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CLAIMSURE RESEARCH PAPER

Are Australia's Life Insurers Ready for LICOP 3.0?

A current-issues review of claims-handling service standards on the road to a revised Life Insurance Code of Practice.

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June 2026 · Total and permanent disability (TPD) · income protection · insurance through superannuation · claims handling · insurer conduct. General information only — see disclaimer.

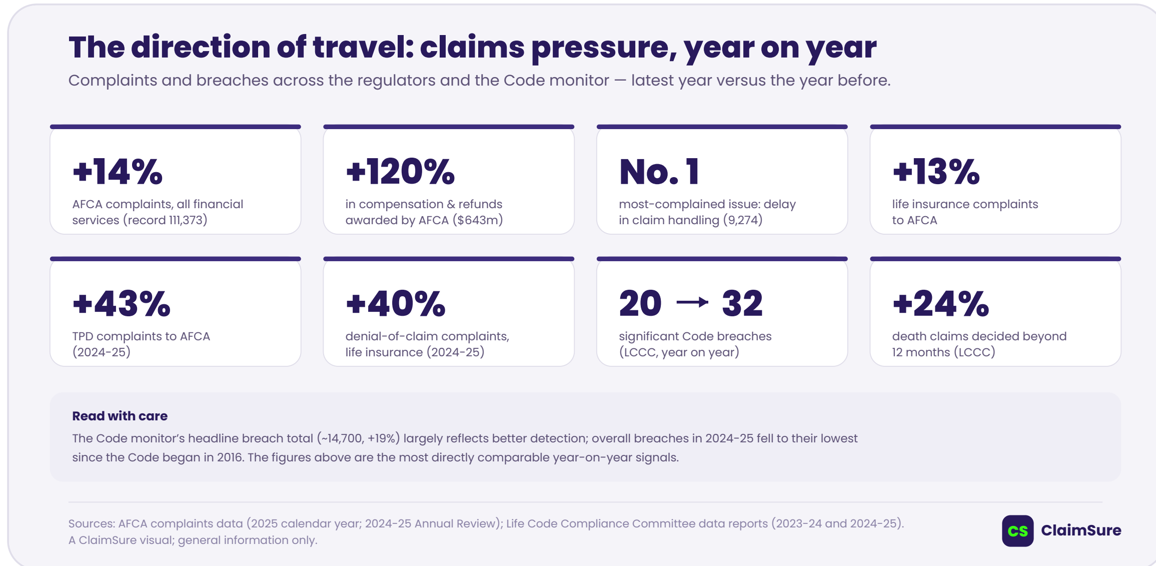
Executive summary

The Life Insurance Code of Practice is the industry's central promise on how claims are handled, and it is being rewritten. An independent review led by former ASIC Deputy Chair Peter Kell, commissioned by the Council of Australian Life Insurers (CALI), is due to deliver its final report to CALI by 30 June 2026[1][2]. The incorporation of its recommendations into a revised Code will form what the industry already refers to as "LICOP 3.0." The reviewer's Interim Report is direct about the direction of travel: insurers "will need to raise their standards" across claims handling, mental health, vulnerability, hardship, complaints and enforcement[1][29].

This paper asks a narrower, practical question. Judged against the evidence available today, are insurers ready for that higher bar? The findings, in brief:

- The current Code already sets firm claims timeframes: two months to decide an income-protection claim, six months for a lump-sum (TPD or death) claim. Yet the regulator records a meaningful tail of breaches, with around 18% of TPD claims taking longer than six months and around 14% of income-protection claims longer than two months[2].
- APRA's data for the 12 months to 31 December 2025 shows high headline acceptance but concentrated weak points. TPD and income protection carry by far the highest dispute ratios, and the non-advised ("direct") channel underperforms: direct income protection generated 446 disputes per 100,000 lives, and direct TPD recorded the lowest acceptance rate of any major cell, at 69%[5][6].

- The Code's own monitor, the Life Code Compliance Committee, recorded roughly 14,700 breaches in 2023-24, up 19%, with communication obligations the most-breached duties and a 24% rise in death claims decided beyond twelve months[7]. In 2026 it sanctioned an insurer for 358 breaches over 23 months[8].
- ASIC has moved from guidance to penalty. In November 2025 the Federal Court ordered the Cbus trustee to pay $23.5 million for failing to handle death and TPD claims "efficiently, honestly and fairly," with roughly half of open death claims and over a third of open TPD claims unresolved beyond a year[14].
- On industry figures, mental health is now the single largest driver of permanent-disability claims, close to one in three TPD claims and one in five income-protection claims, and it is the most contested issue in the review[23][24][1].



The picture is not one of an industry failing wholesale. Acceptance rates for advised and group cover are high, and several timeliness measures are improving. The gaps are real but concentrated: in TPD and income protection, in the direct channel, in claims communication, in mental-health claims, and in the operational discipline the new Code's tighter rules will demand. CALI is already resisting some of those rules[3]. For the people who depend on these claims, and for those who help them, the practical message is plain: **holding cover is not the same as satisfying a claim**, and the standard a claim is judged against is about to change.

Scope and method

This is a review paper. It draws together publicly available primary sources to assess insurer claims-handling service standards at a single point in time (June 2026): the Life Insurance Code of Practice and its independent review; regulator data and reports from APRA and ASIC; the data reports and determinations of the Life Code Compliance Committee; and complaints data from the Australian Financial Complaints Authority (AFCA).

A note on the data. Figures are attributed to their source and period throughout. Industry-collected statistics, such as CALI's and KPMG's mental-health claims figures, are identified as such and are not presented as independent regulator findings. APRA's "December 2025" claims and disputes release was published on 29 April 2026 and covers the rolling twelve months to 31 December 2025[5]. AFCA reports on

both a calendar-year and a financial-year basis, and the two are distinguished where used. "LICOP 3.0" is industry shorthand, not an official designation; the formal output of the review is a revised Life Insurance Code of Practice. Nothing in this paper is financial, legal, medical or tax advice.

