ASIC
Australian Securities & Investments Commission

Insurance in superannuation: Industry progress on delivering better outcomes for members

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About this report

This report examines progress by superannuation trustees to improve their arrangements for life insurance in superannuation. These improvements respond to issues identified in ASIC's public communications on life insurance in superannuation since 2019 and recent regulatory reforms.

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About ASIC regulatory documents

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This report does not constitute legal advice. We encourage you to seek your own professional advice to find out how the Corporations Act and other applicable laws apply to you, as it is your responsibility to determine your obligations. Examples in this report are purely for illustration; they are not exhaustive and are not intended to impose or imply particular rules or requirements.

Executive summary

This report examines progress made by superannuation trustees to improve their arrangements for life insurance in superannuation. As conduct regulator, the Australian Securities and Investments Commission (ASIC) looked at trustees' actions to address issues we have highlighted since 2019 and changes trustees have made following recent regulatory reforms, including the design and distribution obligations and the extension of the financial services obligation to act efficiently, honestly and fairly to all trustee activities, including claims handling.

Of the approximately 15 million Australians with accumulation-phase superannuation accounts, about 8 million have some form of insurance through superannuation. Roughly 71% of accounts with insurance have the default insurance automatically provided by the superannuation trustee.

Note: The first two figures are sourced from data provided by the Australian Taxation Office (ATO) for June 2022 based on member account reporting by large superannuation funds regulated by the Australian Prudential Regulation Authority (APRA). The third figure is sourced from unpublished data for June 2022 obtained from APRA. All figures exclude self-managed superannuation funds.

Most trustees automatically provide members with:

- death cover (also known as 'life cover'), which pays a set amount of money when the insured person dies or is diagnosed with a terminal illness, and
- total and permanent disability (TPD) cover, which pays a set amount of money towards rehabilitation, debt repayments and future costs of living if the insured person is totally and permanently disabled.

Some superannuation trustees also automatically provide members with income protection (IP) cover, which pays an income for a period if the member is unable to work due to sickness or injury.

Since 2019, ASIC has undertaken a broad range of work to address consumer harms in life insurance: see Appendix 1. This includes a focus on insurance in superannuation that unnecessarily erodes a member's retirement balance (because members are paying for insurance that does not meet their needs), insurance that does not provide cover if a member becomes disabled (due to restrictive definitions and exclusions), and claims handling processes that are unnecessarily onerous or lengthy.

We have also taken enforcement action against trustees who have not met their obligations relating to insurance in superannuation. As well, there has been a range of regulatory reforms implemented since 2019 designed to improve the way in which trustees deliver insurance in superannuation: see Background to our review.

What we did in our 2022 review

In this report, we share findings from our engagement with 15 trustees in 2022: see Table 1. Approximately 3 million superannuation accounts in these trustees' funds had death and/or TPD cover, and approximately 800,000 accounts had IP cover, as of 30 June 2022.

We used our compulsory information gathering powers to examine actions these 15 trustees have taken since 1 January 2019. We also sought information about IP offsets from the five trustees and three insurers we engaged with in our review of IP offsets in 2021. We have supplemented this with industry-level data from APRA and the Australian Financial Complaints Authority (AFCA).

Table 1: Participating superannuation trustees and funds in ASIC's 2022 review

Superannuation trustee	Superannuation fund
Australian Retirement Trust Pty Ltd	Australian Retirement Trust (QSuper Government division only)
BT Funds Management Limited (see note)	Retirement Wrap
CARE Super Pty Ltd	CARE Super
Host-Plus Pty Limited	HOSTPLUS Superannuation Fund
I.O.O.F. Investment Management Limited	IOOF Portfolio Service Superannuation Fund
Mercer Superannuation (Australia) Limited	Mercer Super Trust
Motor Trades Association of Australia Superannuation Fund Pty Limited	Spirit Super
N. M. Superannuation Proprietary Limited	AMP Super Fund
NGS Super Pty Limited	NGS Super
OnePath Custodians Pty Limited	Retirement Portfolio Service
Prime Super Pty Ltd	Prime Super
TWU Nominees Pty Ltd	TWU Superannuation Fund
Telstra Super Pty Ltd	Telstra Superannuation Scheme
Togethr Trustees Pty Ltd	Equipsuper Superannuation Fund
United Super Pty Ltd	Construction and Building Unions Superannuation Fund

Note: BT Funds Management Limited (BT) is expected to merge some members in the Retirement Wrap fund into Mercer Superannuation (Australia) Limited on or around 1 April 2023: see Changes to your BT superannuation investments and information ahead of the move to the Mercer Super Trust on the BT website.

The changes that trustees have already made or are planning to make should improve member outcomes by:

- increasing members' retirement balances as a result of members not paying for cover that they will not be able to claim on
- providing members with better value insurance and not offering insurance that only pays in very restrictive circumstances
- making it less likely that members withdraw claims because of unnecessarily stressful or onerous claims handling practices, and
- allowing members to make better decisions about their insurance in superannuation, as a result of clearer communication and more consumer-centric processes by trustees.

Figure 1 gives a snapshot of the key findings of our review.

Figure 1: Superannuation industry progress on delivering better insurance outcomes for members

ASIC examined progress by trustees to improve their arrangements for life insurance in superannuation. These improvements respond to issues identified in ASIC's public communications on this topic since 2019 and recent regulatory reforms. Our review looked at:

15 superannuation funds

with **3 million** accounts with death cover and total and permanent disability cover

and **800,000** accounts with income protection cover

ASIC has undertaken a broad range of work to address consumer harms in insurance in superannuation since 1 January 2019.

10 reviews (as set out in 7 reports and 3 media releases)

2 enforcement outcomes

Better value from insurance

ASIC had found that some trustees were offering insurance that did not provide value for money or that funnelled some members into cover they were unlikely to be able to claim on.

Trustees have **made changes so members should get better value for money** from insurance through their fund and trustees need to continue identifying ways to improve value.

This should increase retirement balances if members aren't paying for insurance that does not meet their needs or that they cannot claim on.

Improved claims handling

ASIC was concerned that some members were not pursuing claims because of onerous and complex claims handling processes.

Many trustees have taken steps to **streamline their claims processes** to make them easier for members to navigate, although some trustees have done more than others.

This means members are less likely to withdraw claims due to frictions in the claims handling process.

Better decisions on cover

ASIC previously found that trustees' communications and processes did not make it easy for members to understand their insurance or make changes to their cover.

Some trustees have **improved the way they explain their insurance offerings**, although there is room for more improvement.

This should help members make better decisions about the insurance they hold through their fund.

Note: For a summary of the improvements outlined in this figure, see Table 2, Table 3 and Table 4 (accessible version).

Insurance design and data

We saw improvements to how some trustees are designing default insurance in superannuation to better meet member needs, including using data to monitor member outcomes.

These changes are a positive step towards reducing the risks of members receiving insurance that does not meet their needs or paying for cover they cannot claim on. However, trustees need to continue improving how they monitor and respond to these risks, including by regularly examining outcomes for cohorts of their membership and identifying how they can improve the value for money that members receive from their insurance.

Table 2: Improving design and data practices

Problem	Issues previously identified by ASIC	Improvements by trustees
Restrictive TPD definitions	Some trustees were using eligibility criteria to funnel members into TPD definitions that severely restricted the circumstances under which they could claim. For example, 4% of TPD claims we reviewed were assessed under an 'activities of daily living' (ADL) definition in 2016 and 2017. Of these, 60% were declined, compared with 12% of claims assessed under an 'own occupation' or 'any occupation' definition. ASIC criticised the use of these criteria and said that they were not designed for, and did not operate to meet the needs of, the broad range of members who were funnelled into the restrictive definitions. **Note:** See Report 633 *Holes in the safety net: A review of TPD insurance claims* (REP 633).	Of the 15 trustees, 12 have changed eligibility criteria so that fewer members will be subject to ADL definitions and/or have amended the restrictive definitions. The remaining three trustees were still in the process of making these changes. Across the superannuation industry, the share of TPD claims assessed under an ADL definition has fallen to 1.3%. This figure is likely to fall further as the changes take effect.
Inadequate monitoring of member value from default insurance	Many trustees were not robustly monitoring the outcomes members received from insurance in superannuation and whether their default insurance offered value for money. There was wide variation in the design and pricing of default insurance, with some members paying over 12 times as much as other members of the same age and gender. In an earlier review, ASIC discussed a range of metrics that trustees could use to help analyse the value of the default insurance they were offering. We also raised the need to assess value for different groups or cohorts of members, and not just at an aggregate level. **Note:** See Report 675 *Default insurance in superannuation: Member value for money* (REP 675).	All 15 trustees do some monitoring of member outcomes from default insurance, such as premium affordability at a cohort level. However, trustees need to do more robust monitoring in other areas—for example, fewer than half appeared to regularly compare claim outcomes at a cohort level. Some trustees have made changes to their insurance to address risks of low-value outcomes—for example, eight have removed cross-subsidies that benefitted one group of members at the expense of another group.

Problem	Issues previously identified by ASIC	Improvements by trustees
Inadequate monitoring of IP offsets	Some trustees with default IP cover were not systematically monitoring how members' insurance benefits were being reduced due to offsetting of other kinds of income support (such as sick leave and workers' compensation). ASIC identified the need for trustees to obtain and analyse data to address the risk of insurance premiums unnecessarily eroding members' superannuation balances where offset clauses mean that some groups of members may receive little or no value from their default insurance. **Note:** See Media Release (21-343MR) *Super trustees offering default income protection insurance urged to check on member outcomes*.	Trustees are increasingly receiving data from their insurers to monitor the impact of offsets on their members' IP claims. This will assist them to identify if some groups of members are receiving low-value outcomes.

Claims handling practices

The trustees in our 2022 review have all taken steps towards reducing frictions in their claims handling process that make it unnecessarily stressful or onerous for members and beneficiaries who may already be impacted by sickness or injury, or the death of a family member. We have also seen trustees take steps to enhance their oversight of their insurers' claims handling practices.

However, data on claims handling across the superannuation industry suggests that trustees and insurers need to do more to remove frictions in the claims handling process, including by helping members to understand what their insurance covers them for and what they need to do to make a successful claim. For example, the share of TPD claims that are withdrawn increased to 6.7% in June 2022, and the number of disputes relating to insurance in superannuation claims that are recorded by insurers through internal dispute resolution remains relatively high.

Table 3: Improving claims handling practices

Problem	Issues previously identified by ASIC	Improvements by trustees
Frictions in the claims process	The end-to-end TPD claims process of trustees and their insurers sometimes involved onerous processes to lodge a claim, lengthy claims forms, long delays, and poor communication practices. ASIC considered that insurers subjecting consumers who are vulnerable (due to a life-altering illness or injury) to a claims process that was unnecessarily onerous contributed to members withdrawing claims. **Note**: See REP 633.	Most trustees have made changes to improve their claims processes, including by making it easier for members to lodge claims and providing clearer communications about what members can expect during the process. Some trustees are tailoring the support they provide for vulnerable members. Only 10 of the 15 trustees are also analysing withdrawn claims and complaints to identify and address frictions in the claims handling process.

