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APRA LIFE CLAIMS DATA DEFINITIONS – PHASE 1 ROUND 1

This document contains instructions and definitions in respect of life claims data to be submitted to APRA using the Excel template titled APRA Life Claims Data Template – Phase 1 Round 1.

A. INCLUSIONS FOR PHASE 1 ROUND 1 COLLECTION – 2016 CALENDAR YEAR

The Australian Prudential Regulation Authority (APRA) claims data collection communicated in May 2017, hereafter referred to as Phase 1 Round 1 (P1R1), is defined to encompass the following:

1. It pertains to Individual and Group Insurance products and benefits, whether classed as superannuation or ordinary business, that provide the Cover Types as defined in this document. It only includes gross business written directly i.e. excluding inwards and outwards reinsurance. Insurance benefits that are rider benefits on investment account and investment linked contracts should be included if they provide the Cover Types defined in this document. For P1R1, funeral, consumer credit, business overheads, as well as whole of life and endowment business are excluded.

2. The P1R1 collection is in respect of the Reporting Period covering the 2016 Calendar Year (CY 2016), i.e. from 1 January 2016 to 31 December 2016 (inclusive).

3. The P1R1 collection includes detail on all inforce business of the product and Cover Types included in the data collection. Detail at the start of the Reporting Period, at the end of the Reporting Period, as well as defined movements during the Reporting Period is included.

4. The P1R1 collection includes detail on all claims that were notified and/or reported during CY 2016, as well as claims that were undetermined at the start of the Reporting Period. For disability income insurance business the focus of the P1R1 collection is on whether a claim is admitted, declined or withdrawn, not on payment of regular disability benefits once a claim has been admitted. The P1R1 collection is not intended to capture disability income claims already in course of payment at the start of the Reporting Period.

For admitted claims, the P1R1 collection captures both the Sum Insured and a Claim Amount Paid, which may be less than the full Sum Insured where a Policy Contract makes provision for partial payments, for example, disability income insurance policies where the insured life is only partially disabled or severity based trauma claims. Partial payments that are consistent with the contract provisions are to be classified in the 'Claim admitted with full benefit payable' category.

5. The P1R1 collection includes all claims related disputes that were notified and/or lodged during CY 2016, as well as claim related disputes that were undetermined at the start of the Reporting Period.

B. GENERAL DEFINITIONS

This section contains definitions of a general nature and includes terms that are used throughout the remainder of this document.

1. **Reporting Period** refers to the period in respect of which claims data is collected. For the P1R1 collection the Reporting Period is the 2016 Calendar Year (CY 2016).

2. **Policy Contract** refers to the life policy as defined by section 9 or 9A of the *Life Insurance Act 1995* (Life Act).

3. **Life Insured** refers to the individual life (or lives) covered under a Policy Contract.

4. **Policyholder** is the owner of the Policy Contract. It could be the same as the Life Insured.

5. **Product Type** refers to the type of product or rider benefit that provides any of the Cover Types. For P1R1 the collection relates to term insurance. Funeral insurance, consumer credit insurance, business expense insurance, whole of life and endowment business should be excluded.

6. **Insurance Type** refers to the types of insurance that are included in this data collection, namely:

    - Group Insurance business, where an employer or the trustee of a superannuation fund with at least five members makes a decision to purchase a group insurance policy to provide cover for the employees or superannuation fund members and the amount of cover on each life, excluding any voluntary additional cover, is determined by application of a formula; and

    - Individual Insurance business, for insurance cover held outside superannuation or within a retail superannuation fund where each member selects the amount of death, TPD and income protection cover he or she requires.

    The distinction between Individual and Group Insurance should be consistent with how insurance business is classified and reported in APRA's D2A collection. The Individual Lump Sum Risk (L4) and Individual Disability Income Insurance (L5) product groups should be classified as Individual Insurance business and the Group Lump Sum Risk (L6) and Group Disability Income Insurance (L7) product groups should be classified as Group Insurance business.

    The following categories are defined for Insurance Type:

a) Individual Insurance sold outside Superannuation Fund;

b) Individual Insurance sold inside Superannuation Fund; and

c) Group Insurance

Category 6a should correspond to business that is reported in D2A with a business class of "Ordinary business" and category 6b should correspond to business that is reported in D2A with a business class of "Superannuation business". Category 6c should predominantly relate to "Superannuation business" but may include "Ordinary business" e.g. where an association purchases a group insurance contract that provides insurance cover for its members.

