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APRA LIFE CLAIMS DATA DEFINITIONS AND INSTRUCTIONS – PHASE 1 ROUND 2

This document contains instructions and definitions for Phase 1 Round 2 of the APRA life claims data collection (P1R2).

It includes the following sections:

A. Inclusions for P1R2 collection
B. General instructions for completing the template
C. Changes from P1R1
D. General definitions
E. Policy data detail
F. Claims data detail
G. Dispute data detail
H. Qualitative collection

A. INCLUSIONS FOR PHASE 1 ROUND 2 COLLECTION – 1 JANUARY TO 30 JUNE 2017

P1R2 is defined to include the following:

1. It includes the following products:

    a) Individual and Group Insurance products and benefits, whether classed as superannuation or ordinary business, that provide the Cover Types as defined in this document.

    b) Products providing Funeral Insurance, Consumer Credit Insurance (CCI) and Accident Insurance are included. Business Expense insurance is excluded from the P1R2 collection.

    c) 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.

    d) It only includes gross business written directly i.e. excluding inwards and outwards reinsurance.

2. The P1R2 collection is in respect of the Reporting Period covering the first six months of the 2017 Calendar Year, i.e. from 1 January 2017 to 30 June 2017 (inclusive).

3. P1R2 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. P1R2 includes detail on all claims that were notified, reported or re-opened during the defined Reporting Period, as well as claims that were undetermined at the start of the Reporting Period. Consistent with P1R1, disability income insurance (DII) business should only consider the initial reporting and assessment of claims and not any detail about claims already in course of payment at the start of the Reporting Period.

5. P1R2 includes all claims related disputes that were lodged during the defined Reporting Period, as well as claim related disputes that were undetermined at the start of the Reporting Period.

B. GENERAL INSTRUCTIONS FOR COMPLETING THE TEMPLATE

The following general instructions are noted:

1. Insurers are requested to complete the P1R2 life claims collection template, including the information requested in the Qualitative Collection section. As with P1R1, it is accepted that submissions will be completed on a best endeavours basis.

2. Select the relevant insurer name on the cover sheet.

3. The template has been password protected to help ensure its structural integrity for use by APRA. An unprotected version of the template is available on request, however only the protected version will be accepted for submission.

4. As each input cell has data validation, it will not be possible to enter links to other cells or workbooks. If desired, the unprotected version could be used in this way and then subsequently unformatted cell values copied to the protected version.

5. Before final saving and submission of the workbook, please ensure that any workbook multi-user sharing that may have been utilised is turned off. Please also ensure that the workbook is **not** saved as read only.

C. CHANGES FROM PHASE 1 ROUND 1

The following changes from P1R1 are noted:

1. The following products are added in P1R2:

    a) Consumer Credit Insurance

    b) Funeral Insurance

    c) Accident Insurance

2. Introduced for claims and disputes, sub-categories for the following cover/product types (refer Section D for detail):

   a) TPD – Own Occupation, Any Occupation and Other disability definitions;

   b) CCI – Death, Incapacity and Redundancy;

   c) Accident Insurance – Death and Injury.

3. Simplified the policy statistics section, including the removal of categories with different benefit combinations, as well as the split between business with and without terminal illness.

4. Expanded the template to accommodate claims that are re-opened in the Reporting Period (after previously being declined or withdrawn). See the definition in Section F (item F.5) and note the interpretation of this item for DII.

5. Revised the categories for claims and dispute processing durations to allow for more information at the short and long end of the duration spectrum.

6. Removed policy benefits from the collection template.

7. Introduced a unique Policy Contract and Life Insured count.

8. Split Group Insurance into Inside Super and Outside Super.

9. Removed disputes notified from the collection template.

10. Modified outcomes for claims and disputes and introduced reasons for withdrawn claims, reasons for declined claims, reasons for disputes, reasons for withdrawn disputes and reasons for claim outcomes being reversed (following a dispute).

11. Reviewed the definitions of claim and dispute amount paid and adjusted the reporting template to simplify the collection of these items.

12. Updated the claim incidence year periods to reflect the new Reporting Period.

13. Amended Voluntary Discontinuances to Lapses and refined the definition to provide more clarity and achieve greater consistency.

14. Refined some definitions to improve understanding and achieve greater consistency.

15. As with P1R1, the template contains worksheets showing sub-totals for different sections. For P1R2, these have been expanded to show sub-totals for Individual and Group business. In addition, a number of checks and measures have been incorporated into the input sheets to aid the review of data. These appear below the input section.

D. 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 P1R2 collection the Reporting Period is the six months from 1 January 2017 to 30 June 2017 (inclusive).

2. **Policy Contract** refers to the life policy as defined by section 9 or 9A of the *Life Insurance Act 1995* (Life Act). In respect of Individual Insurance business, this contract is between the policyholder (who could also be the Life Insured) and the life insurance company. In respect of Group Insurance business, this contract is between the trustee (of a Superannuation Fund) or an employer and the life insurance company and provides insurance for a group of eligible members.

3. **Life Insured** refers to the individual life (or multiple lives in the event of joint life contracts) covered under a Policy Contract. In respect of Group Insurance contracts, Lives Insured are also referred to as members.

