# UniSuper Claims Philosophy

**DATED: NOVEMBER 2024**

## 1. Introduction

This is intended to be a guide only. Nothing in the claims philosophy is intended to bind the trustee or administrator in any way. To the extent of any inconsistency between the claims philosophy and the trust deed or the law, then the trust deed and the law will prevail.

All eligible UniSuper members are offered insurance cover as part of their superannuation product.

UniSuper members or their beneficiaries may be entitled to a benefit if they die, become terminally ill or cannot work due to injury or illness. These benefits are provided through either:

- external insurance via the group life insurer engaged by UniSuper to provide external insurance cover, or
- inbuilt benefits by UniSuper in accordance with the Fund's Trust Deed and Regulations.

This claims philosophy relates predominantly to the handling of ***inbuilt claims*** and UniSuper's governance and oversight obligations as the Trustee, in respect to the handling of external insurance claims. The philosophy is intended to provide clarity of intent, and facilitate a consistent, reliable approach and a transparent set of standards.

Whilst this claims philosophy provides valuable guidance, it is acknowledged that the Trustee will consider each claim on its own merits on a case by case basis. There will be members or potential beneficiaries whose difficulties are compelling and urgent. In such cases, appropriate discretion may be employed to accommodate their needs, whilst ensuring the eligibility requirements under the Trust Deed, Regulations and/or external insurance policies are met.

## 2. Fund Obligations

UniSuper has various obligations to its members and their potential beneficiaries under the Trust Deed and Regulations, superannuation law, external insurance policies, the general law and various service agreements. In addition, the Fund has adopted the ***'Claims handling standards for Superannuation Funds - Guidance Notes'*** which underpin this philosophy (attached at Schedule 1).

## 2.1 UNISUPER'S OBLIGATIONS TO ITS CLAIMING MEMBERS:

- pay all valid claims in accordance with the Trust Deed & Regulations and/or relevant Insurance policy;
- ensure that claim decisions made by the Insurer are in accordance with the relevant provisions of the applicable policy document;
- provide '*easy to do business with*' processes for members;
- pay claims in an efficient and timely manner;
- make decisions that are evidence based;
- only collect medical and other evidence that is deemed relevant and necessary in the assessment of the claim;
- communicate in a timely, efficient, and transparent manner;
- communicate regularly with claimants to follow up any outstanding requirements and keep them informed of claim status
- be accessible to members during the claims process;
- support all members during the claim process and have appropriate support services in place (i.e. interpreting services, referral networks);
- advocate for the member where we disagree with the Insurer's decision;
- provide the member with information about their right to make a complaint in accordance with the Fund's complaint process and or external dispute resolution body with the Australian Financial Complaints Authority (**AFCA**).

## 2.2 UNISUPER'S OBLIGATIONS TO POTENTIAL BENEFICIARIES OF A DEATH CLAIM:

- make reasonable efforts to identify all potential beneficiaries who may be eligible to claim for a death benefit and seek their intention to claim;
- collect appropriate financial and proof of relationship evidence at the relevant date (date of death of member);
- consider any other potential ancillary benefits which may be payable, such as Disabled Child Pension, Dependent Child Pension, specific illness benefits;
- provide the claimant with information about their right to make a complaint relating to the distribution of a death benefit and how they can do so through the fund's internal complaint process, or with AFCA.

## 2.3 UNISUPER'S OBLIGATIONS TO THE 'BROADER MEMBERSHIP BASE':

- undertake appropriate innovation to improve claims management performance;
- ensure material relating to claims is regularly updated to ensure it is current, relevant and easy to understand so that members considering making a claim are well informed
- collect and analyse claims data for effective reporting and to support recommendations for enhancements to process and procedures;
- continue to strive for high levels of member and/or beneficiaries' satisfaction;
- actively manage the duration of claims and costs of assessing claims, to minimise risk of overpayment of insured benefits;
- ensure personal and sensitive information is protected and in accordance with the Australian Privacy Principles;

- apply offsets (reduction in disability benefits) in accordance with the Trust Deed and/or relevant insurance policy.

### 2.4 FULFILLING ITS OBLIGATIONS UNDER THE TRUST DEED AND SUPERANNUATION LAW

To satisfy the Fund's obligations, UniSuper will wherever possible, recruit experienced claims staff who:

- have a genuine desire to provide the best service possible and exhibit empathy towards the member and/or potential beneficiaries;
- are passionate about the work that they do;
- can demonstrate the UniSuper values;
- have previous group insurance experience, preferably within industry super.

