# Appendices

| |
|---|
| N/A |
| Phase 1 |
| Future phases (TBC) |

## *Proposed data framework*

The data framework provides an overview of the proposed target state for different aspects of the Insurance Data Transformation (IDT) for Life Insurance. It only covers risk products and may be expanded to cover non-risk products in due course.

| | | | **DIRECT WRITER** | | | | **REINSURER** | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | **Retail** | | **Group** | | **Retail** | | **Group** | |
| ***Existing data*** | ***Related aspect of IDT*** | ***Proposed level of granularity*** | ***IDII*** | ***Other risk products*** | ***GSC*** | ***Other risk products*** | ***IDII*** | ***Other risk products*** | ***GSC*** | ***Other risk products*** |
| Policy contract data [1,2] | LRS750 | Record | | | | | Limited data points | Limited data points | Limited data points | Limited data points |
| Benefit data [1,2] | LRS750 | Record | | | | | Limited data points | Limited data points | Limited data points | Limited data points |
| Claims data [1] | LRS750 | Record | | | | | Limited data points | Limited data points | Limited data points | Limited data points |
| Claims disputes data | IDII | ***Removed from LRS 750 once IDT Phase 1 commences - this will be collected through ASIC's IDR collection*** | | | | | | | | |
| Product Series [4] | New | Record | | | | | N/A | N/A | N/A | *N/A* |
| Reinsurance treaty table | New | Reinsurance treaty code | | | | | | | | |
| Revenue | IDII | ***Removed for Phase 1*** | | | | | | | | |
| IF liabilities | IDII | ***Removed for Phase 1*** | | | | | | | | |
| NB liabilities | IDII | ***Removed for Phase 1*** | | | | | | | | |
| IDII Business Profile | IDII | ***Removed from IDII collection and fully absorbed in new LRS 750 collection at a policy record level*** | | | | | | | | |
| Reserve movement | IDII | Specified cohort [6] | | | | | | | | |

| | | | DIRECT WRITER | | | | REINSURER | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Retail | | Group | | Retail | | Group | |
| ***Existing data*** | ***Related aspect of IDT*** | ***Proposed level of granularity*** | ***IDII*** | ***Other risk products*** | ***GSC*** | ***Other risk products*** | ***IDII*** | ***Other risk products*** | ***GSC*** | ***Other risk products*** |
| Claim reserve by cause [3] | IDII | Record | | | | | | | | |
| Earnings and benefits | IDII | ***Removed from IDII collection*** | | | | | | | | |
| Premium changes | IDII | Specified cohort [6] | | | *N/A* [5] | *N/A* [5] | N/A | N/A | *N/A* | *N/A* |
| Premium discounts | IDII | Specified cohort [6] | | | *N/A* | *N/A* | N/A | N/A | *N/A* | *N/A* |
| Commission | IDII | Specified cohort [6] | | | *N/A* | *N/A* | N/A | N/A | *N/A* | *N/A* |
| Target surplus position | New | Statutory Fund | | | | | | | | |
| Target surplus capital management | New | Statutory Fund | | | | | | | | |
| Business management | New | Aggregate | | | | | | | | |
| Claims management | New | Aggregate | | | | | | | | |

Notes:

1. It is proposed that data items under the current LRS 750 be expanded to align with existing industry-wide collection specification. Some additional data items have been added to collect additional insights, allow connectivity with other (internal and external) data collections or consolidate data points from the pilot IDII data collection.
2. Details from LRS750 and IDII business profile have been incorporated into this data table.
3. The data points are currently being collected at an aggregated level and are now proposed to be collected at an individual record level. Most data points have been absorbed into Policy contract, Benefit and Claims data tables.

4. Data items are broadly consistent with definitions used in the industry experience study collection, with some exceptions. While these are not individual/different records, they will assign attributes at record level.
5. Premium increase data for group arrangements inside superannuation is currently collected through Superannuation Data Transformation.
6. Specified cohort means each unique combination of data dimensions relevant for reporting under the relevant data table.

## *Proposed data structure*

It is proposed that the data collected in Phase 1 of the Insurance Data Transformation for life insurance will focus on risk products. It is proposed that Phase 1 will consist of a mixture of data collected at an individual record level and aggregated data collected in specified cohorts. The Agencies will continue to review and may change the proposed data items, data structure and prioritisation based on further internal deliberations and taking account of industry feedback.

The following is an overview of the proposed structure of the data to be collected at a record level:

| Data Table | Notes |
|---|---|
| Policy Contract Data Table | The Policy Contract Data Table captures key information separately for each individual life insured covered by the policy contract.<br><br>The main purpose of this data table is to understand the profile of customers covered by life insurance policies.<br><br>It should be noted that the Policy Contract Data Table, Benefit Data Table and the Claims Data Table are linked together through the use of the Policy Identifier and the Life Insured Identifier data items. It is, therefore, imperative that there is consistency in these data items to ensure that the tables can be linked together. |
| Benefit Data Table | The Benefit Data Table captures key information separately for each benefit provided for each individual life insured under the policy contract.<br><br>The main purpose of this data table is to understand the cover provided to customers under life insurance policies.<br><br>For each Benefit Data Table record there must be a corresponding Policy Contract Data Table record, linked by a Policy Identifier and a Life insured Identifier.<br><br>It is noted that there may be more than one record in the Benefit Data Table which corresponds to a Policy Contract Data Table entry e.g. a Life Insured may have more than one Product Type under a single policy contract.<br><br>It should be noted that the Benefit Table and the Claims Data Table are additionally linked together using the Benefit Identifier data item. It is, therefore, imperative that there is consistency in Benefit Identifier data item to ensure that these two tables can be linked together. |
| Claims Data Table | The Claims Data Table captures the claims information separately for each benefit under the policy contract in respect of which claims are submitted.<br><br>The main purposes of this data table are to understand the benefits provided to customers who hold life insurance policies and gain insights to the service they receive.<br><br>For each Claims Data Table record there must be a corresponding Policy Contract Data Table record and Benefit Data Table record.<br><br>Records are linked across the three data tables by a Policy Identifier and a Life insured Identifier. Additionally, Claims Data Table records are linked to Benefit Data Table records by a Benefit Identifier.<br><br>It is noted that there may be more than one record in the Claims Data Table which corresponds to a Benefit Data Table entry (e.g. there may be more than one claim which is made under a single cover). |

| Data Table | Notes |
|---|---|
| CICP and RBNA Reserve Data Table | Reserves for CICP and RBNA for insurers and reinsurers are captured in this data table at an individual claims record level.<br><br>The characteristics of the key claims causes for claims which are currently open will be considered by combining this table with data items in the Policy Contract Data Table, Benefit Data Table and Claims Data Table through a Policy Identifier, a Life insured Identifier and a Benefit Identifier. |

It is proposed that Phase 1 also includes the collection of the following aggregated data grouped by specified cohorts:

| Data Table | Notes |
|---|---|
| Product Series Data Table | The Product Series Table provides information about the main benefit features and options of products which share a combination of specified characteristics. |
| Reinsurance Treaty Data Table | This table captures key aspects of all outwards reinsurance arrangements for insurers and reinsurers.<br><br>The key purposes of this data table are to understand:<br><br>• the level and profile of reinsurance/retrocession usage by each insurer/reinsurer; and<br><br>• the exposure of each insurer/reinsurer to reinsurers/retrocessionaires operating in the Australian life insurance market. |
| Reserve Movements Data Table | Data relating to CICP, RBNA reserve movements grouped by specified cohorts of the business will be collected from insurers and reinsurers.<br><br>The purpose of this table is to understand the key drivers of changes in reserves in respect of known past claims (i.e. CICP and RBNA reserves) on different cohorts of an insurer's business.<br><br>Unearned premium reserves and level premium reserves at the start and the end of the reporting period are also captured. |
| Premium Change Data Table | Information relating to rates of premium change will be collected from insurers only.<br><br>The key purposes of this data table are to understand:<br><br>• the volatility of premiums over time; and<br><br>• how pricing for in-force is different to that for new business. |
| Premium Discount Data Table | Premium discount structure information will be collected from insurers only.<br><br>The key purposes of this data table are to understand:<br><br>• the stability of premiums over the lifecycle of a policy; and<br><br>• how discounts for in-force are different to that for new business. |
| Commission Data Table | Commission structure information will be collected from insurers only.<br><br>The key purpose of this data table is to understand the structure of commissions being paid to advisers. |

## *General Provisions*

It is proposed that information collected under IDT includes:

a) risks underwritten in Australia only;
b) detail on all business of the product and sub-product types, as defined in the collection, that was in force for any period of time during the Reporting Period; and
c) details on all claims that were notified, received or reopened during the Reporting Period, claims that were undetermined at the start of the Reporting Period, and for claims paid by a series of payments that were in payment at the start of the Reporting Period.
d) all dates provided in the DD/MM/YYYY format.
e) all monetary amounts provided as Australian dollar amounts rounded to the nearest dollar.

Data points should be left blank if there is no applicable data e.g. Claim Reopened Date should be left blank if a claim has not been reopened.

The proposed data dictionary includes the following fields:

| Field | Notes |
|---|---|
| Field number | This is the unique reference for each data point. |
| Field name | This is the name of the data point. |
| Proposed definition | This is the proposed definition for each data point. |
| Exp study ref | To minimise the industry burden, policy contract, benefit, claim and product series data table are broadly consistent with the existing industry experience study data collection where possible. For each data point, the comparable industry experience study field reference has been included for ease of reference. |
| Ins/reins | This is to indicate whether this data point is to be provided by insurers only or by both insurers and reinsurers. |

## *Policy Contract Data Table*

The Policy Contract Data Table captures key information separately for each individual life insured covered by the policy contract.

| Field Number | Field Name | Proposed Definition | Exp study Ref | Ins/reins |
|---|---|---|---|---|
| PC1 | Policy Identifier | *Policy identifier* means a number which uniquely identifies each policy contract, as defined by section 9 or 9A of the Life Insurance Act 1995 (Life Act).<br>• For Individual Insurance business, this is the contract between the policyholder (who could also be the life insured) and the insurer.<br>• For Group Insurance business, this is the contract between the trustee (of a Superannuation Fund) or an employer and | A4 | Insurers and reinsurers |

| Field Number | Field Name | Proposed Definition | Exp study Ref | Ins/reins |
|---|---|---|---|---|
| | | the insurer providing insurance for a group of eligible members.<br><br>Reinsurers should use the same Policy Identifier as their cedant. | | |
| PC2 | Life insured identifier | *Life insured identifier* means a number which uniquely identifies each life insured covered under the policy contract.<br><br>In respect of group insurance contracts, lives Insured are also referred to as members.<br><br>If a unique life insured identifier is not used within the company, please provide an identifier such that, if there are multiple lives on the policy, this can be identified. For example, a combination of policy identifier and the life insured number on the policy (e.g. XYZ2 being policy identifier XYZ and life insured 2 on that policy). The life insured identifier must be consistent between policyholder information records, benefit records and claims information records, so the three sets of records can be linked.<br><br>Life insured identifier for each policy contract should also be consistent over time, so that lives, benefit and claims under the policy contract can be tracked between reporting periods.<br><br>Reinsurers should use the same Life Insured Identifier as their cedant. | A5 | Insurers and reinsurers |
| PC3 | Location | *Location* means the latest available postcode of the life insured's current residential address. If postcode information is not available, the statistical area 4 code (as per ABS) or the state level code should be provided.<br><br>If none of this data is available, the Location code of "10" should be provided.<br><br>Postcode which begins with 0 should be provided as a string with '0' preceding the postcode i.e. '0800'. | A2 | Insurers only |
| PC4 | End of reporting period | *End of reporting period* is the last day of the period in respect of which data is collected. Any developments between the end of reporting period and the date of the data submission should not be reflected in the data collection.<br><br>Reporting period refers to the period in respect of which claims data is collected. | A3 | Insurers and reinsurers |

| Field Number | Field Name | Proposed Definition | Exp study Ref | Ins/reins |
|---|---|---|---|---|
| PC5 | Gender | *Gender* means the gender of the life insured recorded on the policy contract.<br>This should be a single numeric field, with values between 1 and 4. A value of "4" should only be chosen if gender is not collected and therefore not used as a rating factor.<br>1 = male<br>2 = female<br>3 = other<br>4 = unknown | A6 | Insurers only |
| PC6 | Date of birth | *Date of birth* is the date of birth of the life insured under the policy contract.<br>If unknown, it should be recorded as 31/12/9999. | A7 | Insurers only |
| PC7 | Smoking status | *Smoking status* means the smoking status of the life insured as recorded on the policy contract.<br>The following numeric codes should be used:<br>1 = Smoking status is not collected, or used for premium rating<br>2 = Assumed Non-smoker (if accurate classification is not known)<br>3 = Non-smoker during 12 months before entering into the contract (i.e. cannot revise premium status afterwards)<br>4 = Non-smoker for over 12 months before entry (i.e. cannot revise premium status after entering into the contract)<br>5 = Smoker | A8 | Insurers only |
| PC8 | Occupation class at underwriting | *Occupation class at underwriting* means the occupation class of the life insured at the last of underwriting date.<br>Occupation class should be at the most detailed level recorded, based on the insurer's internal classification. "Generic rating" should be used to indicate where occupation is not a rating factor and is not collected. | A9 | Insurers only |
| PC9 | Number of lives | *Number of lives* means the number of lives insured covered under the policy contract. | A11 | Insurers only |
| PC10 | Superlink policy identifier | *Superlink policy identifier* means the policy identifier of any policy to which the Policy Identifier (PC1) and life insured identifier (PC2) are linked. It should only be filled in for policies inside and outside superannuation when taken together (i.e. when they are linked).<br>For linked policies with the same sum insured inside and outside super, separate benefit records should be reported, each with its associated benefit record. Where the sum insured outside super | A12 | Insurers only |

