

Life Insurer Conduct and Culture

Findings from an FMA and RBNZ review of conduct and culture
in New Zealand life insurers

January 2019

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Executive summary

Purpose

The overall objective of this review was to understand whether there are widespread conduct and culture issues present in life insurers in New Zealand, and to understand how life insurers identify and remediate issues.

The conduct of life insurers directly affects customers, regardless of whether the insurers sell insurance directly or through other parties. High standards of conduct support the fair, sound, efficient and transparent provision of insurance, and confident participation in the insurance market by insurers, intermediaries and customers. Poor conduct is a contributing factor to poor customer outcomes, and can result in a loss of trust and confidence in the life insurance industry.

One of the key drivers of conduct is culture. Culture influences how managers and staff behave on a daily basis. An effective organisational culture is one that consistently puts the customer at the centre of decision-making, product design, sales, advice and claims processes, and all day-to-day activities.

New Zealand's two main regulators of financial markets are the Financial Markets Authority (FMA), which focuses on conduct regulation of some financial market participants, and the Reserve Bank of New Zealand (RBNZ), which focuses on maintaining a sound and efficient financial system through prudential regulation.

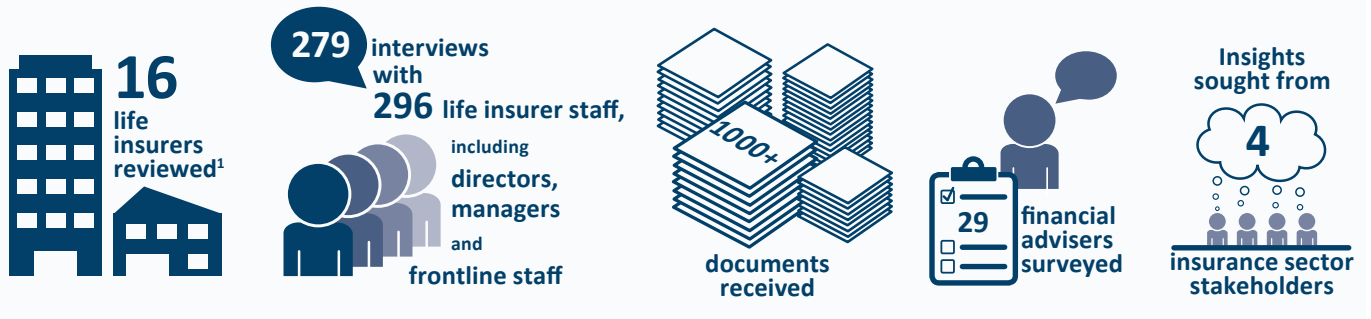
Neither regulator has an explicit legislative mandate for the regulation of conduct in relation to life insurance. However, standards of life insurer conduct are implicit and important to the statutory purpose of both regulators. Therefore, we decided to seek assurance from New Zealand life insurers that there are not widespread conduct and culture issues present in their businesses. Our work also set out to assess the maturity of life insurers' systems, controls and governance around conduct risk.

Background

In November 2018 the FMA and the RBNZ published the [findings of a review of conduct and culture in New Zealand retail banks](#). This review was prompted by the Australian Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry (ARC). The ARC was a response to widespread misconduct incidents in Australia's financial services industry over the past decade. Our concern about the ARC's impact on confidence in New Zealand's financial institutions and the potential for complacency in the industry led to the bank review.

This report is the second phase of our review of conduct and culture in the financial services industry. We have chosen to review life insurers because:

- The ARC highlighted failings in the treatment of life insurance customers in Australia.
- Some life insurers operating in New Zealand are Australian-owned, including some by Australian banks, which raises the question of whether the same failings highlighted in Australia exist here.
- The nature of life insurance means:
 - products are complex, high value, long term and can be difficult to replace or switch between, which creates risks for customers
 - poor customer outcomes arising from poor conduct may only be discovered after a customer has had an insurance policy for a long period of time, and in the difficult circumstances that give rise to a claim.
- [Previous FMA reviews](#) conducted between 2016 and 2018 in relation to life insurance highlighted methods of selling life insurance that create risks in relation to good customer outcomes.



What we reviewed

We reviewed 16 life insurers¹ that issue (ie underwrite) life insurance products (see page 36). In this report, we do not attribute findings to individual life insurers, because our focus is on the life insurance sector as a whole.

Our review took place between June and November 2018. It was based on analysis of documents provided by life insurers, followed by onsite interviews with frontline staff, management and executives, as well as a sample of directors. We looked for clear evidence to support what we were told and compared this to the other information supplied during our review.

We also sought insights from other insurance industry stakeholders and financial advisers who distribute life insurance.

Our view of life insurers' conduct and culture

Our review found extensive weaknesses in life insurers' systems and controls. Across the sector, governance and management of conduct risks is weak and there is a lack of focus on good customer outcomes. There is a serious risk of further conduct issues arising. Insurers need to act urgently and undergo major change to address these weaknesses, as they leave the industry vulnerable to misconduct and escalation of issues, as

¹: During the review four life insurers were undergoing merger activity: AIA with Sovereign, and Cigna with OnePath. Where appropriate our information requests and interviews were combined for these two pairs of life insurers to avoid unnecessary duplication.

seen in other jurisdictions.

We also saw several instances of poor conduct and some examples of potential misconduct (ie breaches of the law). Some of the issues and themes are similar to those highlighted in Australia, albeit on a much smaller scale. Although these conduct and culture issues resulting in poor customer outcomes are serious, the number of instances identified means we would not currently categorise these issues as widespread.

However, given the weaknesses we observed in life insurers' processes for identifying risks and issues, and effectively managing them, we cannot be confident that insurers themselves are aware of all current issues.

Remediation of conduct issues and risks is also generally very poor. Insurers have been too slow to respond to the issues they are aware of, and in some cases are not sufficiently remediating them. In a few extreme cases they have shown disinterest in remediating them at all.

Overall, our view is that life insurers have been too complacent when it comes to considering conduct risk, too slow to make changes following previous FMA reviews, and not focused enough on developing a culture that balances the interests of shareholders with those of customers.

Consumer trust is paramount to the effective functioning of the life insurance industry in New Zealand. We are concerned that this trust could be eroded unless life insurers – led by boards and senior management – transform the way they approach conduct risks and issues, and achieve a customer-focused culture.

What we found

We saw serious weaknesses in the approach of insurers to identifying, managing and remediating conduct risks and issues. While we found relatively few instances of potential misconduct, the lack of consideration given to investment in and maintenance of robust systems and processes is causing poor customer outcomes.

The issues we found were compounded by the fact that insurers' products are often sold by intermediaries². Some insurers appeared to believe they have no responsibility for customer outcomes that are influenced by the conduct of these intermediaries, and make little effort to maintain visibility of customer outcomes where an intermediary is involved. Insurers ultimately need to take responsibility for whether or not customers are experiencing good outcomes from their products, regardless of how they are sold.

Delivering good customer outcomes

- We saw several instances of poor conduct and some examples of potential misconduct that have resulted in poor customer outcomes (see page 28).
- In situations where third-party advisers were selling life insurers' products (and receiving commissions or other incentives), a few life insurers saw the adviser – not the policy-holder – as the customer.
- There was limited evidence of products being designed and sold with good customer outcomes in mind, and very little in the way of policies for identifying and dealing with potentially vulnerable customers.
- While some insurers had good policies and practices for regular ongoing contact with customers to assess ongoing suitability or provide information about policy changes, others did little or nothing in this area.

²: An intermediary is person or entity who sits between an insurer and a customer, and promotes or facilitates an insurance contract between them. Intermediaries include third-party advisers, banks (including banks that are in the same group of companies as an insurer), other insurers, and organisations that arrange group insurance for their employees or members. Some intermediaries work for just one insurer. Others distribute products of multiple insurers.

More information is available in the 'Detailed findings' section, where we have organised our findings into themes based on four elements of managing conduct and culture.



- We saw evidence of sales incentive structures (internal and external) creating risks of sales being prioritised over customer outcomes, and of policies being 'churned', ie, customers being sold new policies that are not in their best interests so the salesperson can earn a commission.
- There was clear evidence of claims staff having a strong focus on good customer outcomes, but this attitude was not always reflected across life insurance organisations as a whole.

Conduct and culture governance

- Few life insurers had given any serious thought to conduct and culture prior to this review. Most boards had not started to think about conduct risk in their business prior to our review.
- We saw little evidence that life insurers had analysed conduct, systems and processes against the ARC, and the expectations set out in the FMA Conduct Guide (see page 34) prior to our review.
- Boards and senior management were not setting the tone for managing conduct risk and prioritising good customer outcomes.

- We noted some issues around independence, autonomy and control with boards of life insurers that are part of a group such as bank insurers³ and foreign-owned insurers. This affects their ability to identify and manage conduct and culture risks related to the insurance functions of the business or the local market.
- Where sales and advice were handled through intermediary distribution channels, there was a serious lack of insurer oversight and responsibility for sales and advice, and customer outcomes.

Conduct and culture risk management

- Reporting of conduct risk was limited, often ad hoc and reactive, and focused on 'lag' (retrospective) indicators of conduct risk such as complaints.
- Overall, conduct risk management was insufficiently integrated across all parts of life insurers' businesses. Risk management functions were often thinly resourced, with little focus on conduct and culture risk.
- Formal whistleblower policies were not well understood or utilised. Some policies did not have anonymous, confidential or independent channels for raising matters.
- Staff training on products, and sales and advice processes was typically under-resourced and under-prioritised. Some life insurers were starting to introduce conduct training for staff. Training for intermediaries appeared inadequate and patchy, and there was little evidence of guidance being provided on conduct expectations.

Issue identification and remediation

- Our review identified 16 specific remediation activities that were in progress or had recently been completed (see page 27 for examples). However, across the industry, there was an acute lack of effort or processes in place to identify, monitor and manage issues requiring remediation. Where issues were identified, this was frequently as a result of customer complaints rather than the life insurer's

own monitoring processes. In a few cases, life insurers were disinterested in remediating known issues, even where there had been a poor customer outcome.

- Most life insurers' processes and systems for customer complaints, incident management and analysis of issues suffered from under-investment, and were poorly embedded and inconsistently used.

Next steps

The RBNZ and FMA will be providing specific findings to each individual life insurer, along with our general observations, so they can understand what improvements are needed.

By 30 June 2019, each insurer will need to:

1. Develop an action plan to address our feedback, and report their progress to us. Life insurers need to prioritise the development and implementation of these plans.
2. Explain how they will meet our expectations regarding staff incentives and commissions for intermediaries. We will report on these responses.
3. Complete the following exercises and report the results to us:
 - A detailed gap analysis against the final ARC report and all findings relevant to insurance and the sales and advice process for insurance. This analysis should include identification of the risks, issues and implications for the life insurer's business.
 - A systematic review of the insurer's existing life products and policy-holder portfolios in order to proactively identify any conduct and culture risks and issues. This should highlight any issues that require customer remediation and document the root cause of the issues. The review should cover at least the past five years. Where any issues identified pre-date this period, they should be traced back to their origin to determine the full extent of the issue.

