Claims Philosophy – UniSuper

1 Introduction

A full-service superannuation fund provides effective life insurance cover for the benefit of its members. An essential component in providing such cover is the effective management of life insurance claims, including financial risk. This can be challenging due to the conflicting pressures of paying members an insured benefit in a timely manner whilst ensuring that the fund is not exposed to unwarranted financial risk through payment of an insured benefit where eligibility is not met.

UniSuper Limited (**Trustee**) members[1], depending upon which division of the fund they are a member of from time to time, may be entitled to make a life insurance claim due to temporary disability, permanent disability, terminal illness and/or death under the UniSuper Trust Deed (**Trust Deed**) and UniSuper Regulations (**Regulations**) and/or the Group Life Policy and Group Salary Continuance Policy (collectively referred to as **External Insurance Policies**).

Given the technical nature of the Trust Deed, Regulations and External Insurance Policies, an underlying interpretative document, such as a claims philosophy is required to incorporate the values, knowledge and language of the organisation into the interpretation and application of these technical documents. The intention of the claims philosophy is to provide clarity of intent and facilitate a consistent and reliable approach that will afford predictability and a transparent set of standards.

Whilst this claims philosophy has general guidance value, it is acknowledged that common sense should prevail at all times. There will be members or potential beneficiaries whose difficulties are compelling and urgent. In such cases, appropriate discretion should be employed in order to accommodate their needs whilst ensuring the eligibility requirements under the Trust Deed, Regulations and/or External Insurance Policies are met.

2 The Fund's obligations

UniSuper Management Pty Ltd (**UniSuper**) and the Trustee (collectively referred to as **the Fund**), have various obligations to its members and their potential beneficiaries as defined by the Trust Deed and Regulations, Superannuation Law, External Insurance Policies and various service agreements. In addition, the Fund has also adopted the Insurance in Superannuation Voluntary Code of Practice and compliance to the code will underpin this philosophy.

The Trustee will exercise its power and discretions in good faith, acting upon real and genuine considerations in accordance with the purpose of those powers conferred.

The Fund's obligations to its 'claiming members' are to:

1. pay all valid claims
2. assess claims on their individual merit
3. provide 'easy to do business with' processes for members (e.g. case management, member education and flexible claiming options)
4. finalise claims in an efficient and timely manner
5. make decisions that are evidence based

[1] Including beneficiaries of deceased members

6. collect appropriate medical and other evidence (in volume and quantity) at the appropriate time
7. communicate in a timely, efficient and transparent manner
8. be mindful of members' medical conditions when engaging in all communication
9. ensure that claim decisions made by the external insurer are fair and reasonable and in accordance with the relevant provisions of the applicable policy document; and
10. provide early and ongoing triaging of claims to recognise the complexity of claims
11. Support vulnerable members during the claim process and have appropriate support services in place (i.e. interpreting services, referral networks, etc)
12. Ensure a member's personal and sensitive information is protected and the Fund adheres to the National Privacy Principles
13. To provide the member with information about their right to make a complaint and what the fund's complaint processes are.

The Fund's obligations to 'potential beneficiaries of a death benefit' are to:

1. consider all genuine claims
2. identify and contact all potential beneficiaries
3. provide 'easy to do business with' processes (e.g. case management, member education and flexible claiming options)
4. finalise claims in an efficient and timely manner
5. make decisions that are evidence based
6. collect appropriate financial and proof of relationship evidence (in volume and quantity) at the appropriate time
7. communicate in a timely, efficient and transparent manner
8. be mindful of potential beneficiary grief or emotional state when engaging in all communication
9. ensure that claim decisions made by the external insurer are fair and reasonable and in accordance with the relevant provisions of the applicable policy document; and
10. exhaust all avenues of investigation in seeking potential beneficiaries in line with the Australian Taxation Office (**ATO**) requirements.
11. Ensure personal and sensitive information is protected and the Fund adheres to the National Privacy Principles
12. To provide the applicant with information about their right to make a complaint relating to the distribution of a Death and what the fund's complaint processes are.

