Life Insurance Claims and Disputes Statistics

Explanatory notes

Introduction

This publication reports claims and disputes statistics for Australian authorised life insurance companies. The publication is released on a six-monthly basis and reflects the 12-month period up to the reporting date.

Source of data

This publication is compiled primarily from regulatory returns submitted to APRA under the *Financial Sector (Collection of Data) Act 2001* by authorised life insurance companies. APRA-regulated life companies (including friendly societies) are prudentially supervised under the *Life Insurance Act 1995* (Life Act).

Blank copies of the returns and associated instructions are available on the APRA website.

Basis of preparation

Figures in this publication:

- represent the total Australian operations of Australian authorised life companies;
- reflect insurers' gross exposures, that is, excluding inwards and outwards reinsurance; and
- are presented at a total statutory fund level for life insurers, and a total approved benefit fund level for friendly societies.

Possible cover / channel combinations

The table below highlights which cover type / distribution channel combinations are catered for in LRS 750.0. Those listed as 'not applicable' cannot be submitted through the reporting form, and will therefore never show any data in the Life Insurance Claims and Disputes publication.

Cover type	Individual Advised	Individual Non-Advised	Group Super	Group Ordinary
Death	Yes	Yes	Yes	Yes
TPD	Yes	Yes	Yes	Yes
Trauma	Yes	Yes	Yes	Yes
DII	Yes	Yes	Yes	Yes
CCI	Not applicable	Yes	Not applicable	Yes
Funeral	Not applicable	Yes	Not applicable	Not applicable
Accident	Yes	Yes	Not applicable	Yes

Note that some combinations, while possible, have no policies written against them and will be listed as not applicable (n/a) in relevant industry-level tables.

Masking

APRA may mask certain data items with an asterisk (*) if the sample size is too small to be statistically credible. For any cover type and distribution channel combination, APRA applies masking in the following cases:

- If an insurer reports more than 0, but fewer than 50 claims finalised.
- If only one insurer is masked due to having fewer than 50 claims, the next-lowest is also masked, as otherwise it would be possible to reverse engineer the masked data from the industry total and the sum of the non-masked insurers.
- If only one insurer provides a specific combination and it has fewer than 50 claims finalised, the industry-level data is also masked.
- Where insurers with fewer than 50 claims comprise more than 70 per cent of the total number of claims finalised, the other insurers are also masked (but the industry totals are still provided).

Masking is applied consistently across claims and disputes data for the relevant cover type and distribution channel combination. That is, if an insurer's Individual Advised Death claims data is masked, all Individual Advised Death data across claims, claims duration, disputes and disputes duration is masked for that insurer. Conversely, if claims data is not masked for the insurer, all claims, claims duration, disputes and disputes duration data is shown.

Glossary

This Glossary explains terms used in the Life Insurance Claims and Disputes Statistics publication. For the exact, technical definitions of the items set out below, please refer to *Life Insurance Reporting Standard LRS 750.0 Claims and Disputes* (LRS 750.0).

Advised business refers to the sale of individual insurance, with the provision of personal advice, where personal advice has the same meaning as it does in section 766B(3) of the *Corporations Act 2001* (Corporations Act). The publication assumes this does not apply to CCI, Funeral or Accident Insurance businesses.

Annual premium refers to the annualised premium payable in respect of the policy contract. Annual premiums reported are gross of reinsurance and commissions, and before profit share rebates (group insurance). Reported premiums are also inclusive of stamp duty, policy fees, loadings and discounts. For single-premium business, the annual premium is estimated by spreading the single premium over the contract term. Policy fees must be appropriately apportioned between the relevant cover/product types.

Claim admitted refers to claims where the full benefit that the claimant was entitled to in terms of the policy contract was paid (or is payable). For the purposes of this statistical publication, it includes **Claims admitted fully on an ex-gratia basis**. These are claims that technically do not meet the policy contract definition for a claim, but where the insurer has decided to pay the claim in full.

