# Making better claims decisions

## A thematic inquiry

July 2023

GENERAL INSURANCE
Code Governance Committee

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# About this report

This report provides the findings of our inquiry into the practices of six general insurers that subscribe to the General Insurance Code of Practice (the Code).

The inquiry set out to determine whether the six insurers use complaints to improve business processes, practices and compliance with the Code.

The inquiry analysed data from complaints about denied claims. When a decision to deny a claim is overturned at Internal Dispute Resolution (IDR), we expect insurers to identify insights from the data to improve business processes, practices and products in a way that enhances their compliance with the Code.

In the report, we highlight examples of good practice, make recommendations for using complaints data effectively, and identify opportunities to improve claims-handling practices.

We encourage all insurers that subscribe to the Code (subscribers) to use our examples and recommendations to make improvements to their business processes and practices.

**Background**

Subscribers that are Australian Financial Services (AFS) Licensees are required to have IDR procedures that comply with standards and requirements made by ASIC, as set out in ASIC Regulatory Guide 271: Internal Dispute Resolution (RG271).

RG271 notes that consumer complaints are a key risk indicator for systemic issues within an organisation. It sets out expectations that organisations analyse complaints data regularly to improve their IDR processes and identify systemic issues and areas for improvement.

Capturing data on claims decisions overturned through IDR is not a specific requirement of the Code, but it contributes to Code compliance because doing so ensures a subscriber can identify issues and rectify them efficiently. It is an essential part of a culture of continuous improvement.

## Participating subscribers

For this inquiry we selected six subscribers of various sizes that represented a significant proportion of the industry's total retail claims experience.

Collectively, the participating subscribers handled 53% of the industry's home insurance claims in 2021-22. They handled more than 1.6 million retail claims, equivalent to 37% of the total claims lodged with all subscribers for the financial year.

This selection provided a sufficiently representative sample from which we could draw insights and findings applicable to the industry more broadly.

## Methodology

The six subscribers that participated in the inquiry each responded to four questions and provided a sample of 20 denied home insurance claims that were overturned in favour of the consumer following a dispute. For detail regarding the information sought see our Issues Paper.

The dataset that we analysed comprised 119 case files because one case file did not meet the sample data criteria.

Following analysis of the dataset, we consulted with each subscriber to better understand the information they provided and gain insights into their processes and practices.

# Chair’s Message

Our inquiry set out to investigate how subscribers use their complaints data to gain insights into decisions to deny claims. As we began analysing the information that subscribers provided, we found a concerning trend in the number of claims denied because of maintenance or wear and tear exclusions.

Consumer advocates have long raised their concerns about this.

While we did not set out to examine the details of claims decisions being overturned, the findings emerged and revealed issues that we had to draw attention to. So, in addition to making recommendations about the use of complaints data to drive process improvements, we have also taken the opportunity to convey the issues we see with the way that subscribers are applying wear and tear or maintenance clauses.

The General Insurance Code Governance Committee (Committee) is responsible for identifying areas for improvement of industry practices, amongst other things. It is therefore incumbent on us to share findings that will improve subscriber practices and consumer outcomes, even if they were not the initial focus of our inquiry.

In examining the information, we found the quality of reports prepared by experts engaged by subscribers to be poor.

We saw too many reports that failed to provide a clear and demonstrable link between the cause of damage and the loss. We often read in the reports that wear and tear was visible and could have caused damage, but we did not always see sufficient evidence to justify the assessments.

This is a concerning finding because 45% of the expert reports we analysed offered a recommendation for a decision on the claim. While an expert may be technically proficient in a certain field, making a recommendation to accept or deny an insurance claim goes beyond that.

Data provided by the six subscribers that participated in the inquiry shows that in 2021-22, a quarter of denied home claims proceeded through to IDR. This worked out to be nearly 11,000 complaints.