| Field Number | Field Name | Proposed Definition | Exp study Ref | Ins/reins |
|---|---|---|---|---|
| | | is greater than inside super, an additional benefit record will be required under the 'outside super' benefit record. Please see item BE3 for additional detail. | | |
| PC11 | Superlink life insured identifier | *Superlink life insured identifier* means the life insured identifier of any life insured to which the policy identifier (PC1) and life insured identifier (PC2) are linked. It should only be filled in for lives insured inside and outside superannuation when taken together.<br><br>For linked policies with the same sum insured for the same product type inside and outside superannuation, a separate record should be set up for any additional cover for the same product type. The associated fields (PC10 and PC11) for the additional cover record should be left blank. | A13 | Insurers only |
| PC12 | Self employed | *Self-employed* indicator notes the life insured's type of employment.<br><br>The following numerical values should be used to indicate the employment type:<br><br>1 = Self-employed / sole trader<br><br>2 = Employee<br><br>3 = Combined (e.g. Policyholder is self-employed part time and works part-time for an employee).<br><br>This field should be filled in on a mandatory basis for all IDII policy contracts sold on or after 1 October 2021 and for all other policy contracts sold on or after 1 January 2024. For older products, it should be provided on a best endeavours basis. | A15 | Insurers only |
| PC13 | Salary at latest underwriting date | *Salary at latest underwriting date* means the total monthly income received by the life insured at the latest underwriting date.<br>• If the life insured is not self-employed, the normal monthly value of the remuneration package paid to the life insured by their employer, including salary, superannuation contributions, fees, commissions, regular overtime and bonus payments and packaged fringe benefits. Remuneration package does not include income which is not derived from the life insured's personal exertion or activities, such as interest or dividend payments; or<br>• If the life insured is self-employed:<br>○ The normal monthly income earned by the life insured's business, practice or partnership due the life insured's personal exertion or activities; and<br>○ If the policy contract for the life insured includes coverage for business expenses, also the life insured's share of the expenses of the business, practice or | A14 | Insurers only |

| Field Number | Field Name | Proposed Definition | Exp study Ref | Ins/reins |
|---|---|---|---|---|
| | | partnership that were necessarily incurred in producing the normal monthly income. | | |
| PC14 | Superannuation Choice Member | *Superannuation Choice Member* is a flag to indicate whether the life insured has made a choice regarding the insurance cover provided under this policy contract where it is written inside superannuation.<br>Y = A choice regarding insurance cover has been made by the life insured<br>N = A choice regarding insurance cover has not been made by the life insured<br>For retail policies, it is expected that the Life Insured will have made a choice regarding insurance cover. | N/A | Insurers only |

## *Benefit Data Table*

The Benefit Data Table captures key information separately for each benefit provided for each individual life insured under the policy contract.

| Field Number | Field Name | Proposed definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| BE1 | Policy identifier | *Policy Identifier* is the policy identifier (using the same definition as PC1 Policy Contract Data Table) relating to the cover details provided. | A4 | Insurers and reinsurers |
| BE2 | Life insured identifier | *Life Insured Identifier* is the life insured identifier (using the same definition as PC2 Policy Contract Data Table) relating to the cover details provided. | A5 | Insurers and reinsurers |
| BE3 | Benefit identifier | Benefit identifier means a number which uniquely identifies each benefit (in accordance with the product/sub-product type, as defined in item PC1 and PC2.<br>The benefit identifier must be consistent between benefit records and claims information records, so the two sets of records can be linked.<br>It should also be consistent over time, so that benefit and claims can be tracked between reporting periods.<br>Where there are two super-linked policies with a sum insured outside superannuation being higher than the sum insured inside superannuation, a separate Benefit Data Table record should be | N/A | Insurers and reinsurers |

| Field Number | Field Name | Proposed definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| | | added to provide details of the excess sum insured outside superannuation.<br><br>Reinsurers should use the same Benefit Identifier as their cedant. | | |
| BE4 | Product type | *Product type* describes which cover was provided under the policy contract.<br><br>This includes benefits sold on a stand-alone basis and as a rider to an investment or conventional policy. It excludes “free” cover.<br><br>They are defined as follows:<br><br>1 = Death – cover that provides a lump sum payment in the event of the death of the insured life. This product type can be with or without a terminal illness benefit. Where terminal illness is included, the death benefit can be paid before death occurs, provided certain predefined conditions are met. Death cover is relevant for both individual and group contracts.<br><br>2 = 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. TPD can be either a death acceleration benefit or standalone. TPD cover is relevant for both individual and group contracts.<br><br>3 = Trauma – cover that provides a lump sum payment in the event of the occurrence of a predefined illness or traumatic event. Trauma can also be either an acceleration of the death/TPD benefit or standalone. Most trauma contracts also include partial payments for less severe conditions, with continuation of the remaining cover. Trauma cover exists mainly under individual insurance, but there are some older group insurance products where it is included. Trauma is sometimes referred to as critical illness insurance.<br><br>4 = 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 (IP) and group salary continuance (GSC) respectively. There are also older versions of this cover known as TTD (total temporary disablement) which should also be included in this group. | B2 | Insurers only |

| Field Number | Field Name | Proposed definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| BE5 | Sub-product type | *Sub-product type* describes why the cover was provided under the policy contract.<br><br>They are defined as follows:<br>1 = Standard – covers standard risks.<br>2 = Business expense – covers business overhead where the life insured is reimbursed for certain regular business expense including rent, utilities, lease costs or depreciation, as defined in the underlying policy contract.<br>3 = Consumer Credit Insurance (CCI) credit card – Insurance providing for a lump sum payment of the insured's credit card balance (in part or in full) or regular payments limited to the minimum repayments for a period of time, payable in the event of one or more of a number of predefined events occurring. CCI products included should be those written under a life insurance license. This should include 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 license, under section 12A of the Life Insurance Act 1995 (Cth). Where a life insurance company also offers CCI products written on a General Insurance (GI) license, either its own license or that of another entity, the cover should not be included.<br>4 = CCI loan protection – Insurance providing for a lump sum payment of the insured's outstanding loan balance (in part or in full) or regular payments limited to the minimum repayments for a period of time, payable in the event of one or more of a number of predefined events occurring. (Same rules as Credit Card Insurance with respect to excluding GI components.)<br>5 = Funeral – Insurance for paying the expenses of, or incidental to, the funeral, burial or cremation of the person covered under the policy.<br>6 = Accident Insurance – Insurance providing for the payment of a lump sum in the event of accidental death or injury of the person covered under the policy.<br>7 = Involuntary Redundancy (CCI) – where a benefit is payable upon the life insured being made redundant at their place of work, in accordance with the provisions of the underlying policy contract.<br>8 = Other – Any other type of insurance.<br><br>These are our understanding of the most common permutations of product type/sub-product type in the market. Please only report the core benefit in the Benefit data. Where there are some non- | N/A | Insurers only |

<table>
<tr><th>Field Number</th><th>Field Name</th><th>Proposed definition</th><th>Exp study ref</th><th>Ins/reins</th></tr>
<tr><td></td><td></td><td>core benefits, please exclude them from the Benefit Data Table and report them in the Claims Table as they occur.<br><table><tr><td>Product Type</td><td>Death</td><td>TPD</td><td>Trauma</td><td>DII/GSC</td></tr><tr><td>Sub-product Type</td><td>Standard<br>Accident<br>CCI loans<br>CCI credit card<br>Funeral<br>Other</td><td>Standard<br>Other</td><td>Standard<br>Accident<br>CCI Loans<br>CCI Credit card<br>Involuntary Redundancy<br>Other</td><td>Standard<br>Business expenses<br>CCI Loans<br>CCI Credit card<br>Involuntary Redundancy<br>Other</td></tr></table>CCI incapacity and accidental injury cover previously reported under LRS750 have been consolidated into the Trauma Product Type above. Please report:<ul><li>CCI incapacity as Product Type = Trauma and Sub-Product type = CCI credit card and loan</li><li>Accidental Injury under Product Type = Trauma and Sub-Product type = Accident.</li></ul></td><td></td><td></td></tr>
<tr><td>BE6</td><td>Sale status</td><td>Sale status indicates whether a product is still open for sale.<br>For retail insurance, distinction is made between the following categories:<br>1 = Open for sale. Products that are open for sale at the time of data submission.<br>2 = Closed for sale: Products that are no longer open for sale at the time of the data submission. These are also referred to as legacy products. New business is still to be possible for such products.<br>For group insurance status, distinction is made between the following categories:<br>1 = Active category: Group risk categories remain active.<br>2 = Terminated category: Group risk categories which have terminated, but claims may still be generated from exposure in prior periods.</td><td>B3</td><td>Insurers only</td></tr>
</table>

| Field Number | Field Name | Proposed definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| BE7 | Date of entry | *Date of entry* means the commencement date of product cover for the life insured. This may be after the commencement date of the policy.<br>• If the individual commencement date is not known, please report the policy commencement date.<br>The following convention regarding policy events should be noted:<br>• If the cover was increased (e.g. sum insured increase) and additional underwriting was performed then an additional record with the new cover is required to be provided in addition to the original cover.<br>• If the cover is reduced (e.g. increased wait period) then the entry date should remain the original entry date.<br>• If this is replacement cover and the sum insured and benefit type is unchanged, please update the date of entry.<br>Otherwise, where a policy has tranches of the same benefit, on the same insured that per the above rules can be reported on the same record, the date of the oldest tranche should be supplied. | B4-B6 | Insurers only |
| BE8 | Sickness waiting period | *Sickness waiting period* means the defined period of time that has to expire after the claim event before benefit payments will commence for sickness income protection benefits provided under disability income policies or CCI Incapacity or Redundancy policy contracts.<br>This waiting period to be provided is broadly measured in days. An illustration of the convention to be followed for this field is as follows:<br>0 = 0 days<br>14 = 2 weeks<br>30 = One month<br>60 = Two months<br>90 = Three months<br>180 = Six months<br>365 = One year<br>730 = Two years<br>999 = Not Applicable i.e. Where the policy contract does not provide disability income or CCI Incapacity or Redundancy cover (e.g. lump sum benefit) or where there is no cover for sickness.<br>Where there are different waiting periods for certain elements of the cover, please use the shorter waiting period. | B7 | Insurers only |

| Field Number | Field Name | Proposed definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| BE9 | Accident waiting period | *Accident waiting period* means the defined period of time that has to expire after the claim event before benefit payments will commence for accident income protection benefits provided under disability income policies or CCI Incapacity or Redundancy policy contracts.<br><br>This waiting period to be provided is broadly measured in days. An illustration of the convention to be followed for this field is as follows:<br>0 = 0 days<br>14 = 2 weeks<br>30 = One month<br>60 = Two months<br>90 = Three months<br>180 = Six months<br>365 = One year<br>730 = Two years<br>999 = Not Applicable i.e.. Where the policy contract does not provide disability income or CCI Incapacity or Redundancy cover (e.g. lump sum benefit) or where there is no cover for accident.<br><br>Where there are different waiting periods for certain elements of the cover, please use the shorter waiting period and provide an indication of the proportion of the business with such a feature as well as the difference in the waiting periods.<br><br>For example, if the policy contract has an option such as<br>• "Day 4 Accident" with payment commencing after a 3 day waiting period after the life insured is disabled due to accident (as defined by the policy terms and conditions) then this field should be coded as "3".<br>• "Day 1 Accident" with payment commencing without a waiting period after the life insured is disabled due to accident then this field should be coded as "1". | B8 | Insurers only |

| Field Number | Field Name | Proposed definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| BE10 | Sickness benefit period | *Sickness benefit period* means the duration for which monthly benefits will be payable–- measured in years or the age to which sickness benefits will be paid.<br><br>Some common examples of Sickness Benefit Periods are listed below:<br>0.5 = 6 months<br>1 = 1 year<br>2 = 2 years<br>3 = 3 years<br>5 = 5 years<br>50 = To age 50<br>55 = To age 55<br>60 = To age 60<br>65 = To age 65<br>70 = To age 70<br>98 = to expiry date (see BE12 Expiry Date)<br>99 = for the life of the insured<br>99.9 = Claim on policy benefits with different sickness benefit period.<br><br>APRA will interpret benefit periods under 50 in years and those above 50 in ages.<br><br>The following should be noted when completing this field:<br>• The field is mandatory for disability income policies or CCI Incapacity or Redundancy, for other product type the field should be 0.<br>• Where different benefit periods apply for different claim conditions under the policy contract, please provide the longest benefit period. this field should contain the maximum sickness benefit period applicable to the policy contract at the earlier of the end of reporting period and the date of disability.<br>• It is acknowledged that the Sickness Benefit Period may change for a policy contract from one reporting period to another in accordance with the terms and conditions. | B9 | Insurers only |

| Field Number | Field Name | Proposed definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| BE11 | Accident benefit period | *Accident benefit period* means the duration for which monthly benefits will be payable–- measured in years or the age to which accident benefits will be paid.<br><br>Some common examples of Sickness Benefit Periods are listed below:<br><br>0.5 = 6 months<br>1 = 1 year<br>2 = 2 years<br>3 = 3 years<br>5 = 5 years<br>50 = To age 50<br>55 = To age 55<br>60 = To age 60<br>65 = To age 65<br>70 = To age 70<br>98 = to expiry date (see BE12 Expiry Date)<br>99 = for the life of the insured<br>99.9 = Claim on policy benefits with different accident benefit period.<br><br>APRA will interpret benefit periods under 50 in years and those above 50 in ages.<br><br>The following should be noted when completing this field<br><br>• The field is mandatory for disability income policies or CCI Incapacity or Redundancy, for other product type the field should be 0.<br>• Where there are different benefit periods for different claim conditions under the policy contract, please use the longest benefit period<br>• This field should contain the maximum sickness benefit period applicable to the policy contract at the earlier of the End of reporting period and the date of disability. It is acknowledged that the Accident Benefit Period may change for a policy contract from one reporting period to another in accordance with the terms and conditions. | B10 | Insurers only |
| BE12 | Benefit payment expiry date | *Benefit payment expiry date* is the expiry date of the policy where the Sickness Benefit Period and/or Accident Benefit Period is payable to the end of the expiry date of the policy. | B11 | Insurers only |

