Insurance claims summary guide

Macquarie Investment Management

20 MARCH 2020

1. Our role and that of your insurer

Macquarie Investment Management Ltd (MIML) as Trustee of the Macquarie Superannuation Plan, is the owner of the insurance policy issued by your insurer. Our role is to work constructively with your insurer to guide you and your adviser through the claims process.

If we determine that you have an active policy on which you could make a claim, we'll take action to ensure that any claim with a reasonable prospect of success is pursued. We'll be in regular contact with your insurer to ensure that your claim is on track and to see if there is additional support that we can provide.

Once you've submitted your claim form and supporting documents to the insurer, a claims assessor will be allocated to your case, who will help you:

- **Collect information required for your claim**

  We'll do this by identifying the information you will be required to provide to assess your claim and, if you need it, will assist you in obtaining that information. If your medical condition hasn't yet stabilised to allow a decision to be made, we'll tell you that your claim will be progressed further when more information is available and we'll let you know the information you're required to obtain and provide to us once your condition has stabilised.

- **Stay updated**

  We'll keep you up to date on the progress of your claim. If there are issues delaying assessment of your claim, we'll let you know what these are. If the insurer tells us that it is unable to a make a decision on your claim in the timeframes provided in the Financial Services Council's (FSC) Life Insurance Code of Practice because information necessary for assessment hasn't been provided, we'll inform you of this and tell you the revised timeframes for assessment.

Your insurer is responsible for issuing your insurance. The terms of your insurance product are outlined in the insurer's PDS. The insurer assesses your claim based on the terms within the PDS.

2. Our claims philosophy

Our philosophy is to manage claims by:

- treating you with respect and compassion
- seeking to understand your situation without judgement and identifying any cover held within our fund under which you may be entitled to claim
- not discouraging you from making a claim
- handling claims with empathy and professionalism
- overseeing the claims process and your insurer in a thoughtful and proactive manner, helping you to navigate this process
- proactively engaging with other parties in the claims process, such as any representative that you engage, to minimise delays and remove unnecessary duplication from the process
- adopting a continuous improvement approach, solving any problems as they arise
- advocating on your behalf if we don't agree with your insurer's decision.

3. Claims handling process

3.1 Contact us

If you'd like to lodge a claim, call us on 1800 025 063 or email **wrapsolutions@macquarie.com**. If you're unsure if you should apply, call us and we'll help you work out the next steps. You can also lodge a claim directly with your insurer.

3.2 Eligibility check

As the Trustee of the superannuation fund, we're available to assess your initial eligibility to claim and provide you with assistance in lodging your claim with the insurer. Your insurer will run through further eligibility requirements with you as part of the claims process.

We'll also answer any questions you have about the claims process, including what information the insurer may require, how the process will work and provide you with contact details of your MIML Claims Manager.

Our record of your claim request is available to you on request.

3.3 Submitting your claim

If you qualify, we'll notify the insurer that you wish to submit a claim and request they send you a claim notification pack via email or post which contains claim forms and other supporting information.

We'll only ask for and rely on information and assessments that are relevant to the claim and policy, and you can ask us to give you an explanation of the relevance of the information requested. If you disagree with the relevance of any requested information, the request will be reviewed.

Information which may be required to assess your claim includes:

- medical information from your treating practitioners
- financial records (including ATO records, for example, Income Tax Returns and Notices of Assessment)
- personal statement
- occupational, rehabilitation or workplace assessments
- independent medical examinations with specialists chosen by the insurer, files from other insurers where you may have submitted a claim (including workers compensation, life insurance and motor accidents)
- Centrelink and Medicare information.

The claim pack will also provide you with the contact details of the insurer. In addition to your insurer, you can also get information about your claim from your MIML Claims Manager.

3.4 Claims assessment

Once your claim has been submitted, your insurer will conduct a comprehensive assessment of your claim.

The time it takes to assess a claim depends on the type of benefit you're applying for, the complexity of your claim and the speed at which relevant information can be requested by the insurer.

As a guide, the FSC Life Insurance Code of Practice provides that income protection claims should be assessed within 2 months and claims for terminal illness, death and total and permanent disablement (TPD) within 6 months, subject to unexpected circumstances. Where unexpected circumstances do occur, you will be advised by the insurer. If your condition has not stabilised, we'll tell you the revised timeframes for assessment.

You can access the FSC Life Insurance Code of Practice at **www.fsc.org.au**.

We'll work together with your insurer to ensure a consistent and efficient process for you, complying with the timeframes provided in the FSC Life Insurance Code of Practice.

3.5 Claims review

The insurer will review all the information you have provided before forming a view on your claim. The decision will be communicated to you once MIML has completed its review of that decision.

Before declining your claim, the insurer will provide you with a list of all the information it's relying on to determine your claim. You'll have an opportunity to respond to this material before the insurer makes any decision on the claim.

