The Compliance Compass

October 2026 | UAC members | By Paul Muir

SECTION 1 – REGULATORY UPDATES

1. ASIC's 2026–27 general insurance priorities

ASIC general insurance supervisory letter | 30 September 2026

1. Brief Summary:

ASIC's sector letter prioritises consumer and small business outcomes. New work includes reviewing paid home insurance claims advocates and assessing the proposed GI Code once submitted for approval. Continuing scrutiny covers motor premium disclosure, home building cash settlements and conduct implications of emerging cyber risks. ASIC's oversight spans product design, distribution, pricing, claims and dispute resolution.

2. Impact for UAC Members:

Although addressed to insurer boards and executives, the letter should inform agencies' reviews of delegated services and reporting to insurer partners. Suggested actions for UAC members:

- Map the priorities to your products and delegated functions. Agree improvement owners and reporting with each insurer, including where your agency operates under its own AFSL.
- For motor portfolios, test quote and renewal documents for clear premium explanations, instalment costs and changes to excess or insured value, including documents delivered through brokers and portals.
- Where you handle claims, verify customer representatives' authority and maintain fair communication. Treat the review of paid advocates as a prompt to examine why customers seek help.
- Monitor the proposed Code and plan for systems and training changes. Keep draft requirements separate from the current Code and applicable binder commitments.

2. Hollard judgment and the consequences of claims delay

Federal Court judgment | ASIC v Hollard [2026] FCA 1487

ASIC outcome announcement | 9 October 2026

1. Brief Summary:

The Federal Court imposed a $2 million penalty on Hollard for breaching its duty of utmost good faith in a storm claim. Prolonged inaction, delayed expert assessment and inadequate support left the family in a deteriorating home. The judgment also recognised later investment and operational changes as evidence of a culture that valued timely, efficient claims management. Remedial action mattered, but did not erase the contravention.

2. Impact for UAC Members:

The penalty was imposed on the insurer. Agencies with claims authority should identify customer harm and intervene before delay compounds it. Suggested actions for UAC members:

- Review aged claims for periods of inactivity, overdue expert reports, unsafe living conditions and accommodation needs. Escalate harm indicators as well as authority limits.
- Test whether supplier instructions, competing expert evidence and coverage decisions receive competent review, with reasons and customer updates recorded.
- Agree urgent escalation routes with insurers. Retain accountability for your own licensed service and apply relevant Code commitments through your delegated arrangements.
- After a failure, evidence what changed in staffing, supervision and claims controls. Review other affected files and measure whether the changes improve customer outcomes.

SECTION 1 – REGULATORY UPDATES continued

3. OAIC transparency obligations for automated decisions

OAIC resources | 30 September 2026

OAIC APP 1 Guidelines | automated decision-making

1. Brief Summary:

From 10 December 2026, APP entities must update their privacy policies where they arrange for computer programs using personal information to make, or do something substantially and directly related to making, decisions reasonably expected to significantly affect individuals' rights or interests. The disclosure covers the kinds of personal information used and the kinds of decisions made solely by programs or informed by their outputs. The obligation extends beyond AI and can apply even when a person makes the final decision.

2. Impact for UAC Members:

An agency should assess its own APP entity status and arrangements, rather than assume that the insurer's privacy policy covers its activities. Suggested actions for UAC members:

- Inventory relevant systems, including underwriting rules, individual risk scoring, pricing tools, renewal selection, fraud flags and claims recommendations. Assess each use against the statutory conditions.
- Ask insurers and vendors how personal information and program outputs influence decisions. Identify who arranged each use and which entity must disclose it.
- Assign an owner to prepare and publish meaningful privacy policy wording by 10 December. Generic wording that "we use AI" may not describe the relevant information and decisions.
- Keep the inventory current when products or systems change. The transparency requirement complements existing privacy and conduct obligations; a human approval step alone is insufficient to rule it out.

