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APRA LIFE CLAIMS DATA DEFINITIONS AND INSTRUCTIONS – PHASE 1 ROUND 3

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This document contains instructions and definitions for Phase 1 Round 3 of the APRA life claims data collection (P1R3).

It includes the following sections:

A. Inclusions for P1R3 collection
B. General instructions for completing the template
C. Changes from P1R2
D. General definitions
E. Policy data detail
F. Claims data detail
G. Dispute data detail
H. Supplementary information

A. INCLUSIONS FOR PHASE 1 ROUND 3 COLLECTION – 1 JULY TO 31 DECEMBER 2017

P1R3 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.

    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.

    P1R3 only includes gross business written directly, i.e. excluding inwards and outwards reinsurance.

2. The P1R3 collection is in respect of the Reporting Period covering the second six months of the 2017 Calendar Year, i.e. from 1 July 2017 to 31 December 2017 inclusive.

3. P1R3 includes detail on all in-force 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 are included.

4. P1R3 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 P1R2, disability income insurance (DII) business should only consider the initial reporting and assessment of claims and not any detail about claims already in the course of payment at the start of the Reporting Period.

5. P1R3 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 P1R3 life claims collection's Data Input Template and Supplementary Collection Questionnaire (the workbooks). As with P1R2, 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. The unformatted cell value should be subsequently copied to each relevant cell in the protected version.

5. Before final saving and submission of the workbooks, please ensure that:

    a) Any workbook multi-user sharing that may have been utilised is turned off.

    b) The workbooks are **not** saved as read only or compressed file.

    c) Any links to external files are removed.

    d) All balancing item cells are zero.

6. Please rename the saved workbooks with a file name in the following format:

    a) Format: <Insurer short name>_P1R3_<yyyymmdd>_<optional additional alphanumerics to identify version>.xlsx

    b) Example: ABC Life_P1R3_20180615.xlsx

C. CHANGES FROM PHASE 1 ROUND 2

The following changes from P1R2 are noted:

1. Introduced the sub-categories Personal and Business Expense for DII (refer to Section D).

2. Expanded CCI and Accidental Cover policy statistics to include the same sub-categories included for claims and disputes in P1R2. That is:

   a) CCI – Death, Incapacity and Redundancy; and

   b) Accident Insurance – Death and Injury.

3. Introduced additional sub-categories for CCI as a one-off collection for P1R3 (refer to Section H). Depending on the results, permanent changes to the collection template may be introduced. Additional sub-categories include:

   a) Loan vs Credit Card protection; and

   b) Lump Sum vs Monthly benefits.

4. Refined the treatment of re-opened claims to distinguish between claims that have been previously withdrawn vs claims that have been previously finalised:

   a) Re-opened claims that were previously withdrawn remain included in the main collection, as reflected on the various claims sheets.

   b) Re-opened claims that were previously finalised should not be included in the main collection. These claims, together with additional related information should be reported in a supplementary sheet in the main collection template.

   c) In addition, specific instructions are provided to calculate processing durations for re-opened claims from the original Claim Reported Date and not the date the claim was re-opened.

   See items F.5 on page 18 and F.26 on page 24 for more detail.

5. Expanded the outcomes under disputes to isolate disputes related to the claims process.

6. Clarification on the treatment of various categories of premium refunds.

7. Introduced a separate excel template to collect the detail in the supplementary collection (Section H). In total, two templates should be submitted in P1R3:

   a) The main template - LI Claims Data Input Template

   b) The supplementary collection template - LI Claims Supplementary Collection Questionnaire. Please note that there are two items covered in the supplementary

collection (reopened claims and CCI data) where the collection sheets are in the main template.

8. Provided specific guidance regarding the treatment of one Policy Contract with multiple Policy Benefits in the policy statistics and claims sections. This is consistent with the guidance provided in the P1R2 FAQ.

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

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 P1R3 collection, the Reporting Period is the six months from 1 July 2017 to 31 December 2017 inclusive. The classification of a claim 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 the data submission should **not** be reflected in the data collection.

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 providing 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 decides 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 categories should be classified as Individual Insurance business. The Group Lump Sum Risk (L6) and Group Disability Income Insurance (L7) product categories should be classified as Group Insurance business.

The following categories are defined for Insurance Type:

a) Individual Insurance sold outside Superannuation Funds;

b) Individual Insurance sold inside Superannuation Funds;

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 following Cover Types:

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, payable in the event of one or more predefined events occurring. CCI products included in the P1R3 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 Act.