1. Why now: a Code being rewritten around claims

The Life Insurance Code of Practice (LICOP) is the Australian life insurance industry's self-regulatory commitment to consumers. It establishes minimum service standards for insurers, including the timeframes for deciding claims, obligations to keep claimants informed, limits on surveillance and medical examinations, and additional protections for customers experiencing vulnerability or financial hardship. Responsibility for the Code transferred from the Financial Services Council to the Council of Australian Life Insurers (CALI) in September 2023[2].

In 2025 CALI commissioned an independent review of the Code, appointing former ASIC Deputy Chair Peter Kell as the independent reviewer. The review formally commenced on 1 October 2025, followed by a Consultation Paper on 17 October 2025, with submissions closing on 15 December 2025. An Interim Report was published on 10 April 2026, and the final report is due to CALI by 30 June 2026[1][2]. Its recommendations will inform the next version of the Code — already referred to within the industry as "LICOP 3.0" — and are intended to support a future application for ASIC approval[2].

The timing of the review is significant. It coincides with growing regulatory scrutiny of insurers' claims-handling performance. Complaints about claims delays have reached record levels at AFCA, the Life Code Compliance Committee has reported increasing Code breaches and a number of significant determinations, and ASIC has secured its largest claims-handling penalty to date[7][8][9][14].

The Interim Report leaves little doubt about the direction of reform. It concludes that insurers "will need to raise their standards", proposing changes across product design, underwriting, claims handling, vulnerability support, financial hardship, complaints, governance and Code enforcement[1][29].

This raises the central question examined in this paper: if the standard is about to rise, how well are insurers meeting the standard that already exists?

2. The regulatory architecture: Code, law and oversight

Claims handling in Australian life insurance operates within four overlapping layers of accountability. Understanding how these frameworks interact is essential to understanding what insurers' claims-handling obligations and service standards require.

The first layer is legislation. Since 1 January 2022, handling and settling an insurance claim has been regulated as a financial service under the Corporations Act 2001, following the Hayne Royal Commission and the earlier Parliamentary Joint Committee inquiry that had recommended closing the exemption for insurance claims handling[28]. Insurers and their representatives must hold the appropriate Australian financial services licence authorisation and handle claims “efficiently, honestly and fairly”[11]. This is a statutory obligation, enforceable by ASIC through the courts, regardless of any industry Code.

The second layer is ASIC’s dispute-resolution framework. Regulatory Guide 271 (RG 271) prescribes maximum timeframes for internal dispute resolution, including 30 calendar days for most complaints, 45 days for most superannuation complaints, and 90 days for superannuation death-benefit distribution complaints[12]. It also requires firms to identify, investigate and address systemic issues revealed through complaints.

The third layer is prudential supervision and industry reporting. APRA collects and publishes industry-wide claims and disputes data, working jointly with ASIC to improve transparency and public reporting[5][6].

The fourth layer is the Life Insurance Code of Practice. Owned by CALI and monitored by the independent Life Code Compliance Committee (LCCC), the Code establishes service standards beyond the minimum legal requirements[2]. It is not currently approved by ASIC, nor are its provisions directly enforceable by individual consumers through the courts. Instead, alleged breaches are investigated by the LCCC, which may require remediation, issue formal warnings and, in cases of significant non-compliance, impose sanctions[4][7]. The Code also informs the standards AFCA considers when determining complaints.

This layered framework has two important practical consequences. First, consumers dissatisfied with the handling of a claim have multiple avenues for redress, including an internal dispute under RG 271, an external complaint to AFCA, and a referral to the LCCC — although not every avenue has the power to alter the outcome of a claim. Second, the current Code review seeks to narrow the gap between the Code’s commitments and their practical effect. Among other reforms, the Independent Reviewer has recommended strengthening the LCCC’s transparency and enforcement powers and incorporating the Code into customer contracts, while stopping short of recommending that its provisions become directly enforceable by ASIC[1][8].

Taken together, these four layers demonstrate that claims handling is no longer governed by the Code alone. It sits within an increasingly integrated framework of statutory obligations, regulatory oversight and industry accountability, against which the revised Code will be assessed.

3. The current service standards

The current Life Insurance Code of Practice (March 2025 edition) establishes the benchmark against which insurers' claims-handling performance can be measured. At its core, the Code prescribes service standards governing both decision-making and communication, setting maximum timeframes within which insurers are expected to act.

Importantly, these timeframes represent outer limits, not targets. In certain prescribed circumstances, insurers may extend these deadlines by relying on the Code's defined "Circumstances Beyond Our Control" (CBOC) provisions.

Two aspects of the current standards warrant particular attention. First, the Code's two-month timeframe for income protection claims and six-month timeframe for lump-sum claims are not absolute. Both may be extended where an insurer can demonstrate that a defined CBOC applies, most commonly where information reasonably required to assess the claim has not yet been received from a claimant, treating practitioner, employer or another third party[1][4]. While these provisions recognise that some delays are unavoidable, they also mean that compliance with the prescribed timeframes does not always equate to a timely resolution for claimants.

Second, the Code does not prescribe a dedicated decision timeframe for death or terminal-illness claims. Instead, both fall within the broader six-month decision limit applicable to lump-sum claims[4]. This distinction becomes particularly significant in light of the increasing prevalence of prolonged delays in death claims, discussed later in this paper[4][7].

These standards are neither aspirational nor discretionary — they are measurable service commitments. The more important question, however, is not what the Code requires, but how consistently insurers meet these obligations in practice.

LIFE INSURANCE CODE OF PRACTICE

The claims-handling clock: key timeframes

What the current Code (March 2025) commits insurers to, stage by stage of a claim.

