QFCI

Date: 11/11/11 JM

Exhibit Number: 1026

STATEMENT OF MARK STEPHEN RICHARDS IN RESPONSE TO REQUIREMENT TO PROVIDE INFORMATION ISSUED TO SUNCORP INSURANCE DATED 2 NOVEMBER 2011

MARK STEPHEN RICHARDS, c/- Suncorp, Level 31, 266 George Street, Brisbane, states on oath:

1. I am the Executive Manager, Internal Dispute Resolution for the general insurance brands of the Suncorp Group.

2. I have authority on behalf of AAMI to respond to the Requirement to Provide Information issued by the Commission of Inquiry dated 2 November 2011 and addressed to the Suncorp Group.

3. My formal qualifications are a Bachelor of Economics (1974) and Bachelor of Laws (1976). I was admitted to practice as a Barrister & Solicitor of the Supreme Court of Victoria in 1978. Between 1978 and 2003 I was employed as a solicitor in private practice, mainly engaged with insurance and other litigation and conducted my own legal practice for 15 years in that area. In 2004, I joined AAMI as a Dispute Resolution Officer (then called a Deputy Customer Ombudsman). At the start of 2006, I took on the role of AAMI Customer Ombudsman, which involved overall management of the internal and external dispute resolution process for AAMI. In February 2010, I was appointed Executive Manager Internal Dispute Resolution for the general insurance brands of the Suncorp Group and in that role have responsibility for management of the internal dispute resolution process for those brands.

4. I have had previous experience dealing with flood claims, both in private practice as a solicitor and whilst employed at AAMI and the Suncorp Group. Following a number of flood claims in north east New South Wales in 2008, I prepared a guide for dealing with flood claims setting out the legal principles, the evidence required and Financial Ombudsman Service requirements.

5. This response relates to information received by the Queensland Flood Commission of Inquiry in respect of the following matters.

Question 1: Were timeframes taken into account in deciding the outcome of claims at either the initial claim stage or on internal review?

6. Timeframes were not a factor in deciding the outcome of claims, either at the initial claim stage or on internal review. Timeframes were a factor in determining, in some cases, what form of evidence to seek (eg the use of area hydrology reports or site specific hydrology reports) but did not influence claim outcomes. If the evidence obtained was not sufficient to determine the claim, and it was considered that further evidence would enable a decision to be made, that further evidence was sought.

   a. **If yes, in what way? Please provide a copy of any directions given to**

staff about how timeframes were to be taken into account in determining claims.

b. **If no (and you are able to), please provide an explanation with respect to Mr Hazell's reason (ii) above as to why Mr Laszlo's submission was not given to WRM.**

7. Under section 6.6 the General Insurance Code of Practice (the Code) an internal review is required to be completed within 15 business days provided the insurer receives all necessary information and has completed any investigation required.

8. Under section 6.7 where further information, assessment or investigation is required, the insurer is obliged to agree reasonable alternative timeframes with the customer and if agreement cannot be reached the customer can report their concerns to the Financial Ombudsman Service (FOS).

9. Under section 6.10 of the Code if an insurer is not able to resolve a customer's complaint to their satisfaction within 45 days an insurer is required to inform the customer of the reasons for the delay and that the complaint may be taken to the insurer's External Dispute resolution scheme (in AAMI's case the FOS).

10. These timeframe requirements are set out in the Consumer Appeals Service Operating Guidelines and Terms of Reference (CAS TOR) which Dispute Resolution Officers are required to follow. A copy of the CAS TOR is attached as **Annexure 1**.

11. Staff dealing with disputes in relation to flood claims were advised that the timeframes set out in the Code and the CAS TOR had to be complied with where possible.

12. Both the Code and the CAS TOR contain processes for extending the timeframe required to fully investigate complaints. These processes were used in cases where it became clear that the ordinary timeframes could not be complied with because of the need to gather further or additional evidence.

13. We were aware that:

    a. Customers wanted decisions made quickly, particularly in the IDR process given they had already had to wait for initial assessment, hydrology and other process during the initial claim determination process.

    b. Obtaining hydrologist reports would typically take 6-8 weeks, therefore seeking a further report from a hydrologist would delay the final decision by up to two months.

    c. We were mindful of the risk of raising the customer's expectations of a favourable outcome, and therefore took the view that a balance had to be struck, ie, that such a delay was only fair to the customer when the information available to the DRO indicated that further hydrology had reasonable prospects of resulting in a different claim decision.

14. In some cases, the DRO formed the view on reviewing the claim material and any further material from the customer, that the evidence of the hydrologist was less compelling than other evidence suggesting the cause of the inundation was stormwater runoff or escape of water from drains. In those cases, we overturned the decision to deny the claim, without seeking a further hydrology report. For example, there were a number of cases where we overturned decisions based on our view that the inundation was caused by water escaping as a result of backflow from drains, notwithstanding that the claims had been rejected on the basis of hydrology reports that indicated the inundation had been caused by riverine flooding.

15. In some cases, the DRO determined that further hydrology was warranted, for example because the customer had produced new evidence at review which had not been available at claim determination and which raised a real prospect of a hydrologist forming a different view if given that evidence.

16. In other cases, the DRO took the view that the evidence of riverine flooding was strong, and that obtaining further hydrology evidence was unlikely to change that position. For example, in some cases, customers provided a submission or comments which the DRO considered did not constitute 'new' information, or which was not of a kind likely to change the opinion of the hydrologist. In those cases, we believed that the fairer outcome was to provide the final decision, rather than negotiate a 6 to 8 week delay in providing a final decision, thereby raising the customer's expectations in a situation where we believed the outcome would be the same.