UniSuper will ensure that all claims staff appointed 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, 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 continual training and competency assessments and requires its staff to maintain their knowledge. Accordingly, UniSuper is committed to the establishment of a uniform ongoing continued professional development training program for all staff providing claims services to UniSuper members and their potential beneficiaries.

## 3. Assessing *Inbuilt* Temporary Incapacity and Disablement claims

A claim is determined valid if it satisfies the relevant provisions of the Trust Deed and Regulations or superannuation law. 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 claims assessors to make a decision that is in accordance with the relevant provisions of the Trust Deed and Regulations.

The obligation of the UniSuper claims assessor is to:

- be familiar with the relevant provisions of the Trust Deed, Regulations and superannuation law that relate to the claim;
- understand the technical requirements of a valid claim;
- engage the relevant UniSuper Chief Medical Officer (**CMO**) when:
  - the medical evidence is inconsistent;
  - the medical evidence is inadequate to understand how a medical condition may impact/impair functional capacity, or
  - uncertainty exists that may create the risk of an unfair or unreasonable decision.
- act as the primary contact and case manager for the duration of the claim;
- communicate with members in a careful and empathetic manner, noting that members may be compromised due to their medical condition;
- evaluate all forms of evidence;
- provide members with clear and transparent information on the recommendations and decisions;
- record their recommendations and decisions;

- identify any members that require additional assistance, support, and direction, where needed, to assist them with their claim;
- liaise with employers about the anticipated timeframe for return to work where such information is available and reliable;
- refer any members who would benefit from assistance to return to work, to UniSuper's Occupational Rehabilitation Return to Work Specialist;
- liaise with the member's medical practitioner(s) and employer to obtain full and relevant information in order to assess the claim objectively.

In determining the validity of a claim, UniSuper 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:

- relevant claims forms;
- treating doctor medical reports;
- treating doctor clinical/patient notes;
- Medicare and Pharmaceutical Benefits Scheme (**PBS**) records;
- Independent Medical Examinations (**IMEs**);
- CMO advice;
- rehabilitation providers;
- internal legal counsel;
- employer information;
- copies of third party files (e.g. Workers compensation, Centrelink, TAC);
- financial information (e.g. Notice of Assessment, Tax returns and payslips);
- Team Leader and Manager advice;
- underwriting information for cover above the Automatic Acceptance Limit (**AAL**);
- internal practice guidance notes and fact sheets;
- industry practice guidance notes and fact sheets (i.e. from APRA, ASFA and AFCA).

The claims assessor will evaluate the evidence provided without prejudice and record their views on the strengths, weaknesses and relevance of the information provided. The claims assessor will form a view on the evidence provided as to whether the member qualifies for the benefit claimed and on what basis. This information will be summarised and recorded an internal document, referred to as a Recommendation 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 required to facilitate a claims decision.

### 3.1 PROCEDURAL FAIRNESS

In the event that the available evidence indicates that an adverse determination or a lesser benefit entitlement is likely, UniSuper (and the Insurer in respect to insured claims) provides the member or their representative, procedural fairness. Namely, the opportunity to submit additional medical evidence and information for consideration by the Trustee, to assist in making a final decision in relation to the claim as outlined in UniSuper's *Procedural Fairness guide*.

In the procedural fairness letter, the claims assessor will provide a preliminary assessment of the claim, identifying what it considers adverse to the claim, the evidence being relied on to form the view

and the relevant provisions of the Trust Deed and or Regulations which apply. The member can request copies of evidence relied upon in the procedural fairness letter and obtained during the claims process.

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

## 3.2 CLAIM DURATIONS

A key component 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 in setting expected durations including but not limited to:

- their own knowledge and experience;
- MD Guidelines, which will assist based on a range of data such as ICD10 code applicable to the primary condition being claimed for and the presence of any secondary conditions
- psychosocial factors; and
- age and occupation of the claimant.

## 3.3 FORM 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.

Every piece of medical evidence is considered and given its own weighting having regard to a number of factors including (but not limited to):

- the specialisation of the provider (i.e. whether the doctor is a GP or specialist and, if a specialist, what kind);
- how long they've been treating the member;
- what kind of opinion they're actually providing (e.g. pre-existing condition, capacity, treatment);
- whether they've been fully briefed on all relevant information;
- the content of the actual report, how fulsome it is and whether it discloses a cogent path of reasoning;
- the actual opinion expressed by the doctor, and whether it stands alone or is in conformity with the bulk of the other medical opinions.

UniSuper generally prefers reports and opinions expressed by registered medical practitioners. To that extent, whilst UniSuper accepts medical evidence provided by allied health providers, there may be little weight (if any) given to this medical evidence unless provided together with medical evidence from the member's 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 ultimately it is the Trustee that needs to form the opinion on whether a member satisfies the relevant definition. UniSuper will seek objective information (rather than subjective opinion) to aid in assessing work capacity against the relevant benefit 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 inbuilt benefits.