³: An insurer owned by a bank (or in a group of companies with a bank) and distributing products through the bank.

If we are not satisfied with the level of urgency applied to addressing the areas of concern and to remediating identified issues, we will take further action.

In addition, the RBNZ will follow up with individual insurers, in accordance with its risk-based approach, to establish whether the weaknesses identified in conduct and culture governance and conduct risk management apply across other risk areas.

Any conduct issues that have resulted in poor customer outcomes and warrant further investigation and potential enforcement action will be followed up by the FMA, RBNZ or the Commerce Commission, depending on which regulator can take action under the relevant legislation.

We also want to address the regulatory gaps around FMA and RBNZ powers to respond to life insurer misconduct and its drivers. We are recommending that the Government look at options for addressing these gaps as part of its current review of insurance contract law and conduct regulation. See Regulatory gaps on page 31 for more detail.

Recommendations for life insurers

All insurers need to make substantial improvements to how they identify, manage, remediate and report on conduct risks and issues, to deliver consistently good customer outcomes. Insurers need to take our recommendations seriously, and proactively work to achieve maturity in this area.

The following recommendations apply to all insurers and should form the basis of their plans.

The role of boards

- Boards need to take responsibility for setting the tone from the top, improving the insurer's conduct and culture, and articulating how these are integrated into the business strategy and risk appetite. This includes having a clear plan for change that sets targets, assigns responsibility, includes milestones to ensure accountability, and ensures information flows down to all parts of the organisation. A focus on good customer outcomes should underpin this work.
- Boards need to clearly articulate their expectations for how to manage conduct risk within the business, including who is responsible and what reporting is required. For insurers with foreign ownership, boards need to ensure policies and processes are appropriate for New Zealand staff and customers. Boards of bank insurers need to ensure they operate independently and with influence within the wider banking group to ensure good governance and conduct risk management within the life insurance arm.
- Boards need to have sufficient information to satisfy themselves that issues are being adequately identified, and to challenge and hold senior management to account on conduct and culture matters.

Oversight of intermediaries

- Insurers need greater oversight of how intermediaries are selling and managing their products. While insurers and intermediaries both

need to be responsible for ensuring customers experience good outcomes, it is the insurer who is ultimately accountable for this.

- Intermediaries need to receive comprehensive training on insurer's conduct expectations, and on all aspects of the insurer's products (including customer suitability) before they can sell them. They should also be subject to ongoing accreditation to ensure knowledge is maintained.
- Insurers need a robust and transparent policy and processes for dealing with misconduct by intermediaries.

Product design, training and support

- New products should be designed to provide good customer outcomes. Target markets and intended outcomes for products need to be clearly identified and articulated. Products (including policy wording) should be presented clearly, such as through the use of plain English.
- Products (including definitions of covered or excluded conditions) should be reviewed on a regular basis to ensure they remain relevant and continue to provide the intended cover and are fit for purpose.
- Staff should receive ongoing comprehensive training on all aspects of the products they sell and support, including design, suitability, distribution, post-sale advice and claims handling.
- Insurers need a communication strategy that sets out how often and in what circumstances customers are contacted. Insurers should have oversight of all communication about products that takes place through intermediaries.
- Insurers need to proactively and regularly encourage customers to consider their needs and whether their current insurance policy is still suitable, particularly where the customer's circumstances might have changed.

Policies and processes

- Risk management policies need to be appropriate and incorporate all material risks in the business, including consideration of conduct risk. Policies should set out roles and responsibilities, outline systems and processes to monitor and control material risks, and be subject to regular review.⁴
- Insurers must have a relevant code of conduct, and educate staff on what good conduct and culture looks like, focusing on good customer outcomes. Insurers should foster a ‘no-blame, speak-up’ environment to encourage staff to disclose conduct issues, and whistleblower processes must be accessible, confidential and independent.
- Insurers need to develop clear policies, processes and training for staff for identifying and dealing with vulnerable customers.
- Insurers need to prioritise investment in improving internal systems, processes and controls (including reporting mechanisms), in order to effectively monitor and manage conduct risk within the limits articulated in the risk appetite statement set by the board.
- Insurers need to have systems to review the advice provided at, and after, the point of sale, and customer outcomes over time.

Identification and remediation of issues

- Insurers need appropriate systems and processes to record and resolve customer complaints and incidents. This includes defining what complaints and incidents are, and training staff on how to deal with these situations.
- Insurers need to establish formal remediation frameworks, policies and processes, and dedicate appropriate and sufficient resources to the operation of them. They should emphasise that issue identification and remediation needs to be proactive and undertaken without undue delay.

Incentives

- We expect insurers to remove or substantially revise incentives linked to sales for frontline salespeople and all layers of management within their organisation (no later than the first performance year after 31 December 2019). Where sales incentives are not removed, insurers need to explain how they will strengthen their control systems to adequately mitigate conflicts of interest and risks to customers.
- We expect insurers to review their commission structures and volume bonuses for intermediaries – including structures with very high upfront commissions – to ensure they are incentivising intermediaries to deliver good customer outcomes. In our view, high upfront commissions are not acceptable as they drive poor conduct and can result in poor customer outcomes.
- We expect insurers to change their qualifying criteria for soft commissions to ensure they mitigate conflicts of interest and incentivise advisers to improve customer outcomes rather than just reward them for the volume or value of products sold.
- Authorised Financial Advisers (AFAs) are required to disclose all commissions to customers – we expect insurers to encourage all intermediaries to disclose this information.

Non-life insurers

While we prioritised life insurers for review, all insurance sectors should be actively considering conduct risk within their business. Given the similarities between life and non-life insurance, it is possible that the vulnerabilities identified in this report may exist across the broader insurance industry. We expect all insurers to assess their conduct and culture governance frameworks, and consider and act on all relevant recommendations in this report.

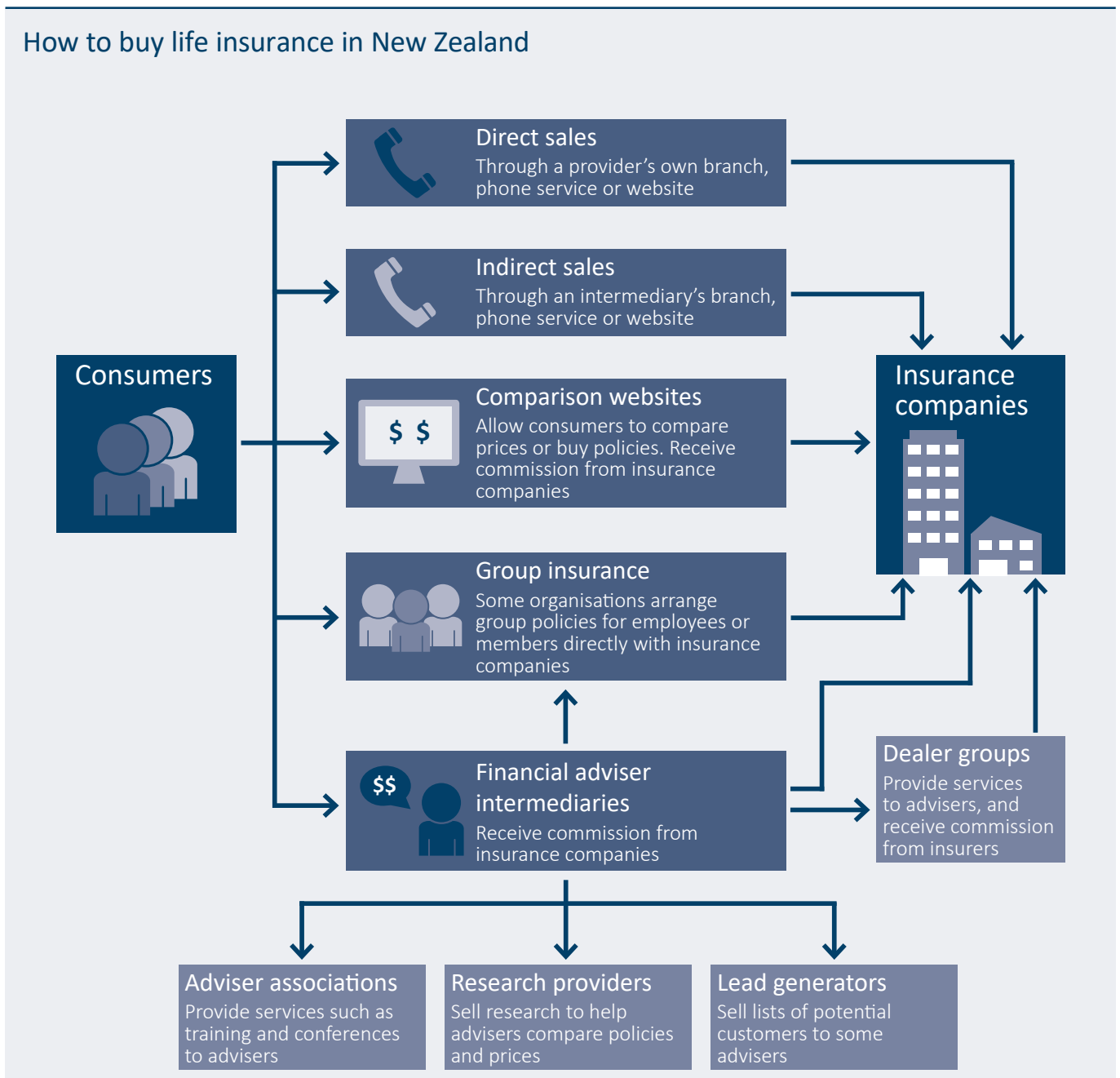
⁴: See the RBNZ’s [Guidelines for Insurers](#)

Overview of the life insurance market

Insurers provide a valuable risk management function for both individuals and businesses. The risk of large, potentially ruinous, financial loss or exposure to significant financial vulnerability can be substantially reduced by taking out insurance.

For this review, we looked at insurers who provide life insurance, which commonly includes the following products:

- Life – life insurance, accidental death cover, funeral cover
- Income protection – disability income, mortgage repayment insurance
- Trauma – critical illness, crisis cover, serious condition cover, serious trauma
- TPD – total and permanent disablement.



There are only a few large New Zealand-owned private sector life insurers. For the year to 30 June 2018, foreign-owned life insurers comprised around 82% of the total private sector life insurance market, based on annual premium income.

New Zealand’s life insurance industry comprises a diverse mix of insurers, including small ‘member-focused’ insurers, direct-to-consumer insurers, insurers owned by banks, and standalone ‘mainstream’ insurers. Many also distribute general or health insurance, underwritten by themselves or other insurers.

