MetLife

# Our claims philosophy

September 2026



# Claims at MetLife

When life takes an unexpected turn, we want you to know you're not facing it alone. We're here to guide you through your claim, make decisions as quickly as we can and pay all claims that meet the terms of your cover.

At MetLife, we're committed to making the claims process as straightforward and supportive as possible. Our digital claims process lets you track your claim at every stage. If the digital claims process isn't the right fit for you, let us know. We'll work with you to find a way to make the process accessible and manageable.

We'll always be upfront about what is and isn't covered, so you know what to expect before you claim and throughout the process. We assess every claim fairly and consistently against the terms of your cover, helping keep insurance fair, affordable and accessible for all customers.

## Our claims philosophy

When you make a claim, you can expect care, understanding and respect from the start. We'll guide you through each step with clear communication, fair decisions and practical support, so you can focus on your health, recovery and life beyond your claim.



### Integrity

We will treat you with honesty, respect, and compassion in every interaction.



### Transparency

We will keep you updated, so you know what to expect at every stage of your claim.



### Fairness

We will assess your claim fairly, be consistent and clear from start to finish.



### Timeliness

We will move your claim forward promptly with care and avoid unnecessary delays.



### Support

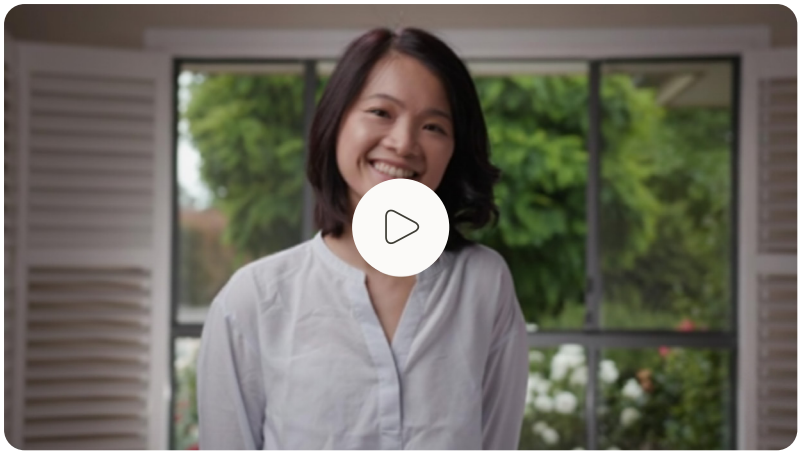
We will help support your health, recovery and wellbeing through 360Health services.

# Meet our claims teams

If you need to make a claim, you'll have a dedicated Case Manager to guide you from start to finish. They're specially trained, including in mental health claims and complex medical conditions, and are supported by a team of experts, including medical professionals. They'll keep you updated and be there when you need support, so you have someone who understands your situation and can guide you through the process.

Here's what that support looked like for one customer during their breast cancer claim.

Mrs M's story



## When you need extra assistance or support

At MetLife, we understand that everyone's situation is different. You may be dealing with one challenge or several at once, such as a physical or mental health condition, financial stress, family violence, language barriers, cultural considerations or accessibility needs.

If you need extra support during a claim, we're here to help. You can let us know at any stage if there's a better way for us to support you. We'll take the time to understand what works best for you and adjust our approach, so the process feels manageable and respectful. This might include changing how we communicate, how we ask for information, or the pace of the process, while keeping your claim moving forward safely and smoothly.

Our team is trained to recognise when someone may need additional support and to respond with care and understanding. We support people from all backgrounds, including culturally and linguistically diverse communities, Aboriginal and Torres Strait Islander peoples, and anyone who may find health information difficult to navigate. Interpreter services are available, and we can also support customers with accessibility needs, such as vision impairment.

If you're experiencing mental health challenges, please know our Case Managers approach every interaction with sensitivity and care. We understand the claims process can feel unfamiliar, and we aim to make it clear, supportive and manageable.

