# Table of Contents

- OVERVIEW 3
- LIFE INSURANCE CODE OF PRACTICE 3
- INITIAL ASSESSMENT 4
- DISCLOSURE 6
- ELIGIBILITY (GROUP) 7
- ASSESSING AGAINST THE CORRECT POLICY/IES 8
- TPD DEFINITIONS 8
- ALTERNATIVE TPD DEFINITIONS 12
- UNDERSTANDING THE OCCUPATION 15
- FUNCTIONAL 16
- BIO-PSYCHOSOCIAL FACTORS 16
- DATE OF ASSESSMENT 17
- REHABILITATION 21
- THE ROLE OF THE CONSULTANT MEDICAL OFFICER (CMO) 22
- TREATING DOCTOR’S REPORTS 23
- INDEPENDENT MEDICAL EXAMINATIONS 23
- FINANCIALS 24
- Investigations 26
- REINSURANCE 27
- ACCEPTANCE 27
- PROCEDURAL FAIRNESS 28
- DECLINATURE 28
- CASE LAW 29
OVERVIEW

Total and Permanent Disability (TPD) insurance provides cover if an insured becomes totally and permanently disabled. Each policy has different definitions of what is considered to be TPD.

Whilst the permanent inability to return to work is the key benefit of a TPD policy, there are usually other events that are covered entitling the insured to payment of the benefit, generally paid as a lump sum.

These provisions are also titled and defined individually depending on the policy but are typically described as follows:

- Unable or unlikely to work again in any occupation within their education, training or experience (ETE)
- Unable or unlikely to work in their own or usual occupation
- Unable or unlikely to perform domestic (home) duties
- the loss of the ability to perform activities of daily living (ADLs)
- cognitive loss
- specific loss (limbs and/or sight)
- permanent impairment

TPD cover can be held inside or outside of superannuation. TPD under a policy outside superannuation can also be linked with TPD Cover through superannuation.

The policy structure and whether TPD is held inside or outside of superannuation is an important consideration for insureds.

All guideline and procedure documents can be located on PathFinder and must be reviewed in conjunction with this document where appropriate.

The locations of these documents are referred to in bold at the conclusion of each applicable section.

LIFE INSURANCE CODE OF PRACTICE

The Code is the life insurance industry’s commitment to mandatory customer service standards.

It has been voluntarily developed by the life insurance industry through the Financial Services Council to:

• Promote high standards of service to consumers
• Provide a benchmark of consistency within the industry
• Establish a framework for professional behaviour and responsibilities

When completing the assessment on a TPD claim, it is important that we identify with and meet the minimum standards as required by the Code.
Please refer to our Claims Governance Framework and the Customer Service Proposition to understand the minimum standards of the Code.

**Claims → Procedures and Work Instructions → Guidelines → General Guidelines**

To review the Code in full please refer to the FSC website (https://www.fsc.org.au/policy/life-insurance/code-of-practice/).

**INITIAL ASSESSMENT**

Once a claim has been set up you will need to complete an Initial Assessment Template specific to the product (e.g. Retail, Group, Direct).

Initial Assessment Templates are available in PathFinder with the exception of FINEOS claims for which you will complete the Group Claim Intake on the FINEOS system.

Completion of this template will provide a solid platform for not only establishing liability but will prompt you to identify, extract and document the key factors from the commencement of cover up to and including the date of the claim.

When assessing the claim you will need to obtain and document details of the policy and coverage details to ensure you are assessing within the correct parameters and identifying any liability issues.

Depending on whether you are assessing a Retail, Group or Direct product some of the information you might capture will include:

**POLICY**

- Application date
- Date joined fund
- Date joined employer
- Policy type
- Policy structure (e.g. SuperLink, Stand Alone, attached to Life cover)
- Risk commencement date
- Policy expiry date
- Premium paid to date
- Fund contributions
- Reinsurance (Company and percentage of reinsurance)
- Replacement business (e.g. policy replacing cover held with another insurer)
- Other cover held with OnePath
- Underwriting assessment
- Acceptance terms (e.g. medical loading, exclusions)
- Alterations or reinstatements since commencement (e.g. were there any periods in which there was no cover? Was there an additional duty of disclosure required at any point in order to reinstate cover?)
- Ancillary benefits (e.g. Financial Advice Benefit, Limited Death Benefit, Double TPD option)
- Built in limitations such as pre-existing condition (PEC) clauses, residency status limitations, criminal activity or self-inflicted act exclusions
TPD ASSESSMENT MANUAL

MEDICAL
- Diagnosis/es
- Commencement of disability
- Objective findings/severity of illness or injury
- Functional capacity
- Current and proposed treatment and rehabilitation including timeframes for which treatment will be undertaken
- Likely response to treatment
- Short term and long term prognosis
- RTW expectations (claimant)
- RTW expectations (doctor)

OCCUPATIONAL
- Employment status (self-employed, independently employed)
- Occupational duties and limitations
- Education, Training and Experience (ETE)

FINANCIAL
- Pre-disability earnings
- Concurrent claims
- Other insurance cover

OTHER
- Red flags or inconsistencies in the information provided and the steps required to investigate/address them
- Biopsychosocial factors
- Other non-clinical issues preventing RTW (e.g. legal obstacles, workplace conflict)

To locate the Initial Assessment Templates refer the Pathfinder;

RETAIL:
Claims → Tools and Internal Templates → TPD Assessment Templates → TPD Initial Assessment Template

GROUP:
Claims → Tools and Internal Templates → Internal Template → TPD Initial Assessment Template

DIRECT:
Claims → Tools and Internal Templates → TPD Initial Assessment Template
DISCLOSURE

If the TPD policy you are assessing was underwritten, a review of the disclosures made at application (or any subsequent variations or reinstatements) is required. We should always consider the information provided at application and should take a reasonable approach to conducting any investigations.