The Fund's obligations to the 'broader membership base' are to:

1. pay all valid claims in accordance with the relevant provisions of the Trust Deed and Regulations, Superannuation Law and External Insurance Policies
2. undertake appropriate innovation to improve claims management performance

3. collect and analyse data that will enable reporting and recommendations to the Trustee
4. continue to strive for high levels of member and/or potential beneficiaries' satisfaction
5. ensure that claim decisions made by the external insurer are fair and reasonable and in accordance with the relevant provisions of the applicable policy document
6. recognise the presence of psychosocial factors in claims and deal with them appropriately; and
7. manage the duration of claims and costs of assessing claims, using best efforts to avoid overpayment of insured benefits.
8. Support vulnerable members during the claim process and have appropriate support services in place (i.e. interpreting services, referral networks, etc)
9. Ensure a member's personal and sensitive information is protected and the Fund adheres to the National Privacy Principles
10. To provide the member with information about their right to make a complaint and what the fund's complaint processes are.

3 Fulfilling its obligations under the Trust Deed and Superannuation Law

In order to satisfy the Fund's obligations, UniSuper will do its utmost to recruit claims staff who:

1. have a genuine desire to provide the best service possible and exhibit empathy towards the member and/or potential beneficiaries
2. are passionate about the work that they do
3. can demonstrate the UniSuper values
4. have, or seek out opportunities to further their education in the claims profession e.g. through ALUCA/ANZIIF
5. have previous experience within the Life Insurance sector, preferably within the Industry Superannuation Life Insurance sector; and
6. have previous claims management and/or assessing experience.

UniSuper will ensure that all claims staff are appropriately trained in the relevant provisions of the Trust Deed and Regulations, Superannuation Law (in particular, SIS Act and SIS Regulations) and External Insurance Policies, the Insurance in Superannuation Voluntary Code of Practice and industry practice guidance notes and fact sheets. In addition, UniSuper will provide training in the relevant claims management processes and systems and will set the standards expected in respect to customer/member and employer services.

UniSuper is committed to well defined refresher courses and competency assessments and requires its staff to maintain their knowledge. Accordingly, UniSuper is committed to:

1. the establishment of a uniform, basic and ongoing training program for all staff providing claims services to UniSuper members; and
2. maintaining a register of employees to participate in training.

4 Temporary and Permanent Disablement Claims

4.1 Assessing a claim

A claim is determined valid if it satisfies the relevant provisions of the Trust Deed and Regulations, Superannuation Law and/or External Insurance Policies. In order to determine whether a claim is valid, UniSuper requires co-operation from the member, employer and treating doctors to supply sufficient information to enable UniSuper claims assessors to make a decision that is fair and reasonable and in accordance with the relevant provisions of the Trust Deed and Regulations and/or External Insurance Policies.

The obligation of the claims assessors is to:

1. be familiar with the Trust Deed, Regulations, Superannuation Law and External Insurance Policies, Insurance in Superannuation Voluntary Code of Practice
2. understand the technical requirements of a valid claim
3. Provide initial claim notification and ongoing updates to the Member or their representative(s) in accordance to Code
4. involve UniSuper's Chief Medical Officer (**CMO**) when:
    a. the medical evidence is inconsistent
    b. the medical evidence is inadequate; and/or
    c. if sufficient uncertainty exists that creates the risk of an unfair or unreasonable decision
5. record and consider both primary and secondary claim causes during the assessment process
6. be accessible to members during the claims process
7. act as the primary contact and case manager for the duration of the claim
8. communicate with members in a careful and empathetic manner, noting that members may be compromised due to their medical condition
9. properly evaluate all forms of evidence
10. carefully explain their decision to the member and the Fund
11. properly record their decisions
12. where a claim is approved, to pay the claim in a timely manner
13. triage claims to recognise complexity and changes in complexity
14. identify any vulnerable members (for vulnerability's unrelated to their claimed medical conditions) and provide assistance, support and direction, where needed, to assist members with their claim
15. comply with the *Privacy Act 1988* and UniSuper's Privacy Statement
16. comply with the standards of the Insurance in Superannuation Voluntary Code of Practice
17. To provide the member with information about their right to make a complaint and what the fund's complaint processes are.
18. having regard to the privacy principles, liaise with employers about the anticipated timeframe for return to work where such information is available and reliable; and

19. refer any members who would benefit from assistance to return to work, to UniSuper's Occupational Rehabilitation Return to Work Specialist.