And, alarmingly, nearly half of these were later overturned in favour of the consumer. This is a significant overturn rate and raises questions about the quality of the decision-making by subscribers. They must get on top of this.

We urge subscribers to improve the collection and analysis of data on overturned claims decisions. The data is a rich resource for uncovering underlying systemic issues in systems and processes and is fundamental in understanding what is happening and what needs to improve.

A comprehensive data collection and analysis process will generate insights that can lead to better decisions and an efficient, fair, transparent and timely experience for the consumer. It will also see a reduction in complaints flowing through to IDR.

While the trend was concerning and became the dominant theme of our inquiry, we were pleased to see that some subscribers had implemented improvements intended to directly enhance decision-making on claims. But many are still not doing enough with their data to extract insights and implement changes.

We launched this inquiry in November 2022, noting in our Issues Paper that the way a subscriber handles a claim has a major role in someone's recovery after they suffer a loss.

In an environment where floods, bushfires and other natural disasters are becoming more frequent, it is crucial that we remind ourselves of the distress that can be felt by anyone who has their claim denied.

Subscribers must strive to ensure all claims are handled efficiently, fairly and transparently.

Since our inquiry, we have opened investigations with each of the six participating subscribers. As part of these investigations we examine the root causes of the breaches, and whether they are linked to external factors such as extreme weather events. We will establish whether there is a connection to these events and what steps the subscribers are taking to ensure their processes improve regardless of external factors.

I would like to thank the six subscribers that were involved in this inquiry. This is our third thematic inquiry report and we hope that it helps the industry comply with the Code, improve practices, and achieve better outcomes for consumers.

**Veronique Ingram PSM**
Independent Chair
General Insurance Code Governance Committee

# Recommendations

Subscribers should improve their collection and analysis of data from overturned decisions on claims to gain insights into underlying issues and enhance their practices.

**We recommend that subscribers:**

1. **Identify themes in the data that may explain trends in complaints about denied claims.**
2. **Improve processes and practices based on the insights obtained from data analysis.**
3. **Analyse how deficiencies in processes lead to gaps in compliance with the Code or breaches of the Code.**
4. **Establish metrics and measure the success of the improvements they implement following data analysis.**

Because of the emergence of the issue with claims denied based on wear and tear or lack of maintenance in this inquiry, we make four additional recommendations to help subscribers improve their claims-handling processes.

**We recommend that subscribers:**

5. **Establish a standard format for expert assessment reports to get more consistent and higher quality input.**
6. **Provide clear explanations for claims that are denied based on wear and tear or lack of maintenance. In particular, explain:**
   **- the maintenance that should have occurred**
   **- how that maintenance would have prevented the loss**
   **- the link between the loss and the wear and tear or lack of maintenance.**
7. **Provide comprehensive training to claim consultants, monitor decision-making and implement processes that ensure the consultants can identify and escalate expert recommendations that are not well substantiated.**
8. **Ensure authorised experts are trained to make recommendations backed by sufficient evidence, consistent with standards and policies of the subscriber.**

# The findings

## Wear and tear and maintenance exclusions

In examining the way subscribers identified and acted on insights from complaints data, we found that wear and tear and maintenance exclusions (collectively referred to as 'wear and tear exclusions') featured prominently in claim denials.

This provided insight into the way subscribers apply wear and tear exclusions when assessing home insurance claims.

Although the assessment of claim decisions was not the intended focus of this inquiry, we found issues that we cannot ignore in accordance with the responsibilities outlined in our Charter.

**Wear and tear and maintenance exclusions:**
When there is normal gradual deterioration that has not been caused by an unforeseen event or when a property has been poorly maintained.

### Denials based on wear and tear

In the sample files we examined, home claims originally denied based on wear and tear clauses made up 55% of cases.