| Field Number | Field Name | Proposed definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| BE13 | Cancellable Policy | *Cancellable Policy* flag indicates whether or not the policy is cancellable by the insurer and the valid responses are as follows:<br>0 = cancellable<br>1 = not cancellable | B32 | Insurers only |
| BE14 | Discontinuance date | *Discontinuance date* is the date cover ceased or reduced under a benefit for life insured due to any reason.<br>For group policies this should be the date when the scheme is terminated. | B12 | Insurers only |
| BE15 | Discontinuance cause | *Discontinuance cause* is the reason for the discontinuance of a cover.<br>The valid responses for retail policies are:<br>1 = Discontinued due to a claim event.<br>2 = Discontinued due to policy contract or benefit reaching the end of its contractual term, including where this is defined in terms of the age of the life insured.<br>3 = Cancellation of the policy during the cooling off period.<br>4 = Policies later cancelled by the insurer from inception, e.g. in the event of misrepresentation or non-disclosure.<br>5 = Policy cancelled and replaced by a new policy contract.<br>6= Partial lapses where there are decreases in sum insured or premium on existing covers.<br>7 = Full Discontinuance of benefit, excluding due to non-payment of premiums.<br>8 = Policy cancelled due to non-payment of premiums.<br>The valid response for group policies is:<br>9 = the cancellation of group insurance policy contract. This does not include the effect of benefit changes at a member level<br>The valid responses for all policies are:<br>10 = cover for the life insured cancelled due to legislation such as Protecting Your Superannuation (“PYS”)<br>11 = Other<br>Where the benefit has not lapsed, this field should be left blank. | B13 | Insurers only |

| Field Number | Field Name | Proposed definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| BE16 | Sum insured (gross of reinsurance) | *Sum insured (gross of reinsurance)* is the contractual sum insured payable in the event of death, total and permanent disablement, trauma, or disability under the policy contract depending on the Product/Sub-product type at the end of the reporting period.<br><br>The contractual benefit payable should be<br><br>- the full sum insured if the insured event occurs and should not include any reductions (such as due to partial disability or workers' compensation offset);<br><br>- gross of reinsurance; and<br><br>- consistent with the frequency of the sum insured in the field "Frequency of sum insure". For example, if the frequency is monthly, a monthly sum insured should be recorded.<br><br>Where a claim has been notified/reported in respect of a life insured, the data provided should reflect the contractual benefit payable as the date of claim. Note the above guidance still applies.<br><br>For CCI loan or credit card, this should be reported as follows:<br><br>• Fixed benefit; or<br><br>• Outstanding loan balance or credit card balance – the latest balance should be reported (or if policies have lapsed, the latest balance prior to lapse); or<br><br>• Percentage of the outstanding loan balance or credit card balance – calculated benefit based on the latest known balance should be reported (or if policies have lapsed, based on the latest balance prior to lapse); or<br><br>• Monthly benefit equal to the loan instalment – This should be the monthly benefit with monthly chosen in Frequency of Sum Insured (Data item BE18).<br><br>For CCI involuntary redundancy, this is the amount payable upon the life insured being made redundant at their place of work, in accordance with the provisions of the underlying policy contract;<br><br>For CCI trauma (previously CCI incapacity), this is the amount payable when the life insured is deemed disabled or suffers an injury, a pre- defined illness or traumatic event, as defined in the underlying policy contract.<br><br>For accident trauma (previously accident injury), this is the amount payable in the event of the life insured suffering an injury as a result of an accident, as defined in the underlying policy contract. | B14 – B16 | Insurers only |

| Field Number | Field Name | Proposed definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| BE17 | Sum insured (net of reinsurance) | *Sum insured (net of reinsurance)*, as defined in BE16 but net of reinsurance.<br><br>For reinsurers this represents the sum insured net of retrocession. | N/A | |
| BE18 | Frequency of sum insured | *Frequency of sum insured* is the frequency of the payment of benefits under the policy and should be consistent with the relevant sum insured(s) set out in sum insured (Data items BE16, BE17).<br><br>The payment frequency should be based on the approximate number of expected payments each year. An illustration of the convention for this field is as follows:<br><br>1 = yearly<br><br>2 = half-yearly<br><br>4 = quarterly<br><br>12 = monthly<br><br>26 = fortnightly<br><br>52 = weekly<br><br>365 = daily<br><br>The following codes should be used in these specific circumstances where the above convention may not be suitable:<br><br>1000 = one-off lump sum payments or capitalised amount<br><br>2000 = lump sum by instalments. The period over which the benefit is paid should be entered in the benefit period BE10 or BE11. | B17 | Insurers only |
| BE19 | Current distribution method | *Current distribution method* refers to the method by which the policy is currently sold and the valid distribution methods are as follows:<br><br>1 = Intermediaries (independent financial advisor).<br><br>2 = Intermediaries (Aligned Advisor).<br><br>3 = Intermediaries (Data item Bank) – sale identified through a bank channel (i.e. teller), but advice is involved.<br><br>4 = Other Bank distribution e.g. tellers, loans etc–- limited advice. Assumed to be non- advised business.<br><br>5 = Direct–- mail, internet, telemarketing etc.<br><br>6 = Group Risk / Tender–- with opt in or opt our insurance provided. Assumed to be non-advised business<br><br>7 = Other advised business<br><br>8 = Other non-advised business | B18 | Insurers only |

| Field Number | Field Name | Proposed definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| | | 99 = Unknown.<br>This field should not be left blank. | | |
| BE20 | Advice type | *Advice type* is to indicate the level of advice provided at the time of sale and the valid advice types are follows:<br>1 = 'Personal advice' 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). This data item does not apply to CCI, Funeral or Accident Insurance businesses.<br>2 = 'General advice' refers to the sale of Individual Insurance, with the provision of general advice, where general advice has the same meaning as it does in section 766B(4) of the Corporations Act.<br>3 = 'No advice' refers to the sale of Individual Insurance, without the provision of advice.<br>4 = 'Other' - if none of the above applies. | N/A | Insurers only |
| BE21 | Original distribution method | *Original distribution method* refers to the method by which the policy was originally sold. The following advice categories are defined in BE19 Current Distribution Method. | B19 | Insurers only |
| BE22 | Underwriting method (medical) | *Underwriting method (medical)* should reflect the medical underwriting at inception i.e. date of entry of the relevant benefit Field Number BE4, BE5 and should be chosen from the list to reflect the highest level of underwriting.<br>0 = No underwriting.<br>1 = Automatic acceptance with pre-existing condition exclusions<br>2 = Short form, with no medical evidence<br>3 = Standard personal statement (SPS), with no medical evidence<br>4 = Medical evidence – mandatory (due to underwriting limits)<br>5 = Medical evidence – discretionary (not required by underwriting limits)<br>6 = Tele-underwriting<br>7 = Unknown<br>8 = Internal transfer (excluding group)<br>9 = Group policy continuation option (both automatic and optional) Option 8 and 9 should be used for conversions | B21 | Insurers only |

| Field Number | Field Name | Proposed definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| | | 10 = Other | | |
| BE23 | Underwriting method (financial) | *Underwriting method (Financial)* should reflect the financial underwriting at inception i.e. date of entry of the relevant benefit Field Number BE7 and should be chosen from the list to reflect the highest level of underwriting.<br>0 = No financial underwriting<br>1 = Financial underwriting (Mandatory due to underwriting limits)<br>2 = Financial underwriting (discretionary)<br>3 = Unknown | B22 | Insurers only |
| BE24 | Type of substandard benefit | *Type of substandard benefit* is the code to indicate the type of loading being applied to the substandard benefit.<br>They include the premium rate being adjusted through:<br>1 = a loading by a specific nominal amount; or<br>2 = a loading by a specific percentage of the standard premium; or<br>3 = an increase in the life insured's age by a number of years for the purpose of setting the premium.<br>Lives insured which have exclusions but no premium rate adjustment should not be classified as substandard. | B23-B24 | Insurers only |
| BE25 | Substandard benefit loading | *Substandard benefit loading* means the percentage increase applied to the standard premium to derive the premium for the life insured's cover. If the loading does not apply to the full amount of cover, the benefit loading percentage provided should reflect the weighted change to the standard premium for the full benefit. | B23<br>B24<br>B25<br>B26<br>B27<br>B28 | Insurers only |
| BE26 | Exclusions | *Exclusions* flag indicates whether exclusions apply to the life insured's benefit under the policy contract.<br>1 = Exclusions apply<br>2 = No exclusions<br>3 = Unknown if exclusions present. | B24A<br>B26A<br>B28A | Insurers only |

| Field Number | Field Name | Proposed definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| BE27 | Benefit type | *Benefit type* provides a high-level description of the main features which apply to the benefits provided under the policy contract.<br><br>If the product type is DII, the valid benefit types are as follows:<br>1 = agreed value–- refers to policies where the monthly benefit is calculated at claim time using actual income at the time of claim.<br>2 = indemnity–- refers to policies where the monthly benefit is based on the declared monthly income when the life insured first applied for cover.<br><br>If the product type is trauma, the valid benefit types are as follows:<br>1 = basic cover (fixed cover) – covers the basic trauma events such as heart attack, stroke, cancer, bypass surgery, neurological and degenerative disorders. Note that this cover is not severity based.<br>2 = basic cover (severity based) – covers the based trauma events such as heart attack, stroke, cancer, bypass surgery, neurological and degenerative disorders. Note that this cover is severity based.<br>3 = premium cover (fixed cover) – covers additional trauma events above the basic such as prostate tumours, carcinoma, melanomas and mobility and sensory conditions such as loss of limbs. Note that this cover is not severity based.<br>4 = premium cover (severity based) – covers additional trauma events above the basic such as prostate tumours, carcinoma, melanomas and mobility and sensory conditions such as loss of limbs. Note that this cover is severity based.<br><br>For all other product type, please leave blank. | B29 | Insurers only |
| BE28 | Level of premium guarantee | *Level of premium guarantee* indicates the period for which premium rates are guaranteed under the terms and conditions of the policy contract. The valid responses for this data item are as follows:<br>0 = non-guaranteed. This includes yearly renewable term products where rates are guaranteed for 12 months.<br>1 = guaranteed until policy expiry.<br>2 to-98 = guaranteed for a period of x years (at benefit inception) where x is between 2 and 98 and the relevant number should be allocated.<br>99 = guaranteed for another period or guarantee period is not specified. | B30 | Insurers only |

| Field Number | Field Name | Proposed definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| BE29 | Premium type | *Premium type* refers to the method by which premium is calculated using the life insured's age. The list of valid options is as follows:<br>0 = level–- refers to benefits where premiums are based on the premium rates applicable at the life insured's age at the start of the benefit and will remain the same within the agreed period.<br>1 = stepped - refers to benefits with which premiums are calculated based on the premium rates applicable at the life insured's age at each policy anniversary.<br>2 = hybrid–- refers to benefits where premiums are a mix of stepped premiums and level premiums | B31 | Insurers only |
| BE30 | Disability definition | *Disability definition* is a high-level description of the main criteria satisfying the disability claim condition for TPD, DI/GSC Product Types. The valid responses are as follows:<br>1 = Own occupation disability definition – where the life insured is considered unable to ever again work in the occupation he/she was working in prior to the disability.<br>2 = Any occupation disability definition – where the life insured is considered unable to ever again work in any occupation for which he/she is reasonably suited by education, training or experience.<br>3 = Duration based – where a benefit can change at a set duration.<br>4 = Other disability definitions.<br>For CCI Sub-Product Types<br>5 = Incapacity – where a benefit is payable when the life insured is deemed disabled or suffers an injury, a pre-defined illness or traumatic event, as defined in the underlying policy contract (i.e. this should include CCI trauma).<br>6 = Redundancy – where a benefit is payable upon the life insured being made redundant at their place of work, in accordance with the provisions of the underlying Policy Contract.<br>For all other product/sub-product type, this field should be blank or use 98 (unknown) or 99 (not applicable). | B33 | Insurers only |

| Field Number | Field Name | Proposed definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| BE31 | Claim indexation | *Claim indexation* indicates whether or not claims under this policy contract increase automatically periodically during the course of claim duration. The valid responses are as follows:<br>1 = level benefit<br>2 = increasing benefit<br>3 = not applicable | B34 | Insurers only |
| BE32 | Premium amount gross of reinsurance | *Premium amount gross of reinsurance* means the premium amount payable as at the end of reporting period for the insurance cover for the life insured in respect of this Product Type and Sub-Product Type. The premium should be provided:<br>• annualised premium payable in respect of insurance cover for the life insured;<br>• gross of reinsurance and before profit share rebates (group insurance) are applied; and<br>• inclusive of commissions, stamp duty, policy fees, loadings and discounts.<br>Policy fees should be appropriately apportioned across<br>• the relevant Cover/Product Types; and<br>• multiple benefit covers where a single policy fee is charged (e.g. linked Superannuation and Ordinary benefit covers).<br>For single-premium business, the annual premium should be estimated by spreading the single premium over the contract term.<br>For Reinsurers this represents the premium amount accepted by the reinsurer as inwards reinsurance. | B35 | Insurers and reinsurers |
| BE33 | Premium amount net of reinsurance | *Premium amount net of reinsurance* is defined as in BE32, but net of reinsurance/retrocession. | N/A | Insurers and reinsurers |
| BE34 | Frequency of premium amount | *Frequency of premium amount* indicates how frequently the premiums is collected in respect of the insurance cover provided for the life insured.<br>The premium payment frequency should be based on the approximate number of expected payments each year. An illustration of the convention to be used for this data item is as follows:<br>1 = yearly<br>2 = half-yearly<br>4 = quarterly | B36 | Insurers only |