Insurers seeking to carry out insurance business in New Zealand are required to be licensed under the Insurance (Prudential Supervision) Act 2010 (IPSA). Existing insurers were required to be fully licensed in 2013. The industry body for life insurers is called the Financial Services Council (FSC). Ten of the insurers in this review are FSC members.

Generally, products are distributed via Registered Financial Advisers (RFAs), AFAs or Qualifying Financial

Entity (QFE) advisers, bank staff, in branches, online, by telephone or through affiliated partnerships (eg through employers).

The annual premiums paid by New Zealand consumers for life insurance total \$2.57 billion⁵. There are approximately 4 million life insurance policies in force in New Zealand. Life insurance products are generally long term; they can be held for decades rather than years.

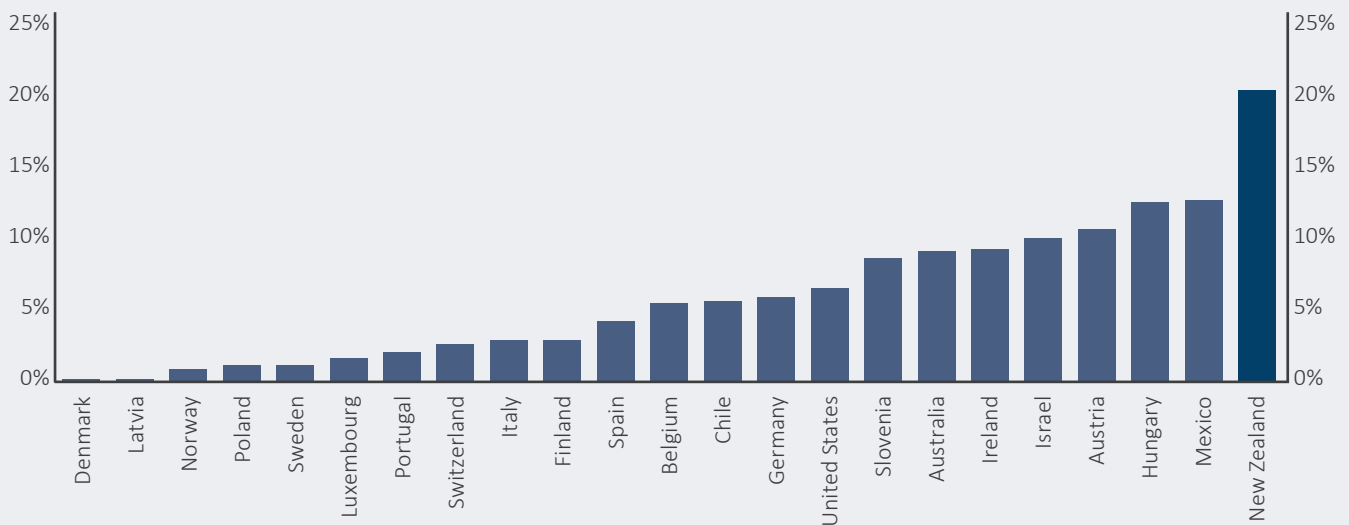
New Zealand has a very high rate of commissions for advisers – far higher than other countries. High rates of commission have a detrimental impact on the premium affordability of life insurance for consumers.

The graph below illustrates the impact of commission on gross premiums. New Zealand’s high rate of commissions accounts for over 20% of gross premiums paid by consumers.

5: Source: Financial Services Council NZ [Quarterly return for traditional and risk business - product summary](#)

Comparison of life insurance commissions worldwide

Life insurance commissions (% of gross premium revenue)



Source: OECD, RBNZ Quarterly Insurer Survey. Note: Data is for 2016.

Detailed findings

Delivering good customer outcomes

Delivering good customer outcomes focuses on how the life insurer has embedded a customer-centric perspective in the design and delivery of its products and services to ensure customers experience appropriate outcomes.

What we looked for

- Are there product, design, advice and sales processes that enable customers to obtain products that are suitable and easy to understand?
- Do incentive and remuneration structures align with good customer outcomes?
- Does the insurer communicate with customers in a clear, transparent, fair, timely and consistent way (including at claim time)?
- Is customer feedback received, and are customer outcomes measured over the short term, long term and at claim time (the full policy lifecycle)?
- Is there ongoing review of customer needs in the post-sales environment?
- Is the behaviour of frontline sales teams consistent with the 'tone from the top'?

Our findings

Overall, insurers were not doing enough to achieve good outcomes for customers. We found evidence that insurers were not adequately assessing product suitability during the product lifecycle. Communication with customers appeared limited, and compliance-orientated rather than proactive. Where intermediaries were involved, there were inadequate checks to make sure they actively ensure ongoing customer product suitability. There was no effective identification and management of vulnerable customers. It appeared that some poor-value products may be being mis-sold. Incentives offered to sales staff and high up-front commissions and 'soft' commissions offered to intermediaries were typically highly focused on driving sales, which increased the risk of poor conduct.

Product suitability

Our review found evidence that insurers were not adequately assessing product suitability during the product lifecycle.

We saw only a few insurers that specifically sought customer input through channels such as focus groups. Information about customer needs was often acquired through their intermediary channel and internal 'customer advocates'. We expect insurers to carefully evaluate the adequacy of customer input (particularly in relation to vulnerable customers – see below) and whether they need to obtain more information from customers directly.

High rates of claims being declined and low rates of

claims being made can indicate that products are unsuitable and may be being mis-sold. Insurers have this information (and other information available from claims), but on the whole did not appear to fully utilise it when reviewing products, developing new products or determining who they are suitable for.

For products sold without advice we observed a lack of adequate systems and controls to prevent or limit sales to customers for whom the product may be unsuitable. For the very few insurers that sell insurance directly online, only some appeared to have processes to help customers determine product suitability for themselves. For insurers that make telephone sales there often appeared to be limited or no processes to consider customer needs and suitability. When a

product is sold without advice, there is an increased risk of the customer making an unsuitable purchase, as the policy document is often long and complex, and doesn't aid understanding.

Insurance products can be complex, and the benefits or limitations of the policies are often not well-understood by customers. Insurers need to do better to present their products (including policy wording) clearly in plain English. Some are simplifying the language they use, but overall progress is slow. Our view is that policy wording should be reviewed on a regular basis, to ensure the policy is understandable and continues to provide cover as promoted. Reviews should include consideration of whether definitions of covered or excluded medical conditions continue to be relevant and align with generally accepted scientific and medical conditions. We think insurers should work to improve consistency and clarity around definitions.

Generally, the product review process appeared to be deficient. Insurers tended to focus on new products and new customers rather than reviewing existing products. We found evidence of only a few insurers proactively monitoring whether a product is being sold to the target audience it is designed for.

Our minimum expectations are that insurers:

- ensure that customer suitability is considered in product development
- have systems and controls to monitor and ensure that distribution and performance of products is in line with the product design and customer suitability
- ensure that customers understand their policy and have processes in place to ensure ongoing suitability
- train and monitor intermediaries to reduce the risk of unsuitable products being sold to customers.

Legacy or closed products

Legacy products are products that are no longer offered to new customers, but continue for customers who already hold them.

Overall, we heard evidence that insurers' staff and intermediaries lack understanding of legacy products, due to insufficient training and guidance. Insurers rely

heavily on a relatively small number of long-tenure staff members' experience with these products. There is a risk to the insurer and its legacy product customers if these staff members leave. Insurers need to better mitigate this risk.

Some insurers' systems for legacy products were outdated, with many relying on manual systems and processes. A lack of investment in systems and training appeared particularly acute for legacy products and needs to be addressed. Our expectation is that legacy customers should not be given less attention than newer customers or treated in a way that risks poorer outcomes for them.

Vulnerable customers

Treatment of vulnerable customers was a focus of the ARC, but we only found clear evidence of one insurer proactively identifying potentially vulnerable customers.

Our review found that insurers lacked:

- policies, processes and training for staff and intermediaries dealing with vulnerable customers
- understanding of what could constitute a vulnerable customer
- oversight of intermediary interactions with vulnerable people.

We expect insurers to identify potentially vulnerable customers, and have policies, processes and training for staff and intermediaries about dealing with vulnerable customers and ensuring they experience good outcomes.

Ongoing customer communications

For insurers distributing products through intermediaries, communication with customers was inconsistent and largely left to intermediaries. A few insurers distributing through third-party advisers said direct communication would be inappropriate, as the customer 'belongs' to the adviser. Insurers had minimal oversight of intermediaries' interactions with customers. There is very little monitoring or quality assurance checking of the advice provided by

third-party advisers and other communications from intermediaries.

Involvement of an intermediary does not discharge an insurer's responsibility for good customer outcomes. Insurers and intermediaries both need to be responsible for ensuring customers experience good outcomes, but it is the insurer who is ultimately accountable for this.

In one example, an insurer sent the customer a policy renewal letter, but did not include details of enhancements to the policy. This information was given to the third-party adviser, but there was no obligation for the adviser to pass on the information to the customer, and no oversight of whether or not they did – leaving the customer possibly unaware of the new benefits of their policy.

We consider insurers to have a responsibility to satisfy themselves that customers are receiving all relevant information about their policies, including any changes, and are given appropriate opportunity to review their cover or product. Insurers using intermediaries need to be clear with the intermediary about who will communicate what information to customers. Insurers also need appropriate checks in place to ensure that communication occurs.

Insurers should think about the best way to encourage customers to consider their ongoing needs, and whether their current insurance policy is still suitable. This will vary based on the nature of the product, the customer's circumstances and whether or not the product was sold with advice. Annual or periodic communications remind customers they have cover, and are an opportunity to check in with customers and encourage them to consider the ongoing suitability of the product. A lack of communication with customers presents a high risk of poor customer outcomes.

Customer-focused culture

We noted a generally good customer focus in frontline claims teams and some contact centres. Many staff interviewed appeared to have a strong desire to 'do right' by customers. Our impression was that insurers are generally looking to ensure fair claims outcomes. In

some instances we saw examples where staff looked at the intention or purpose of the product when dealing with borderline or ambiguous claims, rather than taking a strict literal interpretation of the contract. This same customer focus was not always reflected across insurers' organisations as a whole.

As a good example of customer focus, some insurers in some cases apply (or 'pass back') new product enhancements to products already sold, such as updating medical definitions, so the product continues to provide its intended cover.

A view expressed by a few insurers, publicly and in internal documents, is that the third-party adviser is the 'customer'. While advisers are a key part of some insurers' business models, and offer a valuable service to customers, this 'adviser-centric' philosophy prioritises the needs and outcomes of advisers over those of customers. It can also raise the question of whether products are designed for customers, or to suit advisers' sales strategies. An adviser-centric philosophy can also make it difficult to hold advisers to account for poor behaviour.

