LLOYD'S

MARKET BULLETIN

REF: Y4923

Title	New Zealand: Revised Fair Insurance Code
Purpose	To advise the market of changes to the New Zealand Fair Insurance Code
Type	Event
From	Kim Swan, Senior Manager, International Regulatory Affairs General Counsel Division
Date	04 September 2015
Deadline	To be implemented by 1 January 2016
Related links	Fair Insurance Code

1. Background

In May 2015, the Insurance Council of New Zealand's (ICNZ) Board approved a number of changes to the Fair Insurance Code (the Code), following the Code's regular triennial review. The majority of changes were prompted by consumer feedback following the Canterbury earthquakes. The revised Code comes into effect on 1 January 2016 and will apply to all non-life/health consumer business (i.e. insured individuals and entities with nineteen or fewer employees).

As agents of the underwriters, all New Zealand-based Lloyd's service company, Coverholder and TPA staff will need to be able to document and demonstrate compliance for New Zealand Coverholder business (including service companies).

Lloyd's has been granted a two-year exemption from the Code for business placed directly into the Lloyd's market (as is the position in Australia), provided policy documentation

clearly states it is not subject to the protections afforded by the Code. Following this two-year period, Lloyd's will need to seek a further exemption.

Steps should be taken by Coverholders to implement the changes as soon as possible, to ensure compliance from 1 January 2016. All Coverholder staff as well as their authorised representatives will be required to be trained in the new Code requirements by this date. The ICNZ will be presenting Fair Insurance Code workshops to its members and has offered to provide similar workshops for New Zealand Coverholders and TPAs.

Please note that this Market Bulletin is intended to serve as a general summary and overview of the *changes* to the Code. Practitioners are urged to familiarise themselves with the full text of the revised Code as soon as possible. It is underwriters' responsibility to ensure that those acting on their behalf are adhering to the Code.

2. Key changes to the Code

A number of changes have been made to the Code which place higher standards on insurers. Please see Appendix 1.

Key changes include:

- Enhanced, effective communication with the insured, particularly concerning up-front disclosure of key information;
- Insurers committing to act reasonably when faced with the non-disclosure of relevant information by the insured;
- Introduction of best-practice timeframes for communicating with the insured at claim time;
- Enhanced training requirements for insurers' staff and agents about the Code.

2.1 Breaches and Reporting

Sanctions

Insurers' external dispute resolution schemes (DRS) can consider breaches of the Code. Insurers are bound to comply with the decision of that scheme, and if a scheme decides there has been a 'significant breach', the insurer must report that breach to the ICNZ.

A 'significant breach' is a material breach of any provision in the Code, or a series of material breaches of the Code, where the breach has the potential to bring the insurance industry into disrepute. A dispute resolution scheme will decide whether a breach of the Code is significant.

Insurers can be reprimanded, fined up to $100,000 or expelled from ICNZ by its Board for 'significant breaches' of the Code.

Code Compliance Committee

The new Code establishes a Code Compliance Committee (CCC), comprising a majority of independent experts, charged with investigating 'significant breaches' of the Code (the Committee must have no less than three members at any one time, one of which will be the CEO of the ICNZ).

Reporting Breaches

Insurers (including Lloyd's) are required to report to the CCC 'significant breaches' of the Code identified by the independent dispute resolution schemes. Where these occur, insurers are expected to redress any harm and to ensure changes occur to avoid future occurrences. If the CCC is not satisfied that these steps have been taken, it will report these breaches to the Board of ICNZ.

Coverholders will be required to report *any* breaches of the Code to the relevant Managing Agent, as well as to Lloyd's General Representative in New Zealand (to ensure 'significant breaches' can be reported to the CCC by the local rep).

Annual/Quarterly Reporting

Members of the ICNZ, including Lloyd's, will also be required to report to the ICNZ on a quarterly and annual basis.

All Coverholders will need to report information to Lloyd's General Representative in New Zealand in relation to Lloyd's claims and complaints, so that information can be consolidated and reported. Coverholders will also be required to collect and report information from their TPAs.

ICNZ will only release this data in the aggregate of all members. ICNZ will hold the data reported by each individual member in confidence and will not make individual members' data publicly available or share that information with other members of ICNZ.

Quarterly reporting will require Coverholders to report the number of 'significant breaches' identified by their external dispute resolution scheme in that quarter, and the number of those 'significant breaches' that remain unresolved.

Annual reporting will require Coverholders to report, for that calendar year, their total number of:

a) Claims. This includes all claims across all product lines and all insureds.
b) Complaints referred to the internal dispute resolution process.
c) Complaints referred to the DRS.

d) Complaints upheld by the DRS.
e) Complaints referred to the DRS that involved a 'significant breach' of the Code, and
f) Complaints referred to the DRS that involved a 'significant breach' of the Code that remain unresolved.

An 'unresolved significant breach' is a 'significant breach' that has not been remedied to the DRS's satisfaction, after the complaint involving the 'significant breach' has been through the DRS's dispute resolution process. All members of the ICNZ, including Lloyd's, have filed a waiver of confidentiality so that this information can also be provided by the external DRS's.

A 'complaint' is an expression of dissatisfaction where a response or resolution is explicitly or implicitly expected. Procedures must ensure that Coverholders and TPAs capture and record everything falling within this broad definition.