| Field Number | Field Name | Proposed definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| | | 12 = monthly<br>26 = fortnightly<br>52 = weekly<br>365 = daily<br>A code of 1000 should be used where a single one-off premium is paid at the outset of the contract. | | |
| BE35 | Super or ordinary | *Super or ordinary* flag indicates whether the policy contract is "ordinary business" and "superannuation business" as defined in the Life Insurance Act 1995 using the following codes:<br>1 = superannuation business<br>2 = ordinary business | B37 | Insurers only |
| BE36 | Insurance type | *Insurance type* refers to the type of insurance:<br>The valid options are:<br>1 = group: industry fund and public sector funds (automatic acceptance limits apply).<br>2 = group: corporate fund (automatic acceptance limits apply).<br>3 = individual master trust<br>4 = retail – platform: through a digital platform.<br>5 = retail – off platform: not through a digital platform.<br>It is expected that the distinction between Individual and group Insurance should be consistent with how insurance business is classified and reported in APRA's product groups (as defined in Reporting Standard LRS 001 Reporting Requirements). | B38 | Insurers only |
| BE37 | Stand-alone or rider risk cover | *Stand-alone or rider risk* cover indicates whether the insurance cover is provided on a standalone basis or as a rider benefit.<br>1 = stand-alone (premiums are paid by the policyholder directly)<br>2 = rider (premiums are paid from a modern investment contract)<br>3 = rider (premiums are paid from a Whole Of Life, endowment, investment account, or other traditional/conventional contract type). | B39 | Insurers only |
| BE38 | Product series ID | *Product Series ID* is a unique identifier that captures the attributes listed under product series specification. The identifier will be created by direct insurers, taking into account the attributes listed in the Product Series Data Table.<br>Reinsurers should use the same product series identifiers created by their cedants. | B40 | Insurers and reinsurers |

| Field Number | Field Name | Proposed definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| BE39 | Statutory fund | *Statutory fund* is as defined in Prudential Standard LPS 001 Definitions.<br><br>Direct insurers and reinsurers should each reflect the statutory fund relevant to their own business. | N/A | Insurers and reinsurers |
| BE40 | Product group code | *Product group code* should be consistent with the APRA product groups as defined in Reporting Standard LRS 001 Reporting Requirements. | N/A | Insurers only |
| BE41 | Occupation at the underwriting date | *Occupation at the underwriting date* should be life insured's occupation (job/title/position) at the latest underwriting date. The occupation provided should be consistent with the Australian and New Zealand Standard Classification of Occupations (ANZSCO), 2022 Australian Update.<br><br>The Occupation should be coded as "Generic rating" if occupation is not a rating factor for the insurance cover provided and, therefore, is not collected. | N/A | Insurers only |
| BE42 | Employment status at the underwriting date | *Employment status at the underwriting date* captures the life insured's employment status at the latest underwriting date.<br><br>1 = Full Time–- where the life insured works an average of 38 hours each week and usually employed on a permanent basis or on a fixed term contract.<br><br>2 = Part Time–- where the life insured works less than 38 hours per week with typically regular working hours each week and usually employed on a permanent basis or on a fixed term contract.<br><br>3 = Casual–- where the life insured is employed knowing that there is no firm advance commitment to ongoing work with an agreed pattern of work. | N/A | Insurers only |
| BE43 | Premium commission structure ID | *Premium commission structure ID* is the unique identifier which describes the premium commission structure which applies to this benefit cover as defined CO1. | N/A | Insurers only |
| BE44 | Current commission rate | *Current Commission Rate* is the percentage rate of annual gross premium payable as a fee to the insurance agent by the insurer for their involvement in facilitating the sale of the policy to the policyholder. The rate reported should be the rate applicable at the end of the reporting period (or, if earlier, the date of policy termination during the reporting period).<br><br>For Reinsurers, this represents the percentage rate of the reinsurance premium made by reinsurers to cover part or all of a ceding company's acquisition and other costs. | N/A | Insurers only |

| Field Number | Field Name | Proposed definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| BE45 | Premium discount structure ID | *Premium discount structure ID* is the unique identifier, as recorded in the Premium Discount Data Table, which describes the premium discount rate structures which applies to this benefit cover at the end of the reporting period (or, if earlier, the date of termination during the reporting period) as defined PD1.<br><br>If more than one premium discount type currently applies provide all applicable codes separated by a comma. | N/A | Insurers only |
| BE46 | Total rate of current premium discount | *Total rate of current premium discount* is the percentage by which premium amount gross of reinsurance (data item BE32) at the end of the reporting period is lower than the gross of reinsurance premium prior the application of any premium discount, including duration-based pricing adjustments due to the selective effects of underwriting.<br><br>If more than one premium discount structure is applicable the combined effect of all applicable discounts should be provided. If no discount is applicable, this data items should be recorded as 0%. | N/A | Insurers only |
| BE47 | Sum insured (gross of reinsurance) at last underwriting date | *Sum Insured (gross of reinsurance)* at last underwriting date is the contractual sum insured payable in the event of death, total and permanent disablement, trauma, or disability under the policy contract depending on the Product/sub-product Type at the last underwriting date.<br><br>The data provided should be consistent with the instructions provided in respect of sum insured (Gross of reinsurance) – data item BE16.<br><br>For Reinsurers this represents the sum insured accepted by the reinsurer as inwards reinsurance. | N/A | Insurers only |
| BE48 | Underwriting date | *Underwriting date* is the date on which the insurer has gathered the necessary information about an applicant and made a final decision on that applicant's acceptability for the level of cover at that date. | N/A | Insurers only |
| BE49 | ASIC IDR reference number | *ASIC IDR reference number* is the unique identifier included in the ASIC IDR submission for disputes of all nature.<br>If there is more than one dispute associated with the policy contract, provide all separated by a comma. The data item should be left blank if there is no dispute associated with the policy. | N/A | Insurers only |

| Field Number | Field Name | Proposed definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| BE50 | Consumer brand | *Consumer brand* is the brand visible to the underlying life insured. In most cases, consumer brand will be the brand of the insurer (for retail insurance business) or employer/superannuation fund (for group business). Where insurers distribute business under a different brand (e.g. direct business), or facilitates white label arrangements, the relevant brand should be provided. | N/A | Insurers only |
| BE51 | Advisor group | *Advisor group* is the legal name of the advisor group through whom the policy contract was written. This data item should be left blank if no advisor was involved. | N/A | Insurers only |
| BE52 | Reinsurance treaty ID | *Reinsurance treaty ID* is the unique identifier which identifies the reinsurance treaty a cedant has with its reinsurer, relevant to a particular benefit cover using the same definition as RT1 Reinsurance Treaty Data Table.<br><br>Reinsurers should provide the reinsurance treaty identifier relating to the appropriate retrocession agreement.<br><br>If more than one Reinsurance Insurance Treaty ID applies provide all applicable codes separated by a comma. | N/A | Insurers and reinsurers |
| BE53 | AFCA EDR reference number | *AFCA EDR reference number* is the unique identifier used by AFCA in all disputes lodged with it.<br><br>If there is more than one dispute associated with the policy contract, provide all separated by a comma. This data item should be left blank if there is no dispute associated with the policy. | N/A | Insurers only |

## *Claims Data Table*

The Claims Data table captures the claims information separately for each benefit provided for each life insured under the policy contract. For each claim, Policy Contract Data Table and Benefit Data Table records must be provided.

| Field Number | Field Name | Proposed Definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| CL1 | Policy identifier | *Policy Identifier* is the Policy Identifier applicable to this claim record using the same definition as PC1 Policy contract data table. | A4 | Insurers and reinsurers |
| CL2 | Life insured identifier | *Life Insured Identifier* is the Life Insured Identifier applicable to this claim record using the same definition as PC2 Policy contract data table. | A5 | Insurers and reinsurers |

| Field Number | Field Name | Proposed Definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| CL3 | Benefit identifier | *Benefit Identifier* is the Benefit Identifier applicable to this claim record using the same definition as BE3 Benefit data table. | N/A | Insurers and reinsurers |
| CL4 | Claim number | *Claim number* is the unique identifier given to all claims records resulting from the same original claim.<br>If a claims number has changed due to a change in systems, a table mapping old numbers to the new claim numbers should be separately provided. The new claim number should be used in all reporting thereafter.<br>Reinsurers should use the same Claim Number as their cedant. | C1 | Insurers and reinsurers |
| CL5 | Claim status | *Claim status* is the code to indicate the status of a claim (or reopened claim) at the end of the reporting period using the following convention:<br>1 = Claim Notified (as per Field Number CL8)<br>2 = Claim Form Received (as per Field Number CL9)<br>3 = Claim Received (as per Field Number CL10)<br>4 = Claim Withdrawn (as per Field Number CL11)<br>5 = Claim Finalised (as per Field Number CL14)<br>6 = Claim in Course of Payment (DII/GSC)<br>7 = Claim Terminated (DII/GSC).<br>For clarity, finalised DII/GSC claims should use values of:<br>• 5 for the initial reporting and assessment of a claim in the current Reporting Period. This record should contain information on the payment made during the Reporting Period the claim was assessed.<br>• 6 for open claims in the course of payment, that have already been assessed and admitted in prior Reporting Periods and have not been terminated prior to the end of the current Reporting Period.<br>• 7 for a claim terminated prior to the end of the current Reporting Period, having already been assessed and admitted.<br>For reinsurers, this data item should reflect the reinsurance claims process and status rather than that of the cedant. | C2 | Insurers and reinsurers |

| Field Number | Field Name | Proposed Definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| CL6 | Type of claim | *Type of claim* is the code to indicate the type of claim using the following convention.<br>1 = Death (including Accidental Death) – cover that provides a lump sum payment in the event of the death of the insured life. This Product type can be with or without a Terminal illness benefit. Where Terminal illness is included, the death benefit can be paid before death occurs, provided certain predefined conditions are met. Death cover is relevant for both Individual and group contracts.<br>2 = 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. TPD can be either a death acceleration benefit or standalone. TPD cover is relevant for both Individual and group contracts.<br>3 = Trauma (including CCI trauma) – cover that provides a lump sum payment in the event of the occurrence of a predefined illness or traumatic event. Trauma can also be either an acceleration of the death/TPD benefit or standalone. Most trauma contracts also include partial payments for less severe conditions, with continuation of the remaining cover. Trauma cover exists mainly under Individual Insurance, but there are some older Group Insurance products where it is included. Trauma is sometimes referred to as Critical Illness insurance.<br>4 = Terminal illness Payment – where death benefits can be accelerated upon the diagnosis of the life insured with a terminal illness.<br>5 = Death with prior payment (e.g. a terminal illness payment occurred previously)<br>6 = Partial Trauma, including Partial CCI trauma<br>7 = Partial TPD<br>8 = Incapacity (CCI) - where a benefit is payable when the life insured is deemed disabled or suffers an injury, as defined in the underlying Policy Contract.<br>9 = Involuntary Redundancy (CCI) - where a benefit is payable upon the life insured being made redundant at their place of work, in accordance with the provisions of the underlying Policy Contract.<br>10 = Injury (Accident cover) - where a benefit is payable in the event of the life insured suffering an injury as a result of an accident, as defined in the underlying Policy Contract.<br>11 = DI/GSC – 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 | C3 | Insurers and reinsurers |

| Field Number | Field Name | Proposed Definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| | | 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 (IP) and Group Salary Continuance (GSC) respectively. There are also older versions of this cover known as Total Temporary Disablement (TTD), which should also be included in this group. | | |
| CL7 | Claim event date | *Claim Event Date* is the date on which the claim conditions under the policy contract were met (or deemed to have been met), regardless of when the claim was reported, assessed, all necessary information was received or paid.<br><br>The claim event and claim event date for certain Product and Sub-Product Types and Sub-Product Types are defined as:<br>(a) Death cover, CCI death, funeral or accidental Death: The claim event date is the date of death.<br>(b) Terminal illness: The claim event date is the date of diagnosis of a terminal illness which satisfies the claim conditions.<br>(c) Trauma, CCI incapacity or accidental Injury: The claim event is one of the events. The claim event date is the date on which the defined trauma, incapacity or accident event occurred or was diagnosed as set out in the terms and conditions of the policy contract.<br>(d) TPD and DII: The claim event date is the date on which the medical diagnosis is made that underpins the disabled status of the claimant.<br>(e) CCI redundancy: The claim event date is the date on which the life insured was made redundant while employed at their place of employment. | C4 | Insurers and reinsurers |
| CL8 | Claim notification date | *Claim Notification Date* is the date on which the initial contact with the insurer was made by the claimant, their authorised representative (including advisor), their superannuation fund trustee, or relevant other party informing the insurer of the claimant's intention to lodge a claim.<br><br>The claim notification could take the form of a physical submission (letter, email, etc.) or a telephone call.<br><br>Claim notification date may or may not correspond to the Claim Reported Date. | C5 | Insurers only |

| Field Number | Field Name | Proposed Definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| CL9 | Claim form received date | *Claim form received date* is the date on which the insurer received a claim form from the policyholder (if recorded). This date may be the same date as the claim notification date and/or claim received date depending on the insurer's claims processes. | C6 | Insurers only |
| CL10 | Claim received date | *Claim received date* is the date on which the first piece of information (not necessarily all information) is received by the insurer to allow it to commence the assessment of a claim.<br><br>At the claim received date, it is expected that 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.<br><br>It should be noted that every claim record with a claim received date must also have a claim notified date. However, it is possible that a claim record with a claim notified date may not yet have a claim received date. | C7 | Insurers only |
| CL11 | Claim withdrawn date | *Claim withdrawn date* is the date on which a claimant notifies the insurer that they do wish they do not proceed with the claim to the point where an insurer has assessed and reached a decision on the claim outcome. | C8 | Insurers only |
| CL12 | Reason for claim withdrawn | *Reason for claim withdrawn* is the code to indicate why the claim was withdrawn, using the following convention:<br><br>1 = **Return to work** – the claimant has returned to work in usual or other occupation. For example, insurer rehabilitation support achieving positive outcome.<br><br>2 = **Awareness of eligibility**. Examples of awareness of eligibility are:<br>- The customer has a better understanding of the severity and circumstances of the TPD criteria for their policy;<br>- The date of the claim event is not covered by the policy;<br>- An underwritten or policy exclusion applies to the insured event;<br>- Limited cover applying only for new events because the customer did not meet an At Work test or a PEC applies; or<br>- Cover has expired (e.g. occurred event occurs after benefit ceasing age).<br><br>3 = **Other changes in circumstance**. Examples of changes in circumstances are:<br>- Superlink claims. For example, when the "other" benefit is paid; | C9 | Insurers only |

