INSURANCE ▪ COMMERCIAL ▪ BANKING

Welcome to the Financial Services Bulletin, April 2017

We are excited to release the final three parts of TurksLegal's *What the Life Insurance Code of Practice means for...* series which translates the key elements of the Financial Services Council's Life Insurance Code of Practice from the perspective of the insurer, and how it affects:

- Coverage, Complaints and Governance (Part 1);
- Claims (Part 2 released in December 2016);
- New Business and Underwriting (Part 3); and
- Sales, Marketing and Communications (Part 4).

These handy guides can be accessed using the links above and on the TurksLegal website.

As a reminder, the updated edition of TurksLegal's '*Life Guide*' was released in February. If your company is a TurksLegal client you can register for a copy of the Guide **here.** The updated Guide is available automatically to all clients who have previously registered.

Please read on for the latest industry news, important case law developments, a selection of FOS determinations and TurksLegal Q&A.

We hope you enjoy this edition of the FSB!

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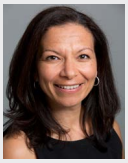

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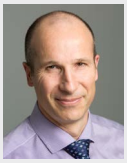

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INDUSTRY NEWS

Proposed design and distribution obligations

In December 2016, the Australian Government issued the *Design and Distribution Obligations and Product Intervention Power* Proposals Paper. The Government accepted the Financial System Inquiry recommendation to introduce design and distribution obligations on issuers and distributors of financial products and a product intervention power for ASIC. The Proposals Paper is in response to that recommendation.

The Proposal Paper outlines that issuers of financial products are expected to:

- identify appropriate target markets for products;
- select appropriate distribution channels for their identified target market; and
- review arrangements frequently to ensure arrangements continue to be appropriate.

In addition, distributors will be expected to put in place reasonable controls to ensure products are distributed in accordance with issuers' expectations and comply with reasonable requests for information related to product.

ASIC's product intervention power would apply to all financial products made available to retail clients.

It is proposed that ASIC could make interventions in relation to the product (or product feature) or the types of consumers that can access the product or the circumstances in which the consumer can access it. Examples of possible interventions include imposing additional disclosure obligations, mandating warning statements, restricting or banning the distribution of the product.

ASIC would only be able to use the intervention power if it identifies a risk of significant consumer detriment, undertakes appropriate consultation and has considered the use of alternative powers.

It is proposed that the obligations will apply to new products issued 6 months after the reforms receive Royal Assent. For products already available to consumers before Royal Assent, it is proposed that these products can continue to be offered to consumers for a period of 2 years before having to comply with the new obligations.

Feedback on the Governments' Proposal was required by 15 March 2017. The Government will consider responses in designing legislation giving effect to the measures. Depending on the outcome of this consultation process, it is expected that there will be consultation on draft legislation by mid-2017.

For life insurers, the reforms contemplated by the Proposals Paper may not create many additional obligations because the design and distribution obligations largely reflect obligations in the Life Insurance Code of Practice. For example, the "Policy design and disclosure" aspects of the Code of Practice.

CASES AND TRIBUNAL DECISIONS

Waiving goodbye to Legal Professional Privilege

The Queensland Local Government Superannuation Board v Lynda Allen [2016] QCA 325

Link to decision

Background

The plaintiff sought declarations that the decisions of a superannuation fund to decline her claim for total and permanent disability (TPD) benefits were void and that she was entitled to that benefit under the trust deed.

As part of disclosure the trustees' 'complaints log' was disclosed. That log revealed that legal advice had been sought as to whether, following a request for review, the board of trustees had to review, for a third time, it's decline determinations. It further revealed that the legal advice had been received and was to the effect that the decision should be further reviewed.

Another document disclosed and headed 'The Queensland Local Government Superannuation Claim Submission for Consideration by the Board' similarly revealed the seeking, receipt and conclusions contained in that legal advice.

The plaintiff solicitor sought disclosure of the actual legal advice claiming that legal professional privilege had been waived.