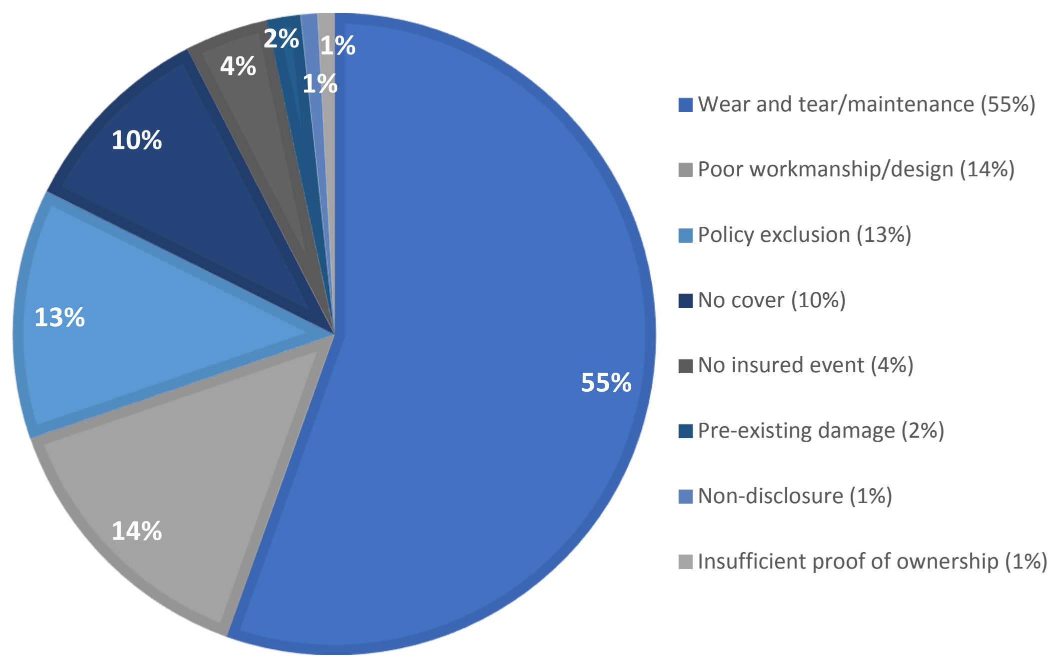
This indicates possible systemic issues in decision-making on claims when wear and tear is a factor.

There will be instances where a claim should be denied because wear and tear has been the main cause of the damage or loss.

But subscribers may apply these exclusions differently because the level of acceptable maintenance is often poorly explained in the policy terms and conditions.

This means that consumers are often unaware of what they should do to avoid an exclusion.

**Figure 1: Claim denials in sample data**




From engagement with consumer advocates, AFCA, and through our own work on Code breach allegations, we are aware of increasing concerns about insurers relying on wear and tear exclusions to deny claims.

We also acknowledge the subjectivity involved in making a claims decision and how considering multiple relevant factors can make it more challenging.

It is crucial that subscribers make accurate decisions on these claims because home insurance is sold with a promise that an insurer will pay to repair or rebuild the home to the insured value when an insured event occurs.

Few consumers would be aware that this is subject to them maintaining their home to a standard that is rarely defined in Product Disclosure Statements (PDS).

It is reasonable to conclude that many consumers would regard a claim denial on the basis of unclear maintenance expectations as unfair.

## Quality of expert recommendations

The data we examined indicated that subscribers relied heavily on reports from experts such as builders, plumbers, electricians and other tradespeople (collectively referred to as 'experts') when assessing the merits of a claim.

**In the sample data, we found…**

**101** cases supported by an expert report

**46** cases with expert recommendation on claim outcome

**36** cases with expert recommendation of a denial

**30** cases in which expert reports arguably contained inconsistencies or ambiguity

In 46 of the 119 sample case files, an expert report provided a recommendation to either accept, deny or cash settle the claim in addition to the assessment of the loss or damage and its cause.

Nearly 80% of these 46 files came with an expert recommendation to deny the claim.

