EDR Response Guide

Superannuation declined insurance claims

This guide assists financial firms to prepare a quality external dispute resolution (EDR) response for complaints about superannuation declined insurance claims. This is a **guide only** and may change over time to reflect feedback.

It is important to note the following:

* All issues raised in a complaint should be addressed. If there are multiple issues, please refer to the additional EDR response guides available or consider addressing them in a separate section.
* This is your EDR response. As such, it is to be sent to both AFCA and the other parties. It benefits all parties to the complaint to understand the reason for your position.
* AFCA will generally seek more information if a complaint does not resolve at Registration & Referral. AFCA still expects a response to any subsequent requests for information.

To ensure a comprehensive response for complaints about the decline of an insurance benefit, an EDR response should include the sections outlined below.

### Complaint summary

|  |
| --- |
| Complaint details |
| Trustee name |  |
| Insurer name |  |
| Financial firm reference(s) |  |
| Complainant name |  |
| AFCA reference |  |

## Policy Summary

|  |
| --- |
| Policy Details |
| Life insured |  |
| Policy number |  |
| Policy type |  |
| Cover type |  |
| Category#  |  |
| Sum insured |  |
| Policy commencement date |  |
| Policy end date |  |

##

# Detail the policy category applicable to the complainant e.g. employer category and any schedules or parts of the policy that apply.

## Complainant’s position

Outline your understanding of the complainant’s position.

Include necessary background information including (but not limited to):

* claim amount
* any payments made to the insured.

## Financial firm’s position

Briefly outline your position on each of the complainant’s issues.

If you have taken steps to attempt to resolve, include details e.g. the financial firm provided a response to the complainant, offering to [ ]. The complainant rejected the offer and said [ ].

## Financial firm’s reasons for position

Outline how you have considered all the issues raised in the complaint and set out the financial firm’s reasons for its position, noting what information you have considered to reach this view. It is important you consider your obligations and whether you have met them.

In relation to denial of claim complaints, AFCA will generally consider if:

* the complainant satisfies the required terms and definitions of the policy
* the decisions of the trustee and insurer are fair and reasonable.

## Jurisdictional issues?

Include the details of any jurisdictional issues you wish to raise. Ensure you refer to the AFCA Operational Guidelines and the Transitional Superannuation Guide and any relevant Approach documents.

Full details of the section of the AFCA Rules must be included to ensure that AFCA and the other parties understand the jurisdictional issue(s) being raised.

## Proposals to resolve the complaint

Set out any action you are willing to take to resolve the complaint, including whether you are open to any offers from the complainant.

If you require further information before you can offer a resolution, please provide details of what information is required.

## Supporting information relevant to a trustee

Provide a list of all the supporting information provided. In relation to a complaint about the denial of a claim, the following information is usually required from trustees:

* your IDR response
* the date the complainant joined the fund
* a copy of the membership application form completed by the complainant
* a copy of any application for insurance made by the complainant
* the complainant’s category of fund membership, including whether the complainant is a MySuper member
* a copy of the PDS given to the complainant, including applicable Incorporated By Reference documents
* a chronology of the trustee’s engagement with the complainant and the insurer throughout the claims process
* copies of any SENs given to the complainant since joining the fund
* copy of the welcome letter sent to the complainant upon joining the fund
* executed copy of the Trust Deed in force at the date of disablement. Specify the provisions relevant to the decision (this should include provisions in Parts/Schedules of the deed applicable to the complainant’s membership category)
* details of relevant legislation relied upon by the trustee in making its decision
* the amount of the benefit. Provide copies of annual statements or system screenshots to show evidence of this
* evidence supporting the trustee’s decision. This may include:
	+ minutes of a trustee committee meeting showing the trustee dis/agreed with the decision of the insurer
	+ documentation e.g. a claims report prepared for the trustee for the purpose of making its decision
* copy of the trustee’s decline letter
* copy of any correspondence between the trustee and insurer relevant to the claim
* copy of any correspondence with the complainant in relation to this claim
* detailed reasons for the trustee’s decision.

Further information regarding AFCA’s expectation of the correct Trust Deed can be found [here](https://www.afca.org.au/media/1219/download).

Additionally, if a complainant disputes receiving a copy of relevant evidence relied on by the trustee, AFCA will expect the trustee to prove despatch of that document. Further guidance in relation to proving despatch can be found [here](https://www.afca.org.au/media/930/download).

## Supporting information relevant to an insurer

Provide a list of all the supporting information provided. In relation to a complaint about the denial of a claim, the following information is usually required from an insurer:

* relevant correspondence, including any procedural fairness, decline or review letters
* chronology of claim assessment process (including payment of benefits)
* a copy of the signed policy in force as at the date of disablement (including endorsements). Please advise the effective policy date
* the policy membership category for the complainant
* clearly outline the policy provisions or clauses you are relying upon and the reasons why, including any specific to the complainant’s policy category
* initial and progress claim forms including initial supporting evidence
* all medical information obtained for the assessment of the claim (including letters of instruction from the insurer to any consultant specialists)
* reports (factual report, occupational/ rehab reports, and financial) and any other evidence relied on in support of your decision
* details of legislative provisions considered when deciding to deny the claim
* other relevant information relied on to deny the claim, including whether and why the insurer is seeking to avoid cover.

If other issues are raised, we offer a range of resources in the member resources section of the Member Portal. These include other EDR response guides, specific complaint topic guides and the Complaint Information Documentation guide.