Submission to the

CGC Monitoring Priorities 2026-2027

CLAIMS HERO

1300 219 469 | www.claimshero.au | claims@claimshero.au

CLAIMSHERO

Level 6/301 Coronation Drive
Milton Qld 4064
1300 219 469
claims@claimshero.au

13 February 2026

Code Governance Committee
info@codecompliance.org.au

Submission to CGC 2026-2027 Monitoring Priorities Consultation

Dear Code Governance Committee,

Thank you for the opportunity to provide feedback on the Code Governance Committee's (CGC) Monitoring Priorities for 2026-2027.

Hero Group Services, trading as Claims Hero, is an insurance advocacy business that supports consumers navigating claims and complaints in the home and contents insurance sector. We operate under an Australian Financial Services Licence (AFSL) and assist clients through home insurance property claims, including internal dispute resolution processes and complaints to AFCA.

Our team works daily with vulnerable customers who are often overwhelmed by complex insurer processes, denied claims, confusing expert reports and protracted disputes. As a result, we are uniquely placed to observe systemic and emerging issues in insurer behaviour and how the General Insurance Code of Practice ("the Code") commitments operate in practice, particularly for vulnerable policyholders.

This submission outlines five (5) key areas that we believe cause significant customer detriment and should be subject to increased oversight and monitoring by the CGC:

- Use of experts in claims management – It is our view that there has been limited practical improvement following previous CGC thematic reviews of expert reports and flawed or biased expert evidence continues to drive unfair claim outcomes, alongside emerging concerns about outsourced expert-management platforms.
- Transparency and provision of information – Consumers routinely struggle to access key documents regarding their claim and clear explanations of decisions, undermining their ability to understand outcomes, challenge errors or effectively use IDR and AFCA processes.
- Complaints teams and processes (Internal and External Dispute Resolution) – Internal Dispute Resolution (IDR) is widely perceived as perfunctory and rarely changes the initial decisions; by contrast, many disputes are resolved once AFCA become involved, often at the earliest stage.
- Loss adjusters and outsourcing – Poor oversight and governance of external loss

adjusters by insurers and outsourced claims management contributes to delays, communication failures and Code breaches, with consumers often unclear who is responsible for decisions.

- Temporary accommodation and vulnerability – Decisions about habitability and support for vulnerable customers are inconsistent and often constrained by narrow interpretations and low policy limits, leading to significant hardship, and in some cases, leverage of accommodation as a bargaining tool.

Strengthening the Code and uplifting compliance across these areas is essential if the Code is to operate as a genuine consumer protection framework rather than a set of "best practice" statements. Claims Hero urges the CGC to adopt an assertive and outcomes focused position in relation to these issues. Rather than treating them as discrete technical problems, they should be recognised as a set of systemic weaknesses that shape the entire claims and dispute lifecycle. By prioritising them in its 2026–27 program of work, the CGC has an opportunity to set clear expectations, rigorously test whether those expectations are being met in practice, and respond decisively where they are not.

We encourage the CGC to use its monitoring, guidance and enforcement powers in a coordinated way, to identify and diagnose emerging patterns of harm, to translate those findings into practical standards for industry behaviour, and to ensure that serious or repeated departures from those standards result in meaningful consequences. In doing so, the CGC can give effect to the intent of the Code, ensure confidence that the framework is enforceable, and directly improve the experience of policyholders navigating insurance claims and disputes.

Claims Hero remains deeply concerned that there has been no substantive improvement in Code compliance. The apparent reduction in reported breaches should be viewed with caution until tangible, verifiable improvements are evident in insurers' underlying controls. We believe that some insurers continue to demonstrate weak compliance cultures, where breaches are not treated with the seriousness they warrant, raising significant doubt about the accuracy and completeness of reported data.

Claims Hero would welcome continued engagement with the CGC, including sharing deidentified case examples and insights to further assist on these issues.

Luke Dugdell
Managing Director
Claims Hero

Use of Experts in Claims Management

Despite earlier CGC scrutiny and formal expert standards, expert reports continue to be a major source of consumer detriment and dispute in claims handling.

