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Global Insurance Focus

An overview of the latest developments in the global insurance and reinsurance industries

Issue 5: November 2016

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Insurance linked securities: a new UK regime for risk transfer

By Adam Levitt, Nick Gardner and Alex Biles

H.M. Treasury is seeking to develop a legal and regulatory framework to create a UK market for insurance linked securities (ILS).

ILS offer insurers and reinsurers an alternative form of risk mitigation from conventional risk transfer techniques by allowing them to transfer risk directly to the capital markets. A new UK regime for ILS would deepen the capacity of reinsurance markets and diversify the type of risk protection available to insurers and reinsurers. For investors, ILS provide an opportunity to invest in higher yielding securities which are generally considered to be unrelated to equity market risk, interest rate risk, credit risk or wider macro-economic trends.

An effective risk transfer from a cedant insurer or reinsurer (i.e. the protection buyer) reduces its capital requirements, thereby improving its equity rates of return and allowing it to underwrite new business. The types of risk commonly covered through ILS structures include damages from extreme earthquakes and high winds – hence the historic concentration of ILS in the US and Japanese insurance and reinsurance markets – but also mortality (high or low) and other risks.

The development of a competitive regime for ILS is intended to address a gap in the UK insurance market and to preserve London's reputation as the leading insurance financial centre. ILS markets have to date been dominated by New York, off-shore financial centres, such as Bermuda, and newcomers, such as Malta and Gibraltar.

A new UK ILS regime aims to provide the legal and regulatory framework for the UK insurance market to compete in this growing area of alternative risk transfer.

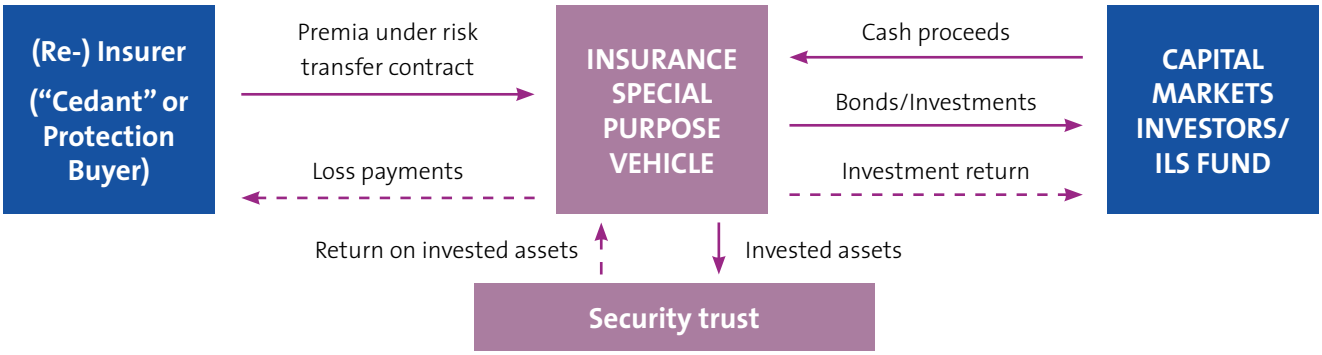
Background to the UK ILS regime

In March 2015, the UK Chancellor of the Exchequer announced as part of the budget that the UK government "will work with the industry and regulators to develop a new competitive corporate and tax structure for allowing Insurance Linked Securities to be domiciled in the UK. This alternative form of reinsurance makes greater use of capital markets and is a key growth opportunity for the sector." As a result, an ILS Taskforce, created by the London Market Group and comprising various industry participants, has been working with key stakeholders, such as H.M. Treasury, H.M. Revenue & Customs, the Prudential Regulation Authority and the Financial Conduct Authority, to consider the requirements necessary to develop a competitive regime for the UK market.

On 1 March 2016, H.M. Treasury published a consultation on ILS, which is available to read here.

Overview of an ILS

ILS normally take one of two forms: catastrophe bonds (or cat bonds) or collateralised reinsurance. Cat bonds were originally developed in the 1990's following Hurricane Andrew. Since then, the cat bond market has seen issues totalling approximately US$70 billion. Collateralised insurance transactions are typically less liquid (i.e. the investment may not be freely transferable), smaller in size and with fewer investors; structures tend to follow more conventional risk transfer transactions. However, both cat bonds and collateralised insurance use similar techniques in transferring risk from the cedant insurer or reinsurer.