Notwithstanding that there was evidence, the legal advice described was only one of four discrete issues addressed in the letter and that the actual legal advice was not before the board when its decision on review was made, Smith DC JA found it was a document that was relevant to the proceedings and found that in the circumstances, the principles of fairness and inconsistency dictated a conclusion that legal professional privilege was impliedly waived.

Decision

The decision of the District Court was appealed to the Court of Appeal of Queensland. The Court of Appeal held that a reference in the disclosed complaint log to legal advice was not inconsistent with the maintenance of legal professional privilege. The onus of proving that legal professional privilege applied was on the trustee, but having done so, the onus of proving that there was a waiver of that privilege was on the applicant and she failed to discharge that onus.

The issue of joint privilege was raised for the first time at the appeal on the basis that as the trustee had fiduciary obligations with respect to the beneficiary of the fund, any privilege that attached to advice provided to the trustee was a joint privilege for the benefit of the beneficiary. This was unsuccessful as it was held that the legal advice that was obtained was obtained for the benefit of the trustees (and not jointly) as it was a legal advice sought in relation to the day to day administration of the trust.

Implications

As claims themselves become more complex and adversarial, the need for legal advice to manage those claims also increases. This case serves as a reminder that the legal professional privilege that attaches to that advice can, and increasingly will be, challenged. Courts will look not only to the content of the documents, but who saw the documents and for what purpose, in determining if the actions of the insurer or trustee are consistent with the maintenance of the confidential nature of the advice.

CASES AND TRIBUNAL DECISIONS

The Contract of Insurance: a sum of many parts

Montclare v MetLife Insurance Ltd [2016] VSCA 336

Link to decision

Background

In approximately 1993, the plaintiff, Mr Montclare met Mr Shilton while Mr Montclare was working as a male escort. The pair became friends and ultimately entered into a de facto relationship which lasted until Mr Shilton committed suicide in 2001.

In 1998, Mr Montclare applied to Citicorp (now MetLife) for insurance cover over the life of Mr Shilton in the sum of $300,000. This was granted through a Master Policy which named Rivkin DM as the Policy owner. In 1999, Mr Montclare increased that sum to $1.1million. Notably, the policy did not contain an exclusion for suicide.

Upon Mr Shilton's death, Mr Montclare claimed the $1.1million benefit.

The insurer refused payment of the claim and avoided the policy from inception on the basis that, by answering 'No' to a question which asked whether Mr Shilton had ever had a "mental or nervous disorder or breakdown" at the time of applying for cover, Mr Montclare and Mr Shilton had misrepresented or failed to disclose Mr Shilton's prior medical history which included treatment for mental illness.

The Supreme Court of Victoria ruled that Mr Montclare was an 'insured' within the meaning of the *Insurance Contracts Act 1984* (Cth) (the ICA) and was therefore subject to the obligations imposed by the ICA. The court ruled that Mr Shilton's and/or Mr Montclare's false answers were plainly misrepresentations, and were able to be sheeted back to Mr Montclare, as the insured, pursuant to section 25 of the ICA. The court ruled that the misrepresentations were fraudulent and upheld the insurer's avoidance of the policy.

Mr Montclare successfully applied for leave to appeal the decision.

The Appeal

The ICA in force at the relevant time did not impose obligations of disclosure or penalties for making misrepresentations upon third party beneficiaries of life insurance policies. Montclare was only subject to the relevant obligations and penalties if he himself was an 'insured' as a party to the contract.

Mr Montclare appealed on the basis that the trial judge had erred in finding that he was 'an insured' within the meaning of the ICA. Mr Montclare did not however, dispute that a fraudulent misrepresentation had been made.

MetLife submitted that Mr Montclare was an 'insured' within the meaning of the ICA and therefore, subject to the obligations under the ICA.

The Court of Appeal found that while the contract of insurance was made up of a 'suite of documents', there was a direct contractual relationship between MetLife and Montclare and that Mr Montclare was an 'insured' within the meaning of the ICA. The Court confirmed that MetLife was entitled to avoid the contract by reason of Montclare's undisputed fraudulent misrepresentation.

First Instance Decision

Mr Montclare gave evidence that he and Mr Shilton completed an application for insurance, which was advertised as being 'arranged by Rivkin Direct Management Pty Ltd… under a Master Policy with Citicorp Life insurance.'