| Field Number | Field Name | Proposed Definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| | | - Other benefit paid. For example, DII paid instead of TPD;<br>- Other. For example, duplicate claim record or claim notified in error;<br>- Deceased.<br>4 = **Expression of dissatisfaction**. Examples of expression of dissatisfaction are:<br>- Claims friction - Evidence requirements considered excessive;<br>- Claims friction - Delays experienced in claims assessment;<br>- Case Manager conduct.<br>5 = **Request for additional information** - No response after the claim is lodged, but before attendance at a medical examination or claims interview<br>6 = **Request for assessment** - Claim withdrawn after non-attendance at a medical examination or claims interview.<br>7 = **Other**<br>8 = **Unknown**<br>Please note that deferred claims, as defined by the Life Code Compliance Committee, should not considered as withdrawn from the claims process. Deferred claims occur where the insurer is not currently in a position to reach a decision on the eligibility of the claim based on information available. For example, the claimant is currently undergoing treatment or rehabilitation. | | |
| CL13 | Earnings at time of claim | *Earnings recorded at time of claim* refers to the total monthly income received by the claimant immediately prior to the claim event date before the deduction of income tax. This pre-disability income should be calculated in a way that is consistent with salary at latest underwriting date (field number PC13).<br>This data item should be recorded as 0 if not available or not required for the purposes of calculating the claim amount(s) payable. APRA expects insurers to collect and report this data item where it is used for calculation of the benefit. | C10 | Insurers only |

| Field Number | Field Name | Proposed Definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| CL14 | Claim finalised date | *Claim finalised date* is the date on which the insurer's decision is communicated to the claimant after the insurer has made a final decision on the claim (i.e. whether to admit or decline the claim) and communicated this decision to the claimant.<br><br>The following should be noted:<br><br>• Claim finalised date is not dependent on payment to the insured having been made.<br><br>• For benefit with regular payments, claim finalised date is not dependent on the claim termination date.<br><br>• Communication by e-mail, text message, facsimile or telephone is deemed to have occurred on the date it was sent.<br><br>• Communication by postal service is deemed to have occurred three business days after it was sent.<br><br>• A claim should not be classified as finalised where DII payments have commenced prior to a final claim decision being made (so-called "goodwill payments"). Such claims should only be classified as finalised once a final claim decision has been made. If that claim decision is to decline the claim, the claim should be recorded as such, regardless of whether a payment has been made. | C11 | Insurers only |
| CL15 | Claim outcome | *Claim outcome* is the decision made by the insurance company following a period of claims assessment.<br><br>It could be either of the followings:<br><br>**Claims Admitted**<br><br>1 = Claims admitted (excluding ex-gratia payments): this includes claims where the full benefit that the claimant was entitled to in terms of the policy contract was paid (or is payable). Where the policy contract makes provision for the payment of a portion of the full sum insured (e.g., severity based trauma or accidental injury benefits, or reductions in income benefits in lieu of other income received by the claimant), and such reductions were applied, the claim should be reflected in this category. No ex-gratia payments should be included here, even where the full benefit was paid.<br><br>2 = Claims admitted fully on an ex-gratia basis: these are claims that technically do not meet the policy contract definition for a claim, but the insurer has decided to pay the claim in full.<br><br>**Claims Declined (with no payment)** | C12 | Insurers only |

| Field Number | Field Name | Proposed Definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| | | This includes outcomes where the claim is declined, with no benefit paid (or payable) to the claimant. Claims declined due to:<br><br>3 = Contractual definition not met (including eligibility criteria): these are instances where the claimant does not meet the requirements of a qualifying claim, as defined in the policy contract. Also included here are eligibility criteria, such as being actively at work, a common requirement for Group Insurance contracts.<br><br>4 - Exclusion clause: these are instances where claims are declined on the grounds of a pre-existing condition exclusion, a limited cover clause, an exclusion imposed during initial underwriting, or any other policy exclusion. This includes the exclusion clauses that may be contained in the standard policy wording.<br><br>5 = Innocent non-disclosure or misrepresentation: where the claim is declined for reasons of non-disclosure or misrepresentation as contemplated in Section 29 (1) of the Insurance Contracts Act 1984.<br><br>6 = Fraudulent claim, including fraudulent non-disclosure or misrepresentation: where a claim is declined on the grounds of fraud or fraudulent non-disclosure or misrepresentation as contemplated in sections 56, 29(2)-3) of the Insurance Contracts Act 1984.<br><br>7 = Other reasons for being declined – Any other reasons for a claim being declined such as:<br><br>a. Claimant not insured with the insurer<br>b. Claimant did not understand cover.<br><br>8 = Declined due to legislation.<br><br>**Other**<br><br>9 = 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, premium refunds or non-cash benefits.<br><br>Where the claim is not finalised, please leave the field blank. | | |
| CL16 | Claim assessment reopened date | *Claim assessment reopened date* is the date on which a claim, that has previously been finalised or withdrawn, is reopened by the insurer for assessment during the Reporting Period. | C13 | Insurers only |

| Field Number | Field Name | Proposed Definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| CL17 | Start of payment period | *Start of payment period* is the date of the start of the payment period representing the first day of the period to which payments relate. This may not coincide with the date of the first payment.<br><br>For lump sum payments, the Start of payment period is deemed to be Claim Event Date or the last time normal benefits were paid for commutation or legal settlement<br><br>Some examples are:<br>• End of waiting period, which is the starting date for a new claim whose payments commence at the end of the waiting period<br>• Date a claim changed from full to partial payment or vice versa<br>• Date a claim resumes after interruption<br>• Date from which an ancillary benefit including specific injury/illness benefits was paid.<br>• Date from which a basic claim commences to be paid after a specific injury/illness benefit was paid.<br>• Starting date to which a lump sum payment relates. For example, the date of death for death benefits or the last time normal benefits were paid for commutation or legal settlement.<br><br>For reinsurers, this item should be reflective of the reinsurance claims process and status. | C14 | Insurers and reinsurers |
| CL18 | End of payment period | *End of payment period* is the date of the end of the payment period captured in this record representing the last day of the period to which payments relates and should be no later than the end of the reporting period. It may not coincide with the date of the last payment.<br><br>For lump sum payments, the End of payment period is deemed to be Claim Event Date or the last time normal benefits were paid for commutation or legal settlement<br><br>The following convention regarding lump sum payments should be noted:<br>• For lump sum payments that lead to the termination of the claim (commutation or legal settlement), please set the end of payment period should be as the start of the payment period even though a theoretical payment period could be calculated.<br>• For lump sum payments for specific injury/illness benefits, a theoretical end of payment period should be calculated. This should be the number of months after the date of disability (plus waiting period depending on benefit design) equal to the specified number of months' benefit payable for the relevant injury or illness. | C15 | Insurers and reinsurers |

| Field Number | Field Name | Proposed Definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| | | The start and end of payment periods of different claim records for the same claim should not overlap, including ending and starting on the same date.<br><br>Some examples are:<br>• Date the day before a claim changed from full to partial payment or vice versa (optional)<br>• Date a claim terminates due to recovery (even if subsequently relapses), death or termination of benefit period<br>• Date that an advanced pay and close claim was paid to if there are no subsequent payments after the initial payment period or the further payments are captured in another claims record.<br>• Date that an ancillary benefit including specific injury/illness benefits was paid to.<br>• The start of payment period for lump sum payments (excluding specific injury/illness benefits).<br><br>For reinsurers, this item should be reflective of the reinsurance claims process and status. | | |
| CL19 | Payment period accuracy | *Payment period accuracy* is to describe the accuracy of the CL17 Start of Payment Period and CL18 End of Payment Period.<br>The valid values are:<br>1 = Payment Periods are Accurate<br>2 = Payment Periods are not Accurate | C15A | Insurers only |
| CL20 | Claim terminated date | *Claim terminated date* is the date on which claim ended with no expectation of further payments. Note that the claim may subsequently be reopened.<br><br>Where the claim has not been terminated, please leave this field as blank.<br><br>For reinsurers, this item should be reflective of the reinsurance claims process and status. | C16 | Insurers and reinsurers |
| CL21 | Claim reopened date | *Claim reopened date* is the date on which a claim is readmitted where the claim was previously terminated. The reopened claim should be an extension of the previous claim, and thus the claimant does not need to satisfy the waiting period condition again.<br><br>It is expected that it will typically be within 6 months of the previous claim termination.<br><br>For reinsurers, this item should be reflective of the reinsurance claims process and status. | C17 | Insurers and reinsurers |

| Field Number | Field Name | Proposed Definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| CL22 | Mode of commencement | *Mode of commencement* describes the reason for commencement of an admitted claim with multiple payments.<br>Possible values are:<br>0 = continuation of claim from previous year. Please ensure there is another claim record for this claim in the previous reporting period.<br>1 = new claim, for which "start of payment period" is immediately after the expiry of the waiting period (including pending claims with basic claim amount of 0).<br>2 = new claim, for which "start of payment period" is not immediately after the expiry of the waiting period. For example, the claim is in the waiting period or if there is a delay between the end of the waiting period and the start of the payment period. This category excludes claims with mode of commencement = 4.<br>3 = claim resumed after interruption.<br>4 = continuation of an existing claim with no interruption after the last payment period. This category excludes claims with mode of commencement = 5.<br>5 = continuation of an existing specific injury/illness benefits claim. That is, after the initial specified period of payment, the claimant remains disabled and a normal disability income benefit commences.<br>For reinsurers, this item should be reflective of the reinsurance claims process and status. | C18 | Insurers and reinsurers |
| CL23 | Mode of cessation | *Mode of cessation* is the reason that an admitted claim with multiple payments ceased.<br>Possible values are:<br>0 = claim in force at end of Reporting Period (including pending claims with basic claim amount of 0).<br>1 = benefit period expired or voided<br>2 = death<br>3 = recovery (includes recoveries that subsequently relapsed).<br>4 = termination by lump sum payment (commutation or legal settlement)<br>5 = partial to full<br>6 = full to partial<br>7 = partial or full to lump sum payment<br>8 = claim interrupted for a reason other than recovery.<br>When treating these events as a mode of cessation, a record should cease and a new record should be created when a claim | C19 | Insurers and reinsurers |

| Field Number | Field Name | Proposed Definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| | | moves from full payment to partial payment or vice versa and when a lump sum payment (excluding non-death ancillary lump sum payments) is made. This does not apply to changes in the level of ancillary benefits paid.<br>9 = recovery which subsequently relapsed (returned to being on claim).<br>10 = end of the specific injury/illness benefit's specified payment period<br>11 = other<br><br>Specific injury/illness benefit - These are benefits where the insured pays a monthly benefit in advance for a specified period if the claimant suffers one of the pre-defined list of specified injuries/benefits regardless of the waiting period.<br><br>For reinsurers, this item should be reflective of the reinsurance claims process and status. | | |
| CL24 | Initial Cause of claim | *Initial Cause of claim* is the claim condition which satisfied the claim condition under the terms and condition of the policy contract at the Claim Event Date. It should be categorised by the version of the ICD-10 used in the latest industry experience study collection. It is mandatory for DII, Trauma (including CCI trauma), TPD but optional for Death.<br>• The cause of claim should be provided at the lowest level of detail of the life company's cause of claim. That is, only map to the "chapter" level of the codes when the next level down is not available.<br>• For unemployment ancillary benefit payments, please use your own cause of claim and map it to U00.<br>• For terminal illness claims, this is the defined cause of death, or the best estimate of the likely cause of death where the client has not died at the date the policy terminated.<br>• For death and TPD, "external" cause should take precedence.<br><br>Please report as "not known" when information is not available (e.g. death). | C20 | Insurers and reinsurers |
| CL25 | Current Cause of claim 1 | *Current Cause of claim 1* is the main claim cause which satisfied the claim conditions under the terms and condition of the policy contract at the end of the reporting period (or Claim terminated Date if earlier). It is mandatory for DI, Trauma (including CCI trauma) and TPD but optional for Death using the codes provided under CL24. | C21 | Insurers and reinsurers |

| Field Number | Field Name | Proposed Definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| CL26 | Current Cause of claim 2 | *Current Cause of claim 2* is additional claim cause which satisfied the claim conditions under the terms and condition of the policy contract at the end of the reporting period (or Claim terminated Date if earlier).<br><br>Codes are as described in CL24 above. | C22 | Insurers and reinsurers |
| CL27 | Total claim amount (gross of reinsurance) | *Total claim amount (gross of reinsurance)* is the cumulative payment made during the start of payment period to end of payment period.<br><br>It should be the total amount paid on the claim and should be:<br>• Rounded to the nearest dollar.<br>• Gross of reinsurance/retrocession.<br><br>Where the policy contract allows for a reduction in the full sum insured (e.g., in the case of severity based trauma or accidental injury benefits, or for DII due to partial disability or a workers' compensation offset), this field should reflect such reduction. Any amounts paid from a consumer's superannuation account balance should not be included in the total claim amount. That is, only the insurance payout component should be included.<br><br>It should be noted that data items CL29 to CL36 provide a breakdown of data item CL27.<br><br>The total claim amount should include any lump sum payments due to resolution of disputes. | C23 | Insurers and reinsurers |
| CL28 | Total claim amount (net of reinsurance) | *Total claim amount (net of reinsurance)* as defined in CL27, but net of reinsurance/retrocession. | N/A | Insurers and reinsurers |
| CL29 | Gross basic claim amount | *Gross basic claim amount* is the amount paid excluding ancillary payments as described in the data item CL30 to CL34 and adjustments described in data items CL35 and CL36.<br><br>For lump sum policies, the amount of a claim will differ from the sum insured when a partial payment has been made.<br><br>For disability income policies, this should be the cumulative amount paid for the basic disability income benefit (including specific injury/illness benefits) between "start of payment period" and "end of payment period". The claim amount should be:<br>• Rounded to the nearest dollar.<br>• Gross of reinsurance.<br>• Includes claims indexation. | C24 | Insurers only |