Problem	Issues previously identified by ASIC	Improvements by trustees
Inadequate oversight of insurers' claims handing	Many trustees were over-reliant on their insurers' processes for handling claims and complaints. ASIC identified a need for trustees to be more engaged in the claims handling process, with some trustees being no more than a 'post box' for lodging insurance claims, and providing little support for their members. **Note**: See REP 633.	All 15 trustees are reviewing all declined claims decisions to test whether their insurers have correctly applied the terms of the insurance policy. Most trustees are regularly monitoring their insurers' compliance with industry codes. Three trustees have real-time access to their insurers' systems so they can monitor the progress of individual claims in real time.

Helping members understand their insurance

The trustees we looked at have made some improvements to how they help members understand and make appropriate decisions about their insurance, including by using consumer research to improve communication and engagement practices and by more clearly explaining key terms and conditions. However, some trustees have not been as responsive and need to focus more on improving member communications and processes.

Good communication practices can help members understand what insurance they have, what it covers them for, and how much they pay for it. Good communication can also help members make decisions about their insurance cover. But ultimately, it is not a substitute for trustees designing insurance that meets their members' needs and provides value for money.

Table 4: Improving communications

Problem	Issues previously identified by ASIC	Improvements by trustees
Barriers to members understanding their insurance or making appropriate decisions	Trustees' communications and processes for members to make changes to their insurance were not always easy for members to navigate or did not address members' concerns. In research commissioned by ASIC, approximately one-third of the research participants reported feeling confused, overwhelmed, or uncertain after engaging with their fund about their insurance. **Note:** See Report 673 *Consumer engagement in insurance in super* (REP 673).	Five of the 15 trustees have started providing members with an annual insurance statement that sets out key information about their insurance. Seven of the trustees have recently conducted consumer testing of their communications and processes for insurance in superannuation and are using this to make improvements. Most of the 15 trustees have made changes to member communications in response to complaints analysis.

Problem	Issues previously identified by ASIC	Improvements by trustees
Unclear explanations of key terms and conditions	ASIC's work found limited and sometimes poor disclosure by trustees in communications to members on key matters such as: › when a TPD claim would be subject to a restrictive definition such as an ADL definition › the implications of occupational categories for a member's premiums and how the member can change their category, and › when IP benefits would (or would not) be offset by other sources of income. **Note**: See REP 633, Media Release (20-309MR) *Trustees to improve occupational classification practices in insurance in superannuation*, and 21-343MR.	Most of the 15 trustees have taken some steps to more clearly explain when and how different terms and conditions apply, including by adding explanations to insurance guides and annual insurance statements.

What superannuation trustees should do

Superannuation trustees play a central role in deciding what life insurance is made available to their members and how it is provided—for example, through the 'choice architecture' they present to members. Trustees are well placed to identify and prevent harms in the way insurance in superannuation is designed and delivered.

Trustees have both specific and general obligations to achieve good outcomes for members in relation to insurance: see The regulatory environment. These obligations are not optional—a failure to deliver is a contravention of the law.

The trustees in our review have shown progress with their insurance arrangements. However, there are specific areas of improvement that we have identified for each trustee and informed them of as part of our review. Trustees not included in this review should also make efforts to apply the examples and action points in this report to deliver better outcomes for their members.

All trustee boards should identify what improvements they will make by:

› using data to monitor member outcomes from insurance and proactively identify how to better meet members' needs and provide value for money
› designing and delivering claims processes with a focus on member experience
› embedding a process to continuously improve member communications and processes in a way that supports members to understand their insurance cover and make good decisions for their circumstances, and
› ensuring they have robust systems, processes and controls to effectively administer their insurance arrangements.

These actions will mitigate the risk of trustees failing to fulfil their obligations to their members and leaving their members materially worse off. There are some actions that trustees can take immediately, and others that will need to be planned well in advance of the next periodic review of their insurance arrangements (e.g. when the existing group insurance policy comes up for renewal). To make improvements trustees need to work collaboratively with insurers.

We will continue to work closely with APRA to drive better practices in the superannuation industry, including to enhance regulatory data collections and to ensure trustees and insurers are designing and pricing group insurance in a sustainable manner. Where appropriate, we will also use our regulatory powers where trustees and insurers are not complying with their obligations.

Background to our review

The regulatory environment

Trustees must offer death and permanent incapacity insurance benefits to all members in MySuper products on an opt-out basis (subject to certain limited exceptions): see s68AA of the *Superannuation Industry (Supervision) Act 1993* (SIS Act). Most trustees comply with this obligation by providing default death and TPD cover. Some trustees choose to also provide default IP cover. Most trustees choose to also provide default insurance in choice superannuation products.

Note 1: Since 1 July 2019, trustees must cancel insurance on member accounts that have been inactive for 16 months, unless the member specifically chooses to retain it: see *Treasury Laws Amendment (Protecting Your Superannuation Package) Act 2019* (PYSP Act).

Note 2: Since 1 April 2020, trustees can no longer automatically provide default insurance cover to members under 25 years or members who have an account balance under $6,000, unless they meet the dangerous occupation exemption: see *Treasury Laws Amendment (Putting Members' Interests First) Act 2019* (PMIF Act).

The law impacts how trustees can offer insurance. In addition to the general obligation under s912A(1)(a) of the *Corporations Act 2001* (Corporations Act) to ensure financial services are provided efficiently, honestly and fairly, trustees must:

- perform their duties in the best financial interests of members (s52(2)(c), SIS Act)
- act fairly when dealing with classes of beneficiaries and with beneficiaries within a class (s52(2)(e)–(f), SIS Act)
- comply with the insurance covenants, including by doing everything that is reasonable to pursue an insurance claim for the benefit of a beneficiary, if the claim has a reasonable prospect of success (s52(7), SIS Act)
- annually assess whether the insurance strategy for each MySuper and choice superannuation product is appropriate for the beneficiaries and whether any insurance fees charged inappropriately erode the beneficiaries' retirement income (s52(11), SIS Act)
- comply with their disclosure obligations in the SIS Act (e.g. where the trustee has elected to treat the member's occupation as a dangerous occupation: see s68AAF of the SIS Act) and the Corporations Act (e.g. where the trustee is required to inform the member that their cover may be cancelled: see s1017DA(1) of Corporations Act)
- comply with the design and distribution obligations in relation to choice superannuation products (Pt 7.8A, Corporations Act), and
- comply with APRA's Prudential Standards, which prescribe matters such as governance requirements (see Prudential Standard SPS 250 *Insurance in superannuation*, which was updated with effect from 1 July 2022), assessing member outcomes (see Prudential Standard SPS 515 *Strategic planning and member outcomes*) and reporting requirements, including the collection of data (see Reporting Standard SRS 251.0 *Insurance*).

Since 1 January 2021, trustees have also been required to act efficiently, honestly and fairly when handling and settling insurance claims as providers of a superannuation trustee service.

Industry efforts at self-regulation

In December 2017, the superannuation industry launched the Insurance in Superannuation Voluntary Code of Practice (PDF 300 KB) (Insurance in Super Code). This was in response to concerns that insurance in superannuation was not meeting community expectations.

In July 2021, the industry bodies that owned the Insurance in Super Code decided to abandon it due to some provisions being superseded by regulatory changes. Industry bodies replaced the code with more specific industry guidance notes on claims handling and vulnerable members.

Note: The industry bodies that owned the Insurance in Super Code were the Australian Institute of Superannuation Trustees (AIST), the Association of Superannuation Funds of Australia (ASFA) and the Financial Services Council (FSC). Each industry body introduced their own guidance notes, which are similar in content: see Industry guidance.

In December 2022, the FSC replaced its guidance note on claims handling with a new standard—FSC Standard No. 28 *Claims handling standard for superannuation funds* (PDF 4.3 MB). This standard came into effect on 1 January 2023 on a voluntary compliance basis, with full mandatory compliance for FSC insurer and trustee members to commence from 1 July 2023.

In October 2021, the FSC introduced FSC Standard No. 27 *Removal of occupational exclusions and occupation based restrictive disability definitions in default cover* (PDF 4.1 MB). This standard prohibits FSC insurer and trustee members from excluding members from default cover because they work in a high-risk occupation, or by applying restrictive disability definitions in default cover based on occupation.

ASIC's review in 2022

In March 2022, we served compulsory notices on 15 superannuation trustees (see Table 1) to examine what actions they have taken since 1 January 2019 to improve their insurance in superannuation arrangements to:

- address issues highlighted by ASIC since 2019, and
- meet new regulatory obligations.

We focused on one superannuation fund for each trustee: see Executive summary. We selected the trustees and funds from across the industry fund, retail fund and corporate fund segments—including larger and smaller superannuation funds—to cover a cross-section of the superannuation industry. This includes some trustees ASIC has previously engaged with about insurance in superannuation.

As of June 2022, approximately 3 million member accounts in these funds had death and/or TPD cover (accounting for about 37% of all superannuation accounts across the industry with death and/or TPD cover), and approximately 800,000 accounts had IP cover (accounting for about 20% of all superannuation accounts across the industry with IP cover).

Note: These figures are sourced from unpublished data for June 2022 obtained from APRA.

Between August 2022 and November 2022, we met with each trustee to better understand their responses to our compulsory notices and their progress in improving their insurance arrangements.

We have since written to each trustee to provide specific feedback with the expectation that such feedback, together with a copy of this report, is tabled at the next meeting of the trustee board.

In 2022, we also re-engaged the five trustees and three insurers that participated in our review of IP offsets in 2021 (see 21-343MR) to examine what steps they had taken in response to our individual findings and obtain better data on IP offsets: see Appendix 2.

Insurance design and data

The design and delivery of insurance cover, especially default insurance, has a powerful influence on member outcomes. Where insurance cover is not well designed, it puts members at risk of paying for insurance that does not meet their needs, is excessively costly (eroding their superannuation balance), or cannot be claimed on.

Changing restrictive TPD definitions

We reviewed a sample of 26,150 TPD claims that insurers assessed between 1 January 2016 and 31 December 2017, and found that 4% were assessed under the 'activities of daily living' (ADL) definition: see REP 633. Of these claims, 60% were declined. Mental health and musculoskeletal claims were approximately five times more likely to be declined under the ADL definition compared to the standard 'any occupation' definition (e.g. where a benefit is paid if a person is unable to engage in gainful employment in any occupation for which the person is reasonably qualified by education, training or experience).

We found that some superannuation trustees and insurers had eligibility criteria for TPD cover that funnelled certain groups of members into these restrictive definitions, meaning they were paying for TPD cover but were much less likely to have a claim accepted—for example:

- casual, seasonal, or part-time employees who work less than a specified number of hours
- members who have been unemployed or on leave without pay for a stated period before the TPD event, and
- members in specified occupations that the insurer considers are high risk.

In our follow-up work with insurers, we observed most showed a willingness to explore alternative TPD definitions in group insurance policies: see Report 696 *TPD insurance: Progress made but gaps remain* (REP 696). Some trustees' insurers had provided options to the trustee to either remove the ADL definition or replace it with an 'activities of daily working' (ADW) definition—sometimes called an 'everyday work activities' test: see Figure 2.

Figure 2: ADL definitions versus ADW definitions

ADL definitions

The member must be permanently unable to perform at least two (in some instances more) activities of daily living, for example:

- Dressing: The ability to put on and take off clothing without assistance.
- Toileting: The ability to use the toilet, including getting on and off without assistance.
- Bathing: The ability to wash or shower without assistance.