4. Cash settlements and fair outcomes in delegated claims

ASIC review | Beyond the payout | 31 August 2026

ASIC media release | cash settlement expectations

1. Brief Summary:

ASIC's home building review remains a continuing supervisory priority. It identified risks from cash offers based on supplier prices consumers may not obtain, unclear explanations and inadequate vulnerability support. ASIC also found that offers could increase significantly after a complaint. It expects fair offers from the outset, clearer information about choices and review rights, and better data to monitor outcomes.

2. Impact for UAC Members:

Agencies handling home building claims should compare their processes with ASIC's findings. Agencies in other classes can use the findings to test comparable settlement risks, without assuming every home insurance requirement applies. Suggested actions for UAC members:

- Check whether repair estimates reflect prices the customer can actually obtain. Discuss any adjustment for supplier discounts and settlement risks with the insurer.
- For applicable retail claims, confirm when a Cash Settlement Fact Sheet is required and who provides it. Ensure options listed are genuinely available and explain the offer's components and review rights.
- Assess the customer's capacity to organise repairs and any support needs. Agree with the insurer what assistance is available and share relevant information appropriately with suppliers.
- Record why cash was offered, changes to the amount, complaints and available outcome information. Use this evidence in portfolio reviews with insurer partners.

SECTION 2 – MONTHLY ARTICLE

A genuine partnership: underwriting agencies, insurers and better customer outcomes

By Paul Muir | Managing Director, Compliance Advocacy Solutions

The value of an insurer–underwriting agency partnership is seen in everyday decisions as well as difficult handoffs. Each party brings different authority, knowledge and resources to the customer's experience.

Underwriting agencies operate at the intersection of several sets of responsibilities. They may design or distribute products, bind cover, manage broker relationships and, where authorised, handle claims. These financial services are usually provided under the agency's own AFSL, while the agency acts under a binder or other agreement with an insurer.

Sometimes an agency continues to handle a difficult claim within its delegated authority but needs the insurer's expertise and support. At other times, a claim exceeds its delegated authority or a complaint requires the insurer to take over. Both situations test whether the parties operate as genuine partners.

The agency needs enough independence to meet its own AFSL obligations and enough access to the insurer's knowledge and capability to deliver good outcomes. When a file does change hands, both parties still need to understand which entity is responsible for earlier conduct, what each licensee must record and investigate, and how they will learn from the outcome.

This is a timely governance issue with reference to APRA's CPS 230 Operational Risk Management. CPS 230 applies to APRA-regulated insurers (who are authorised under s12 Insurance Act) and requires them to manage risks arising from material service providers. Underwriting and claims management are among the services generally classified as material unless the insurer can justify otherwise. CPS 230 does not apply directly to an agency merely because it works for an insurer, but it will influence the assurance, information and continuity arrangements insurers expect from agencies.

Start with the capacity in which the agency acted

A binder does not turn every activity into a service provided under the insurer's AFSL. The agency should map, activity by activity, whose AFSL authorises the financial service, who acts on whose behalf, the scope of its binder authority and who makes the relevant decision. The answer may differ between arranging or issuing cover, giving advice, handling a claim and managing a complaint.

The binder may affect how the agency fulfils its AFSL obligations, for example by requiring unresolved complaints to be referred to the insurer within a stipulated period or complex claims to be escalated.

Where an agency provides a financial service under its own AFSL, its section 912A(1) obligations remain relevant to that service. These include providing financial services efficiently, honestly and fairly, complying with applicable financial services laws and maintaining appropriate compliance measures. ASIC's INFO 253 explains the authorisation requirements for claims handling and settling.

The insurer has its own obligations under Prudential Standards and, where applicable, as an AFS licensee and subscriber to the General Insurance Code of Practice. A genuine partnership identifies each entity's duties and capabilities at each stage. It also gives the agency a clear way to seek help without unnecessarily transferring ownership of a matter.

Partnership while the agency remains in charge

Imagine a home claim following a severe storm. The agency has authority to assess and settle the claim, and there is no dispute about that authority. The insured tells the agency's claims handler that their home is unsafe, they are caring for a family member with a serious health condition and they are struggling to manage calls, documents and temporary accommodation.