The 'Master Policy' nominated Rivkin DM as the 'Policy Owner'. Mr Montclare submitted that this demonstrated that the contractual relationship was between Rivkin DM and Citicorp; not between Citicorp and himself.

In contrast, MetLife relied upon the information brochure provided to Mr Montclare, the wording of which strongly indicated that the applicant for life insurance (Mr Montclare) was the 'owner' of the insurance and not the agent. MetLife argued that this was evidence of an intention to create a direct relationship between Citicorp and Mr Montclare.

The court considered that in this sense, the Master Policy and information brochure were inconsistent.

Having accepted the risk, Citicorp (via Rivkin as its agent) issued to Mr Montclare a certificate of insurance. The trial judge ruled that this document constituted the first contract of insurance between Citicorp and Mr Montclare.

The certificate provided that payment of any benefits would be to Rivkin as trustee (albeit there was evidence that in the usual course payments were made directly to claimants) and that Citicorp's liability under the insurance arrangement would cease in the event that the Master Policy was cancelled for any reason. This suggested that the insurance cover provided to Mr Montclare and the Master Policy were directly linked.

Having successfully applied for an increase of cover on 10 June 1999, Mr Montclare received a second certificate of insurance. The trial judge ruled that this certificate constituted the second contract of insurance between Citicorp and Mr Montclare.

The trial judge ruled that the insurance contract was comprised only of the first and second certificates of insurance.

Appeal Decision

The Court of Appeal rejected the trial judge' s view that the contract was constituted by the certificates alone and held that the contract of insurance did not have its source in a single document. The contract did not wholly reside in the 'Master Policy' as Mr Montclare had submitted and nor did it reside wholly in the certificates of insurance, as MetLife had submitted. The contract was made up of a suite of numerous documents, including the 'Master Policy' between MetLife and Rivkin, the individual certificates of insurance in Mr Montclare's own name and indeed the information brochure provided to Mr Montclare prior to his original application for cover.

The court found that there were sufficient connections between the application forms completed by Mr Montclare and the Master Policy to conclude that the application by Mr Montclare was an application for insurance under the Master Policy. The most significant link between the Master Policy and the certificates was the fact that payment of a death benefit (which was the ultimate purpose for which Mr Montclare had obtained the insurance) pursuant to the terms of the certificates resulted in a discharge of Citicorp's obligations under the Master Policy. Furthermore, the fact that cancellation of the Master Policy for any reason would result in a termination of the insurance also indicated that the certificates did not 'stand on their own' but had a legal operation which was affected by the existence of the Master Policy.

It was held that there was a direct contractual relationship between Montclare and MetLife which was part of a tripartite agreement between MetLife, Rivkin DM and Montclare as evidenced by the documents forming the contract.

As Montclare was in fact a party to the contract, he was 'the insured' and MetLife was entitled to avoid the contract by reason of his pre-contractual fraudulent misrepresentation, pursuant to section 29(2) of the ICA.

Implications

While we are of the view that the decision turned on a fairly unique (and complicated) set of facts, it is worth nothing that the ICA does not contain a definition of a 'contract of insurance'.

The case clearly demonstrates that the terms of a contract of insurance can be found in more than one document, even if those documents are partially inconsistent and highlights the need for insurers to maintain good record keeping practices to assist with the determination of rights and liabilities should disputes arise.

CASES AND TRIBUNAL DECISIONS

Fraud doesn't extinguish innocent beneficiary's claim

Australian Executor Trustee Ltd v Suncorp Life & Superannuation Ltd [2016] SADC 89

Link to decision

Background

On 17 March 2008, a house owned by Mr and Mrs Humby was destroyed by a fire after he deliberately lit the fire. Mr Humby was inside the house at the time of the fire and was killed.

Following the fire, Mrs Humby made a claim on a home and contents insurance Policy and Mr Humby's life insurance Policy that was held with the defendant.