7. **Cover Type** refers to the type of cover provided under a Policy Contract. The following Cover Types are defined:

a) Death: cover that provides a lump sum payment in the event of the death of the insured life. This Cover 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.

b) 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.

c) 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.

d) Trauma: cover that provides a lump sum payment in the event of the occurrence of a predefined illness or trauma 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 and the remaining cover continues. 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.

8. Cover can be provided on a stand-alone or accelerated basis. **Stand-alone cover** is where a Policy Benefit provides insurance for a single Cover Type, unaffected by any claims from a different Cover Type. **Accelerated cover** is where a Policy Benefit provides insurance for multiple Cover Types and where a benefit is usually payable on the occurrence of the first of the events insured. Depending on the nature of the claim event, cover could remain in force for other Cover Types, but usually at a reduced level. For example a policy that provides $500,000 death cover and $300,000 trauma cover on an acceleration basis will continue to provide $200,000 death cover after payment of a trauma claim.

9. **Policy Benefit** refers to a distinct benefit provided under a Policy Contract. It is expected that a Policy Benefit would typically relate to a single Life Insured and Cover Type and where multiple lives or Cover Types are covered under a single Policy Contract, such cover would be provided under separate Policy Benefits.

   For purposes of the P1R1 collection, distinction is made between the following **Policy Benefit Types**:

   a) Death stand-alone: Death Cover on a stand-alone basis e.g. a death only group insurance scheme or an individual insurance policy where the insured life (or lives) only have death cover.

   b) Death & TPD: Death Cover in combination with TPD Cover. This could be a group insurance scheme that offers both death and TPD cover, or an individual insurance policy where both death and TPD is provided. An individual insurance policy that covers one or more insured lives can be reported as Death & TPD if at least one of the insured lives has death cover and at least one of the insured lives has TPD cover and none of the insured lives has trauma cover.

   c) Death & Trauma: Death Cover in combination with Trauma Cover. This is an individual insurance policy where both death and Trauma cover is provided. An individual insurance policy that covers one or more insured lives can be reported as Death and Trauma if at least one of the insured lives has death cover and at least one of the insured lives has Trauma cover and none of the insured lives has TPD cover. This Policy Benefit type can also be used to report trauma contracts where a benefit is payable on death i.e. Trauma Cover with in-built death.

   d) Death, TPD & Trauma: Use this Policy Benefit type to report individual insurance policies that offer death cover in combination with TPD and trauma cover riders.

e) TPD stand-alone: TPD Cover provided on a stand-alone basis e.g. a TPD only group insurance scheme or an individual insurance policy where the insured life (or lives) only have TPD cover.

f) Trauma stand-alone: use this Policy Benefit type to report trauma contracts where no benefit is payable on death.

g) DII: use this Policy Benefit type to report all income protection and Group Salary Continuance cover.

Where multiple Policy Benefits exist under a Policy Contract, related to the same Life Insured and related to the same Cover Type (or combination of Cover Types) and with the same claims criteria, those benefits should ideally be consolidated and counted only once. For example, if an insurer has a practice of creating a new Policy Benefit to reflect an increase in cover under an existing benefit, those benefits should be counted only once.

10. **On Sale Status** refers to whether a product is still open for New Business. Distinction is made between the following categories:

a) Open for New Business: Products that are open for new business at the time of data submission.

b) Closed for New Business: Products that are no longer open for new business. These are also referred to as legacy products.

This item is only recorded for the Insurance Type of Individual Insurance, as described in B.6.

11. **Advice Type** refers to the method by which the policy was sold and specifically the level of advice provided. This data dimension is defined to only apply to Individual Insurance. The following advice categories are defined:

a) **Advised business**, referring to the sale of individual life insurance, with the provision of personal advice, where personal advice has the same meaning as it does in s.766B(3) of the *Corporations Act 2001* (Corporations Act).

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

12. **Annual Premium** refers to the annualised premium payable in respect of the Policy Contract or Policy Benefit as previously defined. Annual Premiums collected in P1R1 should be gross of reinsurance and commissions, and before profit share rebates (group insurance).