In determining the validity of a claim, claims assessors have a variety of tools and resources at their disposal. The frequency and combination of tools used will be determined by the information available on a case-by-case basis. These tools and sources include, but are not limited to:

1. the claims forms
2. the treating doctor medical reports
3. the treating doctor clinical/patient notes
4. Medicare and Pharmaceutical Benefits Scheme (**PBS**) records
5. Independent Medical Examinations (**IMEs**)
6. CMO advice
7. rehabilitation providers
8. legal advice
9. employer information
10. copies of third-party files (e.g. Workers compensation, Centrelink, TAC etc.)
11. financial information (e.g. Notice of Assessment, Tax returns and payslips)
12. Management advice
13. underwriting information for cover above the Automatic Acceptance Limit (AAL); and
14. industry practice guidance notes and fact sheets (i.e. from APRA, ASFA, Superannuation Complaints Tribunal and AFCA).

The claims assessor will carefully evaluate the evidence provided, without prejudice and record their views on the strengths, weaknesses and relevance of the information provided. This information will be summarised and recorded in an internal document, referred to as a Memorandum, which will be used by the responsible delegate of the Trustee in making their final decision.

The claims assessor must be prepared to substantiate their recommendation as required and appropriately participate in any review process.

Where appropriate, communication between UniSuper, the CMO and treating doctor and specialists may be sufficient to facilitate a claims decision.

4.2 Procedural fairness

In the event that the available evidence indicates that an adverse determination is likely, UniSuper provides its members or their representatives with the opportunity to provide additional medical evidence and information that will assist in making a final decision in relation to the claim, as outlined in UniSuper's Procedural Fairness guide.

In the Procedural fairness letter, UniSuper will identify what it considers adverse to the members claim and include all the Trust Deed or Policy terms and conditions which apply

The member, or their representative is typically afforded 28 days to provide their response before UniSuper proceeds with making a final decision. An extension can be requested from the Trustee to enable additional information/material to be provided. Any extension request must be formally approved for it to apply.

4.3 Claim Durations

One of the keys to effective claims management is the process of claim duration management for temporary (and income protection) and permanent disablement claims. Once the claims assessor has gathered sufficient information to make a decision, they will set an expected duration period for each claim type to assist with the proactive management of the claim. The claims assessor has a variety of tools available to them, including their own experience and MD Guidelines, which will assist in setting expected durations based on a range of data:

1. ICD10 code applicable to the primary condition being claimed for
2. the presence of any secondary conditions
3. psychosocial factors; and
4. age and occupation of the claimant.
5. Ensuring or issuing 'Unexpected Circumstances' communication is issued to members or their representatives for IP / TI claims or TPD/Disablement claims, where applicable.

4.4 Acceptable forms of Medical Evidence

It is acknowledged that there are multiple sources of medical evidence, including reports from treating general practitioners, specialists and allied health providers (e.g. physiotherapists, chiropractors, psychologists, occupational therapists and rehabilitation providers), which contribute to UniSuper's understanding of its members' medical status.

It is further acknowledged that there is a usual hierarchy of reliable medical evidence to be obtained from treatment providers. Generally, UniSuper will place weight on opinions according to the expertise of the treatment provided. To that extent, whilst UniSuper accepts medical evidence provided by allied health providers, little weight (if any) will be given to this medical evidence unless provided together with medical evidence from the treating GP and/or treating specialists. UniSuper does not recognise Homeopathy, Naturopathy, Traditional Chinese Medicine, or other such alternative health providers as reliable sources of opinions for claims purposes.