The Claims

The home and contents insurer undertook an investigation into the cause of the fire, which revealed that the fire had been deliberately lit with the use of an accelerant. The investigation also revealed that most of the Humby's contents had been removed from the house prior to the fire, that Mrs Humby had purchased 5 litres of petrol the day before the fire and that the Humbys were under significant financial pressure with the bank in the process of repossessing their house.

Following the outcome of these investigations, Mrs Humby withdrew the home and contents claim, however she maintained the claim on Mr Humby's life insurance policy.

The defendant refused the life insurance claim on the basis that it had been made fraudulently and Mrs Humby had breached her duty of utmost good faith. Suncorp also argued that it was against public policy to allow a person who caused or conspired to cause the loss by wrongful means to obtain a benefit under the life insurance policy arising out of that wrongful act.

Mrs Humby died a year after making the claim and her estate sued the defendant for payment under the life insurance Policy.

Decision

The Court found that Mr and Mrs Humby were involved in a plan to burn down the house for the purposes of obtaining the benefit of the home and contents insurance Policy.

However, the Court did not find that the claim on the life insurance Policy had been made fraudulently as Mr Humby's death was an accident and it was not a part of any plan to obtain a benefit under the life insurance Policy. Further, Mrs Humby was not a party to the life insurance Policy and did not owe a duty of utmost good faith to the defendant.

The Court was not persuaded by the defendant's public policy defence and found that it was not against public policy to allow Mrs Humby's estate the benefit of the life insurance policy.

In making its decision, the Court noted the important role that life insurance plays in society and that the observation of these contracts of insurance are in the public interest.

Particular weight was given to the fact that the claim under the life insurance Policy was being made by the Humbys' children who were blameless in the fire and that

it was unlikely that by granting the life insurance claim it would encourage the commission of similar crimes. The Court did not speculate on what the outcome might have been if the claim had been made by Mrs Humby.

Whilst accepting that the public policy that lay behind the principle was to discourage the commission of crimes, His Honour Judge Stretton, in the District Court of South Australia said "*I do not consider however that in considering the totality of the circumstances, the factors of who makes and pursues the claim before the court, and for whom the ultimate benefit of the policy is sought to be secured, and against who the public policy shield is sought to be brandished, should be excluded from the totality of the circumstances to be considered by a court.*"

Implications

At first glance this decision seems to be at odds with community expectations, as it permits the family of a fraudster to benefit from the fraudulent act of a relative. However, it is in line with previous cases that establish that for the public policy ground to be made out there must have been an intention to commit a fraud on the policy in question.

In this case the fire was never intended by the Humbys to result in a claim being made on the life insurance policy held with Suncorp and the beneficiaries were not implicated in the fraud.

The case also shows the difficulty that insurers can face in mounting a public policy defence in support of a denial of a claim. The success of a public policy defence will depend largely on the particular circumstances of the claim, the nature of the insurance benefit being sought and the likelihood that a payment will encourage the commission of similar crimes.

We understand the decision is currently being appealed by the insurer.

RECENT FOS DECISIONS

PECs and Diagnosis

Link to determination

Facts

The Applicant had an income protection policy with the FSP. He made a claim under the policy due to suffering secondary osteoarthritis of the right ankle which was denied on the basis that symptoms of the condition had first become apparent before the policy commenced.

The FSP submitted that there was evidence that the Applicant had suffered ongoing ankle pain following a fracture to the right ankle in April 2013 and pointed to a link between the fracture, an operation to repair the ankle and the subsequent claimed condition of secondary osteoarthritis of the right ankle (the sickness). The Applicant argued that while he was suffering from ankle pain, he was not aware he was suffering from secondary osteoarthritis of the ankle before the inception of the policy and therefore the claimed condition was a sickness as defined in the Policy.

Held

The FOS considered that while the Applicant had been suffering from ankle pain before the inception of the policy, and there was a causal link between the Applicant's previous ankle injury and the sickness, the sickness did not become apparent until after he took out the policy. While tests revealed that the Applicant developed the sickness after the surgery, it could not establish when the sickness became apparent. The FOS took into consideration that it could take up to 12 months for the Applicant to recover from his ankle surgery, and he would most likely have believed that pain he was suffering was associated with the pain following surgery.