Insurers need to be clear that policy-holders are their customers, and promote a culture that puts customers at the centre of decision-making, product design, sales, advice and claims processes, and all day-to-day activities.

Customer feedback and measuring customer outcomes

Insurers heavily relied on 'lag' indicators such as customer complaints and satisfaction surveys as indicators of conduct and customer outcomes. Our view is that these indicators are insufficient. Customer satisfaction surveys measure short-term satisfaction rather than outcomes – a customer may be satisfied with their purchase in the short term, but won't know until they need to make a claim whether the policy provides the expected value or benefits. Insurers tended to believe that a low number of complaints indicated good conduct, but this had limited validity given their complaints management systems and processes were ineffective at identifying, recording, and

analysing complaints. This is discussed further under Issue identification and remediation (see page 25).

Insurers should also use 'lead' indicators. These can provide insights on potential outcomes and identify emerging trends. Lead indicators can include analysis of:

- who is buying the product compared to who it was designed for (we only found evidence of a few insurers performing this type of analysis)
- high premium income relative to amounts paid or payable under claims
- reasons for non-renewal or cancellation of policies by customers.

All insurers need to better utilise customer feedback to inform continuous improvement of service, policies and processes. Feedback from complaints and incidents should be heard and acted upon. Insurers need to perform root-cause analysis of issues and complaints to mitigate the risk of issues reoccurring. Insurers also need to continually review products to address issues and improve customer outcomes.

Poor-value products

Our review highlighted that certain products often provided poor value, and consequently poor outcomes for customers, because of limited benefits, and misunderstanding of coverage and eligibility. Such products include:

- accidental death cover
- specified injury cover
- funeral cover
- 'guaranteed acceptance' products⁶
- loan or credit card repayment protection insurance (payment protection).

While these products may be suitable for some customers in a limited range of cases, evidence that they have a higher risk of poor value includes:

6: Products for which the customer's personal or medical information is not asked prior to purchase – acceptance is guaranteed. The insurer does not consider whether (or to what extent) the product provides cover for the customer – this is determined when the person makes a claim.

- The loss ratio (for a product, claims divided by total premiums) is extremely low, or considerably below the projected ratio. Some insurers had been aware of extremely low loss ratios on certain products for some time but had done little to address this.
- High rates of claims being declined.

We saw clear evidence of poor outcomes for customers from some poor-value products (see examples on page 28). We are concerned that non-underwritten products are being sold to customers without them fully understanding their limitations. Enhanced disclosure and training needs to be provided to improve transparency and ensure suitable customer outcomes.

A comment made by some insurers when discussing products with a higher risk of poor value was "some insurance is better than no insurance". Given the evidence of poor customer outcomes for some of these products, we do not believe this position is always valid. If there is a justification for selling these products, we expect it to be supported by strong systems, processes and controls for ensuring the products are only sold to the target customers, the particular risks, issues and limitations are fully disclosed, and there is evidence the products meet customer expectations. We expect insurers to be able to justify the rationale for their products in terms of good customer outcomes, and to remove or change products that consistently fail to provide good outcomes or value for customers.

It is also important to note that the issues identified with poor-value products are not limited to life insurers. Although this review focused on life insurance, we are aware that a significant proportion of payment protection insurance products are issued by non-life insurers. We expect all insurers to identify which products may be poor value for customers and consider the recommendations from this report.

Replacement business policies and processes

Replacement business is when a customer replaces one life insurance product with another. Sales incentives and high up-front commissions can motivate intermediaries to 'churn' policies, ie, sell replacement

products that are not in the best interests of the customer. Risks for customers from churn include the increased likelihood of exclusions or limitations associated with changes in health that have occurred since the original policy was taken out.

Of wider concern is the possibility that New Zealanders are paying too much for life insurance, because insurers are spending too much on commissions to intermediaries due to churn. In a report published in May 2016, the NZ Institute of Economic Research⁷ calculated that life insurers are spending around \$430 million a year on commissions. The report suggested that if this were reduced by half, premiums could be cut by up to 12%.

From this review and previous FMA reviews⁸, it was evident that the majority of insurers had inadequate processes in place to:

- ensure customers are adequately advised of these risks
- monitor conduct in relation to replacement business.

The forms used to document the replacement process for customers were compliance-oriented, to protect the insurer rather than to inform customers of risks. Most insurers did not independently identify which sales were replacement business, and most did not assess whether replacement actually provided good customer outcomes. Overall, there appeared to be reluctance by insurers to investigate and address issues and risks arising from replacement business.

Remuneration and incentives

Regardless of the way life insurance products are sold (see Overview of the life insurance market on page 11), how people or entities involved in the sales process are incentivised influences the way they act and tells them what behaviour is valued. Incentives linked to sales tell staff and intermediaries that a sale is a good

outcome. This creates a conflict of interest between the staff member or intermediary (on the one hand), and the customer (on the other) because a sale is not always in the best interests of the customer. Insurers need to manage this conflict of interest to ensure good customer outcomes.

As part of their action plans (see Next steps on page 7), insurers must explain how they will meet the expectations set out below regarding incentives and commissions.

Staff incentives

A number of insurers offer incentives for staff that are based on meeting a number or total value of sales. For some insurers, meeting sales targets is a key performance indicator for frontline staff and their managers, and in some cases extends to senior management.

Sales targets can result in staff pursuing sales in order to avoid negative employment consequences. Criticism from managers about sales performance can create pressure to sell. At one insurer, 20% of sales staff were on performance improvement plans and receiving additional coaching because they were not meeting sales targets. At this insurer, there were visible leader boards showing each person's number of sales, adding to the pressure on staff to sell.

It is for insurers to determine the most appropriate way to design and control incentive structures to sustain good customer outcomes. Removing any incentives linked to sales measures⁹ is a significant step towards this goal. However, it may not be sufficient – the pressure that senior managers put on more junior managers and staff to sell can be very powerful, and insurers need to carefully review the structural design of all incentives. We expect more proactive oversight by boards and senior management in the management of risks associated with incentives.

Some insurers had started to think about the sales focus of their incentive structures, and some had

7: The report, *Resetting Life Insurance*, was commissioned by Sovereign Assurance.

8: Two FMA reports discuss replacement business in more detail: [Replacing life insurance – who benefits?](#), June 2016; and [QFE insurance providers' replacement business practices](#), July 2018

9: We define sales measures as measures that are achieved by retail customer sales or referrals, whether at an individual or a team level. This includes sales/referrals numbers, and sales value.

taken steps to reduce or altogether remove sales-based incentives. While these changes by individual insurers are a positive step, they are not enough to create a sustainable culture of good conduct across the industry. We expect all life insurers to revise any sales incentive structures for salespeople and through all layers of management. Life insurers need to implement changes to incentive schemes no later than the first performance year beginning after 31 December 2019.

Any life insurer that does not, by 30 June 2019, commit to removing incentives linked to sales measures will be required to explain how they will strengthen their controls sufficiently to address the risks of poor conduct that arise with such incentives. We also expect life insurers to manage the risks associated with these changes, as changes to incentives may have unintended consequences. As life insurers develop indicators of good customer outcomes, we expect them to consider incorporating these into staff incentives.

Intermediaries – commissions and incentives

The same incentive-related risks and conflicts are present where insurers who distribute products through intermediaries pay commissions to the intermediaries. This includes bank insurers who pay commissions to banks that distribute their products.

Different rates of commission are paid for different products – sometimes different products offered by the same insurer – increasing the risk that intermediaries act in their own best interests, rather than those of the customer. Large up-front commissions at the time of sale can commonly range from approximately 170% to 210% of first-year annual premiums.

Intermediaries can also receive ‘soft’ commissions such as gifts, business support, educational and training programmes, shares and overseas trips. Soft commissions are usually a reward for meeting sales targets. In a survey of 29 financial advisers conducted as part of this review, the majority responded that their preferred provider offers them incentives based on number of sales. For 27 of the advisers, their preferred provider offered overseas trips.

In a [2018 report](#), the FMA expressed concern that life insurers were designing incentives that potentially set

advisers up to fail in complying with their obligations under the Financial Advisers Act 2008¹⁰ to treat customers with care, diligence and skill. If passed in its current form, the Financial Services Legislation Amendment Bill would require all advisers to give priority to client interests. We consider many current soft commissions will be unjustifiable in light of this requirement.

The FMA has previously strongly encouraged all insurers to consider the nature and value of the soft commissions they provide to intermediaries, to ensure that this method of remuneration supports a focus on good customer outcomes. Insurers have recently responded to this pressure and our further concerns raised during this review. This has seen the last of the insurers that have to date offered overseas trips announcing that they will stop offering overseas trips, either with immediate effect or in the next year. A few insurers were a step ahead of the others advising us earlier in 2018, but the majority only made the decision and advised us through this review process.

We have yet to see any insurer confirm and announce an intention to change the qualifying criteria for soft commissions so that intermediaries are incentivised to improve customer outcomes rather than merely to sell products. We think this change needs to occur.

We also expect life insurers to review their commission structures for intermediaries, including the very high upfront commissions compared to ongoing or ‘trail’ commissions. Insurers need to ensure they are appropriately incentivising the good conduct of intermediaries and the delivery of good customer outcomes. We would like to see advisers incentivised for providing ongoing service and advice to customers about product suitability and for maintaining good customer outcomes.

AFAs are required to disclose all commissions to customers – we expect insurers to encourage all intermediaries to disclose this information to their customers.

10: See section 33 of [the Act](#).

Conduct and culture governance

Conduct and culture governance is the principles, practices and processes that determine how the life insurer's board of directors (board) and senior management oversee the management of conduct and culture risks and issues.

What we looked for

- Do the board and senior management have a strong focus on conduct and culture risk?
- Is there a high level of board and senior management engagement and accountability via risk appetite statements, and regular comprehensive reporting?
- Is the board accountable for the culture of the organisation, including ensuring it has a customer focus and staff are comfortable escalating issues?
- Does the board consider the impact of the insurer's strategy on its customers?
- Is the board accountable for incentive and remuneration structures?
- Are there appropriate management structures and committees in place to oversee conduct and culture risks?
- Are there policies and procedures for monitoring whether poor advice has been given, or whether insurance products sold are providing good outcomes?

Our findings

Few insurers had given any serious thought to conduct and culture prior to this review, or analysed their systems, processes and policies against existing industry guidance. Boards and senior management were not taking responsibility for managing conduct risk or fostering a customer-centric culture, and there was limited information about this flowing down to frontline staff. Reporting to boards about conduct risks was limited, and boards were not clearly articulating what information they required from the business. The lack of oversight and controls of sales and customer outcomes, particularly through intermediaries, was especially concerning.