17. My understanding is that Mr Hazell followed this process, and that on review of the material available to him he formed the view that the material in Mr Laszlo's submission was unlikely to result in WRM changing its view, and that the evidence available to Mr Hazell was strong enough to determine the review, therefore the delay of six to eight weeks to get a further opinion from WRM was not justified. Details of the material available to Mr Hazell and his review process are outlined in Mr Hazell's statement.

18. To date we have conducted internal reviews for 184 AAMI home claims involving rejection of the claim. We maintained the decision in 158 claims, overturned the decision in 12 claims, 5 reviews were withdrawn and 9 reviews remain open. We have also conducted 5 reviews where the sole issue in dispute was service and 7 disputes where the issues were in relation to settlement.

Question 2: What other matters beyond facts going to whether the claims fell inside or outside of the policy, if any, were taken into account in determining the outcome of a claim during the policy, if any, were taken into account in determining the outcome of a claim during the Queensland floods? If such other factors were taken into account, please provide a copy of all directions outlining these other factors.

19. The CAS TOR provide that in making a final decision a dispute resolution officer must have regard to only the following:

    a. All material contained on the file including claim and policy messages, investigation reports, assessment reports, correspondence and information supplied by the

consumer.

b. The terms of the relevant policy of insurance.

c. The Code.

d. The FOS Terms of Reference.

e. Relevant legislation including the Insurance Contracts Act, the Privacy Act, case law and legal principles.

f. What is fair and reasonable in all the circumstances and good insurance practice.

g. Previous FOS determinations.

h. Whether it is appropriate to convene a conciliation meeting to resolve the dispute, giving the consumer the opportunity to be heard by management.

20. No other matters were taken into account during an internal review in determining the outcome of a claim during the Queensland floods.

Sworn by the Deponent)
)
At Melbourne)
)
This 8th day of)
November 2011)

.....
Mark Stephen Richards

Before me

.....
Solicitor

MARTIN IMOSA
15 William Street Melbourne Vic 3000
An Australian Legal Practitioner
(within the meaning of the Legal
Profession Act 2004).

Annexure 1

CONSUMER APPEALS SERVICE

Operating Guidelines and Terms of Reference

Revised 1 January 2011

Introduction

1. Background

The Consumer Appeals Service ("CAS"), formerly known as AAMI Consumer Appeals Service and before that the Consumer Affairs department, commenced operating in January 1996.

The Consumer Affairs department was formed to comply with requirement for an internal dispute resolution process in the original self regulatory General Code of Practice which became fully operational on 1 July 1996. The original code has been reviewed twice and replaced by a revised General Insurance Code of Practice ("the Code"), which became operational on 1 May 2010.

The Code sets minimum standards for buying insurance, claims handling, responding to catastrophes and disasters, information and education and complaints handling procedures. The Code requires all insurers to have internal dispute resolution procedures and to subscribe to the independent external resolution scheme administered by the Financial Ombudsman Service ("the FOS")[1].

The original code of practice was introduced in a response to inappropriate selling behaviour in the life insurance industry as well as general dissatisfaction amongst consumers about their inability to enforce rights enshrined in the Insurance Contracts Act 1984[2]. For many years the only redress for consumers dissatisfied with decisions regarding their claims, was lengthy and costly legal proceedings.

CAS is the internal dispute resolution service for the insurers set out in the definitions section in paragraph 2.

CAS is also carries out the internal dispute resolution process under the Motor Vehicle Insurance & Repair Industry Code of Conduct.

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[1] Chapter 6 of the Code. It is also now a condition of an insurer's licence under the Corporations Act that it have internal dispute resolution processes and subscribe to an external dispute resolution scheme.

[2] In 1976 the Australian Law Reform Commission (ALRC) was given a reference to review the adequacy and appropriateness of the law of insurance contracts. The ALRC's final report was released in 1982 and made a number of recommendations towards improving consumer protection. The Insurance Contracts Act 1984 substantially implemented the Commission's recommendations. For many years the only redress for customers dissatisfied with decisions regarding their claims, was lengthy and costly legal proceedings. In response to pressure for an alternative dispute resolution scheme, the Insurance Council of Australia voluntarily introduced the Claims Review Panel in 1991. The independence and authority of the alternative dispute resolution scheme was reinforced with the establishment of the Insurance Ombudsman Service.

2. Definitions

2.1 **Complaint** is an expression of dissatisfaction made to an organisation, related to its products or services, or the complaints handling process itself, where a response or resolution is explicitly or implicitly expected.

2.2 **Consumer** means a customer or prospective customer of the Insurer or an uninsured third party making a claim against an Insurer as set out in paragraph 5.2 or a third party against whom the Insurer is seeking recovery of a debt or damages.

2.3 **Dispute** means an unresolved complaint.

2.4 **Dispute Resolution Officer** means a CAS decision maker (formerly known as a Customer Ombudsman) acting with the authority of the Insurer to make binding decisions on the Insurer in accordance with these operating guidelines and terms of reference.

2.5 The **FOS** means the Financial Ombudsman Service Limited.

2.6 **The Insurer** means Australian Motor Insurers Limited ("AAMI"), Just Car Insurance Agency Pty Ltd ("Just Car"), AAMI Business Insurance ("AAMI Business"), Bingle, Apia, Shannons, InsureMyRide ("IMR") and CIL.

2.7 **Nominated decision maker** means a decision maker nominated by the Insurer to make final decisions on behalf of the Insurer capable of review by CAS

2.8 **RG165** means the Australian Securities & Investment Commission Regulatory Guide 165 - Licensing: Internal and external dispute resolution. **Aequitas** means the Aequitas complaints recording and tracking system.