Key issues observed include:

- Insufficient evidentiary basis: Reports often lack adequate factual investigation (for example, no physical inspection or assessment, limited scientific testing, or reliance on desktop assessment) yet are treated by insurers as determinative of liability and scope of works.
- Opinions beyond expertise: Experts are asked, and proceed, to provide opinions outside their area of expertise, including on policy interpretation for which they are not appropriately qualified.
- Incomplete or absence of appropriate briefing: Experts are not consistently (if at all) provided with full instructions, including all relevant factual background, details of the event, competing causation hypotheses and prior assessments, undermining the reliability of their conclusions and, in practice, compromising their independence by leading them towards a particular outcome.
- Narrow focus on exclusions: Reports frequently frame findings only around policy exclusions (for example, "wear and tear", "maintenance", "pre-existing damage") without properly considering potential covered causes. In most cases, the identified maintenance issues are not clearly linked to Australian building standards and are instead property improvement opportunities only. Concerningly, these issues are then used by insurers to attempt to cancel policies or deny renewals.
- Omission of necessary further investigation: Reports often fail to specify when further invasive or specialist investigation is required, leaving consumers with unresolved questions and insurers with an incomplete basis for refusing or limiting claims.
- Copy-paste or aligned language with insurer exclusions: Some reports appear to mirror insurer policy wording and exclusions rather than providing genuinely independent technical analysis.
- Conflicts of interest: Experts who are commercially dependent on insurer work, or are engaged via outsourced vendor panels, can be perceived as aligned with insurer interests, undermining confidence in the independence of their opinions.
- Use of 'Event-related' wording: Despite industry standards being clear that experts should not be commenting on policy matters, reports routinely reference terms like 'event-related' in the context of damage. This language effectively makes a policy determination whether certain damage falls within an event, which is beyond the expert's role. Experts should confine their opinion to the underlying causes of damage, rather than trying to distinguish between what is event-related or not. Instead, this analysis should be undertaken by the insurer. Despite clear ICA expert standards prohibiting such commentary, reports still frequently include recommendations on claim acceptance or denial.

A further emerging concern arises from the use of external expert management platforms and panels. In such arrangements, the selection of experts, the instructions provided, and applicable performance metrics are less transparent (discussed in more detail below). We have observed examples where these companies exert undue influence over experts, scrutinising their rates and applying pressure to align with the insurers' position. Many of these firms openly market themselves on the basis of achieving cost savings for insurers, creating a clear conflict of interest that undermines expert independence and breaches regulatory obligations.

There is also little to no governance or oversight of these outsourced functions. It is often unclear to consumers and their representatives how independence is protected and how an expert's ongoing commercial relationship with insurers or platform providers may affect their work. Underlying instructions, scopes and assumptions are often withheld unless specifically requested. Insurers have been seen refusing to provide information and notes from systems used to manage and communicate with these experts, reinforcing serious concerns about transparency and accountability.

Consumer detriment caused

The misuse or poor governance of expert reports causes serious, long-term harm to consumers, extending far beyond financial loss. Claims Hero has seen repeated examples of families left homeless, homes rendered uninhabitable or irreparably damaged, and households experiencing significant mental health impacts due to protracted disputes driven by contested expert evidence.

Other examples include:

- Prolonged displacement and unstable living arrangements, particularly where expert disputes delay repairs or where temporary accommodation is unreasonably declined or withdrawn on the basis of disputed reports.
- Erosion of trust in both insurers and the broader regulatory framework when consumers see flawed reports accepted uncritically while their own independent evidence is discounted or ignored.
- Heightened vulnerability and financial hardship when low sums insured are quickly exhausted by temporary accommodation costs, repeated unnecessary assessments, and self-funded expert reports needed to counter insurer-commissioned opinions.
- Emotional and psychological harm stemming from repeated investigations, inconsistent explanations, and complaint processes that appear designed to defend the original expert view rather than genuinely reconsider outcomes.

In practice, expert reports are often treated as decisive evidence in claims, even when they are incomplete, inconsistent, or demonstrably wrong. When combined with insurers that rarely change decisions and appear reluctant to challenge external experts, this creates a system where flawed expert evidence can lock consumers into unfair outcomes. Insurers routinely breach the obligations to correct errors and mistakes when consumers raise concerns about expert reports.