ADW definitions

The member must be permanently unable to perform at least two (in some instances more) activities of daily working, for example:

- Seeing: The ability to read ordinary newsprint, even with glasses or contact lenses.
- Communicating: The ability to clearly hear with or without a hearing aid.
- Walking: The ability to walk more than 200 metres on a level surface without stopping due to breathlessness.

What we found: Restrictive TPD definitions

In our 2022 review, we found that most of the 15 trustees had taken action to modify or remove restrictive TPD definitions from their default insurance:

- Two of the trustees have removed their ADL definition completely. This means all new TPD claims for their members will be assessed under the standard 'any occupation' definition.
- Nine trustees have replaced, and one trustee is in the process of replacing, the ADL definition with an ADW definition.

  Note: While still a restrictive definition, in some circumstances ADW definitions may be less restrictive than ADL definitions. ADW definitions require the member to be unable to perform a prescribed number of basic activities associated with work, whereas ADL definitions require the member to be unable to perform a prescribed number of basic activities that allow an individual to independently care for themself: see Figure 2.

- One trustee previously required a portion of the TPD benefit to be assessed under the 'any occupation' definition, and the remaining portion under the ADW definition. For all new claims, the entire TPD benefit will be assessed under the 'any occupation' definition.
- The remaining two trustees said they are still reviewing their TPD definitions in consultation with their insurers.

Of the 12 trustees that have retained an ADL or ADW definition, nine trustees have, and one trustee intends to include, mental health specific criteria in the definition.

Most of the 12 trustees with a restrictive definition have also broadened the criteria used to determine whether a claim will be assessed under an 'any occupation' definition rather than the restrictive definition:

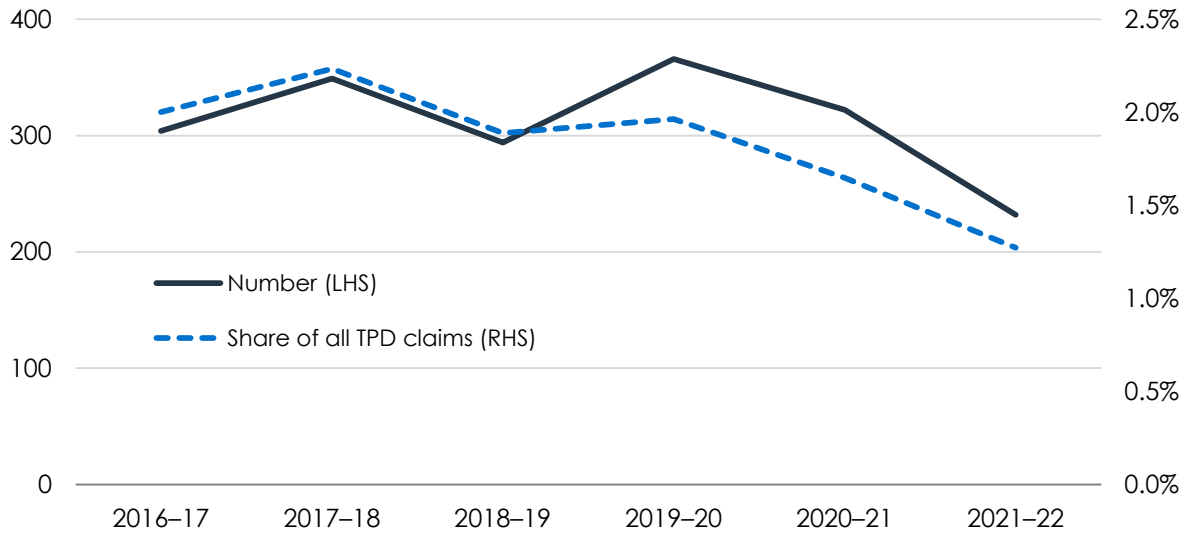
- Nine trustees have increased the period of unemployment before the ADL or ADW definition applies to either 16 or 24 months. This aligns with or exceeds the 16-month period in the PYSP Act where trustees are legally required to cancel insurance on inactive accounts unless the member specifically chooses to retain it (PYSP reforms).
- Nine trustees have removed criteria related to minimum work hours or employment type (e.g. casual employment), and one has removed criteria related to employment status (i.e. to be in gainful employment).

This means that more members are likely to be assessed under the more favourable 'any occupation' definition instead of the restrictive definition.

Across the superannuation industry, the proportion of TPD claims assessed under an ADL definition has been falling. In the 2021–22 financial year, 232 claims (i.e. 1.3% of all TPD claims) were assessed under an ADL definition: see Figure 3. Of these claims, 52% were declined—a much higher rate than TPD claims assessed under the 'any occupation' definition: see Figure 4.

We expect that these figures will continue to fall as the changes trustees have made to TPD definitions flow through to claim outcomes (noting that due to delays in claims being notified, many TPD claims will be assessed under previous group insurance policies for some time after policies are changed).

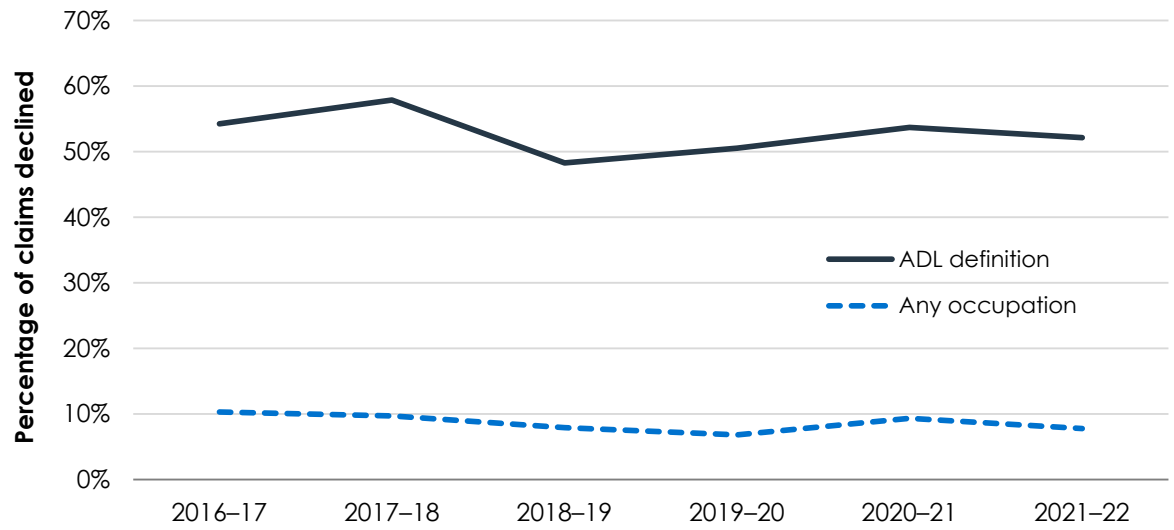
Figure 3: TPD claims assessed under the ADL definition



Source: Unpublished data provided by APRA.

Note: See Table 8 in Appendix 3: Accessible version of figures for the data shown in this figure (accessible version).

Figure 4: Share of finalised TPD claims that are declined, by TPD definition



Source: Unpublished data provided by APRA.

Note: See Table 9 in Appendix 3: Accessible version of figures for the data shown in this figure (accessible version).

Actions for trustees

Where they haven't already, all superannuation trustees with restrictive TPD definitions (e.g. ADL or ADW definitions) in their insurance arrangements for members should:

- **monitor the outcomes of TPD claims assessed under restrictive definitions, including ADW definitions,** to ensure these definitions do not result in poor member outcomes, such as members paying for cover they are unable to claim on when they need to, and
- **assess whether removing restrictive TPD definitions—or changing the criteria so fewer members are funnelled into these definitions—can deliver better outcomes** for members (including members with mental health conditions), including before policy renewal or expiry of the guaranteed rate period.

Using data to improve the insurance design

We previously examined metrics for measuring the value for money that members receive from default insurance offered through superannuation: see REP 675. We found a wide variation in the design and pricing of default insurance, and that some groups of members may be receiving relatively low value for money:

- Some MySuper products in the sample we reviewed offered over 20 times more default death and TPD cover than other MySuper products to members of the same age and gender.
- There were significant differences across superannuation trustees in the claims ratio—that is, the amount of money that insurers pay, or expect to pay, in claims over a specific period, relative to the premiums that members pay. We also found evidence that claims ratios for members aged under 30 were significantly lower, on average, than claims ratios for older members, over the six financial years from 2013–14 to 2018–19.
- There was wide variation in rates of declined claims, withdrawn claims, disputes and claim processing times among the trustees we reviewed.

Further, we found shortcomings in trustees' data and analysis. Some trustees were unable to accurately identify members they automatically provided default insurance to. Some trustees did not appear to routinely analyse the outcomes for default insured members, and some struggled to explain patterns we saw in the data they provided to us.

What we found: Design changes

All of the trustees in our 2022 review had recently made changes to the design of the insurance they offered or were in the process of investigating or making changes (depending on the timing of when their group insurance policy comes up for renewal or retendering).

We found that most of the 15 trustees worked with their insurers to make some changes to specific terms and conditions or the pricing structure to improve member outcomes and address the risk of low-value outcomes:

- Eight trustees have removed or wound back cross-subsidies (primarily age and gender cross-subsidies, but also across fund divisions). To some extent this appears to have been motivated by the PMIF reforms which meant most trustees could no longer offer default cover to

members aged under 25 years. A further two trustees said they are reviewing cross-subsidies between groups of their members.

Note: Cross-subsidies arise where insurance premiums do not reflect differences in the level of risk across groups of members. This means that one group of members pays lower premiums (relative to the amount paid in claims) which are subsidised by another group of members paying higher premiums.

- Four trustees have decoupled, or are considering decoupling, death and TPD cover so that members are able to choose to hold more TPD cover than death cover (e.g. members with no dependents may not see value in death cover).
- All trustees have sought to remove or amend restrictive TPD definitions: see Changing restrictive TPD definitions.
- All trustees that had occupational exclusions in their default death or TPD insurance have removed these exclusions. This means that members working in occupations that the insurer has classified as higher risk are no longer excluded from default death or TPD insurance.

As well, many of the trustees had made changes to their insurance arrangements motivated by:

- implementing regulatory reforms, such as the Putting Members' Interests First reforms under the PMIF Act (PMIF reforms)
- reducing the default level of cover or simplifying product features in order to keep premiums at an affordable level, and/or
- simplifying insurance arrangements across products, corporate offerings and fund divisions.

What we found: Use of data

We found a lot of variation in the detail and frequency with which trustees use data to better understand their members' insurance needs and to monitor whether they are receiving good outcomes from the insurance offered by the trustee.

Based on the trustee documents we reviewed, 13 of the 15 trustees appear to regularly assess the affordability of default insurance, such as whether the cost of premiums is above or below 1% of members' estimated salaries. Some trustees track affordability across a granular set of member cohorts (e.g. by demographic characteristics such as age, gender, occupational category and work status).