13. **Sum Insured** refers to the contractual benefit payable should the insured event occur. Insurers should report a full Sum Insured amount not a partial amount that would be payable under Trauma for a less severe condition or a partial amount that would be payable under DII due to partial disability or a workers' compensation offset. Partial amounts are captured within the Claim Amounts Paid field, not within Claim Sums Insured. Distinction is made between the following the types of sums insured:

    a) Lump Sum: this is a single amount payable when the policy conditions are met. Sums insured in respect of Death, TPD and Trauma Cover Types are normally of a lump sum nature. TPD benefits paid by instalments should be shown at their full face value. For Trauma contracts that include partial payments for less severe conditions the Sum Insured is the full nominal Sum Insured not the severity based payment amount.

    b) Monthly Insured Benefit: for DII the Sum Insured is the regular monthly (or equivalent monthly) benefit that would be paid if the insured were totally disabled. **For DII the focus of the P1R1 collection is on whether a claim is admitted, declined or withdrawn not on how long regular disability benefits would be paid should a claim be admitted**.

    Sum Insured detail collected in P1R1 should be gross of reinsurance.

14. **New Business** refers to a new Policy Contract, or a new Policy Benefit under an existing Policy Contract. Voluntary cover increases that are subject to underwriting should also be considered New Business. Automated premium and/or Sum Insured increases, such as age-related premium increases for a stepped premium product and automatic CPI increases to Sum Insured, should not be counted towards New Business.

15. **Voluntary Discontinuances** refers to a Policy Contract and/or Policy Benefit that is discontinued through a decision by the Life Insured and/or Policyholder.

16. **Disputes**, considered in more detail in Section E, are defined to only include claims related disputes. It includes disputes where a claim decision has been made, but the claims outcome is challenged or questioned, as well as disputes related to the claims process.

17. **Waiting period** refers to a defined period of time, usually in respect of TPD or DII, that has to expire after the Claim Event before benefit payments will commence.

C. POLICY DATA DETAIL

In respect of Policy Data, the following detail needs to be provided:

1. The number of Policy Benefits, as defined in Section B. This detail should be captured in the relevant Policy Benefit type category. One Policy Contract could have more than one Policy Benefit.

2. The number of Policy Contracts, as defined in Section B.

3. The number of Lives Insured, as defined in Section B.

4. The amount of Annual Premium, as defined in Section B. This detail should be captured in the relevant Policy Benefit type category. Where a Policy Benefit type contains more than one Cover Type, the amount of Annual Premium should be reflected separately for each Cover Type. If the insurer does not determine or store separate amounts of premium, the total amount of Annual Premium should be split between the relevant Cover Types on an approximate basis.

5. The amount of Sum Insured, as defined in Section B. This detail should be captured in the relevant Policy Benefit type category. Where a Policy Benefit type contains more than one Cover Type, the Sum Insured in respect of each Cover Type should be recorded separately.

6. Items C.1 to C.5 should be provided to cover each of the following:

    a) The number/amount in force at the start of the reporting period.

    b) The number/amount that corresponds with new business (as defined in Section B) during the reporting period.

    c) The number/amount that corresponds with business that was voluntarily discontinued (as defined in Section B) during the reporting period. The template will treat entries for this item as an outflow and it should not be captured with a negative sign.

    d) The number/amount of other movements that reconciles the detail at the start of the reporting period with the detail at the end of the reporting period. The template will auto-complete this field, treating it as a balancing item to reconcile the various reported items. Insurers should however review this number to ensure that it is reasonable. This item will include the impact of claims that have been finalised during the reporting period.

e) The number/amount in force at the end of the reporting period.

7. Items C.1 to C.6 should be provided for each combination of the following data dimensions:

   a) Insurance Type, as defined in Section B.

   b) On Sale Status, as defined in Section B.

   c) Advice Type, as defined in Section B.

   d) Cover Type, as defined in Section B.

8. Items C.1 to C.7 correspond with the following sheets in the accompanying Excel Reporting Template:

Sheet Name	**Insurance Type**	**On Sale Status**	**Advice Type**
STATS_IndOS_Open_Adv	Individual outside Super	Open	Advised
STATS_IndOS_Closed_Adv	Individual outside Super	Closed	Advised
STATS_IndOS_Open_NonAdv	Individual outside Super	Open	Non-Advised
STATS_IndOS_Closed_NonAdv	Individual outside Super	Closed	Non-Advised
STATS_IndIS_Open_Adv	Individual inside Super	Open	Advised
STATS_IndIS_Closed_Adv	Individual inside Super	Closed	Advised
STATS_IndIS_Open_NonAdv	Individual inside Super	Open	Non-Advised
STATS_IndIS_Closed_NonAdv	Individual inside Super	Closed	Non-Advised
STATS_Group_NA_NA	Group	N/A	N/A

