STATISTICS

Life Insurance Claims and Disputes Statistics

June 2018 (released 29 March 2019)

Forthcoming issues

This publication will be released according to the timetable published on the APRA website.

Notation

The symbol '*' indicates that the data have been masked to avoid publishing data that is not statistically credible.

Rounding

Details on tables may not add up to totals due to rounding.

Glossary and explanatory notes

A set of explanatory notes and a glossary are provided on the APRA website to assist the reader in understanding the source and definitions of the data.

Enquiries

For more information about the statistics in this publication, contact:

DataAnalytics@apra.gov.au

Manager, Life Insurance Strategic Intelligence
Australian Prudential Regulation Authority
GPO Box 9836
Sydney NSW 2001

Contents

Executive summary

Over the past two years, the Australian Prudential Regulation Authority (APRA) and the Australian Securities and Investments Commission (ASIC) (the agencies) have worked to establish and implement a public reporting regime for claims and disputes statistics for life insurers.

To meet the needs of the different audiences of the data, two types of publications are being released. Together, they form a comprehensive and targeted approach to the communication of this important data.

- The first publication is APRA's *Life Insurance Claims and Disputes Statistics* (this publication), which is a comprehensive suite of industry and insurer-level data across a range of dimensions.
- The second is ASIC's *Life insurance claims comparison tool*, a consumer-oriented tool designed to readily assist in making reasonable comparisons of key metrics across the industry.[1]

This is the first formal statistical publication under the regime, and provides data on both an industry-level and named individual insurer-level basis. It follows two publications of pilot round data, which were limited to industry-level results. This document provides and discusses high-level industry results; the accompanying spreadsheet[2] provides more granular information, including at the entity level.

Future publications are intended to be released semi-annually, with each publication covering a rolling 12-month period.

Table 1 summarises the key results from the first formal data collection and provides a comparison with the results reported in the May 2018 Response Paper.

[1] The ASIC tool is located on the MoneySmart website at https://www.moneysmart.gov.au/tools-and-resources/calculators-and-apps/life-insurance-claims-comparison-tool.

[2] Refer to https://www.apra.gov.au/life-claims-data-collection.

Table 1: First formal data collection summary and comparison with May 2018 Response Paper

Claims outcomes	May 2018 Response Paper (6 months to 30 June 17)		First formal data collection (12 months to 30 June 18) ^	
	Number	Ratio	Number	Ratio
Claims Received #	71,170		129,046	
Claims Finalised	47,069	66% of received	106,779	83% of received
- *Claims Admitted*	*43,920*	*93% of finalised*	98,704	*92% of finalised*
- *Claims Declined*	*3,149*	*7% of finalised*	8,075	*8% of finalised*
Claims Withdrawn	4,604	6% of received	5,910	5% of received
Claims Undetermined	19,497	27% of received	16,357	13% of received

^ Compared to the 2018 Response Paper, the first formal data collection includes additional cover types: DII Business Expense, CCI Incapacity and Redundancy, and Accidental Death and Injury.
# Claims received is the sum of: claims that were undetermined at the start of the reporting period; claims that were received during the reporting period; and claims that insurers re-opened during the reporting period.

Compared to the May 2018 Response Paper results, there has been a significant increase in the proportion of reported claims finalised within the reporting period (83 per cent versus 66 per cent). This is largely because the Response Paper covered a shorter reporting period (6 months versus 12 months), with a commensurately shorter period for insurers in which to resolve claims.

The admittance rate across all cover types and distribution channels is 92 per cent in the first formal data collection, in line with the 93 per cent presented in the May 2018 Response Paper. These findings are broadly consistent with the data the agencies released in November 2017, and with the findings published in ASIC's 2016 *Report 498 Life insurance claims: An industry review*.

The 92 per cent admittance rate reported in Table 1 conceals some variability across cover types and distribution channels; Table 2 breaks the admittance rate down by cover type and channel.

Table 2: Claims admittance rate by cover type and distribution channel

	Individual Advised	Individual Non-Advised	Group Super	Group Ordinary
Cover type	% admitted	% admitted	% admitted	% admitted
Death	97%	88%	98%	100%
TPD	85%	68%	86%	81%
Trauma	85%	84%	n/a	88%
DII	94%	83%	96%	95%
CCI	n/a	86%	n/a	*
Funeral	n/a	99%	n/a	n/a
Accident	16%	81%	n/a	n/a

* In this publication, Group Ordinary CCI is masked as there was only one provider of this product, which reported fewer than 50 finalised claims.