However, other forms of analysis appeared to be more limited:

- For most of the trustees, there was limited assessment of how outcomes vary across different cohorts of members for measures other than affordability outcomes. For example, fewer than half of the 15 trustees provided evidence that they regularly monitor claims ratios across member cohorts. Only eight trustees included any assessment of claim outcomes (e.g. claims processing times or claims ratios) in their member outcomes assessments, and of these, only two did so by member cohort.
- Only four trustees regularly monitor data on the cause of claims (e.g. claims related to musculoskeletal or mental health conditions). None of the trustees appeared to regularly monitor claim incident rates by member cohort.
- Most trustees did not appear to have collected additional member data (beyond existing data on age, contributions and occupation) to assess whether the insurance design was meeting member needs (e.g. through surveys or consumer research).

Improving outcomes: Monitoring for risks of low-value outcomes and member harm

- Some trustees receive detailed claims experience data and pricing analysis from their insurer on a six-monthly basis, including by division, member cohort, and claim outcome. This data can help trustees to monitor cross-subsidies between cohorts of members and identify where those members may be at risk of receiving low-value outcomes from their insurance.
- Three trustees have commissioned consumer research (e.g. surveys or qualitative interviews) to better understand how their members perceive features of the insurance offered and how their members would trade off the amount of default level of cover and the premiums. The trustees then used these insights to make decisions about the design of their default insurance.
- One trustee has developed an erosion management guideline which sets out its processes for proactively measuring, monitoring and managing the affordability of insurance premiums against the erosion threshold (in this case, 1% of estimated salary). This trustee monitors 'erosion levels' at the individual member level, product level and fund level (with the product and fund levels disaggregated by member cohort). The trustee uses the analysis to identify members who have an elevated risk of their retirement balance being eroded by insurance premiums, and informs those members of such risk, including how they can assess whether they need to change their insurance cover.

What we found: Target market determinations

We reviewed target market determinations (TMDs) from each of the 15 trustees (focusing on one of the largest choice products for each trustee).

The design and distribution obligations require trustees to make a TMD for their choice products that, among other things, describes the class of consumers that are in the target market for the product (including its key attributes). Insurance, when offered, is likely to be a key attribute of a choice superannuation product. Trustees need to take the 'sub-market' for the insurance into account in their TMD, including by clearly describing the class of consumers for whom the product is likely to be appropriate, having regard to the impact of any eligibility criteria and exclusions. Eligibility criteria and exclusions are also likely to be relevant for the distribution conditions that trustees must also set out in the TMD.

Note: The design and distribution obligations apply to choice superannuation products but not MySuper products or defined benefit interests: see s994B(1)(b) and s994B(3)(a) of the Corporations Act and reg 7.8A.20(3) of the *Corporations Regulations 2001*.

We found that some of the 15 trustees described the target market for the insurance component of their choice product much less clearly than others. For example:

- Some TMDs described a target market for the insurance offering that was very broad (e.g. all consumers who want insurance).
- While many TMDs noted that eligibility criteria or exclusions may apply to the insurance, some did not describe these criteria and exclusions in the TMD, did so only as part of the distribution conditions, or did not clearly express how the criteria and exclusions may affect the class of consumers for whom the choice product is suitable. For example, some TMDs did not include clear statements that particular consumers should be regarded as within or outside the target market based on characteristics such as age or pre-existing conditions.

Where the target market is defined too broadly, a trustee may be in breach of its obligation to define the target market for a choice product (including its key attributes) such that the product is likely to be consistent with the likely objectives, financial situation and needs of an identifiable class of consumers. Trustees need to define the target marked using objective, tangible parameters so that it is clear which consumers form part of the target market. Where there are classes of consumers for whom the insurance component of a choice product is clearly unsuitable—such as those who are unable to claim under the insurance or obtain the insurance cover—a trustee could specifically exclude these consumers from the target market.

The design and distribution obligations also require trustees to review the appropriateness of their TMD and product governance arrangements over time. This requires trustees to monitor outcomes and identify events and circumstances that reasonably suggest that their TMD is no longer appropriate (review triggers). The trustee must set out the review triggers for their choice product in the TMD.

We found that only some TMDs contained specific insurance-related triggers and, of those that did, the majority included only two such triggers. We observed that:

- only six TMDs included review triggers relating to claim outcomes, such as claims ratios or rates of denied or withdrawn claims, and
- only four TMDs included review triggers relating to insurance take-up or cancellation rates.

About half the TMDs did not contain specific insurance-related review triggers. Without the inclusion of adequate insurance-related review triggers, trustees are at risk of failing to identify when the TMD may no longer be appropriate and consequently failing to comply with their design and distribution obligations.

We have raised our concerns directly with each trustee where we had concerns about their TMD. We are also considering what further action to take in relation to some TMDs.

Note: ASIC has undertaken a more general review of a sample of 55 TMDs prepared by 27 trustees: see Media Release (22-236MR) *Super trustees urged to improve effectiveness of target market determinations*. In that review, we found poor practices in how trustees defined their target markets and review triggers.

Actions for trustees

Superannuation trustees must continue to **review whether the insurance they offer is meeting members' needs and providing value for money**: see REP 675.

To do this, trustees should **collect and analyse data**, including by regularly obtaining detailed data from their insurer, to proactively:

- assess whether members' needs are being met
- understand what outcomes each member cohort is receiving from a group insurance arrangement and why these outcomes may differ across cohorts
- assess whether members are receiving value for money and identify where risks of low-value outcomes (or member harms) may be emerging
- assess whether their choice superannuation products are being distributed to consumers in the target market for the products, and
- determine if changes need be made to the TMD, to the insurance design, or to distribution channels.

Trustees should **check their TMDs** to ensure that these clearly describe the target market for their choice superannuation products (including the insurance component) and include appropriate review triggers.

REP 675 and REP 633 describe ways trustees can use data to meet member needs. Regulatory Guide 274 *Product design and distribution obligations* (RG 274) outlines ASIC's general approach to administering the design and distribution obligations and expectations for compliance, including information about preparing a TMD.

Analysing offsets applied to IP claims

Most IP insurance policies contain offset clauses under which the IP benefit is offset (i.e. reduced) if the claimant receives other income support (e.g. sick leave, workers' compensation, or other insurance benefits).

Offset clauses play an important role by ensuring that members receiving benefits do not have income that exceeds their pre-disability income, which can reduce their incentive to return to work. However, our concern is the potential for insurance premiums to unnecessarily erode members' superannuation balances if offset clauses result in particular groups of members getting little value from their IP insurance because it is likely their benefit will be offset if they need to make a claim: see 21-343MR.

In our review of IP offsets in 2021, we found that the five trustees—each having a significant number of members with default IP cover—were unable to demonstrate that they had sought reliable data on offsets and reviewed the appropriateness of their default insurance.

What we found: IP offsets

In our 2022 review, we looked at what actions the 15 superannuation trustees had taken to analyse IP offsets. We also followed up with the five trustees from our review of IP offsets in 2021 about actions they have subsequently taken. Across both sets of trustees, we found the following:

- Almost all trustees said they are now receiving, or about to receive, granular data about IP offsets from their insurer on a regular basis.
- Some trustees have undertaken their own analysis of the data provided by their insurer or received an analysis from their insurer about the impact of offsets on their members' IP claims.
- One trustee has removed offsets relating to Centrelink payments.
- One trustee has changed the waiting period (i.e. the number of days a member must wait before receiving an IP benefit) to the greater of 90 days or the expiry of the member's accrued sick leave. This trustee also allows members who subsequently accrue sick leave to pause their IP benefits so they do not lose part of their maximum benefit period as a result.

These changes will help trustees to identify if some groups of members are receiving low-value outcomes.

Improving outcomes: Re-engaging with life insurers from ASIC's review of IP offsets in 2021

In our 2021 review of IP offsets, we sought data on IP offsets from three large insurers. However, the data provided by the insurers was insufficient to determine the proportion of claims with an offset, or the types of income that are offset and the impact on insurance benefit payments.

In 2022, we re-engaged with the same three insurers to obtain data on IP claims relating to the five trustees in our earlier review. The three insurers had taken steps towards improving their data practices to better record and monitor offsets being applied to IP benefits.

We obtained data on claims processed or paid between April and June 2022 and found the following:

- Across all IP claims in the data, an estimated 6% of monthly IP benefits had an offset applied, of which 23% had the IP benefit reduced to zero.
- Workers' compensation payments were the most common type of payment offset, accounting for an average of 71% of claims where an offset was applied.

Note: For more information on our methodology and findings, see Appendix 2.

Actions for trustees

Superannuation trustees that offer IP insurance, particularly where it is provided to some or all groups of members by default, should:

- obtain and analyse data, including data from their insurer, on a regular basis to **assess how IP offsets affect member outcomes**, such as whether some groups of members are receiving low or no value from default IP insurance, and
- **consider whether there are specific groups of members for whom it is not appropriate to continue to provide default IP insurance** because it provides low or no value.

Claims handling practices

Trustees play a frontline role in shaping the experience of members (and beneficiaries) when they need to make an insurance claim. While insurers are responsible for determining whether to accept or decline a claim, trustees provide beneficiaries with information about how to make a claim, collect information about the claim to provide to the insurer, and make decisions about whether or how to release insurance benefits to beneficiaries. Trustees are also obliged to do everything that is reasonable to pursue an insurance claim for the benefit of a beneficiary, if the claim has a reasonable prospect of success: see

Designing and delivering claims processes with the member's experience in mind

In our previous work on claims handing practices, we found that members faced a number of hurdles in making a successful TPD claim: see REP 633. These hurdles included onerous processes to lodge a claim, lengthy claims forms, intrusive surveillance, multiple requests for information, long delays, requirements for the member to see multiple medical specialists, and poor communication practices. This can significantly affect members' experience and lead to members withdrawing claims.

Withdrawn claims are a potential indicator of frictions in the claims handling process leading to consumer harm. Insurers and superannuation trustees were not sufficiently aware of withdrawn claims and the reasons for withdrawal.

What we found: Claims processes and communications

Most trustees in our 2022 review have considered their end-to-end claims process and made changes to improve member communications (particularly around timeframes and what to expect during the claims process), reduce frictions in the process, and deliver a better experience for members:

- Some trustees have introduced death, TPD and IP claims guides that explain how to make a claim and provide an overview of the claims process, including expected timeframes. The trustee sends these guides with the claim forms to members who contact the trustee to make a claim.
- All trustees generally offer members the option to lodge a claim in paper form or make a tele-claim. Some trustees have also worked with their insurers on digital claims functionality for members to lodge, and monitor the progress of, their claim.
- Most trustees have benchmarked their practices against the industry guidance notes on claims handling and vulnerable members, and made changes where necessary to improve their practices to align with the guidance notes.
- Most trustees have also developed, or are in the process of developing, a vulnerable member policy to provide additional support through the claims process to members experiencing vulnerability or financial difficulty. Some trustees have delivered training to staff specifically on dealing with vulnerable members.

Note: The industry guidance notes on claims handling set expectations for timeframes and communications in the claims handling process. The industry guidance notes on vulnerable members recommend that trustees have internal policies in place to help staff identify vulnerable members and ensure staff are provided with the necessary tools to better assist members who require additional support: see Industry efforts at self-regulation.

