[redacted]

Submission regarding Policy issues following Round 6 submissions

WITHOUT PREJUDICE

Dear Sir/Madame,

I sincerely apologise for the delay in the submission of this information, due to work commitments and personal circumstances.

It was highly unfortunate in my instance to submit a submission to the Commission before the cut-off closure date, as I currently have a submission currently being reviewed by the Financial Ombudsman Service. However, without addressing specific circumstances in my case, I feel it important to other members of the Australia public to raise some issues for further discussion.

I will try to address some key points that I would like the Commission to consider, which is primarily targeted at the Insurance Industry, in particularly 'Travel Insurance' issues, which I believe is captured within the 'General Insurance' area captured in Round 6 of the Commissions work.

Module 6 Part A (2). PRODUCT DESIGN - Insurance

Are there particular products that should not be sold? YES

[redacted] How is it possible that an Insurance company is selling a product to customers that is highly probable to be a 'Frustrated contract' from the outset, as it is impossible for the client to ever comply with the conditions set out in the PDS?

Take [redacted] an example: Application of the PDS stipulations, in a simple personal Travel Insurance Policy, regarding stipulations leaving luggage in an unattended vehicle and the compliance requirements are totally impossible and unrealistic for anyone to meet, rendering the contract 'Frustrated' from the minute it is taken out by the client.

To demonstrate I refer to the requirement that; 'Luggage' etc '**MUST BE IN Lockable Concealable Compartment'** in a vehicle in a standard [redacted]

documents'. The client then needs to refer back to the definitions of this type of compartment, which reveals that in essence, the client would need to hire an 'Armoured car' to comply with the requirements. A locked vehicle boot or hidden completely out of sight in a station wagon would not meet these required criteria.

Utilising the aforementioned example, I have applied the test of a Frustrated contact following the High court precedent via an Australian Case: *Codeelfa Construction Pty Ltd V SRA of New South Wales (1982) 149 CLR 337,* and it is my belief (having a legal background) that this could be easily established.

Should an unsuspecting client leave their luggage in their vehicle in daylight hours to stop, fill up their hire car with fuel or park it to go and have lunch and the car is broken into and the luggage is stolen, their claim will either be rejected or a small value of the claim will be met, if at all. Unless of course they have hired an armoured car or leave someone with the car as a guard to fight off potential thieves at all times, which is impractical or impossible to achieve.

The current policy requirements of Insurance companies MUST be better scrutinized than they currently are, whereby this type of behaviour in policy documents has been allowed to occur.

Policies such as the one mentioned, must have to provisions so that the Insurance Company must provide real life examples by way of illustrated in 'a layman's' terms when a client by way of example is not covered. This policy should be demonstrated in every form or insurance taken out by individuals rather than having to go through the current process after the event.

Government bodies or the Insurance governing bodies must be accountable to check the validity of products like the aforementioned example, using real life examples to assess fair and reasonable consumer protection. Authorities should be testing real world examples and test against the examples provided by the Insurance Company for compliance a fairness test.

Module 6 Part A (2). DISCLOSURE

Is there scope for insurers to make greater use of standardised definitions of key terms in insurance contracts? Yes

A person taking out insurance reads on the policy that what they have taken out is Comprehensive Insurance and generally a 'Reasonable normal person' would assume that this would cover the majority of events giving rise to triggering a claim on their policy. However, this does not appear to be the same standard that Insurance Companies utilise when applying that test to specific claims.

The Oxford dictionary definition of the word 'Comprehensive' comprises of: *"Including or dealing with all or nearly all elements or aspects of something",* yet after examination of many policies would prove that this is not the case.

I propose that companies using definitions such as 'Comprehensive' or 'Lockable concealed compartment' or 'Flood' or 'Natural Disaster', by way of example, MUST provide examples of what is and is NOT covered to reduce confusion and be fairer to clients.

GENERAL INSURANCE

Should the General Insurance Code of Practice be amended to provide that, when making a decision to cash settle a claim, insurers MUST,

22.1 Act fairly? Yes

22.2 AND "...policy holder is indemnified against the loss insured..."

Clients wishing to lodge a review to the Financial Ombudsman MUST go through the individual Insurance Company claim dispute Resolution process before this can proceed to the Ombudsman Service for a final review. In the case of compliance with the Allianz processes, a client would need to perform the following steps: (using a theft as an example)

1. Prepare and lodge claim providing often comprehensive lists, photographs receipts of items stolen, statements made to police or additional witnesses and in the case of an overseas country incident further measures to substantiate the validity of the claim.
2. Then a client is subjected to be made to 'jump through a multitude of hoops' such as: the claimant will be contacted requesting further information on items or circumstances of the scenario leading to the claim, the Insurer will contact the client and advise them they have lost all of their documentation etc as some examples
3. Should the claim be rejected or accepted (but with a substantial variation in offer value to settle the claim) the client would need to spend considerable time writing to the Insurer seeking a review of the circumstances.
4. The Insurer would then write back to the claimant with an explanation to justify their decision making.
5. A client with a legal background could request a copy of all audio recordings made by the Insurer during the 'Sales' process, to test the validity and fairness of what they were sold to assess that what they purchased was 'Fit for Purpose' for their needs. This too would require a multitude of more hoops to jump through to request all of the recordings, having to go through and transcribe the conversations, before submitted them back for a further review.
6. The client then has to write back to the Insurer and request a review of the first review rejection, again all done by the Insurer deciding against another employee of their company.
7. If this is rejected the client would need to spend hours if not days making further submissions to the Financial Ombudsman Service (FOS) for an 'Independent Review Process'.
8. The FOS would then contact the Insurer informing them of the client request for review, which would trigger the Insurer to write to the client with an offer to settle the claim (still at a value way less than the original claim, hoping this will resolve the issue) with a DEED of Confidentiality silencing the client from making any further comment regarding their circumstances. As a ridiculous scenario the same person rejecting the clients claim in the Insurer's final process is the same person offering the client a ridiculous settlement amount.
9. The client would then need to write back to the FOS advising them of the acceptance or rejection of the offer or with any potential counter offer for resolution.
10. The client would generally write back to the Insurer accepting or rejecting their offer.

All up the client has spend weeks typing submissions, requesting information, put through rigorous processes before a final decision is made.

In addition to the value of the claim being determined by the Independent FOS on behalf of the client, there MUST be substantial penalties applied to Insurance companies whereby following a review the Insurance Company rejection of a claim is overturned. There must also be a 'Reasonable' compensation value for the client (in addition to the value of the claim) for the stress caused and time taken to prepare their submission.

I have no doubt the average person could not prepare the required documentation or be bothered going through the substantial stress in trying to overturn an Insurance Company's claim rejection with the current processes. Somehow the process must be simplified.

I believe greater penalties for Insurers in this area will dramatically reduce the work by the FOS and reduce what clients are currently expected to undertake which is unfair. If following a review by FOS and any Deceptive or Misleading behaviour (Policy wording 'Wrongs') are identified the Insurer MUST be penalised substantially by authorities, forced to make public apologies to the client and state the reasons behind the apology. The client MUST be indemnified from litigation by the Insurer, should they choose to publicly state all of the truthful facts about the entire process following a successful FOS review. Clearly there must be penalties attached to the client if any publicly disclosed information is proven to not be truthful.

I am more than happy to provide any further reference material regarding the PDS documents discussed in this submission or any further assistance to clarify any of my discussion points.

I appreciate the wok undertaken by the Commission which is extremely long overdue.

Regards,