As shown in the diagram above, an ILS structure typically involves the following steps:

- a cedant insurer transfers specific risks to a special purpose vehicle – under Solvency II, designated as an Insurance Special Purpose Vehicle or "ISPV" – pursuant to a binding and enforceable risk transfer contract. Where the insurer or reinsurer is subject to Solvency II, the transfer must be effective and comply with the requirements of Article 320 of the Solvency II Delegated Regulation;

- the ISPV raises capital from investors through the issue of cat bonds or a collateralised reinsurance investment to cover the insurance risk it has acquired. Investors receive an investment return for putting their capital – or principal – "at risk";

- the ISPV enters into collateral management arrangements under which the proceeds from the issue of the cat bonds or the collateral reinsurance investment are held in a collateral account and invested in certain high quality investments (e.g. US Treasuries, UK gilts or Euro government securities). Security is granted over the collateral account and collateral to secure the ISPV's obligations to the cedant and investors. Premium payable by the cedant plus the yield on the investments fund the interest payments on the cat bonds or collateral reinsurance investment – hence, returns for investors which generally exceed yields that they would otherwise achieve by investing directly in high quality investments;

- the investors' capital – or principal – is "at risk" because the cedant's claims against the ISPV under the risk transfer contract are senior to the investors' subordinated claims under the cat bonds or collateralised reinsurance investment: proceeds from the ISPV's collateral must be applied to pay the cedant under the risk transfer contract first and investors under the cat bonds or collateral insurance investment second; and

- at maturity, the ISPV will return the investors' original capital less amounts (if any) paid to the cedant under the risk transfer contract.

Transactions are typically for a duration of between three and five years. ILS have certain pre-defined "trigger" points at which investors suffer loss on their investment. These can be structured as an indemnity trigger based on claims against the cedant exceeding a specified amount; an industry trigger based on claims against the wider insurance industry exceeding a specified amount in relation to a certain event or certain events; a parametric trigger linked to a specified quantitative measure (e.g. wind speed); or a modelled trigger based on claims exceeding a certain amount under financial loss model.

ILS can also be structured to cover one or more pre-determined "slices" of risk. The point at which investors start to incur loss is called the "attachment point", and the point at which the cover provided by the ILS expires is called the "exhaustion point". By way of example, an ILS could be structured to provide a cedant insurer with cover in respect of losses over £1 billion and up to £1.5 billion. This could be done through a single tranche of ILS with an attachment point of £1 billion and an exhaustion point of £1.5 billion. Alternatively, the ILS could be issued in two tranches with the first having an attachment point of £1 billion and an exhaustion point of £1.25 billion and the second with an attachment point of £1.25 billion and an exhaustion point of £1.5 billion.

Conclusions

The development of a domestic ILS regime promises to be a significant development for the UK insurance and reinsurance market – especially in an area of alternative risk transfer which has traditionally been a key strength for financial centres such as New York and offshore jurisdictions, such as Bermuda. The critical challenge to H.M. Treasury and other stakeholders in developing a UK regime will be to achieve a regime that is competitive against other financial centres, particularly with regards tax treatment and the authorisation and supervision of ISPV structures. However, it could prove to be an exciting development for alternative risk transfer opportunities for the UK reinsurance markets.

Ashurst is hosting the "Insurance Linked Securities: the New Opportunities" conference on Monday 5 December organised by City & Financial Global.

UK

The death knell has finally rung for the secondary annuities market

By Sarah-Jane Gemmell

In his 2014 Budget the then Chancellor, George Osborne turned the pensions industry on its head by announcing radical changes to the way individuals could access their pension pots. From April 2015, individuals aged 55 and over with defined contribution (money purchase) pensions would be able to access their entire pension savings as they wished, subject to their marginal rate of income tax. The tax free lump sum would continue to be available.