Improving outcomes: Supporting members during the claims journey

- **Digitisation**: One trustee has partnered with their insurer to offer a 'digital pathway' to members who contact the trustee to make a claim. This includes a digital tool that guides the member through the claims process. It shows them the documents they may need to submit and allows them to submit documents and receive updates on the progress of their claim, including requests from the insurer (e.g. for more information or to attend a medical examination) and when a benefit payment is made.
- **Vulnerable members**: One trustee has tailored their claims process for various condition types (e.g. mental health, neurological and cancer) to help provide vulnerable members with support that is tailored to their medical condition. Another trustee has a priority care team for members identified as vulnerable. The priority care team can put the member in contact with specialised external support services relevant to their vulnerability (e.g. medical condition or financial hardship).

What we found: Acting on complaints

We found that some superannuation trustees have bolstered their management and analysis of complaints about the claims process, including identifying systemic issues and areas for improvement. Most trustees have worked with their insurers to make changes to their claims processes in response to insights gleaned from complaints.

Improving outcomes: Making changes in response to complaints

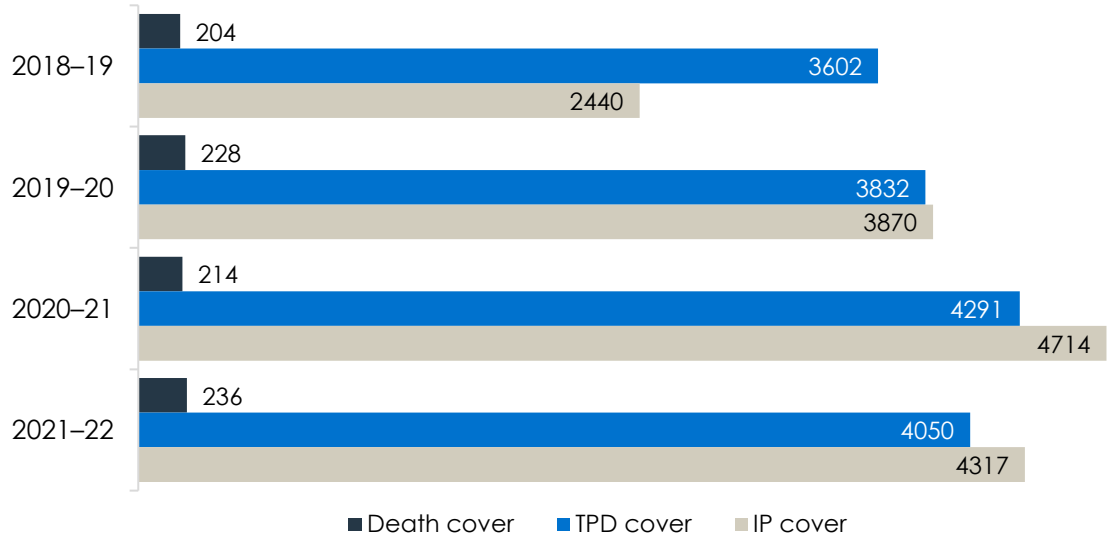
- One trustee received complaints about the amount of time it was taking for death claims to be assessed. They streamlined the death claims process to avoid seeking unnecessary information from parties not relevant to the claim.
- One trustee received complaints about communications sent by their insurer to members for declined claims. The trustee implemented a feedback register and shared it with their insurer to improve the quality of letters from their insurer advising members of a declined claim, to minimise errors, and to communicate their decision to members more clearly.

However, data made available to us by APRA suggests trustees need to do more when acting on complaints. We looked at the number of disputes recorded by insurers through internal dispute resolution relating to insurance in superannuation claims. The number of disputes about TPD and IP claims increased at the start of the COVID-19 pandemic (i.e. at the end of 2019–20 financial year) and remains high, even though it declined somewhat in 2021–22 financial year: see Figure 5.

Note: A member may lodge a dispute (complaint) about an insurance in superannuation claim with either the trustee or the insurer. Where the dispute is lodged with the trustee, the trustee generally must inform the insurer, which will also record it as a dispute. However, disputes recorded by insurers will not necessarily capture all disputes relating to insurance in superannuation. Trustees may not report to the insurer disputes that do not require input or approval from the insurer to resolve (e.g. disputes relating to a misunderstanding of the claims process).

Any member who is not satisfied with the outcome of a complaint handled through internal dispute resolution can take the complaint to AFCA. The number of complaints to AFCA about insurance in superannuation claims has been falling, although complaints about delays in claim handling remain the most common type of claim-related complaint: see Figure 6.

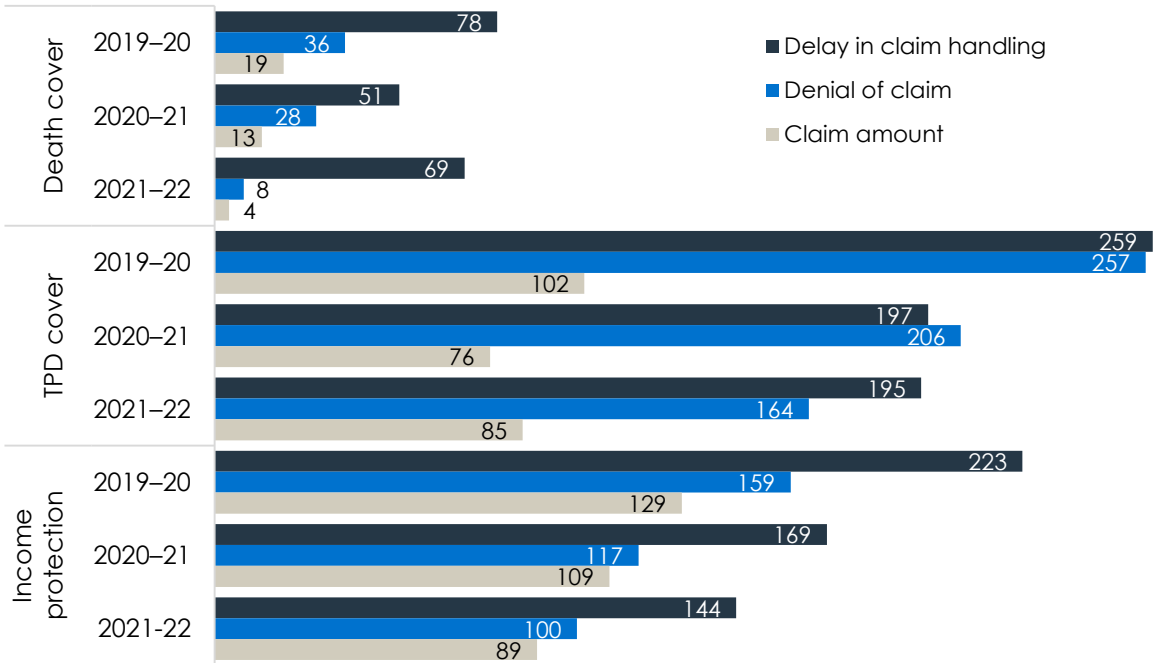
Figure 5: Number of claims-related disputes about insurance in superannuation lodged with insurers for internal dispute resolution



Source: APRA life insurance claims and disputes statistics June 2022. The data is for disputes relating to group superannuation insurance claims that were recorded by insurers through internal dispute resolution, including disputes notified to the insurer by a trustee. This data excludes disputes relating solely to a trustee's decision about how to distribute the death benefit.

Note: See Table 10 in Appendix 3: Accessible version of figures for the data shown in this figure (accessible version).

Figure 6: Number of claims-related complaints about trustees regarding insurance in superannuation lodged with AFCA for external dispute resolution



Source: Unpublished data provided by AFCA relating to AFCA complaints made against superannuation trustees. Some complaints may comprise more than one issue type. This data excludes AFCA complaints relating solely to a trustee's decision about how to distribute the death benefit.

Note: See Table 11 in Appendix 3: Accessible version of figures for the data shown in this figure (accessible version).

What we found: Withdrawn claims

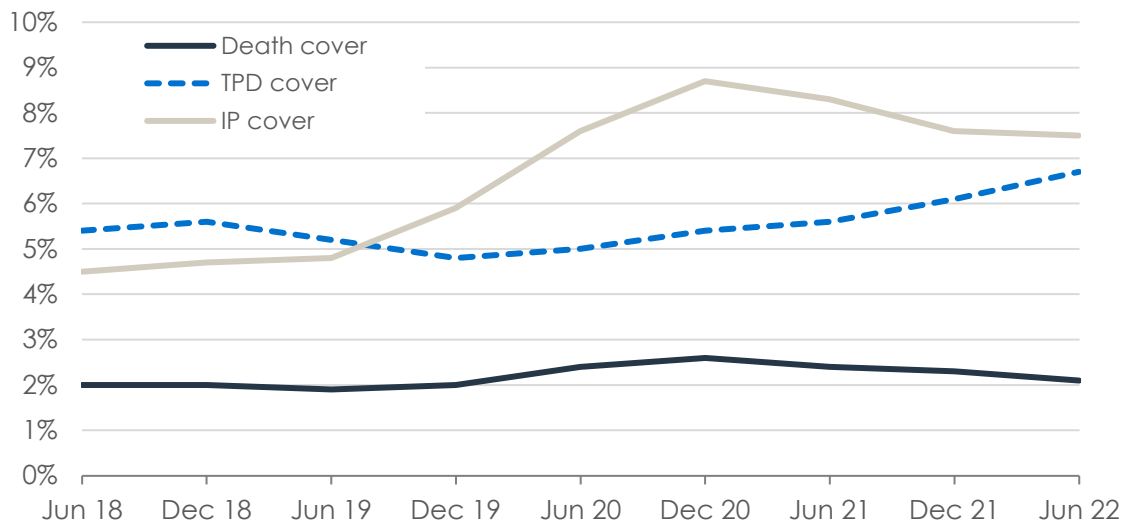
Withdrawn claims are a potential indicator of consumer harm. The way in which a claim is withdrawn, and the timing of the withdrawal, may indicate where there are frictions in the claims handling process. Withdrawn claims can also indicate issues with insurance eligibility criteria and definitions (and so may also mask the real rates of declined claims).

In our 2022 review, we found the following:

- Of the 15 trustees, only 10 have reviewed at least a sample of withdrawn claims to understand why the claims were withdrawn and to identify frictions in the claims handling process.
- The remaining five trustees have not undertaken any analysis to understand why claims were withdrawn or to identify any frictions in the claims handling process.

Data on claims handling across the superannuation industry suggests that more needs to be done by trustees and insurers to remove frictions in the claims handling process, including by helping members to understand what their insurance covers them for and what they need to do to make a successful claim. There has been a modest decline in the proportion of death and IP claims that are withdrawn, but there has been an increase in the share of TPD claims that are withdrawn, from 5.0% in June 2020 to 6.7% in June 2022: see Figure 7.

Figure 7: Percentage of claims received by insurers that are withdrawn



Source: APRA Life claims and disputes statistics June 2022.

Note: See Table 12 in Appendix 3: Accessible version of figures for the data shown in this figure (accessible version).

Actions for trustees

Where they haven't already, trustees should:

- **analyse complaints and reasons for claims being withdrawn** to identify frictions and hurdles that members may face when making a claim on their insurance in superannuation, and
- **work together with insurers to proactively address these frictions and hurdles**, and to identify ways to enhance the timeliness of claims handling, reduce procedural burdens, enhance transparency and fairness, and tailor the claims process for members experiencing vulnerability or financial difficulty.

INFO 253 sets out ASIC's expectations for insurance claims handing by trustees and insurers.