Call to action

Claims Hero recommends that expert reports continue to be a key monitoring and enforcement priority for the CGC's 2026–27 program of work. We recommend the following:

- Follow up review of expert reports in disputed claims, including:
    - Analysis of whether the quality, accuracy and fairness of expert reports have improved since the previous thematic inquiry.
    - Examine cases where AFCA rejected or criticised insurer-commissioned expert evidence to identify common deficiencies and systemic issues.
    - Assess whether insurers have implemented the earlier recommendations on expert oversight in a way that delivers measurable improvements for consumers.
- Strengthened disclosure and governance of expert reports, including clear public guidance by the CGC regarding the engagement of experts and ensuring insurers have appropriate documented policies on how experts are selected, instructed and

monitored.
- Examination of vendor contracts and performance measures for experts and expert management platforms to identify conflicts of interest or incentives that could undermine independence.
- Examine the conduct of key insurance providers across insurers and the harm this may cause – for example, indoor environmental providers frequently concluding mould is 'environmental' or not 'event-related' without undertaking adequate testing and providing credible evidence.

While the CGC has noted improvement of 'some' insurers, we call on the CGC to conduct more public reviews of industry practice and hold insurers accountable where systemic non-compliance persists. The avoidable mental and financial harm inflicted on consumers by these experts must be addressed. We believe that this should be a coordinated enforcement approach across regulatory bodies.

Transparency and Provision of Information

Transparency and provision of information is a foundational element of fair claims handling and an essential precondition for any effective dispute resolution framework. A consumer cannot meaningfully understand, assess or challenge an outcome unless they are given clear reasons for a decision and access to the underlying material on which that decision is based. When key documents and explanations are withheld, incomplete or inconsistent, it is not merely a matter of poor communication; it goes to the heart of whether Code obligations around fairness, honesty and efficiency are capable of being realised in practice.

Key issues observed include:

- Incomplete documentation provided: Insurers frequently do not give consumers full claim documentation (for example, complete expert reports, full scopes of work, unredacted claim file notes, call recordings), or instead release only selected excerpts that support the insurer's position.
- Unclear and non-final decision communications: Decision letters often lack a clear explanation of how the policy has been applied to the facts, with limited linkage between evidence and specific clauses, and in some cases no formal acceptance or denial being issued at all.
- Inconsistent disclosure practices across and within insurers: There are marked differences between insurers, and in some cases within the same insurer, in how and when information is released to consumers, leading to notable inconsistencies in transparency. Insurers take different approaches to provision of information under the Privacy Act and the General Insurance Code of Practice. Some insurers in particular engage in questionable interpretation to withhold information, including requiring customers to seek AFCA involvement. Guidance should be provided to avoid inconsistencies.
- Opaque refusals to disclose information: Some subscribers refuse to provide key documents, relying on narrow interpretations of privacy or legal exemptions and without clearly identifying the specific exemption relied upon or explaining how it applies in the circumstances. This lack of clarity further impedes consumers' ability to understand the insurer's position. In practice, some insurers contend that materials such as internal file notes, emails, and call recordings are exempt from disclosure on the basis that they were not "relied upon" for the purposes of Part 12 of the General Insurance Code of Practice. This reasoning is often applied as a blanket justification to withhold information, rather than being considered in a case-specific manner. As a result, consumers are commonly denied access to information that is

directly relevant to the handling of their claim or complaint (and that may contain personal information) central to understanding how decisions were reached. This conduct forms part of a broader pattern in which some insurers appear to withhold information in pursuit of preferred claims outcomes or to avoid adverse findings. There is particular concern that these insurers treat the Code as limiting their disclosure obligations by using the phrase "relied upon" as a basis for restricting access. In reality, the Code operates to expand, rather than constrain, insurers' obligations under the Privacy Act: it requires full compliance with all Privacy Act requirements and goes further by committing insurers to disclose any information they relied upon when making a decision, including information that may not constitute personal information. These issues have also been recognised in external dispute resolution processes, including AFCA Determination 12-24-115581, in which AFCA was required to consider an insurer's refusal to provide call recordings and internal documents to the complainant. The determination illustrates the tension between narrow interpretations of disclosure obligations and the overarching requirements of fairness, transparency, and accountability owed to consumers, and underscores the need for closer regulatory scrutiny of how insurers apply both the General Insurance Code of Practice and the Privacy Act in practice.