Table 2 reveals significant variance in the admittance rate between different cover types and distribution channels, from 100 per cent for Group Ordinary Death to 16 per cent for Individual Advised Accident. These results, however, are affected by the number of observations – the latter combination only reflects 116 finalised claims, whereas 13 out of the 19 combinations published in Table 2 have more than 1,000. (Table 7 in the main body of the publication gives the number of finalised claims for each combination.)

Generally, Individual Advised business shows higher admittance rates than Individual Non-Advised for the same cover type. This could be due to the policyholder having clearer expectations up front of what is covered by the product, or (related to the previous point) the adviser discouraging the policyholder from lodging a claim that is not covered by the policy. The exception is Individual Advised Accident, which has an unusually low admittance rate. However, as noted above the number of observations is quite small (116 finalised claims, versus 3,260 for Non-Advised), plus the agencies were informed by the main writer of this product of some existing data limitations that have reduced the accuracy of their reported results.

In terms of overall data quality, the reported results have significantly improved over the course of three pilot rounds. With some exceptions, like the one mentioned in the previous paragraph, the data is of good quality. Insurers are currently addressing the few remaining issues.

Table 3: Claims paid ratio^ by cover type and distribution channel

Cover type	Individual Advised	Individual Non-Advised	Group Super	Group Ordinary
Death	41%	28%	81%	70%
TPD	42%	26%	73%	30%
Trauma	61%	39%	n/a	68%
DII #	66%	72%	87%	56%
CCI	n/a	24%	n/a	*
Funeral	n/a	23%	n/a	n/a
Accident	26%	49%	n/a	n/a

^ The claims paid ratio is the dollar amount of claims paid out in the reporting period as a percentage of the annual premiums receivable in the same period.
# DII has recurring monthly payments. For the purposes of the reported claims ratio, total payments are approximated using an average 24-month payout period.

Table 3 provides the claims paid ratio by cover type and distribution channel. There is significant variance between products, ranging from 23 per cent (Individual Non-Advised Funeral) to 87 per cent (Group Super DII). As this information is based on finalised claims, the caveats regarding sample size accompanying Table 2 apply here as well. However, it is notable that the two products with the lowest claims paid ratios have a relatively large sample: Individual Non-Advised Funeral (11,708 finalised claims) and Individual Non-Advised CCI (9,490 claims).

In general, Individual products will have higher acquisition costs associated with the policy compared to Group products. As these costs will make up a larger proportion of the overall premium income, the claims payments will be a correspondingly lower percentage.

Across all distribution channels except Group Ordinary, DII business has the highest claims paid ratio. This aligns with the observations made in APRA's thematic review into the sustainability of this product.[3]

The agencies urge caution in interpreting the information presented in Table 3 as a measure of consumer value or product profitability. For insurers, claims payments are only one part of the costs associated with an insurance policy. Other costs, such as administration, acquisition costs and claims reserves, are not included. Whether and how profitable the product is to the insurer will depend in part on these factors.

Please note that the claims paid ratio reported in this publication is only a proxy of the loss ratio; refer to the *Industry-level results* chapter for more information on this.

[3] Refer to *Seeking sustainability: challenges facing individual disability income insurance*, APRA Insight (2018).

Background

In 2016, ASIC conducted a thematic review to identify any systemic concerns with claims handling in the life insurance industry. A key finding was that there is a clear need for better quality, more consistent and more transparent data about insurance claims. The report recommended the establishment of a consistent public reporting regime for claims data and claims outcomes, including claims handling timeframes and dispute levels across all policy types.

Commencing in May 2017, the agencies undertook a joint initiative to collect and publicly report on life insurance claims and disputes data. The agencies adopted a two-phase approach to this work: the first involved collecting data in a pilot process to establish an effective and consistent collection approach (pilot data phase), with the second being the ongoing collection and publication of credible, reliable and comparable data (ongoing reporting phase).

The pilot data phase commenced in May 2017, and comprised three rounds of voluntary data collection of claims and disputes data. Data was collected from approximately 20 insurers. Over the course of the three rounds, the definitions used, the scope of data collected and the collection template were incrementally improved.