Increasing oversight of insurers' claims handling

ASIC identified a need for trustees to be more engaged in the claims handling process, finding, for example, that some trustees were no more than a 'post box' for lodging insurance claims, and provided little support for their members: see REP 633. This reinforced ASIC's previous findings that many trustees were over-reliant on insurers' processes for claims and complaints and some trustees lacked oversight of insurers' claims handling: see Report 591 *Insurance in superannuation* (REP 591).

What we found: Trustee oversight of insurers' claims handling

In this review, we found that all 15 superannuation trustees have taken action to give them greater oversight of their insurers' claims handling practices:

- All 15 trustees review all declined claims decisions to check that the insurer has correctly and appropriately applied the terms and conditions of the group insurance policy. Where the trustee does not agree with the insurer's decision, they request that the insurer review the decision before it is communicated to the member.
- Nine trustees review some or all accepted claims decisions to assess whether the insurer is correctly applying the terms and conditions of the group insurance policy. One of these trustees does a periodic 'deep dive'—that is, a review of all death, TPD and IP claims for all superannuation products for a defined period.
- Most trustees receive reports from their insurers at least monthly on the insurer's adherence to service level agreements, and the standards for insurers in the Life Insurance Code of Practice (Life Insurance Code).
- Most trustees meet with their insurers at least monthly to review complex and declined claims, and to discuss any emerging trends and day-to-day operational concerns.

Improving outcomes: Introducing better insurer oversight practices

- **'Procedural fairness' or 'show cause' letters**: Generally, where the insurer intends to decline a claim, they must provide the member with a letter setting out the insurer's position and inviting the member to provide further information in support of their claim. While all trustees are provided with a copy of the letter at the time it is sent to the member, only five of the 15 trustees had a process to review the letter and raise any concerns with the insurer before it is sent to the member. Some trustees meet with their insurer to discuss the claim before the letter is sent to the member. These steps may reduce unnecessary stress on the member where the trustee identifies ways the insurer can obtain information without imposing an additional burden (and potentially longer timeframes) on the member, but need to be weighed against the potential impact on the timeliness of decisions.
- **Quality assurance frameworks**: Three trustees audit a sample of claims files—including open and finalised claims—monthly or quarterly. The claims are reviewed based on set assessment criteria covering the member's experience during the claims process. Another trustee monitors telephone calls made and received by its insurance and claims team, and provides feedback and training to staff dealing with members.
- **Access to data**: Three trustees have real-time access to their insurers' claims reporting portals. This allows the trustees to monitor the progress of individual claims in real time.

Actions for trustees

Superannuation trustees should **check whether their oversight of their insurers' claims handling is structured to drive the right outcomes for their members**. Areas for trustees to consider include:

- the frequency with which they meet with their insurers to review complex and declined claims, and to discuss any emerging trends and day-to-day operational concerns
- what processes and procedures relating to 'procedural fairness' or 'show cause letters' exist, and
- how they monitor their insurers' compliance with the Life Insurance Code.

Helping members understand their insurance

Good communication practices can help members to understand what insurance they have, what it covers, and how much they pay for it. Good communication can also help members to make decisions about their insurance cover.

Trustees negotiate group insurance cover on behalf of their members. They are responsible for explaining to their members the features of this insurance, including the premiums members will pay and the terms and conditions. Trustees also design the 'choice architecture' in which members make decisions about their insurance in superannuation—for example, the accessibility and prominence of information, the way it is presented, and the processes for members seeking to make changes to their cover.

However, communication and disclosure are not a substitute for trustees designing insurance that meets their members' needs and provides value for money. Simplifying disclosures does not reduce the underlying complexity of insurance in superannuation.

Note: For more detail on the limitations of disclosure, see Report 632 *Disclosure: Why it shouldn't be the default* (REP 632).

Helping members make appropriate decisions for their circumstances

In our previous work, we found trustees' communications and processes for members to make changes to their insurance were not always easy to navigate or did not address members' concerns.

We commissioned qualitative consumer research which found that members experience barriers when looking for information on their superannuation fund's insurance arrangements or seeking to make changes to their insurance cover: see REP 673. Approximately one-third of the research participants reported feeling confused, overwhelmed, or uncertain after engaging with their fund about their insurance. Some participants found information they did not understand or know how to respond to.

In our previous work, we also found examples of trustees not providing members with appropriate context and balanced communications about how they would be affected by the PYSP reforms: see Report 655 *Review of member communications: Protecting Your Superannuation Package (PYSP) reforms* (REP 655). Some trustees failed to explain the purpose of the reforms, provided only a limited range of options for action, and failed to highlight the impact of account proliferation. Many trustees also failed to provide information that would have been helpful for members to make decisions related to the reforms, such as details of the member's last contribution date, account balance or insurance.

Note: Since 1 July 2022, trustees have been required through a prudential standard to ensure there is a process that enables members to easily opt-out of insurance cover, and for the process to cover how this will be communicated to members: see Prudential Standard SPS 250.

What we found: Helping members make decisions

In our 2022 review, we observed some positive practices by trustees to improve how they communicate with members about their insurance and help members to make appropriate decisions for their circumstances:

- Five of the 15 superannuation trustees have introduced standalone annual insurance statements that set out key information about the member's insurance cover and explain how they can cancel or vary their cover.
- We observed some improvement in communications sent to members about regulatory reforms. The sample communications we reviewed relating to the PMIF and stapling reforms generally provided clear and balanced information about the importance and purpose of the reforms and clearly set out options to help members make an informed decision about their insurance.
- Some trustees are making greater use of digital technology to help their members access information about their insurance and make changes online (including cancelling their insurance).
- Most of the 15 trustees are using insights from their members to improve their communication and disclosure materials. Of the 15 trustees, ten have made changes to these materials as a result of monitoring issues in complaints. Seven trustees have made changes following recent member surveys and/or consumer testing of the usefulness of communications materials, and four of these trustees are subsequently tracking how members are using the revised materials in practice.

However, some trustees had not made sufficient effort to improve their member communications and processes. All trustees need to embed a process to continuously improve member communications and processes in a way that supports members to understand their insurance cover and make good decisions for their circumstances.

Improving outcomes: Understanding members' information needs and monitoring the effectiveness of member communications

- One trustee's annual insurance statement to members sets out key information about their insurance cover, including their sum insured, premiums, occupational rating and any pre-existing condition exclusions. The statement also explains how a member can calculate how much insurance they need and how they can make changes to their cover. The trustee told us that it had seen an increase in the number of members making changes to their insurance cover following the introduction of these statements.
- One trustee commissioned consumer research to identify gaps in members' knowledge about insurance in super to help prioritise topics to discuss in future communications. The same trustee also commissioned consumer testing for communications informing members of changes to their TPD cover, communications issued in accordance with the PYSP reforms, and communications more generally for adherence to the former Insurance in Super Code. This trustee has embedded insights from consumer testing into its standard approach to communications.

Actions for trustees

Superannuation trustees should take the following actions:

- **Harness member data and consumer research** to better understand their members' needs, behaviours (i.e. how members behave and interact with the fund and how this relates to their financial outcomes) and potential frictions. Data and research can also help trustees monitor the effectiveness of member communications and identify opportunities for improvements.
- **Ensure member communications and processes are easy to understand.** Clear, straightforward communication, including information available on websites, can help to build members' awareness of issues they need to consider and support them to make decisions appropriate to their circumstances (which may include cancelling their insurance). Trustees should consider adopting different communications strategies and processes to reflect the diversity of their members' characteristics, preferences and needs.
- **Provide members with clear and balanced information about changes to their insurance, including changes as a result of regulatory reforms**. Trustees should give members context on why the changes are being made, explain how the changes may affect the individual member, provide appropriate options, and provide any other relevant, factual information (e.g. the member's insurance premiums and level of cover).
- **Conduct robust testing of processes, procedures and member communications** when making changes to their insurance arrangements. This includes working with their administrator to proactively identify and rectify system deficiencies so that members do not receive the wrong information or the wrong insurance cover.

Trustees should also consider the areas for improvement identified in REP 632, REP 655 and REP 673.

Explaining key terms and conditions

ASIC has previously found deficiencies in the way trustees explain to their members when and how different terms and conditions of the insurance policy apply, and how these affect members' premiums or cover. This information is important for members who are seeking to understand their insurance and who may be considering whether to change or cancel their insurance cover.

What we found: Explaining key terms and conditions

In our 2022 review, we looked at progress by trustees in explaining to members key terms and conditions in three main areas:

- occupational categories and how to make changes
- when a member is subject to a restrictive TPD definition, and
- when IP benefits will be offset.

Occupational categories and how to make changes

In our previous review of occupational classification practices in 2019 and 2020, we found poor disclosure by trustees about the cost of premiums in the trustee's default occupational category, which was often the highest risk and most costly occupational category: see 20-309MR. We identified that trustees needed to do more to help members make informed decisions about their insurance cover.

Most of the trustees in our 2022 review use default occupational categories when they do not know a member's occupation. We found the following:

- Most trustees have improved (or are in the process of improving) how they communicate with members about which occupational category they are in, how occupational categories affect their premiums and insurance cover, and how members can make changes. Many trustees now include this information on insurance confirmation letters, annual member statements or in the member login area of the website.
- However, some trustees continue to use generic labels for default occupational categories (e.g. 'standard' or 'general') that do not promote understanding of the level of risk and associated cost of the category.

When a member is subject to a restrictive TPD definition

We have previously found that differences in eligibility and disability criteria between insurance policies make it extremely difficult for consumers to compare policies and understand what they will be covered for: see REP 633. We said that trustees need to improve communications to members about the types of TPD cover they are eligible for under various circumstances.

In our 2022 review, we found that most of the 12 trustees that have retained a restrictive TPD definition have made minimal efforts to improve how they explain to members what the definition means and when it applies:

- Most trustees only provide an explanation of the circumstances in which a TPD claim will be assessed under the ADL or ADW definition in their detailed disclosure documents (e.g. insurance guides). In some cases, the information is written in legalistic language or buried in the definitions section of the document, making it difficult to locate or understand. However, two of the trustees included a scenario table to more clearly set out which TPD definition would apply under different circumstances.
- Most trustees did not include clear information about when restrictive TPD definitions apply in the other communication materials they send to members, including materials about making a claim.

Note: For our findings about changes to restrictive TPD definitions, see Changing restrictive TPD definitions.

When IP benefits will be offset

In our review of IP offsets in 2021, we found that all trustees we looked at included information about IP offsets in their insurance guide disclosures: see 21-343MR. However, this information was often difficult to locate and written in technical or legalistic language, limiting members' ability to make informed decisions about whether they should opt out of default IP cover.

In our 2022 review, we looked at what action had been taken by the 15 trustees, most of which offered default IP cover to some groups of members. We also followed up with the five trustees in

our review of IP offsets in 2021about actions they have subsequently taken. Across both sets of trustees, we found some positive steps being taken:

- Some trustees have made changes to public disclosures about offset clauses, including on their websites, to more clearly and concisely explain how offsets are applied.
- Some trustees have made changes to direct member communications (e.g. welcome letters, annual statements, initial IP claims letters) to include details about offset clauses.
- Many other trustees said that they planned to specifically review their disclosures and member communications which refer to offset clauses.

Actions for trustees

Superannuation trustees should **proactively and prominently communicate with their members about key terms and conditions in the insurance policy** in a way that helps members make informed decisions about their insurance cover.