Claim declined refers to outcomes where the claim is declined, with no benefit paid (or payable) to the claimant. For the purposes of this statistical publication, it includes **All other ex-gratia payments, settlements or premium refunds**. These are claims where the full claim has not been admitted, but where the insurer has decided or agreed to make some form of payment, including ex-gratia payments, commercial settlements, and premium refunds or non-cash benefits.

Claim duration refers to the time period between the claim being received and being finalised.

Claim finalised refers to when the insurer has made a final decision on the claim (e.g. whether to admit or decline the claim) and communicated this decision to the claimant.

Claim received refers to the point in time where the first piece of information (not necessarily all information) is received by the insurer to allow it to commence the assessment of a claim. At this stage, the insurer has confirmed there is a policy in force that could potentially cover the indicated claim event and has recorded the existence of a claim. For the purposes of this publication, claim received includes claims that were undetermined at the start of the reporting period; claims that were received during the reporting period; and claims that insurers re-opened (subsequent to being withdrawn) during the reporting period.

Claim withdrawn refers to the instance where a received claim is withdrawn and closed before being assessed and finalised. This includes claimants returning to work prior to the expiry of a waiting period (where applicable).

Claims frequency refers to the number of claims received as a percentage of the average number of lives insured for the reporting period.

Claims paid ratio refers to the dollar amount of claims paid out in the reporting period as a percentage of the annual premiums receivable in the same period. Note that DII has recurring monthly payments; for the purposes of the claims paid ratio, total payments are approximated using an average 24-month payout period.

Claims undetermined refers to all received claims that remain open for assessment at the end of the reporting period.

Cover type refers to the following cover and/or product types:

Cover type	Description
Death	Cover that provides a lump-sum payment in the event of the death of the insured life. Can be with or without a Terminal Illness benefit.
Total and Permanent Disability (TPD)	Cover that provides a lump-sum payment in the event of the insured life being considered totally and permanently disabled in accordance with the policy definition.
Disability Income Insurance (DII)	Cover that provides for a regular payment for a maximum defined benefit period after a defined waiting period, in the event of the insured life being considered totally or partially disabled in accordance with the policy definitions. DII is relevant for both Individual and Group contracts and is commonly referred to as Income Protection and Group Salary Continuance, respectively.
Trauma	Cover that provides a lump-sum payment in the event of the occurrence of a predefined illness or traumatic event. Trauma can be either standalone or an acceleration of the death/TPD benefit.
Consumer Credit Insurance (CCI)	Insurance providing for a lump-sum payment of the insured's outstanding loan or credit card balance (in part or in full) or regular payments limited to the minimum repayments for a period, payable in the event of one or more predefined events occurring. CCI can relate to the death, incapacity or involuntary redundancy of the insured life.
Funeral Insurance	Insurance for paying the expenses of, or incidental to, the funeral, burial or cremation of the insured life.
Accident Insurance	Insurance providing for a lump-sum payment in the event of the accidental death or injury of the insured life.

Dispute amount paid refers to the amount paid by the insurer in relation to the resolution of a dispute, and can be the full contractual benefit or a partial payment.

Dispute lodged refers to a claims-related dispute, regardless of whether it was raised with the insurer by the claimant (or their representative) or communicated to the insurer by a superannuation fund trustee, an EDR scheme, tribunal or court of law. For the purposes of this publication, disputes lodged includes disputes that were undetermined at the start of the

reporting period; disputes that were received during the reporting period; and disputes that insurers re-opened (subsequent to being withdrawn) during the reporting period.

Dispute lodgement ratio refers to the number of claims-related disputes lodged during the reporting period per 100,000 lives insured. The number of lives insured is the average for the reporting period.

Dispute resolved refers to the point where the insurer has communicated its final decision about how it will resolve the claims-related dispute to the claimant (or their authorised representative) or the point where an EDR scheme, the SCT, a similar scheme or tribunal, or a court of law has made a final determination/judgment that is binding on the insurer.

Dispute withdrawn refers to the instance where a lodged dispute is withdrawn before being resolved.

Disputes undetermined refers to all disputes lodged that remain open for assessment at the end of the reporting period.