2.9 The **Dispute Resolution Process** is the Insurer's dispute resolution process as set out in Appendix A.

3. The role of CAS

Dispute Function

CAS will:

3.1 Conduct reviews in a fair, transparent and timely manner.

3.2 Only ask for and take into account relevant information and make decisions, which are consistent, fair and in accordance with all governing statutory regulations and legislation.[3]

3.3 Ensure decisions are made in accordance with the Dispute Resolution Process and the Code.

3.4 Ensure decisions are made by a Dispute Resolution Officer within 15 business days of receiving notification of the dispute, provided it receives all necessary information and has completed any necessary investigation required.[4]

3.5 In cases where further information, assessment or investigation is required, agree reasonable alternative timeframes with the consumer.

3.6 In cases where it is unable to provide a decision within 15 business days keep the customer informed of the progress of its review at least every 10 business days.

3.7 Provide detailed reasons for decisions written in plain language and information about how to access available external dispute resolution schemes and the timeframes for doing so.

3.8 Comply with relevant promises in the Insurer's Customer

[3] Insurance Contracts Act 1984, Insurance Contracts Regulations 1985, General Insurance Code of Practice

[4] General Insurance Code of Practice 6.6 (c)

Charter (or other such document).

3.9 Where possible ensure decisions are made within 45 calendar days of the receipt of the complaint as required by RG 165 and in cases where the complaint or dispute cannot be resolved to the satisfaction of the consumer within 45 days, inform the consumer, before the end of the 45-day period, of the reasons for the delay and that they may take the complaint or dispute to the FOS, even if CAS is still considering it (and provided the complaint or dispute is within the scheme's Terms of Reference) and inform the consumer of the details of the FOS.

Conciliation Function

In order to facilitate the timely resolution of a complaint between a consumer and the Insurer, CAS where appropriate will:

3.10 Conciliate informally between the consumer, the Insurer and any other relevant parties.

3.11 Promote disclosure of relevant information to consumers.

3.12 Encourage the early conciliation and resolution of disputes, reducing the possibility of matters being elevated to the FOS, tribunals and courts.

Education Function

CAS will:

3.13 Facilitate the education of staff about the legislative and regulatory framework including the Insurance Contracts Act, the Corporations Act, RG 165, the Privacy Act and the Code.

3.14 Promote consumer understanding about the role and procedures of insurance companies and dispute resolution.

3.15 Act as an internal 'clearing house' for information and guidance on:

(a) Policy interpretation
(b) Legislation and case law
(c) FOS determinations
(d) Emerging policy issues
(e) Privacy

3.16 Maintain a register summarising the Insurer's interpretation of their contracts with customers including the historical and legal context for current operational procedures and policy intent.

3.17 In consultation with the Insurer liaise with industry, media and consumer groups about the role of CAS.

3.18 Contribute to public discussion and debate on matters of public interest relating to broad matters of consumer interest and dispute resolution.

3.19 Research and develop papers on consumer issues in insurance law as identified by casework and at request of senior management.

3.20 Attend and participate at industry conferences to enable exchange of policy considerations in the consumer interest.

Who can appeal to CAS?

4. CAS can determine disputes at the request of[5]:

4.1 The Insurer's policyholders.[6]
4.2 Uninsured third parties who have a claim against the Insurer pursuant to the liability section of a motor car insurance policy.[7]
4.3 Third parties against whom the Insurer seek recovery.
4.4 Repairers as defined in the Motor Vehicle Insurance & Repair Industry Code of Conduct.

What is outside the CAS Guidelines?

5. CAS will not determine the following disputes[8]:

5.1 Compulsory third party motor vehicle insurance policyholders[9].
5.2 A claim by an uninsured third party where the Insurer's policyholder has not lodged a claim on their policy and/or paid any relevant excess.
5.3 A claim against the Insurer by a third party under the liability section of an insurance policy other than a motor car insurance policy.
5.4 Industrial disputes involving the Insurer's staff.

Is there a monetary limit?

6. CAS

CAS can make a determination in relation to a dispute regardless of the amount of the claim.

7. FOS

7.1 The FOS can only deal with claims for consumers not exceeding $500,000.
7.2 The FOS can only make determinations not exceeding $280,000 or not exceeding $3,000 for uninsured third party claims.

What types of disputes can CAS review?

8. Types of disputes:

8.1 A dispute in relation to a claim including[10]:
- 8.1.1 Interpretation or application of the policy.
- 8.1.2 Liability under the policy.
- 8.1.3 Amount of a claim.
- 8.1.4 Delay in payment.
- 8.1.5 Denial of a claim.

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[5] General Code of Practice
[6] Any reference to a 'policyholder' includes customers with interim cover provided by cover notes, prospective policyholders and those whose policy is alleged to have lapsed.
[7] Provided the Insurer's customer has made a claim on their policy.
[8] FOS Terms of Reference
[9] The Insurer's have established their own internal dispute resolution process to review CTP disputes.
[10] FOS Terms of Reference

8.1.6 Whether or not an excess is payable.
8.1.7 Quality or timeliness of repairs or replacement.
8.1.8 General dissatisfaction with the claims process.
8.1.9 Recovery of costs from an insured where a claim is denied.
8.1.10 Failure to agree an alternative timeframe for providing a decision in relation to a claim where further information, assessment or investigation of a claim is required.
8.1.11 Refusal to release information and reports relied on in assessing a claim.
8.1.12 A customer's request for fast-tracking of the assessment or decision process of a claim and/or an advance payment to alleviate financial hardship.
8.1.13 Settlement of claims as a result of a catastrophe or disaster where the customer seeks review of the claim on the basis that the assessment of the loss was not complete or accurate.