- Non-compliance with legislated consumer information: required materials, such as cash settlement fact sheets and other prescribed disclosures, are not consistently provided when cash settlements or key options are presented. The absence of mandatory disclosures heightens the risk that consumers will agree to settlements that do not meet their needs or fully reflect their policy entitlements.

Consumer detriment caused

These practices materially disadvantage policyholders. When consumers do not receive full reports, scopes and underlying file records, they cannot properly understand the factual and technical basis for an insurer's position. That in turn prevents them from identifying errors, seeking advice, or advocating their position. Where decisions are expressed in vague terms, or where no clear decision is communicated, consumers may be uncertain about their rights and the time limits for escalation, increasing the risk that valid concerns are never raised with the insurer. Collectively, these shortcomings contribute to unnecessary escalation of disputes, longer resolution times, and increased stress and cost for consumers.

Of particular concern is the impact of these practices on consumers who seek to challenge decisions through internal dispute resolution processes or via AFCA. When insurers withhold information, consumers are significantly constrained in their ability to advocate their position to AFCA, which can result in adverse AFCA determinations. AFCA's ability to compel production of all relevant material prior to issuing a determination is limited which some insurers exploit for strategic advantage. This dynamic exacerbates the inherent imbalance of power between insurers and consumers. It underscores the importance of insurers fully complying with their regulatory obligations under the Privacy Act and the Code rather than requiring consumers to escalate to AFCA simply to obtain access to information to which they are already entitled. AFCA Determination 12-24-115581 which required a customer to go to determination to access call recordings demonstrates a failure of some insurers to consider how the Privacy Act and the Code work together to enable disclosure. These AFCA determinations should be used by the CGC to demonstrate systemic issues that require remediation.

Call to action

Claims Hero encourages the CGC to adopt transparency and provision of information as a defined focus area within its upcoming monitoring program. This should include a structured review of how insurers communicate decisions and what documentation is routinely provided at key stages of the claim, with particular attention to the availability of full expert reports, scopes of work and file material. This would include reviewing insurer's compliance with information provision obligations within the Code. The CGC should also develop clear guidance for insurers and consumers on what information should be provided to consumers and set clear minimum expectations for decision letters and information disclosure in common scenarios. AFCA determinations could be used as case studies to educate the industry on compliance requirements.

In addition, we suggest the CGC develop guidance that clarifies when and on what basis information may legitimately be withheld and requires insurers to explain such refusals transparently and in plain language. Monitoring of compliance with specific disclosure obligations should form part of this work, with systemic non-compliance treated as a serious compliance matter requiring remediation. Where reviews reveal persistent or widespread deficiencies in transparency that have caused consumer detriment, the CGC should be prepared to use its enforcement powers, including sanctions and remediation directions, to drive improvement and reinforce the central role of transparency in the Code. We would also encourage the CGC to work with AFCA to identify insurers where provision of information is a common theme in complaints and undertake specific reviews and enforcement action.

Dispute Resolution Processes

An effective complaints framework is central to the operation of the Code. IDR should function as a genuine, merits-based review that is capable of correcting errors made at first instance, while AFCA provides an external safeguard where agreement cannot be reached. We routinely observe that, in practice, IDR often falls short of this standard and that robust outcomes are too frequently achieved only once external scrutiny is engaged. Insurers are slow to address errors and mistakes in the claims process, resulting in unnecessary disputes and stress for consumers. The obligation to address errors and mistakes appears to be poorly understood.

Key issues observed include:

- IDR outcomes rarely depart from initial decisions: Internal reviews frequently restate the original decision with minimal engagement irrespective of new information or arguments. Even where consumers or their representatives provide detailed submissions or additional expert evidence, IDR responses often mirror the initial reasoning rather than critically reassessing it. The responses do not respond to the issues raised by consumers and regularly do not involve the IDR representative discussing the complaint with the consumer prior to issuing the outcome. The underlying drivers of this practice remain unclear but may include cultural factors (for example internal metrics about maintaining decisions, resourcing constraints or delegation issues).
- Limited capability and authority within complaints functions: IDR staff are not always equipped with the technical expertise needed to interrogate complex expert reports or opinions, adjuster findings or nuanced policy issues, and may lack the delegation necessary to overturn earlier decisions or commission further investigations.
- Inconsistent identification and handling of complaints: Complaints are sometimes acknowledged via automated processes but receive little substantive contact before

a final response is issued. In some instances, matters are re-categorised or downgraded so as to not constitute a complaint, creating uncertainty about whether full IDR obligations have been triggered and adhered to. It would appear that these are not being recorded as breaches of the Code.