If you need support, contact us on 1300 555 625 or auservices@metlife.com.
You can also visit Claims support and resources for additional support options.

# Guiding your recovery journey

We know recovery looks different for everyone, and our experienced rehabilitation practitioners are here to help.

If you have MetLife cover and need to take time away from work, or are on claim due to illness or injury, you can access support from a dedicated Recovery Specialist who can help you understand and manage your situation through 360Health Recovery Support.



"I've learnt so much about managing my condition, my go to behaviours and thoughts and how to get the most of my day including rest, play, rehab, recover, work and social time. I'm so thankful for my support from beyond pain, the difference this help has made in my life is immense."

Beyond Pain Customer Feedback, January 2026

## Supporting your return to work

If you're receiving income protection benefit payments and returning to work becomes a realistic option, we're here to support you, guided by your medical advice and healthcare team.

If a gradual or supported return to work is right for you, we'll work with you, your healthcare team and, where needed, your employer to find an approach that feels realistic and sustainable.

## Caring for your lifestyle and wellbeing

If you're recovering from an injury or illness, MetLife 360Health gives you access to expert support to help you look after your health and wellbeing. From medical advice to mental health, nutrition and recovery support, these services are there when you need them, whether you're making a claim or not.

# When you make a claim

## How we will assess your claim

Every claim is different, so we consider your individual situation. To make a fair decision, we consider the information you provide alongside the terms of your cover and the definitions in the policy.

We also take the time to understand what you're going through. This may include information from you, your doctor or other treating health professionals, your employer, and sometimes independent medical or employment specialists. We review this information carefully so we can make a fair decision about whether your claim is covered under the terms of your cover. We have a responsibility to all our customers to only pay claims that are covered. This helps keep insurance fair, affordable and accessible.

When you lodge your claim, please share anything you think will help us assess it. Your Case Manager will let you know what we need to make a decision, and we'll only ask for information that is relevant to your claim. If we need any extra reports, information or assessments, we'll explain why in clear, simple language. We'll also review your claim for all benefits available under your cover.

## Our guide to claiming

We'll guide you through each step of the claims process, with clear information, fair decisions and human support along the way.

Understand each step of your claim

1

**Start your claim**

- Lodge your claim

2

**We assess your claim**

- We start to assess your claim
- Your Case Manager
- If we need more information
- Why some claims take longer
- If an independent assessment is needed

3

**Stay informed**

- How we'll keep you updated

4

**Your claim outcome and next steps**

- Your claim outcome
- Your payment
- Access 360Health

5

**For Income Protection claims**

- Regular progress check-ins during your claim
- Recovery Support after your claim is approved

**Follow the steps below to learn what happens at each stage of your claim, what information you may need to provide, and how we'll support you throughout the process.**

## 1. Start your claim



### Lodge your claim

When you start a claim, we'll ask for details to help us understand what happened and how your illness or injury affects your daily life and work. This may include information about your illness or injury, treatment, healthcare providers, employer and work history. You can use your own words and share what you know at the time.

## 2. We assess your claim



### We start to assess your claim

We'll review the information you give us, along with the terms of your cover. Every claim is different, so we'll take the time to understand your situation.



### Your Case Manager

Within **10 business days** of lodging your claim, your Case Manager will contact you to introduce themselves, explain their role and take you through what happens next.



### If we need more information

Sometimes we need more details before we can make a decision. This could come from you, your doctor, other health professionals, your employer or another relevant party. We'll explain what we need and only ask for information that is relevant to your claim.



### Why some claims take longer

Timing can vary, especially when we need information from others, such as a report from your doctor or details from another third party. If this happens, we'll keep you updated so you know how your claim is progressing.



### If an independent assessment is needed

We'll explain why an independent medical or employment assessment is needed, what's involved and what to expect. The type and number of assessments will depend on your circumstances and what's needed to fairly review your claim.