8.2 A dispute in relation to compliance with underwriting guidelines including:
8.2.1 Whether an endorsement placed on a policy has been correctly applied pursuant to the underwriting guidelines.
8.2.2 Whether an additional excess is payable by a customer in accordance with the underwriting guidelines.

8.3 A dispute in relation to a policy including the cancellation of a policy.
8.4 A dispute in relation to a refusal to provide insurance cover.
8.5 An alleged breach of privacy.
8.6 An alleged breach of the Insurer's Customer Charter.
8.5 A dispute in relation a claim made by a third party against the Insurer.
8.6 A dispute in relation to a claim made by the Insurer against a third party for recovery of a debt including the failure to reach an agreement with a third party about repayment of a debt.
8.7 Complaints relating to or received by the Insurer's service providers whilst acting on the Insurer's behalf.
8.8 A dispute arising under the Motor Vehicle Insurance & Repair Industry Code of Conduct.

What is the procedure for handling disputes?

9. A final decision is required to be made by a nominated decision maker before CAS will review a matter

9.1 CAS will not make a determination in relation to a dispute if the consumer has not either:
9.1.1 received a letter confirming the final decision at operational level from a nominated decision maker containing the following paragraph:
"If you are not satisfied with our response, you are entitled to have it reviewed at no cost to you by our

Consumer Appeals Service, which will respond to you within 5 working days of receiving your phone call, letter or email. The Consumer Appeals Service is independent of this department and its Dispute Resolution Officers have the appropriate experience, knowledge and authority to carry out a review. Your participation in this review process does not affect or compromise your entitlement to seek remedies elsewhere or to issue legal proceedings. Should you wish to exercise this right please write to The Consumer Appeals Service, PO Box 14180, Melbourne City Mail Centre, VIC, 8001, or facsimile (03) 9529 1214 or telephone 1300 130 794 (M-F, 9-5EST) or email to consumerappeals@aami.com.au"; or

9.1.2 been advised by telephone of the nominated decision maker's final decision in relation to a complaint.

9.2 CAS will review a dispute if specifically requested to do so by a nominated decision maker.

9.3 CAS will follow the process set out in Appendix B for reviewing disputes under the Motor Vehicle Insurance & Repair Industry Code of Conduct.

10. Previous determinations

CAS will not review a dispute, if CAS has previously made a determination in a dispute in respect of the same subject matter, unless the consumer is able to show that significant new evidence has become available since the previous dispute was determined.

What happens when a consumer requests CAS to review a decision?

11. CAS will:

11.1 Review messages on the claim or policy to determine if a final decision has been made by a state nominated decision maker in accordance with the Dispute Resolution Process.

11.2 If a final decision has not been made, contact the decision maker and request that the complaint be reviewed and a final decision conveyed to the consumer within any applicable timeframes.

11.3 Record the matter on the referral back to the nominated decision maker tracking sheet and review the tracking sheet on a daily basis to ensure any applicable timeframes are being adhered to.

11.4 If or once a final decision has been made contact the relevant department and request the file be sent to CAS within one working day.

11.5 Enter the dispute in Aequitas.

11.6 Within 1 business day allocate the dispute to a Dispute Resolution Officer.

11.7 On the day of the file is allocated the Dispute Resolution Officer must contact the consumer by telephone, email or

letter and advise they will be the person who the consumer will liaise with regarding the dispute and provide their contact details.

11.8 Record in Aequitas the date which is 15 business days from the date of receiving notification of the dispute by which date a decision must be provided or the consumer contacted to negotiate a reasonable alternative timeframe.

11.9 Note the date the complaint was first received at the Insurer and the date 42 calendar days after that date.

11.10 In cases where CAS are unable to provide a decision within 15 business days CAS will:

11.10.1 Contact the consumer and attempt to negotiate a reasonable alternative timeframe with the consumer and in the event of being unable to agree on an alternative timeframe advise the consumer of the right to report their concerns to the FOS.

11.10.2 Update Aequitas with the date upon which the consumer was last contacted.

11.10.3 Record the date agreed upon for the alternative timeframe.

11.10.4 Record the date 10 business days from the date of last contact (including the date of last contact) by which date the consumer is to be provided with an update.

11.10.5 Keep the consumer informed of the progress of our review of the dispute at least every 10 business days (calculated by including the commencement day as one of the 10 business days).

11.11 In cases where a final IDR decision has not been made by day 42, for whatever reason, and it appears it will not be able to be made by day 45, the Dispute Resolution Officer must notify the consumer, prior to the expiration of 45 calendar days, of the reasons for the delay and of the right to take the complaint to FOS and provide FOS contact details.

12. CAS Dispute Resolution Officers will:

12.1 Be the first point of contact for consumers via the CAS 1300 number and take details of the dispute, advise the consumer of the process of reviewing the dispute and arrange for the dispute to be processed in accordance with paragraph 11.

12.2 Request any additional information required to make a decision from the nominated decision maker.

12.3 Make a final decision.

12.4 Ensure all material in support of a decision is provided to the insured unless legal professional privilege applies or special circumstances exist as defined by the Code or the FOS.[11]

12.5 Give nominated decision makers the opportunity to elaborate on the reasons for their decisions.

12.6 Liaise with the FOS where appropriate.

[11] FOS Terms of Reference and the Code

12.7 Not participate in making a final decision if he or she has a conflict of interest in the dispute.
12.8 Request recovery proceedings against consumers not commence or continue pending a CAS decision.
12.9 Ensure a final decision is made within applicable timeframes.