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

5. **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. Lives insured are underwritten according to blanket rules that apply to the group and usually provide for automatic acceptance up to prescribed limits; and

    - Individual Insurance business, for insurance cover held outside superannuation or within a retail superannuation fund where each Policyholder selects the amount of death, TPD, trauma and income protection cover he or she requires. Each life insured is individually underwritten. It also includes CCI, Accident and Funeral insurance.

    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 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;

c) Group Insurance sold outside Superannuation Funds; and

d) Group Insurance sold inside Superannuation Funds.

Categories 5a to 5d above should correspond to D2A reports as follows:

Category	D2A Class of business	D2A Product group
Individual Insurance outside Super	Australia – Ordinary Business	L4 and L5
Individual Insurance inside Super	Australia – Superannuation Business	L4 and L5
Group Insurance outside Super	Australia – Ordinary Business	L6 and L7
Group Insurance inside Super	Australia – Superannuation Business	L6 and L7

6. **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.

7. **Product Type** refers to the type of product or rider benefit that provides any of the Cover Types. For P1R1 the collection related to term insurance contracts of the cover types defined. For P1R2, the following additional Product Types are included:

   a) Consumer Credit Insurance (CCI) – Insurance providing for a lump sum payment of the insured's outstanding loan or credit card balance (in part or in full) or regular payments limited to the minimum repayments for a period of time, payable in the event of one or more of a number of predefined events occurring. CCI products included in the P1R2 submission 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 detail of these products (including statistics, claims and disputes) should not be included in the P1R2 data collection template. APRA is however interested in having a more holistic understanding of CCI products and request insurers to provide additional detail on the GI licensed business as part of the Qualitative Collection.

   b) Funeral Insurance – Insurance within a Policy Contract where the primary purpose of all of the benefits is to meet the expenses of, or incidental to the funeral, burial or cremation of the person covered under the policy.

   c) Accident Insurance – Insurance within a Policy Contract providing for the payment of a lump sum in the event of accidental death or injury.

8. In P1R2**, Sub-categories** of Product and Cover Types are defined for selected products as follows:

   a) Death cover – distinction is made between the following sub-categories:

      i. Death – where benefits are payable upon the death of the life insured.

      ii. Terminal illness – where death benefits can be accelerated upon the diagnosis of the life insured with a terminal illness.

b) TPD cover – distinction is made between the following main sub-categories of disability definitions:

i. 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.

ii. 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.

iii. Other disability definitions.

c) CCI insurance – distinction is made between the following main sub-categories:

i. Death – where a benefit is payable on the death of the life insured.

ii. Incapacity – where a benefit is payable when the life insured is deemed disabled or suffers an injury, sickness or other incapacitating event, as defined in the underlying Policy Contract.

iii. Involuntary redundancy – where a benefit is payable upon the life insured being made redundant at his/her place of work, in accordance with the provisions of the underlying Policy Contract.

d) Accident insurance – distinction is made between the following main sub-categories:

i. Death – where a benefit is paid on the death of the life insured as a result of an accident, as defined in the underlying Policy Contract.

ii. Injury – 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.

9. The collection template does not make any distinction between products and covers offered on a stand-alone or an accelerated cover basis.

10. **Annual Premium** refers to the annualised premium payable in respect of the Policy Contract. Annual Premiums collected in P1R2 should be gross of reinsurance and commissions, and before profit share rebates (Group Insurance). Reported premiums should also be inclusive of stamp duty.

11. **Sum Insured** refers to the contractual benefit payable should the insured event occur. Insurers should report the full Sum Insured and not apply any reductions that may exist for severity based Trauma and Accidental Injury benefits or for DII due to partial disability or a workers' compensation offset. Where reductions to the sum insured are made consistent with the policy contract, this will be reflected in the Claim Amounts Paid item (defined in

section F). Sum Insured should be reported gross of reinsurance. Distinction is made between the following 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, as well as Funeral and Accident Insurance product 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 and 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 disabled in accordance of the provisions of the Policy Contract.

c) CCI benefits can be defined in a number of ways, and should be reported as follows:

   i. Lump sum that is fixed: The fixed benefit should be reported.

   ii. Lump sum equal to the outstanding loan or credit card balance: The latest known balance should be reported.

   iii. Lump sum equal to a portion of the outstanding loan or credit card balance: The calculated benefit, based on the latest known balance should be reported.

   iv. Monthly benefit equal to a loan instalment: For purposes of the P1R2 collection, monthly benefits should be reported on a capitalised basis, i.e. the monthly benefit multiplied by the number of months that the benefit is expected to be paid. Additional detail in respect of monthly benefits should be provided as part of the Qualitative Collection.

12. **New Business** refers to a new Policy Contract, or a new policy benefit under an existing Policy Contract. There are a number of specific circumstances worth clarifying:

a) Voluntary cover increases (typically subject to underwriting) or exercise of embedded options (e.g. additional cover for the birth of a child) should be <u>included</u> as New Business;

b) Automated premium and/or Sum Insured increases, such as age related premium increases for a stepped premium product, or automatic CPI increases should be <u>excluded</u> from New Business;

c) Where a policy is cancelled from inception within the P1R2 Reporting Period, with premiums refunded, it is likely to have related to a claim that should be included in the P1R2 collection. If this applies to a policy that was also issued during the P1R2 Reporting Period, those contracts should be <u>included</u> with New Business.

d) Where a new policy is issued and subsequently lapsed during the cooling off period, all within the P1R2 Reporting Period, the new policy should be excluded from New Business.

e) Where an existing policy has been cancelled and replaced by a new Policy Contract, the new contract should be included as New Business.

f) Cover buybacks should be included as New Business.

g) The preceding points mostly relate to Individual Insurance contracts. In respect of Group Insurance contracts, it is the commencement of a new Policy Contract that should be reported under New Business and not the impact of individuals joining the Group Insurance arrangement. Similarly, the effect of benefit changes at a member level should not be reported under New Business.