Among other things, trustees should:

- **clearly explain to members which occupational category they are in**, the implications for their insurance cover, and how to change their occupational category if it is incorrect
- **avoid using generic labels such as 'standard' or 'general'** for their default occupation category, and instead use labels that better promote member understanding of the level of risk and cost associated with the category, especially where the default category is the highest-risk category
- look for opportunities to **proactively communicate with members who are more likely to be affected by restrictive terms or conditions** (e.g. proactively communicate with members who are not receiving contributions about restrictive TPD definitions that may apply after a period of unemployment)
- **consider using scenarios and case studies** to demonstrate when different terms apply and how this would affect a member's insurance benefits (e.g. how employment status affects how a TPD claim will be assessed, or when and how other income will reduce an IP benefit), and
- **clearly and prominently explain when IP benefits will be offset**, including an explanation of whether common sources of disability income (e.g. Centrelink payments) and TPD insurance benefits will be offset.

Appendix 1: ASIC's work on insurance in superannuation since 2019

This appendix summarises ASIC's key findings and expectations in reports and media releases about insurance design and data, member communications and engagement practices, and claims handling practices. It also summarises ASIC's recent enforcement outcomes relating to insurance in superannuation.

ASIC's key findings and expectations in reports and media releases

Table 5: Insurance design and data

Publication	Key findings	Key expectations for trustees
REP 633 *Holes in the safety net: A review of TPD insurance claims*	Claims assessed under the ADL definition generally result in poor outcomes, with three out of five such claims being declined. Eligibility criteria for TPD cover mean that some members are automatically funnelled into low-value ADL cover.	Review all TPD policies that include ADL definitions to: › consider removing restrictive definitions, and › develop measures to assess the value of the product offered. Improve data collection on outcomes for different types of TPD cover.
REP 675 *Default insurance in superannuation: Member value for money*	There is wide variation in the design and pricing of default insurance. Some groups of members may be receiving relatively low value for money. Trustees have shortcomings in data and analysis.	Proactively consider how the design and pricing of default insurance (including terms and conditions) can be refined. Collect and analyse data to monitor and review member outcomes.
REP 696 *TPD insurance: Progress made but gaps remain*	All insurers have started discussions with trustees about restrictive TPD definitions to improve member outcomes. Insurers face challenges in addressing gaps in claims and membership data in group insurance.	Embed detailed data-sharing arrangements in service level agreements with insurers to manage member harm.
20-309MR *Trustees to improve occupational classification practices in insurance in superannuation*	There was significant variation in the sophistication of trustees' assumptions when designing default occupational categories and in how they classified members by occupation.	Make an effort, through engagement with members and employers, to gather better occupation data about individuals and cohorts so that default settings are based on appropriate statistical assumptions and are fair and reasonable.
21-343MR *Super trustees offering default income protection insurance urged to check on member outcomes*	There was variation in the types of income that were offset against IP benefits. There was no evidence that the trustees had rigorously analysed how their IP offset clauses affect member outcomes.	Obtain and analyse data, including data from the insurer, to assess how offsets affect member outcomes, including whether some groups of members are receiving low or no value.

Table 6: Claims handling practices

Publication	Key findings	Key expectations for trustees
REP 633 *Holes in the safety net: A review of TPD insurance claims*	Insurers' claims handling practices created frictions that contributed to members withdrawing TPD claims. Trustees did not have adequate understanding of the reasons for withdrawn claims.	Incorporate additional or enhanced obligations in industry codes for: › proactive communication with members during their claim, and › documenting guidelines on training and competency requirements for claims handling staff. Where relevant, take immediate steps to make recommended changes to claims handling practices, reinsurer arrangements and claims staff remuneration scorecards. **Note:** see Industry efforts at self-regulation.
REP 696 *TPD insurance: Progress made but gaps remain*	There was variation in the methods trustees and insurers provided to members to lodge a claim (e.g. paper form, online form, tele-claim). Trustees' level of involvement in the claims process varied.	Work with their insurer to proactively address hurdles that members face when making a claim.

Table 7: Member communications and engagement practices

Publication	Key findings	Key expectations for trustees
REP 633 *Holes in the safety net: A review of TPD insurance claims*	To make an informed decision about whether the TPD cover in their group insurance policy offers any real value and whether to opt out of their cover, members need clear and effective communication when they are or become only eligible under restrictive definitions.	Improve communications with members about the type of TPD cover they will be eligible for under various circumstances.
REP 655 *Review of member communications: Protecting Your Superannuation Package (PYSP) reforms*	Some of the communication material reviewed by ASIC did not provide sufficient context for the reforms or adequately explain what the changes meant for members. Some material used complex language, promoted a particular option that may not have been suitable for the member or failed to include relevant information about the member's existing superannuation arrangements.	Provide members with clear, balanced information about the importance and purpose of the PYSP and other reforms to help members make decisions in their best interests.

Publication	Key findings	Key expectations for trustees
REP 673 *Consumer engagement in insurance in super*	The process of gaining information from their fund about insurance arrangements or making changes to their insurance presented hurdles to many members.	Consider the issues raised in this report and how to improve the experience of members when they seek to engage about insurance.
20-309MR *Trustees to improve occupational classification practices in insurance in superannuation*	Some funds had poor disclosure practices such as the use of generic labels (e.g. 'standard' or 'general') for the most expensive occupational category. The process for members to update their occupational category was generally not readily apparent or accessible.	Provide clearer disclosure about how members can change their occupational category. Label the default category in a way that is meaningful and promotes understanding of the level of risk and associated cost of the category.
21-343MR *Super trustees offering default income protection insurance urged to check on member outcomes*	Disclosures about IP offset clauses were incomplete and difficult to understand.	Improve the extent and quality of disclosures to members relating to IP offsets, especially when a member will receive a reduced benefit.

ASIC's recent enforcement outcomes

The following is an overview of ASIC's recent enforcement outcomes relating to insurance in superannuation:

- *Australian Securities and Investments Commission v Statewide Superannuation Pty Ltd* [2021] FCA 1650 – Statewide Superannuation Pty Ltd was ordered to pay $4 million in penalties after the Federal Court found that the superannuation trustee had provided members with misleading information about their insurance and failed to breach report the issue to ASIC in the time required by law: see Media Release (22-001MR) *Statewide Superannuation to pay $4 million penalty for misleading correspondence to members*.
- *Australian Securities and Investments Commission v Westpac Banking Corporation (Omnibus)* [2022] FCA 515 – BT Funds Management Limited, a subsidiary of Westpac Banking Corporation, was ordered to pay $20 million in penalties after the Federal Court found that the superannuation trustee had charged members insurance premiums that included commission payments, despite commissions having been banned under the Future of Financial Advice reforms. Some members also paid commissions to financial advisers via their premiums even though they had elected to have the financial adviser component removed from their account: see Media Release (22-097MR) *Westpac penalised $113 million after multiple ASIC legal actions*.

Appendix 2: ASIC's follow-up work with life insurers on IP offsets

What we did

As part of our 2022 review, we used our compulsory notice powers to obtain data from three insurers relating to IP claims. In April 2022, we required the insurers to record data, in a specified format, for IP claims processed or paid from April to June 2022 under the group insurance arrangements of five superannuation trustees. We requested the data on a forward-looking basis because, in our previous engagements, these three insurers were unable to extract reliable and consistent historical data from their systems.

Note: The three insurers and five trustees are the same entities that were included in ASIC's 2021 review of IP offsets: see 21-343MR. Together, the trustees provided IP insurance to approximately 2 million MySuper member accounts as of June 2021. In the 2021 review, the data provided by the insurers was insufficient to determine the proportion of claims with an offset or the types of income that offset insurance benefits and the impact on insurance benefit payments.

The data included:

- the number of IP claims with a benefit payable, and the number of these claims to which an offset was applied (not including income from work), and
- for claims with an offset—the type of offset, the reduction in benefits payable due to the offset, and the number of claims where the benefit payable was reduced to zero.

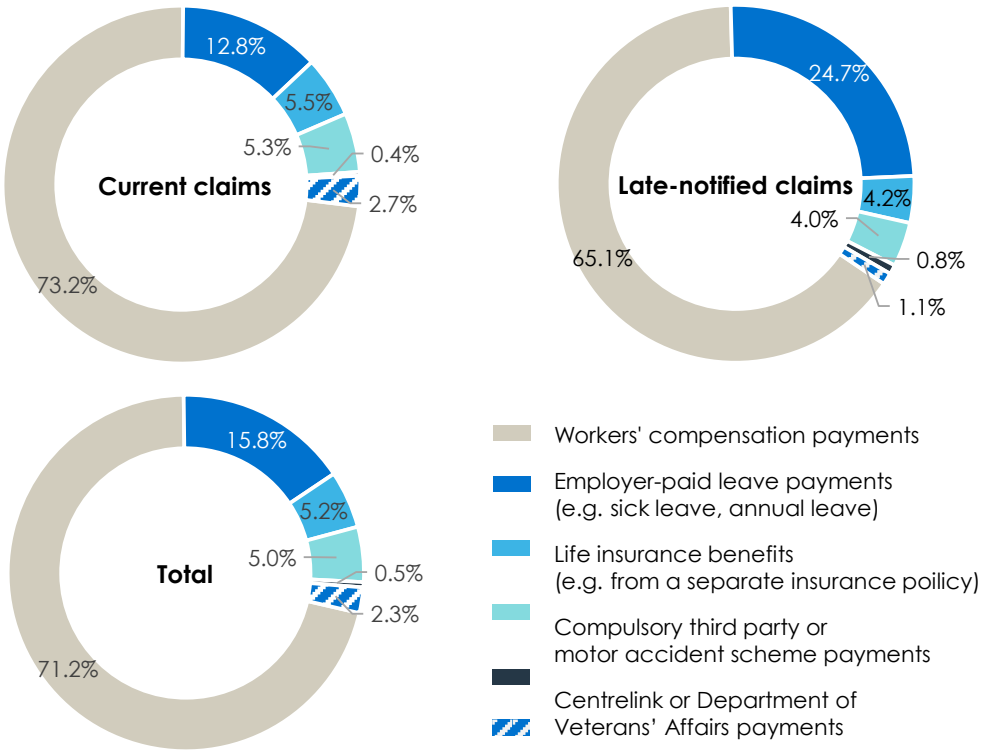
We required data for current claims (i.e. claims where a benefit was paid for April, May or June 2022) and for late-notified claims (i.e. claims which were processed during April, May or June 2022, but for which all benefit payments related to an earlier period). We used the data on late-notified claims to estimate the rate of offsets for 'unobservable' claims—i.e. claims for which benefits were payable for April, May or June 2022 but the claim had not yet been lodged with the insurer. For example, an IP claim could be paid late if the claimant had access to other sources of income and delayed reporting the claim to their trustee.

What we found

On average, we estimated that across April, May and June 2022:

- one in 16 (or 6.3%) monthly IP benefit payments had an offset applied to the benefit payment
- late-notified claims were much more likely to have an offset (26%) than current claims (5%)
- monthly benefit payments with an offset had a benefit payment that was reduced by 63%, on average, compared to monthly benefit payments without an offset
- roughly a quarter (or 23%) of monthly benefit payments with an offset were reduced to zero because of the offset
- workers' compensation payments were the most common type of offset, and in total accounted for 71% of monthly benefit payments with an offset: see Figure 8.