The following considerations may influence whether you believe an investigation into disclosure is warranted:

MEDICAL
- Claim received soon after policy commencement
- Reference to past medical history on the Treating Doctor’s Statement or clinical notes
- Degenerative condition claimed upon shortly after policy commencement
- Medical condition not resolving within expected duration (could indicate a possible underlying history)
- Changes in treating doctor since application
- Family history documented in medical reports but not on application
- Evidence of a claim with a previous insurer or social security

OCCUPATIONAL
- Occupation at claim time is different to the occupation on application
- The insured’s duties have changed (e.g. from sedentary to manual)
- If self-employed the insured’s business structure, including number of directors and employees differs from the application
- If self-employed the insured’s business continues to operate successfully in their absence despite advising the opposite on application
- There is evidence that the insured performs hazardous work (e.g. working at heights) which was not declared at application
- The insured is working in an uninsurable occupation or is an apprentice – was this the case at application
- If employed, the position description provided by the employer at claim time is different to that advised on the application

FINANCIAL
- Is the current income less than the income at application
- Stated income not commensurate with occupation
- Occupation at claim time is different to the occupation at application
- If self-employed, discrepancies in reported income splitting arrangements, distributions and company directorship
- Was the insured recently self-employed?
- Noted history of bankruptcy or debt

PASTIMES
- Claimed event occurred whilst participating in a listed pastime (e.g. football, martial arts)
- There is mention of participation in pastime in clinical notes or medical reports
- The nature of the injury is a renowned sports injury (e.g. multiple cruciate ruptures of the knee)

For more information refer to the PathFinder guideline under Claims → Procedures and Work Instructions → Guidelines → General Guidelines → Investigating Non-Disclosure and Misrepresentation.

ELIGIBILITY (GROUP)

Members can become insured under a group insurance policy by one of three ways:

1. Automatic Acceptance

Default cover is the standard level of cover a member receives automatically upon satisfying certain eligibility conditions. If the Automatic Acceptance Limits under the policy are higher than the standard Default cover, it may be necessary for a member to apply to receive a higher level of cover. Cover is provided with no underwriting or health evidence necessary.

2. By submitting an application for cover

A member of the group may not satisfy the requirements of Automatic Acceptance and they may voluntarily seek to join the fund or plan rather than being offered cover by default. Or, they may seek additional cover above the Automatic Acceptance Limits. In this instance, an application for cover may be submitted, in which case in addition to satisfying the eligibility criteria set out in the policy schedule and document, the duty of disclosure must also be considered.

We should also keep in mind any special offers as part of insurance upgrades, for example, the member of the group may not have been eligible for Automatic Acceptance upon joining the fund, but may have become eligible under a special offer thereafter – this may require certain eligibility requirements such as completion of a personal statement or subject to a pre-existing condition (PEC) clause.

3. Transfer terms (also known as takeover terms)

Transfer terms are the terms on which the incoming insurer agrees to provide cover to existing members of the group, who were covered under a previous insurance policy and are intended to provide members of a group with a minimum level of cover that is at least equal to the level of cover held under the previous policy.

Regardless of how a member becomes insured under a plan, they MUST meet the eligibility criteria set out in the plan. Eligibility criteria vary widely from plan to plan, and even within plans across different categories of members. When determining if a member is eligible, it is necessary to review the policy document and the policy schedule, where then eligibility criteria will be set out.

For more information refer to the PathFinder guideline under Group Claims → Procedures and Work Instructions → Guidelines → General Guidelines → Assessing Eligibility Under Group Plans Claims.
ASSESSING AGAINST THE CORRECT POLICY/IES

It crucial that the right policy/ies are reviewed when determining whether a TPD definition has been satisfied.

RETAIN AND DIRECT

Just as important is reviewing any upgrades and historical definitions.

In all cases, an insured can NEVER be disadvantaged by a product upgrade. Typically upgraded definitions in policies are more favourable to the insured but this is not always the case. We must therefore review the claims against all TPD definitions that the insured was entitled to over the life of their cover.

GROUP

With a GSC policy, the terms and conditions can change at any time without the insured’s agreement. At the date of disability the insured does not have the option to use more favourable wording under a previous policy they were covered under.

The policy applicable is the policy as at the date of assessment – the date of assessment has different parameters which may also change as you obtain more evidence. This will be explained in more detail later in the document.

TPD DEFINITIONS

Following is a brief description of the key benefits of TPD policies. As demonstrated below it is paramount that the EXACT policy wording is referred to in every instance when assessing a claim.

OWN OCCUPATION

Put very simply, ‘Own Occupation’ TPD definitions require an insured only to be unable to perform the occupation they were working in when they become disabled (depending on the policy). These policies are more costly, but offer the most claim certainty, depending on the insured’s individual circumstances and the specific policy definition. Should the insured be unable to work in their occupation but can work in another occupation, this is irrelevant to us as the insurer and policy criteria is still met in these circumstances.

‘Own Occupation’ is sometimes referred to as ‘usual occupation’ or ‘regular occupation’.
Following are some examples of different 'Own Occupation' definitions:

OneCare (November 2016)

'Own Occupation' relates to the most recent occupation in which the life insured was engaged before the date of disability.

Own Occupation TPD means that, as a result of illness or injury, the life insured:

1. a. has been absent from and unable to engage in their 'Own Occupation' for three consecutive months; and
   b. is disabled at the end of the period of three consecutive months to such an extent that they are unlikely ever again to be able to engage in their 'Own Occupation';

World of Protection (October 2004)

Where you are engaged in a business, profession or occupation, whether as an employee or otherwise:

(a) you have been absent as a result of illness or injury from employment for six consecutive months; and
(b) at the end of the period of six months, you are disabled to such an extent as to render you likely never again to be engaged in your Own Occupation.