13. **Lapses** refer to a Policy Contract (or underlying benefit) being discontinued through a decision of the Life Insured or Policyholder. There are a number of specific circumstances worth clarifying:

a) Instances of the contract being discontinued as a result of the Life Insured dying, or another claim of the types covered by this collection, should be excluded from Lapses;

b) Instances of the 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, should be excluded from Lapses.

c) Cancellation of the policy during the cooling off period should be excluded from Lapses;

d) Policies later cancelled by the insurer from inception, e.g. in the event of misrepresentation or non-disclosure should be excluded from Lapses; and

e) Where an existing policy is cancelled and replaced by a new Policy Contract, the cancelled contract should be included with Lapses.

f) The preceding points all relate to individual insurance contracts. In respect of group insurance contracts, it is the cancelation of the full contract that should be reported under Lapses and not the impact of individuals leaving the Group Insurance arrangement. Similarly, the effect of benefit changes at a member level should not be reported under Lapses.

14. **Disputes**, considered in more detail in Section G, 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.

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

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

    a) Open for sale: Products that are open for sale at the time of data submission.

    b) 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 as defined above is still possible.

    This item is only recorded for the Insurance Type of Individual Insurance, as described in D.5.

17. **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 section 766B(3) of the *Corporations Act 2001* (Corporations Act). The template assumes this does not apply to CCI, Funeral or Accident business.

    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 section 766B(4) of the Corporations Act.

E. POLICY DATA DETAIL

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

1. The number of Policy Contracts, as defined in Section D. This detail should be captured in the relevant Cover/Product type category. Where a single policy contract contains multiple cover types, it should be counted in each of the cover/product types where benefits are offered. In addition, the total number of unique policy contracts, across all relevant cover and product types should be reported.

2. The number of Lives Insured, as defined in Section D. This detail should be captured in the relevant Cover/Product type category. Where a single life has multiple cover types, it should be counted in each of the cover/product types where benefits are offered. In addition, the total number of unique lives insured, across all relevant cover and product types should be reported.

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

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

5. Items E.1 to E.4 should be provided for 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 D) during the Reporting Period.

    c) The number/amount that corresponds with business that has Lapsed (as defined in Section D) 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 should include the impact of claims finalised during the Reporting Period.

    e) The number/amount in force at the end of the Reporting Period.

6. Items E.1 to E.5 should be provided for each combination of the following data dimensions:

   a) Insurance Type, as defined in Section D.

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

   c) Advice Type, as defined in Section D.

   d) Product/Cover Type, as defined in Section D.

7. It is possible that there are instances where a single Policy Contract contains a benefit (or benefits) that spans multiple data dimensions. Where multiple benefits all exist in the same combination of Insurance Type, On Sale Status and Advice Type, the various items should be dealt with as defined in E.1 (Policy Contracts), E.2 (Lives Insured), E.3 (Annual Premium) and E.4 (Sum Insured) above.

   Where a Policy Contract contains a benefit (or benefits) that exist across more than one combination of Insurance Type, On Sale Status or Advice Type, the different data items should be dealt with as follows:

   a) Policy Contract should be recorded in each relevant data dimension combination. The number of unique Policy Contracts should however only be recorded once, in the category regarded as the main or dominant data dimension combination.

   b) Lives Insured should be recorded in each relevant data dimension combination. The number of unique Lives Insured should however only be recorded once, in the category regarded as the main or dominant data dimension combination.

   c) Annual Premium should be split across the different data dimensions that may be relevant to a specific Policy Contract. If the insurer does not determine or store separate amounts of premium, the total amount of Annual Premium should be apportioned between the relevant data dimensions.

   d) Sum Insured detail should be recorded separately for each relevant data dimension.

   One specific application of the methodology outlined above is where a single Policy Contract contains benefits both inside and outside Super, typically with TPD cover.

Items E.1 to E.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_GrpOS	Group outside Super	N/A	N/A
STATS_GrpIS	Group inside Super	N/A	N/A

F. CLAIMS DATA DETAIL

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

1. **Claim Event** refers to the event that resulted in a Death, TPD, DII, Trauma, CCI, Funeral or Accident 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, CCI Death, Funeral or Accidental Death: 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, CCI Incapacity or Accidental Injury: The Claim Event is one of the defined trauma, incapacity or accident events. The Claim Event Date is the date on which the event occurred or was diagnosed.

    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 medical diagnosis is made that underpins the disabled status of the claimant.

    e) CCI Redundancy: The Claim Event is the date on which the life insured was made redundant at his/her place of employment.

2. **Claim Incidence Year** refers to the calendar year in which the Claim Event occurred. P1R2 will collect data in respect of 3 claims incidence year categories, namely:

    a) Calendar Year 2017

    b) Calendar Year 2016

    c) Calendar Year 2015 or earlier.

3. **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.