- Disparity between IDR and AFCA outcomes: A significant proportion of general insurance disputes resolve at an early stage of AFCA's process with different case managers within the same insurer revising outcomes despite there being no material change in the consumer's submission. For example, in the 2024-25 financial year[1], 45% of general insurance complaints were resolved at Registration and Referral stage of the AFCA process, which may suggest that first instance. A targeted review of this issue by the CGC would clearly identify if there are underlying causes for this.
- Perceived use of IDR as a screening mechanism: Taken together, these patterns give rise to a concern that IDR is, in effect, being used by some firms as a filter to determine which consumers will persist to AFCA, rather than as an independent mechanism genuinely directed at identifying and correcting errors. We are aware that some insurance companies have metrics around avoiding complaints escalating to AFCA, which may have unintended consequences of IDR teams pressuring consumers not to lodge AFCA complaints despite standard letters and wording.
- Code Obligation Forgotten During AFCA Process: We have observed instances where insurers and their external dispute resolution teams do not appear to comply with ongoing Code obligations once a matter proceeds to AFCA. In some cases, insurers have refused to engage further with consumers during the AFCA process, notwithstanding that Code obligations continue to apply throughout that period. Where insurers adopt aggressive complaint management practices, this non-compliance is sometimes demonstrated openly in the AFCA forum. In our view, this reflects a broader cultural indifference to Code compliance rather than isolated oversight.

When claims disputes proceed beyond IDR and into the AFCA process, we have observed additional likely systemic issues that further undermine fair outcomes and confidence in the complaint's framework. It appears that insurer conduct reflects a "win at all costs" mentality, with an emphasis on defending the existing position rather than impartially reassessing the merits in light of all available material. This is often accompanied by selective presentation of information: insurers sometimes provide only those documents and excerpts that support their position, while omitting or downplaying evidence that is neutral or adverse to their position. In practical terms, this can mean incomplete claim notes, partial expert reports, or omission of earlier internal acknowledgements of error being provided to AFCA, requiring consumers or their representatives to identify and supply missing material, or correct misstatements, themselves. We consider that the CGC should provide clarity on how insurers should engage in the process in an honest, efficient and fair manner to meet the underlying obligations of the Code and recognising the significant power imbalance of consumers.

We also encounter cases where known errors or mistakes are not corrected in the material submitted to AFCA, even after they have been clearly pointed out in correspondence. This behaviour is difficult to reconcile with the duty to act in good faith and with the expectation that insurers will assist in resolving disputes fairly and efficiently (i.e. the obligations under the Code). Internal win-rate targets and performance metrics can appear to reinforce this approach, creating a culture in which concession is avoided, and settlement is treated as a last resort rather than as an appropriate response to identified shortcomings. It would appear that the targets, KPIs and oversight of these teams may not have sufficient controls to ensure

[1] AFCA Datacube 2024-2025; https://www.afca.org.au/annual-review-general-insurance-complaints).

compliance with the Code. Often, the operational teams are distant from these processes.

Concerns also arise regarding the use of policy benefits as leverage in the dispute context. In some AFCA matters, we see partial settlements, deeds of release, or offers relating to temporary accommodation being structured or timed in a way that exerts pressure on complainants to compromise, particularly where they are displaced or in financial stress. We also observe allegations of policy breaches and delay are also used to pressure consumers, despite the right to make a complaint being in the Code and within insurance policies. In parallel, indicators of vulnerability, such as serious illness, disability, caring responsibilities or financial hardship, are not always given appropriate weight in how settlement options are framed and how negotiations are conducted.

These patterns inevitably influence perceptions of the relationship between insurers and AFCA. When consumers see selective disclosure, reluctance to correct errors, and aggressive negotiation around essential benefits, they may reasonably question whether the process is balanced and whether both parties are approaching AFCA with a shared commitment to fair resolution. While insurers may at times obtain favourable outcomes at AFCA, this prompts legitimate questions about the manner in which those outcomes are achieved and whether compliance has genuinely been central to the culture and conduct of the teams involved. In our assessment, for some insurers, compliance is subordinated to a "win at all costs" approach. In such cases, insurers appear to persist with contested positions not because they are objectively defensible, but because they are already heavily invested in the outcome and prefer to assume the risk of an AFCA determination rather than recalibrate their approach in line with their regulatory obligations.