To facilitate the start of the ongoing reporting phase and publication of data, in October 2018 *Life Insurance Reporting Standard LRS 750.0 Claims and Disputes* (LRS 750.0) was released. LRS 750.0 requires life insurers regulated under the *Life Insurance Act 1995* that write certain specified types of life insurance business to report life insurance claims and disputes data to APRA twice a year, covering six-month reporting periods. In addition to forming the basis of statistical publications, the data collected will be shared with ASIC, in order to assist them in performing their regulatory duties.

The agencies' objectives in these new reporting requirements are to:

- improve accountability and performance of life insurers; and
- facilitate an informed public discussion about the performance of the life insurance industry.

The new reporting requirements have been developed through extensive consultation with life insurers, consumer representatives, service providers and the Financial Services Council. In particular, the May 2018 Response Paper[4] sought feedback on the core principles to be met by the publication, industry-level data tables, proposed insurer-level data tables, individual data items, and the provision of educational materials. The agencies have considered the feedback provided as part of the consultation process in the development of this publication. ASIC has developed a consumer-tested tool, hosted on its MoneySmart website, in order to help consumers make reasonable comparisons across the industry.[5]

[4] Refer to https://www.apra.gov.au/life-claims-data-collection.

[5] Refer to https://www.moneysmart.gov.au/tools-and-resources/calculators-and-apps/life-insurance-claims-comparison-tool.

Data interpretation and disclaimer

Data interpretation

This publication provides claims and disputes data for the seven cover types listed in Table 4.

Table 4: Cover types included in this publication

Cover type	Description
Death	Cover that provides a lump-sum payment in the event of the death of the insured life. Can be with or without a Terminal Illness benefit.
Total and Permanent Disability (TPD)	Cover that provides a lump-sum payment in the event of the insured life being considered totally and permanently disabled in accordance with the policy definition.
Disability Income Insurance (DII)	Cover that provides for a regular payment for a maximum defined benefit period after a defined waiting period, in the event of the insured life being considered totally or partially disabled in accordance with the policy definitions. DII is relevant for both Individual and Group contracts and is commonly referred to as Income Protection and Group Salary Continuance, respectively.
Trauma	Cover that provides a lump-sum payment in the event of the occurrence of a predefined illness or traumatic event. Trauma can be either standalone or an acceleration of the Death/TPD benefit.
Consumer Credit Insurance (CCI)	Insurance providing for a lump-sum payment of the insured's outstanding loan or credit card balance (in part or in full) or regular payments limited to the minimum repayments for a period, payable in the event of one or more predefined events occurring. CCI can relate to the death, incapacity or involuntary redundancy of the insured life.
Funeral Insurance	Insurance for paying the expenses of, or incidental to, the funeral, burial or cremation of the insured life.
Accident Insurance	Insurance providing for a lump-sum payment in the event of the accidental death or injury of the insured life.

This publication also distinguishes four life insurance distribution channels, as explained in Table 5. Note that the split differs slightly from the split used in the May 2018 Response Paper; refer to the glossary accompanying this publication for an exact breakdown of the distribution channels.

Table 5: Distribution channels included in this publication

Channel	Description
Individual Advised	Individually underwritten insurance that was sold with the provision of personal advice.
Individual Non-Advised	Individually underwritten insurance that was sold without the provision of personal advice. This includes where no advice or general advice is provided.
Group Super	Group superannuation business, where the trustee of a superannuation fund with at least five members purchased a group insurance policy to provide cover for the fund members.
Group Ordinary	Group business outside of superannuation, where an employer purchased a group insurance policy to provide cover for its employees.

All distribution channels except Group Ordinary are also included in ASIC's MoneySmart tool. Note that one channel that is collected through LRF 750.0, Individual Non-Advised Super, is not included in this publication, as this channel is very small with only 74 finalised claims in total across all cover types.

Six cover type and distribution channel combinations are not provided for in APRA's reporting form, and are listed as 'n/a' in the relevant industry-level tables:

- Individual Advised CCI
- Individual Advised Funeral
- Group Super CCI
- Group Super Funeral
- Group Super Accident
- Group Ordinary Funeral

Further, while they are possible combinations, no business was reported for Group Super Trauma and Group Ordinary Accident; these combinations therefore also show 'n/a' in this publication.

Some of the tables in this industry-level publication combine the four distribution channels for a cover type. This may conceal some variability across distribution channels – in other words, consumer experience may differ across the channels. A breakdown by distribution channel is provided in the accompanying entity-level spreadsheet publication.