4. **Claim Reported** refers to the point where an insurer acknowledges or records the existence of a potential claim after confirming that the Life Insured has a valid Policy Contract that could potentially cover the indicated claim event. 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.

Regarding the relationship between Notified and Reported claims please note that:

a) It is expected that every claim recorded as Reported, should also be recorded as Notified. It is however possible that claims recorded as Notified may not be recorded as Reported.

b) It is possible (and acceptable) that the Notification of a claim does not happen in the same Reporting Period as the claim being recorded as Reported.

5. **Claim Re-opened** refers to instances where a claim has previously been Finalised or Withdrawn, but is re-opened by the insurer during the Reporting Period. Re-opened claims should be treated like any other reported claim and be classified as Withdrawn, Finalised or Undetermined at end, as may be the case. It is expected that Re-opened claims would predominantly relate to claims that have been Finalised or Withdrawn during previous Reporting Periods. It is however possible (and acceptable) that re-opened claims could also relate to claims that have been withdrawn or finalised in the same Reporting Period as the claim being Re-opened.

   It is important to note that when it comes to DII claims, Re-opened claims do not refer to instances where a claim in payment has been terminated and the claimant submitted a request for payments to recommence.

6. **Claim Withdrawn** refers to the instance where a reported claim is withdrawn and closed before being assessed and finalised.

7. **Claim Finalised** refers to when the insurer has made a final decision on the claim (e.g. whether to admit or decline the claim) and communicated this decision to the claimant. The **Claim Finalised Date** is the date on which the insurer's claim decision is communicated to the claimant. This is not dependent on payment to the insured having been made. Communication by e-mail, text message, facsimile or telephone is deemed to have occurred on the date it was sent. Communication by postal service is deemed to have occurred three business days after it was sent.

   The Claim Finalised Date for DII refers 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 has recovered from disability, the end of the benefit period was reached, or the claimant has died).

   Where DII payments have commenced prior to a final claim decision being made (so-called goodwill payments), the claim should not be classified as Finalised. 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 payments already made.

8. **Undetermined Claim** refers to a Reported Claim that has not been finalised or withdrawn at the end of the reporting period. Classification of a claim as withdrawn, finalised or undetermined should be based on its **status at the end of the reporting period**. Any developments between the end of the reporting period and the date of data submission should **not** be reflected in the data collection.

9. **Claim Sum Insured** refers to the sum insured in respect of the Policy Contract and relevant cover type or benefit being claimed for. The full sum insured should be reflected, with no allowance for any reduction, even where this is allowed for in the terms of the policy contract. The Claim Sum Insured should be gross of reinsurance.

10. **Claim Amount Paid** refers to the actual amount paid or, for DII, the regular monthly payment to the insured life, policyholder or nominated beneficiary. 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 DII benefit reduction in lieu of other income received), this field should reflect such reduction. In the event of varying DII payments during the Reporting Period, the average monthly payment amount should be reported.

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

11. It is possible that the same claim event is considered and assessed for multiple benefits under the same Cover Type or Product. The most common example is the structuring of TPD benefits with different definitions for disability. The life insured could then be assessed under multiple disability definitions, arising from the same claim submission. Different outcomes are possible, including:

    a) The claim is admitted under the first disability definition tested, with no further consideration of other disability definitions; or

    b) The claim is declined under the first disability definition, but admitted under a subsequent disability definition; or

    c) The claim is declined under all disability definitions assessed.

    From the perspective of the claimant, this is experienced as a single claim and should be reflected in the data collection, as follows:

    d) If the claim is admitted under any disability definition and there is no difference in the benefit level associated with the different disability definitions, it should be recorded as admitted in the relevant sub-category.

    e) If the claim is admitted under a disability definition with a lower benefit level than available under other disability definitions in the Policy Contract, for which the claim was either declined or not considered, it should still be recorded as admitted in the relevant sub-category. To aid our understanding of these instances and deal with them more effectively going forward, additional information should be provided, as specified in the Qualitative Collection section.

f) If the claim is declined under all disability definitions, it should be recorded as a single declined claim in the sub-category with the definition that is considered least onerous.

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

12. The total number of claims that are undetermined at the start of the Reporting Period, split by Claim Incidence year (labelled A on the various claims sheets in the collection template). It is expected that numbers undetermined at the start of the Reporting Period would correspond to numbers reported undetermined at the end of the corresponding Claim Incidence Year in the P1R1 submission. If this is not the case, please provide an explanation.

13. The total number of claims notified during the Reporting Period (labelled B). Where the claim incidence date is known, the notified claim should be allocated to the relevant claim incidence period. Where the claim incidence date is not known, the notified claim should be allocated to the most recent claim incidence period.

14. The total number of claims that have been reported during the Reporting Period, split by Claim Incidence year (labelled C).

15. The total number of claims that have been re-opened during the Reporting Period, split by Claim Incidence year (labelled D).

16. The total number of claims that have been withdrawn during the Reporting Period, split by Claim Incidence year (labelled E). Claims withdrawn should be split between the following categories:

    a) **No reply/response to request for information** (labelled E.1).

    b) **Informed of withdraw decision by claimant** (labelled E.2).

    c) **Insured deceased and claim no longer relevant** (labelled E.3). Where the passing away of the claimant results in another claim, this should be dealt with as a separate item in the data collection.

    d) **Other or unknown reasons withdrawal** (labelled E.4).

