Welcome to the Financial Services Bulletin (FSB), August 2017

This edition of the FSB is packed with industry news and a swag of recent cases which we hope you will find useful and interesting.

In 'What's Happening Here and Now', we are delighted to tell you about recent promotions in our Financial Services team. You can also arrange to have some quality 'face time' with our experts at our next 'Life Matters' seminars in Sydney, Melbourne and Brisbane, the dates for which have just been announced! To register, please click here.

Last but not least, the 2017 ALUCA TurksLegal Scholarship is open and ALUCA members are encouraged to enter for a chance to win an overseas conference package valued at up to AU$8,000! Applications close on Sunday, 10 September so make sure you head over to our website for all of the details.

We hope you enjoy this edition of the FSB!

INSURANCE ▪ COMMERCIAL ▪ BANKING

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CONTACT US

John Myatt
Practice Group Head
T: 02 8257 5740
Email John

Alph Edwards
Partner
T: 02 8257 5703
Email Alph

Fiona Hanlon
Partner
T: 07 3212 6703
Email Fiona

Michael Iacuzzi
Partner
T: 02 8257 5769
Email Michael

Sandra Nicola
Partner
T: 02 8257 5752
Email Sandra

Lisa Norris
Partner
T: 02 8257 5764
Email Lisa

Darryl Pereira
Partner
T: 02 8257 5718
Email Darryl

Peter Riddell
Partner
T: 03 8600 5005
Email Peter

Peter Murray
Partner
T: 03 8600 5031
Email Peter

Ros Wicks
Special Counsel
T: 02 8257 5779
Email Ros

INSURANCE ▪ COMMERCIAL ▪ BANKING

WHAT'S HAPPENING HERE AND NOW

NEW APPOINTMENTS

TurksLegal is pleased to announce the following appointments effective 1 July 2017:

Peter Murray
Partner,
Financial Services
(Melbourne)

Max Hardy,
Senior Associate,
Financial Services
(Brisbane)

These promotions are an expression of the continued progress of our firm and are well-deserved recognition of each individual's skills, hard work and dedication to our clients.

We are absolutely delighted to welcome and support these talented individuals as they advance to the next stage of their careers as senior members of our team.

SPRING 'LIFE MATTERS' SEMINARS

The next in our 'Life Matters' seminar series will take place in **Sydney on 7 September**, **Melbourne on 21 September and Brisbane on 28 September 2017.** You can register below for the Sydney, Melbourne and Brisbane seminars.

TurksLegal's 'Life Matters' seminar series is designed to give our clients a more in-depth opportunity to explore recent developments in life insurance and financial services with our experts.

Topic 1: TPD: Events subsequent to the Date of Assessment. How should they be viewed?

Invariably life insurers are assessing TPD claims many years after the notional Date of Assessment (DOA) has come and gone. How does one deal with events such as returns to work and deterioration in symptoms, after the DOA? Our presenters will share their thoughts on how to make sense of the case law and provide a working template on how to tackle this issue going forward.

Topic 2: Recent developments in anti-discrimination: a life insurance perspective

Changes to the AD legislative framework may now expose some group coverage decisions to potential challenges under those acts. Additionally, the evidence needed to support the life insurers' legislative carve outs to discriminatory behaviour remain under the spotlight. Our presenters explore the latest challenges facing life insurers navigating the AD landscape.

SYDNEY SEMINAR

Date	**Thurs, 7 September 2017**
Time	12.45pm light lunch / registration 1pm - 2pm seminar
Venue	TurksLegal Level 44, 2 Park St, Sydney
Cost	Free
RSVP	4 September 2017

SOLD OUT

Please note places are limited.

MELBOURNE SEMINAR

Date	**Thurs, 21 September 2017**
Time	12.45pm light lunch / registration 1pm - 2pm seminar
Venue	TurksLegal The Rialto Towers, Level 8, South Tower, 525 Collins St, Melbourne
Cost	Free
RSVP	18 September 2017

REGISTER FOR **MELBOURNE**

Please note places are limited.