Wherever possible, UniSuper will avoid asking medical practitioners to assess the validity of the claim against the relevant definition under the Trust Deed and Regulations; recognising that the focus of treating medical practitioners is on the clinical management of their patients. UniSuper will seek objective information (rather than subjective opinion) to aid in assessing work capacity against the relevant definition as not all medical practitioners are best placed to make the most informed and accurate work capacity assessments.

Under the terms of the current Trust Deed and Regulations, a member is not required to be under the care of a medical practitioner and/or actively receiving treatment in order to be eligible to receive benefits. Therefore, UniSuper is not in a position to factor a member's treatment, or lack thereof, in any adverse determinations.

It is acknowledged that members have a right to access the medical reports obtained by UniSuper. These will be provided without delay after seeking permission from their author. In exceptional circumstances, where it is considered that this has the potential to be harmful/have an adverse effect on the member (i.e. psychological distress), efforts will be made to provide the report to the member's treating doctor or authorised representative and have them present it to the member.

4.5 Ongoing progress reports

It is reasonable to expect members in receipt of inbuilt Temporary Incapacity (**TI**) and Disablement benefits to participate in regular reviews and arrange the completion of progress review forms. The regularity of these reviews will be determined on a case-by-

case basis having regard to the medical evidence available, the claim type and the cause of claim. The longer a member is on claim however, the less frequent the need for reviews is given the definition of 'disablement' and the requirement as to 'permanent incapacity'.

As a guideline, the default position will be:

1. Disablement claims – every 2 years
2. TI claims – every 6 months

A review may be limited to medical or financial information only or may be a combination of these. In conducting a medical review, the claims assessor will review the medical information already on file and, where appropriate, request up-to-date and/or additional medical information to assess the member's ongoing entitlement to the benefit they are claiming. In conducting a financial review, the claims assessor will review the financial information already on file and, where appropriate, request up-to-date and/or additional financial information (e.g. Income Tax Assessments and Returns, payslips, etc.).

4.6 Independent Medical Examinations (IMEs)/Specialist reports

In the absence of consistent, objective medical evidence that specifically speaks to the member's incapacity, it may be necessary to obtain independent medical evidence. The opinion of an IME is distinct from that which may be obtained from a CMO, in that the IME is asked to provide an objective opinion specifically within a medical context and upon examination of the member. It is not their place to apply a claims perspective to their opinion. It is the role of the claims assessor to utilise the objective information appropriately.

IMEs, when supplied with sufficient background information, may provide guidance on:

1. pre-existing conditions
2. diagnostic information; and
3. work capacity information, prognosis and return to work opportunities.

Questions asked of the IME will be limited to information which is necessary to assess the member's eligibility under the Trust Deed and Regulations and/or External Insurance Policies, and for claim duration management purposes.

During the life of a claim, if multiple IMEs are required, claims assessors will attempt to have the same IME re-examine the member. This assists with rapport and continuity and is generally less disruptive to members.

When a decision to utilise an IME is made, it is generally accepted that the information provided by the IME will be given greater weight. Generally, more weight will be given to the opinion of an IME over other medical information on file as it is generally considered to be more objective than that provided by a treating GP, and on par with the opinions obtained from a treating specialist.

Complaints received concerning IMEs will be escalated to the Manager, Insurance and Claims. The IME examiner should have the opportunity to address the complaint. Members will be advised about their options for escalating complaints within UniSuper.

UniSuper regards external reports as being of high quality when the following features are present:

1. there is a clear narrative describing the passage from health to impairment
2. there is a comprehensive description of the member's symptoms
3. there is evidence that the examiner understands the member's usual roles and responsibilities
4. the examiner provides non emotive, definitive advice relying on evidence-based medicine

5. the report is provided to UniSuper in a timely manner; and
6. the cost of the information is appropriate for the quantity and quality of information provided.