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 be excluded from the P1R3 data collection template.

b) Funeral Insurance – Insurance for paying the expenses of, or incidental to, the funeral, burial or cremation of the person covered under the Policy Contract.

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

8. **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) DII cover – distinction is made between the following sub-categories:

i. Personal – where the life insured is reimbursed for a proportion of his/her regular income, as defined in the underlying Policy Contract.

ii. Business Expense – where the life insured is reimbursed for certain regular business expense including rent, utilities, lease costs or depreciation, as defined in the underlying Policy Contract.

d) CCI cover – 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.

e) Accident insurance cover – 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 Data Input 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 P1R3 should be gross of reinsurance and commissions, and before profit share rebates (Group Insurance). Reported premiums should also be inclusive of stamp duty. For single premium business, the annual premium should be estimated by spreading the single premium over the contract term.

11. **Sum Insured** refers to the contractual benefit payable when the insured event occurs. 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, as well as Funeral and Accident Insurance 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 with the provisions of the Policy Contract.

c) CCI benefits 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: 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 Supplementary Collection Questionnaire.

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 P1R3 Reporting Period, with premiums refunded, it is likely to have related to a claim that should be included in the

P1R3 collection. If this applies to a policy that was also issued during the P1R3 Reporting Period, those contracts should be included with New Business;

d) Where a new policy is issued and subsequently lapsed during the cooling off period, all within the P1R3 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; and

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 be excluded from New Business.

13. **Lapses** refer to Policy Contracts (or underlying benefits) being discontinued. 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;

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

f) Where an existing policy is cancelled due to the non-payment of premiums, the cancelled contract should be included with Lapses;

g) 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 be excluded from Lapses; and

h) Any contract that was discontinued during the reporting period, other than through a claim and not explicitly covered in the circumstances listed above, should be included with lapses.

14. **Disputes**, 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 after the Claim Event that must expire 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 the 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 section 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** refers 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 Data Input Template assumes this does not apply to CCI, Funeral or Accident Insurance businesses.

    b) **Non-advised business** refers 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.

18. **Ancillary Benefit** refers to the payment made by an insurer in addition to the core benefit. Examples of Ancillary Benefits include rehabilitation benefits, family support benefits, bed confinement benefits, transportation benefits etc.

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

Although information in the Data Input Template is not required at a Policy Benefit level, consideration of information at this level is still necessary, for both policy and claims data. Where a policy contract has multiple Policy Benefits within the same cover/product type, the policy and claims treatment will depend on the nature of these benefits. Distinction is made between the following categories:

a) Policy Benefits that can be added together, with the same claim conditions. These Policy Benefits are typically the result of administrative processes, such as a separate benefit created for an annual automated cover increase.

b) Policy Benefits that can be added together, with potentially different claim conditions. For example, a second death cover benefit under a policy contract has a pre-existing condition exclusion that does not apply to the original death cover benefit under the same policy contract.

c) Policy Benefits that cannot be added together and provide for benefits under different claim conditions. The most common example is where a disability benefit is provided with different disability definitions, typically reflected in separate underlying benefits.

Refer to section F.11 for policy treatment instructions, and section E.7 for claims treatment instructions.

20. **Traditional Insurance** refers to products that include but may not be limited to Whole of Life or Endowment Policies.

    a) Whole of Life is a policy that, while it provides a death benefit, it also has an investment component so that the policy can be surrendered for a cash value during the term of the policy. If the life insured is still alive at a predetermined age the policy is paid out for the full face value of the policy. Level premiums are charged and the death benefit does not change throughout the life of the policy.

    b) Endowment Policies have the cash value built up inside the policy until it is equal to the death benefit at a predetermined age. The age that this commences is known as the endowment age. Endowment Policies pay out whether the insured lives or dies after a specific term or age.

21. **White Label** refers to a product issued under your license or authorisation for another or third-party entity to sell or distribute, and rebranded under a product name that is not tied to your organisation. This product may also be referred to as ‘rebadged’.