BRISBANE SEMINAR

Date	**Thurs, 28 September 2017**
Time	12.45pm light lunch / registration 1pm - 2pm seminar
Venue	Sofitel 249 Turbot St, Brisbane
Cost	Free
RSVP	25 September 2017

REGISTER FOR **BRISBANE**

Please note places are limited.

CASES AND TRIBUNAL DECISIONS

Court of Appeal rules on TPD cover cessation

MLC Nominees Pty Ltd v Daffy [2017] VSCA 110

Link to decision

The Supreme Court of Victoria – Court of Appeal has reversed the lower court decision of *Daffy* (VSC), finding for the life insurer. The judgment is highly relevant for determining when the insured TPD event has occurred under what might be termed, a standard TPD insuring clause.

Background

The contest in *Daffy* was whether the insured's TPD claim fell to be determined under a standard 'any occupation' definition or the harder to meet 'activities of daily living' (ADL) definition. The life insurer's group policy in this instance shifted an insured from 'any occupation' TPD definition to an ADL one when their working situation altered.

In this particular case, the trigger for the switch was the insured ceasing to be an employee of a Participating Employer. In that instance, they switched 'schedules'.

The 'any occupation' clause contained a fairly standard 6 month qualification period and then the formation of the opinion as to permanent incapacity for ETE work.

The contest came to be determined, in essence, by when the insured TPD event occurred. That is, was it before or after the insured coverage had switched to the ADL cover, it being accepted that the insured could not meet the ADL definition (but he could meet the 'any occupation' definition).

In what was primarily a construction argument, the lower court found that the 'any occupation cover' responded to the claim. It did so on the basis that whilst it found that the insured had moved to the ADL cover, by this stage, his entitlement to the 'any occupation' TPD benefit had already accrued.

In essence the lower court found the legal right had accrued when the underlying injury occurred.

Court of Appeal – Reversal of the Decision

The Court of Appeal said the case 'involves a pure question of construction' and approached the issues in a distinctly black letter way. Specifically it emphasised that it could not 'attribute different meaning to the words of a policy simply because the court regards the meaning as otherwise working a hardship on one of the parties'.

Approaching the matter in this way, the Court found that the 'any occupation' TPD benefit could not have accrued before the transfer to the ADL schedule because the essential element of the 'any occupation' TPD benefit, being the 6 months qualifying period, had not been met. It said:

> *On any view of the facts, the 'six consecutive months' period referred to in paragraph (b) had not elapsed (or occurred) prior to the termination of Mr Daffy's employment. On the judge's findings, that period did not commence until sometime after the termination of Mr Daffy's employment. Moreover, and in any event, on Mr Daffy's notice of contention, only four days of the requisite six month period had elapsed at the time of his termination.*

The Court noted that this construction placed an extra burden on the insured in satisfying the harder ADL definition but:

> *That, however, is not a sufficient basis upon which one might torture the language of cl 27.1 of the policy so as to hold that in a particular case of injury, a TPD benefit that might subsequently be payable (and paid) under the policy is an accrued benefit at the time of injury, and no matter what part any such injury might ultimately be found to play in any subsequently determined disability. That would deny the requirement in the First Schedule and the Sixth Schedule that the member had been absent from an occupation for six consecutive months. While Mr Daffy pointed to ways in which that requirement could easily work unfairness, it cannot simply be ignored.*

Implications

Determining the date an insured TPD event occurs is often a critical question facing life insurers particularly in the context of claims straddling cover lapses and the switch from 'any occupation' to ADL cover.

Here the lower court, seemingly determined to reach a final result that the more generous 'any occupation' cover applied, 'tortured' the language of the policy to arrive at that result and in effect found that the insured TPD event occurred or accrued when the underlying injury happened. In doing this, clearly it overstepped the mark although its findings in this regard were not dissimilar to the findings of the NSW SC in *Harrison* which decision has not been disturbed.

One should be careful in drawing too much out of this judgment in which the Court was at pains to point out, it was dealing with the construction of a particular policy. Having said that, the judgment clearly supports the proposition that the relevant 6 months qualification period (in TPD definitions similar to the present) must at least commence before the cover ends or switches – in this case the qualification period started after the cover had already switched.