Figure 8: Proportion of offset types for IP monthly benefit payments with an offset



Source: Data obtained by ASIC on IP claims assessed from April to June 2022 by three life insurers.

Note: See Table 13 in Appendix 3: Accessible version of figures for the data shown in this figure (accessible version).

We also found variation across group insurance policies and insurers in the proportion of IP benefit payments with an offset. Some of the variation across policies and insurers may reflect differences in policy clauses in the insurance arrangements—for example, the default benefit levels or types of income that are offset. The variation may also reflect different demographic compositions of fund membership—for example, occupational profile or average income.

We have excluded data for one group insurance policy from the results in this report. This is because it was an outlier with a very high proportion of benefit payments with an offset, which would materially distort the average for our sample if we were to include it. This is a legacy policy that is no longer available (i.e. no longer in force), even though claims relating to past periods are still being paid (e.g. ongoing IP claims).

Appendix 3: Accessible version of figures

Table 8: TPD claims assessed under the ADL definition

Year	Number	Share of all TPD claims
2015-16	119	0.9%
2016–17	304	2.0%
2017–18	349	2.2%
2018–19	294	1.9%
2019–20	366	2.0%
2020–21	322	1.6%
2021–22	232	1.3%

Note: This is the data shown in Figure 3.

Table 9: Share of finalised TPD claims that are declined, by TPD definition

Year	ADL definition	Any occupation
2015-16	47%	16%
2016–17	54%	10%
2017–18	58%	10%
2018–19	48%	8%
2019–20	51%	7%
2020–21	54%	9%
2021–22	52%	8%

Note: This is the data shown in Figure 4.

Table 10: Number of claims-related disputes about insurance in superannuation lodged with insurers for internal dispute resolution

Year	Death cover	TPD cover	IP cover
2018–19	204	3602	2440
2019–20	228	3832	3870
2020–21	214	4291	4714
2021–22	236	4050	4317

Note: This is the data shown in Figure 5.

Table 11: Number of claims-related complaints about trustees regarding insurance in superannuation lodged with AFCA for external dispute resolution

Type of cover	Delay in claims handling	Denial of claim	Claim amount
Death cover	78 (2019–20) 51 (2020–21) 69 (2021–22)	36 (2019–20) 28 (2020–21) 8 (2021–22)	19 (2019–20) 13 (2020–21) 4 (2021–22)
TPD cover	259 (2019–20) 197 (2020–21) 195 (2021–22)	257 (2019–20) 206 (2020–21) 164 (2021–22)	102 (2019–20) 76 (2020–21) 85 (2021–22)
IP cover	223 (2019–20) 169 (2020–21) 144 (2021–22)	159 (2019–20) 117 (2020–21) 100 (2021–22)	129 (2019–20) 109 (2020–21) 89 (2021–22)

Note: This is the data shown in Figure 6.

Table 12: Percentage of claims received by insurers that are withdrawn

Reporting date	Death cover	TPD cover	IP cover
Jun 18	2%	5.40%	4.50%
Dec 18	2%	5.60%	4.70%
Jun 19	1.90%	5.20%	4.80%
Dec 19	2%	4.80%	5.90%
Jun 20	2.40%	5%	7.60%
Dec 20	2.60%	5.40%	8.70%
Jun 21	2.40%	5.60%	8.30%
Dec 21	2.30%	6.10%	7.60%
Jun 22	2.10%	6.70%	7.50%

Note: This is the data shown in Figure 7.

Table 13: Proportion of offset types for IP monthly benefit payments with an offset

Type of offset	Current claims	Late-notified claims	Total
Workers' compensation payments	73.2%	65.1%	71.2%
Employer-paid leave payments (e.g. sick leave, annual leave)	12.8%	24.7%	15.8%
Life insurance benefits (e.g. from a separate insurance policy)	5.5%	4.2%	5.2%
Compulsory Third Party or motor accident scheme payments	5.3%	4.0%	5.0%
Centrelink or Department of Veterans Affairs payments	0.4%	0.8%	0.5%
Other	2.7%	1.1%	2.3%

Note: This is the data shown in Figure 8.

Key terms and related information

Key terms

ADL	Activities of daily living—that is, a set of disability criteria (e.g. dressing, toileting, bathing, feeding) that are a sub-definition of TPD under many insurance policies
ADW	Activities of daily working—that is, a set of disability criteria (e.g. seeing, communicating, walking, lifting) that are a sub-definition of TPD under many insurance policies
AFCA	Australian Financial Complaints Authority
AIST	Australian Institute of Superannuation Trustees
'any occupation' definition	Where a benefit is paid if a person is unable to engage in gainful employment in any occupation for which the person is reasonably qualified by education, training or experience (definitions vary across insurance contracts)
APRA	Australian Prudential Regulatory Authority
ASFA	Association of Superannuation Funds of Australia
ASIC	Australian Securities Investments Commission
ATO	Australian Taxation Office
beneficiary	A person who has a beneficial interest in a superannuation fund, or to whom an insurance claim is paid
choice architecture	The features in an environment, noticed and unnoticed, that influence member decisions and actions. These design features are present at every stage of product design and distribution and include how the product or service is framed, options are presented, processes are organised and products are sold: see RG 274
choice superannuation product	A superannuation product that is not a MySuper product or defined benefit interest
claims ratio	The dollar value of insurance claims divided by the dollar value of insurance premiums
claims received	Claims for which the first piece of information (not necessarily all information) has been received
Corporations Act	*Corporations Act 2001*
death cover	A type of life insurance that pays a set amount of money when the insured person dies or is diagnosed with a terminal illness
declined claim	Claims that are declined, with no benefit paid (or payable) to the claimant

declined claim rate	The number of declined claims as a share of all finalised claims received during a period
default occupational category	The occupation group(s) used (for the purposes of determining premiums and level of cover) if the trustee does not have information from the member or employer about the member's occupation
design and distribution obligations	The obligations contained in Pt 7.8A of the Corporations Act
eligibility criteria	The criteria used to determine whether a claim will be assessed under a restrictive TPD definition or an 'any occupation' or 'own occupation' definition (e.g. employment status, number of hours of work per week)
FSC	Financial Services Council
fund (superannuation)	Has the same meaning given to 'superannuation fund' in s10(1) of the SIS Act
group insurance policy	A life insurance policy issued to a third party (e.g. a trustee) that policyholders can access through their membership to the third party's fund
Insurance in Super Code	Insurance in Superannuation Voluntary Code of Practice, which was owned by AIST, ASFA and FSC
insurer	A company that issues a life insurance policy
IP	Income protection
IP cover	A type of life insurance that pays an income for a period if a member is unable to work due to sickness or injury
level of cover	The contractual benefit payable under the life insurance policy, should the insured event occur
Life Insurance Code	Life Insurance Code of Practice owned by the FSC
maximum benefit period	The maximum term that the IP benefit will be paid for
member (superannuation)	A member of a superannuation entity, including a prospective member
member outcomes assessment	Assessments of outcomes provided to members. Trustees must undertake these assessments annually under Prudential Standard SPS 515 and s52(9) of the SIS Act
MySuper product	A default superannuation product provided under Pt 2C of the SIS Act
'own occupation' definition	Where a benefit is paid if a person is unable to work again in their own occupation, that they worked in immediately before becoming totally and permanently disabled (definitions can vary across insurance contracts)
PMIF Act	*Treasury Laws Amendment (Putting Members' Interests First) Act 2019*

PMIF reforms	Reforms under the PMIF Act
PYSP Act	*Treasury Laws Amendment (Protecting Your Superannuation Package) Act 2019*
PYSP reforms	Reforms under the PYSP Act
s52 (for example)	A section of the SIS Act (in this example numbered 52), unless otherwise specified
SIS Act	*Superannuation Industry (Supervision) Act 1993*
target market determination	Has the meaning given in s994B of the Corporations Act
TMD	Means a target market determination document
trustee (superannuation)	A person or group of persons licensed by APRA under s29D of the SIS Act to operate a registrable superannuation entity (e.g. superannuation fund)
superannuation trustee service	Has the same meaning given to 'provides a superannuation trustee service' in s766H of the Corporations Act
TPD	Total and permanent disability
TPD cover	A type of life insurance that pays a set amount of money towards the costs of rehabilitation, debt repayments and future cost of living if the insured person is totally and permanently disabled
waiting period	A period during which the insured must be absent from work to qualify for a life insurance benefit
withdrawn claims rate	The number of withdrawn claims as a share of all claims received during a period

Related information

Headnotes

Activities of daily living, activities of daily working, ADL, ADW, choice superannuation product, claims handling, consumer research, default insurance, design and distribution obligations, insurance in superannuation, income protection, IP, income protection, life insurance, member harm, MySuper, occupational classification, occupational category, superannuation, superannuation trustees, target market determination, TMD, total and permanent disability, TPD, value for money

Legislation

Corporations Act, s912A(1)(a), Pt 7.8A

PMIF Act

PYSP Act

SIS Act, s52(2)(c), s52(2)(e)–(f), s52(7)(a), s52(7)(c), s52(7)(d), s52(11), s68AA

ASIC documents

REP 591 *Insurance in superannuation*

REP 632 *Disclosure: Why it shouldn't be the default*

REP 633 *Holes in the safety net: A review of TPD insurance claims*

REP 655 *Review of member communications: Protecting Your Superannuation Package (PYSP) reforms*

REP 673 *Consumer engagement in insurance in super*

REP 675 *Default insurance in superannuation: Member value for money*

REP 696 *TPD insurance: Progress made but gaps remain*

INFO 253 *Claims handling and settling: How to comply with your AFS licence obligations*

RG 274 *Product design and distribution obligations*

20-309MR *Trustees to improve occupational classification practices in insurance in superannuation*

21-343MR *Super trustees offering default income protection insurance urged to check on member outcomes*

22-001MR *Statewide Superannuation to pay $4 million penalty for misleading correspondence to members*

22-097MR *Westpac penalised $113 million after multiple ASIC legal actions*

22-236MR *Super trustees urged to improve effectiveness of target market determinations*

APRA documents

Prudential Standard SPS 250 *Insurance in superannuation*

Prudential Practice Guide 250 *Insurance in superannuation* (PDF 751 KB)

Prudential Standard SPS 515 *Strategic planning and member outcomes*

Reporting Standard SRS 251.0 *Insurance*

Life insurance in superannuation: Improving outcomes for members

Industry guidance

AIST, ASFA and FSC Insurance in Superannuation Voluntary Code of Practice (PDF 300 KB)

AIST Guidance Note *Claims handling standards for superannuation funds* (PDF 611 KB)

AIST Guidance Note *Developing a vulnerable member policy* (PDF 430 KB)

ASFA Guidance Note *Claims handling standards for superannuation funds* (PDF 537 KB)

ASFA Guidance Note *Developing a vulnerable member policy* (PDF 638 KB)

FSC Guidance Note No. 41 *Developing a vulnerable member policy* (PDF 8.5 MB)

FSC Standard No. 27 *Removal of occupational exclusions and occupation based restrictive disability definitions in default cover* (PDF 4.1 MB)

FSC Standard No. 28 *Claims handling for superannuation funds* (PDF 4.3 MB)