Given the sample we requested, this is not unexpected, but it raises a question about the extent to which a subscriber's initial decision on a claim was influenced by the expert's recommendation.

If the level of influence is high, or there is reasonable risk of this, then the quality and impartiality of the expert's decision-making will be important to the claim decision. Subscribers should ensure their claims staff question, challenge and critically evaluate an expert's recommendation as a routine part of the decision-making process.

## Consistent information

Our inquiry found a lack of consistency in the formats of builders' assessments and reports for each subscriber.

Each builder provided an assessment report using their own template. Some reports contained more information than others, and some included prescribed questions on selected issues.

The information provided did not indicate that any subscriber had requirements for builders to provide a minimum or standard set of information in an established format.

**We found…**

- **instances of a builder stating that there was wear and tear but not providing sufficient evidence to justify the recommendation to deny the claim based on the wear and tear.**
- **examples of builder assessments containing inconsistent statements.**
- **examples of loss assessors contradicting the views of builders or other experts without providing the additional information that contributed to their view.**

Although many builder reports examined wear and tear and recommended denying claims, we did not find any controls imposed on the builder to ensure:

- the cause of loss or damage was adequately connected to the wear and tear identified when recommending to deny the claim
- consistency in different parts of their assessment.

**Room for improvement…**

In an example of inconsistency, a builder in one case asserted that damage was due to lack of maintenance. However, in the report, the builder responded:

- "N/A" to "Would the damage have occurred if there were no maintenance issues?", and
- "N/A" to "Are the maintenance issues a contributing factor to the resulting damage?".

Such inconsistencies appear to be routinely missed by the loss assessor and the subscriber.

This presents an opportunity for subscribers to improve their processes by ensuring they get consistent information from every expert they engage on common cases.

Greater consistency in information from experts would support greater consistency in decision-making.

Subscribers should require experts they engage to provide assessments in a standard template developed by the subscriber which elicits the right information for a quality decision. They should be explicit with experts about their expectations for assessments, the information and presentation of reports, and the substance of recommendations.

At a minimum, when an expert recommends a subscriber deny a claim based on wear and tear, we expect that the expert explains:

- what maintenance should have occurred
- how that maintenance would have prevented the loss
- the clear causal link between the loss and the wear and tear or lack of maintenance.

A subscriber should communicate this information to the consumer in the written claims decision. This will improve transparency and potentially result in fewer complaints about claim denials.

**There may be a role for the Insurance Council of Australia to play in providing guidance about good expert assessment reports.**

## Training and conflicts

We understand that many subscribers have a range of preferred experts on their panels, some of which have greater delegated authority than others.

Most subscribers that participated in this inquiry indicated that their experts cannot make the decision on a claim, but they can offer a recommendation.

We expect subscribers to ensure their experts are trained in making recommendations consistent with the subscriber's standards, practices and policies. A decision on a claim involves an assessment of both technical factors and non-technical factors (such as fairness). Training should be ongoing as subscribers improve training programs and update policies.

We also advise caution in situations where the expert initially engaged to assess a loss is subsequently engaged to undertake the works for the claim. Subscribers should be wary of possible conflicts of interest and have processes to manage them if they arise.

Furthermore, subscribers should carefully consider the risk that their panel of preferred experts feel an expectation to work in favour of the subscriber. While we do not suggest that subscribers actively place this pressure on experts, we acknowledge the inherent risk in any arrangement of preferred experts.

This emphasises the importance of critically assessing an expert's recommendation for a decision on a claim.

We also acknowledge that subscribers may have better oversight of the expert on their preferred panels who are expected to meet their standards.