## 3. Stay informed



### How we'll keep you updated

While your claim is being assessed, there may be times when you don't hear from us, but we'll still be working through your claim. This can include reviewing documents, following up with others and checking when information is due back.

We'll contact you when there's an update, if we need more information from you, or at least every **20 business days**. If you have access to the **MetLife Insurance Portal**, you can log in anytime to check your claim progress.

## 4. Your claim outcome and next steps



### Your claim outcome

Once we have all the required information, we'll usually let you know the decision within **15 business days**.



### Your payment

If your claim is approved, we'll let you know how and when payment will be made. Your Case Manager will explain what to expect, including timing and any details about ongoing payments.



### Access 360Health

You and your family[1] can access 360Health services at no extra cost, including advice on mental health, nutrition, or fitness. Use these services to stay on top of your health, whether you're on claim or improving your wellbeing.

## 5. For Income Protection claims



### Regular progress check-ins during your claim

We'll check in to understand how your illness or injury is affecting your ability to work as your claim continues. Your Case Manager will take you through what updated medical and financial information we need, why we need it and what happens next. We do this so we can confirm you still meet the requirements for further payments.



### Recovery support after your claim is approved

You can use MetLife 360Health for Recovery Support, including help with pain, cancer support programs, sleep, and structured activity or exercise-based support. Your Case Manager will work with you to plan the right next steps for your recovery, including support to help you take practical steps towards returning to work.

1. The term 'family' consists of your children, partner, parents, and parents-in-law, and only includes those residing in Australia or New Zealand.

# Life Insurance Code of Practice

We follow the service standards set out in the Life Insurance Code of Practice (Code). The Code sets minimum standards for service, timeframes and complaints handling across the life insurance industry.

We aim to meet these standards and, wherever possible, go beyond them to provide a better experience for you.

# Your privacy matters

We know your personal information is important, and protecting it is a priority for us. When you make a claim, we collect, use and disclose your personal information only when needed to assess your claim. You can find more information in our Privacy Policy.

# When a claim may not be approved

We understand it can be disappointing to hear that your claim can't be paid, especially when you're already dealing with illness or injury. If this happens, we'll explain the reasons clearly and let you know what options are available if you'd like us to review the decision.

We're here to assess your claim fairly and pay claims that meet the terms of your cover as quickly as we can. At the same time, it's important to be upfront about the fact that not every claim can be paid.

For your claim to be paid, it needs to meet the terms and conditions of your cover. There are some situations where this may not happen. Understanding this before you make a claim can help set clear expectations and may reduce unnecessary delays.

Your claim may not be approved if:

- **The claim doesn't meet the definition that applies to your cover**

  This means the circumstances of your claim don't meet the definition for that benefit in the policy.

- **An exclusion applies**

  This is a specific circumstance or cause where a benefit isn't payable, even when cover is otherwise in place. These are applied strictly in line with the policy wording and are commonly used to manage known or heightened risks. Examples include:

  - "Pre-existing condition exclusions."

    Where the illness, injury, or symptoms existed (or were present) before cover started, often within a defined look-back period.

  - "Cover ceased due to Protecting Your Super legislation."

    For example, where a superannuation account became inactive and insurance cover stopped.

  - "The person making a claim was not At Work or in Active Employment when cover commenced, recommenced, or increased."

    In simple terms, this usually means the person wasn't working their usual duties and hours, or was away from work due to illness or injury, at the time their cover began or changed.

- **There isn't enough information to support your claim**

  In some cases, there may not be enough medical or supporting information to complete a full assessment. When this happens, additional details may be requested to help us review the claim thoroughly and fairly.

If our assessment suggests your claim may not be able to be paid, we'll give you the opportunity to respond before we make a final decision. This is called procedural fairness.

If we need more information, there are gaps in what's available, or evidence from a medical professional, employer or another source could affect the outcome, we'll explain what we need or any concerns we have. We'll then give you the opportunity to provide further information of anything else you'd like us to consider.