D. CLAIMS DATA DETAIL

In respect of Claims Data, the following additional items are defined:

1. **Claim Type** refers to the type of claim that can be submitted under a particular benefit. It largely corresponds to the Cover Types defined. The following Claim Types are relevant:

    a) Death: The Life Insured dies and a death claim is submitted.

    b) Terminal Illness: The Life Insured is terminally ill and a terminal illness claim is submitted under the Death cover policy.

    c) TPD: The Life Insured is totally and permanently disabled in accordance with the provisions of the policy and a TPD claim is submitted.

    d) Trauma: The Life Insured suffers a trauma event and submits a Trauma claim.

    e) DII: The Life Insured is considered disabled in accordance with the provision of the policy and an IP (Individual) or GSC (Group) claim is submitted.

2. **Claim Event** refers to the event that resulted in a Death, TPD, DII or Trauma claim and the **Claim Event Date** the date on which the Claim Event occurred, or is deemed to have occurred. Consider the following Cover Type specific detail:

    a) Death Cover: The Claim Event is death and Claim Event Date the date of death.

    b) Terminal Illness: The Claim Event is the diagnosis of a Terminal Illness and the Claim Event Date the date of said diagnosis.

    c) Trauma: The Claim Event is one of the defined trauma events or conditions. The Claim Event Date is the date on which the trauma event occurred or was diagnosed for the first time.

    d) TPD and DII: The Claim Event is what caused the condition of disability under either TPD or DII. The Claim Event Date is the date on which the disability causing event occurred or when the Life Insured is considered to be disabled for the first time.

3. **Claim Incidence Year** refers to the calendar year in which the Claim Event occurred. P1R1 will collect data in respect of 3 claims incidence year categories, namely:

    a) Calendar Year 2016

b) Calendar Year 2015

c) Calendar Year 2014 or earlier.

4. **Claim Notified** refers to the initial contact made by the claimant in respect of a potential claim. This could take the form of a physical submission (letter, e-mail, etc.) or a telephone call. The **Claim Notification Date** is the date on which the claim was first notified.

5. **Claim Reported** refers to the point where an insurer acknowledges or records the existence of a potential claim. Instances where a claim is notified, but the claimant does not hold an insurance policy with the relevant Cover Type, should be recorded as a notified claim, but not a reported claim. Claims should be classified and recorded as Reported regardless of whether a claims decision has been reached and regardless of whether all information required to make a claim decision has been received.

   Claim Reported Date is the date on which the insurer records a claim being reported.

6. **Claim Finalised** refers to the date where an insurer has received all the information necessary to assess a claim and a claim decision has been made by the insurer. The **Claim Finalised Date** is the date on which the insurer's claim decision made. For the purposes of this collection the Claim Finalised Date for DII relates to the date that the claim is admitted, declined or withdrawn and not to the **Claim Termination Date** when any regular payments cease because the insured life has recovered from disability or reached the end of the benefit period (or died).

7. **Claim Withdrawn** refers to the instance where a reported claim is withdrawn before being finalised. There are two types of withdrawals, namely:

   a) An **Active Withdrawal**, where the claimant informs the insurer that he/she will not be pursuing the claim further.

   b) A **Passive Withdrawal**, where it appears that the claimant is no longer pursuing the claim by virtue of the fact that he/she is not providing the information necessary to assess and finalise a claim. In this instance it is effectively the insurer that is withdrawing the claim.

   The **Claim Withdrawn Date** is the date on which the claim is withdrawn. For an Active Withdrawal it will be the date on which the claimant notifies the insurer of his/her decision

not to continue. For a Passive Withdrawal, it will be the date on which the insurer changes that status of the claim to "Withdrawn", in accordance with its standard practices.

8. **Undetermined Claim** refers to a reported claim that has not been finalised or withdrawn (actively or passively).

9. **Claim Amount Paid** refers to the actual amount paid or, for DII, the regular monthly payment to the insured life, policyholder or nominated beneficiary. This field is used to distinguish between the full Sum Insured amount and partial amounts payable for severity based trauma conditions or for DII due to partial disability or workers' compensation offsets. It is also used to distinguish between the full Sum Insured and ex-gratia payment amounts for less than the full Sum Insured.