Governance of conduct and culture risk

Overall, we found a lack of governance of conduct and culture risk. For some insurers we found little evidence that boards were adequately performing their governance function. Of the boards that had already considered conduct and culture, many had done so only recently, and this seemed to be very reactive and not prioritised. In some cases, boards and senior management appeared to be taking action only because of this review.

In late September 2018, the Financial Services Council (FSC) released a [code of conduct](#) to promote good conduct and a strong customer-focused culture amongst its members. It came into force on 1 January 2019. Ten of the insurers in this review are FSC members¹¹. However, they made little reference to the

FSC code during the review, and we saw little evidence of them analysing whether their conduct risk systems and processes would be compliant by 1 January 2019.

For insurers with foreign ownership and bank insurers, evidence varied across the insurers that the board was performing its functions with sufficient independence from the parent/group and with a clear focus on the governance of the insurer itself.

RBNZ has previously signalled to the industry that it wants to see improvement in the quality of governance. Its [Governance Guideline](#) outlines the characteristics expected from sound boards. For governance to be effective, it must be kept separate from ownership, by having independent directors to provide objectivity and impartiality. At the time of licensing the life insurers, RBNZ accepted proxies for independence where, for example, 'dual-hatting' directors in a group may still be viewed as independent if also a director of a parent or sister company. However, in RBNZ's [2015 report on risk governance](#) it was noted that, while subsidiaries are

11: AIA, AMP Financial Services, Asteron Life Ltd, BNZ Investments and Insurance, CIGNA Life Insurance NZ Ltd, Fidelity Life Assurance Co Ltd, Partners Life, Pinnacle Life, Sovereign Ltd, Westpac Bank

receiving support from overseas owners, RBNZ would like to see the strength of local boards grow. This can be helped by increasing independence and diversity on local insurance boards.

In our review, the expected level of genuine director independence was not always present and we saw instances of a lack of empowerment and challenge, and weak local agendas. This was evidenced by insurers with foreign ownership being overly reliant on policies and processes used in the home country of the parent. These were not always suitable for the local market, and can result in fragmented governance and accountability for conduct and culture risk.

For most insurers there appeared to be insufficient investment in and resourcing of effective systems and processes, which increased the risks to good customer outcomes. Where insurers had been focusing on growth and expansion, the risks were exacerbated by the diversion of already-stretched resources.

We expect boards to take ownership of conduct risk, including allocating sufficient resources to the development of effective policies and processes (including, where relevant, that they are tailored to local requirements). Some boards need to take the fundamental first step of understanding what conduct and culture governance is, and what the risks are for their business.

Boards need to be more effective in setting the tone and expectations around conduct and culture, and ensuring that good customer outcomes and good conduct are central to the business strategy. There is no one-size-fits-all approach, but we expect boards to ensure conduct governance is considered at a board and sub-committee level, and to have effective two-way communication channels and clear expectations for senior management.

Awareness of conduct issues

Insurers were too slow to analyse their conduct against the FMA's Conduct Guide (see page 34). Only three of the insurers had done so prior to our review, despite this being encouraged when the guide was published in February 2017. Nearly half have subsequently

undertaken some form of review.

Similarly, just under half of the insurers had subsequently undertaken any form of gap analysis against the issues highlighted by the ARC (and investigations referred to in the Australian Securities and Investments Commission (ASIC) [CommInsure report](#)¹²). This suggests insurers are being complacent in developing an understanding of the risks facing their industry.

Conduct and culture reporting

There was a lack of adequate reporting to boards on conduct and culture issues. Many boards did not appear to be receiving enough information to know whether, or how, conduct and culture risks were being managed. Examples of issues that were not reported to boards include:

- low staff engagement rates
- poor behaviour by advisers that impacted customer outcomes
- high rates of claims being declined.

Reporting on conduct and culture risks and issues varied across insurers. In several insurers it was not occurring or was still in development; in others it was not regular enough, generally focused on identifying issues that had already occurred rather than tracking trends that may indicate future issues, and did not contain enough detail.

There was a general lack of established metrics for conduct risk. Quantifiable data was largely limited to customer satisfaction survey results or complaints (see Customer feedback and measuring customer outcomes on page 15). With some exceptions, boards did not proactively seek further information about conduct and culture risks.

We expect boards to determine what information is required from senior management to enable them to effectively oversee conduct and culture risk, require

12: CommInsure had trauma policies with medical definitions that were out of date with prevailing medical practice, specifically for heart attack and severe rheumatoid arthritis. ASIC report issued March 2017.

senior management to provide it regularly, and then test and challenge it when necessary. Some directors noted it was challenging to get information – senior management should be open with the board and give them the information they need.

Some senior managers commented that their access to the board was restricted. Insurers initially told us they had high levels of board engagement – but when interviewed, some senior managers and executives talked about a lack of board visibility and engagement.

Messaging on conduct and culture

At most insurers, consistent and strong messages on conduct and culture were not being shared by senior managers. Where this messaging did exist, it was not cascading through to all parts of the organisation. Nor was there much in the way of evidence of specific communication to staff about the ARC issues and the potential impact for the insurer and their business.

Specific communication by insurers to intermediaries on the ARC was not evidenced, and few insurers had clearly communicated their conduct expectations to intermediaries.

Sales oversight and controls

Where insurers distributed their products to customers through intermediaries, the insurers did not have adequate processes for monitoring or evaluating:

- who intermediaries were selling their products to
- whether the products were suitable for these customers
- any advice provided as part of the sale, and testing whether that advice was causing poor customer outcomes.

We found a few examples of poor conduct by intermediaries that were inadequately dealt with by insurers. One example was an insurer addressing fraudulent behaviour by providing training, when the situation objectively warranted suspension of the agency agreement until a complete file review was undertaken.

Some insurers stated that the conduct of intermediaries was not their responsibility. This extended to some bank insurers suggesting it was the responsibility of the bank, not the insurer, to monitor bank staff selling insurance. While this ‘outsourcing’ of conduct risk management might make sense from a commercial perspective, we expect the bank insurer (including its board) to have sufficient oversight, including receiving information about issues and risks specific to the sale of the bank insurer’s products, and giving appropriate attention to how they are addressed.

We agree with the International Association of Insurance Supervisors’ view that:

- the insurer has a responsibility for good conduct throughout the insurance lifecycle
- where there is more than one party involved in distribution of products, good conduct in relation to distribution is a shared responsibility of the insurer and the intermediary¹³.

An insurance contract is between the insurer and the customer (policy-holder). Therefore, insurers need to make a real effort to determine whether customers are receiving good outcomes from their products. Insurers should have adequate mechanisms to monitor the sales and advice processes of intermediaries, to minimise the risks of their products being mis-sold and customers experiencing poor outcomes. As they are the interface between customers and insurers, intermediaries’ good conduct is critical in building and justifying public trust and confidence in the life insurance sector.

A few insurers stated that the Financial Services Legislation Amendment Bill, which proposes that all financial advice providers would be licensed and subject to a code of conduct, would resolve issues related to the conduct of third-party advisers, and any oversight by them of advisers’ behaviour or processes was not necessary. However, our strongly held view is that increased regulation of third-party advisers would not discharge insurers’ responsibility for customer outcomes. We expect insurers to have an interest in and oversight of intermediaries’ conduct when selling

¹³: [Insurance Core Principle 19: Conduct of Business](#) – Introductory Guidance sections 19.0.8 to 19.0.10.

their products on their behalf, to ensure good customer outcomes.

Qualifying financial entities (QFEs)

Life insurers who are QFEs or an associated entity of a QFE (eight of the insurers we reviewed are QFEs or an associated entity of a QFE) need to do more to meet their obligations. In one-third of the QFE insurers we reviewed, we did not observe suitable controls in place to monitor sales outcomes and ensure customer suitability. A QFE takes full responsibility for the financial advice provided by its employees or nominated representatives at all times and is further responsible for ensuring compliance with each employee's or nominated representative's financial adviser obligations. The FMA monitors QFEs and will address inadequacies identified in this review through the individual feedback letters to insurers, and will seek confirmation in their action plans of the specific steps they will take to address any concerns.

Conduct and culture risk management

Conduct and culture risk management is the frameworks, practices and processes the life insurer has in place to manage conduct and culture risks and issues on a day-to-day basis.

What we looked for

- Are there well-defined roles that are responsible for proactively identifying conduct and culture risks, and assessing and managing these risks?
- Does the insurer have capable, well-trained staff who have good customer outcomes front of mind?
- Does the culture of the insurer support staff to speak up and escalate conduct and culture issues to management and the board?
- Is there an effective whistleblower policy?
- Do policies and procedures have a customer focus?
- Does the insurer have a fully functioning 'three lines of defence' (or equivalent) structure?
- Is the insurer able to identify and manage conflicts of interest?

Our findings

Conduct risk management across insurers was generally immature. Insurers did not have effective and robust systems to proactively identify conduct risk issues. Initial and ongoing training provided to staff and intermediaries was inadequate. Whistleblower policies lacked visibility, were not well understood and in some cases were not independent and confidential.

Conduct and culture risk management

Overall, risk management of conduct and culture was immature, and insurers had only recently started to consider conduct risk. Many insurers appeared to equate good conduct with good compliance, rather than recognising it as an integral part of their business and factoring it into their strategy and product design, sales and after-sales customer communications.

Responsibility for conduct risk management generally sat with risk and compliance functions, and fell within the mandate of audit and risk committees. While these functions and committees can play an important and independent supervisory role, they cannot have sole responsibility. To achieve good customer outcomes, responsibility for conduct risk management needs to be integrated across all parts of the insurer's business.

The three lines of defence¹⁴ framework lacked robustness in relation to conduct risk for most insurers, and was poorly implemented and under-resourced.

There was insufficient consideration of conduct risk and customer outcomes. The first line was heavily relied on to manage risk, but lacked understanding of conduct risk. There was not enough training on how to identify and manage conduct risk.

Most insurers had risk and compliance teams operating as a second line. However, they were often under-resourced and relatively small, indicating insufficient attention and prioritisation. They were generally viewed as 'inhibitors' rather than 'enablers'. At one insurer, a compliance officer had responsibility for over 30 branches. Similarly, quality assurance teams were often under-resourced, meaning they could not carry out enough checks to adequately detect issues.

In many of the insurers, the third line – independent audit of conduct risk – was not sufficiently robust. Audit largely focused on compliance. We were also advised of instances where the third line may not have been operating with sufficient independence.

14: 'Three lines of defence' is a model that insurers and other entities use to structure their risk and compliance assurance and oversight functions. The first line of defence is the teams and departments, which carry out the insurer's business; they are responsible for managing the risks associated with those activities. The second line of defence is oversight functions (such as risk and compliance teams), which set direction, define policies and procedures, and provide guidance and challenge the first line. The third line of defence is independent oversight (such as audit) of the assurance provided by business operations and oversight functions.