The right response is not automatically to transfer the file to the insurer. The agency can remain the claim handler and a consistent point of contact while drawing on the insurer's specialist vulnerability team, claims expertise and available support services. With appropriate handling of the customer's information, the agency can ask the insurer for guidance on practical adjustments: a preferred contact method and time, a support person, simpler requests for evidence, urgent assessment of accommodation needs and whether a financial payment advance or other assistance is available under the PDS and applicable Code provisions.

The insurer's specialists can help the agency recognise needs it might otherwise miss and decide what extra care and support is appropriate. The agency then implements the agreed steps, documents the reasons, checks that suppliers know what they need to do and keeps the insured informed. It retains responsibility for the decisions and services it provides under its own AFSL and delegated authority. The insurer's guidance strengthens the response without creating an unnecessary hand-off.

The GI Code recognises that vulnerability may change with a person's circumstances and calls for support tailored to individual needs. It contemplates reasonable accommodation of a support person and assistance with communication. For an insured in urgent financial need following the event that caused the claim, its specific fast-tracking and advance-payment provisions may also be relevant, depending on the facts. ASIC has likewise highlighted the need to identify vulnerability throughout the claims journey and extend appropriate controls to third parties acting for insurers. Agencies should also monitor the proposed Vulnerability Framework supporting the draft new GI Code, while continuing to meet current applicable requirements.

This is the practical value of partnership: the agency knows the product, customer and claim; the insurer can contribute deeper specialist resources. Both can help the customer without losing clarity about who is doing what.

When the insurer takes over a claim

Consider an agency authorised to assess and settle claims up to a stated limit. It initially handles a storm claim, obtains an expert report and tells the customer that wear and tear may be involved. The matter becomes complex and moves to the insurer, which later accepts that storm damage is covered.

The agency is no longer making the final claim decision. It should nevertheless ask:

- Was its initial handling within its licence authorisation and delegated authority?
- Were the expert instructions, evidence, customer communications and any delay appropriate?
- Did it identify an expression of dissatisfaction that should have been recorded as a complaint?
- Does the insurer's decision reveal a weakness in the agency's process, training or earlier decisions?
- Might other customers have been affected by the same issue?

The hand-off should include a complete, usable claim record and a clear account of outstanding actions, customer needs, complaint status and applicable deadlines. The insurer should continue to consult the agency where its earlier actions or underwriting decisions are relevant, and update it on material developments, the outcome and reasons for any change of decision. Otherwise, the agency cannot properly review its own conduct or improve its controls.

When the insurer takes over a complaint

A complaint may concern the insurer's claim decision, the agency's earlier financial service, or both. The insurer may be designated to investigate and respond to the customer. That arrangement should not cause a complaint about the agency's own conduct to disappear from the agency's records.

ASIC's RG 271 requires financial firms to recognise a complaint when the customer's expression of dissatisfaction meets the definition, rather than waiting for referral to a specialist IDR team. Firms must record complaints they receive and have processes to identify systemic issues. If a firm outsources part or all of its own IDR process, it remains responsible for ensuring that process complies with RG 271. Whether the insurer's takeover amounts to outsourced IDR for the agency, or involves the insurer dealing with a complaint about its own service, depends on the issues and the actual arrangements.

Any hand-over from agency to insurer should be a warm hand-over, with the customer told who will respond. It should not require the customer to lodge the complaint again or elect to escalate it before the firm provides its IDR response. RG 271.102–106 addresses multi-tiered IDR processes.

A practical hand-off should establish:

- Receipt and classification: What was said, when was it first received, and does it concern the agency's conduct, the insurer's conduct or both?
- Ownership and communication: Who will acknowledge, investigate and respond, and who will explain that arrangement to the customer?
- Timeframes and records: Which dates are running, what records move with the matter, and what does each firm retain in its own complaint system?
- Findings and remediation: How will the agency receive the outcome, assess any failing in its service, address affected customers and consider reportable situations where applicable?