   Claim Amount Paid detail collected in P1R1 should be gross of reinsurance.

In respect of Claims Data, the following detail should be provided:

10. The total number of claims (by Policy Benefit count) of which the insurer has been notified during the Reporting Period, split by Claim Incidence year.

11. The total number of claims (by Policy Benefit count) that are undetermined at the start of the Reporting Period, split by Claim Incidence year.

12. The total number of claims (by Policy Benefit count) that have been reported during the Reporting Period, split by Claim Incidence year.

13. The total number of claims (by Policy Benefit count) that have been finalised during the Reporting Period, split by Claim Incidence year. The template will calculate finalised claims as the total of the categories listed under D.17 below.

14. The total number of claims (by Policy Benefit count) that have been withdrawn during the Reporting Period, split by Claim Incidence year. Active and Passive withdrawals should be shown separately.

15. Total number of claims (by Policy Benefit count) that are undetermined at the end of the Reporting Period, split by Claims Incidence year.

16. A claims balancing item will be calculated by the template, such that D.11 plus D.12 minus D.13 minus D.14 equals D.15. Please provide explanatory notes in the event of this balancing item not showing a value of zero.

17. The number of claims that have been finalised during the reporting period (D.13), should be split between the following categories:

    a) **Claims admitted with full benefit payable**. 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 assured (e.g. severity based trauma benefits, or reductions in income benefits in lieu of other income received by the claimant), and such reductions were applied, the claim should still be regarded as 'paid in full' and included in this category.

    b) **Claims declined, but an ex-gratia payment made**. This includes claims where the claim is not valid in terms of the provisions of the contract, but the insurer has decided to make a full or partial payment on compassionate grounds, for commercial reasons, to give fulfilment to the spirit/intent of the contract, or some other reason.

    c) **Claims declined, but admitted under a different cover type**. This refers to the situation where the initial claim is declined, but a different claim, under a different Cover Type is admitted and paid or payable.

    d) **Claims declined, with Policy Benefit or Policy Contract cancelled and premiums refunded**. This refers to instances where, upon the assessment of a claim, the insurer decides that, based on the information it received during the claims process, it would not have granted cover in the first instance, or granted cover under different terms and conditions (resulting in less premiums than what was paid originally). Instances like these, or any other instances where the insurer decides to retrospectively cancel the Policy Benefit or Policy Contract and return the claimant's premiums (in part or in full), should be recorded in this category.

    e) **Claims declined with no payment**. This would include all instances where a claim is declined and no benefit is paid, but excluding the instances defined under D.17.b, D.17.c and D.17.d above.

    f) **Other claims outcomes**. This would include claims declined or not paid in full that are not covered by the categories defined above. Explanatory notes should be provided for any claims included in this category.

18. Items D.10 to D.17 should also be provided with the Sum Insured associated with the claims reported (i.e. Claim Sum Insured). Please note the following in respect of Trauma, DII and TPD claims:

a) The full Sum Insured should be reported here, regardless of whether the insurer made a reduction in accordance with the provisions of the Policy Contract (such as severity based Trauma benefits, DII income payments reduced in lieu of other income received by the claimant, or TPD benefits spread over multiple years).

b) In respect of DII claims, the Sum Insured should reflect the monthly benefit under the contract.

19. In respect of claim outcomes where a benefit was paid, items D.10 to D.17 should also be provided for the Claim Amount Paid associated with the claims reported. The following should be noted:

a) Where a claim is admitted and, consistent with the provisions of the contract, the Claim Amount Paid is less than the full Sum Insured the insurer should use the 'Claim admitted with full benefit payable' line in the relevant part of the template for reporting the Claim Sum Insured and the Claim Amount Paid. The reported amounts will differ because the full Sum Insured and partial amounts differ but this is consistent with the contract provisions.

b) Where a claim is declined but an ex-gratia payment is made the insurer should use the 'Claim declined but an ex-gratia payment made' line in the relevant part of the template for reporting the Claim Sum Insured and the Claim Amount Paid. If the ex-gratia payment amount is less than the full Sum Insured the reported amounts will differ.

c) For DII the claim Sum Insured is the regular monthly benefit that would be paid if the insured were totally disabled and no workers' compensation or other offsets were applied. The claim amount paid should reflect the corresponding actual regular monthly benefit payment. Approximations can be used to estimate an actual regular monthly benefit payment where the payment rate varies from month to month e.g. because the insured is partially disabled and can work part-time but the hours worked fluctuated from month to month.

