Client Care Guide
Making a claim

About this guide

Genus Life Insurance Services (Genus) complies with The Life Insurance Code of Practice (the Code).

The objectives of the Code are to ensure that we:

- Deliver a high standard of customer service throughout your relationship with us
- Continuously improve the services we offer you
- Communicate with you in plain language unless medical or other technical terminology is needed
- Seek to increase consumer trust and confidence in the life insurance industry.

Genus follows and complies with the Code, as the insurance policies we administer are issued by Australian Life Insurers who are bound to comply with the Code's standards and principles.

The Code deeply resonates with Genus' own values which has been built around the principles of Clarity and Transparency, Fairness and Respect, Honesty, Timeliness and Plain Language.

As part of Genus' commitment to the Code, we have developed Client Guides that set out the standards you can expect from our services every step of the way.

This guide sets out the claims process including how your claim will be progressed and our communications with you.

Communicating with you

We acknowledge that claims time is difficult for claimants and that each situation is unique.

We will treat you with empathy, compassion, and respect throughout the claims process. We will not discourage you from making a claim. If you tell us that you are having trouble providing the information we need, we will work with you to take steps to find a solution. This may include endeavours to collect the information on your behalf, with your permission.

Genus is the administrator of your claim. Most assessment and decisions are made by the insurer of your policy, and we relay these decisions to you.

Within **10 Business Days** of the Claim Received Date, we will tell you:

a) how you can access the Life Insurance Code of Practice
b) about your cover and any waiting periods that may apply
c) about all the relevant benefits under the Life Insurance Policy you are claiming on, and
d) about the claims process and how to contact us for more information.

We will update you on your claim's progress at least every **20 Business Days** and we will continue to do this until:

a) we have made a decision, or
b) issued a Procedural Fairness letter.

If you ask us for information about your claim at any point, we will respond within **10 Business Days.**

Information your insurer made need to assess your claim

Every time you make a new claim, we will ask for your consent for us to collect information about you. We may ask you to consent to us requesting information from more than one source. Unless you tell us you do not want us to, we will tell you each time we use your consent by phone, SMS, email or similar where possible, to ensure you know quickly. If you do not agree that we need some of this information, we will review our request.

Your insurer will ask for the information they reasonably need from you and third parties as soon as possible and will minimise multiple information requests.

When your insurer assesses your claim, they will respect your privacy by only asking for information they reasonably need to make our assessment.

If your claim is for a lump sum benefit, your insurer will obtain all the information they reasonably need, complete all reasonable enquiries, and make a decision on your claim **within 6 months** of the claim received date.

Once your insurer has received all the information they reasonably need and completed all reasonable enquiries, we will tell you their decision in writing within **15 Business Days**.

If your insurer needs a medical or financial report to assess your claim, we will ask the provider to give us their report within **20 Business Days** of the request, If they do not meet this deadline, we will tell you and update you on our progress getting the report.

If you claim is declined, we will always tell you in writing:

a) The reasons and a summary of the information about your claim that your insurer relied on
b) Where a pre-existing condition is the reason for declining your claim, we will explain the medical connection between the pre-existing condition and your claim
c) That you can ask us for copies of the documents about your claim that we relied on, which we will send to you, or to your doctor if we think that is more appropriate in line with privacy laws. We will send these copies within **10 Business Days** of your request
d) That you can ask your insurer to review the decision, or provide additional information to consider, and
e) About the Complaints process.

Financial hardship

While we are assessing your claim you can tell us if you are in urgent financial need of the benefits that you are covered for as a result of the condition that has caused the claim. We will ask you to provide documentation to support this, but will only ask for information that is reasonably necessary to assess your request, such as:

- Centrelink statements (if applicable); or
- Financial documents including bank statements.

If you are in urgent financial need, we will attempt to:

- Prioritise the assessment and decision in relation to your claim; and/or
- Make an advance payment to assist in alleviating your immediate hardship.

How to make a claim

We pride ourselves on paying genuine claims quickly and efficiently. When you make a claim with Genus, you can be confident knowing you or your family will be dealing with a dedicated claims consultant from beginning to end.

Please contact the Genus Claims team;

- **Call: 1300 88 44 88** between 8.00am-6.00pm Mon-Fri (AEST),
- **Email:** claims@genuslifeservices.com.au
- **Mail:** Genus Life Insurance Services GPO Box 2548, Sydney NSW 2001

Our Simple 4-Step Claim Process

1. **Notify**
   To make a claim, please notify our Client Service Team on **1300 88 44 88**. They will walk you through the process, send you a claim form and explain which documents are required.
2. **Complete**
   Complete the claim form and send it back to us with the supporting documents to allow us to assess the claim.
3. **Assess**
   Once we've received the completed claim form and supporting documents, we'll assess the claim and advise you of the outcome.
4. **Payment**
   Once a claim is accepted, we will make the payment to you or your nominated beneficiary/ies. All claims are paid in Australian dollars.

If you have any questions please:

- **Call: 1300 88 44 88** between 8.00am-6.00pm Mon-Fri (AEST),
- **Email:** enquiry@genuslifeservices.com.au
- **Mail:** Genus Life Insurance Services GPO Box 2548, Sydney NSW 2001