Stage	What the insurer must do	Timeframe	Code clause
1 When you lodge a claim	Tell the claimant about cover, benefits and the claims process	Within 10 business days of the claim received	5.5
2 Keeping you updated	Update the claimant on progress	At least every 20 business days	5.6
	Respond to a claimant’s request for information	Within 10 business days	5.7
3 Claim decision timeframes	Decide an income protection (income-related) claim	Within 2 months of claim received / end of waiting period	5.48
	Decide a lump-sum claim (TPD, trauma, death / terminal illness)	Within 6 months	5.49
	Notify the decision once all information is held	Within 15 business days	5.50
4 Your rights in the assessment	Limit on continuous surveillance	No longer than 4 months	5.42(h)
	Claimant interview	Max 90 minutes + a 5-min break at least every 30 min	5.32–5.33
5 Financial hardship	Tell a customer in urgent financial hardship what help is available	Within 5 business days of receiving evidence	6.26
6 Complaints & disputes	Final internal complaint response (insurer-owned policy)	Within 30 calendar days	7.13
	Final internal complaint response (super-trustee-owned policy)	Within 45 calendar days	7.17

Source: Life Insurance Code of Practice, March 2025. Timeframes are outer limits; some may be extended in defined “circumstances beyond c ntrol.”
A ClaimSure visual; general information only.

4. Performance against the standards

4.1 APRA: high acceptance, concentrated weak points

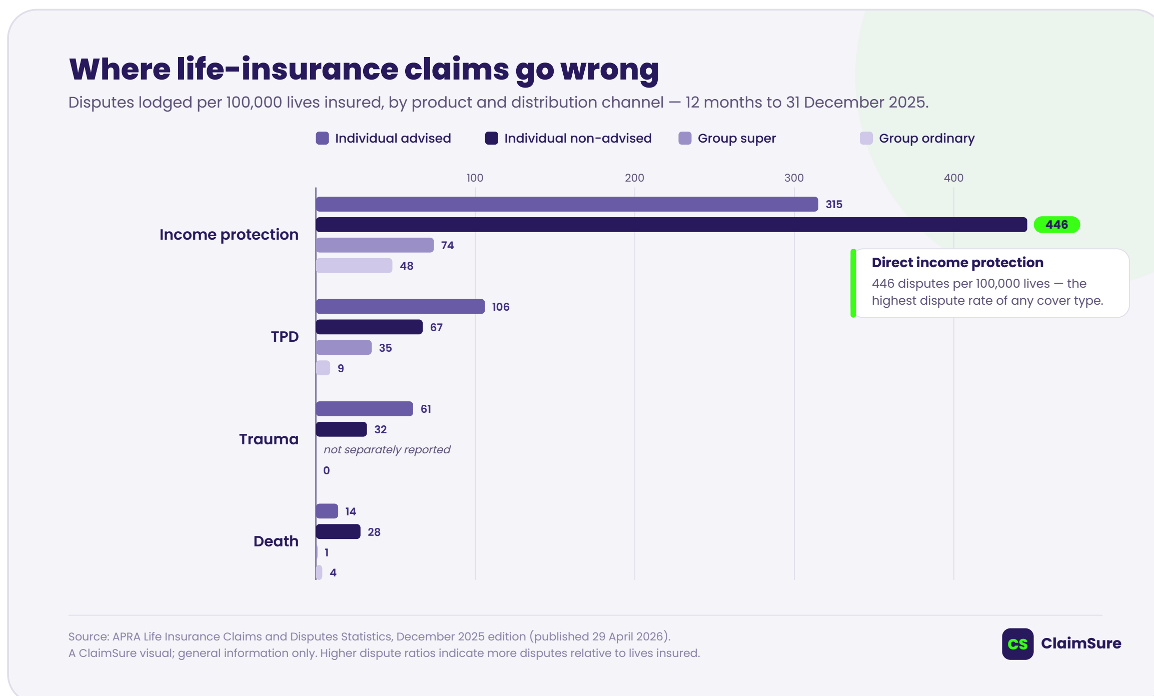
The most comprehensive picture of claims performance comes from APRA’s Life Insurance Claims and Disputes Statistics for the twelve months to 31 December 2025, published jointly with ASIC on 29 April 2026[5][6]. Covering thirteen direct life insurers, the data present a generally positive picture. Death claims continue to record exceptionally high acceptance rates of between 97% and 98% across most distribution channels, while the majority of other product-channel combinations exceed an 80% acceptance rate. The headline figures, however, mask two consistent weaknesses.

Table 2. Claim acceptance (admittance) rates by product and distribution channel, 12 months to 31 December 2025

Product	Individual advised	Individual non-advised	Group super	Group ordinary
Death	97%	92%	98%	98%
TPD	82%	69%	90%	89%
Trauma	88%	84%	—	95%
Income protection (DII)	94%	86%	96%	98%

Source: APRA Life Insurance Claims and Disputes Statistics, December 2025 edition[5][6]. "—" indicates not separately reported.

The first is product complexity. Claims involving total and permanent disability (TPD) and disability income insurance (income protection) continue to experience substantially lower acceptance rates and significantly higher dispute volumes than death or trauma claims. TPD acceptance ranges from 90% in group superannuation to just 69% in the individual non-advised market, and income protection generates the highest dispute ratios of any cover type — 315 disputes per 100,000 lives in the individual advised channel and 446 in the non-advised channel, against 106 for TPD in the individual advised channel[5][6].



The second is distribution channel. Across almost every measure, the non-advised (direct) channel performs materially worse than advised or group insurance. It records both the lowest TPD acceptance rate and the highest incidence of disputes, reinforcing concerns identified by the 2018 Parliamentary Joint Committee inquiry into the industry[28], and by ASIC in 2019, that consumers who buy insurance without financial advice, often under policies with technical definitions, experience poorer claims outcomes[13].

Timeliness data reveal a similar pattern. Death claims are typically determined within approximately one month, whereas TPD claims average around 3.8 months and remain the slowest product to resolve. Approximately 16% of TPD claims exceed the six-month Code timeframe, broadly consistent with the Consultation Paper's finding that around 18% of TPD claims and 14% of income-protection claims fall outside the Code's prescribed decision periods[2][5].

Overall, APRA's data indicate that Australia's life-insurance claims system performs well at a population level, but its weaknesses are concentrated within particular products, distribution channels and claim types rather than being spread uniformly across the industry.