Distribution channel refers to the channel through which insurance was sold. The table below maps the various channels from LRS 750.0 to how they are reported in the APRA *Life Claims and Disputes* publication and whether they are included on ASIC's MoneySmart website:

Insurance type	Advice type	Class of business	Reported in APRA publication as:	Included in MoneySmart tool:
Individual	Advised	Outside Super	Individual Advised^	Yes^
Individual	Advised	Inside Super	Individual Advised^	Yes^
Individual	Non-Advised	Outside Super	Individual Non-Advised	Yes
Individual	Non-Advised	Inside Super	Not included	Not included
Group	n/a	Outside Super	Group Ordinary	Not included
Group	n/a	Inside Super	Group Super	Yes

^ The 'Individual Advised' distribution channel reported in APRA's publication and on ASIC's MoneySmart website combines the Outside Super and Inside Super classes of business.

EDR refers to External Dispute Resolution.

Est. average duration refers to the estimated average duration to process a claim or dispute, expressed in months. This estimate is calculated as an average of the below duration buckets, weighted by the number of claims. For each bucket (other than the >36 months bucket), the mid-point is used as an input to the calculation; for the >36 months bucket a fixed value of 48 months is used.

Claim duration buckets	Dispute duration buckets
0 to 2 weeks	0 to 45 days
>2 weeks to 2 months	>45 days to 90 days
>2 months to 6 months	>90 days to 6 months
>6 months to 12 months	>6 months to 12 months
>12 months to 24 months	>12 months to 24 months
>24 months to 36 months	>24 to 36 months
>36 months	>36 months

Group refers to insurance business where an employer or the trustee of a superannuation fund with at least five members purchased a group insurance policy to provide cover for the employees or superannuation fund members and the amount of cover on each life, excluding any voluntary additional cover, is determined by application of a formula. Lives insured are underwritten according to blanket rules that apply to the group and usually provide for automatic acceptance up to prescribed limits.

IDR refers to Internal Dispute Resolution.

Individual refers to insurance business, for insurance cover held outside superannuation or within a retail superannuation fund where each policyholder selects the amount of Death, TPD, Trauma and Income Protection cover they require. Each life insured is individually underwritten. It also includes CCI, Accident and Funeral insurance.

Lapses refer to policy contracts (or underlying benefits) being discontinued. The **lapse rate** is the annual premium of the lapsed policies divided by the average in-force annual premium for the reporting period.

Life insured refers to the individual life (or multiple lives in the event of joint life contracts) covered under a policy contract. In respect of group insurance contracts, lives insured are also referred to as members.

New business refers to a new policy contract, or a new policy benefit under an existing policy contract. It is reported as the number of new lives insured divided by the average number of lives insured for the reporting period.

Non-advised business refers to the sale of individual insurance, without the provision of personal advice. This includes where no advice or general advice is provided. General advice has the same meaning as it does in section 766B(4) of the Corporations Act.

Policy contract refers to the life policy as defined by section 9 or 9A of the Life Act. In respect of individual insurance business, this contract is between the policyholder (who could also be the life insured) and the insurer. In respect of group insurance business, this contract is between the trustee (of a superannuation fund) or an employer and the insurer providing insurance for a group of eligible members. In respect of CCI, it includes policies written

under a Life Insurance licence. This includes products that may be of a General Insurance nature, but where the insurer has been authorised by APRA to write it on a Life Insurance licence under section 12A of the Life Act.

Sum insured refers to the contractual benefit payable when the insured event occurs. The sum insured is reported gross of reinsurance and without application of any reductions that may exist for severity-based Trauma and Accidental Injury benefits or for DII due to partial disability or a workers' compensation offset. For DII, the sum insured is the regular monthly (or equivalent monthly) benefit that would be paid if the insured were disabled in accordance with the provisions of the policy contract.

Withdrawn by the insurer due to claimant inactivity refers to instances where the insurer receives no response from the claimant when requesting further information, as well as instances where the insured has deceased subsequent to the claim being lodged and the claim is no longer relevant. This category corresponds to 'Withdrawn by the insurer' in LRS 750.0.