# How to share your feedback or complaint

We want to get it right for you every time. That's why we have dedicated Quality Assurance and Customer Relations teams who regularly review feedback and look for ways to improve the service we provide.

We also regularly complete Quality Assurance reviews of claims decisions against our assessment standards to help make sure they're fair, consistent and well supported. We use what we learn to keep improving. This includes looking at decisions that are reviewed by the Australian Financial Complaints Authority (AFCA) or by a court, so we can strengthen the quality of our claims assessment.

If you make a complaint, we'll work to resolve it as quickly as possible and within the required timeframes. If it can't be resolved straight away, you can access both internal and external dispute resolution options so your complaint can be reviewed fairly and independently.

If you don't agree with a decision about your claim, we'll arrange a fair and transparent internal review. We can also help you access an independent external review, including through AFCA.

You can find information about our feedback and complaints process at metlife.com.au/support/make-a-complaint



# How we assess different types of claims

Your claim is about what's happening in your life, not just the information we need to assess it. We'll take the time to understand your situation and support you with honesty, respect and care. This guide explains what you can expect based on the type of claim you're making and how we'll assess it.

## What we consider across every type of claim

Whatever type of claim you're lodging, we'll be clear, fair and consistent in how we assess it. This means:

- We'll tell you early what information we need and why we need it.
- We'll only ask for information that is relevant to your claim.
- If we need an independent assessment, the type and number of assessments will be necessary and appropriate for your claim.
- We'll consider all available information before making a decision. We won't rely on just one piece of information.
- If there is conflicting information, for example between your treating doctor and an independent assessor, we'll look carefully at why the views differ. We'll consider the quality, relevance and reasoning behind each opinion in the context of your claim, rather than automatically favouring one source over another.
- If we're unable to approve your claim, we'll clearly explain which part of the definition has not been met and talk you through your review options.



## Income Protection

We assess your Income Protection claim using the disability definition in the policy. This may be a total disability or partial disability definition. In most cases, this means looking at whether you can do the duties of your usual job.

We look at what you're able to do day to day, not just your diagnosis. To understand this, we'll review medical reports from your treating health professionals, information from your employer about your role, and sometimes independent medical or work assessments if needed. We'll ask for financial information to calculate your benefit payment. We'll let you know which documents we need, which may include payslips, income statements, tax returns and employer records. We'll also ask for this information again, so we can confirm you still meet the requirements for further payments.

Your Income Protection benefit is based on several factors, including your earnings before your illness or injury, any other payments you receive and whether you're still unable to work. Payments continue while you meet the requirements of your cover, including while you're unable to work or returning to work in a reduced capacity.

If you're able to start returning to work, we'll support a gradual return that suits your situation. If you work fewer hours or in a reduced role, you may still be able to receive partial disability benefits, depending on your cover. Where appropriate, we can also provide support to help make your return to work safe, realistic and sustainable.

Check the terms of your cover to understand whether a waiting period applies and how it works. A waiting period is the time between when you stop working due to illness or injury and when a benefit payment can be made.



## Total and Permanent Disability (TPD)

TPD cover is designed to help reduce financial stress if a serious illness or injury means you're permanently unable to work again. The assessment for a TPD claim takes into account whether you're unlikely to return to work in a role that aligns with your education, training or experience. This includes what you can do now, as well as what work you may be able to do in the future, even in a part-time capacity or with reasonable retraining.

Depending on your cover, there may be other things we need to consider. This could include how your condition affects your ability to manage daily life, complete everyday tasks, or think clearly and make decisions.

Some types of cover also have specific requirements for certain conditions, including mental health conditions. We explain our process for Mental Health claims further in the document.