13. What will be considered by an Dispute Resolution Officer?

In making a final decision a Dispute Resolution Officer will have regard to the following:

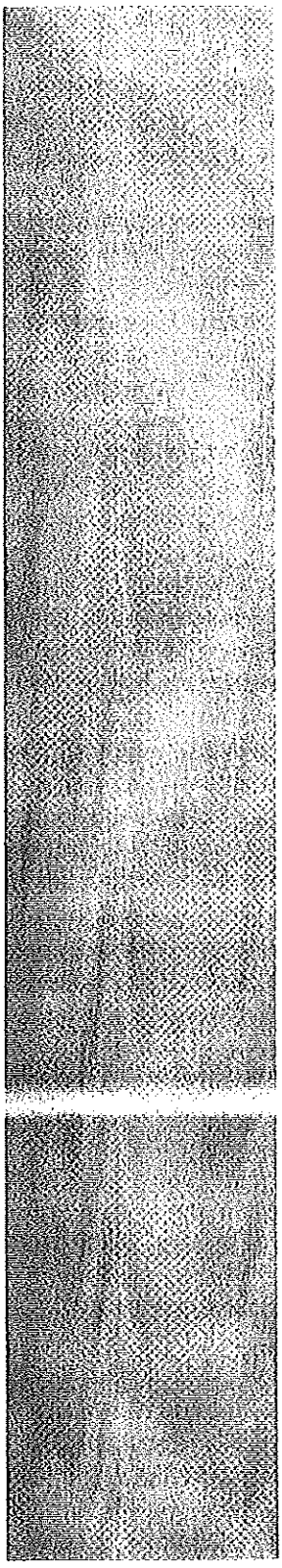
13.1 All material contained on the file including claim and policy messages, investigation reports, assessment reports, correspondence and information supplied by the consumer.
13.2 The terms of the relevant policy of insurance.
13.3 The Code.
13.4 The FOS Terms of Reference.
13.5 Relevant legislation including the Insurance Contracts Act , the Privacy Act, case law and legal principles.
13.6 What is fair and reasonable in all the circumstances and good insurance practice[12].
13.7 Previous FOS determinations.
13.8 Whether it is appropriate to convene a conciliation meeting to resolve the dispute, giving the consumer the opportunity to be heard by management.

14. How will a Dispute Resolution Officer resolve a dispute?

A Dispute Resolution Officer will resolve a dispute by deciding one or more of the following:

14.1 Whether or not a customer is entitled to be indemnified under the terms of the policy and the extent of that indemnity.
14.2 Whether or not the Insurer is liable to pay an amount of money to the consumer or is liable to repair or replace any item of property or is otherwise required to do something pursuant to the policy.
14.3 Whether or not interest is payable or the consumer be otherwise compensated for a delay in payment or a delay in having repairs or replacement effected.[13]
14.4 The amount of the loss or value of property damaged, lost or destroyed.
14.5 Whether or not the quality of repairs is satisfactory and whether or not rectification of repairs is required.
14.6 Whether or not it is appropriate to seek recovery of costs from a customer where a claim is denied.
14.7 Whether or not timeframes for provision of a decision in relation to a claim, where further information, assessment or investigation is required, are reasonable.
14.8 Whether or not it is reasonable to decline to release information and reports relied on in assessing a claim.
14.9 Whether or not to fast-track the assessment or decision process of a claim and/or make an advance payment to

[12] FOS Terms of Reference
[13] *s. 57 Insurance Contracts Act 1984* e.g. if there has been an unreasonable delay in making a decision



alleviate financial hardship.

14.10 Where a customer seeks review of settlement of a claim resulting from a catastrophe or disaster, on the basis of a belief that the assessment of the loss was not complete or accurate, whether or not the customer is entitled to a review of the claim.

14.11 Whether or not an endorsement should be placed on a policy

14.12 Whether or not an excess or excesses are payable.

14.13 Whether or not a policy be cancelled.

14.14 Whether or not a customer or prospective customer is entitled to insurance cover,

14.15 Whether or not a breach of privacy has occurred.

14.16 Whether or not a breach of the Insurer's Customer Charter (or other such document) has occurred.

14.17 Whether or not a third party is entitled to payment or other benefits pursuant to a claim made.

14.18 Whether or not it is reasonable to seek recovery of a debt from a third party and whether or not the terms for repayment of a debt are reasonable.

14.19 Whether or not the conduct of service providers is in accordance with the requirements of the Code.

14.20 Recommend that an ex gratia benefit should be granted to a consumer, taking into account:

- 14.20.1 the process of the claim management.
- 14.20.2 undue delays/inconvenience to the consumer.
- 14.20.3 the duty of utmost good faith.[14]
- 14.20.4 the number of years the customer has been with the Insurer and number of policies held with the Insurer.
- 14.20.5 the customer's claim history.
- 14.20.6 Whether or not there are commercial reasons for making a payment.
- 14.20.7 what is fair and reasonable in all the circumstances and good insurance practice.[15]

14.21 If a Dispute Resolution Officer determines an ex gratia benefit is warranted in a particular case:

- 14.21.1 The Dispute Resolution Officer will make a recommendation to the relevant Executive General Manager (EGM) or their delegate by telephone, fax or email and request a response within 24 hours.
- 14.21.2 The EGM can nominate an alternative person to make a decision in his or her absence.
- 14.21.3 If the EGM agrees an ex gratia benefit is appropriate, the Dispute Resolution Officer is to advise the consumer of the benefit.
- 14.21.4 An ex gratia benefit will not be granted if a EGM

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[14] *s.13 & s. 14 Insurance Contracts Act 1984.* For example the failure to meet claims promptly may result in liability for damages (not limited to interest only) see *Moss v Sun Alliance Australia Ltd (1990) 93 ALR 592*

[15] FOS Terms of Reference

does not agree with the Dispute Resolution Officer's recommendation.