4.2 The LCCC: breaches rising, communication the weak point

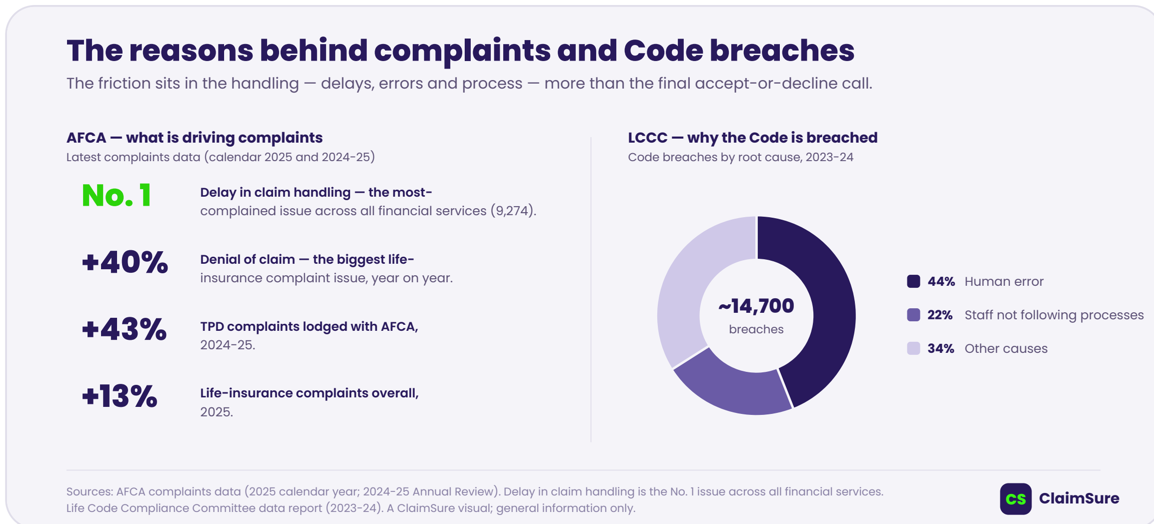
While APRA measures claims outcomes, the Life Code Compliance Committee (LCCC) measures compliance with the obligations imposed by the Life Insurance Code of Practice. Its 2023-24 Annual Industry Data and Compliance Report recorded approximately 14,700 Code breaches — a 19% increase on the previous reporting period — affecting more than 210,000 consumers[7]. While the Committee noted that improved breach detection contributed to the increase, the pattern of breaches is more significant than the overall number.

Communication obligations accounted for the four most frequently breached provisions of the Code, representing approximately 6,700 breaches, with more than 80% attributable to just three insurers[7]. By comparison, compliance with decision-making timeframes continued to improve, with 80% of TPD claims determined within six months and 84% of income-protection claims finalised within two months[7].

Nevertheless, the number of death claims remaining unresolved for more than twelve months increased by 24%, indicating that prolonged delays continue to affect some of the most sensitive claims[7]. The Committee also reported 32 significant breaches affecting more than 182,000 consumers, compared with 20 in the previous year[7].

Its willingness to impose sanctions has likewise increased. In a determination made in March 2026 and disclosed in June 2026, the LCCC sanctioned an insurer for 358 Code breaches spanning almost two years, after it failed to request information from claimants at the earliest reasonable opportunity[8]. Seven claimants experienced delays exceeding 180 business days, a further 53 waited between 91 and 180 business days, and approximately $160,000 in interest was ultimately paid to 101 affected customers[8]. Equally concerning was the twelve-month delay before the insurer identified and self-reported the systemic failure[8].

Although the Committee's 2024-25 report subsequently showed overall breach numbers falling to their lowest level since the Code commenced in 2016, concerns persisted around income-protection payment delays and rising TPD complaints[8].



4.3 AFCA: claims delay the number-one complaint

AFCA's complaints data reinforce the patterns emerging from both APRA and the LCCC. AFCA received a record 111,373 complaints during the 2025 calendar year, an increase of 14%, and secured a record $643 million in compensation and refunds for consumers[9]. Across the entire financial-services sector, delays in claims handling represented the single most common complaint, accounting for 9,274 matters[9].

Although life insurance represents a relatively small proportion of AFCA's overall jurisdiction, complaints continue to increase. The lead ombudsman reported a 13% rise during 2025[9], while AFCA's 2024-25 Annual Review identified denial of claim as the leading life-insurance complaint, increasing by 40% over the previous year; complaints relating to TPD claims increased even more sharply, rising by 43%[10].

The consistency between APRA's dispute statistics, the LCCC's compliance data and AFCA's complaint trends suggests that the principal service challenge facing the industry is no longer widespread claim declinature, but rather the timeliness and quality of claims handling.

4.4 ASIC: from guidance to penalty

The most significant development since the introduction of claims handling as a financial service has been ASIC's increasing willingness to pursue enforcement action for systemic failures. In November 2025, the Federal Court imposed a $23.5 million civil penalty on United Super, trustee of Cbus, after it admitted failing to handle death, terminal-illness and TPD claims efficiently, honestly and fairly, affecting more than 7,000 members[14]. During the relevant period, between 48% and 56% of all open death claims, and between 38% and 43% of open TPD claims, had remained unresolved for more than 365 days[14]. Separate remediation payments totalled approximately $32 million for more than 7,400 affected members[14].

The Cbus proceedings reflected broader concerns identified by ASIC. Its 2025 review of death-benefit claims handling across ten superannuation trustees found that none monitored end-to-end claims-handling times, that the fastest trustee finalised only around 48% of death claims within 90 days while the slowest managed only 8%, and that approximately 78% of delays were attributable to factors within the trustees' own control[15]. One trustee required more than 500 days to pay a death benefit of approximately $100,000 to a First Nations claimant[15]. ASIC's 2026 follow-up review concluded that some trustees had still not implemented fundamental improvements[15].