17. The total number of claims that have been finalised during the Reporting Period, split by Claim Incidence year (labelled G). Claims finalised should be split between the following categories:

    a) **Claims admitted (excluding ex-gratia payments)** (labelled G.1). 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.

b) **Claims declined (with no payment)** (labelled G.2). This includes outcomes where the claim is declined, with no benefit paid (or payable) to the claimant. Claims declined should be split between a number of categories, defined in F.18 below.

c) **Claims admitted on an ex-gratia basis** (labelled G.3). 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. The experience of the claimant has been consistent with that of a typical admitted claim.

d) **All other ex-gratia payments, settlements or premium refunds** (labelled G.4). 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.

18. Claims declined (with no payment) should be split between the following categories:

a) **Contractual definition not met (including eligibility criteria)** (labelled G.2.1). – 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.

b) **Exclusion clause** (labelled G.2.2). – These are instances where claims are declined on the basis of a pre-existing condition exclusion, a limited cover clause, an exclusion imposed during initial underwriting, or any other policy exclusion.

c) **Innocent non-disclosure or misrepresentation** (labelled G.2.3). – Where the claim is declined for reasons of non-disclosure or misrepresentation as contemplated in Section 29 (1) of the Insurance Contracts Act 1984.

d) **Fraudulent claim, including fraudulent non-disclosure or misrepresentation** (labelled G.2.4). – 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.

e) **Other reasons for being declined** (labelled G.2.5). – Any other reasons for a claim being declined.

19. Total number of claims that are undetermined at the end of the Reporting Period, split by Claims Incidence year (labelled H).

20. The template will automatically calculate “Claims Open for Assessment in period” as the preceding items F.12 plus F.14 plus F.15 minus F.16, labelled as F in the template. In addition, the template will perform a check to confirm reconciliation of the various items of entry. It is expected that F minus G minus H should equal zero. Where this is not the case, the template will highlight the resultant difference. Insurers are requested to provide an explanation when this occurs.

21. Items F.12 to F.19 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, Accident, 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 or Accident 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.

22. In respect of claim outcomes where a benefit was paid, F.12 to F.19 should also be provided for the Claim Amount Paid associated with the claims reported. The template only needs to be completed for the entries associated with a claim payment, namely G.1, G.3 and G.4. In addition, 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 detail should be recorded in the ‘Claim admitted (excluding ex-gratia payments)” category.

    b) 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 actual regular monthly benefit payment. In instances where the actual monthly benefit varied over the course of the Reporting Period, an average monthly benefit should be reported.

23. Items F.12 to F.22 should be provided for each combination of the following data dimensions:

    a) Insurance Type, as defined in Section D.

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

    c) Advice Type, as defined in Section D.

    d) Cover/Product Type, as well as sub-categories, as defined in Section D.

24. **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 plus Waiting Period.

    There are a number of potential complications worth noting:

    a) Where a Waiting Period exists, but is waived, the Claims Processing Duration should be measured from the Claims Reported Date.

    b) Where a claim is Finalised prior to the expiration of the Waiting Period, a Claims Processing duration of zero should be recorded.

25. Claims Processing Durations should be reported by allocating the number of claims into the following **duration categories**:

    a) 0 to 2 weeks;
    b) > 2 weeks to 2 months;
    c) > 2 months to 6 months;
    d) >6 months to 12 months;
    e) >12 months to 24 months;
    f) >24 months to 36 months; and
    g) >36 months

26. Claims processing duration detail defined in F.24 and F.25 should also be provided in respect of the Claim Sum Insured, as defined in F.9.

27. Claims processing duration detail defined in F.24 to F.26 should be provided for each combination of the following data dimensions:

    a) Insurance Type, as defined in Section D.

    b) Advice Type, as defined in Section D.

    c) Cover/Product Type, as well as sub-categories, as defined in Section D.

Items F.12 to F.27 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_GrpOS	Group, outside Super	N/A	N/A
CLAIMS_GrpIS	Group, inside Super	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_GrpOS	Group, outside Super	N/A	N/A
CLAIMSDURN_GrpIS	Group, inside Super	N/A	N/A

G. 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. For P1R2 this includes the Financial Ombudsman Service Limited (FOS) and the Superannuation Complaints 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 an instance 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 Lodged** refers to all claims related disputes, regardless of whether it was:
   - Raised with the insurer by the claimant (or his/her representative); or
   - Communicated to the insurer by a superannuation fund trustee, an external dispute resolution scheme, tribunal or court of law.

   Disputes should be classified and recorded as Lodged regardless of whether a decision has been reached and regardless of whether all information required to make a decision on the dispute has been received.

   Dispute Lodged Date is the earlier of the following dates:

   a) The date the claimant (or his/her representative) first raises a claims related dispute with the insurer; and

   b) The date the insurer first receives information about a claims related dispute from a superannuation fund trustee, external dispute resolution scheme, tribunal or court of law.

6. **Dispute Withdrawn** refers to the instance where a Lodged dispute is withdrawn before being resolved.

7. **Dispute Resolved** refers to the point where the insurer has communicated its final decision about how it will resolve the claims related dispute to the claimant (or his/her representative) or the point where FOS, the SCT or a court of law has made a final determination/judgment that is binding on the insurer.