The FOS determined that the Applicant could rely on s47 of the Act as he could not have been expected to be aware that he was suffering from the sickness as ankle pain following surgery was not conclusive evidence that the pain was caused by the sickness. As a result, the FSP could not rely on an exclusion for pre-existing conditions in the circumstances of the dispute and the FSP was ordered to assess and pay the Applicant's claim.

Implications

1. A causal link between a person's sickness as defined in the policy and a previous injury is not relevant to whether a person's claimed condition is a sickness as defined in the policy.
2. While it is not necessary for a person to be aware of an actual diagnosis, there was must be evidence that a person's symptoms or medical testing were such that a person can be argued to be aware of the underlying condition subsequently diagnosed.

RECENT FOS DECISIONS

What was that Question?

Link to determination

Facts

The Applicant took out life and income protection policies with the financial services provider (FSP) and subsequently made a claim for income protection benefits (IP) following a reported disablement.

The FSP declined the claim and avoided the policies on the basis that the Applicant misrepresented his medical history in respect of a number of conditions and as a result it would not have issued the policies if it had known his true history.

One of the conditions the FSP considered the Applicant misrepresented was ulcertative colitis, a bowel disorder. Evidence of the FSP's underwriting practices shows IP cover would have ordinarily been refused where the Applicant had ulcerative colitis.

When applying for cover, the Applicant was asked 'Have you ever had symptoms of, been diagnosed with or treated for, or intended to seek medical advice for any of the following…hepatitis or any disorder of the liver, stomach, bowel, gallbladder or pancreas?' While there was no dispute that the Applicant previously had ulcerative colitis, the issue was that the Applicant answered 'no' before the relevant question was fully read out and the FSP's sales consultant (the consultant) did not repeat the question when he should have been aware that the Applicant answered prematurely.

Held

The FOS considered the recording of the relevant conversation between the sales consultant and the Applicant. The FOS ultimately determined that it was unclear if the Applicant actually heard 'bowel' or the rest of the question when asked, and it was inconclusive if he provided a response in respect of that part of the question. At minimum, the FOS considered that the parties should have been aware that the Applicant answered prematurely and said 'sorry' midway through the question which suggested he was aware the sales consultant was still speaking when he initially answered. Despite this, the sales consultant did not repeat the question.

As a result, the FOS determined that it was difficult to conclude the Applicant necessarily made a misrepresentation in the circumstances and noted that section 27 of the ICA did not consider a misrepresentation had been made just because a person failed to answer a question.

The FSP had declined the claim based on misrepresentations in respect of two other conditions but the FOS ultimately determined that the FSP was not entitled to refuse the claim and avoid the policies as it could not be shown that it would have refused the cover if the misrepresentations were not made.

Implications

The case highlights the importance that FSP sales consultants receive adequate training to ensure they clearly read out every question to a person applying for cover and should there be any indication that a question has not been fully heard, that they are trained to repeat the question irrespective of whether they have been asked to do so or not.

TURKSLEGAL Q&A

Terminal Illness – a Galaxy of Difference

In this edition of TurksLegal Q&A, we respond to the following client's question about terminal illness claims.

Q *Interested in your thoughts on terminal illness claims and if any judgments exist, as this is becoming an increasingly difficult battleground with claim numbers on the rise.*

A There are not a large number of cases dealing with terminal illness, but among them are two appellate level decisions, which means significant legal attention has been paid to some aspects of the benefit.

A good starting point, seeing both those cases came before the relevant appellate courts while the claimants were still alive - well after the twelve month survival period used in the respective policies - is that retrospective evidence of survival is not conclusive and in some respects may not even be relevant.

The first major decision was *Tower Australia Ltd v Farkas*[1] and the NSW Court of Appeal held that because it was impermissible to take into account things that were unknown at the date determined by the policy for assessment of the claim, the fact the plaintiff had survived was not relevant under the terms of that policy.

In the later of the two appellate decisions, *Galaxy Homes Pty Ltd. v The National Mutual Life Association of Australasia Limited*[2] the fact of the plaintiff's subsequent survival was only considered relevant to the limited extent that it showed one medical expert's opinion had been correct and hence that doctor's opinion ought to be preferred to those who had predicted the plaintiff's demise when weighing up the evidence.