ANY OCCUPATION

'Any Occupation' TPD definitions generally require an insured to be both unable to work in their own occupation AND in any occupation for which they are reasonably suited by ETE.

In assessing claims under this definition, we will first assess the insured's ability to perform their own occupation. If they are unable to perform their own occupation we will assess whether they can perform another suitable occupation. If it is deemed that the insured can perform another occupation for which they are reasonably suited, then the definition will not be met.
Following are some examples of different ‘Any Occupation’ definitions:

**OneCare (November 2016)**

Any Occupation TPD means that, as a result of illness or injury, the life insured:

1. a. has been absent from and unable to work for three consecutive months; and
2. b. is disabled at the end of the period of three consecutive months, to such an extent that they are unlikely ever again to be able to engage in any occupation:
   - for which they are reasonably suited by their education, training or experience; and
   - which is likely to generate average monthly earnings of at least 25% of the life insured’s average monthly earnings in the 12 months before claim;

**HostPlus (June 2012)**

If the insured member is employed or engaged in a gainful occupation, business, profession or employment or within 12 months of the date an insured member ceases to be so employed or engaged:

1.1 that insured member has suffered an injury or illness and, as a result of that injury or illness, the insured member:

1.1.1 is totally unable to be employed or engaged in that occupation, business, profession or employment for a period of 6 consecutive months; and

1.1.2 is determined by us at the end of that 6 month period (or such later time as we agree with the policy owner), to be permanently incapacitated to such an extent as to render the insured member unlikely ever to be employed or engaged in any gainful occupation, business, profession or employment for which the insured member is reasonably suited by education, training or experience.
HOMEMAKER / NON-WORKING

Some policies offer TPD cover to unemployed persons performing full-time domestic duties (which may or may not be specifically defined in the policy) or for persons moving in and out of employment:

OneCare (November 2016)

Home-maker TPD means that, as a result of illness or injury, the life insured:
1. a. is under the regular care of a medical practitioner and unable, for three consecutive months, to:
   • perform 'normal domestic duties' and leave their home unaided, or
   • be engaged in any occupation and
   ‘or’

2. b. is disabled at the end of the period of three consecutive months to such an extent they require ongoing medical care and:
   • are unlikely ever again to be able to perform any 'normal domestic duties'; or
   • are unlikely ever again to be able to be engaged in any occupation for which they are reasonably suited by their education, training or experience

Often specific assessments are required in order to arrive at a determination – see 'REHABILITATION'.

OWN OR ANY OCCUPATION – SUPERANNUATION VS NON-SUPERANNUATION

When a benefit is payable under an insurance policy held inside superannuation the Trustee may only pay part or all of the benefit when an insured meets a condition of release under the Superannuation Industry (Supervision) act 1993 (SIS).

For TPD policies under superannuation benefit the payment of a benefit relies on the 'permanent incapacity' condition of release. 'Permanent incapacity' means a Trustee is satisfied that a member is unlikely, because of physical or mental ill-health, to engage in gainful employment for which they are reasonably qualified by ETE.

As the above typically usually aligns with the 'Any Occupation' TPD definitions, insured benefits should be accessible by the insured following a successful claim. However, this may not apply to 'Own occupation' policies, i.e. if an insured has an 'Own Occupation' TPD definition inside superannuation and a benefit is paid, the Trustee may not be able to release the claim proceeds until one of the other conditions of release is satisfied (e.g. reaching age 65).
There are also instances where a TPD Any Occupation definition policy has been paid and the Trustee still cannot release the funds (e.g. the insured satisfies the definition but has retrained and is now working in a new occupation outside of their ETE).

If an insured has not met a condition of release, the Trustee cannot make any payments directly to them. The Trustee will transfer the balance (less eligible adjustments) to an eligible superannuation fund.

There are also tax implications to consider when determining whether to hold TPD insurance inside or outside of superannuation. Inside superannuation, payment of a TPD benefit may give rise to a tax liability. While part of the benefit paid may be tax free, lump sum and income stream payments are taxed under the superannuation benefit payment rules. The Trustee of the superannuation fund may need to obtain further information about the insured including their age and the level sum insured.

In order to get tax concessions, the Trustee requires that two medical practitioners must have certified that the member is unlikely to be gainfully employed again in a position for which they are reasonably qualified, due to their ETE.

**ALTERNATIVE TPD DEFINITIONS**

As noted in ‘OVERVIEW’ whilst the permanent inability to return to work is the key benefit of a TPD policy there are usually other events that are covered entitling the insured to payment of the benefit, generally paid as a lump sum.

They are individually defined depending on the product but are usually described as follows:

- the loss of the ability to perform activities of daily living (ADLs)
- cognitive loss
- specific loss (limbs and/or sight)
- permanent impairment

**ACTIVITIES OF DAILY LIVING (ADLs)**

ADLs are a term used in healthcare describing a person’s daily self-maintenance activities.

In the context of life insurance ADLs are a defined set of specific activities considered necessary for the claimant to live independently which need to be fulfilled in order to be eligible for a benefit. The provision is often defined as ‘Loss of Independent Existence’.

Many TPD policies across all product lines consider the insured’s permanent inability to perform certain ADLs to determine whether they are eligible for the sum insured. The majority of policies will pay a lump sum benefit when the insured is permanently unable to perform, for example, 2 out of 5 ADLs, but these figures depend on the specific policy wording.