Masking

A few data items have been masked with an asterisk (*), as the sample size was too small to be statistically credible. For any cover type and distribution channel combination, APRA applies masking in the following cases:

- If an insurer reports more than 0, but fewer than 50 claims finalised.
- If only one insurer is masked due to having fewer than 50 claims, the next-lowest is also masked, as otherwise it would be possible to reverse engineer the masked data from the industry total and the sum of the non-masked insurers.

- If only one insurer provides a specific combination and it has fewer than 50 claims finalised, the industry-level data is also masked. In this publication, that is the case for Group Ordinary CCI.
- Where insurers with fewer than 50 claims comprise more than 70 per cent of the total number of claims finalised, the other insurers are also masked (but the industry totals are still provided).

Masking is applied consistently across claims and disputes data for the relevant cover type and distribution channel combination. That is, if an insurer's Individual Advised Death claims data is masked, all Individual Advised Death data across claims, claims duration, disputes and disputes duration is masked for that insurer. Conversely, if claims data is not masked for the insurer, all claims, claims duration, disputes and disputes duration data is shown.

Important disclaimer

If you are a consumer and should you wish to use the information in this publication when making a decision on what life insurance policy to acquire, please consider the following:

- The data is historic and provides no guarantee for future experience;
- Some samples are small, especially for disputes data. Outliers can therefore have a disproportionate impact on an insurer's reported results; and
- Next to the claims and disputes experience, consumers should take other relevant considerations into account, including (but not limited to):
    - personal circumstances and medical history;
    - product coverage;
    - any exclusions;
    - waiting periods;
    - pricing, including premium structure (level or stepped); and
    - in the case of insurance in superannuation: the fund's overall superannuation offering and the impact on your super savings.

Consumers should use this information to compare claims and disputes outcomes only. Whatever insurance you choose, it is important to review your cover against your needs on a regular basis.

ASIC's MoneySmart website explains what to look for in insurance products so you can find the right policy for your needs: https://www.moneysmart.gov.au/insurance.

Industry-level results

This chapter presents the key industry-level claims and dispute outcomes for 20 Australian life insurers[6] writing direct business (i.e. excluding reinsurance), covering the period from 1 July 2017 to 30 June 2018. A spreadsheet publication with additional information and entity-level data, and a glossary explaining in detail all relevant terms used, are available on APRA's website.[7]

Attachment B presents additional information on the key characteristics of the Australian direct life insurance market for the cover types included in this publication: lives insured, annual premium volume, sum insured, new business written and lapse rate.

Claims outcomes

Table 6: Claims outcomes by cover type (combines distribution channels)

	Claims Finalised	*Claims Admitted*	*Claims Declined*	Claims Withdrawn	Claims Undetermined^
Cover type	% of received#	*% of finalised*	*% of finalised*	% of received	% of received
Death	89%	*97%*	*3%*	3%	9%
TPD	67%	*86%*	*14%*	6%	27%
Trauma	86%	*85%*	*15%*	4%	10%
DII	84%	*95%*	*5%*	5%	11%
CCI	83%	*86%*	*14%*	10%	8%
Funeral	98%	*99%*	*1%*	0%	1%
Accident	91%	*79%*	*21%*	3%	6%

'Claims received' is the sum of: claims that were undetermined at the start of the reporting period; claims that were received during the reporting period; and claims that insurers re-opened (subsequent to being withdrawn) during the reporting period.
^ 'Claims Undetermined' refers to all claims that remain open for assessment at the end of the reporting period.

Table 6 summarises the claims outcomes by cover type, combining all distribution channels. The share of claims that are finalised during the reporting period varies considerably across the cover types. This is due in part to the relative complexity of assessing the claim: a TPD product generally takes longer than a Funeral claim, so a high share of Funeral claims are

[6] A list of contributing entities is provided in Attachment A.

[7] Refer to https://www.apra.gov.au/life-claims-data-collection.

finalised, whereas a relatively large share of TPD claims remains undetermined at the end of the reporting period.

The relatively lower admittance rate in respect cover types such as TPD, Trauma and Accident in part reflects the complexities of assessing these claims, as well as consumer clarity on what exactly is covered by the policy. Death and Funeral claims, on the other hand, are relatively straightforward to assess, which is reflected in their high admittance rate.

Compared to other cover types, CCI has a large share of withdrawn claims. The withdrawn reasons are provided in Table 10.