Wherever possible, it is desirable to develop service level agreements with external providers so that the above standards are agreed and monitored. In this process, UniSuper will undertake appropriate due diligence on external providers to ensure that appropriate technical and professional standards are maintained.

UniSuper acknowledges that medical specialists are usually remunerated on a time and materials basis. The cost of reports to UniSuper should reflect this. Accounts rendered to UniSuper must be appropriately itemised for invoicing purposes.

It is appropriate to give a member a minimum of 2 weeks' notice to attend an IME. It is desirable to have the member examined as close as possible to their place of residence.

4.7 CMO

UniSuper has access to two CMOs with differing specialities: Psychiatry and General Medicine.

A CMO's opinion is generally sought when there is the need to explore or examine the medical evidence with expert trained medical knowledge, whilst maintaining a clear focus on claims considerations. The advice provided by a CMO can be claims-centric and can offer opinion as to how the medical evidence relates specifically to claims considerations.

The value of a CMO is most evident when there is some level of contention within the content of the medical information on file. The opinion can be utilised when conditions are subjective and/or ambiguously diagnosed. Given the diversity of opinions in the medical profession about subjective conditions, it can be considered appropriate that there be a closer review of such conditions under the guidance of the CMO.

The CMO may also be utilised when there is some uncertainty as to how best to utilise existing medical evidence in the context of maintainable claim decisions. They can provide an insight into the medical evidence that non-medically qualified claims assessors may not be able to provide. They can guide and advise claims assessors towards making the most fair and reasonable claim decisions based on an accurate and complete assessment of the medical evidence on file.

Claims that exceed predicted durations, irregularities and uncertainty about pre-existing conditions may also be reviewed.

4.8 To make decisions that are evidence based

All decisions made by claims assessors will be based on the reasonable and holistic application of all medical and factual evidence collected during the assessment of the claim.

UniSuper accepts that medical and other providers may provide opinions in relation to claims. UniSuper places greater weight on those opinions that are based in documented facts or observation. To that end, it is acknowledged that a diagnosis itself does not necessarily speak to the member's capacity.

Decisions on incapacity will be made once there is a comprehensive, clear understanding of the member's symptoms and the impact that those symptoms have on their roles and responsibilities at work.

Occupational physicians are often best placed to advise UniSuper on work capacity decisions for physically based disorders/illnesses and psychiatrists for mental disorders.

4.9 Occupational Rehabilitation & Return to Work Assistance

UniSuper's claims team understands the importance of helping members get back to work.

A member is referred to the Occupational Rehabilitation & Return to Work Specialist (ORRWS) by an assessor. The referral is triggered by the medical evidence available to the assessor showing the member is deemed to have a partial capacity for work.

The key function of the ORRWS is to provide these members with assistance in negotiating and facilitating a return to work with the member's treating practitioners and employer or preparing a member for new employment either at a new employer or in a different vocation.

All referrals will result in the provision of individual and tailored services including (but not limited to):

- Resume Review and Cover Letter preparation
- Assistance with upskilling or retraining in a new career
- Support and direction through the job application process
- Interview Practice
- Job searching

The ORRWS records and monitors all the claims they assist with and works closely with the Claims Assessors to ensure there is a consistent approach to the management of these claims. The progress and commentary on each referral is documented and all outcomes are recorded.

5 Death claims

The distribution of death benefits is heavily guided by the Trust Deed and Regulations, Superannuation Law (in particular, the SIS Act and SIS Regulations) and ASFA Guidance papers. Pursuant to the Trust Deed and SIS regulations, upon the death of a member, and in the absence of a binding death nomination, the trustee must pay any residual benefit of a deceased member to a 'Dependant' or to the Legal Personal Representative (**LPR**).

Dependants include are but not limited to

1. Spouse – legal or de facto
2. Children – Adult and Minor
3. Persons in an interdependent relationship with the deceased; and
4. Persons with a financial dependency on the deceased.

Where there is no Dependants and no LPR, the Trustee has discretion to pay the death benefit to any other appropriate third parties as non-dependants (e.g. Parents of the deceased member or siblings of the deceased member).