14.21.5 If the EGM fails to respond within 24 hours the Dispute Resolution Officer will determine whether or not to grant the ex gratia benefit.

14.21.6 CAS will report on ex gratia benefit recommendations and acceptances in its monthly and annual reports.

14.21.7 Any decision to grant an ex gratia benefit will be clearly identified as such and will not be held as a precedent.

15. What happens when a decision has been made by a Dispute Resolution Officer?

15.1 Final decisions made in accordance with these operating guidelines and terms of reference will be provided in writing and :

15.1.1 contain detailed reasons for the decision in plain language.

15.1.2 include information on how the consumer can access available external dispute resolution schemes (including the FOS).

15.1.3 Where the FOS Terms of Reference extend to the dispute, contain the following paragraph:

"My decision represents (*insert Insurer's name*) final decision in relation to your complaint. If you wish to pursue the complaint further you are entitled to apply to the Financial Ombudsman Service (the FOS). The FOS is an independent external dispute resolution scheme approved by the Australian Securities and Investments Commission (ASIC). AAMI is a member of this scheme and we agree to be bound by its determination about a dispute. You must make such an application within two years of the date of this letter to:

Financial Ombudsman Service
GPO Box 3
MELBOURNE VIC 3001

Telephone: 1300 780 808
Facsimile: (03) 96136399
Website: www.fos.org.au
Email: info@fos.org.au

15.1.4 Where the FOS Terms of Reference do not extend to the dispute, contain advices to the consumer to seek independent legal advice or provide information about other external dispute resolution options (if any) available to the consumer – for example certain State and Territory Governments provide for the resolution of builders warranty disputes through their

consumer tribunals.

15.1.5 In the case of a dispute in relation to a claim made by the Insurer against a third party for recovery of a debt, will include information about the existence of the Australian Financial Counsellors and Credit Reform Association (www.afccra.org) for a referral to a not for profit, free financial counselling service.

15.1.6 are binding on the Insurer.

15.1.7 are referred back to the nominated decision maker with an explanation for the decision and feedback where appropriate.

15.1.8 will be implemented by the Insurer within five working days.

15.2 The consumer does not have to accept the decision and has the right to appeal to the FOS, Court, Tribunal or other external dispute resolution scheme (subject to the jurisdiction or terms of reference of such schemes).

15.3 Will be recorded in Aequitas and claim or policy messages will be updated and the file returned to the Insurer.

Reports provided by CAS

16. What reports will be distributed by CAS?

Each month and annually CAS or Group Regulatory Affairs will compile a report of dispute activity statistics including:

16.1 Time taken for decision making by CAS.

16.2 Number of matters referred to CAS by:

- 16.2.1 class of insurance.
- 16.2.2 nature of dispute.
- 16.2.3 number of disputes decided in favour of consumers.
- 16.2.4 number of disputes maintained in favour of the Insurer.
- 16.2.5 by product.
- 16.2.6 by company
- 16.2.7 statistics by state.

16.3 Number of complaints received by CAS which are referred back to nominated decision makers for a final decision.

16.4 Analysis of FOS determinations.

16.5 Systemic issues identified by CAS or the FOS.

Additional reports will be produced as required or if requested.

Support provided to the Insurer's decision makers

17. How does CAS assist nominated decision makers?

CAS will support the Insurer's decision makers by:

17.1 Facilitating a case conference with nominated decision makers prior to a final decision being made, where appropriate.

17.2 Acting as a clearing house of information and current issues for decision makers.

17.3 Reporting on FOS determinations.
17.4 Providing guidance in drafting letters to consumers.
17.5 Facilitating conferences for decision makers from time to time.
17.6 Promoting education and training of decision makers.
17.7 Providing constructive feedback on the progress of disputes.

What happens when an application is made to the FOS?

18. CAS will:

18.1 Upon receipt of a referral notice from the FOS, refer this to the External Dispute Resolution (EDR) team within Group Regulatory Affairs.
18.2 Co-operate with the EDR team where necessary to ensure a response can be provided to the FOS within required timeframes.
18.3 Where necessary seek additional information from the relevant nominated decision maker or request that further investigations be undertaken or reports obtained.
18.4 If necessary, seek additional information or obtain reports from other persons, such as expert witnesses. This will be done in consultation with the relevant department of the Insurer.
18.5 In appropriate cases consider recommendations from the EDR team that attempts be made to settle the dispute prior to determination by the FOS.
18.6 Administer and distribute all correspondence received from the FOS to CAS and/or the Insurer.
18.7 Be responsible for all payments to the FOS.

Audit Function

19. CAS will:

Conduct regular audits of its processes to ensure compliance with the Code and keep and maintain records of such audits.

Future Directions for CAS

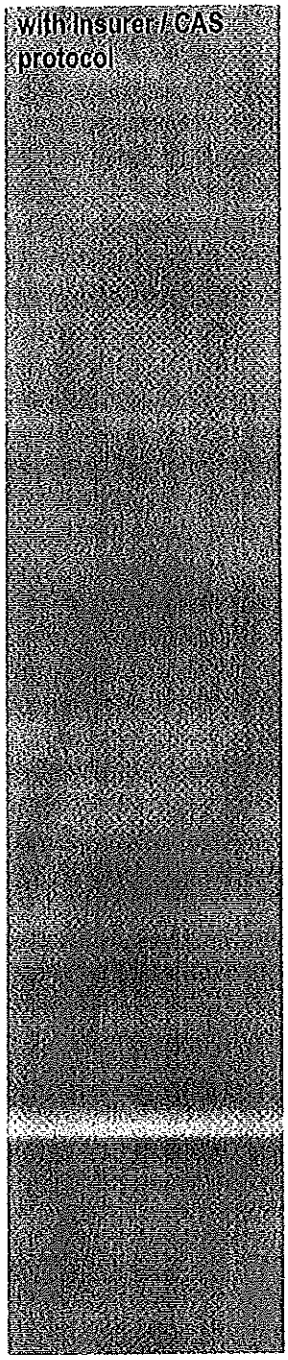
20. What is planned for CAS?