If the insurer determines that you don't meet the conditions of the policy, it'll provide us with the reasons for the decline of your claim. We'll review all the information the insurer has relied on to make their decision and determine whether we agree with the insurer's decision. If we don't agree, we'll advocate on your behalf and return the claim to the insurer to consider further.

3.6 Claim outcome

Once there is a decision, you'll receive a letter from your insurer or us to let you know our final decision and confirm any payments if, and when they're due.

Any payment of a benefit is dependent on the insurer accepting your claim. Further, the release of the benefit to you outside of superannuation is dependent on satisfaction of a condition of release.

We'll assess whether you've met a condition of release within 5 days of the insurer confirming that it intends to make a payment to us. We'll have a process in place to review the amount paid to ensure it's correct.

4. Accepted claims

4.1 Income Protection claims

Accepted Income Protection claims are paid directly to you on a monthly basis in arrears and require ongoing assessment before each payment is made. The insurer will require you to complete personal statements, as well as provide medical certification that you're either totally or partially disabled. Any delay in providing these forms may result in your payment also being delayed.

Please note that Pay As You Go (PAYG) tax may be deducted from your benefit. The insurer will provide you with an annual statement which sets out the amount of PAYG which has been withheld at the end of each financial year.

How your level of cover is calculated, as well as the waiting period and any loading or exclusions, are set out in your policy schedule which was provided to you when the insurance policy was initially taken out. It's important to review both the policy terms and the policy schedule before making a claim as it'll set out the terms on which you are able to claim.

The benefit of this type of policy is designed to replace a percentage of lost income during a period of disability. The benefit is generally limited to a proportion of your pre-disablement earnings, usually up to 75% of your salary, as specified in your policy schedule. If you're receiving income from other sources such as other income protection policies, Centrelink and workers' compensation, your monthly benefit payments may be offset by the amount you are receiving. This means that your benefit payment may be reduced. If we become aware of this impact, we'll provide you with information about the factors you may want to consider in order to determine the best financial outcome for you.

The insurer may offer rehabilitation or other support services to assist in returning to work. Any rehabilitation services require the pre-approval of the insurer rather than being an automatic benefit. We'll support the insurer to:

- seek to identify ways to support your recovery as quickly as possible to maximise health outcomes
- promote best-practice rehabilitation and injury management where these are consistent with the terms of the policy.

4.2 Total and Permanent Disablement claims

If you're eligible for a TPD benefit and meet the terms of the policy, the lump sum benefit is paid into your superannuation account (not to you directly). For the benefit to be released from superannuation, you must also satisfy a condition of release and complete a withdrawal form available at **macquarie.com/yourwrap**.

The condition of release which enables funds to be paid out of your superannuation account may be different to the TPD definition that applies under your policy. This means that whilst you may be paid a benefit by your insurer, it can't be released from your superannuation account until you meet a condition of release. For more information, please contact your adviser.

4.3 Death claims

A representative of the estate of a life insured who has deceased can begin the claims process by contacting us. We will request that the insurer provide the representative with the necessary information to lodge the claim.

The Death benefit will form part of the life insured's superannuation balance. This balance is subject to any binding nomination made by the life insured and does not form part of the estate of the life insured. We'll pay the Death benefit to the person(s) that are nominated so long as the nomination remains binding and effective.

4.4 Terminal Illness claims

You may be able to claim on your Death policy if you've been diagnosed as being terminally ill. This benefit is then paid into your superannuation account and you can apply to us to have this amount released.

If you request that we release part of your superannuation due to terminal illness, it's important to ensure that you leave enough money in your account to cover any insurance premiums.

In each circumstance there may be financial, or tax implications and you may wish to get independent advice.

5. Declined claims

If your insurer intends to decline your claim, you'll be contacted and provided with:

- an explanation in plain language to enable you to understand the reasons for the insurer's view
- an outline of the evidence relied upon in forming that view
- a list of all documents obtained by the insurer and us during the assessment
- an opportunity to receive any documents on request.

You'll then have the opportunity to review this information and provide further information to clarify the insurer's reasons for their view. If you require any assistance with this process, you can contact your MIML Claims Manager. If you respond during this process with additional information, we'll ensure that the insurer reconsiders your claim with the new additional information received. We'll also review your claim within 15 business days of receiving the new information.

As part of our review, we'll consider your insurer's reasons for the declining of your claim. This involves reviewing all the information provided by you during the claim assessment process and relied on by the insurer to make their decision. If we believe there isn't enough information to make a properly informed decision, we'll let you know. We'll request any further information or assessments we need as early as possible and will avoid multiple information requests where possible.

We'll then determine whether we agree with your insurer's decision. If we don't agree, we'll tell the insurer within 5 business days of completing our review. If we believe the claim has a reasonable prospect of success, we'll advocate on your behalf and return the claim to the insurer to consider further. We'll keep you informed as the claim proceeds.