Another requisite of most policies is that the insured relies on the assistance of another person to perform an ADL.
OneCare (July 2014)

'Loss of independent existence' means the life insured is totally and irreversibly unable to perform at least two of the following five 'activities of daily living' without the assistance of another adult person:

- bathing and/or showering
- dressing and undressing
- eating and drinking
- using a toilet to maintain personal hygiene
- getting in and out of bed, a chair or wheelchair, or moving from place to place by walking, wheelchair or with assistance of a walking aid;

When assessing these claims the crucial terms we need to consider are 'totally' and 'irreversibly' (or as otherwise defined). As with many claims, the level of impairment as well as the permanency of the impairment can be difficult to establish.

The Rehabilitation Team may need to arrange an ADL assessment (see 'REHABILITATION') at the insured's residence.

Particularly challenging or contentious ADLs claims may require Legal input or may need to be presented to the Claims Review Forum prior to making a determination.

For more information refer to the Pathfinder guideline under Claims → Procedures and Work Instructions → Guidelines → General Guidelines → ADLs Philosophy.

COGNITIVE LOSS

Cognitive impairment can cause problems with a person's thinking, communication, understanding or memory and can be caused by illness or injury. It can be a short-term problem or a permanent condition. TPD policies that provide these definitions cover the latter subject to the definition being met.

ACSRF (November 2016)

Part 5) Cognitive loss

As a result of Illness or Injury, the Insured Member suffers Cognitive Loss.

'Cognitive loss' means we have determined a total and permanent deterioration or loss of intellectual capacity has required the Insured Member to be under continuous care and supervision by another adult person for at least six consecutive months and, at the end of that six month period, they are likely to require permanent ongoing continuous care and supervision by another adult person.
As with ADLs, the level of impairment as well as the permanency of the impairment can be difficult to establish.

Cognitive disorders are a part of the neurocognitive disorder classification in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). In order to establish both the severity and the permanency, you will likely need to seek input from the insured’s treating specialist and potentially have an independent neuropsychologist or neuropsychiatrist conduct relevant testing.

Ensure that you have reviewed the specific policy wording and requirements so that your request is tailored to obtain answers sufficient for you to determine whether the definition is met.

CMOs can also be of assistance in both preparing the request to the physicians and/or independent examiners and interpreting the clinical data when the reports are received.

SPECIFIC LOSS

Specific loss in TPD policies generally refers to the loss of use of limbs (e.g. by amputation, paralysis or severe injury) or sight or a combination of both.

HostPlus (17 June 2012)

3. Specific loss

As a result of illness or injury, the insured member suffers the total and permanent loss of the use of:

• two limbs (where ‘limb’ is defined as the whole hand or the whole foot), or
• the sight in both eyes, or
• one limb and the sight in one eye.

These definitions are typically straightforward and clearly defined.

PERMANENT IMPAIRMENT

These definitions provide payment of a lump sum where an insured meets a certain percentage level of impairment as defined usually in combination with being unable to return to work in any occupation.

Often insured’s are assessed against this definition if they are not eligible to claim against the working TPD definitions due to eligibility issues such as unemployment.
HostPlus (17 June 2012)

2. Permanent impairment

The insured member suffers an injury or illness and, as a result of that injury or illness, the insured member:

a) suffers a permanent impairment of at least 25% of whole person function as defined in the American Medical Association publication 'Guides to the Evaluation of Permanent Impairment', 4th edition, or an equivalent guide to impairment approved by us; and

b) is disabled to such an extent, as a result of this impairment, that the insured member is unlikely ever again to be able to be employed or engaged in any gainful occupation, business, profession or employment for which the insured member is reasonably suited by education, training or experience.

The impairment rating must be established by a suitably qualified person such as the insured's treating specialist, a medico-legal examiner or a CMO.

UNDERSTANDING THE OCCUPATION

Understanding the insured's occupation is the cornerstone of TPD assessment.

As much detail as possible about the insured's usual occupation (for 'Own Occupation' policies) and their ETE (for 'Any Occupation' policies) should be obtained in order to gain the level of understanding necessary to assess the claim and make a determination.

Information to obtain can include:

- Job title
- Employment type
- Normal hours worked (including shifts)
- Location of the workplace (home, office, worksite) and layout / design
- Tasks performed (including 'importance', time and frequency)
- Physical requirements for each task (including tools and machinery used)
- Cognitive requirements for each task
- Work environment / environmental demands
- Travel requirements
- Qualifications and certifications, known hobbies or participation in volunteer work

HOW CAN I OBTAIN THIS INFORMATION?

- Occupational Questionnaire and ETE forms
- Rehabilitation Team (Worksite Assessment, Job Analysis, Transferable Skills Analysis)
- Consultant Medical Officer (Occupational Physician)
- Telephone Interview / Factual Interview
- Workers Compensation files
- Centrelink files (likely to contain a Job Capacity Assessment)
- Employers
TPD ASSESSMENT 
MANUAL

- Tax Returns

Useful websites:

- www.acc.co.nz/for-providers/work-type-detail-sheets/occupational-groups/index.htm
- ANZSCO (ANZ Standard Classification of Occupation)
- O*NET Online
- My future
- Industry Association and Employer Websites
- AC People
- Career FAQs

REMEMBER!!! Never make assumptions about an insured's occupational duties and requirements based on their occupation title alone.

FUNCTIONAL

When considering TPD claims, we do not just assess whether an insured has a medical diagnosis, but we also assess the functional implications of the medical condition, and whether it impacts the ability to perform their occupation as defined in their policy.