Moreover, it is likely that the case goes somewhat further than this and supports the proposition that the 6 months qualification period must be wholly complete before the cover ends or switches, for the TPD event to have occurred.

Some may say that this latter proposition diverges from the view of the High Court in *Finch* although it should be noted that the Court of Appeal referred to *Finch* in the judgment and seemingly did not feel that it was contradicting this decision. Additionally, the Court of Appeal noted the possible unfairness that could result from this construction (the same unfairness that the High Court noted in *Finch*) but was not swayed by this.

CASES AND TRIBUNAL DECISIONS

Return to Sender – court refers trustees decision back

Gomez v Board of Trustees of the State Public Superannuation Scheme [2017] QSC 98

Link to decision

Background

Mr Gomez was working as an intensive care nurse for Queensland Health when he injured his right shoulder and subsequently developed anxiety and depressed mood. In the context of a workers compensation claim he was provided with light duties, however he suffered a further injury to his shoulder. He continued to work in a restricted capacity until April 2013. In August 2013 he accepted a voluntary redundancy offered by Queensland Health.

He made a claim for a total and permanent disability (TPD) benefit pursuant to the terms of the State Public Superannuation Scheme. The scheme is administered by a Board of Trustees (**the Board**) in accordance with the relevant legislation and the *Superannuation (State Public Sector) Deed 1990* (**the Deed**).

Decisions

Mr Gomez's claim for a TPD benefit was determined by the Board and declined by letter of 9 January 2013 (the **first decision**).

He sought a review of that determination and provided both submissions and new material for consideration. That material was considered and the claim was declined on review (the **second decision**).

He sought a further review and again provided additional material for further consideration. A senior Board delegate determined after a review of the additional material that it did not indicate a reasonable possibility of a different result to the Board's second decision, and accordingly affirmed the refusal to pay the TPD benefit (the **third decision**).

Issues

The issues in the proceedings were firstly, whether it was reasonably open to the Board to find that Mr Gomez was not TPD (the first and second decisions) and secondly, whether the Board had failed to properly reconsider the plaintiff's request for TPD benefits (the third decision).

Findings

It was put to his Honour Justice Boddice that all 3 decisions should be considered by him. He found that as the first decision became of no practical effect once the second decision was made, there was no utility in determining whether the first decision was properly made.

Having moved to the second decision his Honour noted that the Courts' power is not a general merits based review stating:

> "if, on a consideration of the evidence as a whole, the second decision was a decision that defendant could properly make in good faith as a real and genuine consideration of the exercise of power, it is not open to successful challenge."

He noted that it is open to a court to set aside a decision if it is satisfied that the decision:

1. was not made in good faith; or
2. was not made on a real and genuine consideration of the material before it; or
3. was not made in accordance with the purpose for which the power to make the decision was conferred.

He went on to state that such "a conclusion maybe inferred by a court if satisfied the trustee has come to a conclusion no reasonable person could have come to on the evidence before it or that a real and genuine consideration of the issue required properly informed consideration by the making of relevant inquiries about giving attention to natural justice requirements. "

His Honour then considered the medical and other evidence to determine whether the second decision was sustainable by reference to the particular TPD definition in the Deed.

Having cited with approval from *Jones v United Super Pty Ltd*[1] that "the identification of some skills acquired or developed in one occupation, which may be applied in another , does not necessarily mean that the worker is fitted by experience for the second occupation"; he nevertheless found in the context of this TPD definition that limitations such as the plaintiff not having previously undertaken specific duties in the alternative occupations suggested did not mean they were occupations that he could not undertake, having regard to his education training or experience.

It was submitted that the Board should not have given weight to IME medical reports in preference to those of treating practitioners, nor preference to reports written following an examination of other reports and clinical notes rather than following examination of Mr Gomez.

His Honour held that the challenge to the second decision amounted to no more than an assertion that a different decision was open on the evidence. He concluded that this was not a sufficient basis to set aside the decision as the Board had made a reasoned choice between competing bodies of medical evidence, in accordance with its obligations and duties. Where a reasoned choice has been made, it is not proper for a Court to interfere.

