SUBMISSION ON POLICY ISSUES RAISED IN ROUND 6

Submitted By: Anthony Russell
Email: [redacted]
Phone Number: [redacted]
Submission for: My Self
Name of other person, business or organisation:
Do you agree to your submission being published: Yes
Do you agree to your full name being published: Yes
Your submission:

This submission will address the specific terms of reference:

1. The need for reform and improvement of the Life Insurance Industry

2. Reform to the unethical practices to avoid paying claims.

I have been insured with my insurance company since 1996 and on 21 December 2001, I was injured in an accident resulting in me becoming totally & permanently disabled. After some investigation I have found that my insurer has acted unethically by underpaying my correct benefits.

Brief History:
I worked in the Insurance Industry as a Life Insurance Agent & General Insurance Broker from the mid 80's up to 2002 and had income protection insurance with [redacted]. The policy sum insured at the time of the accident was $7657 per month to age 65, increasing by 5% per year. My TPD policy sum insured at the time of the accident was $473,402.

I was injured in an accident on 21 December 2001.

I contacted the [redacted] in January 2002 for claim forms for income protection.

My claim was accepted by [redacted] in April 2002. Notes from the underwriting file supplied by [redacted] states on 26 April 2002, claim accepted and to pay the sum insured.

On 20 June 2002, [redacted] have made notes that after further discussion, they have decided to reduce the benefits payable by $1657 per month, a total underpayment of $288,000.

I lodged a claim for Total & Permanent Disablement in 2003 and it was finally approved in 2005. Again an underpayment from the sum insured on the day of accident by $144,000.

In April 2012, after inquiries with [redacted], I found that they had engaged to fraudulently alter my claim from what they had accepted in April 2002. The insurer did admit liability, but stated that due to the Statute of Limitations, they didn't have to pay benefits (via email). The insurer with the full knowledge of my claim and aware of my insured amount, failed to act in my interest and was fully aware of the facts of my claim, and failed to disclose the error since the inception of my claim.

Main Issue:
[redacted] did approve but with intent to cause financial gain for themselves, acted corruptly in reducing my benefits. This is tantamount to fraud.

In August 2005, [redacted] did act the same in processing my claim for TPD. They delayed registering my claim for 9 months and the total time to accept the claim was nearly 2 years. They relied on 1 doctor to access my condition based on many doctors who had treated me. All this information is in the underwriting file.

In April 2012 when I found out that [redacted] had been underpaying my benefits for 11 years, they denied everything and finally admitted liability.

I received a copy of my underwriting file from [redacted] in February 2016 where there actions of [redacted] and the corrupt

actions are noted within that file. The underwriting file is available for the Royal Commission if requested.

Other alarming notes in my file show reports from private investigators who followed my daughters, doctor's reports and all manner of investigations trying to prove that my condition was not as bad as reported.
I filed complaints with FOS, ASIC and APRA, with no action from any of them.

FOS – they are not a regulator but only handle external dispute resolutions. They state that ASIC is the regulator.

APRA - APRA does not investigate individual complaints unless they are of prudential concern, meaning they pose a threat to the safety and stability of the financial institution. Also, there are secrecy provisions contained in the Australian Prudential Regulation Authority Act 1998 which prevent APRA from disclosing information relating to the supervision of a particular regulated institution. Again, referred to FOS and not ASIC.

ASIC – I have emailed Mr James Shipton at ASIC. The response from ASIC – ASIC's Role has the general administration of the corporation's law, including as it relates to actions of financial service providers.

As a regulator, we consider the public benefit and we do not act on behalf of individuals or give personal legal advice.

As a customer of an insurance company, we have nowhere to turn to for help in these matters and it is left to us to engage the legal profession to act on our behalf. The financial detriment caused by [redacted] from the financial losses have taken a significant toll on my health and family security. I had to sell our family home and all our assets, and thus causing me mental health issues that I required to see a doctor and treated for depression several times over the past 17 years. I was pushed to nearly committing suicide due to the conduct of [redacted]. My doctor saw this and immediately took steps for my mental health.

Thus with specific reference to term 1, there needs to be reform so it is not easy for Life Insurance Companies to engage in unethical & Corrupt behavior. As it is, the Life Insurance Companies can act anyway they like without fear of prosecution and knowing we have no avenue to lodge complaints that will be dealt with. I know of many people who have been in my shoes and have been unable to salvage anything from claims with Life Insurance Companies. Looking at my file and all the underwriting notes, I feel betrayed by my insurer.

Unethical Practices:
1. Purposely rejecting the claim based on biased information from their own doctor which is contrary to other doctors opinions.

2. Only using certain parts of a medical report and not the full report to favour their decision to deny a claim.

3. Ignoring the policy wordings of the Policy Document. Over the years of my claim the insurer has failed to act within the policy guidelines, requesting information that had no basis or reference to my claim.
4. I have on file many occurrence's where the insurer has breached conditions of my policy, but the insurer has failed to apologize as they know that they won't be held accountable.
5. They create stress by not paying legitimate claims, not answering questions, requesting information that has no relevance to the claim. Having investigators intrude on private and personal moments. Examples: I was rushed to hospital for a suspected heart attack and the investigator tried to force his way into the emergency department I was being treated in, then a few years later, the same investigators followed my daughters, how is this relevant to my claim? . These records are in my file.

Issues that need to addressed:
1. The insurer should NOT be able to request general information that is not relevant to the claim. The action of the insurer taking this path, has caused me undue stress. I have been under the care of many doctors and specialists over the years, and the insurer has access to those records, but the insurer insisted that I attend their doctors so they could state that my doctor's reports weren't correct and my injuries didn't qualify me for TPD. The constant threats from the insurer that if I don't disclose something then they can cancel my claim. The insurer was even asking my doctors for notes on matters not relating to my claim.
2. The insurers must comply with law in processing claims and paying the correct benefits of the sum insured. In my case there are notes from April 2002, where an underwriter has written that my benefit is the amount insured for, yet someone with the claims department decided to reduce the benefits. There are notes on my TPD claim where the insurer has said I don't meet the criteria because of what their doctor has said, yet I supplied many specialist reports and letters stating I was totally and permanently disabled.
3. The insurers need to be accountable for their actions as proven in my matter where they knowingly caused me financial grief by underpaying me.
4. The insurers should not be able to hide behind the law when it is proven that they have acted unethically and to the detriment of the insured.

5. There needs to be a New Statutory Authority established to act only for customers who have complaints against life insurance companies.
6. The insurers should be made to pay compensation in matters where it has been proven that they have acted fraudulently and caused hardship
7. The insurers need to understand the policies in place.