| Field Number | Field Name | Proposed Definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| | | • Excludes the cost of any waiver of premium amount.<br>• Excludes any ancillary benefit payments, other than specific injury/illness benefits (on disability income policies).<br>• Excludes any interest payable on delayed payments.<br>• Gross of offsets.<br>• Includes any basic benefit payments made under a "Day 1 Accident Option" or similar (with the accident waiting period coded appropriately). | | |
| CL30 | Superannuation payment | *Superannuation payment* refers to the cumulative payment gross of reinsurance made between the start of payment period to end of payment period in respect of contributions to a claimant's superannuation arrangement. | N/A | Insurers only |
| CL31 | Ancillary benefit – Regular rehabilitation payment | *Ancillary benefit – Regular rehabilitation payment* refers to the cumulative payment gross of reinsurance made as regular payments between the start of payment period to end of payment period in addition to the basic monthly benefit which directly relate to rehabilitation services. | N/A | Insurers only |
| CL32 | Ancillary benefit – Lump sum rehabilitation payment | *Ancillary benefit – Lump sum rehabilitation payment* refers to the cumulative single amounts gross of reinsurance between the start of payment period to end of payment period that are in addition to the basic monthly benefit which directly relate to rehabilitation services. | N/A | Insurers only |
| CL33 | Ancillary benefit – Other regular payment | *Ancillary benefit – Other regular payment* refers to the cumulative payment gross of reinsurance made as regular payments between the start of payment period to end of payment period in addition to the basic monthly benefit other than rehabilitation payment. | N/A | Insurers only |
| CL34 | Ancillary benefit – Other lump sum payment | *Ancillary benefit – Other lump sum payment* refers to the cumulative single amounts gross of reinsurance between the start of payment period to end of payment period other than rehabilitation payments that are in addition to the basic monthly benefit. | N/A | Insurers only |

| Field Number | Field Name | Proposed Definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| CL35 | Adjustment in respect of income offsets | *Adjustment in respect of income offsets* is the total reductions in basic monthly benefit that are due to receipt of other sources of income. | N/A | Insurers only |
| CL36 | Adjustment in respect of partial disability | *Adjustment in respect of partial disability* is the total reductions in basic monthly benefit that are due to income from partial work. | N/A | Insurers only |
| CL37 | Earnings from partial work | *Earnings from partial work* is the total monthly income received by the claimant at the end of the waiting period in respect of partial work before the deduction of income tax. | N/A | Insurers only |
| CL38 | Other earnings | *Other earnings* is the total monthly income received by the claimant at the end of the waiting period less earnings from partial work provided in "earnings from partial work", before the deduction of income tax.<br>Please exclude insurance benefits from other earnings. | N/A | Insurers only |
| CL39 | Workers compensation involvement | *Workers compensation involvement* is the code to indicate whether there was a workers compensation claim at the same time as the insurance claim under this policy contract.<br>1 = Yes<br>2 = No<br>3 = Unknown | C30 | Insurers only |
| CL40 | Basis for claim disability admission | *Basis for claim admission* is the code to indicate the basis on which the TPD or DI/GSC claim was admitted.<br>1 = Own occupation disability definition (of any sort) – where the life insured is considered unable to ever again work in the occupation he/she was working in prior to the disability.<br>2 = Own occupation disability definition.<br>3 = Any occupation disability definition (of any sort) – where the life insured is considered unable to ever again work in any occupation for which he/she is reasonably suited by education, training or experience.<br>4 = Any occupation disability definition.<br>5 = Other disability definitions. | N/A | Insurers and reinsurers |

| Field Number | Field Name | Proposed Definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| CL41 | Occupation at time of claim | *Occupation at time of claim* means the claimant's occupation (job/title/position) at time of claim. The occupation provided should be consistent with the Australian and New Zealand Standard Classification of Occupations (ANZSCO), 2022 Australian Update.<br>The Occupation should be coded as "Generic rating" if occupation is not a rating factor for the insurance cover provided and, therefore, is not collected. | N/A | Insurers only |
| CL42 | Employment status at time of claim | *Employment status at time of claim* is a code to indicate the claimant's employment status at time of claim.<br>1 = Full Time - where claimants work an average of 38 hours each week. They're usually employed on a permanent basis or on a fixed term contract.<br>2 = Part Time - where claimants work less than 38 hours per week and their hours are usually regular each week. They're usually employed on a permanent basis or on a fixed term contract.<br>3 = Casual - where claimants accept an offer for a job from an employer knowing that there is no firm advance commitment to ongoing work with an agreed pattern of work. | N/A | Insurers only |
| CL43 | Occupational class at time of claim | *Occupational class at time of claim* means the claimant's occupation class at the time of claim. It should reflect the internal mapping for your entity's occupation class at the most detailed level that is recorded.<br>"Generic rating" should be used to indicate where occupation is not a rating factor and is not collected. | A10 | Insurers only |
| CL44 | Third party involvement | *Third party involvement* is a code to indicate the type of third-party involvement present for the claim or dispute.<br>1 = Lawyer - where a lawyer is working in an advocacy role of some sort and not, for example, for funeral claim where they are overseeing the estate.<br>2 = Claimant intermediaries - where the claimant is represented by some form of intermediaries.<br>3 = Other third-party involvement<br>4= Unknown | N/A | Insurers only |
| CL45 | Actively managed claim flag | *Actively managed claim* flag is a code to indicate whether or not the claim has been actively managed during the reporting period.<br>"Y" = the claim was actively managed at some time during the reporting period<br>"N" = otherwise | N/A | Insurers only |

| Field Number | Field Name | Proposed Definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| | | Noted that the following types of claims are not considered to be actively managed:<br>- 'Pay and Close' claims; or<br>- Low touch claims with minimal reassessment; or<br>- Ongoing management is mainly confined to processing | | |

## *Product Series Table*

The Product Series Table provides information about the main benefit features and options of products which share a combination of characteristics listed under data items PS1 to PS8.

The following should be noted when providing Product Series Table data:

1) Fields PS1 to PS11 are applicable to all Product Types and are mandatory
2) Fields PS12 to PS44 are only applicable to the DII Product Type
3) Fields PS12 to PS44 are mandatory for IDII product series on sale on or after for 1 October 2021 and, where applicable, 1 January 2024 for GSC product series
4) Fields PS45 to PS49 are only applicable to the TPD Product Type
5) Fields PS50 to PS52 are only applicable to the Trauma Product Type
6) Fields PS53 to PS56 are only applicable to the Death Product Type
7) Fields PS45 to PS56 (where they are applicable to the specific Product Type and Sub-Product Type) are mandatory for other product series on sale on or after 1 January 2024

It is noted that many fields after PS11 will be mainly applicable to product series related to retail advised products.

| Field number | Field name | Proposed definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| PS1 | Product series ID | *Product series ID* is the unique identifier for each given combination of attributes in data items PS1 to PS8 this table. | P1 | Insurers only |
| PS2 | PDS identifier | *PDS identifier* is the unique identifier assigned to the product disclosure statement. | N/A | Insurers only |
| PS3 | Product label | *Product label* is to describe key features associated with the product. It could be the PDS title or name. | N/A | Insurers only |
| PS4 | Date sales commenced | *Date sales commenced* is the date that the product is open for sale. | N/A | Insurers only |

| Field number | Field name | Proposed definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| PS5 | Product Type | *Product type* is the Product type applicable to this Product Series record using the same definition as BE4 Benefit Data Table. | N/A | Insurers only |
| PS6 | Sub-product Type | *Sub-product type* is the Sub-product type applicable to this Product Series record using the same definition as BE5 Benefit Data Table. | N/A | Insurers only |
| PS7 | Date sales ceased | *Date sales ceased* is the date that the product is closed for sale (if applicable). | N/A | Insurers only |
| PS8 | MySuper Benefits Indicator | *MySuper benefits Indicator* notes whether this Product Series provides benefits as prescribed by the MySuper legislation for this Product Type and Subproduct Type.<br>Y = benefits provided are as prescribed by the MySuper legislation<br>N = benefits provided are not compliant with the MySuper legislation | N/A | Insurers only |
| PS9 | Sum Insured Indexation | *Sum Insured Indexation* describes increases in the sum insured relating to the benefit provided under the Product Type and Sub-product Type (noted under data items PS5 and PS6 respectively) prior to the Claim event Date and the most suitable option from the following list should be chosen.<br>1 = CPI indexation – where indexation is subject to limits, these limits should be specified in under Minimum Sum Insured Indexation and/or Maximum Sum Insured Indexation as appropriate<br>2 = Fixed percentage- as specified in under Sum Insured Indexation<br>3 = None<br>4 = Other | N/A | Insurers only |
| PS10 | Minimum Sum Insured indexation | *Minimum sum insured indexation* is the minimum percentage rate by which sum insured will be indexed.<br>Where the Sum Insured Indexation Type is<br>• "CPI indexation subject to limits", Minimum Sum Insured Indexation is the minimum percentage rate by which sum insureds can be indexed in the course of payment; and<br>• "Fixed Percentage", Minimum Sum Insured Indexation is the fixed rate by which sums insured are indexed in the course of payment. | N/A | Insurers only |

| Field number | Field name | Proposed definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| | | This field should be left blank if there is no lower limit indexation in the course of payment. | | |
| PS11 | Maximum Sum indexation | *Maximum sum insured indexation* is the maximum percentage rate by which sum insured will be indexed.<br>This field should be left blank if there is no upper limit on sum insured indexation. | N/A | Insurers only |
| PS12 | Replacement ratio 0 – 6 months | *Replacement ratio 0-6 months* is to capture the value of replacement ratio in the 6 months immediately after the Start of Payment Period as defined under CL17 of the Claims Data Table. Please note this does not include optional booster benefits. | P2 | Insurers only |
| PS13 | Replacement ratio 7 – 12 months | *Replacement ratio 7-12 months* is to capture the value of replacement ratio in the period 7 to 12 months after the Start of Payment Period as defined under CL17 of the Claims Data Table. Please note this does not include optional booster. | P3 | Insurers only |
| PS14 | Replacement ratio - 13 to 24 months | *Replacement ratio - 13 to 24 months* is to capture the value of replacement ratio in the period 13 to 24 months after the Start of Payment Period as defined under CL17 of the Claims Data Table. Please note this does not include optional booster. | P4 | Insurers only |
| PS15 | Replacement ratio – 25 to 36 months | *Replacement ratio - 25 to 36 months* is to capture the value of replacement ratio in the period 25 to 36 months after the Start of Payment Period as defined under CL17 of the Claims Data Table. Please note this does not include optional booster. | P5 | Insurers only |
| PS16 | Ultimate replacement ratio | *Ultimate replacement ratio* is to capture the value of ultimate replacement ratio. Please note this does not include optional booster. | P6 | Insurers only |
| PS17 | Offsets | *Offsets* is the code to capture the type of offsets offered by the product. Please include all offsets that apply separated by a comma.<br>1 = Workers Compensation – Payments made by workers compensation relating to loss of income or earning capacity due to disability.<br>2 = Paid leave from employer<br>3 = Other insurance benefits – including any mortgage, loan or credit insurance policy.<br>4 = Business income<br>5 = Accident Compensation – Payments made by moto accident compensation relating to loss of income or earning capacity due to disability. | P7 | Insurers only |

| Field number | Field name | Proposed definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| PS18 | Claims exclusions | *Claims exclusions* is the code to capture the cause of claims excluded by the product. Please include all excluded causes of claims separated by a comma.<br>1 = Unemployment<br>2 = Normal pregnancy, uncomplicated childbirth or miscarriage<br>3 = Other<br>4 = All cause of claim included | P8 | Insurers only |
| PS19 | Claimant is required to participate in recovery programme to receive benefit | *Claimant is required to participate in recovery programme to receive benefit* is the code to indicate whether claimant is required to participate in a recovery programme to receive benefit.<br>1 = Yes<br>2 = No | P9 | Insurers only |
| PS20 | Superannuation contribution indicator | *Superannuation contribution indicator* is the code to indicate whether the definition of income includes superannuation contribution.<br>1 = Yes<br>2 = No<br>3 = Unknown | P10 | Insurers only |
| PS21 | Income included | *Income included* is the code that best describes the type of income included.<br>1 = passive income – rental property, limited partnership, or other business in which a person is not actively involved.<br>2 = investment income – interest, dividends, and capital gains were insured has not actively participated in business, rental, or other income-producing activity.<br>3 = Neither<br>4 = 1 and 2 | P11 | Insurers only |
| PS22 | Income update frequency | *Income Update Frequency* is the number of years after the Policy Commencement Date that income needs to be updated by the policyholder other than at the Claim Event Date.<br>"99" should be entered if income is not required to be updated after the Policy Commencement Date. | P12 | Insurers only |
| PS23 | Disability definition – year 0 | *Disability definition year 0* is the code that best describes the Disability Definition in claim duration Year 0 i.e. at the Claim Event Date .<br>1 = Own occupation, all important income producing duties<br>2 = Own occupation, 1 or more duties for more than 10 hours per week<br>3 = Own occupation, other | P13 | Insurers only |

| Field number | Field name | Proposed definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| | | 4 = Any occupation, education, training and experience (ETE)<br>5 = Any occupation, other | | |
| PS24 | Disability definition year 1 | *Disability definition year 1* is the code that best describes the disability definition in claim duration year 1 using the same options set out in PS23. | P14 | Insurers only |
| PS25 | Disability definition – year 2 | *Disability definition year 2* is the code that best describes the disability definition in claim duration year 2 using the same options set out in PS23. | P15 | Insurers only |
| PS26 | Ultimate disability definition | *Ultimate disability definition* is the code that best describes the ultimate disability definition using the same options set out in PS23. | P16 | Insurers only |
| PS27 | Year ultimate disability definition begins | *Year ultimate disability definition begins* is the claim duration year from which the ultimate disability definition will apply. | P17 | Insurers only |
| PS28 | Claim indexation Type | *Claim indexation Type* describes the claims indexation during the course of payment and the most suitable option from the following list should be chosen.<br>2 = CPI indexation – where indexation is to subject to limits, these should be specified in under Minimum Claims Indexation and/or Maximum Claims Indexation as appropriate<br>3 = Fixed percentage - as specified in under Minimum Claims Indexation<br>4 = None<br>5 = Other | P18 | Insurers only |
| PS29 | Minimum Claims indexation | *Minimum claims indexation* is the minimum percentage rate by which claims will be indexed in the course of payment.<br>Where the Claims Indexation Type is<br>• "CPI indexation subject to limits", Minimum Claims Indexation is the minimum percentage rate by which claims can be indexed in the course of payment; and<br>• "Fixed Percentage", Minimum Claims Indexation is the fixed rate by which claims are indexed in the course of payment. | N/A | Insurers only |