Table 7: Claims admittance rate by cover type and distribution channel

	Individual Advised		Individual Non-Advised		Group Super		Group Ordinary	
Cover type	Claims finalised	*% admitted*	Claims finalised	*% admitted*	Claims finalised	*% admitted*	Claims finalised	*% admitted*
Death	3,800	*97%*	1,321	*88%*	15,362	*98%*	184	*100%*
TPD	1,360	*85%*	56	*68%*	15,923	*86%*	52	*81%*
Trauma	4,617	*85%*	950	*84%*	n/a	*n/a*	17	*88%*
DII	12,601	*94%*	2,349	*83%*	20,663	*96%*	2,913	*95%*
CCI	n/a	*n/a*	9,490	*86%*	n/a	*n/a*	*	*
Funeral	n/a	*n/a*	11,708	*99%*	n/a	*n/a*	n/a	*n/a*
Accident	116	*16%*	3,260	*81%*	n/a	*n/a*	n/a	*n/a*

Table 7 summarises the claims admittance rate by cover type and distribution channel. While only Group Ordinary CCI is masked, several other combinations have a very small number of claims finalised in the reporting period: Individual Advised Accident (116 claims across the industry), Individual Non-Advised TPD (56 claims), Group Ordinary Death (184 claims), Group Ordinary TPD (52 claims) and Group Ordinary Trauma (17 claims). The agencies urge caution in interpreting the results for these combinations, as such a low volume of claims leads to more volatility in the reported admittance rates.

Table 8: Claims decline reasons by cover type (combines distribution channels)

Cover type	Contractual definition not met	Exclusion clause	Unintentional non-disclosure or mis-representation	Fraudulent claim	Other reasons
Death	54%	33%	7%	2%	5%
TPD	85%	7%	1%	0%	6%
Trauma	82%	10%	2%	1%	5%
DII	61%	19%	10%	1%	8%
CCI	71%	26%	1%	1%	2%
Funeral	12%	80%	0%	0%	8%
Accident	61%	31%	0%	0%	8%

Table 8 summarises the reasons provided by insurers for declining a claim, by cover type. With the exception of Funeral policies, the contractual definition not being met is the dominant cause for claims being declined. For Funeral policies, exclusion causes are the main decline reason.

Table 9: Claims withdrawn rate by cover type and distribution channel

Cover type	Individual Advised	Individual Non-Advised	Group Super	Group Ordinary
Death	4%	4%	2%	4%
TPD	11%	11%	5%	6%
Trauma	4%	4%	n/a	0%
DII	6%	7%	4%	2%
CCI	n/a	10%	n/a	*
Funeral	n/a	0%	n/a	n/a
Accident	4%	3%	n/a	n/a

Table 9 summarises the claims withdrawn rate by cover type and distribution channel. Withdrawal rates are relatively low across all cover type and distribution channel combinations, topping at 11 per cent for TPD (both Individual Advised and Non-Advised).

Table 10: Claims withdrawn reasons by cover type (combines distribution channels)

Cover type	Withdrawn by claimant	Withdrawn by insurer due to claimant inactivity	Other reasons
Death	46%	33%	21%
TPD	46%	46%	8%
Trauma	72%	18%	10%
DII	57%	37%	6%
CCI	31%	66%	3%
Funeral	14%	83%	2%
Accident	42%	46%	13%

Table 10 summarises the claims withdrawn reasons by cover type. For Death, Trauma and DII claims, most withdrawals were initiated by claimants. For CCI and Funeral claims, most withdrawals were initiated by the insurer due to claimant inactivity. This could be because the insurer did not receive any response from the claimant when further information was requested, as well as (for some cover types) instances where the insured has deceased subsequent to the claim being lodged and the claim is no longer relevant. Finally, there is a (close to) even split between claimant and insurer for TPD and Accident.

Claim frequency and claims paid ratio

Table 11: Claims frequency by cover type and distribution channel

Cover type	Individual Advised	Individual Non-Advised	Group Super	Group Ordinary
Death	0.18%	0.19%	0.12%	0.10%
TPD	0.11%	0.06%	0.12%	0.02%
Trauma	0.48%	0.26%	n/a	0.27%
DII	1.37%	1.68%	0.44%	0.65%
CCI	n/a	0.30%	n/a	*
Funeral	n/a	1.40%	n/a	n/a
Accident	0.12%	0.34%	n/a	n/a

Table 11 summarises the claims frequency by cover type and distribution channel. The claims frequency refers to the number of admitted claims as a proportion of average lives

insured. As reported in Table 7, certain combinations have a very small number of claims finalised in the reporting period. The same caveats regarding the interpretation of the results therefore apply here as well.