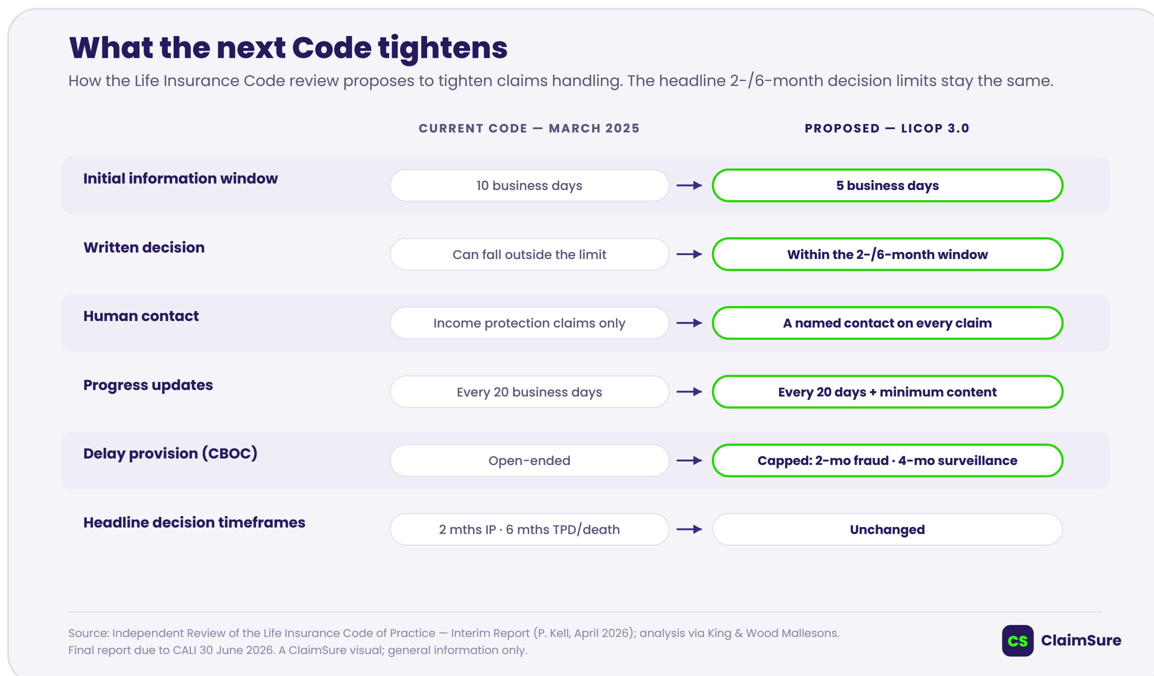
The historical benchmark remains ASIC's landmark 2019 review of TPD claims, which found that claims assessed under "activities of daily living" definitions were declined at a rate of 60%, compared with only 12% for other TPD definitions, while mental-health claims assessed under those definitions were declined at a

rate of 77%[13]. Although APRA's current data demonstrate substantial improvement — particularly within group superannuation, where TPD acceptance has risen to approximately 90% — the direct insurance market continues to exhibit many of the characteristics that prompted ASIC's original intervention.

Viewed collectively, the evidence from APRA, the LCCC, AFCA and ASIC presents a consistent picture. Australia's life-insurance claims system is not characterised by systemic failure; most claims are admitted, and several performance indicators continue to improve. However, where shortcomings occur, they are neither random nor isolated. They are concentrated in TPD and income-protection claims, the non-advised market, communication failures, claims delays and, increasingly, mental health. These are the areas where LICOP 3.0 seeks to raise industry standards, making them the clearest indicators of whether the revised Code succeeds in delivering meaningful reform.

5. What the next Code proposes, and the readiness gap

The Interim Report retains the Code's headline claims-decision timeframes — two months for income-related claims and six months for lump-sum claims — but substantially strengthens the operational requirements that sit around them[1] [29]. On claims handling specifically, the reviewer proposes to cut the initial information-gathering period from 10 to 5 business days; require the written decision to be issued within 15 business days and within the overall two- or six-month window, closing a gap under which the current clause can add time beyond the headline limit; require reopened claims to be reassessed within one month (income) or two months (lump sum) rather than restarting the clock; set minimum content standards for the 20-business-day progress updates, to stop generic "still in progress" messages; require a real, named human contact on every claim, not only income-protection claims; and restructure the "Circumstances Beyond Our Control" provision into defined categories with sub-limits, including a two-month cap on non-disclosure and fraud investigations and a four-month maximum where surveillance is used[1] [29].


What the next Code tightens

How the Life Insurance Code review proposes to tighten claims handling. The headline 2-/6-month decision limits stay the same.

	CURRENT CODE — MARCH 2025	PROPOSED — LICOP 3.0
Initial information window	10 business days	5 business days
Written decision	Can fall outside the limit	Within the 2-/6-month window
Human contact	Income protection claims only	A named contact on every claim
Progress updates	Every 20 business days	Every 20 days + minimum content
Delay provision (CBOC)	Open-ended	Capped: 2-mo fraud · 4-mo surveillance
Headline decision timeframes	2 mths IP · 6 mths TPD/death	Unchanged

Source: Independent Review of the Life Insurance Code of Practice — Interim Report (P. Kell, April 2026); analysis via King & Wood Mallesons. Final report due to CALI 30 June 2026. A ClaimSure visual; general information only.

The proposed reforms to CBOC are driven by evidence rather than principle. The Interim Report records that 79% of CBOC applications arise because information has not been received or assessed, and that "some insurers have applied CBOC because of operational delays rather than uncontrollable events"[1]. The review also proposes to strengthen the Code's governance and enforcement framework: removing

current restrictions on the Committee's $100,000 community-benefit-payment sanction, allowing the Committee to name insurers in inquiry reports, and embedding the Code in new customer contracts so its commitments become contractually enforceable — while declining to recommend that Code provisions be made directly enforceable by ASIC[1] [8].

