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How to make an insurance claim

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LUCRF super

An Industry SuperFund

How to make an insurance claim

LUCRF Super offers you a range of flexible options for insurance through your super account. While we hope that it's never needed, it's comforting to know that our insurance can provide you and your loved ones with greater financial security if any unseen or unfortunate events were to occur.

Insurance is offered on your super account through an agreement between LUCRF Super and our insurance provider, OnePath Life Limited.

If the worst was to happen, you'll need to make an insurance claim with us in order to receive your benefit.

Our responsibility to you

We have a duty to act in your best interests (known as our 'fiduciary duty'). This includes ensuring that you receive all superannuation and insurance benefits that you're entitled to.

Super fund trustees legally have to act in fund members' best interests, including in relation to the payment of insurance claims.

This is a step-by-step guide to assist you when you need to make an insurance claim through your account with us.

Steps to make an insurance claim

Step 1 – Contact us first

If you want to make an insurance claim (or have any questions about your insurance) you should contact us first. One of our dedicated member service representatives will be able to explain the claims procedure and send you the necessary forms and paperwork. They'll help you understand our claims assessment process and will work with you to ensure that we receive all the required information and that your claim is processed as smoothly as possible.

Tip: You'll need to provide us with any information the insurer reasonably considers necessary to properly assess your claim. This may include medical reports and employment records.

Making a claim on the insurance you have in your super is much easier than you might think. Most genuine claims are straightforward and can be made directly through your super fund.

Did you know?

LUCRF Super has dedicated staff who can help you make your claim, or answer any questions you may have about your insurance.

Step 2 – Complete our forms and lodge your claim

After making your initial enquiry, you'll need to complete and submit the forms provided to you and supply all requested information in order for your claim to be further assessed. Many of our forms can be received and/or submitted electronically or in paper form. When you return everything to us, please attach all the documents requested in the claims pack we'll send to you.

If you're unsure about any of the questions asked or need help completing the form, our member service representatives will be more than happy to help.

Tip: It may save you time if you provide all of the requested information and fill in the forms completely and accurately the first time. Your claim could be delayed if we have to clarify anything, or ask for more information.

Did you know?

LUCRF Super has dedicated staff who can help you complete your claim application.

Step 3 – Coordinating your claim

We'll check your application and, if you're eligible to make a claim, we'll forward all of your documents and information to our insurer.

Generally, we'll be the contact between you and our insurer. However, it may be necessary for our insurer to contact you directly during the claims process.

Step 4 – Our insurer assesses your claim

Our insurer will use the information you provided to make their assessment.

They will generally pay for any additional medical reports they request and any examinations they arrange for you to attend.

Our insurer may also:

- *ask for reports from your doctor/s*
- *ask you to provide more information*
- *ask your employer for more information*
- *make an appointment for you to have a medical examination with an independent specialist/s.*

Step 5 – Our insurer makes a decision about your claim

After considering all of the medical evidence and other information, our insurer will decide whether, in their opinion, you meet the relevant definition (for example, 'TPD' for total and permanent disablement claims, or terminal illness) under their insurance policy.

Our insurer will then advise us as to how they have assessed your claim and whether it should be accepted, deferred or declined.

Did you know?

On average, between 85-90% of genuine insurance claims have been paid out historically across the superannuation industry.

Step 6 – The trustee reviews our insurer's decision

We have a legal obligation to act in the best interests of all fund members. This means that we need to independently review your claim and form our own opinion as to whether our insurer's decision is the right one.

Our review of the insurer's decision may result in one of the following outcomes:

Accept	If your claim is accepted, you'll receive a letter from us informing you of this. We'll also send you information on how the benefit can/will be paid to you.
Defer	We may agree with our insurer's decision to defer your claim for a period of time to determine the full extent of your disability and whether it's permanent. Your claim will be reviewed again at the end of this period.
Decline	We may agree with our insurer's decision to decline your claim. In this case, we'll write to you stating the reason/s why we agree with our insurer's decision.

Step 7 – Your claim is reviewed (if it's declined or deferred)

If your claim is declined or deferred, we'll review the insurer's initial decision on your behalf.

If we disagree with our insurer's decision to decline or defer your claim, we may request that our insurer reconsider the claim or ask for further medical evidence.

Step 8 – Final decision

When we finish the review process, your claim may be accepted or it may be deferred or declined. We'll advise you of the decision in writing.

If you do not agree with our final decision

Making a complaint

If your claim is declined and you disagree with our decision, or you're not happy with how your claim has been managed, you can send us a written complaint.

We'll respond as soon as possible following an investigation into your concerns. This may take up to 90 days. Your claim may be referred to our Claims Review Committee for further review and decision making.

If you're not satisfied with our response or how your complaint has been managed (or you do not receive a response from us within 90 days), you may contact:

- the Superannuation Complaints Tribunal (SCT) – up until 31 October 2018
- the Australian Financial Complaints Authority (AFCA) – on or after 1 November 2018.

The SCT and AFCA are independent bodies established by the Commonwealth Government to assist superannuation fund members (or their beneficiaries) to resolve certain superannuation complaints.

The SCT or AFCA may be able to help you resolve your complaint, but you must have complained to your fund first before contacting the SCT or AFCA. The SCT or AFCA will acknowledge your complaint within seven days of receiving it and then send a notice to your fund advising them of the complaint registration. In certain circumstances (for example, with complex cases or those involving mental health issues), individuals may benefit from legal representation.

Did you know?

The SCT and AFCA offer a free, user-friendly alternative to going to court.

Until 31 October 2018

SCT contact information:

You can ring the SCT on 1300 884 114. For more information, visit sct.gov.au.

On or after 1 November 2018

AFCA contact information:

You can ring the AFCA on 1800 931 678. For more information, vist afc.org.au.

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