### Overturns based on existing information

**In 2021-22, the participating subscribers reported…**

**42,956** home insurance claims denied

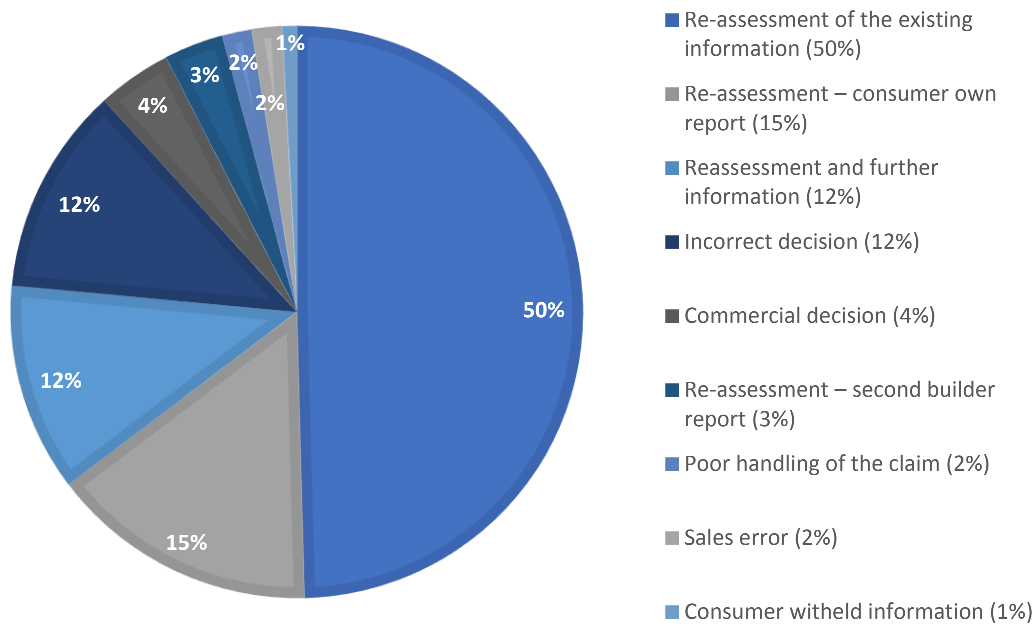
**10,903** complaints about denied home claims resolved

**47%** of resolved complaints were in favour of the consumer (5,108)

Half of the claims decisions we examined in the sample data were overturned after the subscriber reassessed the information it already held. There were two main reasons for these decisions to be overturned:

- The damage subject to the insurance claim were caused by an event, such as a storm, and would likely have occurred without any wear and tear or maintenance issues.
- It was unlikely that the consumer would have been aware of the wear and tear or maintenance issues.

**Figure 2: Overturned claims in sample data**




In 30% of decisions to deny a claim, there was an expert report that recommended the denial. This represents a significant proportion and highlights the risk of relying too much on expert recommendations.

Subscribers should ensure staff form their own views when making a claim decision, taking into account the expert's recommendation, other factors in line with the subscriber's decision-making policies, and obligations in the Code such as the duty to act in an honest, efficient, fair, transparent and timely manner.

It is clear from the case data that overturn decisions considered factors other than technical information provided by an expert. Subscribers should ensure staff consider such other factors when coming to the initial decision too.

## Overturns based on consumers' own reports

Consumers who obtain their own independent expert report may be more likely to have their claim accepted.

We identified that 15% of the sample files were overturned based on the consumer providing their own expert report.

This suggests that the reports from experts engaged by the subscriber may at times be insufficient and/or biased in favour of the subscriber.

When consumers in our sample obtained their own independent reports, they were able to achieve a more favourable outcome than when relying solely on the subscriber's expert report.

The onus to demonstrate that a policy exclusion applies lies with the subscriber. However, we have heard concerns from consumer advocates that this onus now

appears to be shifting to consumers as the experts engaged by subscribers suggest causes of damage without sufficient justification.

Due to costs and accessibility, obtaining an independent expert report is not always possible for a consumer. Consequently, many consumers may be at a disadvantage when having a claim assessed.