Consumer detriment caused

When IDR processes do not operate as an effective internal safeguard, consumers face a heightened risk that incorrect or unfair decisions will stand. Many policyholders lack the knowledge, resources or resilience to escalate to AFCA, particularly where they are dealing with financial hardship, or other vulnerabilities. For those consumers, a weak IDR function means that the initial outcome is, in practice, final, regardless of its accuracy.

Even where matters are ultimately resolved at AFCA, the need to escalate imposes significant additional time, stress and cost on consumers and their families. It can also delay necessary repairs or financial remediation. Where insurers withhold unfavourable information or leverage the inherent power imbalance to pressure consumers into accepting lower settlements, the financial impact of these practices can be significant. In one matter we managed against an insurer, such tactics were challenged and resisted, resulting in an additional payment of approximately $120,000 to the customer - an outcome the customer expressly acknowledged they could not have achieved without advocacy support. The recurring pattern of decisions being revisited only after AFCA involvement undermines confidence in insurers' commitment to fair internal review and may discourage consumers from engaging with IDR at all, thereby weakening the Code's intended protections.

Call to action

Claims Hero encourages the CGC to adopt the effectiveness of IDR and its interaction with AFCA as a core monitoring priority. In particular, we recommend that the CGC:

- Undertake a focused review of complaints functions, assessing change of decision rates at IDR, the quality and completeness of IDR reasoning, and the extent to which

decision makers actively engage with evidence and policy rather than simply endorsing initial outcomes.

- Analyse complaint resolution data across the dispute lifecycle, including the proportion of matters resolved at early AFCA stages, to identify patterns that suggest systemic weaknesses in first instance and internal review processes.
- Clarify expectations that complaints must be accurately recognised and recorded, must not be recategorised to avoid formal obligations, and must involve genuine consideration of all relevant material, including consumer commissioned expert reports and detailed submissions.
- Encourage insurers to structure IDR functions with sufficient independence, authority and technical capability to depart from initial decisions where warranted, and to ensure that complex or high impact disputes receive appropriate senior oversight.
- Review compliance with provision of information obligations in the Code relating to complaints. Review AFCA data to confirm likely systemic issues with insurers and undertake targeted reviews.
- Be prepared to use its enforcement powers, including sanctions and remediation programs, where systemic IDR deficiencies are identified that have led to consumer detriment or to a recurring pattern of decisions being corrected only after AFCA involvement.

By taking these steps, the CGC can help ensure that IDR and EDR operate as complementary components of a fair and effective dispute resolution framework, rather than as sequential hurdles that consumers must overcome to obtain outcomes that should have been available to them much earlier in the process.

Loss Adjusters and Outsourcing

Loss adjusters and outsourcing is a critical area of concern for Claims Hero, as these third-party providers now perform many of the core functions that shape claim outcomes while remaining one step removed from direct Code oversight. Our experience indicates that weaknesses in how insurers engage, brief and supervise loss adjusters and other outsourced providers are a significant underlying cause of consumer detriment across the industry.

Key issues observed include:

- Delays and poor communication: External loss adjusters and outsourced claim managers frequently cause delays in inspections, reporting and follow up, with limited proactive communication to policyholders about progress, next steps, or who currently has carriage of the claim. Consumers often need to contact multiple parties to obtain basic updates, and there is a recurring pattern of "arm's length" management where insurers point to third parties despite retaining ultimate responsibility under the Code.
- Incomplete or inaccurate factual records: Reports produced by adjusters and other outsourced providers often omit relevant observations, misstate key facts (such as dates, extent and location of damage, or prior condition), or inadequately distinguish between event-related damage and alleged maintenance issues. These records then become the factual foundation for critical coverage and scope decisions.
- Commercial incentives misaligned with Code obligations: There are strong indications that some adjuster and outsourcing contracts emphasise cost containment over fairness, accuracy and consumer experience. Loss Adjusters are often employed to reduce or managed costs of insurance claims, which can create an inherent conflict of management in the management and approach taken on claims.