In relation to LPRs, the estate may not be established through Grant of Probate or Letters of Administration where the estate is of small value and the expense of acquiring these court issued documents will materially impact the benefit amount, or where the superannuation benefit (and insurance if applicable) is the only substantial asset.

In determining the distribution of the death benefit, appropriate weighting and consideration is given to (in the order below):

1. the reasonable expectation of continued financial support

2. the extent and degree of dependency
3. the member's wishes and intention for the distribution of their death benefit (i.e. recent Will or beneficiary nomination) and whether other considerations outside of superannuation exist; and
4. the circumstances, nature and duration of the relationship.
5. Whether a potential beneficiary has advised they do not wish to be considered in the distribution of the death benefit.

These should be not considered in isolation to each other where appropriate.

To establish these details information will be collected from:

1. potential beneficiaries
2. the Last Will and Testament of the deceased member
3. Grant of Probate and/or Letters of Administration, including state legislation indicating how assets will be distributed in cases of intestacy
4. proof of relationship (e.g. marriage certificates, birth certificates)
5. death benefit nominations made by the deceased member (e.g. Preferred and Binding nominations), including when these were made and if they pre-date the commencement of a new relationship; and
6. any other documentation deemed appropriate based on the specifics of the case at hand such as sealed court orders.

5.1 Determining the distribution amounts

The SIS Act does not provide a formula for the distribution of death benefits within the Superannuation environment. This is different to the clear directions provided under intestacy laws where a specific formula is provided. This distinguishes the distribution of benefits and allows for trustee discretion. As a result, UniSuper does not subscribe to a standardised formula approach in determining distribution apportionment; notwithstanding the absolute intent to be fair and equitable in making such decisions.

In cases where there are multiple identified beneficiaries, all of the evidence collected must be taken into consideration. This includes evidence of:

1. financial reliance – the extent of financial support provided by the deceased, and the expectation of continued support
2. cultural norms or expectations
3. special needs – such as a disabled child or a minor child and the anticipated duration of reliance, ongoing care and level of financial support needed; and
4. the deceased member's wishes and intentions at the date of death (i.e. terms of a valid will and beneficiary nominations).

5.2 Grant of Probate and Letters of Administration

Grant of Probate is obtained through the court system where a valid Will exists and has been accepted by the courts as the last will and testament. This process also recognises the Executor as the legal personal representative.

Letters of Administration on the other hand, can be applied for when no valid Will exists, and the court has appointed a legal personal representative to administer the estate.

There is a cost associated in obtaining both of these court orders. Where UniSuper is recommending distribution directly to identified Dependants, discretion may be used to waive collection of these documents. UniSuper will also consider paying the benefit directly to

other parties as per the Trust Deed, where the cost of obtaining these court orders significantly negates any benefit. Guiding principles in considering what factors would be reasonable include:

1. benefit amount
2. potential beneficiary and the relationship to the deceased member
3. any indicators that the decision of who the benefit is distributed to is contentious or likely to be contested; and
4. state legislation regarding probate and deceased estate administration.

5.3 Request for additional documentation

UniSuper's approach is to collect evidence that is necessary rather than an extensive and exhaustive list. UniSuper will endeavour to collect all initial information required through the first contact with the initial informant. This will enable UniSuper to tailor the correspondence and requirements from the outset to match the member's personal circumstances. Requirements will be reviewed on a regular basis. This will serve two outcomes:

1. to ensure UniSuper have requested all requirements in a timely manner; and
2. to ensure claims are not delayed by waiting for unnecessary information / documents that are not material to the trustee exercising its power and discretions to act in good faith and reasonably in making a decision.

5.4 Claim Staking

Claim staking is a discretionary process available to trustees where there may be concerns surrounding the decision being accepted. As all potential beneficiaries have the right to object to the decision, this is a safeguard to ensure the death benefit has not been released prior to an objection being received.