This is the readiness gap. Several of these changes are operational, not philosophical, and the industry's own response shows they will not be absorbed without friction. In its response to the Interim Report, CALI asked for the five-business-day rule to be removed, arguing it "may, in fact, undermine the quality of information provided"; opposed fixed timeframes for reopened claims and for fraud and non-disclosure investigations; disagreed with any requirement to consult a claimant's treating doctor; and asked that the contractual-enforceability recommendation be dropped, on the basis that the Code "remains comparatively early in its development"[3]. King & Wood Mallesons advised insurers to "start a gap analysis now rather than waiting for the final report", singling out the five-day timeframe, update content, primary-contact, hardship-notification and delay-explanation requirements as the practical pressure points[29].

In other words, the proposed Code does not fundamentally change what insurers are expected to do. Rather, it expects them to perform existing obligations more consistently, within tighter operational parameters and with greater accountability. It asks them to do, reliably and on tighter clocks, the things the current data shows they are not yet doing reliably — keep claimants informed with substance, give every claimant a human contact, decide within the window, and stop using delay provisions to absorb operational backlogs. The distance between current performance and the proposed standard is the readiness gap.

5.1 The mental-health question

Mental health has emerged as the defining issue of the Code review because it sits at the intersection of increasing claims frequency, complex medical assessment and product design. On industry figures, mental health is now the leading cause of TPD claims, accounting for close to one in three claims paid, and around one in five income-protection claims. CALI reports that insurers paid more than $2.2 billion in mental-health claims in 2024, almost double the figure five years earlier, and that the rate of mental-health TPD claims among people in their thirties has risen 732% over a decade, on KPMG analysis[23] [24]. Insurers say these claims are harder to assess: TAL reports that mental-health TPD claims are notified around six months later than other claims, take longer to assess, and are now supported by legal representatives in more than half of cases[25].

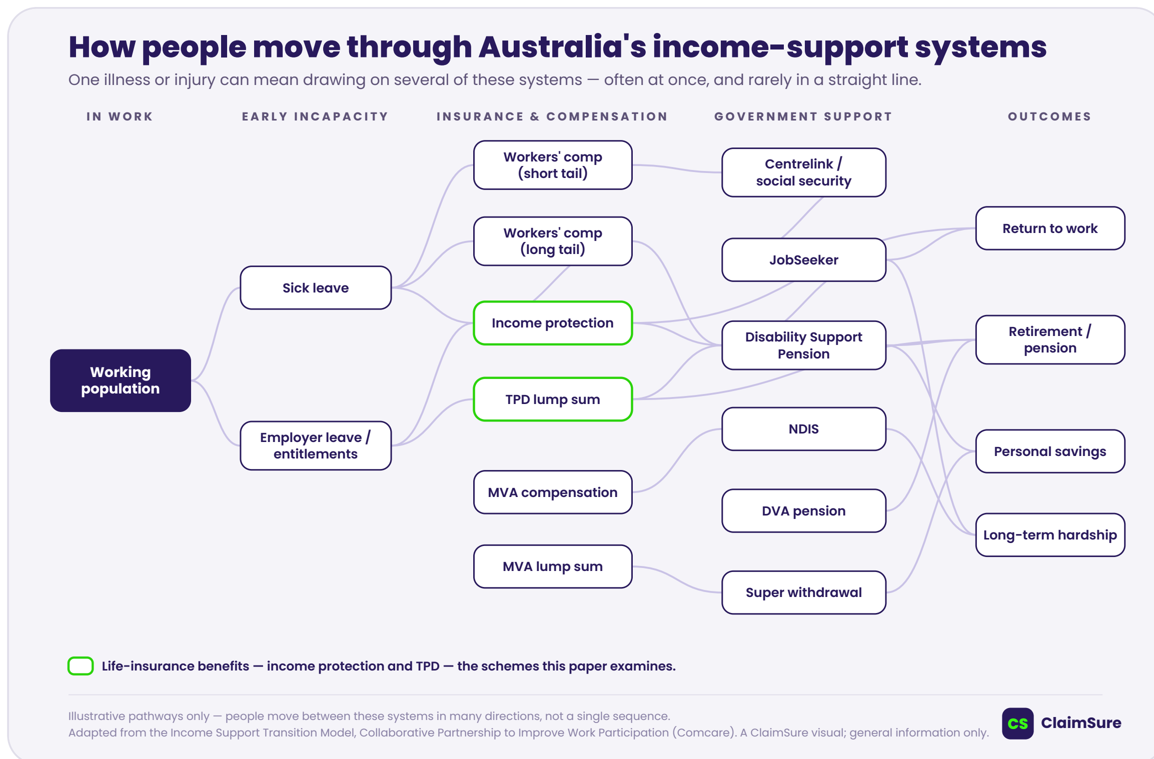
Yet mental health is also where the claims system has historically experienced its greatest friction. ASIC's 2019 review found mental-health claims under the "activities of daily living" test were declined at 77%[13], and consumer advocates have long argued such cover is "ill-suited" to mental-health conditions[26]. The Justice and Equity Centre (formerly PIAC), which has documented the issue for a decade, argues that insurers must comply with the Disability Discrimination Act when they design and apply cover, not only when they assess a claim, and that mental-health exclusions have at times been applied without clear evidence to support them[27]. The Interim Report's central, unresolved question is whether the Code should continue to prohibit blanket mental-health exclusions in standard-form policies. CALI argues that mental-health risk can only be managed sustainably through individual underwriting or product-design features, and wants the Code amended to allow limits on mental-health cover in standard-form contracts; the reviewer has characterised that position as, in effect, "a step back from the current commitment that goes beyond the requirements of the Disability Discrimination Act"[1] [3]. The final position adopted in LICOP 3.0 will influence not only product design, but also the accessibility of cover, underwriting practices and claims outcomes for future generations of Australians experiencing mental illness.

6. The wider system: why claims are complex

Claims-handling standards do not operate in isolation. A life-insurance claim is usually one stage in a longer, fragmented journey through Australia's income-support systems, and that fragmentation is itself a source of claim complexity and delay.