He concluded that the second decision was a decision reasonably open to the Board exercising its powers in good faith and having real and genuine consideration to the claim in accordance with its duties and obligations under the Deed.

In respect of the third decision, his Honour cited with approval the obligations of a trustee in respect of a request for reconsideration as enunciated in *Gilberg v Maritime Super Pty Ltd*[2]:

1. it is relevant for trustee to take into account the trouble and expense to the trust involved in obtaining medical reports;
2. if the trustee did not consider that the material provided in support of the new application indicated a reasonable possibility of a different result by reason of circumstances occurring since the previous application or by reason of evidence not recently available at the time of the previous application, it would be appropriate for the trustee to decline to obtain further reports; and
3. if the trustee considered that the materials provided in support of the new application did reasonably indicate a possibility of a different result, by reason of circumstances post the application, or by reason of evidence not reasonably available at the time of the previous application, and that, having regard to the interests of the application and the interests of other members, that possibility justified the expense

> of appointing medical practitioners to make further report, then it would be appropriate for the trustee to take that course.

Considering the further material before the Board in the context of these obligations, his Honour found that the new material provided with the request for a further re-consideration was material which addressed matters which had not been specifically considered previously and that the Board breached its duty by failing to properly consider the application made to it and referred the claim back to the Board to reconsider, stating that:

> "Whilst there remains in any in that event, a discretion to decline to make an order that the Trustee probably consider the application, the material place before the defendant was of such a nature that it cannot be concluded there is no reasonable possibility that the defendant, acting reasonably will accede to the plaintiff's application in the event of the reconsideration. It is not appropriate to exercise the discretion to decline the order in those circumstances."

Implications

This decision serves as a timely reminder that the things a court will have regard to in determining whether the determination of a trustee has miscarried are not necessarily the same as these of an insurer though they may be similar in some circumstances.

However, a court will be reluctant to substitute its decision for that of a trustee where its determination has miscarried. The court must be satisfied that there is no reasonable prospect of the trustee properly engaging in the task required before the court would step in and exercise its discretion to make the determination instead of for the trustee.

The judgment also demonstrates that the Queensland courts continue to grapple with the lower court determination in the matter of *Jones v United Super Pty Ltd*. While Justice Boddice did not ultimately make a finding that the plaintiff was not reasonably qualified to occupations he had not previously engaged in, the factual circumstances were very limited and the occupations referred to were all nursing occupations though in areas in which the plaintiff had not had specific employment.

[1](2016) NSWSC 1551

[2](2009) NSWCA 325 at [25]-[28]

CASES AND TRIBUNAL DECISIONS

Court grants relief to insurer seeking access to overseas medical records

Yabsley v MLC Limited [2017] NSWSC 832

Link to decision

Background

The insured, Mr Yabsley, claimed a critical illness benefit from the insurer on the basis of major brain injury following eye surgery in Jeddah, Saudi Arabia. He allegedly suffered from cognitive impairment and dysfunction commonly known as 'cotton wool-head.'

In December 2011 the Mr Yabsley wrote to the surgeon responsible for conducting the 2010 eye surgery to request information that might explain the brain injury, the subject of his claim. In response to his request he received a number of medical reports which provided limited information in relation to the surgery.

In the course of proceedings brought by Mr Yabsley in respect of the claim, the insurer's solicitors wrote to Mr Yabsley's solicitors to request a signed authority to enable them to obtain Mr Yabsley's medical records from the Jeddah Hospital. The Yabsley's solicitors did not respond to this request, or to any subsequent reminders.

The insurer's solicitors, who had offices in Saudi Arabia, then proposed that Mr Yabsley grant power of attorney to their Saudi Arabian office, in order to request the hospital records. This proposal was rejected by Yabsley's solicitors.

Decision

The insurer applied for an order of the Court requiring Mr Yabsley to execute Power of Attorney to the solicitors at their Saudi Arabian office, to enable them to obtain the medical records in question.