This raises a risk that scopes of work are drawn narrowly, additional damage is resisted, and cash settlements are benchmarked to low "panel" rates that do not reflect real-world costs of repairs.

- Use of outsourcing to obscure information transparency: Where significant elements of the claim are handled through external platforms such as ENData or builder-led models, it becomes more difficult for consumers and their representatives to access underlying information and understand who holds which documents, instructions and decisions. This fragmentation undermines transparency and can be used, in practice, to shield internal discussions and decisions from scrutiny. It may, in some circumstances, also mean that insurers can remain distant from the breaches of the Code or misconduct as a result of the outsourcing approaches.
- Inconsistent recognition and handling of complaints: Outsourced providers do not always identify, record or escalate expressions of dissatisfaction as complaints, leading to missed or delayed IDR obligations and leaving consumers without a clear record of their concerns in the insurer's systems.
- Failure to address errors and mistakes: These providers and their actions can often result in errors and mistakes, including those that can contribute to worsening damage and overall claims cost. In our observation, these providers will often engage in cost mitigation activities that, in practice, heighten consumer dissatisfaction and contribute to an increased volume of complaints and disputes. Insurers who rely heavily on loss adjusters often lack the internal capability to challenge or critically review these issues resulting in unchecked consumer harm.
- Conflicted Ownership and Influence: Some loss adjusters have conflicted ownership and commercial relationships with experts and service providers. This includes situations where 'independent experts' are actually employed within the same corporate group (e.g. Crawfords and CRD consultants).[2] Of particular concern is that these providers are presented as 'independent experts' without disclosing the conflicted ownership and relationship to consumers. In addition, Loss Adjusters may receive commissions or other financial incentives for directing work to particular building panels or operate under panel arrangements that require providers to prioritise the interests of the loss adjuster. These arrangements are typically not disclosed to consumers, allowing conflicts of interest to operate without effective scrutiny and creating a material risk of consumer detriment.

Consumer detriment caused

These issues produce significant and compounding detriment for policyholders. Delays in inspections and report completion prolong uncertainty, can exacerbate property damage and frequently extend the time consumers spend in unsafe or unsuitable living conditions. When factual records are incomplete or inaccurate, incorrect liability and scope decisions follow, requiring consumers to obtain their own expert evidence or escalate to IDR and AFCA simply to correct basic errors.

Diffusing accountability between multiple outsourced entities makes claims harder to navigate and more stressful, particularly for vulnerable consumers and those already under financial or emotional strain. In these circumstances, consumers can be left without a clear decision-maker to engage with, and legitimate concerns may fall between organisational gaps. Where commercial incentives encourage loss adjusters to minimise cost and scope, and those assessments are accepted uncritically, outcomes risk being driven by internal financial objectives rather than by the merits of the claim and the insurer's duty of utmost

[2] https://www.crawco.com.au/crd.

good faith.

Call to action

Given the central role of loss adjusters and outsourced providers in modern claims handling, Claims Hero recommends that the CGC treat this area as an emerging risk. Specifically, we suggest that the CGC:

- Conduct a targeted review of outsourcing arrangements, including contracts with loss adjusters, builder-led models and external platforms, to examine performance metrics, instructions and oversight processes align with Code requirements on timeliness, fairness, transparency and complaint handling.
- Encourage insurers to provide clear information to consumers about which external parties are involved in their claim, what their roles and limitations are, and how concerns about those parties can be raised, recorded as complaints and escalated where necessary.
- Use enforcement tools, including sanctions, remediation programs and public reporting, where systemic shortcomings in the insurer's governance of loss adjusters or other outsourced providers are identified and have contributed to consumer detriment.

Temporary Accommodation

Temporary accommodation is a critical safeguard for policyholders whose homes have been damaged and are, in practice, unsafe or unsuitable to live in. Our experience shows that decisions about temporary accommodation are often made narrowly and inconsistently, with insufficient regard to health, safety, vulnerability and realistic repair timeframes. Because these decisions have immediate, real-world consequences, shortcomings in this area are among the most acute sources of consumer detriment.