Table 12: Claims paid ratio^ by cover type and distribution channel

Cover type	Individual Advised	Individual Non-Advised	Group Super	Group Ordinary
Death	41%	28%	81%	70%
TPD	42%	26%	73%	30%
Trauma	61%	39%	n/a	68%
DII #	66%	72%	87%	56%
CCI	n/a	24%	n/a	*
Funeral	n/a	23%	n/a	n/a
Accident	26%	49%	n/a	n/a

^ The claims paid ratio is the dollar amount of claims paid out in the reporting period as a percentage of the annual premiums receivable in the same period.
# DII has recurring monthly payments. For the purposes of the reported claims ratio, total payments are approximated using an average 24-month payout period.

Table 12 provides the claims paid ratio by cover type and distribution channel. The agencies urge caution in interpreting this information as a measure of consumer value or product profitability. For insurers, claims payments are only one part of the costs associated with an insurance policy. Other costs, such as administration, acquisition costs and claims reserves, are not included. Whether and how profitable the product is to the insurer will depend in part on these factors.

Please note that the claims paid ratio reported in this publication is only a proxy of the loss ratio, which is normally determined using premiums paid in respect of a period and the cost of claims being incurred in that same period, regardless of when they are reported or finalised. For the claims paid ratio reported here, the premiums used are annualised premiums receivable rather than actual premiums received, and the claims used exclude the claims reserve as well as changes to the claims reserve. However, this is partially offset by the inclusion of claims from earlier periods.

In general, Individual products will have higher acquisition costs associated with the policy compared to Group products. As these costs will make up a larger proportion of the overall premium income, the claims payments will be a correspondingly lower percentage.

Across all distribution channels except Group Ordinary, DII business has the highest claims paid ratio, implying that the all-in costs of the products exceed premiums paid. This aligns with the material losses reported by the Australian life insurance industry from 2014 onwards

for the Individual DII product, and the observations made in APRA's thematic review into the sustainability of this product.[8]

Claims processing duration

Table 13: Claims processing duration by cover type (combines distribution channels)

Cover type	0-2 weeks	>2 weeks to 2 months	>2 months to 6 months	>6 months to 12 months	>12 months	Est. average duration (months)
Death	66%	19%	10%	3%	2%	1.8
TPD	15%	21%	36%	18%	10%	5.7
Trauma	39%	41%	15%	3%	1%	1.9
DII	41%	42%	13%	3%	1%	1.7
CCI	58%	30%	9%	2%	1%	1.4
Funeral	95%	4%	1%	0%	0%	0.6
Accident	81%	12%	4%	2%	1%	1.0

Table 13 summarises claims processing durations in respect of finalised claims. This is the period of time from when a claim is reported to when it is finalised. The table shows, for each cover type, the distribution of finalised claims across different duration categories, with the estimated average duration (in months) reported in the final column. TPD has the longest average claims processing duration, whereas Funeral insurance has the shortest, which reflects the respective complexity of these products. For Death, CCI, Funeral and Accident, the majority of claims are finalised within 0-2 weeks.

[8] Refer to *Seeking sustainability: challenges facing individual disability income insurance*, APRA Insight (2018), and the Quarterly Life Insurance Performance Statistics.

Dispute lodgement ratio

Table 14: Dispute lodgement ratio^ by cover type and distribution channel

Cover type	Individual Advised	Individual Non-Advised	Group Super	Group Ordinary
Death	6	13	1	4
TPD	28	71	14	51
Trauma	38	10	n/a	0
DII #	130	219	14	25
CCI	n/a	28	n/a	*
Funeral	n/a	3	n/a	n/a
Accident	24	10	n/a	n/a

^ The dispute lodgement ratio is the number of disputes lodged during the reporting period per 100,000 lives insured.

Table 14 provides the dispute lodgement ratio, which is defined as the number of disputes lodged per 100,000 lives insured. In this publication, a 'dispute' can refer to a dispute managed within the insurer's internal dispute resolution system, a dispute registered with an external dispute resolution scheme or tribunal, or legal proceedings initiated by the claimant against the insurer regarding a claim.

The dispute lodgement ratio is indicative of the likelihood of a claims-related dispute occurring. However, the agencies urge caution in interpreting this information. The dispute rate per finalised claim could be considered a more appropriate measure of the probability of a claims-related dispute. However, because both the numerator and denominator are very small, the resulting ratio would be very volatile, particularly at the entity level. Assuming that for a fixed number of lives insured the likelihood of a claim is broadly constant over time, using lives insured as the denominator creates a more stable ratio.