When we assess whether your condition means that you are unable to work again, we look at:

- What your condition is, how it affects you, and how it may change over time.
- Your current and past treatments, how they've helped, any future treatment planned, and whether there are other reasonable treatment options that may improve your condition.
- What you can manage now, and whether this may change in the future.
- Your education, training, and work experience, where this is relevant

We take care to understand your situation so we can make a fair decision. To do this, we work with you and your treating health professionals throughout the claims process. If we need more information, we may also work with independent medical examiners or other experts. This helps us gather the information we need, understand your situation more fully and decide whether your condition meets the TPD definition in the policy, including whether you're unlikely to return to work in the future.

Check the terms of your cover to understand whether a waiting period applies and how it works. A waiting period is the time between when you stop working due to illness or injury and when a benefit payment can be made.



## Life (Death) Insurance

We assess Life cover claims in line with the terms of the cover, taking into account the circumstances surrounding your loved one's passing. To help us review the claim, we'll need a certified copy of the death certificate and, in some cases, additional information. We'll explain what we need and do our best to make the process as straightforward as possible.



## Terminal Illness

We recognise the significant impact a terminal illness can have on you and the people close to you. We prioritise Terminal Illness claims and will approach your claim with care, explain what we need and keep you informed along the way.

If your Life cover includes a Terminal Illness benefit, we'll review your medical information carefully and promptly to understand whether you have been diagnosed with a terminal condition and meet the life expectancy requirement for your cover. The life expectancy requirement may be 12 or 24 months, depending on your cover.

To help us assess your claim, we'll ask for confirmation from the specialist caring for you. If needed, we may also arrange an independent medical assessment. This helps us understand your situation and assess whether your condition meets the Terminal Illness definition in the policy.

## Trauma Cover (Critical Illness)

When you make a Trauma claim, we assess it against the specific medical definitions applicable to the policy, including any requirements relating to timing or severity. These definitions apply to medical events such as a heart attack, stroke, cancer or another covered condition. To assess your claim, we'll need detailed medical information from your treating specialists.

We assess whether your diagnosis meets the relevant medical definition, based on the medical evidence provided. This may include test results, scans, specialist reports and other medical records.







# Mental health claims

We recognise that talking about your mental health and sharing personal information may not always be easy. Our Case Managers approach every conversation with care and respect. They understand the sensitive nature of mental health conditions and are trained to provide clear information and practical support throughout your claim.

## How we assess your mental health claim

When you make a mental health claim, we consider the type of claim you've made and the requirements that apply to your cover. As part of this review, we consider your diagnosis, the care you've received, your treatment history and how your condition affects your daily life.

The information we ask for will depend on your claim and the requirements of your cover. The sections below outline the types of evidence we'll typically need.

## How we assess mental health TPD claims, including the long-term impact of your condition

For mental health TPD claims, we consider how your condition affects your ability to work and manage daily life over time. Your symptoms and capacity may change depending on your treatment, support network, personal situation and environment. We take this into account when assessing whether your condition meets the TPD definition in the policy.

This includes considering whether your condition is likely to continue (permanence), and whether further treatment, support or recovery may improve your ability to work in the future.

Our decision is based on objective clinical evidence, not just your diagnosis. We look at your individual circumstances, how your health and treatment have changed, and the overall impact of your condition.

## The role of psychiatric evidence

To assess your mental health TPD claim, we generally need clinical evidence from your treating psychiatrist. This is because mental health conditions can be complex, and a specialist view helps us understand your diagnosis, treatment history and likely outlook in a fair and reasonable way.

What we need may vary depending on your cover, but we'll generally consider:

- ### Your diagnosis

  We may need your diagnosis to be confirmed by a psychiatrist using an accepted diagnostic framework, such as the Diagnostic and Statistical Manual of Mental Disorders (DSM).

- ### Your treatment history

  We look at the treatment you have received, how you have engaged with it, and whether it has been reasonable and evidence-based for your condition.

  We also understand that treatment is not always easy to access or continue. If there have been gaps in your treatment, for example because specialist services were not available, we will consider the reasons as part of the overall assessment.