It is acknowledged that members have a right to access the medical reports obtained by UniSuper. These may be provided 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 in the form deemed appropriate.

## 3.4 ONGOING PROGRESS REPORTS

The Trust Deed and Regulations require those in receipt of inbuilt Temporary Incapacity (**TI**) and inbuilt Disablement benefits to participate in regular reviews and arrange the completion of progress review forms. The regularity of these reviews are determined on a case-by-case basis having regard to the medical evidence available, the claim type and duration, and the cause of claim.

As a guideline, the default position on seeking a review and ongoing progress report are generally every 2 years for Disablement claims and every 6 months for TI claims.

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 must review the relevant 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 relevant 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, profit and loss statements).

## 3.5 INDEPENDENT MEDICAL EXAMINATIONS / 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 independent medical examiner (**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:

- pre-existing conditions.
- diagnostic information.
- 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 policy, 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.

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

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

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

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. In the exceptional circumstances where this cannot be accommodated, UniSuper may cover the costs associated with travel and accommodation.

## 3.6 CHIEF MEDICAL OFFICER

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 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 referred to the CMO for review.

### 3.7 EVIDENCE BASED DECISIONS

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

UniSuper accepts that medical and other providers may provide differing opinions in relation to claims. UniSuper generally places greater weight on those opinions that are based on 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.

### 3.8 OCCUPATIONAL REHABILITATION AND 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 or through a review undertaken by the ORRWS. The referral is triggered by the medical evidence available to the assessor showing the member is deemed to have a capacity for work or a potential 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 should 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, and
- 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.

## 4. Assessment of IP and TPD claims by the External Insurer

Assessment of Total and Permanent Disablement (**TPD**) claims and Income Protection (**IP**) claims is the responsibility of the Insurer. However, the Fund has a fiduciary obligation to oversee the claims process including the decisions being made.

### 4.1 MONITORING THE INSURER'S CLAIMS PROCESS

UniSuper has processes in place to monitor the claims handling process while the claim is with the insurer including regular service and performance reporting, and dedicated resources who monitor the progress of claims.

### 4.2 MONITORING THE INSURER'S DECISIONS

**Approved insurer claims**

UniSuper's claims assessors' review:

- all TPD approved claims to ensure that the conditions of release have been met in accordance with superannuation law, and the correct date of disablement has been identified;
- IP claims where an offset has been applied may be randomly selected and checked for calculation accuracy.

**Declined insurer claims**

Where UniSuper disagrees with the insurer's decision, it will address this with the insurer directly and provide its reasons why it disagrees. The insurer will then be asked to review its decision taking into account UniSuper's concerns. Once the review has been undertaken, if UniSuper is still not satisfied with the decision made by the insurer, a formal escalation process is enacted in accordance with policy terms.

If the Insurer maintains its decision to decline and the claims assessor is:

- satisfied that the decision is in accordance with the policy terms, they will confirm with the insurer to finalise the claim and provide the member with a formal decision letter; or
- still not satisfied with the decision made by the insurer – a formal escalation process is enacted in accordance with policy terms.

## 5. Death Claims

The distribution and management of death benefits is 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 and or to the Legal Personal Representative (**LPR**).

Dependants include, but are not limited to:

- spouse – legal or de facto.
- children – adult and minor.
- persons in an interdependent relationship with the deceased.
- persons with a financial dependency on the deceased.

Where there is no Dependant and no LPR, the Trustee has discretion to pay the death benefit to any other person as a non-dependant (e.g. parents or siblings of the deceased member) as permitted under superannuation law.

In relation to LPRs, the Trustee may exercise the discretion under the relevant provision of the Trust Deed to waive the requirement for a grant of probate or letters of administration to be produced. This discretion is generally exercised where the estate is of small value and the expense of acquiring these court issued documents may materially impact the benefit amount, and the Trustee is satisfied that the recipient of the benefit would be entitled to obtain a grant of probate or letters of administration had it been formally administered.

In determining the distribution of the death benefit, appropriate weighting and consideration is given to the following relevant considerations (among others):

- the reasonable expectation of continued financial support;
- the extent and degree of dependency;
- the member's wishes and intention for the distribution of their death benefit (i.e. recent Will or preferred/expired beneficiary nomination) and whether other considerations outside of superannuation exist;
- the circumstances, nature and duration of the relationship;
- whether a potential beneficiary has advised they do not wish to be considered in the distribution of the death benefit.

These should not be considered in isolation from each other.