20. Items D.10 to D.19 should be provided for each combination of the following data dimensions:

a) Insurance Type, as defined in Section B.

b) On Sale Status, as defined in section B.

c) Advice Type, as defined in Section B.

d) Cover Type, as defined in Section B. In the event of a claim arising on a Policy Benefit that includes multiple Cover Types (as defined in B.9), the claim should be recorded in accordance with the Cover Type under which the claim was submitted.

21. **Claims Processing Durations** should be reported in respect of Claims Finalised during the Reporting Period, measured as the period between the Claims Reported Date and the Claims Finalised Date.

    In respect of Cover Types that involve a waiting period, the Claims Processing Duration should be measured from the later of the Claims Reported Date and the Claim Event Date + Waiting Period. Where a Waiting Period exists, but is waived, the Claims Processing Duration should be measured from the Claims Reported Date.

22. Claims Processing Durations should be reported by allocating the number of claims (by Policy Benefit count) into the following **duration categories**:

    In respect of Lump Sum claims (including TPD claims paid by instalment):

    a) 0 to 6 months
    b) 6 months plus 1 day to 12 months
    c) 12 months plus 1 day to 18 months
    d) More than 18 months

    In respect of Monthly Income claims:

    a) 0 to 2 months
    b) 2 months plus 1 day to 6 months
    c) 6 months plus 1 day to 12 months
    d) 12 months plus 1 day to 18 months
    e) More than 18 months

23. Claims processing duration detail defined in D.21 and D.22 should also be provided in respect of Sum Insured, as defined in B.13 and D.18.

24. Claims processing duration detail defined in D.21 to D.23 should be provided for each combination of the following data dimensions:

    a) Insurance Type, as defined in Section B.

    b) Advice Type, as defined in Section B.

c) Claim Type, as defined in Section D. As explained in Section D, Claim Type is essentially the same as Cover Type, but allowing for Terminal Illness as a separate type of claim.

25. Items D.10 to D.24 corresponds with the following sheets in the accompanying Excel Reporting Template:

Claims Data

Sheet Name	Insurance Type	On Sale Status	Advice Type
CLAIMS_IndOS_Open_Adv	Individual outside Super	Open	Advised
CLAIMS_IndOS_Closed_Adv	Individual outside Super	Closed	Advised
CLAIMS_IndOS_Open_NonAdv	Individual outside Super	Open	Non-Advised
CLAIMS_IndOS_Closed_NonAdv	Individual outside Super	Closed	Non-Advised
CLAIMS_IndIS_Open_Adv	Individual inside Super	Open	Advised
CLAIMS_IndIS_Closed_Adv	Individual inside Super	Closed	Advised
CLAIMS_IndIS_Open_NonAdv	Individual inside Super	Open	Non-Advised
CLAIMS_IndIS_Closed_NonAdv	Individual inside Super	Closed	Non-Advised
CLAIMS_Group_NA_NA	Group	N/A	N/A

Claims Duration Data

Sheet Name	Insurance Type	On Sale Status	Advice Type
CLAIMSDURN_IndOS_Adv	Individual outside Super	All	Advised
CLAIMSDURN_IndOS_NonAdv	Individual outside Super	All	Non-Advised
CLAIMSDURN_IndIS_Adv	Individual inside Super	All	Advised
CLAIMSDURN_IndIS_NonAdv	Individual inside Super	All	Non-Advised
CLAIMSDURN_Group_NA	Group	N/A	N/A

E. DISPUTE DATA DETAIL

In respect of Dispute Data, the following additional items are defined:

1. **Dispute Type** distinguishes between Internal, External and Litigated Disputes.

2. **Internal Dispute** refers to an instance where the claimant has registered his/her dissatisfaction with a claims decision or the claims process and requested the insurer to review its decision. This dispute category would also include disputes that may be raised by the trustees of a Superannuation Fund. **Internal Dispute Resolution (IDR)** refers to the process followed by the insurer to deal with Internal Disputes that have been registered with the insurer.