Mr Yabsley submitted that the insurer should first have demonstrated that the records existed and were relevant to the issues in the proceeding. They also argued that the insurer was first required to establish that a subpoena was not a viable option in the circumstances.

Both arguments were rejected by the Court. In giving its reasons, the Court referred to the test applied in granting the issue of a subpoena in Australia, which it confirmed to be a broad test and not subject to the above qualifications. It was also noted that when considering an application to grant issue of a subpoena in another country, a Court must take into account both the relevant international law and ensure that the issue of a subpoena would not be an affront to the laws of the proposed country. It confirmed that the Courts will also consider the utility of the issue of a subpoena and whether a more economical alternative was available.

In granting the order, the Court found the actions of Mr Yabsley's solicitors to be 'entirely unreasonable' in objecting to the proposal and necessitating the application at hand.

The Court noted that it was commonplace for a litigant to be asked to give authorisation for access to medical records and that it was expected that orders would ordinarily have been made by consent.

In reaching its decision the Court also queried Mr Yabsley's solicitor's reluctance to seek out the hospital records, confirming in the process the burden which falls on a plaintiff to prove their case and noting that the more information that a plaintiff has, the better placed they will be to legitimise their claim.

Implications

The case illustrates a situation in which a court is prepared to assist an insurer in gaining access to overseas medical records.

This process was approved by the Court in preference to granting leave to the insurer to issue an overseas subpoena and having to deal with the additional considerations of the law in the relevant overseas country.

The case also demonstrates that a number of factors should be taken into account when considering the issue of a subpoena to foreign entities. The courts will look not only at compliance with the laws of that country and any relevant international law, but the utility of the subpoena. It suggests that the courts are likely to favour an economical or easier option where available.

CASES AND TRIBUNAL DECISIONS

Game, Set and Match; Court Finds Reasonable Decision

Dotlic v Hannover Life Re of Australasia Limited [2017] NSWSC 986

Link to decision

Background

The Supreme Court of NSW recently delivered a judgment regarding the reasonableness of an insurer's decision in a TPD claim containing an 'opinion' clause (commonly referred to as the 'stage 1' enquiry).

Decision

The plaintiff, Mr Dotlic, claimed an entitlement to a Total and Permanent Disablement benefit as a result of suffering injuries in a motor vehicle accident in 2009. At the time of the accident, Mr Dotlic was performing heavy manual work as a formwork labourer.

The relevant TPD definition was:

> *1.3.1 the Insured Person is unable to follow their usual occupation by reason of accident or illness for six consecutive months and in our opinion, after consideration of medical evidence satisfactory to us, is unlikely ever to be able to engage in any Regular Remuneration Work for which the Insured Person is reasonably fitted by education, training or experience;*

After reviewing medical and other evidence, the insurer and the trustee found that Mr Dotlic was likely to return to lighter work within his education, training and experience and declined the TPD claim. Mr Dotlic commenced proceedings in the Supreme Court.

At the hearing, Justice Pembroke decided to limit the preliminary question to whether the decision to decline the TPD claim was reasonable. The scope of the separate determination question formulated by his Honour was:

> *"I order that there be determined separately and in advance of all other issues in the proceedings the following question, whether the opinion of the first defendant pursuant to cl 1.3.1 of the policy that in its opinion the plaintiff was not "unlikely ever to be able to engage in any regular remuneration work for which he is reasonably fitted by education, training or experience" should be vitiated."*

His Honour recited, with approval, the comments of *McLelland J in Edwards v Hunter Valley* (also followed in *TAL Life Ltd v Shuetrim*) that an insurer is obliged to act reasonably in considering and determining a claim. While noting that it is not the Court's task to "*substitute its own view for that of the insurer*" unless the decision taken by the insurer can be shown to be "*unreasonable*" on the material before the insurer, the decision cannot be attacked.

In relation to the concept of "reasonableness", his Honour had regard to the High Court's decisions in *Minister for Immigration & Citizenship v Li* and *House v The King*, which concerned the exercise of a discretion. These decisions provide that unreasonableness was "*a conclusion which may be applied to a decision which lacks an evident and intelligible justification*".