20.1 CAS will update operating guidelines and terms of reference as new developments arise.
20.2 Each year CAS will develop an Activity Plan outlining the proposed activities for the following 12 months. A report on the lines of activity will be provided to management every six months.

Protocol – Corporate Affairs / CAS

21. CAS will comply

The following protocols are designed to:



1. Ensure consistency in the Insurer's public response to topical issues.
2. Facilitate a communication protocol in respect of matters of interest to both the Insurer and CAS.
3. Identify appropriate areas of engagement in the public arena.

Exchange of Information

4. CAS and the Insurer will meet on a quarterly basis to discuss plans for future activities.
5. CAS will provide the Insurer with a copy of any papers for comment and discussion, prior to being presented in the public arena.
6. the Insurer will make every effort to advise CAS of consumer disputes as they are brought to its attention and to ensure consumers have been advised of their right to have their matter reviewed by CAS

Media

7. CAS will make every effort to advise the Insurer of any threats or circumstances that may result in contact by the media.
8. CAS will make every effort to advise the Insurer of any contact made by the media.
9. In accordance with privacy principles, CAS will not discuss matters it has reviewed through IDR.
10. CAS will not comment on issues where it has or could be perceived to have a conflict of interest.
11. the Insurer will facilitate media training for CAS.

Corporate Policy

12. the Insurer will advise CAS on the Insurer's position on industry matters and assist in drafting position papers on topical issues.
13. the Insurer will assist CAS to develop a register summarising the Insurer's interpretation of its contract with customers including the historical and legal context for current operational procedures and policy intent.
14. CAS will make staff available for comment and discussion on future policy considerations.

Annexure A

Dispute Resolution Process

Dispute resolution

All insurers are required to have an internal dispute resolution (IDR) process and be members of a scheme providing an external dispute resolution (EDR) process.

Definition of a complaint

A complaint is defined as follows:

"an expression of dissatisfaction made to an organisation, related to its products or services, or the complaints handling process itself, where a response or resolution is explicitly or implicitly expected"

Structure

The dispute resolution process consists of different levels

Operational Level

If an operator is unable to resolve a complaint with a customer or a third party, the operator must elevate the complaint to a supervisor. Any complaint which an operator is unable to resolve by the end of the next business day from when the complaint was received must be elevated to a supervisor. The operator must explain the complete complaints handling process to the customer, i.e. review by a supervisor, then by the Consumer Appeals Service (CAS) and then by the FOS. All complaints unable to be resolved within that timeframe or unable to be resolved by the supervisor must be entered into the Disputes System in Protect.

If the supervisor is unable to resolve a complaint to the satisfaction of the customer within 5 days of the when the complaint was first received in the business the supervisor must elevate the complaint to CAS and advise the customer CAS will make contact within 2 business days. CAS will then contact the customer and initiate a review.

Internal Dispute Resolution Level

The customer seeks a review by CAS or a complaint is elevated by a supervisor.

CAS ensures a final decision has been made at operations level – if not, the matter is referred back to a nominated supervisor in the department for review and a final decision at that level.

If a final decision has been made, CAS reviews this and provides the company's final IDR decision and if the decision is maintained, advises the customer of the right to an EDR review by the Financial Ombudsman Service (the FOS).

External Dispute Resolution Level

Customer seeks review by the FOS.

A response to the FOS referral notice is prepared by the External Dispute Resolution (EDR) team within Group Regulatory Affairs.

Recording of complaints in the Disputes System in Protect

We are obliged to record all complaints in the Disputes System in Protect, save for complaints which are able to be resolved to the customer's satisfaction by the end of the next business day from when the complaint was received.

Therefore if an operator is unable to resolve a complaint within that timeframe the complaint must be reported to a supervisor who must record it in the Disputes System.

Supervisors are responsible for updating the Disputes System as necessary.

CAS is responsible for recording the complaint in the Aequitas complaint and tracking system once the matter is elevated to CAS.

Timeframes for dispute resolution

The AAMI Charter contains a promise that it will endeavour to resolve all disputes quickly and fairly. Promise 3 of the Charter requires that it responds to written enquiries within 5 working days.

The General Insurance Code of Practice (the Code) requires all Insurers to respond to complaints at operations level within a maximum 15 business days, unless an alternative timeframe is agreed to by the customer. CAS is required by the Code to respond to complaints elevated to it within 15 business days unless an alternative timeframe is agreed to by the customer.

ASIC regulatory guideline RG165 requires an organisation to provide a final IDR decision within a maximum of 45 calendar days from when the complaint was received. Where a dispute cannot be resolved to the satisfaction of the consumer within 45 days, we must inform the consumer, before the end of the 45-day period, of the reasons for the delay and that they may take the complaint or dispute to the FOS, even if it still being considered (and provided the complaint or dispute is within the scheme's Terms of Reference) and inform the consumer of the details of the FOS.

These are maximum timeframes and it is in the interest of both us and the customer for the complaints and disputes to be dealt with as quickly as possible.