E. POLICY DATA DETAIL

In respect of Policy Data, the following detail should 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 above 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 Lapses (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 above 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. Where a single Policy Contract contains multiple Policy Benefits of the same cover/product type, these should be dealt with as follows:

    a) Where multiple Policy Benefits all exist in the same combination of Insurance Type, On Sale Status and Advice Type, the different data items should be reported as follows, taking into account the different Policy Benefit categories defined in section D.19:

        i. Policy Contract: One Policy Contract should be recorded under the relevant cover/product type, regardless of the Policy Benefit category.

        ii. Lives Insured: The number of lives covered under the cover/product type should be recorded, regardless of the Policy Benefit category.

        iii. Annual Premium: The total amount of premium charged in respect of the Policy Benefits under the cover/product type should be recorded, regardless of the Policy Benefit category.

        iv. Sum Insured: In respect of Policy Benefits that can be added together (i.e. items D.19 (a) and D.19 (b)), the sums insured under the different Policy Benefits should be added together. In respect of Policy Benefits that cannot be added together (i.e. item D.19(c)), the sum insured of a single Policy Benefit should be reported. In the event of different sums insured being payable under different Policy Benefits, the Policy Benefit with the highest sum insured should be reported.

    b) Where a Policy Contract contains a Policy 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:

        i. Policy Contract: One 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.

ii. Lives Insured: The number of lives covered under the cover/product type 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.

iii. Annual Premium: The total 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.

iv. 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.

8. Ancillary Benefit of a type consistent with the provisions of P1R3 should be included. If the removal of Ancillary Benefits of a type not consistent with P1R3 is an onerous task, it is acceptable for such benefits to also remain included. Where this is the case, the insurer should provide the information in its response to section H.Q1 below.

Items E.1 to E.8 correspond with the following sheets in the Data Input 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** refers to 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 redundancy. The Claim Event Date is the date on which the life insured was made redundant while employed at his/her place of employment.

2. **Claim Incidence Year** refers to the calendar year in which the Claim Event occurred. P1R3 will collect data in respect of the following claims incidence years:

    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 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 the 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.

   In P1R3, the treatment of re-opened is refined to distinguish between claims that have been previously withdrawn versus claims that have been previously finalised:

   a) Re-opened claims that were previously withdrawn should be <u>included</u> in the main collection, as reflected on the various claims sheets. Please note that they are recorded as Claim Re-opened (subsequent to being withdrawn) in the template.

   b) Re-opened claims that were previously finalised should be <u>excluded</u> from the main collection. Instead, these claims, together with additional related information should be reported in the relevant supplementary sheet of the Data Input template. Where a claim is re-opened after a partial benefit has previously been admitted, it should be included in this category.

   Where a claim is re-opened in the same reporting period as it was originally reported, or if it was re-opened more than once during the same reporting period, it should be reported only once during the relevant reporting period, reflecting the latest outcome or status. If insurers are not able to eliminate the double-counting of claims reported and/or reopened more than once during the reporting period, they should indicate this in their cover note to the P1R3 submission. In addition, they should provide an indication (on a best estimate basis) of the prevalence of these instances.

   For DII, claims that have been terminated and are re-opened for a possible continuation of benefit payments should be <u>excluded</u> from re-opened claims. It is of course possible for a new DII claim to be submitted in respect of the same policy and life insured, e.g. where a significant period has passed since termination of a previous

claim and/or where the cause of the claim is completely unrelated to that which applied before. Such claims should be considered as a new claim, classified as a reported and not a re-opened claim.

6. **Claim Withdrawn** refers to the instance where a reported claim is withdrawn and closed before being assessed and finalised. Please note that a claim should be recorded in the "withdrawn – no reply/response to request for information" category if the claimant returned to work prior to the expiry of a waiting period (where applicable).

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 the data submission should be excluded from the Data Input Template.

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 reported, ignoring 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 gross of reinsurance. For DII, this is 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.

Any amounts paid from a consumer's superannuation account balance should not be included in the Claim Amount Paid. That is, only the insurance payout component should be included.

11. It is possible that the same claim event is considered and assessed for multiple Policy Benefits under the same Cover Type or Product. Referring to the three categories defined in section D.19, claims in respect of those categories should be dealt with as follows:

    a) Policy Benefits that can be added together, with the same claim conditions:

        i. A single claim outcome should be reported, with the claim sum insured and claim amount paid calculated as the sum of the underlying Policy Benefits.

    b) Policy Benefits that can be added together, with potentially different claim conditions:

        i. If the claim outcome is the same for all the underlying Policy Benefits, a single claim outcome should be recorded, with the claim sum insured and claim amount paid calculated as the sum of the underlying Policy Benefits.

        ii. If the claim outcome is not the same for all underlying Policy Benefits, separate claim outcomes should be recorded. One claim record should be reported for each claim outcome, with the claim sum insured and claim amount paid calculated as the sum of the underlying Policy Benefits with the given claim outcome.

    c) Policy Benefits that cannot be added together and provide for benefits under different claim conditions:

        A single claim outcome should be reported. Specifically:

        i. If the claim was admitted (including an ex-gratia admittance), or any other form of payment made, a single record should be reported in the appropriate category and reflecting the relevant claim sum insured and claim amount paid. The fact that there may have been a decline decision in respect of another Policy Benefit should not be reported.

        ii. If the claim was declined (with no payment) under all Policy Benefits, a single decline decision should be reported.