A year later George Osborne pulled another rabbit out of the hat by announcing that the so-called pension freedoms would be extended even further. A secondary annuities market was to be established where individuals who had already bought an annuity would be able to sell that annuity in return for a lump sum and the proceeds would be taxed at the individual's marginal rate.

From the start creating the secondary annuities market was fraught with potential difficulties. Would there be any appetite to buy back these annuities? If a market could be established, it was felt that individuals would probably receive a raw deal when cashing in annuities. Charges would have already been incurred to purchase an annuity and inevitably individuals would face further charges to cash-in the annuity. If the secondary annuities market was going to succeed then extensive consumer safeguards were essential both to protect individuals against their pension pots being eroded by charges and possible pension scams, and any potential purchasers against another mis-selling debacle.

With April 2017 set as the launch date for the secondary annuities market, the Government issued the surprise announcement last month that it had decided "not to take forward plans to introduce a secondary annuities market because the consumer protections required could undermine the market's development". It had become apparent that although firms had indicated they were willing to permit customers to sell their annuities, there were insufficient buyers to create a competitive market.

Although there might have been some "winners" if the secondary annuities market had been established - for those individuals who needed to access cash quickly, the opportunity to cash-in their annuity could have been the best of a bad bunch – this does not outweigh the individual and industry risks which such a market would have created.

UK

Insurance Act 2015

By Caroline Johansen and Adam Levitt

The Insurance Act 2015 (the "Act) came into force on 12 August 2016. It represents the biggest reform to insurance contract law in the UK in more than a century. In this article, we summarise the key changes being implemented by the Act.

Application of the act

The Act extends to England, Wales, Scotland and Northern Ireland[1]. The Act applies mainly to non-consumer insurance contracts. However, some provisions, notably those relating to the duty of good faith and contracting out, apply to both consumer and non-consumer insurance contracts. A "consumer" in this context is an individual who enters into an insurance contract for purposes which are unrelated to its business.[2]

1 Sections 21(4) and 21(5) do not apply to Northern Ireland.
2 We have not dealt with third party rights in this article.

In broad terms, the Act deals with:

a. duty of fair presentation;

b. warranties;

c. fraudulent claims by policyholders;

d. late payments;

e. good faith and contracting out; and

f. amendments to the Third Parties (Rights Against Insurers) Act 2010.

The duty of fair presentation

The duty of fair presentation applies to non-consumer contracts only. It requires the policyholder to make a "fair presentation of the risks" prior to entering into the insurance contract in question. This means that to discharge its duty, the policyholder must:

a. disclose to the insurer every material circumstance which the policyholder **knows or ought to know**; or failing that, provide sufficient information to put a prudent insurer on notice to make further enquires;

b. disclose information in a way that is reasonably clear and accessible to a prudent insurer, not dumping huge amounts of unsorted information on the insurer; and

c. ensure that in respect of each disclosure, any material representation of fact is substantially correct and any material representation of belief is made in good faith.

The knowledge of the policyholder extends to the knowledge of anyone who is part of senior management or responsible for the policyholder's insurance, but does not include confidential information acquired by the policyholder's agent (for example, its broker) through a commercial relationship with someone other than the policyholder and who is not connected with the insurance contract.

The policyholder must disclose information that it **ought to know**, meaning any information that should reasonably have been revealed by a "reasonable search" of available information. What the policyholder ought to know may be tricky to assess in practice and could possibly develop into an area of contention.

Remedies

For non-consumer insurance contracts, the Act introduces a new remedies regime for insurers. The new regime applies in circumstances where the insurer can show that, but for the policyholder's breach of the duty of fair representation, the insurer would either not have entered into the insurance contract or would only have done so on different terms.

Where the insurer can show that the breach was deliberate or reckless, the insurer can avoid the contract and refuse to pay all claims. Also, the insurer does not need to return any of the premiums paid.

For breaches which are not deliberate or reckless, the insurer can avoid the contract if it would not have entered into the contract on any terms, so long as it returns any premiums paid. If it would have entered into the contract but on different terms, the contract is to be treated as if it had been entered into on those different terms. If the insurer would have entered into the contract but for a higher premium, the insurer can reduce the amount paid on any claim proportionately.