APPENDIX B

MOTOR VEHICLE INSURANCE & REPAIR INDUSTRY CODE OF CONDUCT

CONSUMER APPEALS SERVICE PROCESS

2 day resolution process

For disputes relating to repair and paint method, involving safety, structural integrity etc. prior to commencement or completion of repairs (Clause 10.1(a) of the Code)

1. The repairer contacts CAS by telephone or lodges an IDR form.
2. If the repairer lodges an IDR form with an operational department, the department will immediately fax or email a copy of the form to CAS.
3. CAS will determine, whether the dispute comes within clause 10.1(a).
4. If so, CAS will advise the repairer by telephone, fax or email of the process involved and that a manager or assessor who has not previously been involved in the matter will be appointed to contact the repairer, discuss the dispute, arrange for inspection of the vehicle (if necessary) and make a final decision.
5. The repairer will be advised to provide full details of the dispute together with any supporting evidence to the manager.
6. CAS will record any details provided verbally by the repairer in claim messages.
7. The repairer will be advised a decision will be provided by the manager within 2 business days of the notification of the dispute (not including the day on which the dispute is notified).
8. CAS will enter the matter into a dispute register recording the notification date, the nature of the dispute and the date on which a decision is to be provided.
9. CAS will immediately advise the relevant nominated manager of the dispute, forward any materials submitted by the repairer and advise the date by which the manager is required to provide a decision.
10. The nominated manager may appoint another manager or assessor who has not previously been involved in the matter to carry out the review and make a decision.
11. The nominated manager will advise CAS and record in claim messages details of the outcome of the dispute
12. CAS will record in its disputes register the outcome of the dispute.
13. If the repairer disagrees with the decision, the repairer retains the right to refuse to carry out the repairs and in that case the insurer may transfer the vehicle to another repairer.

Other repair disputes which arise prior to the completion of repairs – Clause 10.1(b)

1. The repairer contacts CAS by telephone or lodges an IDR form.
2. CAS ensures as best it is able to determine, whether dispute comes within clause 10.1(b).
3. CAS will explain the process involved (the same as for repair method disputes as set out above).
4. CAS will also explain to the repairer that this process does not prevent the repairer from subsequently pursuing the matter under the EDR provisions of the Code, once the vehicle has been repaired.
5. Process as per paragraphs 3 to 13 above.
6. On completion of the review by the nominated manager, CAS will advise the repairer in writing that of the right to pursue the matter under the provisions of clause 11 once the vehicle has been repaired.

15 day resolution process

Disputes other than clause 10.1(a) or 10.1(c) disputes and breaches of section 4 to 9 of the Code or contractual disputes

1. The repairer lodges an IDR form with CAS.
2. If the repairer lodges an IDR form with an operational department, the department will immediately fax or email a copy of the form to CAS.
3. If the repairer contacts CAS by telephone:
    a. CAS will explain IDR process to the repairer and that if appropriate the dispute will be first referred to management for review and attempt to resolve;
    b. The repairer will be asked to provide full details of the dispute to CAS together with any supporting evidence.
4. CAS will enter the matter into its dispute register recording the notification date, the nature of the dispute and the date on which a decision is to be provided.
5. CAS will provide written acknowledgement of the dispute as soon as possible, but within a maximum of 5 days from the date of receipt.
6. If the dispute has not previously been reviewed by management, CAS will advise the repairer the dispute is being referred to management for review and possible resolution.
7. CAS will invite the repairer to provide additional information and advise a decision will be provided within 15 business days of the receipt of the IDR form, the telephone call or the day when any additional information is received, whichever is the later.
8. CAS will advise the nominated manager of the dispute and request that the dispute be reviewed and, if appropriate, contact the repairer and seek to resolve the matter. The nominated manager may appoint another manager or assessor who has not previously been involved in the matter to carry out the review.
9. The nominated manager will arrange for the review to be completed within 5 business days.
10. If the matter is resolved to the satisfaction of the repairer the nominated manager will advise CAS and CAS will write to the repairer confirming the dispute has been resolved, but noting that if the repairer believes the dispute has not been resolved, the repairer is entitled to contact CAS and request a further review.

11. If the dispute is not able to be resolved, the nominated manager or delegate is required to advise the repairer verbally or in writing of the decision and the reasons for the decision and that the repairer is entitled to have CAS complete the IDR review.
12. The nominated manager will immediately advise CAS of the decision and the reasons for the decision.
13. The nominated manager will provide to CAS details and evidence in support of the Insurer's position. This will be provided with no later than 5 business days before the day on which CAS is required to provide its final IDR decision.
14. If CAS is considering overturning the decision, it will give the nominated manager the opportunity to elaborate on the reasons for the Insurer's position.
15. CAS will consider the material and make a decision by day 15 and convey this decision to the repairer and the relevant nominated manager.
16. CAS will provide reasons for its decision in writing and advise the repairer of the right to pursue the matter through the EDR process provided by the Code.
17. CAS will record in its disputes register the outcome of the dispute.
18. The determination by CAS will be binding upon the Insurer.
19. If on receipt of the dispute CAS determines that the dispute has previously been reviewed by management and final decision provided, CAS will proceed with its review in accordance with the provisions of paragraphs 14 to 18.

Generally

1. CAS will maintain a register of all disputes.
2. Management will nominate managers to whom CAS can refer disputes not previously considered by management and CAS will maintain a list of such managers and amend that list from time to time as directed by management.
3. CAS will prepare a report on an annual basis detailing the number, nature and outcome of disputes raised under clause 10 of the Code for submission to the Code Administration Committee.
4. Each quarter and annually, CAS will prepare a report setting out the number of disputes under Clause 10 and 11 of the Code by:
    a. nature of dispute.
    b. number decided in favour of repairers.
    c. number decided in favour of the Insurer.
    d. by company.
    e. by state.
    f. by repairer.