This emphasises the need to clearly explain how the cause of damage contributed to the loss. If the expert engaged by a subscriber cannot adequately explain their recommendation, the subscriber should not rely on the exclusion when assessing a claim.

## Are subscribers effectively capturing claims and dispute data?

All six subscribers capture the number of denied claims or the number of decisions overturned in favour of the consumer.

However, in some cases, subscribers are not sufficiently analysing the reasons for overturned decisions at a thematic level. This means they are missing important insights which could lead to business, process and product improvements.

The Code reflects a commitment from the industry to deliver positive outcomes for consumers, and continuous improvement is necessary for subscribers to meet evolving community expectations.

Subscribers cannot uphold this standard and achieve better consumer outcomes without capturing, analysing and distributing the relevant data.

A clear and shared understanding among staff of the purpose of using data for insights will help support efforts to implement these practices.

The subscribers that participated in this inquiry indicated collection and analysis of data on overturned decisions depends on the resources available to a subscriber. With the mix of subscribers that participated, we identified varying approaches to identifying and remediating issues through data collection and analysis.

While we recognise that resources differ for each subscriber, we expect all to adhere to good practice regardless of size and resource availability.

The larger subscribers in our inquiry were able to dedicate more resources to collecting, analysing and actioning data. We also found a stronger capability among larger subscribers to capture themes related to the decisions overturned through IDR.

Smaller subscribers captured data from overturned decisions but with less granularity.

**Room for improvement…**

One smaller subscriber noted that its complaints management system was designed to capture ASIC reporting requirements and it cannot identify themes related to the reasons for an overturned decision. It can only quantify the number overturned.

Despite this, we consider it possible to conduct a thematic analysis because the data is available. The systems may not lend themselves to a simple automated solution, but the fundamental information for a thematic analysis is there.

ASIC's RG271 has reporting obligations that extend beyond capturing the number of complaints. Licensees should be analysing root causes of issues and identifying recommendations for improving products or services as part of regular reporting.

It is a regulatory obligation for all subscribers to identify themes in data and analyse the root causes of complaints. Doing so also contributes to compliance with the Code.

It is not acceptable to cite systems limitations or lack of resourcing for not doing so.

Subscribers must have the appropriate systems and resources to capture the reasons for disputes and overturned decisions.

**Room for improvement…**

One subscriber stated that it collects the number of overturned decisions but was unable to identify themes without manual investigation.

The subscriber acknowledged that it had not been using its data as well as it could have been and is now working on enhancing its complaints reporting.

It will commence an initiative to review decisions on denied claims from a consumer perspective.

Data from complaints is a rich source of insight and it is incumbent on every

subscriber to understand the improvements they can make. Doing so can enhance consumer experience and outcomes and can act as an early warning signal for systemic issues.

## How subscribers analyse and distribute the data

Our inquiry found that formalised reports using data sourced from complaints and claims management systems is the primary way subscribers analyse and distribute data. Other methods include:

- Regular formal and informal meetings with relevant business units to share insights.
- Key performance indicators (KPIs) or dashboards for IDR teams to identify insights while managing complaints.
- Quality assurance programs, reviews and audits for both claims and complaints handling – some have dedicated auditing teams, others use IDR resources for this.

**Doing things well…**

One subscriber highlighted that it had established a Claims Customer Taskforce to review complaints, KPIs and social media feedback to ensure that complaints data is correctly represented to stakeholders.

The Taskforce meets monthly with participants from each claims business unit to ensure it understands complaint themes and finds appropriate solutions to customer dissatisfaction.

Senior leadership awareness and oversight of the issues from complaints is an important element of effective complaint management. This is also in line with the expectations in ASIC Regulatory Guide 271.

All subscribers that participated in our inquiry confirmed that they deliver some form of complaints reporting to the Board or other senior decision makers.

Five of the participating subscribers have established regular meetings with members of relevant business units to address complaint trends and determine what to do about the insights they find. Some have established standalone committees or panels for this purpose.