| Field number | Field name | Proposed definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| | | This field should be left blank if there is no lower limit indexation in the course of payment. | | |
| PS30 | Maximum Claims indexation | *Maximum claims indexation* is the maximum percentage rate by which claims will be indexed in the course of payment.<br>This field should be left blank if there is no upper limit on claims indexation in the course of payment. | P19 | Insurers only |
| PS31 | Waiver of premium | *Waiver of premium* is the code to Indicate whether a premium waiver option applies.<br>Y = Yes<br>N = No<br>Waives the IDII premium whilst the claimant is paid their total or partial disability benefit. | P20 | Insurers only |
| PS32 | Rehabilitation benefit | *Rehabilitation benefit* is the code to indicate whether a rehabilitation benefit is available.<br>Y = Yes<br>N = No<br>Rehabilitation benefit reimburses the insured the costs in participating in pre-approved rehabilitation program, occupational services, aides, equipment and/or modification up to a maximum of a specified multiple of the monthly benefit. | P21 | Insurers only |
| PS33 | Death and terminal illness | *Death and terminal illness* is the code to indicate whether or not a Death/Terminal illness benefit is available,<br>Y = Yes<br>N = No<br>If the insured dies, the insurer will pay a lump sum usually a specified multiple of the monthly benefit capped to a certain amount. Or if the insured is diagnosed with a terminal illness while receiving an income protection benefit, the insurer will make an advance payment of the death benefit. | P22 | Insurers only |
| PS34 | Needlestick benefit | *Needlestick benefit* is the code to indicate whether a Needlestick injury benefit is available.<br>Y = Yes<br>N = No<br>Needlestick Injury benefit payable to medical and allied occupations (e.g. doctors and dentists) when they are accidentally infected with occupationally acquired Human Immunodeficiency Virus (HIV), Hepatitis B or Hepatitis C whilst working their normal occupation | P23 | Insurers only |

| Field number | Field name | Proposed definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| PS35 | Cosmetic or elective surgery benefit | *Cosmetic or elective surgery benefit* is the code to indicate whether a cosmetic/elective surgery benefit is available.<br>Y = Yes<br>N = No<br>Cosmetic or elective surgery benefit pays a monthly benefit if the insured remains disabled after the waiting period due to cosmetic or elective surgery, or as a result of surgery to transplant an organ or bone marrow into another person. | P24 | Insurers only |
| PS36 | Involuntary unemployment | *Involuntary unemployment* is the code to indicate whether an involuntary unemployment benefit is available.<br>Y = Yes<br>N = No<br>Involuntary unemployment waiver of premium option waives the IDII premium including any rider benefits attached for up to a specified number of months if the insured meets the definition for involuntary unemployed. | P25 | Insurers only |
| PS37 | Super guarantee option | *Super guarantee option* is the code to indicate whether a super guaranteed option is available.<br>Y = Yes<br>N = No<br>Superannuation guarantee benefit option is where a claimant is paid a total or partial disability benefit and in addition, the insurer also pays a super guarantee benefit to claimant's nominated super fund. The super guarantee benefit ends when the total or partial disability benefit is no longer payable. | P26 | Insurers only |
| PS38 | Salary increase benefit | *Salary increase benefit* is the code to indicate whether or not a salary increase benefit is available.<br>Y = Yes<br>N = No<br>Salary increase benefit option allows the insured to increase their sum insured without supplying further evidence of their health or insurability whenever the insured receives a permanent increase in their salary package. This amount is usually capped. | P27 | Insurers only |
| PS39 | Booster option | *Booster option* is the code to indicate whether an income replacement ratio booster option is available.<br>Y = Yes<br>N = No<br>The booster option provides an increase in the replacement for a specified percentage set out in PS40 Booster percentage increase and a specified | P28 | Insurers only |

| Field number | Field name | Proposed definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| | | period of months set out in PS41 Booster Duration in Months. | | |
| PS40 | Booster % increase | *Booster % increase* is the maximum increase available (as a percentage of income) under the income booster option. | P29 | Insurers only |
| PS41 | Booster duration in months | *Booster duration in months* is the number of months which the income booster increase will apply. | P30 | Insurers only |
| PS42 | Benefit period option | *Benefit period option* is to indicate whether an option to extend the benefit period is available.<br>Y = Yes<br>N = No | P31 | Insurers only |
| PS43 | Benefit period option covered to | *Benefit period option covered to* is the is the term or age to which the benefit period can be extended under the Benefit Period Option.<br>APRA will interpret benefit periods under 50 in years and those above 50 in ages. | P32 | Insurers only |
| PS44 | Any other features | *Any other features* is a free-text field to capture any other features provided by the product. | P33 | Insurers only |
| PS45 | TPD disability definition | *TPD disability definition* is the code to capture applicable aspects of the TPD disability definition. Please include all applicable codes separated the code by a comma.<br>1 = Loss of income<br>2 = Whole personal impairment<br>3 = Loss of limb/sight<br>4 = Loss of independent existence<br>5 = Cognitive impairment<br>6 =Other | N/A | Insurers only |
| PS46 | TPD cover features automatically included | *TPD cover features automatically included* is the code to capture features automatically included in the policy terms. Please include all applicable codes separated the code by a comma.<br>1 = Indexation of cover/Option to fix cover<br>2 = Guarantee of future insurability/Reinstatement option<br>3 = Premium freeze<br>4 = Premium waiver<br>5 = Death benefit reinstatement<br>6 = Double TPD benefit - reinstates the benefit following a TPD claim. | N/A | Insurers only |

| Field number | Field name | Proposed definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| | | 7 = Limited cover<br>8 = Other | | |
| PS47 | TPD cover feature options available | *TPD cover feature options* available is the code to capture features available as options in the policy terms. Please include all applicable codes set out in PS46 separated the code by a comma. | N/A | Insurers only |
| PS48 | TPD benefit payment by instalment | *TPD benefit payment by instalment* is the code to indicate whether the TPD benefit is payable in instalments.<br>Y = Yes<br>N = No | N/A | Insurers only |
| PS49 | Maximum TPD benefit payment period | *Maximum TPD benefit payment period* is the maximum benefit payment period for TPD benefits paid by instalments. | N/A | Insurers only |
| PS50 | Trauma cover features automatically included | *Trauma cover features automatically included* is the code to capture features automatically included in the policy terms. Please include all applicable codes separated the code by a comma.<br>1 = Indexation of cover/Option to fix cover<br>2 = Guarantee of future insurability/Reinstatement option<br>3 = Premium freeze<br>4 = Premium waiver<br>5 = Death benefit reinstatement<br>6 = Double Trauma benefit<br>7 = Trauma reinstatement<br>8 = Premium waiver on pregnancy<br>9 = Accommodation benefit<br>10 = Financial advice benefit<br>11 = Limited cover<br>12 = Other | N/A | Insurers only |
| PS51 | Trauma cover feature options available | *TPD cover feature options available* is the code to capture features available as options in the policy terms. Please include all applicable codes set out in PS50 separated the code by a comma. | N/A | Insurers only |
| PS52 | Trauma severity based payments | *Severity based payments* is the code to indicate whether the trauma claim condition is based on the severity of the claims cause.<br>Y = Yes<br>N = No | N/A | Insurers only |

| Field number | Field name | Proposed definition | Exp study ref | Ins/reins |
|---|---|---|---|---|
| PS53 | Terminal illness life expectancy limit | *Terminal Illness Life expectancy limit* is the code to indicate the maximum life expectancy which qualifies for a Terminal illness benefit. This is applicable to death/terminal illness product/sub-product type only.<br>1 = 12 months<br>2 = 24 months<br>3 = Other | N/A | Insurers only |
| PS54 | Definition of terminal illness | *Definition of terminal illness* is the code that best describes the definition of terminal illness.<br>1 = SIS Act definition of Terminal illness<br>2 = Certification required by only one doctor<br>3 = Other | N/A | Insurers only |
| PS55 | Treatment requirement for Death/terminal illness benefit | *Treatment requirement for Death/terminal illness benefit* is the code to indicate whether claimant is required to undergo some treatment to receive benefit.<br>1 = Yes<br>2 = No | N/A | Insurers only |
| PS56 | Additional benefits included under Death/terminal illness cover | *Additional benefits included under Death/terminal illness cover* is to capture all features automatically included in the policy terms separated by a comma. This is applicable to Death/terminal illness product/sub-product types only.<br>1 = Financial advice benefit<br>2 = Advance payment benefit<br>3 = Counselling benefit<br>4 = Accommodation benefit<br>5 = Repatriation benefit<br>6 = Orphan benefit<br>7 = Option to fix cover<br>8 = Reinstatement option<br>9 = Limited cover | N/A | Insurers only |

## *Reinsurance Treaty Data Table*

This table captures key aspects of an outwards reinsurance treaty applicable to specified cohorts to understand the exposure of each insurer to reinsurers (or retrocessionaires) available to the Australian market.

| Field number | Field name | Proposed definition | Ins/reins |
|---|---|---|---|
| RT1 | Reinsurance treaty ID | *Reinsurance treaty ID* is the unique identifier which identifies the reinsurance treaty a cedant has with its reinsurer(s), and should be provided by the cedant. Reinsurers should provide the identifier relating to the appropriate retrocession agreement with its retrocessionaire(s). This identifier should uniquely identify the treaty and remain unchanged in successive reporting periods. | Insurers and reinsurers |
| RT2 | Reinsurer name | *Reinsurer name* is the legal name of the reinsurer accepting the risk from a cedant. For reinsurers, the legal name of the retrocessionaire should be provided. | Insurers and reinsurers |
| RT3 | Reinsurer Domicile | *Reinsurer Domicile* is the country of domicile for the Reinsurer with which this reinsurance treaty (or retrocession arrangement) is held. | Insurers and reinsurers |
| RT4 | Date treaty commenced | *Date treaty commenced* is the date that the risk was assumed by the reinsurer or retrocessionaire. | Insurers and reinsurers |
| RT5 | Date new business ceased | *Date new business ceased* is the date that was closed to new policy contracts. Where the reinsurance treaty was never open to new policy contracts the date new business ceased should be the same as the date treaty commenced. | Insurers and reinsurers |
| RT6 | Date cover ended | *Date cover ended* is the date after which the reinsurer ceases to cover new incurred claims under the reinsurance treaty. | Insurers and reinsurers |
| RT7 | Date treaty recaptured | *Date treaty recaptured* is the date after which the reinsurer no longer has any further liability for the risks under the reinsurance treaty. | Insurers and reinsurers |
| RT8 | Product type | *Product Type* is the product type applicable to this Reinsurance Treaty ID using the same definition as BE4 Benefit Data Table.<br><br>Please provide a separate record for each product type cover by the reinsurance treaty. Catastrophe and pandemic should also be shown as a separate product type. | Insurers and reinsurers |
| RT9 | Sub-product type | *Sub-product Type* is the sub-product type applicable to this Reinsurance Treaty ID using the same definition as BE5 Benefit Data Table.<br><br>Please provide a separate record for each sub-product type cover by the reinsurance treaty. Catastrophe and | Insurers and reinsurers |

| Field number | Field name | Proposed definition | Ins/reins |
|---|---|---|---|
| | | pandemic should also be shown as a separate sub-product type. | |
| RT10 | Reinsurance type | *Reinsurance type* is the type of reinsurance effected under this treaty.<br>1 = Quota share<br>2 = Surplus<br>3 = Stop loss<br>4 = Catastrophe and pandemic<br>5 = Hybrid | Insurers and reinsurers |
| RT11 | Proportion of risk retained | *Proportion of risk retained* is an estimate of the proportion of the total risk retained under the treaty based on the reinsurance premium as a proportion of premium from cedants, as at the end of the reporting period.<br>Reinsurers should base their calculation on the retrocession premium as a proportion of inwards reinsurance premium. | Insurers and reinsurers |
| RT12 | Participating/Non-participating | *Participating/Non-participating* is to indicate whether the reinsurance premium is adjusted to reflect the experience of risks covered by the reinsurance treaty.<br>Y= Participating<br>N= Non-participating | Insurers and reinsurers |
| RT13 | Referable reinsurance date | *Referable reinsurance date* is the date on which a reinsurance/retrocession arrangement was approved by APRA as referable arrangement. If there has been a modification, please provide the latest approval date. | Insurers and reinsurers |
| RT14 | Reinsurance premium payable | *Reinsurance premium payable* is the premium payable by the cedant to its reinsurer (gross of any reinsurance commission receivable from the reinsurer) during the reporting period in respect of this Reinsurance Treaty Identifier.<br>Reinsurers should report the premiums payable to the retrocessionaire. | Insurers and reinsurers |
| RT15 | Reinsurance commission receivable | *Reinsurance commission receivable* is the reinsurance commission receivable by the cedant from its reinsurer during the reporting period in respect of this Reinsurance Treaty Identifier.<br>Reinsurers should report the reinsurance commission receivable from the retrocessionaire. | Insurers and reinsurers |

| Field number | Field name | Proposed definition | Ins/reins |
|---|---|---|---|
| RT16 | Reinsurance recoveries receivable | *Reinsurance recoveries receivable* is the claim recoveries receivable by the cedant from its reinsurer during the reporting period in respect of this Reinsurance Treaty Identifier.<br><br>Reinsurers should report the claim recoveries from the retrocessionaire. | Insurers and reinsurers |

## *Reserve Movements Data Table*

The following table is intended to capture movements in CICP and RBNA reserves for specified cohorts during the reporting periods for insurers and reinsurers. Unearned premium reserves and level premium reserves at the start and the end of the reporting period are also captured here.