    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.

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 reported 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 P1R2 submission. If this is not the case, please provide an explanation. The classification of Claim Incidence Year should be based on the Claim Event Date of each individual reported claim.

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 (subsequent to being withdrawn) 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.

    d) **Other or unknown reasons for 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 the categories defined in F.18 below.

c) **Claims admitted fully 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.

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. Please note the treatment of different types of premium refunds as explained in item F.30 below.

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 grounds of a pre-existing condition exclusion, a limited cover clause, an exclusion imposed during initial underwriting, or any other policy exclusion in the Policy Contract. This includes the exclusion clauses that may be contained in the standard policy wording.

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. Claims incorrectly opened due to an administrative error should be excluded.

21. Ancillary Benefits of a type consistent with the requirements of P1R3 should be included. The inclusion of Ancillary Benefits should, however, not result in multiple claims being

reported in respect of a single claim event. Ancillary Benefit of a type not consistent with the provisions of P1R3 should be excluded.

22. 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.

23. 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.

24. 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 should only 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 Policy 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.

25. 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, including sub-categories, as defined in Section D.

26. **Claims Processing Durations** should be reported in respect of Claims Finalised during the Reporting Period, measured as the period between the Claim Reported Date and the date the claim is finalised.

    In respect of Cover Types that involve a waiting period, the Claims Processing Duration should be measured from the later of:

    a) The Claim Reported Date; and

    b) The Claim Event Date plus Waiting Period.

    There are a number of specific circumstances worth noting:

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

    c) Where a claim is re-opened (subsequent to being withdrawn), the Claims Processing Duration should be measured from the original Claim Reported Date and not the Claim Re-opened Date.

27. 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
    g) >36 months

28. 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.

29. 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, including sub-categories, as defined in Section D.

30. Premium Refunds in Item F.17 should be treated in the following ways:

a) Where premiums collected after a claim event are refunded due to a purely administrative process, it should be excluded from the P1R3 submission.

b) Where a premium refund is a contractual benefit, it should be reported and classified as a full benefit. Where a claim is then admitted, it should be reported in the "Claims admitted (excluding ex-gratia payments)" category.

c) Where a premium refund is made following the cancellation of a contract or Policy Benefit (for example, in the event of innocent non-disclosure), it should be reported in the "All other ex-gratia payments, settlements or premium refunds" category.

d) Where a premium refund is made on an ex-gratia basis (for example when death occurs as a result of sickness, but cover is for accidental death only), it should be reported in the "All other ex-gratia payments, settlements or premium refunds" category.

e) Premium waiver benefits should be treated like any other Ancillary Benefit. That is,

i. Included in policy statistics (for reasons of practicality), provided it does not artificially inflate contract counts; but

ii. Excluded in claims and disputes.

31. Items F.12 to F.30 correspond with the following sheets in the accompanying Data Input 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 P1R3 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 the 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 have been solicitors involved, but no legal proceedings were 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 decide 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:

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

   b) For EDR/Litigated disputes, the date the 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. Communication by the postal service is deemed to have occurred three business days after it was sent.

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 Data Input 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.

One dispute should only have one dispute reason. Where a dispute has multiple dispute reasons, only the dominant reason should be recorded.

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 the 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 Dispute Outcomes** (labelled E.5):

        i. **Process related** (labelled E.5.1). This category applies to all disputes related to the claims process.

        ii. **Other disputes** (labelled E.5.2). Any resolved disputes not covered by the preceding categories should be reported in this category.

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, an external dispute resolution scheme, tribunal or court of law decides that the original decision was incorrect.

    b) **Additional information received** (labelled E.2.2). These are instances where the insurer, an external dispute resolution scheme, tribunal or court of law has received additional information and, based on the additional information, decided to reverse (or amend) the original claims decision.

    c) **Other reasons for reversal/amendment** (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 Supplementary Collection Questionnaire (refer to Section H).

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 G.16 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 Data Input Template. Entries should only be reported 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 in the Supplementary Collection Questionnaire. Detail of the information required is contained in the Supplementary information section of this document.

    To calculate 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, including sub-categories as defined in Section D.

    d) Dispute Type, as defined in Section G.