UniSuper will Claim Stake when:

1. there are multiple potential beneficiaries and there is evidence of or material potential for contention amongst the parties; and
2. UniSuper have not been able to establish contact with all potential beneficiaries (i.e. where potential beneficiaries have been non responsive).

Claim staking will not be required when:

1. a potential beneficiary has indicated that they do not intend to claim. This must be expressed through one of the following:
    a. a signed and witnessed statutory declaration; or
    b. a recorded telephone conversation, the details of which will be confirmed through an email to the potential beneficiary
2. the amount for distribution is considered small ($1,000 or less) and the beneficiary is clear
3. there is clearly only one potential beneficiary; and
4. the death benefit is being paid in accordance with the member's valid Binding Death Benefit Nomination or Reversionary Nomination.

5.5 Providing options to Beneficiaries on how to receive the death benefit

Where the Trustee has determined who will receive the benefit the following options may be available to receive the benefit:

1. Lump sum benefits:

a. either via Electronic Funds Transfer directly to the beneficiary's own bank account
b. Cheque made out to the Beneficiary for the percentage approved

2. Payments to minor children:
   If one of the beneficiaries is a minor (under the age of 18) the trustee has discretion to release these benefits as follows:

   a. Formal Minor Beneficiary Trust: funds will be paid to a formal trust where UniSuper will bear the cost to prepare a Trust Deed. In most but not all cases, the Legal Guardian of the minor child will enter into a formal agreement with UniSuper and be appointed trustee, becoming responsible for holding the benefit for the beneficiary. In addition, these funds can be used for the education, maintenance and betterment of the child until they reach the age of 18. Once the child reaches the age of 18, any residual benefit vests and is released to the beneficiary.
   b. Informal Trust where the funds will be released to the Legal Guardian of the minor upon signing of an deed of Trust, confirming the funds will only be used for the education, maintenance and betterment of the child until they reach the age of 18.
   c. These payments can also be released in the form of an EFT or Cheque

3. Payments to a Spouse:
   In some circumstances, the following options may be available to eligible beneficiaries:

   d. Receive the funds as a lump sum; or
   e. Receive the funds as a Death Benefit Income Stream or Beneficiary Income Stream

4. All of the applicable options will be discussed with the beneficiary or their Legal Guardian once the Trustee has determined who will be receiving the benefit and in what proportions. We will recommend seeking financial advice where the beneficiary is uncertain on which option best suits their needs and circumstances.

6 Member communication

UniSuper's intention is to make claim decisions expeditiously and to communicate those decisions carefully to member/claimants as soon as it is practical to do so. UniSuper claims assessors &/or consultants will identify the medical and other evidence that has been relied upon in order to make claim decisions. Claims assessors &/or consultants will be transparent about this evidence with the member/claimants &/or their representative. In some circumstances, it may be necessary to communicate claim decisions to the member with the assistance of their treating doctors or a support person.

It is understood that decisions concerning the member's livelihood are likely to be stressful and possibly perceived as threatening. As such, UniSuper's communications will be sensitive, honest and supportive.

It is acknowledged that the claims vary in complexity. As such, information obtained by UniSuper requires careful analysis by the claim's assessors/consultants, managers, our legal business partner and CMO (when required).

Members making claims are possibly distressed due to their ill health and the nature of their circumstances. It is also possible that medical conditions and their treatments may affect the member's capacity for communication. Medical conditions and their treatment can cause sedation, pain, irritability and reduced comprehension and ability to cohesively communicate with UniSuper.

UniSuper staff having contact with members will be mindful of the values of integrity, professionalism, honesty and compassion at all times.

7 Governance

Claims decisions will be approved in accordance with the prescribed the Delegated Authority Matrix.

The Insurance Committee retains decision making authority for any disputed claim and maintains oversight of all declined claims.

Document Control

Document Owners: Amalia Faba			
Review Date	**Reviewed By**	**Position**	**Next Review Due**
20/09/2018	Nicole Mackay	Insurance and Claims Technical Specialist	September 2020
28/10//2020	Amalia Faba	Insurance and Claims Manager	September 2022