**Doing things well…**

One subscriber supplements its reporting with a quarterly internal newsletter that reports on trends, themes and matters from the complaints management system and Issues Register.

This, in conjunction with several other feedback channels, is a useful way of sharing lessons and increasing the general awareness of all staff. It also underlines the commitment by senior leaders to a positive culture of complaint management.

There is no single approach that suits every subscriber and we expect subscribers to collect and analyse data in ways appropriate to their business circumstances.

Dedicated audit teams, for example, are not feasible for all subscribers. Instead, regular meetings with relevant teams can ensure the subscriber analyses data and identifies areas and opportunities for improvement.

We encourage subscribers to refer to our publication Living the Code, which provides insights and recommendations on embedding Code obligations into compliance frameworks. It emphasises the consumer-centric approach to strategy and decision-making echoed in this inquiry.

## Business improvements from data insights

Although all subscribers in our inquiry capture and analyse complaints data to varying degrees, we did not find that they were all taking action based on these insights. This means that subscribers are not receiving the benefits that would flow from these insights.

**Doing things well…**

One large subscriber highlighted that its IDR team works closely with its Operational Risk team to ensure it acts on opportunities for improvement.

This subscriber also retains a Change Management team which manages large-scale initiatives referred by the Operational Risk team.

Many subscribers provided us with a list of general process improvements they implemented because of external forces such as new regulatory requirements or other operational enhancements.

Although these are positive initiatives, they are not direct outcomes of analysing complaints data and therefore did not directly address our questions.

**Table 1: Actions taken by subscribers in response to insights from complaints data.**

| Area | Action |
|---|---|
| **Internal communications** | • Feedback given to relevant business unit when a claim decision is overturned.<br>• Technical bulletins delivered to affected claims teams to reinforce process. |
| **Product improvements** | • Improved definitions in PDS to provide a clearer understanding of how the cover applies.<br>• Accidental damage changing from an additional benefit to an insured event.<br>• Removing 'no cover' clauses. |
| **Staff training & support** | • Additional training, support and oversight for claims handlers who had decisions overturned.<br>• Training for claims teams when dispute data indicates a systemic issue affecting the team.<br>• Improved induction training. |
| **Awareness campaigns** | • Educating consumers about policy exclusion clauses and the actions they can take to improve likelihood of claim acceptance. |
| **Process and system changes** | • Improvements to claims management systems.<br>• Improvements to claim outcome letter templates.<br>• Updating process guides.<br>• Establishment of working groups to review claims. |

We were encouraged to see that there are feedback loops in place at all participating subscribers.

When a declined claim is overturned at IDR, the outcome and the basis for it, is explained to the relevant claims team and may trigger changes to processes and additional training.

Subscribers should also ensure that they capture the patterns and trends in their data on overturned decisions to inform improvements and staff training.

Effective communication and staff training are essential in reinforcing quality and rectifying issues in claims decision-making. Subscribers must ensure that their processes and systems work to support the efforts of internal communication and staff training.

And they must measure the success of communication and training. For example, one subscriber highlighted that it distributes a bulletin to reinforce learnings with its claims team. While this is a step in the right direction, there is more that can be done to ensure communication and training is effective.

We were pleased to see our inquiry found some subscribers had made improvements to products, processes and systems because of insights they gleaned from data on overturned decisions. And other subscribers have introduced awareness campaigns to inform consumers about policy coverage and exclusions. These efforts have direct effects on improving consumer outcomes.

Consumer awareness and education initiatives are important, and we praise efforts to keep consumers informed. But it is crucial that such initiatives are expressed in plain, non-technical language to be effective.

Subscribers should ensure that these form part of a suite of measures to minimise disputes about decisions on claims. There is no substitute for sound and fair decisions based on clear evidence.

**Doing things well…**

One subscriber had identified common themes in feedback from complaints and its customer relations team about the way claim denials were explained to consumers.