   The **Dispute Resolved Date** is earlier of the following dates

   a) The date the insurer's final decision on the dispute was communicated to the claimant (or his/her representative); and

   b) The date FOS, the SCT or a court of law makes a final determination/judgment that is binding on the insurer.

   Where relevant, this is not dependent on payment to the claimant having been made. Communication by email, text message, facsimile or telephone is deemed to have occurred on the date it was sent by the insurer. Communication by the postal service is deemed to have occurred three business days after it was sent by the insurer.

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

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

9. The total number of Disputes that are undetermined at the start of the Reporting Period (labelled A on the various disputes sheets in the collection template).

10. The total number of claims related Disputes that have been lodged during the Reporting Period (labelled B). Lodged disputes should be split between the following Dispute Reasons:

    a) **Claim outcome: decline decision** (labelled B.1). These are instances where the claim has been declined and the decline decision is challenged or disputed.

    b) **Claim outcome: benefit adjustment (claim amount)** (labelled B.2). These are instances where a claim has been admitted but the benefit amount is challenged or disputed.

    c) **Claim process** (labelled B.3). These are disputes that are not related to the claim outcome, but to any aspect related to the claim process, e.g. delays, requirements, etc.

    d) **Other disputes lodged** (labelled B.4). Any claims related dispute not covered by one of the preceding categories.

11. The total number of disputes that have been withdrawn during the Reporting Period (labelled C). Disputes withdrawn should be split between the following Withdraw Reasons:

    a) **No reply/response to request for information** (labelled C.1).

    b) **Informed of withdraw decision by claimant** (labelled C.2).

    c) **Other or unknown withdraw reasons** (labelled C.3).

12. The total number of disputes that have been resolved during the Reporting Period (labelled E). Resolved disputes should be split between the following Dispute Outcomes:

    a) **Original claims outcome maintained** (labelled E.1). These are instances where the dispute did not result in any change to the original claim declinature decision, including any benefit that may have been paid.

    b) **Original claims outcome reversed** or amended (labelled E.2). These are instances where the original claim declinature decision is reversed to become a 'claim admitted' decision, as well as instances in which the insurer has agreed to pay an additional amount equivalent to the amount sought by the claimant. The Dispute Outcomes reported in this category should be split into a number of sub-categories, defined in G.13 below.

    c) **Ex-gratia payment, premium refund, partial payment, settlement or non-cash benefit** (labelled E.3). These are instances where the original declinature decision is not reversed (as defined in G.12.b), but an amount of compensation is paid (including and any amount that is less than the amount sought by the claimant). This can take the form of an ex-gratia payment, a partial benefit payment, a commercial settlement, a premium refund, or a non-cash benefit.

    d) **Outside jurisdiction (EDR only)** (labelled E.4). This category applies only to EDR disputes and refer to instances where the relevant dispute does not fall within the relevant dispute resolution scheme or tribunal's jurisdiction in accordance with the scheme or tribunal's rules.

    e) **Other (including outcomes for process related disputes)** (labelled E.5). Any resolved disputes not covered by the preceding categories should be reported in this category. This specifically includes all disputes related to the claims process.

13. Resolved disputes where the original claims outcome was reversed (or amended) should be split into the following sub-categories:

    a) **Original decision incorrect** (labelled E.2.1). These are instances where, after review of all relevant detail and information provided, the insurer decides that the original decision was incorrect.

b) **Additional information received** (labelled E.2.2). These are instances where the insurer has received additional information and, based on the additional information, decided to reverse (or amend) its original claims decision.

c) **Other reasons** (labelled E.2.3). Any instances not covered by the preceding categories should be reported here.

14. Total number of disputes that are undetermined at the end of the Reporting Period (labelled F).

15. The template will automatically calculate "Disputes Open for Assessment in period" as G.9 plus G.10 minus G.11, labelled as D in the template. In addition, the template will perform a check to confirm reconciliation of the various items of entry. It is expected that D minus E minus F should equal zero. Where this is not the case, the template will highlight the resultant difference. Insurers are requested to provide an explanation when this occurs.

16. Internal, External and Litigated Disputes relating to the same claim event should be reported as they exist on the administration systems of the insurer. Where the same underlying dispute exists in multiple dispute types (e.g. both as an Internal and External dispute), both should be reported. Insurers are required to provide additional information related to disputes as part of the Qualitative Collection.

17. **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.

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

a) 0 to 45 days
b) > 45 days to 90 days
c) > 90 days to 6 months
d) > 6 months to 12 months
e) >12 months to 24 months
f) > 24 months to 36 months
g) > 36 months

19. Items G.9 to G.18 should also be provided with the Claim Sum Insured associated with the dispute, as defined in F.9.

20. Items G.9 to G16 should also be provided in respect of the actual payments made following the resolution of a dispute. Where the resolution of a dispute includes the payment of a benefit of any kind, be it the full contractual benefit or a partial payment of any kind, the amount of the payment (or equivalent value if the resolution resulted in a non-cash benefit) should be recorded under "Dispute Payment Amounts (Resolved)" on the dispute sheets in the collection template. Entries are only expected in respect of outcome categories

where a payment is possible, namely categories with template labels E.2.1, E.2.2, E.2.3 and E.3.