Information that should be obtained in regards to functioning includes:

- How is the medical condition impacting day-to-day functions including basic activities of daily living (self-care, shopping, domestic duties, child care)?
- How is the medical condition impacting work capacity?
- What are the functional requirements of the occupation (see above)?
- What are the cognitive requirements of the occupation (see above)?
- Are there medically imposed restrictions or limitations?
- Are these limitations expected to improve with time and / or treatment?
- Any inconsistencies?
- Are any of the restrictions or limitations expected to be permanent?
- Any biopsychosocial factors influencing function?
- Can aids/ equipment improve functioning?

REMEMBER!!! Diagnosis alone does NOT always equal disability.

BIO-PSYCHOSOCIAL FACTORS

The biopsychosocial model is a framework that states that interactions between biological, psychological, and social factors determine the cause, manifestation, and outcome of wellness and disease.

BIO: refers to physical or mental health condition.
PSYCHO: recognises that personal/ psychological factors also influence functioning (thoughts, emotions and behaviours).

SOCIAL: recognises the importance of social context, cultural factors, pressures & constraints on functioning.

Consider what tools you may utilise if you identify the following:

- Co-morbid conditions
- The insured’s employment is no longer available / job detached
- The insured was under performance management/ disciplinary action prior to ceasing work
- The employer does not want the insured to return
- The insured has no obvious intention of returning to work
- The insured is legally prevented from returning to their occupation
- Family stressors
- The insured has become a primary carer or was on maternity leave at the time of disablement
- Financial disincentive / level of benefit
- Other insurance / pending TPD claim / pending settlements
- Other parties including financial advisers and legal representatives perpetuating claim
- Lack of social support

It is important that, whilst sometimes we cannot influence or change biopsychosocial factors, we aim to identify their existence and work WITH them when formulating a strategy.

DATE OF ASSESSMENT

Assessing claims for TPD benefits at the correct point in time is critical to the claims assessment process.

The above ‘ALTERNATIVE TPD DEFINITIONS’ aside, ‘Own’ or ‘Any’ Occupation TPD benefits have two limbs which must be met for the insured to be entitled to a benefit.

Firstly, the insured must have been absent from work, due to injury or illness, for a period of time, which is usually 3 or 6 months (the ‘waiting period’).

Secondly, assessed at the end of the waiting period, the insured must be unable or unlikely ever to return to relevant work as defined in the policy.
Example:

OneCare (November 2016)

Own Occupation TPD means that, as a result of illness or injury, the life insured:

1. has been absent from and unable to engage in their ‘Own Occupation’ for three consecutive months; and
2. is disabled at the end of the period of three consecutive months to such an extent that they are unlikely ever again to be able to engage in their ‘Own Occupation’;

The date of assessment could vary depending on the policy definition, such as:

- the date last at work
- the date of termination of employment or becoming unemployed,
- the date of the injury or onset of the illness
- the date after the end of the waiting period
- the date the claim was lodged
- the date on which the evidence was assessed by the insurer

It is extremely important to review the policy terms in every case and ensure that the focus remains on the date of assessment.

CONSIDERATIONS

Each claim and its date of assessment are to be determined on its own merits giving consideration to the evidence to hand and the policy language as noted above.

The focus needs to remain on the date of assessment however you still need to consider ALL information available.

Following are some common scenarios which present challenges to consideration of date of assessment and when to assess whether a person is TPD.

<table>
<thead>
<tr>
<th>SCENARIO</th>
<th>ASSESSMENT / RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>The date of assessment is in the past (e.g. late lodged claim) and there is only current information to hand.</td>
<td>Attempt to source information from or around the date of assessment (e.g. Worker’s Compensation file, clinical notes, Centrelink file, Employer file) If no contemporaneous information is available you will need to try to link the information that is available to the date of assessment</td>
</tr>
<tr>
<td>The date of assessment is in the past (e.g. late lodged claim) and there is no current information available, however there is evidence provided which was contemporary at the date of assessment.</td>
<td>If there is enough evidence around what you have determined to be the date of assessment you may not need current information.</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>Do I need current information?</td>
<td>There may however be indication of potential for increase in function and evidence indicates this may have occurred (e.g. you have undertaken surveillance or have conducted an IME).</td>
</tr>
<tr>
<td></td>
<td>You may wish to send this material to the doctor providing the opinion at date of assessment to see if it alters their view or is inconsistent with the claimed restrictions and expected prognosis.</td>
</tr>
<tr>
<td>The information at the date of assessment indicates that the insured is not TPD but more recent reports provided indicate that the insured is / has become TPD.</td>
<td>Some questions you may ask yourself:</td>
</tr>
<tr>
<td></td>
<td>- Are we dealing with the same illness/injury?</td>
</tr>
<tr>
<td></td>
<td>- Is it the same doctor who provided the prognosis at date of assessment and recently? You may need to ask the doctor why their opinion has changed - a CMO or IME can assist with a peer review of the opinion if you are concerned with objectivity.</td>
</tr>
<tr>
<td></td>
<td>- Are you dealing with multiple doctors who have given different opinions at different times around and since date of assessment? You may need to consider weighting of evidence provided at the date of assessment vs more recent evidence. Again the CMO or an IME can assist with quality and weighting of evidence provided by different doctors at different times. Recent reports by different doctors may need to be presented to doctors who provided an opinion at date of assessment to determine whether they maintain their original opinion or whether the current evidence causes it to change.</td>
</tr>
</tbody>
</table>
| The insured was not TPD at date of assessment but has suffered a subsequent unrelated illness/injury rendering them TPD. | Before you present adverse material / decline a claim in this context ensure that you have determined that the condition is definitely unrelated. For example, a physical condition directly leading to a psychiatric condition cannot
TPD ASSESSMENT MANUAL