We found examples of poor conflict of interest management. For example, at most insurers, complaints about intermediaries were dealt with by the insurer's business development managers or sales managers, who also manage the relationship with the advisers. This creates a conflict, as the managers generally receive incentives based on the number of sales made by the advisers they manage. This was exacerbated where there was a lack of formal processes for managing these complaints, and a lack of recording and reporting of any outcomes.

Training programmes

All insurers had different approaches to training, including on-the-job training, e-learning, induction programmes and other facilitated courses. However, training (including product training) provided to staff and intermediaries by insurers appeared inconsistent and inadequate.

Many internal sales staff commented they did not receive enough product training. We were advised of instances of both internal staff and intermediaries selling or advising with insufficient knowledge of a product and the types of customer it is designed for. This increases the risks of mis-selling and poor customer outcomes. We saw little evidence of insurers validating either initial or ongoing staff product knowledge, and only some insurers had formal accreditation processes to assess and record intermediaries' product knowledge.

On a positive note, we did see evidence that some insurers had started to provide conduct training for internal staff. However, this was still new and its effectiveness had yet to be measured. We were advised of only a few insurers providing conduct training for intermediaries.

Overall, there was a lack of attention, priority and resources given to training. We expect insurers to review their training programmes, to ensure they appropriately support staff and intermediaries in the delivery of good customer outcomes.

Whistleblower policies

Where insurers had whistleblower policies, they were generally not well known, understood or used by staff. Two insurers did not have whistleblower policies in place.

A common theme was a lack of visibility, and in some instances, staff were not aware that a policy existed. Many staff did not know what the policy was, did not understand it, or did not know where to find it. Some of the policies did not have anonymous, confidential, or independent channels for raising matters.

Use of whistleblower mechanisms was rare, including where the policies were widely known. This suggests whistleblower policies are not particularly effective in encouraging staff to speak up about issues they may encounter on a day-to-day basis. Insurers need to do more to raise awareness and understanding of the types of issues that could be reported through whistleblower mechanisms, which should include concerns about conduct and culture.

Staff across most (but not all) insurers said they were comfortable raising issues, including those regarding misconduct, with their direct manager, other senior management or human resources. While this is not a replacement for an effective whistleblower policy, it is positive that most insurers appeared to support staff to speak up and escalate conduct and culture issues to management.

Codes of conduct

Most (but not all) of the insurers had a relevant staff code of conduct in place. With some exceptions, these were largely only referred to when staff started their jobs. As a result, staff lacked awareness of the conduct standards expected of them, and there was little understanding of how to apply code of conduct standards to day-to-day business operations.

Issue identification and remediation

Issue identification and remediation is how the life insurer identifies and manages conduct and culture risks and issues.

What we looked for

- Are there appropriate, timely processes in place to identify conduct and culture risks and issues?
- Is there evidence that issues requiring remediation are dealt with appropriately and in a timely manner?
- Are remediation processes clear and understood by all parties?
- Does the insurer carry out proper root-cause analysis of complaints, and appropriate recording and escalation of issues?
- Is there evidence that broader consequences identified in root cause analysis are assessed and influence the insurer's remediation framework?
- Is there evidence that remediation activities are achieving good customer outcomes?

Our findings

The majority of insurers did not have formal remediation policies or processes in place. Insurers did not seem to appreciate the importance of remediation practices, and there was little urgency or proactive effort to remediate issues. Where insurers saw that things had gone wrong, they were generally not actively looking to uncover the full extent of the impact or identify the underlying causes.

This lack of attention and priority suggests a complacent attitude and a disregard for customers' best interests.

Across the industry, there was an acute lack of processes in place to identify, monitor and manage issues requiring remediation. Therefore, it is highly possible there are more issues that insurers have not identified. Most insurers commented that they were confident there was no evidence of widespread poor conduct issues and poor customer outcomes. We question this, especially as our review identified several examples of poor customer outcomes.

How insurers identify issues

Most insurers were overly reliant on customer complaints to identify issues. Complaints alone are an inadequate indicator, as customers may not complain, or may be unaware of issues that affect them. Also, as complaints occur after the fact, they are ineffective at preventing or minimising problems, and poor customer outcomes may have already occurred. For the majority of insurers there were major flaws in identifying and recording complaints.

The majority of insurers did not have comprehensive processes to systematically and proactively identify potential or emerging issues through the lifecycle of a product. Very few insurers had initiated a systematic review of their product and policy-holder portfolios in order to proactively identify conduct and culture risks

and issues that might require remediation. For insurers using intermediaries, there was a lack of proactive monitoring of the conduct of these intermediaries when advising or selling, or reviewing customers' needs.

Complaint and incident management systems

Our review showed that while the majority of insurers had complaints and incident management frameworks and processes, these were not operating effectively. Complaint and incident reporting was generally poor, and we saw evidence that not all complaints, incidents and issues were being captured and reported on.

Within most insurers there was uncertainty about how to identify and distinguish between complaints and

incidents, how these types of issues are defined, and how they should be recorded. For example:

- Most insurers had not provided staff with clear definitions of 'complaint' and 'incident'.
- Some insurers had multiple systems (one insurer had at least five) where complaints or incidents could be recorded, and there was uncertainty as to which system should be used.
- One insurer told us that subscription costs prohibited system access being granted to all staff.

Most insurers empowered frontline staff or managers to resolve complaints themselves, without escalation, and within certain parameters. However, these complaints were often not being recorded. Some insurers had a definition of complaints that excluded complaints resolved without escalation (ie, by frontline staff). Our view is that while the ability to resolve complaints at the frontline is a good thing, this activity still needs to be recorded to contribute to the overall view of conduct issues and customer outcomes.

Systems and processes were poorly implemented or inconsistently used across most insurers, potentially due to deficiencies in training or supervision. In some cases, senior management did not appear to appreciate staff members' lack of understanding or use of the processes or systems.

A common observation made by frontline staff was that after they escalated an issue they did not hear anything further about it. This lack of feedback meant staff were unable to learn from how the matter was treated, which could help to identify and minimise similar issues in the future, and staff could be deterred from continuing to escalate issues.

These deficiencies meant insurers did not have reliable and complete information on the volume or nature of complaints and incidents, and therefore no clear picture of possible and potential issues, and the impact on customer outcomes. This compromises insurers' ability to identify trends and themes, and determine and address the root causes of issues.

We expect all insurers to have appropriate systems and processes to record and resolve customer complaints.

This includes defining what a complaint is and training staff on how to deal with complaints. There is no common definition across the insurance industry of what constitutes a complaint. This hinders the ability to form a consistent industry-wide view of the issues that cause complaints and how widespread these are. We would like to see the industry, perhaps through the FSC, achieve consistency in this area, raising customer awareness of complaint and dispute resolution processes, and encouraging the use of insights from complaints to improve customer outcomes.

Root cause analysis, systemic assessment and trend analysis

We are not confident that insurers are aware of all current issues in their businesses. Most did not proactively undertake proper root cause analysis of complaints to understand the underlying causes and determine how widespread issues are. There was also a lack of trend analysis to identify recurring complaints and issues. This increased the risk that the full extent of issues would not be uncovered and other impacted customers would not be identified.

For the few insurers that attempted this analysis (or tried to identify trends), their ability to do so was hindered by the lack of robust systems to capture all complaints and incidents.

There was also a lost opportunity to determine how to prevent reoccurrence, which was exacerbated by the lack of feedback to frontline staff.

Insurers need to have systems and processes to proactively identify (from a range of sources) issues that may require remediation. Insurers need to stop relying solely on lag indicators, and use lead indicators to provide insights and positive assurance about customer outcomes. It is also imperative that insurers learn from previous instances of poor conduct or misconduct. Boards should seek positive assurances from management about customer outcomes, and not just rely on the absence of reported issues as a measure of effectiveness of the insurer's conduct and culture.

Treatment of issues

Very few insurers had comprehensive frameworks, policies or processes in place to remediate issues (whether they originate from complaints or incidents). Insurers generally considered complaints as and when they arose. There was little evidence of proactive consideration of whether there were wider implications that required further investigation, or effort to identify other affected customers and provide remediation.

There was also some evidence that insurers who use intermediaries did not share the responsibility with the intermediaries to identify, address and remediate issues.

For some insurers, there has been a significant amount of time between identifying an issue and concluding the remediation activity. We expect insurers to proactively seek to identify issues in a systematic and methodical way, and prioritise remediation.

Issues being remediated

We looked at issues that insurers had identified and were currently, or had recently completed, remediating. Insurers self-identified few issues, and there was limited evidence of them undertaking remediation work. We are concerned by this finding. Our view is that this is likely to reflect the ineffectiveness of the complaints and incident management systems and processes (which we saw clear evidence of) rather than a lack of issues. We are not convinced that insurers had made enough of an effort to uncover issues or understand how they may arise. Over the course of our review we identified other issues that insurers had not yet remediated.

Most activities that insurers classified as ‘remediation’ in their initial responses were internal projects such as product reviews or system upgrades that either were not related to the life insurance business or did not have a direct customer impact.

Our review identified 16 specific activities across 10 insurers that we would classify as ‘remediation’. These were in progress or had recently been completed, and had a direct customer impact – ie, may result in

the refund of overpaid premiums or a change to the customer’s cover or benefits.

Eight of these activities were identified in the individual insurers’ original responses to our request for information and the remaining activities were identified during our onsite monitoring visits.

Two of these 16 activities had been fully quantified, with a total of 92 customers and approximately \$31,000 in remediation involved. For a further eight of these remediation activities, insurers had identified the number of affected customers only (this ranged from 3 to 223). The remaining six activities were yet to be quantified by insurers.

While some of these issues had only recently been uncovered, insurers had known about others for a year or longer and the lack of detail provided appeared to reflect a general lack of urgency and attention by the insurers. For 12 of these issues, insurers had not confirmed their plan and timeframe to remediate. We will be following up on these issues with the individual insurers in our feedback letters.

Some examples of remediation underway are:

- One insurer recently undertook a data cleansing exercise that identified a variety of data discrepancies such as incorrect dates of birth (all of which were due to manual errors) that resulted in customers being overcharged premiums. Work to refund the 30 affected customers was well underway.
- One insurer was going through remediation activities with a third-party distributor where they had identified misconduct in the form of intermediaries making misleading statements to customers about premium payment direct debits. An audit identified around 90 affected customers. The agency agreement had since been terminated and the insurer was closely liaising with the distributor to ensure all affected customers were contacted. Affected customers who wished to cancel their policy were being refunded the premiums paid.

The majority of issues appeared to have been caused by system and process weaknesses, or processing errors – with some related to manual processes. It is of concern that there is a heavy reliance on manual processes, which are more difficult to oversee and more likely to result in errors and omissions.