In respect of DII claims, the template should only reflect benefits paid in the form of a monthly income. Any payments related to the dispute that are not in the form of a monthly income benefit, should be reported separately as an addendum to the collection template. Detail of the information required is contained in the Qualitative Collection section of this document.

For the purpose of calculating the dispute payment amount, the Dispute Outcome "Original claims outcome reversed or amended" includes any compensatory interest payments made under section 57 of the *Insurance Contracts Act 1984* for unreasonably delayed claims.

21. Items G.9 to G.20 should be provided for each combination of the following data dimensions:

    a) Insurance Type, as defined in Section D.

    b) Advice Type, as defined in Section D.

    c) Cover/Product Types, as well as sub-categories, as defined in Section D.

    d) Dispute Type, as defined in Section G.

Items G.10 to G.21 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_GrpOS	Group outside Super	N/A	N/A
DISPUTES_GrpIS	Group inside Super	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_GrpOS	Group outside Super	N/A	N/A
DISPUTESDURN_GrpIS	Group inside Super	N/A	N/A

H. QUALITATIVE COLLECTION

Insurers are requested to provide the following additional information:

1. Detail on cover and product sub-categories

In P1R2 we are introducing sub-categories in respect of a number of product and cover types. This detail is important to ensure that we ultimately end up with data that is comparable. To assist with further refinement of the relevant sub-categories, we request insurers to provide us with the following additional information:

a) A list of the relevant sub-categories of products or benefits in respect of each of the cover/product types offered. The following guiding principles should be considered:

   i. Distinction should be made between benefits with inherently different claim criteria, potentially contributing to different claim outcomes;

   ii. Benefits where differences are expected to only have a marginal impact on claims outcomes should not be reflected separately.

b) An indication of materiality for each of the sub-categories listed in H.1.a. That is the number of policy contracts in force at the end of the reporting period, as well as the average sum insured per sub-category.

Benefits or categories to be considered here would include (but are not limited to) aspects such as:

- Disability or incapacity definitions (TPD, DII, CCI)
- Waiting periods (TPD, DII).
- Terminal illness categories.
- Trauma benefit categories.

2. Detail on CCI monthly benefits

The P1R2 collection template does not make distinction between CCI Incapacity benefits defined as a lump sum vs those defined as a monthly benefit. As specified in item D.11.c.iv, CCI Incapacity benefits defined as monthly benefits should be recorded in the template on a capitalised basis, i.e. the monthly benefit multiplied by the number of expected payment months. To enable a more complete understanding of the underlying product profile, the following additional detail should be provided in respect of CCI Incapacity products where benefits are defined as monthly payments:

a) In respect of in force policy data

On Sale status	Open	Closed
Policy Contracts at end of reporting period		
Lives Insured at end of reporting period		
Annual Premium at end of reporting period		
Sum Insured (at end of reporting period) as reflected in the reporting template, i.e. capitalised value.		
Sum Insured (at end of reporting period) expressed as a monthly benefit		

b) In respect of claims data:

On Sale status	Open	Closed
Number of claims finalised		
Number of claims admitted (excluding ex-gratia payments)		
Claim Amounts Paid in respect of claims admitted (excluding ex-gratia payments), as reflected in reporting template (i.e. capitalised value)		
Claim Amounts Paid in respect of claims admitted (excluding ex-gratia payments), expressed as a monthly benefit.		

c) In respect of disputes data:

On Sale status	Open	Closed
Number of disputes lodged (total)		
Number disputes resolved (total)		
Sum Insured in respect of disputes lodged (total), as reflected in reporting template.		
Sum Insured in respect of disputes lodged (total), expressed as a monthly benefit.		

3. Detail of CCI not written on Life Insurance license

As indicated in D.7, insurers are requested to provide information in respect of CCI business not written on its life insurance license. The following information is requested:

a) Main types/categories of cover

b) In respect of each main category, the number of contracts inforce as at 30 June 2017.

c) In respect of each main category, the amount of annual inforce premium as at 30 June 2017.

d) In respect of each main category, the amount of inforce sum insured as at 30 June 2017.

4. Detail on dispute duplicates

As indicated in G.16, insurers are requested to report disputes without eliminating multiple disputes that may exist across different Dispute Types (of Internal, External and Litigated) relating to the same underlying claims related issue. To enable a more complete understanding of disputes, including the interaction between different dispute types, the following additional information is requested:

Dispute type	Internal	External	Litigated
Reported in Reporting Period			
Number with duplicate dispute related to same underlying claims related issue reported in Reporting Period			
None			
Internal	N/A	N/A	N/A
External		N/A	N/A
Litigated			N/A

5. Detail on DII dispute payments of non-income nature

As indicated in G.20, Claim amounts paid in respect of DII benefits should only reflect monthly benefits (where these occur). Any benefits of a lump sum nature should be excluded from the collection template and instead be reported in this section as follows:

	Number of disputes	Total lump sum paid
Individual, Outside Super, Advised		
Internal		
External		
Litigated		
Individual, Outside Super, Non-Advised		
Internal		
External		
Litigated		
Individual, Inside Super, Advised		
Internal		
External		
Litigated		
Individual, Inside Super, Non-Advised		
Internal		
External		
Litigated		
Group, Outside Super		
Internal		
External		
Litigated		
Group, Inside Super		
Internal		
External		
Litigated		

6. Detail on claims recorded with multiple outcomes

As indicated in F.11, insurers are requested to provide additional information in respect of instances where the claim is admitted under a disability definition that results in a lower benefit than available under other disability definitions (for which the claim was either declined or not considered). In respect of these instances, the following detail should be provided:

a) The number of claims with the defined outcome;

b) The average difference in the benefit level (between the benefit admitted versus the benefit declined or not considered); and

c) The reason(s) for the difference in benefit levels.

d) The reason(s) for admitting the claim under the disability definition selected.