Key issues observed include:

- Overly narrow habitability criteria: Decisions frequently rely on simplistic tests such as whether a bathroom or kitchen remains "functional", with insufficient consideration of hazards like mould contamination, partial demolition, or of the practical reality of living on a construction site with children, elderly people or those with health conditions.
- Unreasonable refusals or early cessation of accommodation: Temporary accommodation is often refused or withdrawn on the basis that the property is deemed by the insurer to be "habitable" or that repairs are expected to be completed within an optimistic timeframe, even where the progress of works and scientific testing and expert evidence suggests otherwise.
- Not like-for-like accommodation options: Options presented by insurers are frequently comparable to the insured property in terms of size, location or suitability for the household. Too often insurers are prioritising their commercial interests over the interests of their vulnerable customers.
- Rapid exhaustion of policy limits: Low sums insured for temporary accommodation, combined with reliance on high-cost short-term options (such as hotels or Air BnB), result in entitlements being consumed long before the home is genuinely restored to a safe and liveable condition. Consumers can be left without support while still displaced from their home due to an accepted insured event.
- Use of accommodation as leverage in disputes: In some matters, continuation or withdrawal of temporary accommodation is closely tied to settlement negotiations, with offers of partial settlements, deeds of release or reduced scopes of work

presented alongside implicit or explicit pressure about ongoing accommodation.[3]

- Failure to proactively offer accommodation: Insurers do not always identify and raise temporary accommodation rights when it is clear a property is not reasonably liveable, instead relying on consumers to know to ask for this policy benefit.
- Insufficient consideration of customer vulnerability: Specific circumstances of vulnerable consumers, including disability, chronic illness, caring responsibilities or financial hardship, are not consistently reflected in accommodation decisions, despite the heightened impact that displacement has on these households.

Consumer detriment caused

These practices expose consumers to significant health, safety and financial risks. Families can be left living in homes that are contaminated with mould, structurally compromised or otherwise unsafe simply because basic utilities still function, or because accommodation has been refused on a narrow interpretation of "habitability". For vulnerable consumers, including those with respiratory conditions, mobility issues or young children, such environments can be dangerous and destabilising.

Premature withdrawal of accommodation or exhaustion of limited entitlements before repairs are complete can result in sudden homelessness or the need to secure inferior, ad hoc arrangements at personal expense. Where temporary accommodation is used as leverage in settlement discussions, consumers may feel compelled to accept unfavourable outcomes to avoid losing access to a safe place to live. The combination of physical displacement, uncertainty about where they will stay, and pressure to agree to terms compounds the stress inherent in the claims process and can have lasting effects on wellbeing. Importantly, these are avoidable issues if insurers have sufficient controls and processes in place to ensure suitable accommodation is obtained at a reasonable cost.

Call to action

We note that temporary accommodation was highlighted as an area of interest in the 2025-2026 monitoring priorities. We recommend the CGC continues with temporary accommodation as a key focus area in 2026-27 within its broader work on claims handling and vulnerable customers. In particular, we recommend the CGC:

- Examine how temporary accommodation limits and practices are operating in practice, including the impact of reliance on high-cost short-stay options and use of external providers, and consider whether improvements in planning, communication and provider selection could prevent premature exhaustion of entitlements.
- Treat the use of accommodation as bargaining leverage, for example, linking continuation of accommodation to acceptance of partial settlements or deeds of release, as a serious concern, warranting close scrutiny and, where systemic patterns are identified, enforcement action.
- Set expectations that insurers must proactively consider and raise temporary accommodation where damage and circumstances indicate the home may not be reasonably liveable, particularly in catastrophe events and for known vulnerable consumers.

Strengthening the General Insurance Code of Practice and uplifting compliance across the industry is essential if the Code is to function as more than a set of aspirational statements.

[3] See example Determination For Case 12-24-100028 · Customer Self-Service.

The issues highlighted in this submission demonstrate that, without robust systems, governance and oversight, critical protections around transparency, fair decision-making, proper use of experts, responsible outsourcing and temporary accommodation can be diluted or displaced in day-to-day practice.

Claims Hero therefore encourages the CGC to use its 2026–27 work program to reinforce the Code as a living, enforceable standard. A stronger, more visible compliance position will not only deter poor conduct but will also support insurers that are investing in good practice, ultimately delivering greater consistency, fairness and confidence for policyholders who depend on the Code when they are most vulnerable.