3. **External Dispute** refers to an instance where the claimant has registered his/her dissatisfaction regarding a claims decision or claims process with an external dispute resolution scheme or tribunal, i.e. disputes in respect of claims under individual contracts lodged with the Financial Ombudsman Service (FOS) or under a group contract with the Superannuation Claims Tribunal (SCT). **External Dispute Resolution (EDR)** refers to the process followed by the insurer to deal with External Disputes that have been registered with FOS or the SCT.

4. **Litigated Dispute** refers to the situation where a claimant has initiated legal proceedings against the insurer regarding a claim. This does not include instances where there has been solicitor involvement, but no legal proceedings initiated. '

5. **Dispute Notified** refers to all claims related disputes raised with the insurer, regardless of whether said dispute resulted in a dispute being lodged in writing or not.

6. **Dispute Lodged** refers to the point where an insurer acknowledges or records the existence of a dispute (be it Internal, External or Litigated). **Dispute Lodged Date** is the date that the insurers first receives and records the existence of a dispute.

7. **Dispute Resolved** refers to the point where an insurer has dealt with and resolved the dispute. The **Dispute Resolved Date** is the date on which the dispute is considered resolved.

8. **Dispute Withdrawn** refers to the point where a Lodged dispute is withdrawn before being resolved. There are two types of withdrawals, namely:

    a) An **Active Withdrawal**, where the claimant informs the insurer that he/she will not be pursuing the dispute further; and

b) A **Passive Withdrawal**, where it appears that the claimant is no longer pursuing the dispute by virtue of the fact that he/she is not providing the information necessary to assess and resolve a dispute.

The **Dispute Withdrawn Date** is the date on which the dispute is withdrawn. For an Active Withdrawal it will be the date on which the claimant notifies the insurer of his/her decision not to continue. For a Passive Withdrawal, it will be the date on which the insurer changes the status of the dispute to "Withdrawn", in accordance with its practices.

9. **Undetermined Dispute** refers to a dispute that has been lodged, but has not been resolved or withdrawn (actively or passively) at the end of the reporting period.

In respect of Dispute Data, the following detail should be provided:

10. The total number of disputes (by Policy Benefit count) of which the insurer has been notified during the Reporting Period.

11. The total number of disputes (by Policy Benefit count) that are undetermined at the start of the Reporting Period.

12. The total number of disputes (by Policy Benefit count) that have been lodged during the Reporting Period.

13. The total number of disputes (by Policy Benefit count) that have been resolved during the Reporting Period. The template will calculate resolved disputes as the total of the categories listed under E.17 below.

14. The total number of disputes (by Policy Benefit count) that have been withdrawn during the Reporting Period. Active and Passive withdrawals should be shown separately.

15. Total number of disputes (by Policy Benefit count) that are undetermined at the end of the Reporting Period.

16. A dispute balancing item will be calculated by the template, such that E.11 plus E.12 minus E.13 minus E.14 equals E.15. Please provide explanatory notes in the event of this balancing item not showing a value of zero.

17. The number of disputes that have been resolved during the Reporting Period, should be split between the following categories:

a) **Disputes resolved with no further payment made**. These are disputes that have been resolved without any additional payment made, e.g. an original decision to decline a claim is upheld.

b) **Disputes resolved with full benefit paid**. These are disputes where the resolution culminated in the payment of the full benefit that the claimant was entitled to in terms of the provisions of the Policy Contract, e.g. an original decision to decline a claim is overturned and a decision is made to admit the claim with full benefit payable.. It includes instances where a reduced payment was made consistent with the provisions of the Policy Contract,

c) **Disputes resolved with a partial benefit payment**. These are disputes where the resolution culminated in the payment of an amount that is less than the full entitlement under the Policy Contract, e.g. an external dispute resolution process results in a decision that the insurer make a payment equal to part of the Sum Insured when the original decision had been to decline the claim with no payment. It excludes instances where a reduced payment was made consistent with the provisions of the Policy Contract. It excludes ex-gratia payments, which are dealt with under a different category (refer E.17.e).

d) **Disputes resolved with a non-cash benefit.** These are disputes where the resolution culminated in the provision of a non-cash benefit, e.g. the provision of rehabilitation benefits or other forms of support offered.

e) **Disputes resolved with an ex-gratia payment**. These are disputes where the resolution culminated in the payment of a benefit on an ex-gratia basis, e.g. an original decision to decline a claim with no payment is changed to a decision to decline the claim but with an ex-gratia payment made. Ex-gratia payments are made when the claim is not valid in terms of the provisions of the contract, but the insurer decides to make a full or partial payment on compassionate grounds, commercial reasons, to give fulfilment to the spirit/intent of the contract, or some other reason.