7. Claim causes

Detail on claim causes is being considered for potential future inclusion. To assist APRA with an appropriate structure for this item, insurers are requested to provide a list of the main claim causes for each of the cover/product types included in its P1R2 submission. It is suggested that insurers limit claim causes to those contributing a minimum of 5% of claims for a particular cover/product type.

8. DII claim management

To provide a better context for the observed claims experience for DII, insurers are requested to provide detail on potential value adding services it may be providing claimants under DII. Please provide answers to the questions below, as well as any additional information deemed appropriate:

a) Are any support services, including counselling or rehabilitation services provided in the period between claim notification and when a final claim decision is made, noting that the latter could take place during or after completion of the waiting period (where one applies)? If such services are provided, please provide detail.

b) Are there instances where monthly benefits are paid prior to the waiting period being served and/or all outstanding requirements met? If this is the case, please indicate:
   - The circumstances under which such payments will be made; and
   - The proportion of claims where this practice occurs.

c) Should the DII claim be admitted, what support services are provided to the claimant after commencement of monthly benefit payments?

d) Should the DII claim be declined, are any further support services provided? If they are, please provide details.

9. Detail on claims and disputes with long claim processing durations

In the event of the claims data collection containing claims or disputes where the recorded processing durations exceed 24 months, please provide detail on the main reasons for this. Reasons could include, but are not limited to so-called "Unexpected Circumstances", as these are defined in the Financial Services Council Life Insurance Code of Practice.

10. All items recorded as "Other" in the template

For any data category labelled as "Other", insurers should provide additional detail on the items included in that category.

11. Detail on data collection capability/preference

The current data collection template collects data in a summarised format. This places a natural limit on the number of claim attributes that can be collected without the collection template becoming overly complex and the process of populating it commensurately burdensome to insurers. As mentioned in the discussion paper released in May 2017, as well as the information paper released in November 2017, APRA is considering alternative data collection approaches that will allow data to be collected in a more effective way.

One possible alternative collection approach is to create two "flat files", one listing each claim open at some point in the relevant reporting period[1] and, in a similar fashion, another for each dispute. The structure of the flat files would be specified by APRA and could possibly be in the form of, for example, a comma delimitated text file or a spreadsheet file. One record with various dimensions and attributes would be created for each relevant claim or dispute.

We envisage that this approach could, in the longer term, potentially be easier to manage for insurers in terms of both ongoing commitments of management and staff resources (actuarial, claims and legal) as well as IT technical support. For APRA, this would allow additional attributes to be collected in respect of each claim and dispute, a simpler and more easily maintainable form of specification, as well as providing greater analytical flexibility. Policy statistics would continue to be collected in a summarised format similar to P1R2.

To assist us with an evaluation of this alternative data collection approach, we request insurers to provide sufficiently detailed responses to the following questions. In your

[1] This includes claims open at the start of the period, newly reported claims, reopened claims and withdrawn claims during the period. Similar requirements apply to disputes in the manner specified in P1R2.

responses, you may want to also distinguish individual insurance from group insurance as well as internal from third party administrators you rely upon.

a) *Data.* To what extent do your individual claim and dispute records (in whatever form) include all the detail defined for inclusion in P1R2 (or the underlying raw claims/disputes data which allows for its determination), as well as additional data items that could include:
   - Product attributes, such as the sub-category detail introduced in P1R2.
   - Demographic attributes of the claimant (e.g. date of birth and gender) and contract (e.g. commencement date).
   - Detailed claims causes, in accordance with a set of defined categories.
   - Tracking a claim or dispute through various stages.

   In order to assist insurers verify the veracity of the data prepared before its submission to APRA, could you envisage benefit from us providing a supplementary tool, probably a workbook with a simple macro, that summarises the details in the flat files generated (perhaps also including various checks similar to those in the P1R2 template)?

b) *Resources*. Do you expect that a flat file approach would enable, at least once it is established, the release of resources and time otherwise committed to the regular production of the statistics in the current (P1R2) format? Or might it have the opposite effect, perhaps with increased involvement of your IT department (both initially and ongoing)?

c) *Processes.* Would a flat file approach present any specific challenges, both during the period when initial processes are established, as well as maintenance and support in the longer term? Please distinguish between the granularity of the content and the process of capturing and consolidating the required data extracts from various databases (including those of third parties) and other non-electronic sources into two files.

Taking your responses above into account:

d) Would it be possible to provide data in individual record format for the next life claims data collection, currently envisaged to be released in May 2018? If not, which of the above areas (data, resources or processes) do you see as the main impediment(s)? Please elaborate if you have not already done so above.

e) Over the longer term, do you have a preference for the current general approach using a stylised workbook of summarised data (P1R2), or a flat file approach of individual records as outlined above?

f) Are there other approaches which you believe should be considered and which may better satisfy both the production needs of the insurers and the analytical needs of APRA/ASIC?