The plaintiff argued the insurer had not addressed the correct question, being whether Mr Dotlic, in the real world, was likely ever to obtain the identified roles in light of the plaintiff's limited English and his past education, training and experience.

His Honour had regard to the voluminous evidence relied on by the defendants in reaching their decisions. With respect to the evidence supportive of Mr Dotlic's claim, his Honour noted the inherent difficulty in relying on a claimant's general practitioner's opinion, as treating doctors generally "*accept the patient's account, questioning neither its truthfulness nor its completeness*".

His Honour found the overwhelming weight of the evidence (both medical and otherwise) was supportive of the decision that Mr Dotlic was likely to return to regular remuneration work within his education, training and experience. In relation to the "real world" arguments made by Mr Dotlic, his Honour found that there was no requirement for the insurer to act as an employment agency and find a particular employer willing to take on Mr Dotlic. It was reasonable for the insurer to base its opinion on the "*considered professional advice of experienced vocational assessors*". The vocational evidence identified the appropriate vocational options taking into account Mr Dotlic's restrictions. The roles identified in the vocational evidence were "*the type of jobs that are frequently available in countless workplaces across a range of industries*". There was no need for the insurer to question the conclusions reached in the vocational evidence.

His Honour found that the insurer acted reasonably in forming its opinion and answered the separate question in favour of the defendants. The proceedings were dismissed and the plaintiff was ordered to pay the defendants' costs.

Implications

This decision is an important case regarding the 'stage 1' enquiry, as it provides guidance on the meaning of a "reasonable decision". Other cases have considered the concept of reasonableness, without providing an explanation of what that term actually means. In this case, his Honour accepted the arguments that a reasonable decision is a decision which has an "*evident and intelligible justification*". The decision is a reminder that the task of the Court is not to decide whether it would have reached a different decision. A court may not agree with a decision but should not disturb the decision if it is supported by evidence. The court is not required to embark on a merits review of the decision. His Honour also provided guidance on the level of analysis expected by an insurer when considering medical and vocational evidence.

RECENT FOS DECISIONS

FOS finds PEC exclusion reasonable and not in breach of *Disability Discrimination Act* (Cth)

Link to determination

Facts

The Applicant held a loan protection insurance policy with the financial services provider (FSP). The Applicant lodged a claim for total disability from work due to a neurological condition.

The medical evidence demonstrated that the Applicant had been diagnosed with the neurological condition of dystonia and psychological condition of conversion disorder. Significantly, she received treatment for dystonia in the 6 months prior to policy inception.

The FSP denied the claim relying on an exclusion which provided that the FSP would not pay claims which are directly or indirectly caused by any injury or illness for which advice or treatment has been received from a registered medical practitioner or health professional within the 6 months prior to commencement of the period of insurance (PEC exclusion).

The Applicant disputed the decision on the basis that she was fully fit and well at the time she took out the policy of insurance and that the PEC exclusion was unlawful discrimination under the *Disability Discrimination Act 1992* (the DD Act).

Held

The FOS found that the FSP had established the Applicant received treatment for dystonia in the 6 months prior to policy inception and that dystonia was therefore excluded by the PEC exclusion. FOS considered that even if the relevant illness was identified in the alternative as conversion disorder, then the evidence still reasonably supports the conclusion that the condition was present within the relevant 6 months. The FOS explained this against the background of prior diagnosis of that condition and that the symptoms of both conditions are essentially the same.

The FOS also determined that whilst the PEC exclusion did discriminate against those people with pre-existing illnesses, this was reasonable having regard to section 46(2) of the DD Act. In reaching this conclusion, the FOS considered that the PEC exclusion was a commercial and underwriting decision for the FSP; the Applicant would likely have found, had she been so inclined to investigate other insurance options, corresponding exclusions in other policies; and the Applicant should reasonably have been aware of the exclusion in the policy at policy inception.