- ### Your ongoing symptoms

  We will look for evidence that your symptoms have remained clinically significant despite appropriate treatment, rather than being resolved by it.

  If we need an independent assessment, the type and number of assessments will be reasonable for your claim.

## Assessing the long-term impact of your condition (Permanence)

The TPD definition in the policy explains how we assess whether your mental health condition means you're permanently unable to work again. The definition can vary depending on your cover.

When we assess a TPD claim, we look ahead, not just at where things are today. We consider the bigger picture, including medical evidence, how your condition affects daily function, and your ability to work.

For a mental health TPD claim, this may include:

- ### Your condition and outlook

  We look at your diagnosed condition, how it has changed over time, and whether improvement is likely. This is usually guided by your treating psychiatrist. In some cases, we may also ask for an independent medical opinion.

- ### Your treatment history

  We consider the treatment and support you've had, how long you've been receiving it, and whether specialist care has been involved.

  We also look at whether your symptoms have continued despite treatment, and whether there are still reasonable treatment options that may help improve your condition.

- ### Your ability to work

  If the definition that applies to your cover requires us to assess your ability to work, we look at whether you can do work that reasonably aligns with your education, training or experience.

  This includes your current work capacity, as well as whether your ability to work may improve in the future. Medical evidence and work-related evidence can both help us make this assessment.

  We recognise that providing detailed information about your condition, treatment and ability to work can take time and effort, particularly when you're managing a mental health condition. We'll explain what we need and why, consider all the available evidence carefully and make a decision based on the definition in the policy.

# Claims governance and commitments

## MetLife's commitments to RSE licensees

MetLife recognises the important role that super fund trustees (RSE licensees) play in group insurance arrangements and is committed to supporting trustees in meeting their own obligations to members.

## Governance reporting

MetLife monitors its performance against its published service levels and provides governance reporting to RSE licensees. This includes claims performance data and approval and decline rates by product and business line.

## Transparency of claims assessment

MetLife provides trustees with information about how claims are assessed against policy definitions through reporting, service agreements and other agreed documentation.

## How we make fair and consistent claims decisions

This Claims Philosophy is supported by MetLife's governance framework, including risk management, claims governance, incident management, breach assessment and a robust control framework.

This includes claims procedures, decision authorities and delegations, specialist referral arrangements, oversight and escalation panels, quality assurance programs, claims capability and training requirements, complaints and dispute resolution processes, and management and Board reporting.

These arrangements help us monitor the quality and consistency of our claims decisions, identify opportunities for improvement and meet our regulatory obligations.

This Claims Philosophy has been developed in line with APRA's expectations for group insurance arrangements, including LPG 270, and is supported by MetLife's governance, risk management and control frameworks.

## How this philosophy applies across business lines

This claims philosophy applies across MetLife's group and individual insurance arrangements, including legacy claims.

Where MetLife no longer provides ongoing group insurance for an RSE licensee but retains obligations under past insurance arrangements, MetLife manages those legacy claims consistently with the principles in this claims philosophy and the terms of the relevant policy.

## Case law and regulatory monitoring

MetLife's claims and legal teams monitor developments in case law and regulatory guidance that affect claims assessment and interpretations of policy definitions - including decisions of AFCA and courts. We update this Claims Philosophy and our assessment processes to reflect these developments.

## Trustee-Insurer Dispute Resolution

Where MetLife and an RSE licensee disagree regarding a claims assessment, MetLife is committed to resolving that disagreement through a transparent and timely process. This includes initial escalation to senior claims management and where the disagreement is not resolved at that level a joint review process involving senior representatives of both MetLife and the RSE licensee will occur. Specific arrangements are set out in the relevant group insurance policy or service agreement.

## Board oversight

MetLife's Board reviews and approves this Claims Philosophy. We review it regularly to make sure it reflects regulatory developments, APRA guidance, case law and industry practice.

**metlife.com.au**

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