| A medical opinion regarding TPD cannot be formed until pending medical treatment e.g. surgical intervention is undertaken. | If an opinion cannot be formed until a certain treatment has taken place this will need to be communicated in our determination and a decision should be made on the claim. Sometimes you will need to revisit a claim after the treatment as the insured may ultimately still be TPD if the treatment is unsuccessful in the context of RTW function. If an insured is refusing treatment we need to determine whether the refusal is reasonable in the circumstances (legal input may be necessary in these scenarios). |
| The insured has not reached maximum functional improvement and it is possible the prognosis will become more favourable in time and with further treatment. | If you have enough information to make a decision it should be made as we are not in the practice of ‘deferring’ TPD claims. These scenarios are challenging and we need to ensure that the medical and other evidence clearly shows prospects for improvement. |

necessarily be viewed as unrelated and ignored as evidence.
Also check specific policy wording and whether the TPD needs to be as a result of the specific illness/injury that caused work cessation.

There is case law which addresses some key issues surrounding ‘Date of Assessment’ in TPD claims.
Refer to the Case Law section for further information.
REHABILITATION

The Rehabilitation Team offer the following services, which may assist you when assessing TPD claims:

MINI EMPLOYABILITY ASSESSMENT

A mini Employability Assessment is an assessment which provides a summary of the insured’s ETE and reviews the medical information regarding the insured’s functioning, in order to determine whether there are any vocational options suitable for the insured.

A mini Employability assessment provides basic labour market information and is predominantly a desktop review which relies on the information already available in the file.

EMPLOYABILITY ASSESSMENT

An Employability Assessment provides more detail than a mini Employability Assessment, and outlines the insured’s ETE, medical information regarding functioning, and determines whether there are any vocational options suitable for the insured.

The assessment provides more detail in regards to the labour market, usually including telephone contact with employers, and can be conducted as a desktop review, telephone based assessment, or face-to-face assessment.

ACTIVITIES OF DAILY LIVING (ADLs) OR HOMEMAKER ASSESSMENT

An Activities of Daily Living or a Homemaker Assessment can assist you with obtaining a better understanding of the insured’s functional capacity, for the purpose of determining whether the insured satisfies the ADL/homemaker definition required under the policy.

This assessment is a medico-legal assessment conducted by Occupational Therapist, usually in the insured’s home. The assessment involves observation of the insured’s functioning specific to performing tasks noted in the relevant policy definition.

To arrange any of the above assessment use the following link which is also located in PathFinder and referenced at the conclusion of this section;

Walk Up Internal Rehab Referral Form

VERBAL REVIEWS

Discussions with the Rehabilitation Team can assist you to determine whether:

- There are any realistic options available
- An Employability Assessment is needed
- Additional ETE information is required
- Additional functional information is required
For more information refer to PathFinder under Retail Claims → Procedures and Work Instructions → Guidelines → Rehab Guidelines → TPD Guidelines for Rehabilitation.

THE ROLE OF THE CONSULTANT MEDICAL OFFICER (CMO)

CMOs are a valuable resource available to all assessors and claim staff.

We have 3 types of referrals:

1. Walk-Up / Case Conferencing Service
2. Formal Review
3. Event Based

It is important that we have a clear idea of why we are referring a claim to the CMO and what it is we hope to achieve by doing so. It is also important to consider the best method for obtaining the advice.

1. Walk-Up / Case Conferencing Service

These are dedicated times whereby you can take the opportunity to verbally discuss any of your claims with the appropriate and available CMO.

2. Formal Review

A formal review entails a fully completed referral and instructions for the purpose of a thorough review of file material and provision of a written review and opinion by the chosen CMO.

3. Event Based

These are referrals where we are engaging the CMO to determine whether a specific definition under a policy has been fulfilled. For TPD claims this may include a specific diagnosis or a medical event under the following:

- Specific Loss
- Cognitive Loss
- Permanent Impairment

WHEN TO REFER TO A CMO

Examples of when you may want to refer your TPD claim to a CMO:

- When you need help understanding the medical conditions or where there are multiple diagnoses (co-morbidities)
- Expected clinical timeframes for the claimed condition/s
- When you need to know the functional deficits expected for the claimed conditions/s
- To determine the adequacy of treatment and whether all treatment avenues have been exhausted
- To help decipher medical terminology / medical shorthand
TPD ASSESSMENT MANUAL

- To interpret clinical data on imaging and pathology results
- To obtain assistance in drafting specialised and targeted questions to health care providers / IMEs tailored to the claimant’s individual circumstances
- To determine whether medico-legal examination is warranted and, if so, the appropriate specialist to undertake the examination
- To assist in determining whether medical definitions are met on event based claims (see above)
- To assist in determining whether [ETE] options for ‘any occupation’ assessments are medically viable (but does not include determination of the claimant’s capacity for such occupations). Also consider that Employability Assessments have already taken into account the claimant’s functional limitations

For more information refer to PathFinder under Claims → Procedures and Work Instructions → Guidelines → CMO Guidelines.

TREATING DOCTOR’S REPORTS

It is important that you request appropriate evidence at the appropriate time from the most appropriate doctor.

Allied health care professionals may be of assistance also and should not be ruled out as a resource (e.g. physiotherapists, chiropractors, psychologists and occupational therapists) as resource. They all play a role in the care of the insured and may have information to offer on treatment responses, motivation, lifestyle and other factors.

Standard letters are on Pathfinder however it is important that you modify these so that they are relevant to your claim e.g. always provide a detailed description of the insured’s occupation and ETE (if applicable). The TPD focus should remain on the date of assessment.

Claims → LICOP Letters → TDR Report Request.