The first template for reporting will be issued by the ICNZ in April 2016 in respect of Q1 2016, and this will be shared with Coverholders and Managing Agents by the local representative.

3. Coverholder Approval and TPA oversight

When approving new Coverholders, Lloyd's will ensure that the Coverholders have an adequate understanding of the Code and have taken steps towards compliance. Lloyd's General Representative in New Zealand will assist with this process.

Managing Agents proposing to delegate authority to TPAs will be responsible for ensuring those TPAs have an appropriate understanding of the Code and have taken steps towards compliance, particularly regarding the best practice claims guidelines (see Appendix 1).

4. Further information

If you have any queries, please contact either of the following:

Lloyd's International Trading Advice (LITA)
Tel: +44 (0)20 7327 6677
Email: lita@lloyds.com

Lloyd's New Zealand
Scott Galloway, Lloyd's General Representative in New Zealand
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Appendix 1 – Key Changes to the Code

General Responsibilities

Higher standards of customer service (clause 9)
The revised Code requires insurers to act honestly, fairly, transparently and with utmost good faith. Insurers must:

- answer questions accurately and in writing if requested;
- explain the information that must be provided when applying for insurance, renewing a policy, or making a claim;
- explain the importance of giving information that is honest, complete, up to date and relevant;
- give access to policy wordings, which set out in plain English what is insured, what is not insured and what the insured's obligations are; and
- tell the insured about any changes to their policy.

Training (clause 10)
The revised Code requires insurers to train their staff and agents (including Coverholder and TPA staff) so that they can fulfil their responsibilities to the insured. Training must include the requirements of the Code and information about the insurer's products.

Clarification of policy (clause 11)
Under the revised Code, the insured is entitled to ask for and receive clarification on the terms, conditions and exclusions of their insurance policy. Insurers must communicate clearly, concisely and effectively with the insured, and take all reasonable steps to assist people with disabilities, or for whom English is a second language.

Responsibilities – Applications and Renewals

Questions (clause 16)
Insurers must ask questions that allow the insured to fully disclose any prior claims and other material information which may affect the insured's ability to take out insurance or make a valid claim.

Policy summary (clause 17)
Insurers must provide a clear summary of the key features of the policy.

Explain responsibilities (clause 18)
Insurers are required to explain the insureds' responsibilities (i.e. to disclose material facts) and what may happen if the insured does not meet these responsibilities, specifically:

- when the insured buys insurance;
- during the term of the insurance policy; and
- when the insured renews their insurance policy.

Code promotion (clause 50)
Insurers must advise where insureds can access copies of the Code when they take out or renew insurance cover.

Responsibilities - Claims

Non-disclosure (clause 20)
Insurers must act reasonably when faced with the non-disclosure of relevant information by the insured.

Standard of service (clause 26)
Insurers are required to manage claims quickly, fairly and transparently.

Clarify process (clause 27)
When a claim is made, insurers must:

- explain to the insured how to report a claim, and what information must be provided to process the claim;
- explain the steps that will be taken while handling the claim;
- tell the insured that information given must be honest, complete, up-to-date and relevant;
- keep the insured informed of the progress of their claim;
- settle all valid claims quickly and fairly;
- clearly explain how they reached their decision; and
- clearly explain the reason or reasons, if a claim is declined.

Best practice timeframes (clauses 28/29)
When a claim is made, the insurer must:

- acknowledge receipt within five business days of receiving the claim; and
- determine whether or not to accept a claim within ten business days of the date the insurer has all the information it needs to determine the claim.

If insurers cannot meet the timeframe for determining whether or not to accept a claim, they must:

- explain why
- tell the insured how long it expects it will take to determine the claim, and
- update the insured at least once every 20 business days, or another such interval as may be agreed, until the claim is resolved.

Relevant information (clause 30)
The insurer must ask for and take into account only relevant information and material information when investigating and making decisions about a claim.

Responsibilities - Catastrophes/disasters

Different timeframes for catastrophes/disasters (clause 38)
The Code explains that when a catastrophe or disaster strikes, the insurer may receive a large number of claims, and may not be able to meet the standard timeframes set by the Code.

However, under the Code, the insurer must:

- use its best efforts to meet all of its commitments in the Code;
- respond as quickly as possible and in a professional, practical and compassionate manner;
- update the insured at least once every 20 business days, or another such interval as agreed, until the claim is resolved; and
- prioritise services for vulnerable customers.

Responsibilities - Complaints

Timeframes and provision of information (clause 43)
The Code sets out the following requirements with respect to the handling of complaints:

- Complaints must be acknowledged within five business days;
- The name and contact details of the person handling a complaint must be provided to the insured;
- The complaint must be fully investigated by an experienced person who has not been handling the case;
- The insurer must respond to the complaint within ten business days of the date it receives all information needed to determine the complaint;
- Where further information, assessment or investigation is required, the insurer must agree reasonable timeframes with the insured. If reasonable timeframes cannot be agreed, the insured can contact the insurer's independent external dispute resolution scheme about those timeframes;
- The insurer must update the insured at least once every 20 business days, or another such interval agreed, until the complaint is resolved.

Deadlock letter (clause 44)
If the insurer cannot resolve a complaint satisfactorily through its internal dispute resolution process within two months, it must explain the reasons to the insured in writing and provide a 'deadlock' letter so the insured can take the complaint to the insurer's independent, external dispute resolution scheme.