Warranties

The Act introduces changes to the law on warranties.

Basis of contract clauses

Clauses in non-consumer insurance contracts which seek to convert all representations by the policyholder into warranties, so called "basis of the contract clauses", are no longer permitted under the Act and the parties are not able to contract out of this.

Remedies

The Act also changes the remedy for breach of warranty in relation to both consumer insurance contracts and non-consumer insurance contracts. Under the old regime, a breach of warranty by the policyholder completely discharged the insurer's liability under the contract from the date of the breach. However, under the new regime, the insurer's liability is merely suspended until the breach has been remedied by the policyholder and the insurer continues to be liable for any valid claims which arose prior to the warranty breach.

Terms not relating to actual loss

If the policyholder under a consumer insurance contract or a non-consumer insurance contract breaches a term of the insurance contract where compliance would tend to reduce the risk of loss, the insurer will not be able to escape liability unless the breach actually increases the risk of loss suffered by the policyholder. This means that the insurer will no longer be able to avoid liability by pointing to an unrelated breach of the contract by the policyholder.

Fraudulent Claims

Under the Act, the insurer is not liable to pay out money for a fraudulent claim under a consumer insurance contracts or a non-consumer insurance contracts and can recover any payments already made in respect of such claim. The insurer can also, by notice, treat the contract as having been terminated from the time of the fraudulent act and keep the whole premium. However, valid claims arising prior to the fraudulent act are unaffected.

If a member of a group insurance policy makes a fraudulent claim, the insurer has a remedy against the fraudulent member only; other policyholders are not affected.

The Act does not define "fraud" or "fraudulent claim" but leaves these to be determined in accordance with common law principles.

Late payment of claims

The Act introduces an implied term under every insurance contract (both consumer insurance contracts and non-consumer insurance contracts), whereby if the policyholder makes a claim under the contract the insurer must pay any amounts due under the contract within a "reasonable time" (unless the insurer is disputing the claim). What constitutes "a reasonable time" depends on the relevant circumstances.

Utmost good faith

The Act abolishes any rule of law that permits the avoidance of consumer insurance contracts and non-consumer insurance contracts for breach of utmost good faith.

Contracting out

The Act contains different contracting out provisions which depend on whether the policyholder is a consumer or a non-consumer.

Consumer

For consumer insurance contracts, contractual terms will have no effect if they relate to warranties, fraudulent claims or late payment of claims and put the policyholder in a worse position than the policyholder would have been in by virtue of the Act.

Non-consumer

For non-consumer insurance contracts, parties are permitted to agree alternative regimes to the provisions of the Act provided the insurer satisfies the following transparency requirements:

a. the insurer must take sufficient steps to draw the disadvantageous term to the policyholder's attention before the contract is entered into; and

b. the disadvantageous term must be clear and unambiguous as to its effect.

However, the parties are not permitted to contract out of the prohibition of basis of contract clauses (see "Basis of contract clauses" above), or the implied term about late payment of claims (see "Late payment of claims" above) if it would result in the policyholder being put in a worse position as respects deliberate and reckless breaches of such implied term.

Conclusion

The Act marks the biggest reform to insurance contract law in more than a century and affects all players in the insurance industry, including insurers, policyholders and brokers. Insurers and brokers should ensure that they have carefully reviewed all relevant contract wordings, policy documents and practices to ensure that they comply with the new regime.

AUSTRALIA

Stamp duty on insurance

By Geoffrey Mann, Kristina Popova and Annie Johnston

In New South Wales, rules relating to duty payable on life insurance policies are set out in Part 2 of Chapter 8 of the Duties Act 1997 (NSW) (Duties Act). The amount of duty chargeable on term insurance policies is 5% of "the first year's premium" on the policy. "Premium" is defined to mean "the total consideration given to an insurer by or on behalf of the insured person to effect insurance without deductions for any amounts paid or payable, or allowed or allowable, by way of commission or discount to an insurance intermediary".

The facts

ERIC Insurance Ltd (Taxpayer) carried on the business of providing insurance to New South Wales residents. As part of this business, it issued life insurance policies for a term of years where premiums were paid upfront on or before the issue of the policy for the term of the policy. The Taxpayer paid duty on the life insurance component of its various policies on the basis that "the first year's premium on the policy" was the amount of premium referable only to the first year on a pro rata basis of the total premium.