The GI Code also sets standards for subscribing insurers and their relevant distributors and service suppliers. For retail insurance, a Code “Service Supplier” must tell the insurer within two business days about a complaint concerning the insurer or the supplier's conduct.

The hand-off may be outsourcing of the agency's function

Where the insurer takes over work that the agency would otherwise perform under its own AFSL, the arrangement can amount to the agency outsourcing that function to the insurer. This is especially important if the insurer performs part or all of the agency's IDR process. ASIC's RG 104 says a licensee remains responsible for complying with its obligations when it outsources functions relating to its licence; RG 271 says the same specifically about an outsourced IDR process.

The label cannot be applied mechanically. If the insurer takes over its own claim decision or complaint, it is performing its own function. A single file may contain both that function and questions about the agency's earlier licensed service. The agreement should identify which work is being undertaken for which entity, rather than treating “the insurer will handle it” as a complete allocation of responsibility.

An agency cannot protect its licence by forwarding a complaint and closing its file. A genuine partnership requires the insurer to keep the agency informed of material allegations, evidence, changes in position and any criticism of the agency's practices; seek the agency's records and response before making findings about its conduct; and provide the final outcome promptly. The agency, in turn, must cooperate fully, review its own conduct independently and consider any necessary remediation or reporting. Consultation protects the accuracy of the response as well as the agency's ability to meet its obligations. It must never be used to delay or constrain a fair outcome for the customer.

An AFCA complaint can expose a wider underwriting problem

Imagine a disputed home insurance claim that the insurer takes over and then manages at AFCA. The customer says the wording of an exclusion did not reflect what the underwriting agency's sales material and renewal communications led them to expect. During the dispute, AFCA notices that the same wording or practice may have affected other policyholders. It raises a potential systemic issue concerning the agency's underwriting or distribution practices.

If the insurer has managed AFCA correspondence without updating the agency, the agency may learn too late that its own underwriting decisions, documents and controls are under scrutiny. It may be unable to promptly test how many policies are affected, preserve relevant records, correct the practice, consider customer remediation or assess its own reportable situation obligations.

The insurer and agency should instead notify each other immediately of a potential systemic issue, agree who will respond to AFCA on each aspect, share the underlying evidence and coordinate any portfolio review. Each entity must still make its own assessment of its legal and regulatory obligations. A joint investigation can be efficient; it should not blur which licensee owns each action.

AFCA has a statutory role beyond resolving the individual dispute. Under section 1052E(4) of the Corporations Act, if AFCA considers that a systemic issue arises from its consideration of complaints, it must give particulars to one or more appropriate regulators, including ASIC where relevant. ASIC's RG 267 says AFCA should refer the matter to the financial firm for response and action; reportable particulars can include the name of the firm, licensee or representative involved. A potential issue raised during a case is not necessarily a concluded systemic finding, but it demands prompt investigation by both partners.

Build the partnership into the operating cadence

In my professional experience, an underwriting agency and insurer should agree on how the agency accesses insurer specialists while retaining a matter; the triggers for taking over a claim or complaint; which function is being performed for which licensee; decision and communication authority; access to records; consultation and update points; responsibility for regulatory and Code reporting; and feedback to the agency. The agreement should expressly require prompt notice of AFCA systemic issue concerns or findings that touch the agency's conduct. These arrangements should be tested on real cases, not left as a paragraph in the binder.

At each risk and compliance meeting, the partners can review both the difficult cases the agency retained with insurer support and those the insurer took over. Did the agency get timely specialist guidance? Were customer needs addressed? Why did other matters move, and did the outcome change an earlier agency position? Does an issue appear elsewhere in the portfolio? A few well-chosen case reviews may tell management more than a large pack of volume and turnaround measures.

There is a simple test of the partnership. When a customer needs extra care, can the agency obtain useful help from the insurer and continue managing the claim well? And when the insurer takes over, can the agency explain what happened, what the insurer found and what changed as a result?

The customer experiences one insurance journey, even where two organisations contribute to it. A genuine partnership lets each use its strengths, share information at the right time and act on what it learns.

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