6.1 A fragmented safety net

Research by the Collaborative Partnership, hosted by Comcare, mapped ten separate benefit and income-support systems available to a person whose illness, injury or disability affects their ability to work. They include workers' compensation (short and long tail), social security, veterans' compensation, motor-accident schemes, early release of superannuation, and life-insurance income protection and TPD as two distinct systems[16]. The peer-reviewed analysis behind the map found that $37.2 billion was spent on income support in a single year, and that there is "a paucity of information relating to movement between systems"[17]. People do not move through a single clear pathway; they move between systems, often starting "upstream" in workers' compensation or insurance and ending "downstream" in social security[16]. A 2026 update led by CALI and SuperFriend makes the point directly relevant to claims handling: "by the time someone turns to life insurance, they have often moved through other parts of the ecosystem... these claims tend to be more complex and longer in duration"[30].



Research case study: one incapacity, four systems

The Collaborative Partnership's modelling illustrates the journey through a representative case it calls Patricia, a 52-year-old aged-care worker with work-related chronic back pain. Over roughly four years she moved through four of the ten systems in sequence: employer sick-leave entitlements, then workers' compensation, then a social-security payment at around a quarter of her previous income, and finally a TPD lump sum through her superannuation before returning to work[16]. The case is illustrative rather than a ClaimSure client, but the lesson is general. A single period of incapacity can trigger several systems one after another; the TPD entitlement sat alongside, not instead of, the other supports; and the path took years, not months. It is exactly the kind of long, multi-system journey in which an insured benefit can be overlooked.

6.2 Insurance through superannuation, and the cover that vanished

For most Australians, life, TPD and income-protection cover is held by default through superannuation. On ASFA's 2026 figures, insurance through super covers 9.3 million Australians for death and 8.2 million for TPD[19]. Two reforms deliberately narrowed that default cover. From 1 July 2019, the Protecting Your Super Package switched off insurance on accounts inactive for sixteen months; from 1 April 2020, Putting Members' Interests First made cover opt-in for members under 25 and for accounts below $6,000[18]. The reforms protected low balances from erosion, but they also removed cover from people who did not realise they had it. ASFA estimates around five million accounts lost cover, that roughly 5,000 people a year now die without cover that would have paid around $670 million in benefits, and that around 11,000 a year miss approximately $1.5 billion in TPD benefits[19]. This is why a claims review must also be an underinsurance review: the first question in many claims is not whether the claim succeeds, but whether the cover still exists.

Separately, the Government has announced mandatory, enforceable service standards for large superannuation funds covering "the timely and compassionate handling of death benefits," "fair and efficient processing of insurance claims," and member communications[20]. The Code review notes that

the Code's group and superannuation claims provisions should be revisited once those standards are finalised, which means two reform tracks are converging on the same claims-handling problem[1][20].

6.3 Overlapping schemes, offsets and independent rights

This complexity is not academic. Cost-of-living pressure is pushing more Australians to lean on the safety net, and to lean on several parts of it at once. On the latest CALI and SuperFriend mapping, around 8.5 million people drew on some form of income support in a single year[30], during a stretch AFCA describes as one of sustained household cost-of-living pressure[31]. For most working Australians, though, the only cover they hold is the default insurance inside their super, and that cover is usually TPD: more than 13 million people hold TPD, almost all of it through superannuation[13]. So when someone under financial strain calls looking for relief, they are often pointed to the one product they have, a permanent-disability lump sum, and decide they might as well lodge a claim, even where income protection, early release of super or another pathway might fit their situation better.

CALI itself has described the result as people being "left with little choice but to label themselves totally and permanently disabled," even where the evidence suggests they could return to work, calling it "a square peg in a round hole"[23]. That mismatch sharpens the onus on the insurer. The Code already treats financial distress as a form of vulnerability[4], and the review would require clearer, minimum-content updates and a named human contact on every claim[1], which means an insurer has to be able to explain, in plain terms, the technical distinctions that decide whether a benefit is paid and which pathway actually fits. Three of those distinctions matter most, and none should be assumed.

First, income protection and lump-sum benefits behave differently. Income-protection benefits are typically reduced ("offset") by other income replacement, such as workers' compensation weekly payments, motor-accident income benefits, and in some policies certain Centrelink payments, usually with a lump sum converted to a notional monthly amount. TPD lump sums are generally not offset against income protection[21]. Whether an offset applies depends on the policy wording, and the distinction between an income benefit and a lump sum can change the result[21].

Second, eligibility under one scheme does not determine eligibility under another. Being on workers' compensation, the Disability Support Pension or a motor-accident scheme does not automatically establish, or defeat, a TPD or income-protection claim, because each scheme applies its own test[21][22]. A TPD claim can be based on all the medical conditions affecting a person's work capacity, whereas a workers'-compensation claim is confined to work-related conditions[21]. The Disability Support Pension applies a statutory impairment test that is separate from any policy definition[22].

Third, the policy definition is decisive. Most TPD cover in superannuation uses an "any occupation" test, under which the claimant must show they cannot work in any occupation suited to their education, training and experience. That is harder to satisfy than the "own occupation" test and turns on vocational as well as medical evidence[22]. A claim can fail not because the person can work, but because the medical evidence addresses only their old job. Being unable to work is not the same as satisfying every insurance definition. These distinctions are where claims are won, lost, delayed or missed, and they are the reason claims navigation can matter as much as eligibility, and why the duty to explain them clearly, a duty the next Code sharpens, is part of handling the claim rather than a courtesy beside it.