Where we did see evidence of issues related to poor conduct and potential misconduct, these were largely (with a couple of exceptions) driven by poor company policies, not putting customer interests first and neglecting to consider customer outcomes, rather than the conduct of individual staff. There were, however, examples of poor customer outcomes that relate to both the specific poor conduct and potential misconduct of intermediaries.

Examples of poor conduct

From our review we became aware of a number of instances of poor conduct and some cases of potential misconduct that resulted in poor customer outcomes. Some of these examples are included in the remediation activities noted above, but others had yet to be remediated. Examples include:

- neglecting to effectively notify policy-holders of increases to their premiums
- old policies not cancelled when customers transferred to a new policy, and premiums still being charged for the old policy
- selling of credit insurance to potentially ineligible customers
- annual inflation rate not applied correctly to cover and premiums
- premiums continuing to be charged after the policy end date.

The following examples are worth noting:

- One insurer's life product had been sold to foreign customers who were ineligible for the insurance cover (as cover is only provided to New Zealand residents) and therefore would never be able to make a claim.
- One insurer sent mail-outs containing information

that – for some customers – the insurer knew to be incorrect. The insurer had taken no steps to advise these customers they had been provided with incorrect information (customers were told of benefit enhancements, but the insurer considered these customers were not entitled to them). The insurer had taken no steps to prevent incorrect information being provided in future correspondence. We were advised this 'error' was due to IT system constraints, but this was equally an example of both a lack of investment in systems and a failure to address a known issue. Evidence provided suggested that the insurer may not honour the benefit enhancements notified and has declined claims from affected customers on the basis that they were not eligible.

- One insurer had a one-off system error that resulted in an excessive consumer price index increase (up to 30 times) being applied to the sum insured, with a corresponding increase in customers' premiums. The 223 affected customers were charged and had been paying the incorrect premiums. This issue occurred (and was discovered) in 2015. Initially the insurer did not proactively contact these policy-holders, and relied on customers making contact. While customers who received larger increases were quick to contact the insurer to have this corrected, many with smaller increases had not made contact and were continuing to pay the higher premium. Three years after the event, the insurer had yet to remediate 111 of the customers.
- One insurer was only remediating customers if they complained about the high premiums for their funeral insurance. The premiums become increasingly hard for customers to afford as they age and in many cases the total amount of premiums paid was more than the sum insured. These policies do not have a surrender value and if the policy is cancelled the premiums paid are not refunded back to the customer. The insurer had a reactive remediation guideline in place for frontline staff to deal with any complaints from customers about not being able to afford the premiums. This was offered on a case-by-case basis (depending on the age of the customer and how much their premiums exceed the

sum insured), creating a ‘two-tier’ premium scale between customers who complain and those who do not.

- One insurer required additional training of intermediaries for their guaranteed acceptance life insurance product, yet this training had not been provided to all intermediaries selling the product. As a result, intermediaries who were not adequately trained in this specialised product run the risk of misinforming customers. This was evidenced by the extremely high rate of claims being declined for this product.

Any conduct issues that resulted in poor customer outcomes and warrant further investigation and potential enforcement action will be followed up by the FMA, RBNZ or the Commerce Commission, depending on which regulator can take action under the relevant legislation.

Assessment against ARC issues

There is concern that some of the issues identified by the ARC may also be occurring (or have the potential to occur) in New Zealand. Some life insurers operating in New Zealand are Australian-owned, including some by Australian banks. They are likely to have some commonalities in their internal governance, policies and procedures.

Insurers expressed confidence that the issues identified by the ARC and other reports from Australia (such as Financial Ombudsman reports into claims handling) are unlikely to be occurring in New Zealand – or if they are occurring, they are less widespread and are likely to be identified more quickly.

We consider this confidence is misplaced. Overall, insurers did not know enough about what issues may exist in their business, and there was insufficient effort made to discover them. There was also a lack of analysis of their systems, processes and controls against matters highlighted by the ARC and related investigations (such as the investigation into CommInsure). Just fewer than half of the insurers we reviewed had undertaken some form of analysis by the end of our review. A few of the insurers were quick to

differentiate their business from the Australian market based on a single point of difference (eg the ARC examples of fees for no service, targeting vulnerable customers, or the issues associated with a vertical integrated business model did not apply to them). Based on this, they appeared to conclude the findings were not relevant to their business. This points to a potential lack of appreciation among New Zealand insurers of the possible drivers of the issues identified in Australia or the broader implications of the issues being highlighted by the ARC for their business.

We expect all insurers to proactively review the work of regulators and related international examples to help identify potential conduct and culture issues here. This includes examining the key themes and issues arising from the ARC, and determining whether there are similar issues present or possible in New Zealand. We will continue to review their progress as part of our ongoing monitoring of the insurance sector.



As part of this review we sought insights from four external stakeholder groups that have an interest in the conduct and culture of New Zealand life insurers:

- Consumer NZ
- Financial Services Council – An industry groups that represents 10 of the insurers we reviewed
- Dispute resolution schemes that have life insurance sellers or advisers (or both) as members:
 - Financial Services Complaints Limited,
 - Insurance and Financial Services Ombudsman

Stakeholders noted that the landscape and expectations around conduct and culture have changed because of the ARC, and this review. They also recognised the gaps in the framework for the regulation of insurance conduct.

Stakeholders told us there is wide variation in approaches to addressing conduct risks across insurers and within adviser practices, and agreed there is a need to raise standards across the board. They believe the industry recognises this need, with all FSC members having signed up to the FSC’s principles-based code of conduct. The code includes a standard that requires members to manage conflicts of interest. Stakeholders believe the conflicts of interest created by sales incentives and soft commissions need to be better managed.

Dispute resolution was raised as an issue. The quality of insurers’ internal dispute resolution varies significantly across the industry. There is a low customer awareness of dispute resolution services and complaints processes. Poor record-keeping by some advisers of the sales and advice process was noted as a problem that is often uncovered when complaints are made.

There was consensus with our finding that the lack of insurer accountability and oversight of the selling of their products through intermediaries creates risks and should be addressed.

We also heard that the customer’s duty of disclosure is not well explained or understood. Insurers could do better explaining the disclosure duty. This is the most frequent problem between customers and insurers.

Stakeholders were concerned about the complexity of some insurance products and policies, and noted that a lack of customer understanding generates many complaints. Customer-focused, plain English terms and conditions would also be an improvement.

Regulatory gaps

Current regulatory environment

The RBNZ, the FMA and the Commerce Commission regulate parts of the wider insurance industry.

The RBNZ licenses and regulates insurers from a prudential perspective, with the purpose of promoting the maintenance of a sound and efficient insurance sector and promoting public confidence in the insurance sector. Under the Insurance (Prudential Supervision) Act 2010 (IPSA), insurers must be subject to and comply with a risk management programme, amongst other requirements.

Insurer conduct is only regulated indirectly, through the regulation of financial advice. The FMA authorises and monitors AFAs, and approves and monitors QFEs who may provide advice in relation to life insurance. The FMA also enforces the prohibition on deceptive or misleading conduct in relation to financial products and services¹⁵ which includes life insurance products.

The Commerce Commission enforces some legislative provisions relating to the sale of credit-related insurance¹⁶.

The Courts have found that a mutual duty of utmost good faith is implied in every insurance contract. Both insurers and customers are therefore expected to act in good faith towards one another at all points throughout the lifecycle of an insurance policy.

While the RBNZ, the FMA and the Commerce Commission regulate parts of the insurance sector, no regulator has oversight of insurers' and intermediaries' conduct over the entire insurance policy lifecycle. In particular, there are currently no specific conduct requirements or obligations on insurance product providers. There is also inconsistency in the protections available for products sold with and without advice and no overarching obligation to protect or enhance customer interests. These conduct regulation gaps were noted by the International Monetary Fund (IMF)

in its [assessment of New Zealand's financial system](#) in April 2017.

Financial Services Legislation Amendment Bill

The Financial Services Legislation Amendment Bill is currently before Parliament. The Bill will strengthen the regulatory framework for the provision of financial advice in New Zealand, including advice on insurance products. It will enhance conduct and competency standards and is aimed at improving access to advice.

However, these improvements will not change the regulation of insurance products that are sold without financial advice, nor will they introduce any conduct requirements for product providers.

Regardless of these gaps in the regulation of insurance conduct, we consider that insurers should have a genuine focus on improving customer outcomes, rather than simply doing the minimum required to comply with the law. The responsibility to make change rests with the insurers. However, closing the regulatory gaps would give us the ability to monitor improvements, and provide options for enforcement where we see non-compliance.

The Government has included consideration of conduct regulation of insurance as part of the Ministry of Business, Innovation and Employment's (MBIE) current review of insurance contract law. MBIE has completed initial consultation on their review. The Minister of Commerce and Consumer Affairs has indicated future deliberations will include the findings from this review.

Review and recommendations

From a prudential perspective, this review has not identified any notable regulatory gaps. However, it does suggest there would be benefit in progressing some of the enhancements being considered in the current RBNZ review of IPSA, in due course. The IMF's Financial Sector Assessment Programme also included several recommendations for the RBNZ and the FMA,

15: Under Part 2 of the Financial Markets Conduct Act 2013

16: Under the Credit Contracts and Consumer Finance Act 2003. Credit-related insurance is insurance connected to a consumer credit contract or consumer lease.

which have implications for conduct regulation. These are being considered as part of MBIE's review of insurance contract law, and where relevant, may also be considered as part of the IPSA review.

Proposed changes to IPSA that may have a direct impact on conduct regulation include a review of overseas insurers, which will consider the treatment of foreign branch and subsidiary operations to balance overseas participation in the New Zealand market with New Zealand policy-holders' and wider economic interests. There will also be a review of the existing statutory funds framework. This will consider whether the framework should be expanded and whether the current exemptions remain appropriate. General disclosure and Financial Strength Ratings disclosures will also form part of the IPSA review.

From a conduct perspective, we consider the regulatory gaps noted by the IMF have contributed to the general lack of maturity in the life insurance sector's understanding, governance, management and remediation of conduct risk, and the subsequent cultural weaknesses. They have also contributed to insurers' lack of oversight and responsibility related to intermediaries, and a general lack of focus on customer outcomes.

In our review of conduct and culture in the retail banking sector, we outlined some areas where the government may wish to consider addressing

regulatory gaps, to incentivise banks to develop and maintain appropriate management of conduct risk.

Given the similarities in the nature of the findings, the drivers of risk and the benefits of having consistent frameworks across regulated populations, we consider these areas may be equally relevant to life insurance. As such, the government may wish to consider the following:

- Establishing basic duties on life insurers to protect and enhance customer interests and outcomes, regardless of the distribution channel.
- Requiring life insurers to have adequate systems and controls to govern, manage conduct risk, and remediate issues, in all distribution channels, and through the life insurance product lifecycle.
- Reviewing whether the regulators have sufficient supervision and enforcement powers and resources to ensure life insurers meet these obligations, including requiring better information on conduct issues or risks, and the option of penalties to incentivise appropriate behaviour.
- Clarifying accountability and individual responsibility for management of misconduct, including the potential for direct liability for senior managers.