INDEPENDENT MEDICAL EXAMINATIONS

Independent Medical Examinations (IMEs) can be conducted at the request of an insurer to aid in claims assessment with the aim being to obtain an impartial and unbiased opinion of the insured’s claimed medical condition/s. The purpose may be varied but could include:

- to clarify or confirm a diagnosis
- to assess the symptoms and their severity
- to comment on the appropriateness and adequacy of treatment
- to assess the level of incapacity and ability to return to work
- IMEs do not need to be arranged on each claim however you may wish to arrange an IME if the following red flags are identified:
  - Subjective/controversial medical conditions e.g. CFS, fibromyalgia
  - Lack of significant pathology/ radiological evidence
  - Lack of diagnosis, or conflicting diagnoses
TPD ASSESSMENT MANUAL

- Lack of treatment, or adequacy of treatment, including compliance
- There has been no referral to a specialist
- Condition inconsistent with level of disability reported
- Activities inconsistent with disability
- Indication of residual capacity for work e.g. ETE TPD definition and the insured’s ability to perform alternative employment
- Objective testing required identifying the existence of psychopathology/ malingering or neurocognitive dysfunction.

As with treating doctor’s reports always tailor your letters to suit the circumstances e.g., always provide a detailed description of the insured’s occupation and ETE (if applicable). The TPD focus should remain on the date of assessment.

FINANCIALS

An insured’s financial information is, in many cases, an overlooked resource when assessing lump claims. There are a number of circumstances during claim assessment where the need to request financial information may arise.

Following are some ways obtaining financials may assist you in assessment of a TPD claim:

DISCLOSURE

Financial statements can assist with assessment of underwritten policies where you suspect there may be an issue with non-disclosure or misrepresentation.

Occupation

➢ Was the occupation accurately disclosed?
➢ Were there secondary occupations? Were they high risk or uninsurable?
➢ Look for income from other entities such as partnerships and trusts – what was the function of these entities and do they bear overall relevance to the claimant’s occupational position at application?

Income / financial position and risk profiling

➢ For self-employed persons, how was the health of the person’s business at application? Was the status and structure of the business as disclosed?
➢ Was the person’s income accurately disclosed?
➢ Is there any evidence of prior bankruptcy or insolvency?
➢ Was the level of income accurate and commensurate with the amount of cover purchased?
➢ Was the person in receipt of claim proceeds from another insurer or from social security?
Medical

- Proceeds from sickness/accident policies? Does the claimant have existing insurance which was not disclosed and do they still have this insurance?
- To identify social security payments representing disability (Disability Support Pension, Department of Veteran’s Affairs)

ELIGIBILITY (GROUP)

At Work (or as otherwise defined) and other Eligibility criteria

- Minimum hours – are the figures commensurate with income and business activity indicated on financial statements at the relevant time?
- Was the claimant working in an excluded occupation?
- Superannuation lump sum payments – has TPD been paid elsewhere?
- Government pension and allowances – was the person in receipt of any such payments at the relevant time?
- Receipt of income from other insurers / compensation providers – was the person in receipt of any such payments at the relevant time?

INVESTIGATIVE / FACTUAL

- For self-employed persons - how was the health of the person’s business at application and at claim time? Was the business profitable? Are there financial motivators present?
- Expense items – for self-employed persons in allegedly manual-only occupations. Where there are there significant amounts of wages and subcontractor expenses it may indicate the person may have just worked in a supervisory or administrative capacity, therefore possessing more transferable skills than first thought (relevant to ETE assessments)
- Is the claimant entitled to other benefits which may contradict reported physical restrictions, e.g. Carer Allowance? What is the claimant required to do and is this consistent with reported limitations? Request copies of Centrelink files including the application for the Carer Allowance submitted by the claimant.
- Education, training and experience (ETE) – do the financial statements indicate the claimant was being paid a wage, or in receipt of personal services income (PSI) for secondary occupations? Do prior financial statements indicate that the claimant worked in positions which may indicate a broader ETE than first thought?
- Address and contact details consistent?
- Employer lump sum payments – was there a termination or redundancy that potentially led to work cessation?
- Has the claimant worked since claimed date of work cessation?
- Are there work-related deductions? Why?
- Income from other entities
- whether the qualifying period (and subsequent ‘date of assessment’) period has commenced/ended

OneCare TPD

- To assess 25% of monthly earnings prior to claim where this criterion is applicable (refer to Page 10 ‘ANY OCCUPATION’ earnings clause example)
For more information refer to PathFinder under Claims → Procedures and Work Instructions → Guidelines → Financial Guidelines → Financials in Lump Sum Claims.

INVESTIGATIONS

During assessment of the claim you will consider whether further investigations are required and if so, in what form.

INTERVIEWS

Factual interviews are often used as an opportunity to meet the insured in instances where there is conflicting information or the facts are not clear. Under those circumstances it is sometimes advantageous to speak to the insured face-to-face and review the inconsistencies and obtain clarification of issues that cannot otherwise be obtained via correspondence alone.

SURVEILLANCE

Surveillance is a useful tool to observe actions and/or an activity that may contradict or support an insured’s stated represented physical and cognitive limitations. Significant video evidence will be required to cease a claim purely on video surveillance and the cost-effectiveness must be considered.

SOCIAL MEDIA AND ONLINE SEARCHES

Social media and online searches can aid the investigation of a claim by:

- Identifying insureds by way of photos, daily activities, postings and reported activities allowing us to generate higher quality referrals to surveillance operatives
- Locating insureds who may be overseas, thereby avoiding scheduling surveillance through these periods
- Providing background information which may relate to likes and interests, their character, activities, financial information, holidays, sports and hobbies
- Identifying relationships and/or associated persons
- Identifying the insured’s potential involvement in business/remunerative activities

Claims → Procedures and Work Instructions → Guidelines → General Guidelines → Surveillance in Claims Management

Claims → Procedures and Work Instructions → Guidelines → General Guidelines → Social and Online Media Policy Guideline
REINSURANCE

Reinsurance is insurance for insurance companies.
Reinsurance enables an insurer, referred to as the ‘ceding company’ or ‘cedent’, to spread the risk associated with a portfolio of business held.