22. **Ancillary Benefit** of a type not consistent with the provisions of P1R3 should be excluded.

Items G.10 to G.22 correspond with the following sheets in the accompanying Data Input 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. SUPPLEMENTARY DATA DETAIL

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

1. As indicated in section F.5, the following supplementary information on re-opened claims that were previously finalised will be collected in P1R3.

   a) The total number of Claim Re-opened previously finalised (labelled G). Only those claims that are subsequently finalised in the current Reporting Period are to be included. Where a claim is re-opened in the same reporting period as it was originally reported, or if it were re-opened more than once during the same reporting period, it should be reported only once during the relevant reporting period, reflecting the latest outcome or status.

   b) The information in (a) should be provided in the following dimensions:

      i. Insurance Type (as previously defined in section D.5)

      ii. Cover Type (as previously defined in section D.6)

      iii. Original claims decision (consistent with previous definitions in section F.17)

      iv. Updated claims decision (consistent with previous definitions in section F.17)

      v. Reasons for re-opened claims that are subsequently finalised:

         - **Additional information received** (labelled G.1). These are instances where the claim has been re-opened after receiving additional information that could potentially overturn the original decision.

         - **Review request or dispute lodged** (labelled G.2). These are instances where the claim has been re-opened because the policyholder, his/her representative or the superannuation fund trustee has requested a review of the original claims decision, or has lodged a dispute.

         - **Administrative error** (labelled G.3). These are instances where the original claims decision was made due to an administrative error.

         - **Other** (labelled G.4). Any claim re-open reasons not covered by one of the preceding categories.

   c) The information in (a) should be recorded in the SUPPLEMENT_Reopened sheet of the Data Input Template. Please note that depending on the results, permanent changes to the Data Input Template may be introduced

2. In P1R3, we request supplementary information on additional CCI classifications to enable a better understanding of CCI. Please note that the detail provided should be consistent with what has been reported in the Data Input Template.

   The additional sub-categories that we request for CCI claims include:

   a) CCI insurance by repayment type – distinction is made between the following main sub-categories:

      i. Loans – where the contract is to cover for the outstanding loan repayments, as defined in the underlying Policy Contract.

      ii. Credit Card – where the contract is to cover for the outstanding credit card repayments, as defined in the underlying Policy Contract.

   b) CCI insurance by payment frequency – distinction is made between the following main sub-categories:

      i. Lump Sum – where a single amount is payable when the policy conditions are met.

      ii. Monthly Benefit – where a regular monthly benefit is payable when the policy conditions are met.

   The above information should be recorded in the SUPPLEMENT_CCI sheet of the Data Input Template. Please note that depending on the results, permanent changes to the Data Input Template may be introduced.

As with P1R2, insurers are also requested to complete the Supplementary Collection Questionnaire. The instructions in the template are simplified. Please refer to the instructions and definitions below for additional information.

Q.1. **Products not explicitly defined in the P1R3 Data Input Template and definitions document**

   a) Please provide detail on any insurance products or product sub-categories that provide cover of a type not specifically defined in the current collection - but excluding any traditional products, which are covered in question Q.1.b below. Please provide:

      i. A short description of the product or sub-category;

      ii. An indication of the materiality of this product and/or sub-category in terms of the number of in-force contracts (at the end of the Reporting Period) and the number of Claims Reported (during the Reporting Period); and

iii. Whether these products were included in the P1R3 submission and, if so, with which product and/or sub-category they were included.

b) In respect of traditional insurance products (as defined in item D.20), please indicate by the type of product:

i. The volume of in-force business, i.e. number of policies inforce at the end of the reporting period;

ii. An estimate of the proportion of these contracts where there is still an amount at risk, i.e. where a sum insured exceeds the fund/cash value associated with the contract;

iii. An estimate of the proportion of claims that are declined if any (all cover types); and

iv. Your view on whether the life claims data collection should be expanded to include traditional products.

c) In respect of ancillary benefits related to the products and cover types included in the P1R3 collection, please provide the following additional information:

i. Do you understand and regard ancillary benefits to be inherent product features that are part of the underlying core benefit, or as optional benefits which may be added at the discretion of the policyholder, or both?

ii. Please provide a list of the ancillary benefits offered in respect of each of the cover types included under P1R3, indicating:

- Which cover/product type they relate to;
- Their nature, i.e. whether they are features or optional benefits; and
- A short description of the benefit.

iii. An indication of their prevalence, as follows:

- For each combination of cover/product type and ancillary benefit, the number of benefits in force at the end of the Reporting Period.
- For each combination of cover/product type and ancillary benefit, the amount of cover in force at the end of the Reporting Period.

iv. An indication of their potential impact on claims, as follows:

- For each combination of cover/product type and ancillary benefit, the number of claims that were admitted during the Reporting Period.