7. Assessment: are insurers ready?

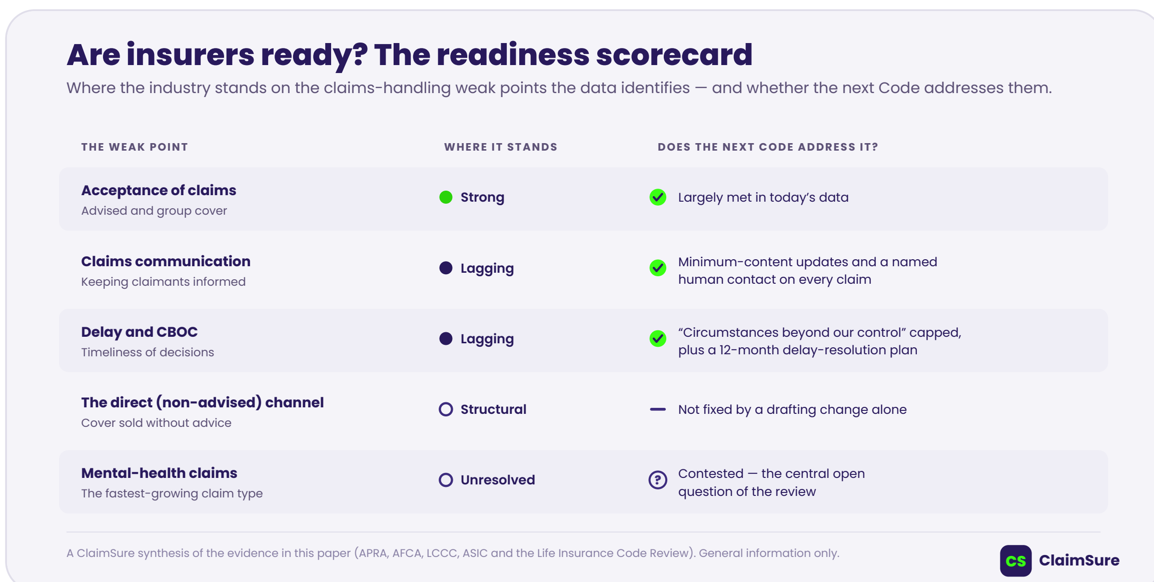
On the evidence, the answer is qualified. Insurers are readier than they were, but not yet ready where it matters most.

The case for readiness is real. Acceptance rates for advised and group cover are high and stable; group-super TPD acceptance has risen to 90% from the troubled picture ASIC documented in 2019; the LCCC's 2024-25 data shows overall breaches at their lowest since the Code began; and the headline decision timeframes are met in the large majority of cases[5][7][8][13]. The industry is not starting from a position of systemic failure.

The gaps, though, are concentrated exactly where the new Code applies pressure. Claims communication, the duty the LCCC found most breached, is the subject of the review's new minimum-content and human-contact requirements[7][1]. Delay and the misuse of "circumstances beyond our control," visible in the LCCC's sanction, in AFCA's number-one complaint category and in the Cbus findings, are the target of the review's tighter CBOC categories and twelve-month delay-plan requirement[8][9][14][1]. The direct channel's weak acceptance and high disputes, and the long tail of TPD and income-protection claims, are structural and will not be fixed by a drafting change alone[5]. And the mental-health question, the largest and fastest-growing source of permanent-disability claims, remains genuinely unresolved, with the industry seeking to limit cover and the reviewer warning against a retreat from existing commitments[23][1][3].

Three things will determine whether the gap closes. The first is operational. The new standards are about systems, staffing and monitoring, and the Cbus case turned on a trustee that did not even measure its own end-to-end claims times, so several insurers will need to invest before, not after, the Code changes[14][15][29]. The second is the industry's own posture. CALI's resistance to the five-day rule, fixed investigation timeframes and contractual enforceability suggests the final Code may land softer than the Interim Report, which would narrow the formal gap but not the performance gap[3]. The third is enforceability. A Code whose commitments are embedded in customer contracts, monitored by a committee that can name insurers and is no longer constrained in its sanctions, is a materially different instrument from today's[1][8].

The honest conclusion is that readiness is not binary. The leading insurers are close; the laggards, concentrated in the direct channel and in the operational discipline of claims communication and timeliness, are not, and the data does not let them hide. The next Code will make that distinction visible in a way the current one does not.



8. Conclusion

The question this paper set out to answer, whether insurers are ready for the next Code, has no single answer, because readiness is not evenly distributed. On the evidence, the leading insurers are close and the laggards are not, and the gap falls in consistent places: TPD and income protection rather than death cover; the non-advised channel rather than advised or group cover; claims communication and delay rather than the ultimate accept-or-decline decision; and, increasingly, claims with a mental-health component[5] [7] [9] [13]. The significance of the next Code is that it will make that distinction visible and, if its enforcement proposals survive, harder to sustain.

The independent reviewer's final report is due to CALI on 30 June 2026, with a revised Code, and a possible application for ASIC approval, to follow. The decisive question is not whether the Code is rewritten, but whether the final version keeps the Interim Report's teeth: enforceable decision timeframes, minimum-content progress updates, a named human contact on every claim, structured limits on "circumstances beyond our control," transparent monitoring, and a committee able to name insurers. CALI's response signals that several of these will be contested, and the mental-health question, whether standard-form policies may limit cover, remains genuinely open[1] [3] [23]. The distance between a Code that raises standards on paper and one that changes conduct in practice is the gap worth watching.

Whatever the final Code says, one finding will outlast it. In a safety net assembled from ten overlapping systems, **holding cover is not the same as satisfying a claim definition**. Behind every figure in this paper is a person, often unwell and under financial strain, trying to navigate a system that was never built to be understood from the inside. A stronger Code can shorten the timeframes and sharpen the language, but the duty to explain a claim, and to make sure a benefit has not been missed, still rests with people. That is the practical reality the data in this paper describes, and it will not change on 30 June.

About the authors

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About ClaimSure

ClaimSure assists Australians navigating life insurance and superannuation claims, including total and permanent disability (TPD), income protection, and death and terminal-illness benefits, and the way these interact with workers' compensation, motor-accident and social-security systems. ClaimSure is a registered business name of CLM Advisory Group Pty Ltd (ABN 35 689 536 847).

Disclaimer

This paper provides general information only. It does not take into account your personal circumstances and is not financial, legal, medical or tax advice. Claim eligibility depends on the relevant policy wording, legislation, medical evidence, employment history and individual circumstances.

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