To establish these details information may be collected from:

- potential beneficiaries;
- the Last Will and Testament of the deceased member;
- grant of probate and/or letters of administration, including state legislation indicating how assets should be distributed in cases of intestacy;
- proof of relationship (e.g. marriage certificates, birth certificates);
- death benefit nominations made by the deceased member (e.g. non-binding and binding nominations), including when these were made and if they pre-date the commencement of a new relationship; and
- 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 and SIS Regulations do 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 pursuant to the provisions of the Trust Deed and Regulations. UniSuper does not subscribe to a standardised formula approach in determining distribution apportionment, notwithstanding the intent to be fair and equitable in making such decisions in weighing the relevant considerations in light of the Sole Purpose Test under superannuation law.

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

- financial reliance – the extent of financial support provided by the deceased, and the expectation of continued support
- 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

- 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 by way of application through the relevant court where a valid will exists and is thereby accepted by the court as the last will and testament of the late member. 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 a Grant of Probate or Letters of Administration. Where UniSuper is recommending distribution directly to identified Dependants, discretion may be used to waive collection of these documents. UniSuper may 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:

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

## 5.3 REQUEST FOR ADDITIONAL INFORMATION

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 to serve the following outcomes:

- to ensure UniSuper have requested all requirements in a timely manner; and
- 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 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 may claim stake when:

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

Claim staking may not be required when:

- a potential beneficiary has indicated that they do not intend to claim. This may be expressed through one of the following:

- a signed and witnessed statutory declaration;
- a recorded telephone conversation, the details of which should be confirmed through an email to the potential beneficiary; or
- completion of Section 5 in the Statement of Dependants - Applying for a death benefit form.

- the amount for distribution is considered small ($1,000 or less);
- there is clearly only one potential beneficiary; and
- the death benefit is being paid in accordance with the member's valid Binding Nomination, Non-Lapsing Binding Nomination or Reversionary Nomination.

## 5.5 PROVIDING OPTIONS TO BENEFECIARIES ON HOW TO RECEIVE THE DEATH BENEFIT

Where the Trustee has determined who will receive the benefit, the benefit will ordinarily be paid as a lump sum to the beneficiary's bank account via Electronic Funds Transfer. However, there may be alternative ways of paying the benefit at the discretion to the Trustee pursuant to provisions in Trust Deed and Regulations where benefits are being paid to a child who is under a legal disability or to a minor child (aged under 18 years).

The trustee **may** exercise its discretion to appoint a trustee for any funds paid in trust to a minor child as part of the death benefit claim decision. Generally, the appointed trustee is the person best suited to look after the needs of a minor child, i.e. the surviving parent or guardian. However, if a suitable trustee cannot be identified, then the trustee may appoint a third-party trustee, such as State Trustees.

**Formal Minor Beneficiary Trust Deed**

Death benefits to a minor child should be paid in accordance with an executed minor beneficiary trust deed drafted by UniSuper. 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, responsible for holding the benefit for the benefit of 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 child as the beneficiary under the trust.

**Informal minor beneficiary trust agreement**

Death benefits to a minor child may be paid to the Legal Guardian of the minor in trust for the minor child, with confirmation of the terms provided in writing. A letter would be drafted to the Legal Guardian in their capacity as the trustee of the minor child confirming that the funds will be distributed to them to hold for the benefit of the child and will only be used for the education, maintenance and betterment of the child until they reach the age of 18, after which any remaining balance is to be released to the child as the beneficiary of the funds.

**Payments to a Spouse**

In some circumstances, the following options may be available to eligible beneficiaries:

- receive the funds as a lump sum; or
- receive the funds as a Death Benefit Income Stream or Beneficiary Income Stream

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 may recommend seeking financial advice where the beneficiary is uncertain on which option best suits their needs and circumstances.

## 6. Member/beneficiary communication during the claim process

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. Whilst UniSuper's preferred method of communicating with the member is via phone, written communication is required in certain circumstances in order to meet compliance and regulatory obligations. UniSuper will wherever possible communicate with the member/claimant in the preferred method and frequency indicated by the member/claimant.

UniSuper claims assessors and/or consultants will identify the medical and other evidence that has been relied upon in order to make claim decisions. Claims assessors and/or consultants will be transparent about this evidence with the member/claimants and/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.

## 7. Governance

Claims decisions will be approved in accordance with the IMC Charter which includes the prescribed Delegated Authority Matrix.

UniSuper's Member Services Committee, a sub-committee of the UniSuper Board, retains decision making authority for any disputed claim and maintains oversight of all declined claims in accordance with the Member Services Committee Charter.

# Document Control

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