RECENT SCT DECISIONS

SCT finds insured cannot rely on misrepresentation of financial planner

Link to determination

Facts

The Complainant obtained group plan insurance through his employer. He subsequently voluntarily ceased work and was automatically transferred to the personal division of the plan. Some weeks later the Complainant suffered an injury and made a claim for temporary salary continuance (TSC) benefits.

The decisions under review were that of the Insurer to:

1. deny the Complainant's claim for TSC benefits pursuant to the policy and
2. deny it misrepresented the relevant policy terms.

The decisions of the trustee were also under review insofar as the Trustee affirmed the decisions of the insurer.

It was not in dispute that the Complainant was not working when he suffered his injury. Rather, the Complainant's position was that he attended a presentation of a financial planner and elected his insurance cover based on representations made in the slideshow that the insurance provided TSC cover "not… just at work".

He also asserted that he was not notified of the requirement to be engaged in work in order to succeed in a claim prior to purchase of the TSC product. It was consequently his submission that the insurer should not be allowed to rely on the "active service" or "engaged in work" qualifier of the "Totally Disabled" definition and deny his claim.

The trustee and Insurer's position was that the Complainant was not working at the time of injury and so could not satisfy the policy definition of "Totally Disabled".

The trustee also made submissions that the Complainant was referred to the relevant policy information, in particular the "Total Disability" definition which requires the member to be working.

With respect to the claim of misrepresentation, the trustee asserted there was no relationship with the financial planner and similarly, the insurer stated that any representations made by the financial planner were not made by it.

Held

The Tribunal held that the insurer's decision to deny the claim on the basis that the Complainant was not working at the time he was injured was fair and reasonable in the circumstances.

With regard to the alleged misrepresentation of the financial planner, the Tribunal accepted that neither the insurer nor the trustee was responsible for the financial planner's conduct and that further, as the Complainant was provided with the relevant policy material, he would have been aware of the requirement that he be employed or working at the time of injury to qualify for the TSC benefits.

TURKSLEGAL Q&A

What constitutes 'Unexpected Circumstances' for the purposes of Part 8 of the Code of Practice

In this edition of TurksLegal Q&A, we respond to a client's question about the Life Insurance Code of Practice.

Q: What constitutes 'Unexpected Circumstances' in claims assessments covered by the Code of Practice?

A primary feature of the Code are promises around how quickly insurers will do things, including making decisions on claims. Failing to meet these promises on timeliness, including important claim milestones, may result in a breach of the Code.

A breach can be averted however, if 'Unexpected Circumstances' apply (see clause 8.14)

'Unexpected Circumstances' are defined in the definitions section of the Code and the definition should be studied closely to see if they apply. In a nutshell, the following represents 'Unexpected Circumstances'

- In aged claims (where the claim is lodged 12 months after the date of disability or the end of the waiting period) where there are 'reasonable delays obtaining necessary evidence'.
- In TPD claims, where the insurer cannot be reasonably satisfied in the 6 months after the end of the waiting period that TPD exists. In other words, where an insurer feels it needs to defer making a decision on TPD.
- When the insurer has not received material reasonably requested from an ISP, a treating doctor, government agency or other entity.
- The group policy owner (or policy owner) has taken a protracted period to consider the insurer's decision.
- The insured or his/her representative has not responded to reasonable enquiries or requests for information regarding the claim.
- There are difficulties communicating with the insured (beyond the insurer's control).
- The insured has requested a delay.
- The claim is fraudulent.

It can be seen that the broad approach to 'Unexpected Circumstances' are that delays in the claims process caused by the myriad of other parties (including the insured) whose cooperation is necessary to ensure the claim process is timely, will not be sheeted home to the insurer.

Some commentators pointing to the broad carve outs contained in Unexpected Circumstances, feel they render the Code timeline promises illusionary. This is not a fair assessment but you should take note that the definition of 'Unexpected Circumstances' is a Code hotspot that will attract regulatory commentary and attention. It would accordingly be prudent to view the definition through this lens.

Our advice is that when a Code claim deadline is looming, carefully consider the 'Unexpected Circumstances' definition and see whether your situation falls within the various categories, as falling within these carve outs, avert your company from lapsing into breach of the code.