The case turned on whether, in circumstances where the premium for the entire term of a term insurance policy is paid up-front, the words "the first year's premium" mean:

- the premium referable or attributable to the first year of the policy, as the Taxpayer had done; or
- the total consideration received by the applicant during the first year of the policy to effect the term insurance, as the Commissioner argued.

First year premium: Amounts attributable to the first year

The Tribunal agreed with the Taxpayer that the words "the first year's premium" meant the amount of premium attributable to the first year, not the total sum paid in the first year of the policy.

The Tribunal considered case law that evidenced courts had previously recognised that as a matter of commercial practice, insurers charged a single premium for different policies and types of insurance, and for various time periods, and thus have apportioned income tax and stamp duty liability accordingly. The Tribunal interpreted the decisions in showing that apportionment was adopted because the true actuarially established premium for life insurance could be calculated and that even where actuarial material is unavailable, provided there is a reasonable basis for calculation, apportionment was still available.

The Tribunal proceeded to consider the meaning of "first year's premium" in the context of Chapter 8 of the Duties Act, which provides rates of duty according to types of insurance. The Tribunal's interpretation of the language of the provision was that the words "first year" relate to the immediately following words, "premium on the policy", which favoured an interpretation that duty is payable on so much as could be attributed to the first year as opposed to the total paid in the first year.

The Tribunal considered that if it had been the legislature's intention for those provisions to have the effect submitted by the Commissioner, the wording could have been drafted to refer to the premium paid. We understand that the Commissioner has decided not to appeal this decision.

AUSTRALIA

Progress of significant retail life insurance reforms in Australia

By Rehana Box and Marie Vlassis

Background

As discussed in Issue 4 - August 2016, a significant reform package was announced by the Federal Government on behalf of the retail life insurance industry in Australia in 2015. The package has been progressed since the Australian Liberal Party was re-elected to Government in July 2016.

Corporations Amendment (Life Insurance Remuneration Arrangements) Bill 2016 (Bill)

As discussed in our update in August this year, the Bill was previously introduced into the Parliament on 11 February 2016. However, the Bill lapsed at prorogation on 15 April 2016. On 12 October 2016, the Bill was reintroduced to parliament in its original form. By way of refresher, the purpose of the Bill is to amend the Corporations Act 2001 (Cth) (Act) to:

- remove the exemption from the conflicted remuneration ban on benefits paid in relation to certain life risk insurance products;
- enable regulations to prescribe other circumstances where a benefit paid in relation to life insurance is conflicted remuneration even where no advice is provided;
- enable ASIC to permit benefits in relation to life risk insurance products when certain requirements are met; and
- ban volume based payments in life risk products.

The Bill is at the second reading stage in the House of representatives and will take weeks or months to pass through parliament, hence, it is possible the Bill will not be made law until 2017.

Implementation and Effect

Should the Bill be passed into law, the reforms will commence on 1 January 2018, and will be a joint effort between the insurance industry, ASIC and the Government. The Government is amending the Act to give ASIC the power to create a legislative instrument to set caps on commissions and implement clawback arrangements. Consequently, the final form of ASIC's instrument will be a matter for ASIC, as the independent regulator.

Corporations Amendment (Life Insurance Remuneration Arrangements) Regulation 2016

On 19 October 2016, the Government released the revised draft Corporations Amendment (Life Insurance Remuneration Arrangements) Regulation 2016 (Regulation) to support the Government's life insurance reform package. The Regulation supports the reform package introduced by the Bill by:

What you need to know

- The Corporations Amendment (Life Insurance Remuneration Arrangements) Bill 2016 (Bill) was previously introduced into the Parliament on 11 February 2016. However, the Bill lapsed at prorogation on 15 April 2016. On 12 October 2016, the Bill was reintroduced to parliament in its original form and is now at the second reading speech stage. If the Bill is passed into law, it will take effect in 1 January 2018.
- In early October 2016, the Financial Services Commission (FSC) launched the Life Insurance Code of Practice (Code). The Code is mandatory for all FSC members and any other industry participants who elect to be formally bound by the Code. Under the Code, insurers will be required to improve disclosure to customers, provide greater transparency in communications, decide claims within set timeframes, limit the use of surveillance, and provide additional support for vulnerable consumers.
- ASIC Report 498 - Life insurance claims: An industry review was released on 12 October 2016. This report found that insurers are paying the majority of claims, but there were higher claim denial rates and claims handling for TPD and trauma cover, and for those policies sold direct to consumers with no financial advice.
- On 19 October 2016, the Government released the revised draft Corporations Amendment (Life Insurance Remuneration Arrangements) Regulation 2016 to support the Government's life insurance reform package.
- It still remains uncertain whether the Bill in its current form will progress through the Senate at all or unchanged as the Government does not have a majority in the Senate.

- prescribing circumstances where benefits paid in relation to life risk insurance products are considered to be conflicted remuneration, such as where information is given in relation to these products;

- prescribing circumstances where "clawback" does not apply, such as in situations where a policy is cancelled automatically due to the age of the insured or where a premium rebate is offered to encourage customers to take up a policy; and

- grandfathering benefits paid in relation to life risk insurance products issued after the commencement of the reforms, in circumstances where those products are substantially related to products issued prior to the commencement of the reforms.

Effect

Under the draft Regulation, a benefit can be conflicted remuneration if it could be reasonably expected to influence the financial product advice. A benefit is conflicted remuneration if it is given to an AFSL licensee or its representative in relation to:

- a dealing with a life insurance product with a retail client;

- financial product advice provided to a retail client in relation to a life insurance product; or

- information given to a retail client in relation to a life insurance product.

As exemplified above, the Regulation is broad, and will apply in addition to any ban of volume based commissions.

Life Insurance Code of Practice

In early October 2016, the Financial Services Commission (FSC) launched the Life Insurance Code of Practice (Code). The purpose of the Code is to ensure that insurer practices and obligations are raised significantly to better meet consumer needs and expectations. To achieve this objective, insurers will be required to improve disclosure to customers, provide greater transparency in communications, decide claims within set timeframes, limit the use of surveillance, and provide additional support for vulnerable consumers. Case studies provided by the FSC on how the Code operates are useful in illustrating the practical implications of the Code.

Who does the Code apply to?

The Code will be an FSC standard, which means it is mandatory for all FSC members. The Code also applies to:

- registered life insurance companies issuing life insurance policies that are covered under membership of the FSC; and

- any other industry participant, including a non-FSC member, which adopts the Code by entering into a formal agreement with the FSC and the Life Code Compliance Committee (Life CCC) to be bound by the Code.

The Code does not apply to:

- superannuation fund trustees;
- financial advice companies or financial advisers; or
- other industry participants,
- unless they have adopted the Code by entering a formal agreement as discussed above.

Effect, Monitoring and Enforcing compliance

The Code commenced on 1 October 2016, and insurers will have a transition period until 30 June 2017 to comply with the Code. The Code operates alongside, and is subject to, laws and regulations.

The Life CCC is the body responsible for monitoring and enforcing compliance with the Code. The Life CCC will determine whether a breach of the Code has occurred and will monitor the implementation of any corrective measures. Where an insurer fails to implement corrective measures, the CEO of the insurer will be notified prior to a final determination being made. In the event that there is a failure to correct a significant breach, the Life CCC may at its discretion impose one or more of the following binding sanctions:

- a requirement that particular rectification steps be taken by the insurer within a specified timeframe, taking into account any rectification related to the breach imposed on the insurer by any regulatory body;
- a formal warning;
- a requirement that a Code compliance audit be undertaken;
- a requirement that the insurer undertake corrective advertising or write directly to the customers impacted by the breach; and or
- publication of the insurers non-compliance on their website and on the FSC website.

Where an insurer does not comply with a sanction imposed on them, this will be regarded as a breach of FSC standard and the FSC board has the power to undertake disciplinary action.