Such examples include, but aren't limited to:

- we're unsatisfied with the insurer's reasoning for declining the claim
- we're of the opinion that further information (such as additional medical evidence, or other relevant information) might be available which we believe may alter the outcome of the insurer's decision, and
- we believe additional inquiries need to be made to resolve any conflicting or insufficient information on the claim.

We won't accept the insurer's decision to deny a claim until we're satisfied that the insurer has reviewed the information that we consider relevant to the claims decision and thus, as policy holder and Trustee, we have acted in a manner that provides you sufficient opportunity to be assessed for a benefit.

If we're satisfied with your insurer's decision, your claim will be declined. In declining your claim, we'll:

- explain this decision to you in writing with the reasons why your claim is being declined
- advise how, if you aren't satisfied with the decision, you can make a complaint and explain our complaints process.

6. Complaints

You can get in touch with us at any time to discuss your claim, your cover or any issues you're having with your insurance. We'll work with the insurer to ensure any complaints are considered and reviewed as quickly as possible. If you're unhappy with our products or our service, please tell us about it and let us know how you think we can fix it.

How to lodge a complaint?

If you have a complaint about the service provided to you, please contact:

- your adviser and discuss your concerns
- our contact centre on **1800 899 485**.

Alternatively, if you prefer to submit a written complaint, please do so to:

The Complaints Officer
GPO Box 4294
Sydney NSW 1164
Email: **complaints@macquarie.com**

We'll assess your complaint and advise you of the outcome, either by telephone or in writing.

What happens after your complaint is lodged?

1. We'll let you know the name and contact details of the person who'll handle your complaint. Your complaint contact will answer any questions you have about the process and explain any relevant timeframes. We may also provide your complaint to the insurer for review.
2. Your complaint contact may require additional information from you or the insurer. Only information relevant to your complaint will be requested.
3. We'll then review the available information and provide a written response. We'll address any issues identified promptly.
4. We'll provide a final response to your complaint in writing within 45 calendar days of receiving your complaint. Our response will provide the reasons for our decision and you can request copies of documents which were relied on in coming to that decision.

In exceptional cases, we may need more time to investigate and respond to your complaint. If so, we'll tell you that we need more time, and will clearly communicate our revised expected timeframe, which won't exceed 90 calendar days.

If our clients aren't satisfied with our handling of a matter, they have the option to request their complaint to be reviewed free of charge by either the Customer Advocate or contact an external dispute resolution scheme. The Customer Advocate's role, should you decide to pursue this avenue, is to review the reasonableness and fairness of the outcome of your complaint.

You may contact our Customer Advocate via the following:

The Customer Advocate
Macquarie Bank Limited
GPO Box 4294
Sydney NSW 1164
Tel: 1800 898 307
Email: **customeradvocate@macquarie.com**

What if you aren't satisfied with our response?

If any issue hasn't been resolved to your satisfaction, you can lodge a complaint with the Australian Financial Complaints Authority (AFCA). AFCA provides fair and independent financial services complaint resolution that is free to consumers.

You may lodge a complaint with AFCA if:

- your complaint relates to a Macquarie product or services and
- you are not satisfied with our response after 45 days.

AFCA can be contacted via the below details:

Australian Financial Complaints Authority Limited
GPO Box 3
Melbourne VIC 3001
Tel: 1800 931 678 (free call)
Email: **info@afca.org.au**
Website: **www.afca.org.au**

7. Contact details

Your MIML Claims Manager is here to support you through the claims process. Their contact details are:

Attention: The Claims Manager
Macquarie Investment Management Limited
GPO Box 4045
Sydney NSW 2001
Email: **MIMLPlatformInsurance@macquarie.com**

Please note that we make staff available who are cross-cultural to assist with translation for non-English speaking clients.

If you require an interpreter service, please contact the Translating and Interpreting Service (TIS National) on 13 14 50 (or +61 3 9268 8332 if calling from outside Australia).

If you have any questions regarding your claim process, please contact us directly using the details above.

We understand lodging an insurance claim may be an emotional process and our aim is to provide you with a service that's fair, straightforward and transparent for all parties. This claims summary has been designed to give you an overview of our claims process. In particular, we'll provide you with information on how we interact with your insurer and how to contact people who can assist you with your claim.

For specific details about your insurance product, you should refer to the Product Disclosure Statement (PDS) issued by your insurer.

No Personal Advice

The information contained in this Guide is not personal financial product advice. It's been prepared without reference to your particular investment objectives, financial situation, taxation position and needs. It's important that you read this Guide in its entirety, as well as the PDS for your superannuation and insurance products. You should consider your own objectives, financial situation and needs before making any decision in relation to your insurance. If you're in any doubt in relation to these matters, you should consult your investment, financial or other professional adviser.