In response, it sought to simplify and improve the language, format and tone of its claim denial letters.

This subscriber assessed its letter, taking a human-centred design approach, and tested a range of templates before finalising changes that improved them.

Our inquiry found that the subscribers that had implemented changes to address concerns cited anecdotal improvements to demonstrate success. They did not have controls in place to help measure success nor specific metrics with which to measure success objectively. We urge subscribers to improve this capability.

**Doing things well…**

One subscriber began regularly publishing information and conducting awareness campaigns to educate consumers about exclusion clauses.

The information and awareness campaigns vary over the course of a year and align with the seasons. For example, before the start of a flood season, it publishes information about the need to make sure household gutters are clean.

## Code breaches

Although we did not set out to find Code breaches in the sample data for this inquiry, we identified potential breaches when analysing the case files from all participating subscribers. The relevant Code obligations are set out in Appendix A.

We have a total of six investigations ongoing as a result of this inquiry. Three subscribers reported significant breaches of the Code after being prompted by the inquiry and we are investigating the significance of breaches from three other subscribers.

We continue to work with subscribers in their investigations to ensure consumers are appropriately remediated if necessary and to mitigate the risk of recurrence of the breaches.

The six subscribers should also consider whether they have also breached the *Corporations Act 2001* (Cth) with these breaches.

# Appendix A: Identified Code breaches

| | |
|---|---|
| **Paragraph 62** | 'If we identify, or you tell us about a mistake we make in handling your claim, then we will immediately take action to correct the mistake.' |
| **Paragraph 69** | 'When we assess your claim, we will consider all relevant facts, the terms of your insurance policy and the law.' |
| **Paragraph 70** | 'We will tell you about the progress of your claim at least every 20 Business Days.' |
| **Paragraph 77** | 'Our decision will be made within 4 months of receiving your claim, unless paragraph 78 applies. If we do not make a decision within that time, we will tell you in writing about our Complaints process.' |
| **Paragraph 81** | 'If we deny your claim, or do not pay it in full, then we will tell you, in writing:<br>a. the aspects of your claim that we do not accept;<br>b. the reasons for our decision;<br>c. that you have the right to ask us for the information about you that we relied on when assessing your claim;<br>d. that you have the right to ask us for copies of any Service Suppliers' or External Experts' reports that we relied on; and<br>e. about our Complaints process.' |
| **Paragraph 147** | 'We will make a decision about your Complaint within 30 Calendar Days. If we cannot make our decision within this timeframe, then before this deadline passes we will tell you, in writing, the reasons for the delay and about your right to take your Complaint to the Australian Financial Complaints Authority, and its contact details.' |
| **Paragraph 149** | 'Our written response to you will include the reasons for our decision and inform you of your right to take your Complaint to the Australian Financial Complaints Authority if you are not satisfied with our decision. We will provide you with its contact details and the timeframe in which you are able to complain to it.' |

## DISCLAIMER

Examples and case studies used in this report are purely for illustration; they are not exhaustive and are not intended to impose or imply particular rules or requirements.

## About the General Insurance Code Governance Committee

The General Insurance Code of Practice is a voluntary industry code that promotes high standards of service and better customer relationships in the general insurance industry.

The Committee is the independent body responsible for monitoring and enforcing Code subscribers' compliance with the Code standards.

**Statement of Recognition**

We acknowledge the traditional custodians of the different lands across Australia, and pay respects to elders past, present and future.

For they hold the songlines, the stories, the traditions, the culture and the hopes of First Nations Australia.

This land is, was, and always will be traditional First Nations country.

We also acknowledge and pay respects to the traditional custodians of the lands on which our Code team works: the Wurundjeri, Boonwurrung, Wathaurrung, Daungwurrung and Dja Wrung peoples of the Kulin Nation and Gadigal people of the Eora Nation.

**Contact the Code Governance Committee**

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