ASIC Report 498 – Life insurance claims: An industry review

On 12 October 2016, ASIC released Report 498 - Life insurance claims: An industry review (Report 498). Report 498 found that while life insurers are paying the majority of claims, there are significant issues regarding claims handling. ASIC found that there is a need for public reporting on life insurance claim outcomes, at an industry and individual insurer level.

Report 498 identified the following issues of concern in relation to higher claims denial rates and claims handling procedures associated with:

- TPD and trauma cover: The rates of declined claims were highest for TPD cover (average declined claim rate of 16%) and trauma cover (average declined claim rate of 14%).
- A considerable variation in declined claims among insurers, with TPD denial rates being as high as 37% and trauma (up to 25%) for some types of cover.
- The most common types of life insurance disputes were about the evidence insurers require when assessing claims (including surveillance), and delays in claims handling.

Report 498 also reported that there were higher claims denial rates in relation to insurance policies sold direct to consumers with no financial advice (compared to policies sold through advisers and group insurance policies).

In light of the Report 498, ASIC has proposed the following actions to raise claims handling standards.

New public reporting requirement with APRA

ASIC and APRA are to work with insurers and other stakeholders over 2017 to establish a consistent public reporting regime for claims data and claims outcomes, including claims handling timeframes and dispute levels across all policy types. Data will be made available on an industry and individual insurer basis.

The Government to strengthen legal framework covering claims handling

At present, "insurance claims handling" is explicitly exempted from the financial services conduct provisions of the Act. ASIC is recommending that this exemption be removed by the Government and that more significant penalties for misconduct in relation to insurance claims handling are included in the current review of ASIC's penalty powers.

The consumer dispute resolution framework for claims handling be strengthened

ASIC has highlighted the need to ensure better and more effective consideration of issues of fairness to supplement the existing jurisdiction; and give better access to consumers with complaints about delays in claims handling, to ensure better remedies when these complaints are found in favour of the consumer.

Follow up ASIC surveillances and reviews

ASIC will target the areas of concern identified in Report 498, applying targeted surveillances of particular insurers that have the highest decline rates and highest proportional dispute numbers, and examining TPD claims procedures and timeframes. ASIC will also conduct a major review of the life insurance sold without personal advice (also known as "direct" life insurance).

Strengthen industry standards and practices

ASIC has recommended a number of initiatives for the insurance sector to undertake including:

- immediately reviewing the currency and appropriateness of policy definitions (the FSC is already undertaking this with adoption of the Code by FSC and non-FSC members as discussed above);
- examining and ensuring advertising and representations about the cover align with the definitions and the policy, and reporting any discrepancies to ASIC;
- ensuring that claims timeframes are consistent with industry standards and expected claims timeframes are adequately communicated to policyholders; and
- ensuring that incentives and performance measurements for claims handling staff and management do not conflict with the obligation to assess each claim on its merit.

These recommendations are intended to supplement the Code in order to improve claims handling standards.

Future Review

ASIC will conduct a review in 2021 to consider whether the new industry arrangements for life insurance advice have better aligned the interests of firms and consumers. ASIC has consulted with the industry to ensure appropriate and reliable data will be available to support this review. If the review does not identify significant improvement, the Government will move to mandate level commissions, as was recommended by the Financial Services Inquiry.

Contacts

London

Adam Levitt	Partner	+44 20 7859 1633	adam.levitt@ashurst.com
Nicholas Gardner	Partner	+44 20 7859 2321	nicholas.gardner@ashurst.com
Nicola Higgs	Partner	+44 20 7859 1033	nicola.higgs@ashurst.com
Euan Burrows	Partner	+44 20 7859 2919	euan.burrows@ashurst.com
Christopher Bates	Partner	+44 20 7859 2388	christopher.bates@ashurst.com

Hong Kong

Ben Hammond	Partner	+852 2846 8914	ben.hammond@ashurst.com

Sydney

Rehana Box	Partner	+61 2 9258 6407	rehana.box@ashurst.com

"They are a great team who provide an individual service which was tailored to our needs. They were able to give advice when we needed it and challenge where required - despite a number of competing stakeholder requirements. With their help, we were able to deliver to tight timescales."

CHAMBERS UK 2017

"They are very helpful in terms of thinking of solutions to problems."

CHAMBERS UK 2016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