The agencies also note that disputes generally relate to old claims, and even older claim events; any insurer that has rapidly grown or shrunk its in-force book since then may report dispute lodgement ratios that significantly differ from the 'true' underlying experience. This is particularly likely for insurers in run-off and for the Group Super channel.

Table 14 shows that more complex products have higher dispute lodgement ratios. TPD and DII in particular show relatively high ratios. While DII shows higher ratios than TPD, it also has a higher claims frequency (Table 11). Comparing distribution channels, the Individual Non-Advised channel generally shows higher dispute ratios.

Disputes outcomes

Table 15: Disputes outcomes by cover type (combines distribution channels)

	Disputes Resolved	*Original decision maintained*	*Original decision reversed*	*Other outcomes*	Disputes Withdrawn	Disputes Undetermined ^
Cover type	% of lodged#	*% of resolved*	*% of resolved*	*% of resolved*	% of lodged	% of lodged
Death	73%	*33%*	*12%*	*55%*	5%	22%
TPD	65%	*32%*	*10%*	*57%*	3%	33%
Trauma	79%	*50%*	*12%*	*38%*	4%	17%
DII	76%	*34%*	*10%*	*56%*	5%	19%
CCI	93%	*6%*	*5%*	*89%*	0%	3%
Funeral	82%	*26%*	*22%*	*52%*	7%	11%
Accident	85%	*33%*	*11%*	*56%*	1%	13%

'Disputes lodged' refers to disputes that were undetermined at the start of the reporting period; disputes that were received during the reporting period; and disputes that insurers re-opened (subsequent to being withdrawn) during the reporting period.
^ 'Disputes Undetermined' refers to all disputes that remain open for assessment at the end of the reporting period.

Table 15 summarises disputes outcomes by cover type. It includes all claims-related disputes in the data collection, whether they are internal, external or litigated. Apart from Trauma, most disputes are resolved by other means. These include, but are not limited to, those resolved through ex-gratia payment, premium refund, partial payment, settlement or non-cash benefit and resolved outside jurisdiction (the latter for external disputes only). CCI has the highest proportion of disputes resolved by other outcomes. The highest rate of claim reversal decisions is in relation to Funeral at 22 per cent, albeit with a low number of total disputes resolved (23 – shown in the entity-level publication).

As the number of claims-related disputes will be a fraction of the number of claims, it follows that there is only a relatively small sample of disputes. A total of 4,521 disputes were resolved during the reporting period. TPD and DII make up the vast majority of disputes, representing 31 per cent and 38 per cent of the total, respectively. Two products in particular have a small number of disputes resolved: Funeral (23 disputes) and Accident (70 disputes).

Table 16: Original decision reversed reasons by cover type (combines distribution channels)

Cover type	Original outcome incorrect	Additional information received	Other reasons
Death	27%	46%	27%
TPD	36%	54%	10%
Trauma	54%	34%	11%
DII	40%	47%	13%
CCI	5%	49%	46%
Funeral	40%	40%	20%
Accident	0%	75%	25%

Table 16 summarises original decision reversed reasons by cover type. Claims outcomes were mainly reversed due to additional information being received. The main exception is Trauma policies, where outcomes were primarily changed due to the original outcome having been determined to be incorrect.

Table 17: Dispute withdrawn reasons by cover type (combines distribution channels)

Cover type	Withdrawn by claimant	Withdrawn by insurer due to claimant inactivity	Withdrawn by EDR, court or tribunal	Other reasons
Death	40%	27%	20%	13%
TPD	65%	27%	4%	4%
Trauma	64%	18%	0%	18%
DII	65%	19%	10%	5%
CCI	100%	0%	0%	0%
Funeral	50%	0%	50%	0%
Accident	0%	100%	0%	0%

Table 17 summarises disputes withdrawn reasons by cover type. Note that during the reporting period, 198 disputes in total were withdrawn across all cover types; the reported results will therefore be subject to significant margins of error. Possible exceptions are DII (103 disputes withdrawn) and TPD (57 disputes). At the other extreme, CCI, Funeral and Accident have 7 withdrawn disputes between them.

