunded to the member's superannuation account back to the date they became eligible to claim.

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The 'date they 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.

2.8.4 If the trustee becomes aware of errors in the administration of insurance with cover being in place when it should not be, or where cover was ceased incorrectly, it will resolve these errors with the member and life insurer as quickly as possible and aim to put the member in the position they would have been in had the error not occurred.

2.9 Review

2.9.1. This standard will be reviewed within three years of coming into effect.

3. Definitions

Automatic insurance cover means cover that trustees provide to members for protection against illness or accidents resulting in disability, terminal illness, or death as applicable under the policy terms. Automatic insurance cover is not tailored to individual needs and circumstances.

Members are considered to have automatic insurance cover in circumstances where members elect to take out or maintain the default insurance cover that trustees provide automatically even if the member:

- is under the age of 25 years;
- has a super account balance that is less than $6,000; or
- has an account that has become inactive.

Automatic insurance cover does not apply if:

- no election was made to maintain cover (if required as above) even if premiums were paid
- the member has voluntarily selected the level of cover;
- the member has varied the level of automatic insurance cover;
- the member is a defined benefit member; or
- the insurance premiums are wholly paid for by an employer (whether through contributions to the superannuation account or otherwise) or not paid by deduction from the member's account.

Business days means Monday to Friday excluding public holidays.

Exceptional Circumstances means any of the following:

a) The trustee or the life insurer have not received or had a reasonable time to assess reports, records, evidence or other information the trustee or life insurer reasonably requested from the member, a Service Provider, the member's doctor, a government agency, or another person or entity (but not a reinsurer).
b) The member has not responded to reasonable enquiries or requests for documents in a reasonable timeframe.
c) The trustee or the life insurer have not had a reasonable opportunity to complete their assessment of a claim and make a decision after they issue a Show Cause or Procedural Fairness letter.
d) The trustee or the life insurer have been unable to contact the member about the claim.
e) The member is, or will be, undergoing rehabilitation, retraining or further treatment, which means the trustee or the life insurer are unable to make a final decision about the claim.
f) The member has asked for a delay or extension to part of the claims process.
g) The trustee or the life insurer reasonably suspect there was non-disclosure or misrepresentation or a failure to take reasonable care before the cover or policy started that they believe may impact the claim, and they need further investigation, evidence and/or information.
h) The trustee or the life insurer reasonably suspect that the claim is fraudulent and need further investigation, evidence and/or information.

Life Code means the Financial Services Council's Life Insurance Code of Practice as amended from time to time. The Life Code can be found on the FSC website at Life Code - Financial Services Council (fsc.org.au).

Life Insured means a person insured under an insurance policy covered by this Standard, whether or not they are a party to the policy. A Third Party Beneficiary is not a Life Insured.

member means, as the context may require:

a) the Life Insured
b) a person authorised to act on their behalf, such as a named representative, adviser, parent, guardian or a person with power of attorney, or
c) a Third Party Beneficiary, if relevant.

Procedural Fairness letter means letter where the trustee or life insurer write to a member with their preliminary view on the claim and which gives the member an opportunity to respond before they make a decision.

Service Provider means another party that the trustee engages to provide a service on its behalf; for example, a claims management service or a fund administrator. A life insurer, in its capacity as an insurer, is not a **Service Provider**. A Service Provider does not include a surveillance provider, medical report retrieval provider or other similar service.

Show Cause letter means a letter the trustee or life insurer will send a member before they make a decision to vary or avoid cover, that gives the member an opportunity to respond.

Third Party Beneficiary means a person or entity who is entitled to benefits from a claim but is not a Life Insured or policy owner. This may include someone:

a) an insurance policy covered by the Standard specifies or refers to, by name or otherwise, as someone who may receive the benefit of the insurance, or
b) seeking the benefits of the insurance.