- For each combination of cover/product type and ancillary benefit, the average benefit amount in respect of admitted claims.

- For each ancillary benefit, an indication if the claims outcomes are typically consistent with that of the core benefit that they relate to e.g. would they typically be admitted if the core benefit is admitted?

v. Confirmation of how ancillary benefits were treated in the P1R3 collection, as follows:

- In the policy statistics section.

- In the claims section.

- In the disputes section.

Q.2. **Disputes related to the claims process**

As indicated in G.12.e, insurers are requested to report disputes related to the claim process. To enable a more complete understanding of process-related disputes, the following additional information is requested:

a) An indication of the type of process disputes that arise, including a breakdown of submitted data between these types.

b) How these are typically resolved, including an indication of the proportion of these disputes resulting in a changed claims outcome.

c) When these disputes are regarded as resolved.

d) The typical Dispute Processing Duration recorded in respect of these disputes.

Q.3. **White labelled arrangements and superannuation business**

Please provide additional detail on the following arrangements:

a) In respect of individual insurance business, detail on White Labelled arrangements, as defined in section D.21. Please provide:

i. A list of the white labels or brands in respect of which business is underwritten (excluding your own brands).

ii. In respect of each of the white labels listed, a list of the cover/product types provided.

iii. In respect of each combination of white label and cover/product type, the count of policy contracts and amount of annual premium in force at the end of the Reporting Period.

b) In respect of group insurance business, detail on the superannuation funds for whom insurance products are underwritten. Please provide:

i. A list of the superannuation funds with more than 10,000 members.

ii. In respect of each of the superannuation funds listed, a list of the cover/product types provided.

iii. In respect of each combination of superannuation fund and cover/product type, the count of members covered and amount of annual inforce premium in force at the end of the Reporting Period.

Q.4. **All items recorded as "Other" in the Data Input Template**

For any data category labelled as "Other", insurers should provide additional detail on the items included in that category. The following items from the template should be included:

a) Policy statistics: Other movements

b) Claims Withdrawn: Other or unknown reasons for withdrawal (E.4)

c) Claims Finalised: Other reasons for being declined (G.2.5)

d) Claims Finalised: All other ex-gratia payments, settlements or premium refunds (G.4)

e) Disputes Lodged: Other disputes lodged (B.4)

f) Disputes Withdrawn: Other or unknown reasons for withdrawal (C.3)

g) Disputes Resolved: Other reasons for reversal/amendment (E.2.3)

h) Disputes Resolved: Other disputes (E.5.2)

i) Reason for reopening of a claim decision: Other

Q.5. **Blocked-out cells in the Data Input Template**

To avoid confusion, the Data Input Template has blocked out cells with unlikely combinations. Where the insurer may still have detail to report on, please provide the following for each relevant combination:

a) Detail of the blocked cell.

b) The relevant amount/number.

Q.6. **Additional information on Claims Reported**

To enable a more complete understanding of the appropriate starting point for the claims process, please provide the following:

a) In the normal course of business, at what exact point in time does the insurer record the existence of a claim?

b) What might be the impact of the definition used for Claims Reported in P1R3 on claims processing durations and compliance with the Life Insurance Code of Practice timeframes?

Q.7. **The extent of reinsurer involvement**

Please provide detail on the extent of reinsurer involvement in the claims decision making process. For example, a reinsurer may have influence over the claim outcome, particularly with claims with a large sum insured. It is possible that the insurer wishes to admit a claim as ex-gratia, but that it may still be declined if the reinsurer refuses to pay for the reinsured amount.

Detail could include, but is not limited to, the proportion of claims decisions that were solely made by the insurer.

Q.8. **CCI monthly benefits**

To enable a more complete understanding of the underlying product profile, the following additional detail should be provided in respect of CCI products where benefits are defined as monthly payments (refer to section H.3.b). CCI monthly benefits should be reported on a capitalised basis, i.e. the monthly benefit multiplied by the number of expected payment months.

Information in respect of the in force policy data, claims data and disputes data should be reported in the relevant tables in the supplementary collection questionnaire.

Q.9. **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 main collection template and instead be reported in the relevant table in the Supplementary Collection Questionnaire.

Q.10. **Dispute duplicates**

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