Both cases demonstrate that the way the court approaches a dispute about a terminal illness benefit is to examine whether, at the time the insurer had to assess the claim, the expert medical evidence was sufficient to demonstrate the probability of death during the survival period with the required degree of certainty.

The time for assessing whether the illness is terminal can be spelled out expressly in the policy, but in *Farkas* it was not, and had to be inferred from the terms of the definition itself.

The policy defined terminal illness as "*an illness or condition which is highly likely to result in death within 12 months, where this assessment is confirmed by appropriate specialist medical practitioners approved by us*".

The Court consequently concluded that the entitlement to the benefit arose under the policy at the point when the insured suffered the relevant illness or condition.

This became a central issue in *Galaxy Homes* because the policy owner cancelled the policy only to discover shortly afterwards that the life insured was suffering advanced metastatic melanoma. The condition was diagnosed after the policy was cancelled but probably contracted while it was in force and the insurer refused the claim on multiple grounds, including the fact that the policy had ceased to be in force.

Whether the entitlement to the benefit arose while the policy was still current was a factual question that was determined by the Court with the benefit of expert medical evidence.

The next issue in both cases was whether at that point the expert medical evidence indicated with the required degree of certainty that death as a result of that condition would occur during the survival period.

The case law in relation to this issue indicates there is a clear hierarchy in the degree of certainty of the prospects of survival depending on the choice of policy wording. Each definition of terminal illness carries its own nuances and hence the result in one case is not always a predictor of the same outcome in another case. However, some general principles have emerged from these decisions.

Justice Bergin was the original trial judge in *Farkas*. In that case, the policy said the condition had to be "*highly likely to result in death within 12 months*" (emphasis mine).

Her Honour concluded that the word "likely" meant "a real and not remote chance". Coupled with the word "highly" it moved the likelihood of death, into the realms of probability, so the insurer would be obliged to pay the benefit when the medical evidence was sufficient to conclude that in all probability death will result in 12 months.

The Court of Appeal affirmed Her Honour's conclusions in *Farkas* and in *Galaxy Homes* the Full Court of the Supreme Court of South Australia poured cold water on the idea of expressing that reasoning in terms of percentages.

In *Galaxy Homes* the language of the definition was much more emphatic. Terminal illness relevantly meant "*any illness which, in our opinion, will result in the death of the person insured within 12 months, regardless of any treatment that might be undertaken. Our decision will be based on medical evidence provided to us by the person insured's doctor, and any other medical evidence that we may require.*" (emphasis mine).

The claimant's counsel argued that the degree of likelihood required by this definition was in fact much like that in *Farkas* and similar in intent to *McArthur v Mercantile Mutual Life Insurance Company Limited*[3] where the permanent disability definition was that the insured "was likely never to work again".

Counsel contended that the use of the word "will" in the definition was merely used as a matter of grammar to denote the future tense and submitted to the Full Court that it was not used as an aid to interpreting the degree of probability whether death would occur. If that was correct, in counsel's submission, that meant the insurer had to be in effect completely certain that the life insured would die within 12 months before the terminal illness would be payable.

In that case, counsel's argument continued, this was not a functioning commercial interpretation of the policy because the benefit would almost never be payable as no doctor would commit themselves to that degree of certainty.

The Full Court agreed that this was indeed the effect of the words but not that this was an impermissible commercial interpretation of the policy, citing among other things that the benefit was clearly provided as a "accelerated" death benefit and in other circumstances a claim would become payable when the life insured died.

The claimant in *Galaxy Homes* failed but the claimant in *Farkas* succeeded.

As is almost always the case, the product wording is crucial, and insurers are in a position to express their appetite for risk in the policy wordings they go to market with.

[1][2005] NSWCA 363. At first instance before Bergin J; *Farkas v Northcity Financial Services Pty Ltd & 3 Ors* [2004] NSWSC 206).

[2][2013] SASCFC 34 (3 May 2013)

[3][2002] 2 QLR 197