Disputes processing duration

Table 18: Disputes processing duration by cover type (combines distribution channels)

Cover type	0-45 days	>45 days to 90 days	>90 days	Est. average duration (months)
Death	65%	13%	21%	4.0
TPD	42%	10%	48%	6.1
Trauma	67%	19%	14%	2.1
DII	72%	10%	18%	2.7
CCI	92%	5%	4%	1.1
Funeral	88%	8%	4%	1.0
Accident	79%	6%	16%	2.5

Table 18 summarises disputes processing duration by cover type. The majority of disputes were resolved in 0-45 days. TPD has the longest estimated average disputes processing duration at roughly six months, reflecting the product's complexity, whereas CCI and Funeral disputes tend to have significantly shorter processing durations.

Attachment A – List of insurers

The following entities have submitted data for this statistical publication:

Life insurer or Friendly Society	Short name
AIA Australia Limited	AIAA
Allianz Australia Life Insurance Limited	Allianz
AMP Life Limited	AMP
ClearView Life Assurance Limited	ClearView
The Colonial Mutual Life Assurance Society Limited	CMLA
Hallmark Life Insurance Company Ltd	Hallmark
Hannover Life Re of Australasia Ltd	Hannover Re
H C F Life Insurance Company Pty Ltd	HCF
MetLife Insurance Limited	MetLife
MLC Limited	MLC
NobleOak Life Limited	NobleOak
OnePath Life Limited	OnePath
QBE Life (Australia) Limited / Integrity Life Australia Limited *	QBE / Integrity
QInsure Limited	QInsure
St Andrew's Life Insurance Pty Ltd	St Andrews
Suncorp Life & Superannuation Limited / Asteron Life & Superannuation Limited ^	Suncorp / Asteron
Swiss Re Life & Health Australia Limited	Swiss Re
TAL Life Limited	TAL
Westpac Life Insurance Services Limited #	Westpac
Zurich Australia Limited	Zurich

* Integrity Group Holdings acquired QBE Life (Australia) Limited in December 2017, and renamed it Integrity Life Australia Limited.
^ Suncorp Life & Superannuation Limited was renamed Asteron Life & Superannuation Limited in February 2019.
# St. George Life Limited's business was transferred to Westpac Life Insurance Services Limited in September 2018. For the purposes of this publication, St. George's data is combined with Westpac's.

Attachment B – Policy statistics

Table B.1 provides, for each cover type and distribution channel, the key characteristics of the Australian direct life insurance market: lives insured, annual premium volume, sum insured, new business written and lapse rate.

Table B.1: Policy statistics by cover type and distribution channel

	Death	TPD	Trauma	DII ^	CCI	Funeral	Accident
Individual Advised							
Lives insured ('000)	2,070	1,216	842	946	n/a	n/a	16
Annual premium ($ million)	3,186	1,218	1,365	2,581	n/a	n/a	6
Sum insured ($ million)	1,303,079	768,515	213,450	6,312	n/a	n/a	6,441
New business #	6%	9%	7%	9%	n/a	n/a	14%
Lapse rate #	15%	15%	15%	13%	n/a	n/a	11%
Individual Non-Advised							
Lives insured ('000)	612	50	332	121	2,972	885	815
Annual premium ($ million)	625	28	72	169	369	492	114
Sum insured ($ million)	225,650	17,317	15,992	560	60,688	8,273	79,545
New business #	17%	26%	20%	26%	19%	23%	14%
Lapse rate #	14%	13%	15%	22%	23%	9%	13%
Group Super							
Lives insured ('000)	13,059	11,968	n/a	4,974	n/a	n/a	n/a
Annual premium ($ million)	2,486	2,235	n/a	1,788	n/a	n/a	n/a
Sum insured ($ million)	2,595,465	2,037,677	n/a	17,413	n/a	n/a	n/a
New business #	11%	8%	n/a	12%	n/a	n/a	n/a
Lapse rate #	14%	7%	n/a	13%	n/a	n/a	n/a

	Death	TPD	Trauma	DII ^	CCI	Funeral	Accident
Group Ordinary							
Lives insured ('000)	185	239	5	459	101	n/a	n/a
Annual premium ($ million)	46	24	2	422	4	n/a	n/a
Sum insured ($ million)	33,414	21,156	278	3,174	1,023	n/a	n/a
New business #	16%	15%	58%	13%	0%	n/a	n/a
Lapse rate #	19%	14%	91%	6%	0%	n/a	n/a

New business and the lapse rate are as a percentage of average annual premiums.
^ DII sum insured is expressed as a monthly benefit.

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