Reinsurance enables OnePath and a reinsurer to enter into an agreement which details the conditions upon which the reinsurer pays a share of the claims incurred by OnePath. In turn the reinsurer is paid a reinsurance premium by OnePath which receives premiums from policy owners issued with insurance policies.

As the ceding company, OnePath has a responsibility to manage the claims portfolio in an efficient, competent and consistent manner.

OnePath has a number of obligations and responsibilities under a reinsurance agreement.

For more information refer to the following guideline in Pathfinder;

ACCEPTANCE

In the event you conclude the claim is to be admitted, you will present the claim with supporting documentation to the authorised delegate for approval.

Please refer to the Delegated Authorities Matrix on Pathfinder for details of who approve your determination;
Claims → Procedures and Work Instructions → General Guidelines → Delegated Authorities Matrix.

For policies held inside superannuation, the recommendation is passed onto the Trustees to make the final decision.

For policies owned by an internal trustee you must follow the "Internal Trustee Process" located on Pathfinder;
Claims → Procedures and Work Instructions → Procedures → Internal Trustee Process.

NON-SUPER AND SMSF

- Does the Lost Policy Advertising Process need to be followed?
- Buy-Back period (if Double TPD applies)
- Policy structure (e.g. will payment under this claim reduce the sum insured under any linked cover? What should the policy look like once the claim is paid?)
Ancillary benefits to be enacted (e.g. Financial Advice Benefit)

Once you have concluded your assessment payment correspondence will be issued to the policy owner and to their adviser and any amendments that have made to the policy (e.g. reduction of sum insured under linked covers, cancellation of cover) will also need to be communicated in this correspondence.

PROCEDURAL FAIRNESS

Procedural Fairness is a common law principle developed to ensure that decision making is fair and reasonable.

If adverse material has been received and will be used when making a decision, we must first communicate with the life insured / policy owner and provide copies of all the evidence. The life insured / policy owner is provided with an opportunity to review the material collected during the assessment before any final determination is made.

In this context the concept of Procedural Fairness flows from what the courts have said in TPD cases.

When an insurer’s decision is challenged, the court will consider whether or not the decision was reasonable. If the court finds that the insurer’s decision was not reasonably made, the court can substitute its own decision.

Some of the TPD court cases have specified that insurers are required to disclose to the life insured / policy owner all adverse materials, and provide that person with an opportunity to respond prior to the insurer arriving at a determination. Some cases have gone further and stated that the insurer was required to inform the life insured / policy owner of what it regarded as necessary to establish that they fell within the TPD definition i.e. the potential barriers to the claim being successful.

OnePath’s process is to provide the life insured / policy owner with not only the evidence we consider to be adverse, but with all evidence which we relied upon in conducting our assessment.

The correspondence and our internal filenotes must be clear that we have NOT reached a determination of any kind.

Procedural Fairness correspondence and the enclosed material MUST be reviewed and signed off by a Principal Claims Consultant or above prior to being sent.

For more information about Procedural Fairness refer to PathFinder under Claims → Procedures and Work Instructions → Guidelines → General Guidelines → Procedural Fairness.

DECLINATURE

In the event the claim is to be declined you will present the claim with supporting documentation to the authorised delegate for sign off. A decline MUST be signed off by a Principal Claims Consultant and above.
Please refer to the Delegated Authorities Matrix on PathFinder for details of who can sign off on any adverse decisions;

Claims \rightarrow Procedures and Work Instructions \rightarrow General Guidelines \rightarrow Delegated Authorities Matrix.

Remedies for redress (IDR and EDR) are to be provided in the letter of declination.

For policies held inside superannuation, the recommendation is passed onto the Trustees to make the final decision.

For policies owned by an internal trustee you must follow the "Internal Trustee Process" located on PathFinder;

Claims \rightarrow Procedures and Work Instructions \rightarrow Procedures \rightarrow Internal Trustee Process.

Declination correspondence MUST be reviewed and signed off by a Principal Claims Consultant or above prior to being sent.

Correspondence for accepted and declined claims is located on PathFinder under Claims \rightarrow LICOP Letters.

CASE LAW

You can peruse case law concerning the key issues and learnings in recent TPD cases in the "Summary of Recent TPD Cases" available in PathFinder and below;

| SUMMARY OF RECENT TPD CASES |

Some of the issues considered include;

\rightarrow Meaning of "Previous education training or experience and retraining"
\rightarrow Meaning of "unlikely ever"
\rightarrow Meaning of "reasonably fitted by previous education, training and experience"

This section will be expanded on as new cases arise.
## VERSION HISTORY

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<th>Version Date</th>
<th>Author/s</th>
<th>Version</th>
<th>Change Description</th>
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<tr>
<td>02/12/2016</td>
<td>Catherine Santangelo</td>
<td>1.0</td>
<td>Initial document</td>
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<tr>
<td>30/06/2017</td>
<td>Alison Tang</td>
<td>2.0</td>
<td>Updated to include LICOP Reference and conducted annual review</td>
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<tr>
<td>03/05/2018</td>
<td>Catherine Santangelo</td>
<td>3.0</td>
<td>Annual review - removal of role &quot;Technical Claims Consultant&quot;; change link to &quot;Standard Letters&quot; to &quot;LICOP Letters&quot;; minor formatting changes</td>
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