f) **Dispute resolved with a benefit payment made under a different cover type**. These are disputes where the resolution involved the payment of a benefit under a different Cover Type than the Cover Type that the original dispute related to.

g) **Dispute resolved with claim declined, with contract cancelled and premiums refunded**. These are disputes where the resolution involved the cancellation of the Policy Contract or Policy Benefit, with a full or partial refund of the premiums paid, e.g. an original decision to decline a claim with no payment is changed to a decision to decline the claim but with a cancellation of the contract and premium refund.

h) **Dispute resolved through any other means**, not covered above. Please provide explanatory notes in respect of any disputes included here.

18. Internal, External and Litigated Disputes relating to the same claim event should be reported independently, with no attempt to consolidate the reported information. If there is significant duplication of disputes between Dispute Categories, insurers should provide APRA with explanatory notes, giving an indication of the extent of duplication.

19. Items E.10 to E.18 should also be provided with the Sum Insured associated with the dispute, as defined in B.13 and D.18.

20. In respect of disputes that have been resolved (i.e. item E.17 above), the dispute payment amount should also be captured on the template. This is defined as the additional claim amount (if any) that was paid as a result of the dispute. If no additional claim payment was made, this should reflect as zero on the template. Payments that do not relate to the Cover type (e.g. rehabilitation costs) and dispute handling expenses incurred by the insurer should be excluded from the dispute payment amount field.

    In respect of DII claims, any additional claim amount paid as a result of the dispute should be expressed in relation to the monthly Sum Insured. For example, if a claim on a DII policy with a Sum Insured (monthly insured benefit) of $5,000 was originally declined, but following the dispute, the claim was admitted with the insurer making partial payments of $3,000 per month, $3,000 should be recorded.

21. Items E.10 to E.20 should be provided for each combination of the following data dimensions:

    a) Insurance Type, as defined in Section B.

    b) Advice Type, as defined in Section B.

    d) Claim Type, as defined in Section D. As explained in Section D, Claim Type is essentially the same as Cover Type, but allowing for Terminal Illness as a separate type of claim.

22. **Dispute processing durations** should be reported in respect of Disputes Resolved during the reporting period, measured as the period between the Dispute Lodged Date and the Dispute Resolved Date.

23. Dispute processing durations should be reported by allocating the number of disputes (by Policy Benefit count) into the following **duration categories**:

    a) 0 to 6 months
    b) 6 months plus 1 day to 12 months
    c) 12 months plus 1 day to 18 months
    d) More than 18 months

24. Dispute processing duration detail defined in E.22 and E.23 should also be provided in respect of Sum Insured, as defined in B.13 and D.17.

25. Dispute processing duration detail defined in E.22, E.23 and E.24 should be provided for each combination of the following data dimensions:

    a) Insurance Type, as defined in Section B.

    b) Advice Type, as defined in Section B.

    c) Claim Type, as defined in Section D. As explained in Section D, Claim Type is essentially the same as Cover Type, but allowing for Terminal Illness as a separate type of claim.

    d) Dispute Type, as defined earlier in Section E.

Items E.10 to E.25 corresponds with the following sheets in the accompanying Excel Reporting Template:

Dispute Data

Sheet Name	Insurance Type	On Sale Status	Advice Type
DISPUTES_IndOS_Adv	Individual outside Super	All	Advised
DISPUTES_IndOS_NonAdv	Individual outside Super	All	Non-Advised
DISPUTES_IndIS_Adv	Individual inside Super	All	Advised
DISPUTES_IndIS_NonAdv	Individual inside Super	All	Non-Advised
DISPUTES_Group_NA	Group	N/A	N/A

Dispute Duration Data

Sheet Name	Insurance Type	On Sale Status	Advice Type
DISPUTESDURN_IndOS_Adv	Individual outside Super	All	Advised
DISPUTESDURN_IndOS_NonAdv	Individual outside Super	All	Non-Advised
DISPUTESDURN_IndIS_Adv	Individual inside Super	All	Advised
DISPUTESDURN_IndIS_NonAdv	Individual inside Super	All	Non-Advised
DISPUTESDURN_Group_NA	Group	N/A	N/A