| Field number | Field name | Proposed definition | Ins/reins |
|---|---|---|---|
| RM1 | Product series ID | *Product Series ID* is the Product Series of the cohort of policy contracts to which Reserve Analysis Amount relates – using the same definition of Product Series ID as PS1 Product Series data table. | Insurers and reinsurers |
| RM2 | Current distribution method | *Current Distribution Method* is the Current Distribution Method of the cohort of policy contracts to which Reserve Analysis Amount relates – using the same definition as BE19 Benefit Data Table. | Insurers and reinsurers |
| RM3 | Benefit type | *Benefit Type* is the Benefit Type of the cohort of policy contracts to which Reserve Analysis Amount relates – using the same definition as BE27 Benefit Data Table. | Insurers and reinsurers |
| RM4 | Premium type | *Premium type* is the Level or Stepped Premium basis of the cohort of policy contracts to which Reserve Analysis Amount relates – using the same definition as BE29 Benefit Data Table. | Insurers and reinsurers |
| RM5 | Product type | *Product Type* is the Product Type of the cohort of policy contracts to which Reserve Analysis Amount relates – using the same definition as BE4 Benefit Data Table. | Insurers and reinsurers |
| RM6 | Sub-product type | *Sub-product Type* is the Sub-product Type of the cohort of policy contracts to which Reserve Analysis Amount relates – using the same definition as BE5 Benefit Data Table. | Insurers and reinsurers |
| RM7 | Super or Ordinary | *Super or Ordinary* is the Super or Ordinary classification of the cohort of policy contracts to which Reserve Analysis Amount relates – using the same definition as BE35 Benefit Data Table. | Insurers and reinsurers |
| RM8 | Reinsurance status | *Reinsurance status* is to indicate whether the Reserve amount provided is gross or net of reinsurance for the cohort of policy contracts to which Reserve Analysis Amount relates.<br>The valid responses are:<br>"Gross" | Insurers and reinsurers |

| Field number | Field name | Proposed definition | Ins/reins |
|---|---|---|---|
| | | "Net" | |
| RM9 | Economic assumptions | *Economic assumptions* are to capture the economic assumptions used to calculate the Reserve Analysis Amount provided for this cohort of policy contracts. The valid responses are:<br>• "Start of Period" means the economic assumptions at the start of the reporting period used in calculating reserves on the capital basis.<br>• "End of period" means the economic assumptions at the end of the reporting period used in calculating reserves on the capital basis. | Insurers and reinsurers |
| RM10 | Demographic assumptions | *Demographic assumptions* are to capture the demographic assumptions used to calculate the Reserve amount Analysis Amount provided for this cohort of policy contracts. The valid responses are:<br>• "Start of Period" means the demographic assumptions at the start of the reporting period used in calculating reserves on the capital basis.<br>• "End of period" means the demographic assumptions at the end of the reporting period used in calculating reserves on the capital basis. | Insurers and reinsurers |
| RM11 | Reserve type | *Reserve type* is the type of reserve to which this Reserve Analysis Amount provided for this cohort of policy contracts. The valid responses are as follows:<br>• "Claims in course of payment reserve (CICP)" means reserves for expected future claims cost for those claims that are admitted into payment, including allowance for claims being closed and reopened in the future<br>• "Reported but not admitted claims reserve (RBNA)" means reserves held in respect of claims that have been notified, but where no decision has yet been made to either admit or decline.<br>• Unearned premium reserve (UPR)<br>• Level premium reserve (LPR) | Insurers and reinsurers |
| RM12 | Reserve analysis item | *Reserve analysis item* is the type of reserve movement analysis item to which the Reserve Analysis Amount relates.<br>The following Reserve analysis items are valid for all Reserve types:<br>• Opening balance<br>• Closing balance<br>The following additional Reserve analysis items are only valid for where the Reserve type is Claims in course of payment reserve (CICP): | Insurers and reinsurers |

| Field number | Field name | Proposed definition | Ins/reins |
|---|---|---|---|
| | | • Unwind of discount rate<br>• New claims (admitted and reopened)<br>• Terminations<br>• Claim payments during period<br>• Other reserve movements<br>This reserve analysis item refers to material movements in the CICP reserve during the reporting period not captured under other listed Reserve analysis items including changes in CICP due to benefit changes.<br>The following additional Reserve analysis items are only valid for where the Reserve type is Reported but not admitted claims reserve (RBNA):<br>• New claims reported<br>• Claims admitted<br>• Claims withdrawn<br>• Claims declined<br>• Other reserve movements<br>This reserve analysis item refers to material movements in the RBNA reserve during the reporting period not captured under other listed reserve analysis items including changes in RBNA due to benefit changes. | |
| RM13 | Reserve analysis amount | *Reserve analysis amount* is the amount relating the specified Reserve type and Reserve analysis item which is applicable to this cohort of policies.<br>CICP and RBNA "Closing balance" Reserve analysis item should be provided on the following bases:<br>• "Start of Period" for economic and demographic assumptions.<br>• "End of Period" for economic assumptions and "Start of Period" for demographic assumptions<br>• "End of Period" for economic and demographic assumptions.<br>• UPR and LPR "Opening balance" Reserve analysis item should be provided on the "Start of Period" for economic and demographic assumptions.<br>• UPR and LPR "Closing balance" Reserve analysis item should be provided on the "End of Period" for economic and demographic assumptions.<br>All other Reserve analysis items should be provided on the "Start of Period" for economic and demographic assumptions only.<br>Separate records should be provided for Reserve Analysis Amount on gross and net of reinsurance bases. | Insurers and reinsurers |

| Field number | Field name | Proposed definition | Ins/reins |
|---|---|---|---|
| | | Where there is more than one reinsurance treaty relating to this specified cohort of policy contracts, the Reserve Analysis Amount should be reported in separate records. | |

## *CICP & RBNA Reserves Data Table*

This data table collects CICP and RBNA reserves for insurers and reinsurers at an individual claims record level.

| Field number | Field name | Proposed definition | Ins/reins |
|---|---|---|---|
| CR1 | Policy identifier | *Policy Identifier* is the Policy Identifier of the claim to which reserve amounts relate - using the same definition as PC1 Policy Contract Data Table. | Insurers and reinsurers |
| CR2 | Claim Number | *Claim Number* is the Claim Number of the claim to which reserve amounts relate - using the same definition as CL4 Claim Data Table. | Insurers and reinsurers |
| CR3 | Reinsurance treaty ID | *Reinsurance Treaty ID* is the Reinsurance Treaty ID of the claim to which reserve amount relates - using the same definition as RT1 Reinsurance Treaty Data.<br><br>Where there is more than one reinsurance treaty relating to this claim, the Reserve Amount should be reported in separate records. | Insurers and reinsurers |
| CR4 | Reserve Type | *Reserve Type* should indicate the type of reserve amounts being reported for this claim.<br><br>The valid responses are as follows:<br><br>• "Claims in course of payment reserve (CICP)" means reserves for expected future claims cost for those claims that are admitted into payment, including allowance for claims being closed and reopened in the future<br>• "Reported but not admitted claims reserve (RBNA)" means reserves held in respect of claims that have been notified, but where no decision has yet been made to either admit or decline. | Insurers and reinsurers |
| CR5 | Reserve amount gross of reinsurance | *Reserve amount gross of reinsurance/retrocession* is the amount relating the specified reserve applicable to this policy contract calculated using the economic and demographic assumptions at the end of the reporting period on the capital basis. | Insurers and reinsurers |
| CR6 | Reserve amount net of reinsurance | *Reserve amount net of reinsurance/retrocession* is the amount relating the specified reserve applicable to this policy contract using the economic and demographic assumptions at the end of the reporting period on the capital basis. | Insurers and reinsurers |

## *Premium Changes Data Table*

Information relating to rates of premium increase grouped by specified cohorts will be collected at an aggregated level from insurers only. Specified cohort means each unique combination of data dimensions relevant for reporting under the Premium Change Data Table.

| Field number | Field name | Proposed definition | Ins/reins |
|---|---|---|---|
| PCH1 | Product series | *Product Series ID* is the Product Series of the cohort of policy contracts to which Reserve Analysis Amount relates - using the same definition of Product Series ID as PS1 Product Series data table. | Insurers only |
| PCH2 | Current distribution method | *Current Distribution Method* is the Current Distribution Method applicable to this specified cohort of policy contracts for which the premium rate information using the same definition as BE19 Benefit Data Table. | Insurers only |
| PCH3 | Benefit type | *Current Distribution Method* is the Current Distribution Method applicable to this specified cohort of policy contracts for which the premium rate information using the same definition as BE27 Benefit Data Table. | Insurers only |
| PCH4 | Premium Type | *Premium Type* is the Premium Type applicable to this specified cohort of policy contracts for which the premium rate information using the same definition as BE29 Benefit Data Table. | Insurers only |
| PCH5 | Product type | *Product Type* is the Product Type applicable to this specified cohort of policy contracts for which the premium rate information using the same definition as BE4 Benefit Data Table. | Insurers only |
| PCH6 | Sub-product type | *Sub-product Type* is the Sub-product Type applicable to this specified cohort of policy contracts for which the premium rate information using the same definition as BE5 Benefit Data Table. | Insurers only |
| PCH7 | Super or Ordinary | *Super or Ordinary* is the Super or Ordinary flag applicable to this specified cohort of policy contracts for which the premium rate information using the same definition as BE35 Benefit Data Table. | Insurers only |
| PCH8 | In force or new business | *In force or new business* is to indicate whether the premium change applies to this specified cohort of existing policy contracts or to new policies only.<br>• "In-force" means the premium change is only applicable to policy contracts already in-force on the effective date of the premium change<br>• "New business" means the premium change is only applicable to policy contracts which come into force on or after the effective date of the premium change<br>Please provide separate entries in-force and new business even where the same increase applies from the same date. | Insurers only |

| Field number | Field name | Proposed definition | Ins/reins |
|---|---|---|---|
| PCH9 | Effective date of premium change | *Effective date of premium change* is the date on which premium rates changed for this specified cohort of policy contracts regardless of the policy anniversary date on which this change applies to specific policy contracts. | Insurers only |
| PCH10 | Rate of premium change for affected policy contracts | *Rate of premium change* for affected policy contracts is the premium weighted average percentage change in premium rates for the subset of policy contracts in each specified cohort that will be subject to a premium change, based on the expected mix and volume.<br>• For in-force, the expected mix and volume should be based on the policies in-force on the effective date of the premium increase and that will be subject to a premium rate change regardless of the policy anniversary date on which this change applies to specific policy contracts.<br>• For new business, the expected mix and volume should be based on the new business policies on which the premium increase proposal was finalised, and which will be subject to a premium rate change. | Insurers only |
| PCH11 | Premiums affected by premium rate change | *Premiums affected by premium rate change* is the aggregate amount of annual in-force premium in this specified cohort of policy contracts, as at the end of the reporting period, to which the premium changes will apply.<br>For new business, it is the aggregate amount of annual premiums in this specified cohort of policy contracts used to calculate the rate of premium change for affected new business policy contracts. | Insurers only |

## *Premium Discount Data Table*

Premium Discount Structure Data Table information will be collected from insurers only. It is expected that each premium discount structure will be applicable to a cohort of policy contracts.

| Field number | Field name | Proposed definition | Ins/reins |
|---|---|---|---|
| PD1 | Premium discount structure ID | *Premium discount structure ID* is the unique identifier which describes the premium discount rate structure(s) which applies to the cohort of individual policy contracts. | Insurers only |

| Field number | Field name | Proposed definition | Ins/reins |
|---|---|---|---|
| PD2 | Premium discount type | *Premium discount type* is the type of discount applicable:<br>• New members discount means a premium discount or premium adjustment offered to new customers taking out a policy contract or existing customers who have been re-underwritten where this adjustment has been informed by an experience investigation.<br>• Superannuation discount means a premium discount offered to policy contracts written through a superannuation arrangement.<br>• Sum insured discount means a premium discount offered on policy contracts based on the sum insured.<br>• Multiple policies discount means a premium discount offered on a policy contract where a customer also has a policy contract for another insurance product.<br>• Healthy life discount means a premium discount on a policy contract where a customer is considered to be at a lower risk of claiming on the policy contract based on the policyholder's good health.<br>• Other means a type of premium discount which is not listed above, including marketing/commercial offers (e.g. those offered to specific advisor or dealer groups).<br>A separate entry should be provided for each type of discount that applies to any cohort of policies. | Insurers only |
| PD3 | Other premium discount type | *Other premium discount type* is a free-text box to provide a brief description of the discount if the premium discount type is not appropriately described by the list provided by APRA | Insurers only |
| PD4 | Start date of premium discount rate structure | *Start date of premium discount rate structure* is the date on which this premium discount structure came into effect. | Insurers only |
| PD5 | End date of premium discount rate structure | *End date of premium discount rate structure* is the date on which this premium discount structure ceased to apply. | Insurers only |
| PD6 | Policy contract duration year of discount | *Policy contract duration year of discount* is the policy contract year in which the Rate of premium applies. For example, where a policyholder has a new member discount for the first year of their policy contract, this should be recorded as 1.<br>The policy year of contract of "99" should be recorded where a discount rate applies for the remainder of the policy contract. | Insurers only |
| PD7 | Rate of premium discount | *Rate of premium discount* is the premium discount in percentage terms that is applicable for each relevant discount structure / policy contract year combination. | Insurers only |

## *Commission Data Table*

Premium Commission Structure Data Table information will be collected from insurers only. It is expected that each premium discount structure will be applicable to a cohort of policy contracts.

| Field number | Field name | Proposed definition | Ins/reins |
|---|---|---|---|
| CO1 | Premium commission structure ID | *Premium commission structure ID* is the unique identifier which describes the premium commission structure which applies to individual policy contracts. | Insurers only |
| CO2 | Start date of premium commission rate structure | *Start date of premium commission rate structure* is the date on which this premium commission structure came into effect. | Insurers only |
| CO3 | End date of premium commission rate structure | *End date of premium commission rate structure* is the date on which this premium commission structure ceased to apply. | Insurers only |
| CO4 | Policy contract year of commission rate | *Policy contract year of commission rate* is the policy contract year in which the Rate of premium commission applies.<br>The policy year of contract of "99" should be recorded where a commission rate applies for the remainder of the policy contract. | Insurers only |
| CO5 | Premium commission rate | *Premium commission rate* is the premium commission in percentage terms for each relevant premium commission structure / policy contract year combination. | Insurers only |