We appreciate that further policy work will be required to fully explore all options.

Appendix: Background to the review

Globally over the past decade, there have been significant concerns about weaknesses in life insurers' governance and risk management frameworks, and inappropriate behaviour in the industry that has led to poor customer outcomes. In response to a series of known misconduct incidents by Australian financial service providers, the ARC was established in December 2017. Some examples of the types of misconduct identified by the ARC relevant to life insurance include:

- incentives for sales staff and advisers conflicting with good customer outcomes
- lack of ability to review and detect poor financial advice provided to customers
- misappropriation of client funds and forged customer signatures
- limiting the scope of services provided to minimise regulatory requirements
- failure to maintain and keep appropriate records, hindering the ability to monitor customer outcomes.

The FMA and RBNZ are concerned about the impact that the evidence of widespread misconduct in Australia could have on confidence in New Zealand's financial institutions. Equally, we are concerned about the risk of complacency in the industry with respect to these conduct and culture issues. Rightly, the level of public concern in Australia has raised public questions and speculation about whether there are similar issues in New Zealand.

Risks to customers

Insurers have multiple stakeholders: customers, shareholders, employees, intermediaries and the public. Insurers need to be aware of, and responsive to, their customers' needs and understanding of insurance, and tailor their conduct accordingly.

Customers have a responsibility to act in their own interest and make good decisions. However, our view is that insurers should think about how their conduct supports customers, including by providing them with the necessary information and understanding to exercise that responsibility properly. All customers,

regardless of their level of knowledge, are entitled to expect good conduct from their insurer.

Delivering financial services comes with challenges and risks, particularly due to information asymmetry and conflicts of interest. Information asymmetry occurs when one party holds more information than another party, and can use that information to their advantage. This is particularly true with insurance products, where customers are typically reliant on the provider providing information so that they understand the products.

Another information asymmetry exists for life insurance. The customer at the time of sale will know more about their health than the insurer. If they do not disclose information the insurer considers relevant, the insurer can cancel the contract when the customer makes a claim.

Conflicts of interest can arise from how staff and intermediaries are incentivised. If they are incentivised to prioritise selling certain products or reaching sales targets over addressing customers' needs there is a conflict of interest. They may recommend or sell a product that is not suited to the customer's needs.

It is difficult for customers and insurers to know at the point of sale if a product will be suitable to meet their needs in the longer term. Additionally, any harm caused by poor product design, or by inappropriate sales or advice, may not become apparent until years later (perhaps when a claim is made), if at all. Poor conduct or misconduct by insurers can have a significant impact on customer outcomes: customers may have insurance they do not need or cannot afford; customers may have insurance that does not give them the cover that meets their needs (cover that they thought they had).

When an insurer does not demonstrate good conduct and culture, their customers face a range of risks, such as:

- The insurer prioritises its own interests over those of the customer.
- The customer is not treated with professional standards of care.
- The cost of the insurer's product or service is not reasonable, and may reduce the return or benefit

customers get from it, to the point where the customer’s need is not met.

- The purpose, benefits and risks of the services and products, and their suitability to different types of customers, are not clear to customers.
- Customers do not understand how staff performance benefits or any arrangements with related parties impact the product or service they are receiving from their insurer, and make poor financial choices as a result.
- Customer claims, feedback and complaints are not dealt with appropriately, resulting in adverse consequences for customers.

What is conduct and culture?

At its most basic level, conduct is how people behave. Standards, systems, processes and controls are all necessary, but they are predictable and can be exploited by inappropriate behaviour.

From our perspective, culture refers to the shared behaviours, values and norms of the individuals and groups within an organisation. An insurer’s culture is one of the key drivers of its conduct. It also determines how people identify, understand, discuss and act on the risks that the organisation faces.

What does ‘good’ conduct and culture look like?

When we think about what ‘good’ looks like, we are looking at insurer behaviour from the point of view of customers. Therefore, good conduct aims to achieve good outcomes for customers (policy-holders). A good outcome is where the cover provided by the insurance is understood by the customer, and meets their needs and reasonable expectations.

A healthy culture is one where staff are encouraged and expected to behave in a way that improves customer outcomes.

Setting and embedding corporate values is the role of boards and management, not regulators. However, there are broadly applicable principles that should underpin the culture of all insurers.

The 2017 publication “A guide to the FMA’s view of conduct” (FMA Conduct Guide) contains guidance relevant to all financial service providers (even those not licensed by the FMA), including this profile of good conduct.



We expect financial service providers, including insurers, to have compared their conduct to the principles in the FMA Conduct Guide and taken action where their conduct falls short of what is set out in the guide. This expectation was widely communicated at the time the guide was published.

Scope and methodology

The overall objective of this review was to understand whether there are widespread conduct and culture issues present in life insurers in New Zealand. This report is ‘thematic’ in nature; that is, our findings are described in relation to general themes relevant to our objective of the review.

On 16 May 2018, the RBNZ Governor and the FMA Chief Executive met with the board of the Financial Services Council. At the meeting the FMA and RBNZ reiterated the view that the nature and extent of the issues within financial services in Australia and the obvious cross-over in terms of entities, people and practices into New Zealand demands a strong response from the industry here, and from the regulators.

Following the meeting, the RBNZ and the FMA, with the support of the Commerce Commission, wrote to the Chief Executives of 16 life insurers in May 2018. The letter was published. It stated:

“Our objective in this exercise is to understand what work you have undertaken to review your operations to promptly identify and address any conduct and culture issues. We expect you to show us what you have done in order to be comfortable that there are no material conduct issues within your business ... The purpose of this exercise is for us to understand how you have obtained assurance that misconduct of the type highlighted in Australia is not taking place here.”

Responses were received from all 16 insurers. We assessed the information provided, seeking answers to the following questions:

- What conduct and culture risks and issues are present in New Zealand life insurers?
- What governance, frameworks, processes and controls are in place to achieve good conduct and culture, and to effectively manage and remediate any conduct and culture issues or risks?

- Are there areas within the framework for regulation of life insurers where we consider there are regulatory or supervisory gaps or inefficiencies?
- What are our recommendations to deal with these gaps or inefficiencies?

We undertook further monitoring activity with the insurers to validate the information provided. As part of this we received additional documents from the insurers, and interviewed staff, including frontline staff, management, senior executives and some directors.

Additionally, we sought insights from four external stakeholders that have an interest in the conduct and culture of New Zealand life insurers (see page 30). We also conducted a survey of financial advisers who distribute life insurance.

Limitations of our review

We undertook the review over a five-month period using existing resources of the RBNZ and FMA. Our review was limited to the documents provided by insurers and information from interviews. We did not seek information directly from customers, but where appropriate we did consider information that customers had provided to FMA via enquiries or complaints.

Life insurers

The review focused on New Zealand insurers that issue (ie underwrite) life insurance products. Some insurance providers sell life insurance products that they do not issue – sometimes under their own branding. They are not the actual life insurer entering into the contract

with the person being insured. These insurance providers are excluded from this review.

Our review involved the insurers detailed in the table below. These insurers vary in terms of their size – from less than \$15 million to over \$700 million annual income from premiums.

Insurer	Ultimate parent	Country of parent
AIA International Limited (trading as AIA New Zealand)	AIA Group Limited	Hong Kong
American Income Life Insurance Company	Torchmark Corporation	USA
AMP Life Limited	AMP Limited	Australia
Asteron Life Limited	Suncorp Group Limited	Australia
BNZ Life Insurance Limited (BNZ Bank)	National Australia Bank Limited	Australia
Cigna Life Insurance New Zealand Limited	Cigna Corporation	USA
Co-operative Life Limited (Co-operative Bank)	The Co-operative Bank Limited	New Zealand
Fidelity Life Assurance Company Limited	Fidelity Life Assurance Company Limited	New Zealand
Kiwi Insurance Limited (KiwiBank)	Kiwi Group Holdings Limited	New Zealand
Medical Life Assurance Society Limited	Medical Assurance Society New Zealand Limited	New Zealand
OnePath Life (NZ) Limited (previously owned by ANZ Bank)	Cigna Corporation Entity combined with Cigna 30 November 2018	USA
Partners Life Limited	Partners Group Holdings Limited	New Zealand
Pinnacle Life Limited	Pinnacle Life Limited	New Zealand
Southsure Assurance Limited (SBS Bank)	Southland Building Society	New Zealand
Sovereign Assurance Company Limited	AIA Group Limited	Hong Kong
Westpac Life NZ Limited (Westpac Bank)	Westpac Banking Corporation	Australia

Glossary

Term	Definition
Accidental Death Benefit	A benefit payable as a result of death by accident (ie non-natural causes).
Adviser (Financial adviser)	Provides financial advice to consumers. Includes AFAs, RFAs and QFE Advisers.
AFA (Authorised Financial Adviser)	An individual financial adviser authorised by the FMA to provide personalised advice on most types of financial products, including insurance. Can also be licensed to provide investment planning services.
Annual premium	The amount of money paid annually to the insurer for insurance cover.
Bank insurer	An insurer typically owned by a bank (or in a group of companies with a bank) and distributing products through the bank.
IMF (International Monetary Fund)	An international organisation which works to secure financial stability, facilitate international trade and promote high employment and sustainable economic growth.
Insurer	The insurance company that has underwritten and issued the policy.
Intermediary	A person or entity who sits between an insurer and a customer, and promotes or facilitates an insurance contract between them. Intermediaries include third-party advisers, banks (including banks that are in the same group of companies as an insurer), other insurers, and organisations that arrange group insurance for their employees or members. Some intermediaries work for just one insurer. Others distribute products of multiple insurers.
International Association of Insurance Supervisors (IAIS)	A voluntary membership-driven standards-setting organisation of insurance supervisors and regulators from over 190 jurisdictions in more than 140 countries.
Non-life insurers	For the purposes of this report, non-life insurers refers to fire and general insurers, and health insurers.
RFA (Registered Financial Adviser)	An individual adviser who is registered on the Financial Service Providers Register but who is not authorised by the FMA. Can give personalised advice on most insurance products including life and health insurance, and non-personalised KiwiSaver advice. They are not permitted to give advice on more complex financial products such as KiwiSaver, bonds, shares, managed funds and derivatives.
Trauma insurance	A benefit payable to the insured upon diagnosis of one of a range of specified illnesses or conditions, eg cancer or stroke.
QFE (Qualifying Financial Entity)	A business to which the FMA has granted QFE status. The business takes responsibility for the financial advice provided by its employees and nominated representatives, without those people having to register individually as advisers.
Underwriting	The task of assessing and determining the risk of providing insurance cover.

